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EDITORIAL

Quality or Quantity? The Quiet Influence of Industry-Sponsored Centers of Excellence

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The rise of industry-sponsored "Centers of Excellence" (COEs) in Pain Medicine reflects a troubling shift in how we define quality in healthcare. While framed as badges of clinical distinction, these designations often serve marketing goals more than meaningful improvements in patient care. Their frequently opaque, variable, and heavily volume-driven criteria raise fundamental concerns regarding how device manufacturers and for-profit industry partners define and promote these programs.

Industry-sponsored COEs do offer potential benefits that should be acknowledged. They can provide standardized training opportunities, increase awareness of emerging therapies, and facilitate networking among specialists. In certain instances, they may improve documentation practices and encourage more consistent post-procedural follow-up. When these programs require participation in data registries, they may contribute to our understanding of procedural outcomes across diverse practice settings. However, prioritizing volume to be considered a COE raises multiple practical and ethical concerns.

At its best, a COE is a beacon of comprehensive, patient-centered, and multidisciplinary care that fundamentally provides "excellent healthcare".[1] Historically, COE designations - such as those once awarded by the American Pain Society - recognized programs advancing the field through rigorous, multidisciplinary practice and innovation.[2] These were academic and community teams meeting critical needs with evidence-based, whole-person care. That model has all but vanished in Pain Medicine. To our knowledge, no major professional pain society currently offers a COE designation.

Some may point to established COE programs in other specialties, such as bariatric surgery, as a defense of the model. But this comparison misses the mark. Bariatric COEs, developed through surgical societies and accrediting bodies, are grounded in transparent, evidence-based standards: minimum procedure volumes, demonstrated outcomes, structural capabilities, and adherence to rigorous patient safety protocols.[3,4] The American College of Surgeons' Commission on Cancer offers another instructive model through its accreditation program. This program evaluates cancer centers through rigorous on-site reviews, requiring adherence to comprehensive standards that span the entire care continuum from prevention through survivorship. Centers must demonstrate not only technical proficiency but also commitment to quality improvement, multidisciplinary care conferences, clinical trial access, and psychosocial support services. Notably, the program requires participation in a national cancer database with standardized outcomes reporting and regular performance reviews against national benchmarks.[5]

In its place, industry has purportedly filled the vacuum. But when the creators of medical devices and interventions define the standards for excellence, a dangerous incentive structure emerges, whereby procedural volume, training attendance, and promotional visibility eclipse independent outcomes and effective, thoughtful care. Industry-driven COEs require case minimums and nominal outcomes tracking, but too often, these are self-reported and unverified.

Although these programs may offer some benefits - encouraging post-procedural follow-up, professional development, and broader procedural awareness - they risk becoming vehicles for commercial expansion rather than clinical refinement. There is a well-documented volume-outcome relationship in some areas of medicine. However, using procedural quantity as

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a proxy for quality, without regard for patient selection, procedural appropriateness, or longitudinal outcomes, is an over-simplification with potentially serious consequences.[6]

The downstream effects of this model are concerning. Academic pain centers, multidisciplinary practices, and rural or resource-limited programs may be excluded from COE designation not because of poor outcomes, but because they do not conform to an industry-centric template. Despite delivering excellent care, practices that prioritize non-procedural therapies or remain independent from commercial affiliations risk being marginalized.

Some academic pain centers face a significant case complexity bias that industry-sponsored COEs rarely acknowledge. These centers frequently serve as referral destinations for the most challenging cases, eg, patients with multiple comorbidities, complex pain syndromes, previous treatment failures, and psychosocial factors that complicate management. When measured purely by procedural outcomes without risk adjustment, these centers may paradoxically appear less "excellent" despite providing more sophisticated, comprehensive care. The current industry model, emphasizing procedural volume as well as success rates disconnected from case complexity, creates a perverse incentive structure in which centers might improve their metrics by simply avoiding complex patients. This undermines the mission of academic centers that should be intentionally accepting complex cases as part of their commitment to advancing care for all patients, regardless of complexity.

