Published in final edited form as:

Subst Abus. 2011 April ; 32(2): 84–92. doi:10.1080/08897077.2011.555702.

Specialized Training on Addictions for Physicians in the United States

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Abstract

In the United States accredited residency programs in addiction exist only for psychiatrists specializing in addiction psychiatry (ADP); non-psychiatrists seeking training in addiction medicine (ADM) can train in non-accredited “fellowships,” or can receive training in some ADP programs, only to not be granted a certificate of completion of accredited training. Information about ADP residency programs has been tabulated, but it is not available for ADM fellowships. The authors conducted a national survey to compile information about the location, structure, curriculum and other characteristics of active ADM fellowships. Of the 40 accredited ADP residency programs, 7 offered training in addiction to non-psychiatrists. The authors identified 14 non-accredited ADM fellowships. In 2009 and 2010, there were approximately 15 non-psychiatrists in ADP programs and 25 in ADM fellowships. Clinical experiences included inpatient services, outpatient treatment services such as methadone maintenance or buprenorphine maintenance, and providing addiction consult services. The most common academic activities included weekly lectures and the teaching of medical students.

Keywords

graduate medical education; organization and administration; standards; trends

Introduction

According to the National Survey of Drug Use and Health, over 23 million people in the United States were in need of treatment for illicit drug or alcohol use in 2008, of whom 20.8 million did not receive any specialized treatment [1]. Only 672,000 people reported receiving treatment for a substance use disorder in a private physician’s office. Addressing this unmet gap in addiction treatment will require expanding office-based treatment capacity by providing addiction medicine training for existing primary care physicians and by training additional addiction specialty physicians. Currently, however, Addiction Medicine (ADM) is rarely taught as a formal discipline in any of the nation’s 132 medical schools.

After medical school, physicians receive specialty and sub-specialty clinical training in “residency programs,” which are overseen by a variety of organizations (see Table 1). Currently, addiction training in accredited residency programs exists only for psychiatrists sub-specializing in addiction psychiatry, and detailed information about these programs is easily available [2,3].

Various post-graduate training opportunities are available for non-psychiatrist physicians who wish to pursue specialized training in the addiction disorders; however, information concerning these fellowships is limited. The purpose of this study is to conduct a national inventory to better understand the availability and characteristics of formal training opportunities for non-psychiatrist physicians in addiction medicine. This study examines only those Graduate Medical Education training programs with an overall focus on ADM, and not rotations or lectures on addiction topics that provide education on addiction to physicians-in-training in ACGME-accredited residency programs, e.g., in family medicine, internal medicine, pediatrics, psychiatry, anesthesiology, emergency medicine or other specialties.

Background

The specialties of Addiction Medicine and Addiction Psychiatry have evolved gradually in recent decades. The American Society of Addiction Medicine (ASAM) was established as a national medical specialty society in 1989 from a progression of predecessor organizations; it has its origins in the New York City Medical Society on Alcoholism, founded in 1954. The American Medical Society on Alcoholism and Other Drug Dependencies was accepted into membership by the House of Delegates of the American Medical Association (AMA) as a national medical specialty society in 1988, a year prior to changing its name to ASAM. Physicians have been able to list addiction medicine as a self-designated area of practice in the AMA’s Physician Masterfile using the specialty code “ADM” since 1990. Since 1984, ASAM or predecessor organizations have offered professional certification in Addiction Medicine for 4,514 physicians. This certification was granted by the specialty society based on a candidate’s completion of a 1-year fellowship training program and/or 1950 hours of clinical experience, in addition to successful completion of a 250-item written examination developed through a partnership of ASAM with the National Board of Medical Examiners.

Concurrently, a national medical specialty society in addiction psychiatry (ADP) was founded at the end of 1985, the American Academy of Addiction Psychiatry (AAP). Leaders of AAP successfully achieved formal recognition for the subspecialty of addiction psychiatry from the American Board of Medical Specialties (ABMS) in 1991. The Accreditation Council for Graduate Medical Education (ACGME) approved the establishment of residency training in ADP (such programs, which candidates entered after completion of a primary residency in general psychiatry, were at that time called “fellowships” by the ACGME). Requirements for formal recognition of a sub-specialty by the ABMS include: 1) an independent national board whose sole purpose is the certification of physicians for the discipline and 2) the existence of a relatively uniform infrastructure of residency-training programs, which must be approved by the ACGME. In the case of Addiction Psychiatry, the new subspecialty fit under the credentialing purview of the existing American Board of Psychiatry and Neurology (ABPN), and its training infrastructure could be built upon already accredited residency programs in general psychiatry. For almost two decades, ADP certification has been granted by the ABMS-member specialty board, the ABPN, while ADM certification has continued to be granted by the national medical specialty society, ASAM.

