To the Editor: Let This Be the Last Call to Action to Train Residents in Addiction

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We strongly support the call to action in the perspective piece by Sokolski et al titled "It's Time to Train Residents in Addiction Medicine."[1] It highlights the many educational gaps that remain despite the high prevalence of substance use disorders (SUDs), the existing SUD treatment gap, and prior calls to integrate addiction medicine training into graduate medical education (GME). They rightfully highlight the need for faculty education to make meaningful progress toward SUD education in GME. To train residents in SUD effectively, faculty must be appropriately trained first.

While the authors provide helpful resources for faculty to learn more about this topic, faculty need protected time for SUD training. One study estimated that primary care clinicians would require a staggering 26.7 hours a day to provide guideline-based clinical care.[2] Clinical faculty are unlikely to spend additional time on self-directed learning about SUD without further incentives and support from institutions, accrediting bodies, and government agencies.

Institutions must prioritize SUD training for faculty beyond self-directed didactics. There is much to be learned from similar efforts to integrate new clinical content into residency training. Just like with SUD, learning point-of-care ultrasound (POCUS) requires balancing existing skills, current practice patterns, and local concerns.[3] To develop and integrate POCUS training into residency education, many faculty required experiential training to increase uptake.[4] Similar dedicated hands-on experiential learning can be achieved for SUD. Institutions lacking clinical SUD sites should prioritize partnering with local addiction clinics to provide these opportunities. Furthermore, institutions should hire and support addiction-trained faculty who can develop and provide train-the-trainer programs on this topic.

Accrediting bodies play a critical role in ensuring SUD competency among faculty training residents. While the Accreditation Council for Graduate Medical Education (ACGME) requires all residents to be trained in SUD, in a 2020 national survey of internal medicine program directors, only 15% reported their program was "very effective" in teaching opioid use disorder treatment.[5] This level of subpar training is unacceptable. Accrediting bodies must incentivize institutions to meet a higher SUD training standard. In our experience, having an institutional champion has been vital to improving SUD education. The ACGME could require every GME office to have a director of addiction curriculum.

We agree with the authors' call to the federal government to expand addiction fellowships and grant funding for SUD clinical care. This call should go further to include faculty training and the hiring of addiction-trained clinicians. At the state level, we advocate utilizing opioid resettlement funds toward these efforts.

Undoubtedly more resources are urgently needed to train residents in addiction. To achieve this, addiction-trained faculty are essential. Our patients have waited beyond long enough to receive evidence-based SUD care by capable physicians prepared to deliver it.

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