

OPINION

Sibling anesthesiologists suggest clinical logbooks to counterbalance research publications and mitigate disparity between research output and clinical output

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ABSTRACT

The question is which medical specialties are most commonly performing biomedical research. The question is which medical specialties are most commonly receiving research funding. The question is which medical specialties are most commonly suffering research addiction. Considering that delivery of healthcare for humanity is closely intertwined with innovation in science for humanity, clinicians benefitting professionally by creating public records of their clinical logbooks may be able to mitigate disadvantaged disparity in professional growth secondary to clinical output as compared to professional growth secondary to research output.

OPINION

Every medical specialty is different and so is each medical specialty's research output. Every medical specialist is different and so is each medical specialist's research output. Sometimes, productive medical researchers work in medical specialties which are not able to provide conducive conditions for research output. Sometimes, research-resourceful specialties work with clinical specialists who are not able to translate research-conducive conditions into enriching research output.

Rephrasing the sibling authors' earlier questions (1-3), which medical specialties are most commonly performing biomedical

research (4-5)? Is high ranking in their research-resourcefulness secondary to their natural inclination to mandate their practitioners to be well-verse in paperwork management (6), whether for clinical, administrative, education or innovation purposes? Is there a vicious cycle where the research funds may be getting channelized to the already research-resourceful specialties (7-10), thus maintaining the status quo for medical specialties already marginalized by their multifactorial-low research output? Are disproportionately allocated research funds decomposing research scholars of research-resourceful specialties with research addiction as if age-old work addiction amalgamating with

new-age information addiction via round-the-clock internet connectivity available on smart-devices (11-19)?

Maybe medical specialties marginalized by their multifactorial-low research output can get inspired from 2003 biographical book “Moneyball – The Art of Winning an Unfair Game” and its Academy Award-nominated adapted screenplay for 2011 movie “Moneyball” (20-21). This book and its movie-adaptation have chronicled how a Major League Baseball team pioneered the Moneyball Strategy so that marginalized cash-strapped baseball teams can put up winnable fights in professional sports leagues (22). Maybe anesthesiology would need to think out of the box to overcome its low profile in terms of funding by the funding agencies whether they are public funders or private funders and whether they are government-based payors or industry-based payors.

Anesthesiology research is sometimes not even represented in major multidisciplinary journals (23). Sometimes, superior research aptitude among the applicants is not even the prerequisite to enter residency programs of anesthesiology (24). Interestingly, as compared to other medical specialties, anesthesiologists spending less time in paperwork management could be misinterpreted that they have sufficient time for administration, education and innovation (25). However, this may not be true. The apparent lagging of anesthesiology as compared to other medical specialties in research-resourcefulness could be multifactorial. As complexity of patients’ multimorbidity varies among medical specialties (26), is the avenue of clinical anesthesiologists’ round-the-clock management of multimorbidity in patients who belong to multispecialty surgical departments deterring clinical anesthesiologists from evolving as research anesthesiologists? Is the avenue of even administrative and education responsibilities of clinical anesthesiologists moving to operation rooms-theaters for sandwiching administrative and education responsibilities

perioperatively precluding clinical anesthesiologists from innovating as research anesthesiologists? Is the rarity of even dedicated office desks for anesthesiologists precluding the opportunities of even desk research (27), which may have limited but definite role in medical specialties aiming to innovate and excel? Is time-intensive perioperative clinical management accentuated work-life imbalance conflicting with time-intensive perioperative anesthesia research worsened work-life imbalance? For future growth of not only the medical specialists but also their medical specialties, isn’t the quality of research output more time-intensive than the quantity in research output? Shouldn’t the quality and quantity of clinical output tread shoulder-to-shoulder with the quality and quantity of research output? Shouldn’t medical specialties prevent their specialist researchers from descending into the rabbit hole of irreversibly imbalanced work-research-life?

Essentially, to mitigate disparity between research output and clinical output, it is time for clinicians to begin documenting their clinical logbooks on a daily basis (28-32), which should be in the public domain and thus accessible to peers and patients profiling their clinical acumen’s evolution. This would be analogous to researchers updating their research vita on a regular basis in the public domain (33), because peers and experts are expecting to profile their research aptitude’s evolution.

AUTHORS CONTRIBUTION

All authors have contributed equally.

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The authors haven’t used any generative AI/AI assisted technologies in the writing process.

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