In the case of ADM, ASAM as a membership society has had a mission broader than serving as a national credentialing body. Moreover, a number of primary medical specialties (e.g.,

family medicine, internal medicine, etc.), as well as psychiatry, were involved in the development of ADM. Therefore, it was not a discipline that fit squarely under a single existing specialty board that was a member board of the ABMS. Although accredited residency programs existed for all the primary specialties involved in ADM, they differed by specialty and there was no single platform to facilitate the growth of uniform Addiction Medicine residencies. As a result, ADM has remained an informal, non-ABMS specialty characterized largely by mid-career entry of physicians who became addictionists via Continuing Medical Education training and clinical experience rather than via GME training. A minority of physicians entering the ADM discipline have done so via completing post-residency fellowships in ADM which are not ACGME-accredited, or by enrolling in an ADP training program even though such training will not result, for them, in being granted an ACGME-recognized certificate of completion.

Aside from recognition by ABMS, there are some distinctions between ADP and ADM. Psychiatrists who specialized in ADP tend to include a focus on behavioral approaches and on patients who have coexistent mental illness, whereas, physicians who specialize in ADM tend to have an orientation toward medical treatments and patients with coexistent medical/surgical problems (e.g., infectious diseases, acute injuries and chronic pain). Individuals who wish to pursue a career in ADP must complete a 4-year general psychiatry residency followed by a 1-year ADP residency in one of the 40 accredited residency programs. Following this training, those who meet the qualifications and successfully sit for a certifying examination are considered to be “board-certified” in the subspecialty of ADP by the ABPN.

Non-psychiatrist physicians and psychiatrists who wish to qualify for certification in ADM must meet rigorous requirements [4], including one year’s full time-equivalent (1950 hours) over the last 10 years in teaching, research, administration, and clinical care of the prevention of as well as the treatment of individuals who are at risk for or have a substance use disorder. At least 400 of these hours must be spent in direct clinical care of patients. In addition, candidates must be board-certified by an ABMS member board, or have successfully completed an ACGME-accredited residency. The majority of candidates meet these requirements by working in a chemical dependency treatment facility, taking continuing medical education courses in addiction, or participating in research. Non-psychiatrist physicians are not eligible for ADP certification, but some accredited ADP residency programs offer a limited number of training positions to non-psychiatrists seeking ABAM certification.

Addiction specialty certification offers potential personal, professional, and financial benefits. Certified physicians have met rigorous standards [4], which is a source of professional pride. Academic institutions actively involved in addiction research may offer career advancement for faculty members with ADM or ADP certification. The federal government, through the Drug Addiction Treatment Act of 2000 which authorized office-based treatment of opioid addiction with buprenorphine, and led to the issuing of regulations by the federal Center for Substance Abuse Treatment overseeing office-based opioid treatment (OBOT), recognizes certification in ADM offered by ASAM as well as certification in ADP offered by ABPN as some of the ways physicians can demonstrate acceptable knowledge and skills to become registered prescribers of buprenorphine. Some state alcohol/drug treatment agencies specify that medical directors of state-licensed treatment facilities must be ASAM or ABPN certified in ADM or ADP. Hospitals may require board certification for privileges. Many health insurance companies recognize ADM certification as equivalent to other ABMS-approved subspecialty certificates, including ADP, and offer reimbursement comparable to that of other specialist visits. However, there are some medical schools, hospitals and insurance companies that do not recognize ADM as

a specialty or subspecialty. For this reason, gaining ABMS recognition of ADM may carry both professional and financial benefits to physicians practicing ADM.

The pressing need for addiction specialists has continued to motivate the pursuit of more formal recognition for ADM, and in 2007 ASAM encouraged the formation of the American Board of Addiction Medicine (ABAM), and assisted its creation, in order to meet the ABMS' requirement for an independent national board for a specialty. As of 2010, ABAM began administering the certification examination for ADM which for the previous 24 years had been administered by ASAM.

