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The New Phenotype of a Successful Medical Career. Something is Wrong?

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ABSTRACT

Importance: Liberal democracies based on merit and transparency have so far been rewarded by scientific and industrial production with the generation of greater wealth. However, meritocracy contains some weaknesses. The non-univocal definition of merit, the changed attribution of value between meritocracy and mediocracy, the lack of equal opportunities for the generation of skills as credentials of merit, and finally the parameters identified for its attribution as well as the easy instrumental manipulation of the same.

Objective: Therefore, a deep rethinking of merit, its essence, its value, and its evaluation seems an evident need.

Evidence reviews: Recently, in several healthcare compartments around the world, mediocracy was received attention and valorization for a lower attitude toward clinical performances but the highest attitude to passive prosthetic ramifications of administrative determinations. A new category capable of doing their bureaucratic work well without any personal thinking. The so-called coachable represents the new credential for the progression of medical careers.

Findings: A new phenotype of a medical doctor with great aspiration for a career is substituting pure competent. Merit in the definition that we know, is still the prevalent credential usable for medical career promotion? What is the system for the progression of medical careers in democracies?

Conclusion: Hereafter we are reporting the journey of a young aspirant to become a good doctor and the difficulties related to the critical parameters used to identify the talents and the criteria to accept to advance in a career.

Relevance: Whatever would be the perspective intrinsic value of merit in the forthcoming society we must defend the meritocratic equality of opportunity as the opposite of arbitrary discrimination, to be attractive for a young scientist.

Keywords: Medical Career; Academic; Non-Academic; Merit; Career Promotion; Phenotype of Medical Career-Advancing Doctor; Medical Parameters; Medical Competence; Medical Obedience; Medical Performances; Various Degree Of Performance's Complexity; Medical Credentials For Career Advancement; H-Index; K-Index; Transparency; Cooptation; Contest, Expected Results/Results Achieved

Introduction

Meritocracy Versus Mediocracy

Merit has so far represented the added value of democracies over authoritarian countries. Merit is the ability to perform a certain performance and how this something is done introduces a ranking of skills. In a complete democracy, merit is the necessary credential for social and career progression [1,2]. Competence is the result of the variable unitary composition of three different factors: intelligence, training, sacrifice. Talent must be rewarded in any way but never with the attribution of power. Therefore the term meritocracy here indicates who is designated to trace the paths of social paths, and who has the burden of giving indications for the benefit of the community not to lead to oligarchic degeneration. It needs formal recognition

for his greater social contribution. Talent owes its social credential to the randomness of fate, which made him born in that place and from that family, which allowed him qualitatively high training. If he had been born by chance elsewhere, with scarce economic possibilities he would not have had. This part of his merit - he must always think so - is a gift of fate, not his right. The same intelligence that supported his talent is strictly linked to the randomness of his birth and his unaware inheritance. Finally, the sacrifice used for his training commitment and the personal choices made following it is all personal merit. Which however is extremely inferior to those talents who become such by being born with humble origins, with scarce educational possibilities even with equal intelligence. Because the latter, to obtain the same credentials, must make considerably greater sacrifices. And despite this, even though democracy will never be complete until there are equal education opportunities, the social lift given by merit is the only virtuous ordinary tool to change and allow families to change social environments. Growing up.

If we consider the recruitment, selection, and valorization of applicants to medical careers both, academic and non-academic, several different criteria are adopted in different democracies. Where medical facilities have at least three categories public, private, and private affiliated with public or private non-profit institutions. Each with its method of interception and autonomous career promotion. From contest to cooptation through criteria including both of them. Always considering and declaring merit as the polar star of the selection. Recently, in several healthcare compartments around the world, mediocracy was received attention and valorization for a lower attitude toward clinical performances but the highest attitude to passive prosthetic ramifications of administrative determinations. A new category capable of doing their bureaucratic work well without any personal thinking. The so-called coachable represents the new credential for the progression of medical careers. Merit in the definition that we know, is still the prevalent credential usable for medical career promotion? What is the system for the progression's medical careers in democracies? With globalization, we have learned that we are all waves of the same sea. Hereafter we are reporting the journey of a young aspirant to become a good doctor and the difficulties related to the critical parameters used to identify the talents [3] and the criteria to accept to advance in a career [4,5].

Subsections Relevant for the Subject

How do you Train as a Doctor?

The career progression system in the medical community is structured and follows a well-defined pathway. Here are the key stages and designations within the career progression system by using different definitions according to the countries:

- Undergraduate Education
- Medical School
- Residency
- Board Certification
- Fellowship (Optional)
- Attending Physician
- Academic Medicine and Research
- Leadership and Administration

Continuous professional development, participation in conferences, research activities, and ongoing education are essential for staying current in the medical field and advancing one's career. With profound differences between countries.

What are the Procedures to Choose a Director in the Medical Department Unit? What Parameters are Used? There is a Contest or it is Coopted?

Some common procedures and parameters are typically considered in the selection process. Here are some key aspects:

- Job Posting
- Application and Screening
- Interview Process
- Evaluation of Qualifications
- Reference Checks
- Final Selection and Appointment

The specific process and parameters used can vary between institutions. Some organizations – often public administrations- may involve a formal contest or election process, where eligible candidates campaign and seek support from department members through voting. And their curricula should be coherent with the parameters requested and scored. Others may adopt a cooptation model, where the decision is made by senior leadership or a committee officially based on the qualifications and merits of the candidates. With or without responsibility for one's choice. It is important to note that the selection process aims to identify the most qualified candidate who aligns with the institution's goals, values, and strategic vision for the department. The process is typically designed to be fair, transparent, and focused on selecting a leader who can effectively manage the department, foster collaboration, promote excellence in patient care, and advance the field of medicine. However, it is useless to hide the co-optation, even if with these methodological premises, it is also more vulnerable than the competition (which also has weak points). Often the skill necessary for the position for which leadership is sought in some medical communities are built on the measure of the predestined winner and not the other way around, building the necessary skill and evaluating who has the requisites (6.9).

