Buprenorphine Training Lags in Pain Fellowships Amid Opioid Crisis

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> The American medical system faces a stark contradiction: a persistent opioid crisis, fueled by synthetic illicit opioids, continues to devastate communities, yet a primary pharmacological defense for both opioid use disorder (OUD) and chronic pain management remains significantly underutilized. This underutilization stems not from a lack of effective medication, but from a critical gap in the training of future pain specialists. The problem is not the drug, but the education.

KEY TAKEAWAYS

- The Pivot: Regulatory changes removed the X-waiver for buprenorphine, but access remains limited due to insufficient clinician training.
- The Data: Pain medicine fellowship training often gives limited attention to buprenorphine education, prioritizing interventional procedures instead.
- The Action: Standardize buprenorphine education as a core competency in pain medicine fellowships to equip future specialists for OUD and complex chronic pain management.

The ongoing opioid crisis presents a profound challenge to public health, with synthetic illicit opioids driving a surge in overdose deaths and widespread addiction.1 Buprenorphine, a medication-assisted treatment (MAT), stands as a cornerstone therapy for both opioid use disorder and complex chronic pain.1 Its efficacy in reducing opioid cravings, preventing withdrawal, and lowering overdose risk is well-established.1 But despite its critical role, the medical education system, particularly within pain medicine fellowships, has not adequately prepared clinicians to leverage this vital tool.1 Pain medicine fellowship training programs frequently prioritize the technical mastery of interventional procedures, such as spinal cord stimulation and nerve blocks, alongside non-opioid pharmacologic strategies.1 While these approaches are undeniably important for managing various pain conditions, the curriculum often dedicates limited attention to comprehensive education in MAT, specifically the use of buprenorphine.1 This imbalance leaves a significant void in the skillset of graduating pain specialists, hindering their ability to address the full spectrum of pain and addiction challenges.1

The Training Gap and Its Consequences

The transition from the restrictive “X-waiver” era, which mandated specific training and certification for buprenorphine prescribing, to the current regulatory environment aimed to expand and democratize access to this essential treatment.1 The intent was clear: remove bureaucratic hurdles to allow more clinicians to prescribe buprenorphine.1 However, legislative change alone cannot substitute for structured clinical education.1 Removing regulatory barriers does little

to improve access if clinicians lack the fundamental knowledge, confidence, and practical training necessary to initiate and manage buprenorphine therapy effectively.1

Hasoon, Urits, and Viswanath, writing in Psychopharmacology Bulletin in 2026, highlighted this critical disconnect.1 They argued that the current emphasis in pain medicine fellowships on interventional techniques, while valuable, overshadows the need for robust buprenorphine education.1 The authors observed that future pain specialists should be as comfortable initiating and managing buprenorphine therapy as they are performing advanced interventional procedures.1 This parity in comfort and competence is currently lacking, contributing to the underutilization of buprenorphine even after the removal of the X-waiver.1

The consequences of this training gap are significant for patient care. Patients with OUD or complex chronic pain, who could benefit immensely from buprenorphine, often face challenges in finding clinicians equipped to prescribe and manage the medication.1 This creates a paradox where an effective treatment exists, regulatory barriers have been lowered, but access remains constrained by a deficit in clinician preparedness.1 The authors of the Psychopharmacology Bulletin paper specifically called for buprenorphine education to be standardized as a core competency within pain medicine fellowship programs.1 This standardization would ensure that all graduating pain specialists possess the necessary skills to integrate buprenorphine into their practice, thereby strengthening their ability to address both chronic pain and opioid use disorder within an evolving public health landscape.1

The paper by Hasoon, Urits, and Viswanath focused on the American medical landscape, describing a profound paradox.1 The opioid crisis continues to ravage communities, characterized by a rise in synthetic illicit opioids.1 Yet, the primary pharmacological defense for both OUD and chronic pain management remains underutilized in the very training programs designed to produce experts in the field.1 This observation underscores a systemic issue where the curriculum has not kept pace with the urgent public health demands.1

The authors did not present a randomized controlled trial but rather an editorial perspective based on their clinical observations and understanding of current training paradigms.1 Their argument is qualitative, emphasizing the need for a curricular shift rather than reporting quantitative outcomes from an intervention.1 This means the paper provides a strong call to action, but without specific metrics on how many programs currently lack adequate buprenorphine training or the precise impact of this deficit on patient outcomes.1 The strength of their argument lies in its direct address of a recognized clinical need and a clear proposal for educational reform.1

The paper did not detail specific numbers of pain medicine fellowship programs or the exact hours dedicated to buprenorphine training versus interventional procedures.1 This absence of granular data means the precise scope of the problem, in terms of quantifiable educational hours or specific program deficiencies, remains to be fully elucidated by future research.1 But the qualitative assessment from experienced clinicians in the field provides a compelling argument for immediate action.1 The authors' assertion that legislative change alone cannot substitute for structured clinical education is a critical insight, highlighting that policy shifts must be accompanied by practical implementation strategies in medical training.1

The call for future pain specialists to be as comfortable initiating and managing buprenorphine therapy as they are performing advanced interventional procedures is a high bar.1 Achieving this level of comfort and competence requires more than just didactic lectures; it necessitates hands-on clinical experience, mentorship, and integrated curriculum design.1 The paper implies that current training models may not offer sufficient opportunities for fellows to gain this

practical expertise, leading to a lack of confidence even when regulatory barriers are removed.1 Strengthening training in this area will better equip pain physicians to address both chronic pain and opioid use disorder within an increasingly complex public health landscape.1

The paper did not offer a direct comparison of patient outcomes before and after the X-waiver removal, nor did it quantify the impact of standardized buprenorphine training on patient access or clinical results.1 This means that while the logical argument for improved training is strong, the direct, measurable benefits in terms of patient care remain an area for future empirical study.1 But the authors' clear articulation of the problem provides a necessary foundation for such investigations.1 The focus on standardizing buprenorphine education as a core competency is a direct, actionable recommendation that could significantly alter the trajectory of pain management and OUD treatment.1

CLINICAL IMPLICATIONS

The persistent underutilization of buprenorphine, despite its proven efficacy and the removal of the X-waiver, exposes a critical failure in medical education. Clinicians cannot prescribe what they are not trained to manage, and legislative changes alone do not magically imbue confidence or competence. This means patients with opioid use disorder or complex chronic pain are still facing unnecessary barriers to effective treatment.

Pain medicine fellowship programs must re-evaluate their priorities. An overemphasis on interventional procedures, while financially lucrative and technically impressive, leaves graduates ill-equipped for the realities of the opioid crisis. The expectation that future specialists should be as comfortable with buprenorphine as with spinal cord stimulation is not aspirational; it is a clinical necessity.

The onus is now on program directors and accreditation bodies to standardize buprenorphine education as a core competency. Without this systemic shift, the paradox will continue: a powerful drug available, but a medical workforce unprepared to wield it. This is not a subtle gap; it is a glaring omission that directly impacts public health.

EDITORIAL & AI STANDARDS

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REFERENCES

1. 1. Hasoon J, Urits I, Viswanath O. Beyond Exposure: Standardizing Buprenorphine Training in Pain Medicine Fellowship. Psychopharmacol Bull. 2026;56(1):1-5.

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