The next step for ADM will be the development of residency programs which meet uniform standards. Comprehensive baseline information is lacking regarding the characteristics of the existing training programs for ADM. This study's objective, therefore, was to compile such information, which in turn could be used by the ADM discipline to apply to the ABMS for formal recognition of ADM as a specialty or subspecialty. The information could also be made available to physicians interested in ADM training to help them choose the appropriate ADM training program to meet their educational needs.

METHODS

Collecting systematic information about ADM training programs in the United States was carried out in three phases. During the first phase, the authors attempted to collect general information about the number and location of ADM training programs; in June 2008, the authors sent a 1-page survey via surface mail to the dean and to the associate dean or director of graduate medical education of 133 medical schools and 37 independent teaching hospital in the United States. The survey inquired about the existence of and contact information for an ADM training program at their institution. Individuals were instructed to complete the survey and return it to the authors by either surface mail or facsimile before August 2009.

During the second phase, the contact persons identified in phase 1 were mailed a second, more comprehensive survey, asking for details about the ADM training program at their institution. This survey was to be returned by surface mail. Non-responders were contacted by telephone, facsimile or electronic mail. The survey instrument that was used for surface mail reply, telephone interviews, and for electronic-mail and facsimile queries utilized a set of questions developed specifically for this project, including: location and address of the program, ACGME accreditation status of the host institution, duration of training, number of positions available, number of current trainees, educational components, clinical experience, the principal goals of training, and a list of the faculty members and their credentials. Individuals were instructed to complete and return the survey to the authors by January 2010.

During the third phase, the authors attempted to contact the program director of every ADP residency program to inquire if their program offered training to non-psychiatrists. Programs who answered "yes" were sent the survey instrument developed for phase II. The same procedures were used to collect the information from ADP programs that were used to collect information about ADM programs.

RESULTS

Phase I Results

By June 2009, completed questionnaires were received from 117 medical schools and 24 teaching hospitals, revealing the existence of 15 ADM training programs. The contact person for each of the 15 programs was sent the second survey.

Phase II Results

By January 2010, detailed information was obtained from 15 ADM programs. There was 1 program that was expected to close in 2010 due to lack of funding. The remaining 14 programs are summarized in Table 2. In 2010 there were 26 ADM fellowship positions and 22 fellows in training in the 14 non-ACGME fellowships. The number of trainees in 2009 ranged from 0 to 4 (average 1.5) and in 2010 it ranged from 1 to 5 (average 1.9). The duration of training varied between 1 year (50% of the programs), 1 or 2 years (42.9%) and 2 years (7.1%). In fellowships where the duration of training was listed as 1 or 2 years, conversation with the program directors revealed that the duration is largely determined based on the program's evaluation of the fellow's performance and the fellow's interest in additional training. Salaries for ADM fellows ranged from \$42,000 to \$61,000 (average \$53,000). Funding for ADM fellowships was derived from multiple sources, including hospital revenue (50.0% of the programs), research grants (42.9%), university revenue (21.4%), private foundations (21.4%), and the Veterans Health Administration (7.1%). The most common clinical experiences included inpatient detoxification training (78.6%), outpatient addiction services (71.4%), inpatient consult service (57.1%), and pain management (57.1%). The most common academic activities included monthly journal club, where the fellows discussed current topics from the literature (57.1%), and weekly didactics (50.0%). In about half of all ADM fellowships, the fellows taught addiction medicine to medical students, family medicine residents and psychiatry residents. There were 10 ADM fellowships affiliated with an ACGME-approved teaching institution, typically a medical school (90.0%) or an independent teaching hospital (10.0%). If the word "research" appeared in the name of an ADM program and if the ADM fellowship was partially or fully funded by a research grant, it was considered an "ADM research fellowship." The authors found that 5 of the 14 ADM programs met such criteria, accounting for 8 research positions available with 7 research fellows in training in 2010. The number of fellows in training per program in 2009 ranged from 1 to 2 (average 1.4) and the number of available positions in 2010 ranged from 1 to 2 (average 1.6). The duration of training varied between 1 year (60%) to 1 or 2 years (40%). Salaries for ADM research fellows ranged from \$52,000 to \$60,000 (average \$55,800). Support for these came from research grants in all (100.0%) of these program and additional university revenue in 2 (25.0%) programs.