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And What About Criteria and Contests to Identify Associate and Full Professors in Medicine Areas?

The criteria and process for identifying associate and full professors in medicine areas around the countries selected typically involve a thorough evaluation of the candidate's qualifications, accomplishments, and contributions in several key areas [6-9]. While the specific criteria and process can vary among countries and institutions, here are some common factors considered:

- Academic Excellence: This includes a strong publication record with contributions to the field through original research, publications in reputable journals, book chapters, and other scholarly works. The impact and quality of the candidate's research, including citations and recognition from peers, are also important considerations. However, in some countries, scientific production can be questioned by the commission which, beyond the values, can invalidate its consistency with the role it intends to assume through competition. In other words, the discretion of the commissioners is that of the medieval prince. Or again the country standard provides for a period of specific scientific production to be evaluated and not the entire life. In some situations, this attribute is like a blanket that decision-makers throw at will by intentionally not looking at what they leave uncovered [10].
- Teaching and Mentoring: The candidate's ability to effectively teach and mentor students, residents, and fellows is an essential aspect. This includes evidence of teaching effectiveness, development of educational programs or curricula, and mentorship of trainees. Feedback from students, residents, and colleagues may be considered to assess the candidate's teaching and mentoring skills. Broad discretion.
- Clinical Expertise and Patient Care: In medicine areas, clinical expertise and excellence in patient care are significant factors. Candidates are evaluated on their clinical skills, experience, and outcomes. This can include patient satisfaction ratings, leadership in clinical programs, involvement in quality improvement initiatives, and other contributions to the advancement of patient care. Broad discretion because in a few countries, patient satisfaction is evaluated and above all the ratio for each candidate of the expected results for each performance performed by the candidates and the results obtained by them this evaluation is often bent at the will of the commissioners [11].
- Leadership and Administrative Abilities: Candidates are assessed on their leadership qualities and administrative abilities. This includes experience in leading research teams, clinical programs, or educational initiatives. Candidates who have demonstrated effective management skills, strategic planning, and the ability to collaborate and lead interdisciplinary teams are highly valued.
- National and International Recognition. Recognition within the broader medical community, including at national and international levels, is often considered. This can involve invitations to speak at conferences(by distinguishing academic versus pharma), participation in professional societies, serving on editorial boards, and receiving awards or honors for contributions to the field.

The selection process typically involves a committee or panel of senior faculty members who review the candidate's application, curriculum vitae, letters of recommendation, and other supporting documents. In some cases, external letters of evaluation from experts in the field may also be sought. The committee assesses the candidate's qualifications and accomplishments in the above-mentioned areas and makes a recommendation for appointment or promotion to the rank of associate or full professor. The prevalence of agreements between full professors of the discipline on the individual merit of candidates in some systems analyzed is clear and distorting. Non-transparency is an atavistic rule. Contests require value parameters and rules to be respected and it is not possible to announce a contest but know the name of the winner before its completion. The winners of a competition are often determined before the competition is completed. With direct or indirect "advice" that the commissioners address to the candidates to withdraw the applications under penalty of censorship from there to always the next opportunities for competition [12-17].

It is important to note that the criteria and process for identifying associate and full professors can vary between countries and institutions. Some countries may have specific guidelines and promotion tracks, while others may allow for more flexibility in evaluating candidates based on their unique contributions and strengths. The ultimate goal is to identify individuals who have made significant contributions to the field of medicine, demonstrated leadership and excellence, and have the potential to further advance their field as academic faculty members. However, the presence of many biases in the category of these criteria and the growing possibility of doping of the evaluation parameters themselves makes some criteria obsolete and too open to the discretion of those who favor agreements to censure the merits [5]. (Table 1). Today's question is: "Better a contest with these elusive rules or better a responsible co-optation (with concrete responsibility of the co-opt than the results obtained by the co-opt)?"(Tables 1 & 2) (Figures 1 & 2).

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Table 1: H Index abuse normalization attempt. Establishing ex-ante, the number of maximal studies a doctor performs in academic and non-academic environments. The evaluation of the specific value should be done within this number. All the exceeded number of productions is doping to obtain false credentials.

H Index Normalization Proposal		
H index started by first name	H index started by first name, divided by those with non-first author with various coefficient	H Index divided for the number of medical and biologist's components of the group with various coefficient
Crossbreed with authors not from your own unit to see swap works	Commissioner for competitions	Identify previous works of 5 years in which the judge was co-author and is working in another group.
Articles in first name / in second name or more >50%	Articles with last name <30%	Randomized interview on article content
Biological papers if you are clinical and vice versa (% if >10% cancel)	Meta-analytical works and systematic review (% if >25% and, descarted).	Original papers with first name/all published papers x100
Name exchange identification algorithm on jobs		
Citation exchange identification algorithm		
Speaker at congresses sponsored by pharmaceutical companies.	Invited as non-pharma sponsored academic speaker.	Speaker at congresses sponsored by pharmaceutical companies/ Invited academic speaker.
		==>1

Table 2: Clinical Competence. The % of expected results according to gold standard and achieved results as divided for degree of performance complexity are representing the clinical competence as part of the attributes which include empathy, team working and leadership.

Performances of Dr						
Degree of Complex	Date	Theatre	Severe complications	Gold standards expected results	Achieved results	Expected/Achieved Results %
High Complexity						
Mid Complexity						
Low Complexity						
TOTAL						

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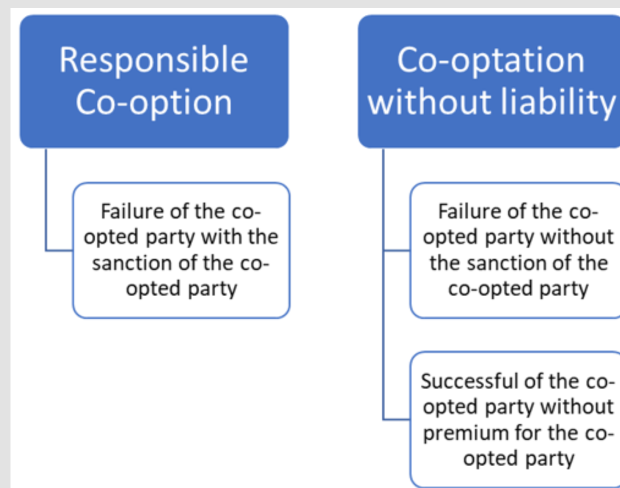

Figure 1: Responsible co-option for a medical position would be valuable for better selection rather than non-responsible co-optation. The co-opting membership candidates in the former case are discouraged if the sanction was significant.

