EDITORIAL

Technology, Bureaucracy and Common Sense.

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In the last issue, Cartes *(2018)* commented on the relevance of the Centers for Health Piloting *(Centros de Pilotaje en Salud, CePIS)*. CePIS could be a great opportunity for entrepreneurs and startups in the health sector, as they might help "to validate hypotheses, perform tests and implement the solutions that each team has in mind through an acceleration methodology, under a specific segmentation, according to public and private market requirements".

As Cartes *(2018)* explained, there are some obvious differences between a health product/service and a non-health one, especially on "quality standards, intrahospital interoperability, safety, precision, patient care, among others". Thus, in order to comply with these standards, some basic regulations must be considered. These regulations are commonly well intended, of course, but in practice those good intentions are not enough to assure positive results. Moreover, as Cartes *(2018)* pointed out "within the same health sector arise the main barriers to the development of technological alternatives. Until now, there was no entity in charge of articulating and communicating innovators with healthcare providers, whether due to distrust, reluctance to change or any other reason".

Thus, from my point of view, the critical aspect in this regard is what kind of regulation must be implemented in order to comply with minimum standards of quality and care, but also how these regulations foster and motivate stakeholders *(especially entrepreneurs)* to create better *(maximum)* standards of quality and care. In other words, how can non-maleficence be assured without compromising beneficence.

In my experience, this is and will be a hard task to accomplish, as there are persons focused on non-maleficence *(bioethical committees)* and other persons focused on innovation *(entrepreneurs and startups)*. The interests and practices of these two groups of people are clearly different; in fact, their professions are commonly different. However, if you see the bigger picture you could realize that interests are quite similar for both groups, that is, to deliver the best healthcare possible.

I propose three ways to address this situation, all related to education or training of these groups of people. First, to create multidisciplinary programs where health and social science professionals can work side by side with engineering and design professionals. Second, to create and foster dual degree programs where professionals from both areas can get training *(and degrees)* in order to get the bigger picture. Third, to create and fund positions inside the hospital for engineering and design professionals. These proposals have been extensively used across the world. In Chile, some programs have been created,

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but we are very far from an ideal situation. The aim of these three ways is to integrate different views in order to get the bigger picture, which is the ideal situation.

Integration is really important when you want efficacy, and especially efficiency, because that demands trust, and it is hard to trust if you do not know how a health/social or engineering/design professional works. Furthermore, if there is distrust inside a team, it will be quite likely that many regulations will be created to reduce the vulnerabilities generated by that distrust. Thus, many regulations and resource allocations will be aimed at avoiding vulnerabilities, but not at delivering the best healthcare possible.

On many occasions I have heard that the problem of regulations is a problem of good intentions and common sense, but that is half of the truth. Common sense must be shared; it is not intrinsically but socially common. Thus, we must create a common sense for all professionals working in healthcare.

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