Phase III Results

The authors were able to directly contact the program director of 32 of the 42 ACGME-accredited ADP residency programs, and of these, there were 7 (22%) ADP programs that offered training to non-psychiatrists with 17 positions available in 2010 and 14 ADM fellows in training. See Table 3 for details. The number of trainees in 2009 ranged from 0 to 6 (average 2) and for 2010 the number of trainees ranged from 1 to 6 (average 2.4). Most programs (71%) were 1 year in duration, and 29% were 2-year programs. Salaries for ADP program residents ranged from \$45,000 to \$67,000 (average \$58,000). Funding for these programs was derived from a number of sources, including Veterans Health Administration hospital revenue (71.4% of the programs), private foundations (57.1%), teaching hospital revenue (42.9%) and research grants (28.6%).

The most common clinical experiences for ADP and ADM trainees in ADP residency programs included inpatient detoxification training, methadone maintenance treatment, buprenorphine maintenance, and inpatient consultation service (Table 4). The most common academic activities included weekly didactics and continued medical education conferences. Trainees taught addiction medicine to medical students in 85.7% of the programs and to psychiatry residents in 71.4% of the programs. Other clinical experiences encountered during ADP and ADM training included: dual diagnosis, outpatient addiction services, residential treatment programs, women's addiction, perinatal addiction, sexual addiction, geriatric addiction, post-traumatic stress disorder, smoking cessation, interventions for victims of emotional trauma, acupuncture, outpatient psychiatric services, and sleep disorders during recovery, among others. Educational activities for each ADP and ADM program were deduced from a variety of sources, including self-report by program directors, the program's website, and telephone or electronic communication with the programs' contact persons.

DISCUSSION

While psychiatrists may become board-certified subspecialists in ADP through accredited residency training that is standardized and fairly uniform across the nation, the only option for addiction specialization currently available to non-psychiatrist physicians is through a less formal training process with relatively limited capacity. The results of this national inventory show that a total of 43 training positions are available in one of 7 Addiction Psychiatry (ADP) residencies that accept non-psychiatrists or in one of 14 Addiction Medicine (ADM) fellowships, which have the capacity to produce 20 to 30 new ADM specialists annually. The programs are heterogeneous and offer a range of clinical and academic experiences; some are heavily oriented toward research training. The salaries offered to ADM fellows are comparable to those in other specialty training programs [2,3]. After this training those who meet the certification requirement and successfully sit for the certification examination may become board certified by ABAM, although ABAM is not yet a member board of the ABMS.

This study has important implications for the more than 20 million Americans needing drug or alcohol treatment, approximately 90% of whom are not receiving any services or are being treated by clinicians who are not certified in addiction. Officials from ASAM have estimated that there will need to be 6,720 ADM specialists to meet patient treatment needs by 2020. This is based on the assumption that one physician would be able to provide care for approximately 1,000 patients in need of an addiction specialist. Based on the number currently certified by ABPN and ABAM, there is a need to certify 5,089 new physicians between 2010 and 2020 [5]. The inclusion of substance use disorder (SUD) services in the essential health benefit coverage to be offered under the Patient Protection and Affordable Care Act of 2010 could further increase demand. However, existing ADP programs are producing 20 to 40 new subspecialists a year [2], and the existing ADM fellowships identified in the current study are producing another 20 to 30 specialists a year, which leaves an annual training shortfall of 30 to 60 physicians. Moreover, 19% of the available ADM training positions went unfilled in 2009, as compared to 9% of ADP training positions for psychiatrists [2]. This may be due in part to unique requirements of individual programs. For example, at one program, fellows must be certified in obstetrics, because the training program provides medical care services to a 26-day program for pregnant women with an SUD. While that program's two training positions were filled during the study period, it should be noted that obstetricians constitute only 4.5% of ASAM membership [personal communication], which may be indicative of the overall availability of such candidates.

Another reason for unfilled positions may relate to perceived costs and benefits for potential trainees. Physician training is a long process, generally taking 7 to 9 years from medical school through residency in a primary specialty. Many physicians begin their careers with high debt burdens and thus may wish to enter the physician workforce as soon as possible to begin to pay down their debts. The subspecialty of ADP requires another year of training after a 4-year general psychiatry residency. For non-psychiatrist physicians, who complete 3 to 5 years of training, the 21 Addiction Medicine fellowships currently available entail either 1 or 2 years of training.