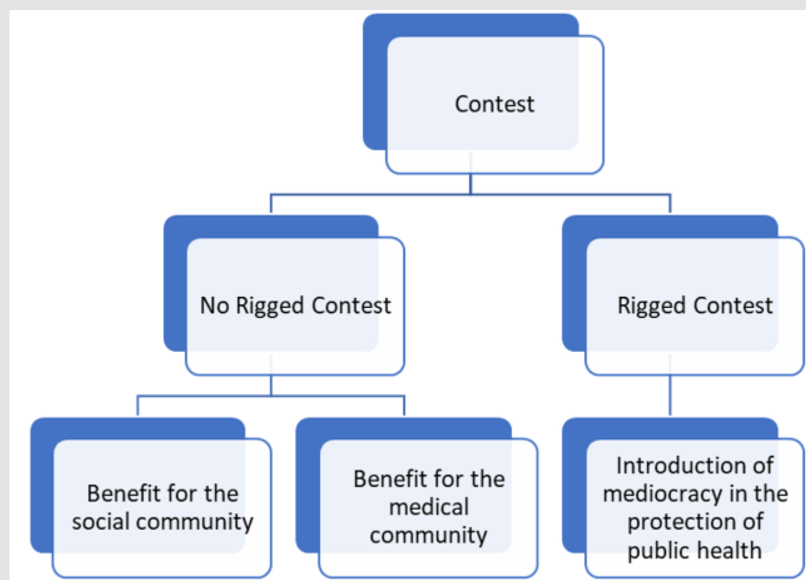

Figure 2: Unrigged contests are the best possible public service selection but are difficult to perpetrate in transparency and adherence to measurable benchmarks. The dangers consist of doping the titles to the profiling method of the required skill up to the discretion of attributing the scores. in some countries by the factual non-contestability of the results.

Leadership Positions in Medicine Areas of Non-Academic and Academic Hospitals are Based on Contests or are Recruited by Cooptations.

- The process of filling leadership positions in medicine areas, both in non-academic and academic hospitals, can vary depending on countries, institutions, administration (public versus private), and the specific position. In general, leadership positions can be filled through a combination of contests and recruitment by cooptation, depending on the organization's structure and policies.
- Contests/Elections: Some organizations, particularly public academic hospitals or those with a more democratic governance structure, may utilize contests or elections to select leaders. In this process, eligible candidates may campaign and seek support from colleagues or members of the organization. The selection may involve voting or other mechanisms to determine the most suitable candidate for the leadership position. Curricula parameters indicated as the contest's values should be evaluated with transparency and without conflict of interests.

- Recruitment and Cooptation: For leadership positions in both academic and non-academic hospitals, recruitment by cooptation is also common. Specifically in private property institutions. This involves identifying potential candidates through a targeted search or nomination process. The selection is typically made by a committee or a panel of senior leaders or stakeholders who evaluate the candidates based on their qualifications, experience, leadership skills, and alignment with the organization's goals. The selected candidate is then invited to assume the leadership position.
- It's worth noting that the specific process can differ among organizations, and some may adopt a hybrid approach that combines elements of both contests and cooptation. In these cases, the organization may encourage nominations or applications from qualified individuals, and then the selection committee or panel evaluates the candidates based on predetermined criteria.
- The ultimate goal in filling leadership positions is to identify individuals with the necessary skills, expertise, and vision to effectively lead the organization or department. The selection process typically involves careful consideration of the candidate's qualifications, leadership abilities, track record, and potential to contribute to the growth and success of the organization.
- It is important to note that the selection process for leadership positions may also vary depending on the level of the position (e.g., department chair, chief medical officer, or hospital administrator) and the specific requirements of the role. Additionally, organizations may have policies and guidelines in place to ensure transparency, fairness, and equal opportunity in the selection process.

What are the Most Important Attributes for the Evaluation of Medical Leadership for Both Contests and Cooptations? are the Evaluations and Committee Public and Transparent? Actions?

- When evaluating medical leadership, whether for contest or cooptation, several important attributes are commonly considered. These attributes can vary slightly depending on the specific leadership position and the organization's needs, but the following are generally significant factors.
- Clinical Expertise: Medical leaders should have a strong foundation of clinical knowledge and expertise in their respective fields. This includes staying up-to-date with advancements in medicine, demonstrating excellence in patient care, and maintaining a track record of successful clinical outcomes (this track varies depending on countries and its validation process is not uniform). The minimal objective records that are accessible and transparent are the number of performances collected for results expected (according to the gold standards) / results obtained. With specific records for the hospital or clinical centers and dates where were done.
- Leadership Skills: Effective leadership requires strong interpersonal and communication skills, the ability to motivate and inspire others, and the capacity to make informed and timely decisions. Leaders should also possess strategic thinking, problem-solving abilities, and the capacity to navigate complex healthcare systems. The reputation to be present for everybody who needs professional help in emergencies as an expert problem solver makes the figure of a leader stronger.
- Vision and Innovation: Medical leaders should have a clear vision for the future of their department or organization. They should demonstrate the ability to think innovatively and adapt to changes in the healthcare landscape. A leader who can identify emerging trends, implement new technologies or practices, and foster a culture of innovation is highly valued. The prerequisite for this evaluation is to have commissioners provide both vision and Innovation attitude otherwise this parameter remains unused.
- Administrative and Management Abilities: Leadership positions often involve administrative responsibilities, such as managing budgets, overseeing operations, and guiding strategic planning. Evaluating candidates for leadership roles include assessing their administrative and management skills, including financial acumen, resource allocation, and the ability to lead teams and initiatives effectively. These abilities are considered for whatever medical units but should be [18] deeply evaluated for the general director of a health care unit that administers a large number of resources.
- Collaboration and Team Building: Leaders should be able to foster collaboration, build effective teams, and promote a positive work environment. This includes cultivating strong relationships with colleagues, encouraging interdisciplinary cooperation, and supporting professional growth and development. Collaborative and coachable are different attitudes, the first always positive the second often introducing mediocracy rather than meritocracy
- Ethical and Professional Conduct: Integrity, ethical conduct, and professionalism are crucial attributes for medical leaders. They should uphold the highest standards of ethics, demonstrate accountability, and adhere to legal and regulatory requirements. This parameter is widely considered within the countries considered. Some of them are considered secondary rules, normally in countries with low evidence of transparency.
- Regarding the evaluations and committees, the level of transparency can vary between organizations [16-20].