From a patient perspective, navigating the landscape of pain care is already daunting without the added confusion of potentially misleading quality designations. Patients seeking relief often interpret a COE designation as an objective marker of superior care, unaware of the commercial relationships underwriting these titles. A form of informational asymmetry undermines informed consent and patient autonomy. Any legitimate quality designation must prioritize transparency for patients, clearly communicating what metrics were evaluated, by whom, and with what potential conflicts of interest.

Even more concerning, this approach may unintentionally exacerbate existing health disparities, as variations in insurance coverage can lead to patient self-selection, granting access to some while excluding others from essential therapies. At a time when healthcare equity is a growing priority, we should reflect on the potential consequences of participating in programs that could further constrain access to high-quality care, particularly for patients who are already among the most vulnerable.

The research implications are equally unsettling. As COE-affiliated practices become preferred sites for data collection, future trials may be skewed toward high-volume, highly selected cohorts, limiting generalizability and biasing outcomes in favor of participating products. We posit that clinical outcomes data are vital for improving patient care and furthering the field, yet these data must be legitimate.

Our standards should be anchored in transparency, impartiality, and patient-centered metrics to elevate pain care. While volume can be used as one parameter to define a COE, other metrics such as outcomes, infection rates, and complication rates should be considered when designating a COE. Independent bodies should award them with clearly defined criteria, publicly accessible data, and rigorous, peer-reviewed oversight.

The path to true excellence is not paved by branding, marketing, or procedural counts. It is measured by meaningful outcomes, ethical integrity, and our unwavering commitment to patients, not prestige. This effort demands action from multiple stakeholders. Professional societies must reassert leadership in defining and recognizing quality care. Clinicians should critically evaluate industry designations and prioritize evidence-based practice over promotional affiliations. Patients deserve transparent information regarding the meaning of these designations and what they do not mean. Policymakers and regulators should scrutinize the relationship between industry-sponsored recognitions and coverage decisions that may impact access to care.

As pain specialists, we should focus on collectively reclaiming the narrative regarding excellence in our field. We should celebrate and promote practices demonstrating commitment to comprehensive assessment, appropriate intervention selection, equitable access, and meaningful long-term outcomes, not merely procedural volumes or device utilization. Our patients, struggling with complex and debilitating conditions, deserve nothing less than excellence defined by their needs rather than market forces. The time has come to build a more transparent, equitable, and genuinely patient-centered pain care system, one in which a "Center of Excellence" designation truly reflects these values and serves as a beacon of best practices in Pain Medicine.

Disclosure

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References

1. Kandasamy T, Stockley RC, Hendriks JM, Fini NA, Bulto LN, Lynch EA. Conceptualising centres of clinical excellence: a scoping review. *BMJ Open*. 2024;14(12):e082704. doi:10.1136/bmjopen-2023-082704
2. Noe C, Kishino N, Gatchel R. Centers of excellence in pain management: past, present, and future trends. *Pract Pain Manag*. 2017;17(6). Available from: https://www.medcentral.com/pain/chronic/centers-excellence-pain-management-past-present-future-trends. Accessed May 3, 2025.
3. American College of Surgeons. Metabolic and bariatric surgery accreditation and quality improvement program. ACS. Available from: https://www.facs.org/quality-programs/accreditation-and-verification/metabolic-and-bariatric-surgery-accreditation-and-quality-improvement-program/. Accessed May 3, 2025.
4. American Society for Metabolic and Bariatric Surgery. MBSAQIP. Available from: https://asmbs.org/about/mbsaqip/. Accessed May 3, 2025.
5. Commission on Cancer Standards. ACS. Available from: https://www.facs.org/quality-programs/cancer-programs/commission-on-cancer/standards-and-resources/. Accessed May 3, 2025.
6. Amato L, Fusco D, Acampora A, et al. Volume and health outcomes: evidence from systematic reviews and from evaluation of Italian hospital data. *Epidemiol Prev*. 2017;41(5–6 Suppl 2):1–128. doi:10.19191/EP17.5-6S2.P001.100