The challenges of making ADM or ADP training attractive for young physicians have been discussed in the literature [6]. According to this study's findings, 63% of the available slots are in 1-year programs, 12% are in 2-year programs, and 24% are in programs that offer both 1-year and 2-year training options. The average salary for ADM fellows in 2009 was \$53,000. Despite the substantial training commitment, Addiction Medicine lacks formal recognition by the American Board of Medical Specialties, which could be a disincentive for potential candidates weighing their options.

Creating the necessary residency training programs that will train enough physicians to address the underserved population of persons with SUDs in the United States will invariably require the funding of additional training programs. Currently the Veterans Health Administration is an important source of funding for all medical education and provides partial or full support of 71% (5 of 7) of ADP programs and 7% (1 of 14) of ADM fellowships.

The authors note that meeting the demand for new addiction specialists may be accomplished by several means. First, more ADP residencies could systematically offer their unfilled positions to non-psychiatrists. Second, the program directors of existing ADM fellowships could request that the ACGME accredit existing ADM fellowships and create standards for accrediting additional ADM fellowships as these come into existence. Third, ABAM could become a member of board of the ABMS, or could successfully encourage the ABMS to develop a multispecialty subspecialty certification program in ADM for physicians not eligible to receive ABMS recognition as subspecialists in ADP. ABMS recognition would provide additional incentive for physicians to pursue ADM certification. In the meantime, ABAM and its sister organization, The ABAM Foundation, will continue to maintain and provide systematic information about ADM fellowships to help increase awareness of ADM and to help interested candidates in their search for the most appropriate addiction training. These solutions are offset by the finding that not all those who complete ADP residency training actually practice in that subspecialty [7].

The limitations of this study include reliance on self-report and answers to open-ended questions. Also, while the response rate of training programs was encouraging (80% for ADP programs and 100% for ADM), it cannot be determined whether any existing ADM programs were missed or whether any non-responding ADP programs offer training to non-psychiatrists. For example, another recent survey of ADP residencies (response rate 80%) reported that there were 12 ACGME-accredited ADP residency programs that offered training to non-psychiatrists [2].

CONCLUSIONS

ADM training in the United States is evolving. ASAM certification began in 1986, but since 2009 the responsibility for Addiction Medicine certification has moved from ASAM to the independent organization ABAM, whose sole purpose is to administer and maintain certification. The trend in ADM training has shifted from CME for mid-career entry

addiction medicine specialists or self-designated GME training for either early- or mid-career physicians seeking such training, to the development of informal ADM residencies which have uniform program characteristics and training standards. The next step will be to have these ADM training programs obtain formal recognition by the ACGME. These will be important changes for ADM, because they make ADM similar to other ABMS-recognized specialties and subspecialties, and would, in turn, allow ADM to enter the existing structure of medical education and board certification within organized medicine in the United States.

Acknowledgments

This study was supported, in part, by funding from: the University at Buffalo (Dr. Tontchev), the ABAM Foundation (Mr. Housel) and by grant number K23AA015616 from the National Institute on Alcohol Abuse and Alcoholism (Dr. Blondell). Assistance in manuscript preparation was provided by Andrew Danzo, Laurene Tumiel-Berhalter, PhD, and John S. Taylor, M.B.A.

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Table 1

Key organizations involved in the development of Addiction Medicine as a specialty in the United States.

Organization	Function
AAAP, American Academy of Addiction Psychiatrists	Professional organization for physicians interested in Addiction Psychiatry; membership is almost exclusively psychiatrists.
ABAM, American Board of Addiction Medicine	Organization responsible for certification in Addiction Medicine (not a member of ABMS).
ABMS, American Board of Medical Specialties	Responsible for the oversight of the certification process for all medical specialties and subspecialties.
ABPN, American Board of Psychiatry and Neurology	Member of ABMS and responsible for certification in General Psychiatry, Addiction Psychiatry, Child and Adolescent Psychiatry, Clinical Neurophysiology, Forensic Psychiatry, Geriatric Psychiatry, Hospice and Palliative Medicine, Neurodevelopmental Disabilities, Neuromuscular Medicine, Pain Medicine, Psychosomatic Medicine, Sleep Medicine, or Vascular Neurology.
ACGME, Accreditation Council for Graduate Medical Education	Organization responsible for the establishment of training standards and the accreditation of graduate medical education training programs.
ASAM, American Society of Addiction Medicine	Professional organization for physicians interested in Addiction Medicine; membership also includes a variety of primary specialties, including psychiatry.