- In many cases, organizations strive for transparency and make efforts to ensure that the evaluation process is fair and unbiased. However, the specific details of the evaluations and the composition of the committees may not always be disclosed publicly due to privacy and confidentiality concerns. Organizations may have policies and guidelines in place to maintain the integrity of the evaluation process while respecting the privacy of candidates.
- In some instances, organizations may involve representatives from various stakeholders, such as medical staff, administrators, and board members, in the evaluation committees to ensure a diverse perspective. However, the exact composition and processes can vary between institutions.
- While transparency and public disclosure of evaluation details may not always be feasible, organizations typically aim to follow established protocols, maintain accountability, and select leaders who can effectively drive positive change and meet the organization's goals and objectives.
- Unfortunately in some cases committees themselves contain biases. The commissioner of public service may be the prosthesis of the employer of another commissioner who will never give an opinion that does not conform to that of the employer[12-15].
- Another example of a sensational conflict is that of scientific societies that have owners or paid representatives on their board of directors owned by most of the medical centers that the society deals with. Every guideline and every position paper of the society will be prosthetic of the property that stands behind it. And this happens too often in some countries analyzed. The authors, convinced of their honesty, only see the conflicts of others but not their own [21].

How to Select General Directors of Healthcare Structures

This aspect applies to candidates for directors of departmental medical units but not to fiduciary co-opted general directors of health care structures. On different parameters from country to country. In some countries (e.g. Italy) candidates can be appointed within those registered in the national list of directors general. Requirements for enrollment in the national register are a) degree under the regulations in force before the ministerial decree of 3 November 1999, n. 509, or specialist or master's degree; b) proven managerial experience, at least five years, in the health sector or seven years in other sectors, with managerial autonomy and direct responsibility for human, technical, and or financial resources, gained in the public sector or the private sector; c) certificate issued upon completion of the training course on public health and health organization and management; d) under sixty-five years of age [22].

- In other words without high stratified competence requirements but only of belonging (political or other lobbies) while administering without a board of directors huge amounts of money up to 2.2 billion dollars a year [23]. Fiduciary co-optation some call it, political clientelism others. Since they were often Caligula's horses.
- The cascade of vicious phenomena envisages here that a plenipotentiary general director is uncritically co-opted by local politics, he in turn co-opts a department director on a trust basis and often the director of an operational unit is chosen by direct competition. What guarantees does the client of healthcare services delegate to someone to receive qualitatively adequate services?

How Would you Define the Medical Career Selection System: Valorization of Merit or Valorization of Membership in the Academic Community and Lobbies??

- The medical career selection system is generally based on a combination of merit and membership in the academic community. Often by belonging to lobbies rather than by the merit of the candidate. This appears more understandable in pure co-optation systems or mixed ones, whereas it also happens in public tenders. too much discretion of the commissioners and too many conflicts of interest. If an academic does not comply with the decisions of the elite of the discipline, he will never have any winning candidates in future competitions. In some countries with less transparency [11-21], the decision to win a competition is always taken first by a few who then have the dirty work done by conditioned commissioners.
- In non-academic competitions, in the same countries, the discretion of the Director General in the choice and the conditioning for different reasons of the commission produce the same result [11-21]. Of belonging, not necessarily being, to win It is important to note that the system is complex and can vary among specialties, institutions, and individual career paths.
- Merit-based Selection: Merit is a crucial factor in the medical career selection system. Physicians' qualifications, skills, achievements, and contributions are evaluated based on objective criteria such as academic performance, clinical expertise, research productivity, leadership abilities, teaching effectiveness, and patient care outcomes. These factors are typically assessed through rigorous processes such as academic reviews, peer evaluations, research publications, grants, and professional accomplishments. Merit-based selection aims to identify and reward individuals who have demonstrated excellence in their respective areas of specialization. While merit plays a significant role in career advancement, including appointments, promotions, and recognition, membership in the academic community and professional

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networks can also influence opportunities and success in the field. However today the credential of merit is losing value for two reasons: the lack of transparency in its determination of values and the search for the mediocrity that is more functional to administrative powers, even if less to those of care.

- Academic Community and Professional Networks: Membership in the academic community and professional networks can also have an impact on career opportunities. Being affiliated with prestigious academic institutions, participating in research collaborations, and engaging in academic activities such as publishing, presenting at conferences, and serving on committees can enhance visibility and reputation within the medical community. Academic affiliations can provide access to resources, mentorship, research funding, and career development opportunities. Professional networks and associations also offer opportunities for networking, collaboration, and advocacy, which can influence career advancement [22-28].
- Lobbies and Advocacy: While not exclusive to the medical field, lobbies, and advocacy groups can influence the healthcare landscape and policies, which can indirectly impact career opportunities. These organizations advocate for specific interests, such as research funding, policy changes, or regulatory reforms, which can shape the environment in which medical professionals operate [22-28]. Involvement in these groups can provide opportunities to influence policy decisions and drive change that benefits the medical community and patients. While the influence of lobbies and political connections exists in various domains, including healthcare, it should be not the primary factor for career advancement in the academic medical field [22-28].
- It is important to recognize that the medical career selection system is influenced by multiple factors, and the balance between merit, academic affiliation, and professional networks can vary across different specialties, institutions, and regions. While merit is generally valued and serves as the foundation for career progression, the support and opportunities provided by academic affiliations and professional networks can enhance a physician's career trajectory. Ultimately, a combination of merit, professional networks, and advocacy efforts can contribute to success in the medical field.
- The possibility of doping the qualifications that allow one to obtain career promotion credentials has made the whole system less authoritative and therefore the meritocratic system which has always been criticized by those who resented its authoritativeness is now being questioned through its specific replacement with a system of mediocrity talent replacement with good executors of bureaucratic procedures better coachable and very administratively efficient. [5-21].

