Strengthening opioid use disorder training among obstetrician-gynecologists: Hollander et al's call to action

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TO THE EDITORS: "Do you feel prepared?" As newly minted physicians starting residency training this summer, we are now accustomed to this loaded question.

While our seniors sagely advise that there is no way to prepare for what is to come, our medical schools have tried to ensure that we enter intern year as competent physicians. Subinternships and residency preparatory courses have covered everything from suturing and laparoscopic skills to pelvic anatomy.

However, the recently published study by Hollander et al[1] highlights an area of vulnerability for us as future obstetrician-gynecologists: we are ill equipped to care for pregnant women with opioid use disorders (OUDs). Medication-assisted treatment such as buprenorphine is recommended for women with OUDs,[2] yet Hollander et al demonstrated that just over 5% of pregnant women on buprenorphine for OUD received their prescriptions from an obstetrician-gynecologist.[1]

These results are unsurprising. A 2015 study showed that just 0.4% of obstetrician-gynecologists have a Drug Enforcement Administration waiver to prescribe this evidence-based medication.[3] Unfortunately, caring for women with OUDs appears to be a weakness that extends beyond just incoming trainees.

As both surgeons who prescribe perioperative analgesics and primary care physicians, we are uniquely poised to care for this vulnerable group of women. While there are infrastructure and reimbursement challenges to consider, consolidating care during pregnancy would undoubtedly benefit our patients. It has the potential to optimize trust between patients and their obstetricians while also lessening the socioeconomic burdens of appointments with additional providers in the prenatal period.

To address the gaps in care for women with OUDs, addiction training, like knot tying and laceration repairs, should be a core competency of all obstetrician-gynecologists residency program graduates. As it stands, the Substance Abuse and Mental Health Services Administration requires physicians to complete an 8 hour training (in person or online) to obtain a waiver to prescribe buprenorphine.

While recently proposed legislation aims to eliminate this requirement,[4] we see value in this training for undergraduate medical trainees. In conjunction with more clinical exposure to patients with OUDs, this curriculum would allow us to enter residency better prepared to provide the care that we firmly believe our patients deserve.

Given the current opioid crisis, management of OUDs can no longer be seen as a niche clinical interest. It is our collective responsibility to understand and treat OUDs during our training and throughout our careers. We appreciate this timely call to action from Hollander et al. ■

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Incorporating the probability of competing event(s) into the preeclampsia competing risk algorithm

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TO THE EDITORS: We read with great interest the paper by Wright et al[1] in which the authors assessed the predictive performance of their competing risk algorithm for preeclampsia. Using such an approach, the authors estimated the detection rate for early, preterm, and all preeclampsia to be 90%, 75%, and 50%, respectively. The authors are to be