Table 2

Addiction Medicine Fellowships

Institution	Department	positions available for 2010	positions filled in 2009	Duration (years)	Salary (thousands)
Boston University School of Medicine *	Internal Medicine	3	0	2	\$61
Brighton Hospital	Addiction Medicine	1	1	1 or 2	\$45
Caron Treatment Center	Addiction Medicine	1	1	1 or 2	\$50
Loma Linda University Medical Center *	Preventative Medicine	3	3	1 or 2	\$50
Marworth Treatment Center	Addiction Medicine	1	1	1	\$60
Massachusetts General Hospital *	Psychiatry [†]	2	2	1 to 2	\$60
Pine Grove Behavioral Health	Addiction Medicine	1	1	1	\$42
Swedish Medical Center *	Addiction Medicine	2	2	1	\$61
University at Buffalo *	Family Medicine [†]	2	2	1 or 2	\$56
University of California- Los Angeles *	Family Medicine [†]	1	1	1	\$52
University of Florida College of Medicine *	Psychiatry	5	4	1	\$50
University of Michigan *	Psychiatry [†]	1	1	1	\$58
University of Wisconsin *	Family Medicine ^{†§}	2	1	1	\$53
Virginia Commonwealth University *	Internal Medicine	1	1	1 or 2	\$45
Totals		26	21		
Average		1.86	1.50		\$53

* Accreditation Council for Graduate Medical Education (ACGME) accredited institution

[†] Research Fellowship[§] A fellowship opportunity also exists under the Department of Psychiatry at the Madison Veterans Administration

Table 3

ACGME-accredited Addiction Psychiatry Residency Programs that Train non-psychiatrists

Institution	Affiliated Medical School	positions available in 2010	positions filled in 2009	Duration (years)	Salary (thousands)
Cedars Sinai Medical Center	None	2	2	1	\$45
VA Medical Center San Francisco	University of California San Francisco	1	0	2	\$67
VA Healthcare System Connecticut	Yale University School of Medicine	6	6	1	\$67
Pacific Addiction Research Center	University of Hawaii	1	1	1	\$60
VA Medical Center Cincinnati	University of Cincinnati	2	1	2	\$52
VA Medical Center Portland	Oregon Health and Science University	2	2	1	\$59
VA Healthcare System North Texas	University of Texas-South Western	3	2	1	\$54
totals		17	14		
average		2.43	2.00	1.29	\$58

Abbreviations: ACGME = Accreditation Council for Graduate Medical Education, VA = Veterans Affairs

Table 4

Clinical Experience during Addiction Psychiatry and Addiction Medicine Training

Clinical Experience	Offered in ADM (N=14)		Offered in ADP (N=7)	
	n	%	n	%
Acupuncture and Complementary/Alternative Medicine	4	28.6%	0	0.0%
Adolescent Addiction	5	35.7%	5	71.4%
Buprenorphine	7	50.0%	4	57.1%
Hospital Consult / Liaison Service	8	57.1%	4	57.1%
Dual Diagnosis (Psychiatry and Addiction)	5	35.7%	3	42.9%
Geriatric Addiction	4	28.6%	1	14.3%
Inpatient Detoxification Services	11	78.6%	4	57.1%
Methadone	5	35.7%	5	71.4%
Primary Care and Addiction	10	71.4%	3	42.9%
Ambulatory Dual Diagnosis Psychiatry	4	28.6%	0	0.0%
Pain Medicine and Addiction	8	57.1%	3	42.9%
Perinatal Addiction	3	21.4%	2	28.6%
Post Traumatic Stress Disorder (PTSD)	3	21.4%	1	14.3%
Residential Addiction Services	6	42.9%	3	42.9%
Sexual Addiction	2	14.3%	2	28.6%
Sleep Medicine and Addiction	4	28.6%	0	0.0%
Smoking Cessation / Nicotine Addiction	3	21.4%	1	14.3%
Student Health Addiction Services	4	28.6%	0	0.0%
Trauma Surgery and Addiction	3	21.4%	1	14.3%
Women with Addiction	5	35.7%	3	42.9%