As an Inevitable Consequence, a Young With a Vocation for a Medical Career Asks His Tutor: to Make a Career in the Academic Medical Field is it Better to Be a Bearer of Culture and Competence or Belong to Lobbies of Power?

- In the academic medical field, both culture and competence as well as involvement in professional networks and advocacy efforts can be influential factors for career advancement. While there is no definitive answer as to whether one is inherently better than the other, it is generally recognized that a combination of both can be advantageous. We are not talking about what is right but what is convenient for this potential candidate.
- Culture and Competence: Being a bearer of culture and competence, meaning possessing a strong foundation of knowledge, skills, and expertise, is crucial for success in the academic medical field. Academic institutions and organizations value individuals who demonstrate scientific integrity, critical thinking, and the ability to contribute to advancements in medical research and education, exceptional clinical expertise, research capabilities, teaching abilities, and a commitment to patient care. Building a reputation for excellence in these areas can open doors to research opportunities, leadership positions, and academic recognition. Demonstrating a dedication to lifelong learning, staying up-to-date with advancements in the field, and consistently honing one's skills are important aspects of advancing in the academic medical field. Being a bearer of culture and competence is highly valued in the academic medical field. Demonstrating a deep understanding of medical knowledge, clinical expertise, research capabilities, and a commitment to ongoing professional development is essential for success. Academic institutions prioritize scientific integrity, critical thinking, and the ability to contribute to advancements in medical research and education. Building a strong academic profile, publishing high-quality research, and participating in academic conferences and activities are important for career progression.
- Involvement in Professional Networks and Advocacy: Being involved in professional networks and engaging in advocacy efforts can also contribute to career development in the academic medical field. These activities provide opportunities for networking, collaboration, mentorship, and exposure to new ideas and research. Joining professional organizations, attending conferences, participating in committees, and contributing to the academic community through research publications and presentations can expand professional connections, enhance visibility, and open doors to career advancement. Advocacy work can influence policy decisions, shape the healthcare landscape, and create opportunities for

professional growth and leadership roles.

- Lobbies of Power: While political influences and lobbies of power exist in various sectors, including healthcare, their impact on individual career progression in the academic medical field is generally less pronounced compared to factors such as competence and merit. With the large degree of variability depending on the country and the institutions [21], The academic medical system prioritizes rigorous evaluation processes based on scientific expertise, research quality, and teaching abilities rather than lobbying or political connections. Individual achievements and contributions in terms of research, publications, teaching, and clinical excellence are typically the key drivers of career advancement. With some important exceptions due to lack of country transparency in academic and non-academic medical career promotion and disvalues becoming apparent in the supposed strong parameters to use as credentials in meritocratic medical community organizations.
- The combination of culture and competence with involvement in professional networks and advocacy efforts can be particularly advantageous. Demonstrating expertise and a commitment to advancing the field, while also building relationships and actively contributing to the larger medical community, can enhance career opportunities and influence the direction of one's career.
- It's important to note that individual career paths can vary, and different factors may hold more weight depending on personal goals, interests, and the specific academic institution or organization. Ultimately, a well-rounded approach that combines culture, competence, networking, and advocacy can maximize opportunities for career growth and success in the academic medical field.

Medical Leadership Selection Criteria Around the World: What Countries are Based on Contests, What on Cooptation, and What on Both Criteria?

- The selection criteria for medical leadership positions can vary across countries, and different countries may employ different approaches such as contests, cooptation, or a combination of both. It's important to note that the following information provides a general overview and there may be variations within each country.
- Contests-Based Selection: United States: In the United States, leadership positions in medicine are often filled through a competitive process that involves open recruitment, applications, and interviews. Academic medical centers and healthcare organizations typically have established selection committees or search committees responsible for evaluating candidates based on their qualifications, experience, leadership skills, and vision for the institution.
- Cooptation-Based Selection: In France, the selection of medical leaders can involve a cooptation-based approach. The process often involves senior medical professionals nominating and selecting candidates based on their expertise, reputation, and contributions to the field. The role of professional networks and relationships can be significant in this process.
- Combination of Contests and Cooptation: In the United Kingdom, the selection of medical leaders can involve a combination of contests and cooptation. Some leadership positions, especially within academic institutions, may be filled through competitive processes that include applications, interviews, and assessments. However, cooptation can also play a role, with existing leaders or influential figures nominating or recommending individuals based on their reputation, achievements, and connections. Germany employs a mixed approach, combining contests and cooptation. Leadership positions in medical institutions are typically filled through a competitive process that involves applications, interviews, and evaluations based on qualifications, experience, and leadership abilities. However, the influence of cooptation and professional networks can also be present, with recommendations and endorsements from respected individuals within the medical community carrying weight in the selection process.
- It is important to remember that these categorizations provide a general overview, and practices may vary within each country depending on specific institutions, regions, and contexts. The selection criteria for medical leadership positions are subject to local policies, cultural norms, and organizational practices.

In some countries (e.g. Italy), the selection of medical leaders typically involves a combination of contests and cooptation, with variations depending on the specific context and institution. Here's an overview to try to better understand this specific complex system:

Contests-Based Selection:

- Academic Institutions: Within academic medical institutions in Italy, leadership positions such as department chairs or directors are often filled through competitive processes. These processes may include public calls for applications, assessments of candidates' qualifications, interviews, and evaluations by selection committees. The selection criteria generally focus on academic qualifications, research productivity, teaching experience, and leadership potential.
- Why the winner is known before the contest is concluded? Do not chase the commissioner, follow his container. The way by which to orient the commission is not so much to rig the commissioner recruitment system as to make the container of potential commissioners subject to tacit blackmail. Whoever is chosen is in a position to follow the indications

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or no longer have any chance of a career for their disciples. Because sooner or later one of his candidates will find himself in the same position with the same actors. No one asks anyone but everyone knows what they have to do.

