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Review of article by Bez-Tzion Karsh et al.

I believe fallacious thinking is an inevitable subproduct of strong human agendas, particularly when there are multiple misaligned incentives among participating agents. The ability of the human brain to tolerate cognitive dissonances is fascinating, as well as understandable from an evolutionary perspective. It was not in-depth scrutiny for logical consistency and sound reasoning what caused the exponential dominance of our species, but our ability to cooperate at increasingly larger and more complex levels by sharing narratives that simplify said complexity into a unified intersubjective truth towards a shared interest. Healthcare systems have an interesting overlap of multiple levels of sociotechnical complexity in which a very heterogenous set of agendas often get in conflict. Logical fallacies, like the ones described in the article, represent one of the many cognitive devices aimed at reconciliating the inevitable dissonance and misalignments in these conflicting agendas.

It is my opinion that the role of the corporate capitalist agenda is often underappreciated when analyzing healthcare complexity in non-single-payer systems. It might be mentioned, as in the article, as just another thing to take into consideration. To me, this is equivalent to naming **gravity** as just one more thing to consider when analyzing the issue of objects falling to the ground, at the same level than air friction or object size and form.

This can lead to some naive assumptions, such as the optimistic tone of the article when inviting us all to just “remind” that what we all want and care about is better, more efficient, higher quality health. Whose priority is that? That would certainly be in the best interest of patients and their loved ones, but what about everyone else? Behavior science is descriptive, not prescriptive. A predictable set of responses is expected upon different incentive structures. Change incentives, and you will get different behaviors. Capitation Vs. fee-for-service models will lead to tremendously different clinical algorithms. What makes us expect free-market incentives towards potentially limitless profit from HIT development would stay grounded on an implicit unenforced ethical consensus?

Unfortunately, it is not as simple as proposing an endless set of bureaucratic regulations until incentives get aligned. As HIT users, agents tend to seek and find workarounds, potentially looking like “adoption” and “compliance” without the supposed goal being achieved.

Is adding new things (HIT, regulations, etc.) the best way to fix a complex problem? Why don’t we ever think about subtracting/curating what is in place first?

The counterargument to this the article brings up is the potential slowdown in “innovation”. Is slowing down always bad? I don’t think so. I believe it might sometimes be the best we can do to break out of inertia and be actually able to achieve the goals promoted in the article, which I wholeheartedly agree with, but am not as optimistic about.