- Candidates receive transversal messages to withdraw from the competition, especially if they have major qualifications, under penalty of exclusion in this and all future competitions. Sometimes through their superiors.
- Transparency does not exist because the system has a solid majority of the academic world in particular who barter power for their advantages with methods as old as the world but refined and unrepentant.
- Whoever asks why someone doesn't rebel is answered that it has always been like this and always will be like this. Every process carried out ends with an acquittal or with modest penalties that border on impunity but always with the ruin of those who report [22-31].
- In the academic and non-academic recruitment system of Italian doctors, for example the crime of office abuse (article 323 of the Italian penal code) - which also includes rigged competitions to a small extent led - in 2021 - 4745 entries in the register of suspects and only 18 first-degree convictions and that of trafficking in illicit influences (a crime foreseen and punished by article 346-bis of the penal code) were classified as crimes in 2023, leaving new prairies for prevarication of the merits

Cooptation-Based Selection:

- Hospital and Healthcare Institutions: In non-academic hospitals and healthcare institutions in Italy, the selection of medical leaders can involve a cooptation-based approach. Existing leaders or influential figures within the institution may nominate or recommend individuals based on their expertise, professional reputation, and track record of achievements. Professional networks and personal relationships can play a significant role in this process.

Combination of Contests and Cooptation:

- Professional Associations and Societies: In certain cases, leadership positions within professional medical associations and societies in Italy can involve a combination of contests and cooptation. These organizations may have formal election processes where members vote for candidates, and the results determine the leadership. However, cooptation can also come into play, as influential individuals within the association may endorse or support specific candidates based on their professional standing, contributions to the field, and relationships within the association.
- It is important to note that the specific selection procedures and criteria may vary across different regions, institutions, and organizations within Italy. Additionally, changes in regulations or practices over time can also influence the selection process for medical leadership positions.

Do We Need More Talents or Mediocrity?

While the question seemed rhetorical up to 10 years ago, today it appears very topical. Talent in the category of predefined organizations with consolidated procedures, not very prone to unplanned change, is worth less than a good bureaucrat well trained in applying the rules and executing the protocols and the procedures elsewhere designed without customizations. Management of a healthcare company or a hospital increasingly prefers to select mediocre people, giving up extraordinary performances to have ordinary management of good and efficient quality. Except when the manager himself will need care and will be busy looking for talent. The issue is destined to worsen and the proof is given by the fact that artificial intelligence applications are in the process of being approved as a medical devices in the USA [32].

How to Select Talents?

Scientific publications should be evaluated in hierarchical order in respect of the original works as largely first and much lower evaluation for systematic reviews and meta-analysis. Proportions should be put in place in each CV of original papers with the meta-analysis by establishing minimum coefficients of value attributed to the authors (e.g. at least 10:1). Costs should be contained with evaluation by international third-party commissions (e.g.reviewers of international journals) to economically support by government founds original studies based on good ideas. Because today the cost of studies of interest not from big pharma is unsustainable by anyone but in particular by young people who - by birth certificate - have good ideas but lack the resources to implement them

Work should have a substantially higher rating when:

- Develops promising concepts for the progression of the discipline
- It marks a change in the medical procedures carried out thereto
- Discover new significant characteristics of diseases or protection against them
- Bring about any significant change in medical practice

Relegating the others to lower scores, because there are a plethora of articles that do not advance the medical profession in anything but are equally cited to rewrite other articles that add nothing except citations for instrumental use. Conflict of interest with Big Pharma's indirect relationship with the authors should be investigated more deeply. Guidelines, position papers, classification criteria, etc are activities of great collective importance but they cannot come under the same individual attribution of value as that of original works with significant achievements for metrics. Yet they often have much larger

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citations because they serve to frame groups of patients, procedure standards, and more. Yet they often have much larger citations because they serve to frame groups of patients, procedure standards, and more. Often the inclusion in the groups that prepare these documents is done for militancy not for competence. Bias in selection criteria (Tables 1 & 2).

What is the Worst Consequence of the Inability and/or Unwillingness of the System to Identify, Recruit and Value Merit and to Deliberately Choose Mediocracy as a New Epochal Deal?

That if you promise merit as a credential for social promotion while penalizing it at the expense of belonging to lobbies of any kind, you break the lives of generations and frustrate the hopes of young people. Abnegating the virtue of medical culture to the pragmatism of its orderly, even less ambitious management. Thus shifting the center of gravity of the objectives of the young aspirants from the value of culture to that of making important friends. [5-21].

Parameter to identify merit

H-Index

Questions

- What can be the reasonable maximum scientific production in a year of a doctor? 3 to 6 ? 6 to 8 or what else?
- And for how many years can I produce at most?
- And how many articles can be considered: all or just a part? What part? [33].
- Must the scientific production of a candidate as well as continuous be limited to a period per associate professor and per full professor?
- Why if the full professor has a prominent didactic function should be not valuable to the complete life scientific production?
- How it is possible to compare the H index of a doctor of some disciplines which include different skills medical or surgical such as Obstetrics and Gynecology where that medical have larger potential productivity?

H index biases

In the evaluation of the H Index, there are some easily identifiable biases

- Is the value of an author who has done the work compared to the one who found you the money to do it equal value?
- The doctor who owns a health facility (clinics, institution, directors of network of institutions) who gets his name put in the study doesn't even know what he's talking about or has equal value.
- Does the head school or director of a unit or department who does not even participate in the final draft of the work but claims its name, under penalty of retaliation, have the same value?
- Does the full professor who is a commissioner in competitions and is cajoled with a name on the works have the same value as the one who conceived and made the work with his own hands?
- Does anyone who co-opts a work unit with 40 doctors who do scientific work and includes the director in the group of authors have more merit than someone who manages a group of three doctors?
- Do the new open-source journals have the same value as classic journals?
- Does the reviewer's policy of most reputational journals have a new and revisited transparency policy?
- Are journals of scientific societies that have their author on the editorial board or in Special interest Groups subject to a conflict of interest?
- Does the assessment of merit based on the previous 10 years for a full professor qualification make sense given that its main function should be teaching? Or is it done speciously to recruit predestined people to attribute titles by concentrating them for the purpose?
- Quotations are mistaken for friendship or plenipotentiary stable orders, i.e. they are easily doped. If an essential parameter of a ranking can be doped, is the ranking reliable?
- There are public university departments with more than 40 doctors who publish annually according to their duty, scientific directors can profit from the scientific production of individual doctors without dedicating work to it with an abnormal scientific production. Scientific directors can also enhance the CV of their candidates for the next appointments to associate and full professors by having their names put in the works of all 40 doctors Who will not refuse tacit blackmail. Merit?
- There are private healthcare networks (whether plastic surgeons, dentists, or reproductive doctors) that move over $20 billion each year. Thanks to the number of doctors who revolve around these volumes of money, directors can profit from the scientific production of individual doctors without dedicating work to it with an abnormal scientific production. Merit?
- The scientific production of medical disciplines towards surgical disciplines is notoriously greater due to the complex nature of the work. There are disciplines (obstetrics and gynecology) in which we have surgical skills and medical skills that compete in some countries for positions of director of a complex structure that include both. Those with mainly medical skills will always win a competition on the H index even if they don't know how to solve highly complex surgical

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problems that they would have to do. That is unless he is a surgeon who has bartered his surgical expertise with those who have written his works, covering up their surgical weaknesses. Which merit singles out the H index here

- There are biologists or MDs fully dedicated to research supporting all disciplines or in medical departments who have a job that allows them a far greater scientific production than doctors due to the absence of clinical activity, the almost general lack of need for authorizations from ethics committees, etc. The scientific production of these professionals in the medical area should be separated from that of doctors but often it is not, introducing an evident bias
- There are present or past Editor in Chief of some journals who publish in their Journal or doctors of their team that are publishing without mention of the conflict of interest
- There are doctor partners in commercial companies that publish papers of his partner in the journal where they are Editor in Chief without mentioning of conflict of interest
- There are papers published with 14 to 18 names and more without roles rather than the country's opinion leaders of the disciplines.
- There are papers published with the assistance of commercial companies of Pharmaceuticals or Devices and financial company owners of clinical or medical centers network. Are those efforts equal to that without them?

The K-Index Was Introduced to Avoid Part of the Biases Included in the H Index and Its Use Should Be Discussed [34].

The Conflict of Interest: Predatory Versus Reputable Journals Run by Disvalues

Today an original study that meets the preferential requirements of good reputable journals (e.g. NEJM) "original research that is destined to change clinical practice and teaches something new about the biology of disease" has high costs, unaffordable by most of the bearers of innovative ideas [35] These studies can be financed by large donors of public funds (few, selective and usually donors to structures with a well-established reputation) or by pharmaceutical groups which, however, finance projects on pre-finished products not on ideas and projects and with short-term returns. not within the reach of young bearers of ideas Today, therefore, the search for original studies is mainly produced by economic interest groups. Therefore, it is the market and not the community that establishes the direction of research in one direction or another. Which, when it comes to private money, is not scandalous, when it concerns public money, yes. There is a lack of informed social consent to the allocation of public resources. Then there is a visible growing plethora of reviews, systematic or otherwise, with half or fewer reviews being encouraged by all scientific journals in dire lack of original studies. Some journals are now called predatory because they are new, often open access, and, according to some, very aggressive in recruiting articles but not very critical in access. But if this is true, another truth is never denounced at the same time.

The one for which most titled journals are largely permeable to magical circles of notable researchers, often co-opted by big pharma groups, often included in the elite of scientific societies or in their special interest groups that function with the tacit identity of mutual aid societies. By publishing works on nothing by some and rejecting works of some interest by others. Without criteria of merit but only of belonging. The journals themselves spontaneously or at the request of the industry co-opt the most visible elements on the editorial boards to co-opt them by sweetening their critical activities. So in truth if we have predatory journals on the one hand we also have journals that interpret conflicts of interest in a rather lax and convenient way for their purposes, only sometimes editorial ones, on the other. We then have groups of researchers brought together by large financial groups which, by managing chains of clinics or medical centers, are privileged interlocutors of big pharma in its commercial capacity and directly or indirectly promote studies or reviews with populations of stadium authors for the promotion of opinion leaders who pay. With some influence on the editorial boards of all the journals which are made up of scientists who are unlikely to be orphans of pharmaceuticals or large business groups anointed by a profit-making interest in the exercise of their duties. Sometimes proposing with proposals that are difficult to refuse, even editors in chief. So there is this problem, which has not been adequately addressed.

The Phenotype for Leadership Positions in a Medical Career. How to Change the Paradigm

The phenotype of the doctor who makes a career today is the astute doctor capable of governing practices without the necessary intimate medical competence for mid and high complex performances. A doctor who - having acquired the knowledge of slavish compliance with bureaucratic, formal procedures and compliance with visible or invisible hierarchies - employs his time in the search for his inclusion in professional, political, or business lobbies, and in researching voluminous scientific production, even if of little value, through the inclusion of one's name in the majority of possible works, exchange of names with other accomplice authors, use of journals with low critical selectivity, use of magic circles for the exchange of scientific citations, use of many articles through systematic reviews or not, with meta-analysis or not often produced on commission from pharmaceutical companies and/or paid by analysts and statisticians by properties with purposes other than that of the patient's good. By creating a pamphlet of titles, mostly fake and in any case without any value of originality, without any qualitative procedural or knowledge advancement that marks a fundamental step for the discipline itself. To be weighed rather than critically evaluated. Whether it is carried to the goal by a plenipotentiary of the medical community or by a majority group of it. Without any reference to professional competence

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but with a very close relationship to cunning in the spirit of the accomplice of a system aimed at recruiting the obedient rather than the competition or the courtier rather than the leader. The time has come to change the paradigm of the identification, recruitment, selection, and enhancement of merit. Introducing a new phenotype of a doctor who accesses leadership functions.

A re-definition of merit is understood as competence in carrying out performances at any level of complexity or compliance with the exercise rules written by the management with medium problem-solving skills for intimate medical problems but good skills in respecting administrative procedures. A redefinition of the parameters useful for profiling and selecting candidates through culture and competence instead of doped indicators of scientific productivity and no longer meaning as well as interpersonal knowledge and memberships in magic circles of power within the medical community. A rewarding and valorization system for those selected through the recognition of merit established with new and shared criteria, with clear and transparent methods whether they are applied through competitions, responsible co-opting, or non-responsible co-opting. The credibility of this medical and scientific community is at stake. The future of entire generations of people suited to the practice of medicine is at stake. the future of our health is at stake

Discussion

Identification, recruitment, selection, and enhancement of merit in the medical, academic, and non-academic fields. Two variables are recently endangering the attribution of credential value to merit and some system degeneration in the parameterization of merit in the medical, academic, and non-academic fields. The first variable is that of the progressive lack of attribution of value to less qualified work with an evident imbalance between talents and those who do not have this talent. Generating populism towards cultural leaderships The second variable is that of the attention, progressively more and more benevolent, given to good bureaucrats who know the rules and slavish executors of procedures, often referred to as talents. Medical career and its pathway [36] are described in the milestones guide [37] Indeed, the primary credential for the promotion processes of scientists at research universities in the U.S. and many other countries is the number of published articles and the ranking of the journals in which they were published [38]. The parameterization of merit is then staggering. It happens today that there are too many distortions of values with the H Index doped and confusing the values of merit. Often identifiers of cunning and non-competence. There is tremendous attention to the publication metrics among doctors [17]. The h-index is a great scientific community indicator [17]. And it is often used in doctors' recruitment in academic medical careers [39]. However, there are also examples of scientists who advertise their h-index on the front page of their website.

We have reached the point of ridicule with doctors who, driven by the aspiration of becoming characters lacking in personality, promote their h-index on the first page of their site [21] Despite the biases in using uncritically h Index as a credential for competence in the recruitment of talents within the academic medical career [20] today you are forced to choose between adapt or perish [38-40] [5]. However several behaviors in medical research should run within the intimate ethical integrity of both researchers and medical journals [33-43] (Tables 1 & 2).Otherwise, the entire system in both academic and nonacademic medical careers will collapse into the ranks of poor collective reputation As already established in the past "We need more controlled studies on authorship issues, an increased awareness and a buy-in to consensus views by non-editor groups, e.g., managers, authors, reviewers, and scientific societies, and a need for editors to express a greater understanding of authors' dilemmas and to exhibit greater flexibility" [44]. Because the inappropriate authorship attribution generates biases in evaluating merit and competence for some medical career advancement [45,46]. The h Index is the main metric parameter used in medical scientific production [47] However, the k-index was introduced to avoid part of the biases included in the h Index and its use should be discussed and possibly encouraged [48]. In one symposium of 2021, the speakers emphasized the importance of distinguishing between the concepts of the number of citations and their impact and that scientometric analysis should take into account two very important variables: each author's contribution, when there are co-authors of the article, so the number of citations from the total number of authors should be divided by each co-author individually, and not for each co-author to receive a citation as if they were the first; and it is necessary to take into account the evaluation of the quality of the content published in the research results in the paper published and stored in the index databases.

Furthermore, scientometric indices (h-Index, Google Scholar index, etc.) to evaluate scientific research and their results are necessary for academic practice but their ambiguities must be improved in the future (Tables 1-3). Between the method of cooptation - responsible or not for whoever is co-opted - and competition, it is no longer possible to identify the best (Figures 1 & 2). Or maybe you don't want good and honest executors of procedures for better efficiency at the base of the pyramid of medical services offered than excellent and imaginative talents. A profound review of the criteria for qualifying merit in the medical-scientific field is needed, just as analytical strength and evaluation transparency to the selection choices of doctors in their academic and non-academic, public or private career progression.

Table 3: Competential Titles to Establish as Credential of Merit.

Competent Titles	
Parameter	**Score**
Performances: Expected results according to gold standards/Results achieved by type of performance, date, institution of origin. Free access for verification	1-10
Publications of original research that is destined to change clinical practice and teaches something new about the biology of disease.	1-10
H Index evaluated for the maximal production per year established (number of articles published/ Maximum number of scientific studies that a medical researcher can carry out per year) normalized for first name authorship, authorship sharing, citations sharing, argument of the publication coherent with the skill, knowledge of the content	1-10
Annual patient satisfaction rating. Free access for verification	1-8
What colleagues says about him.	1-5
Number of civil and criminal prosecutions suffered/convicted and without conviction- Free access for verification	1-5

Conclusion

Liberal democracies based on merit and transparency have so far been rewarded by scientific and industrial production with the generation of greater wealth. Alternative systems based on the misunderstanding between equal rights and wage egalitarianism have lost the comparison if it is true that these are all autocratic countries from which there is a propensity to expatriate while there is no equal propensity against. However, meritocracy contains some weaknesses. The non-univocal definition of merit. the changed attribution of value between meritocracy and mediocracy. the lack of equal opportunities for the generation of skills as credentials of merit and finally the parameters identified for its attribution as well as the easy instrumental manipulation of the same. Therefore, a deep rethinking of merit, its essence, its value, and its evaluation seems necessary Whatever would be the perspective intrinsic value of merit in the forthcoming society we must defend the meritocratic equality of opportunity as the opposite of arbitrary discrimination, to be attractive for a young scientist.

Conflicts of Interests

No conflicts of interests.

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28. Concorsi truccati, sospesi il rettore dell'università di Catania e 9 professori.
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