

## **President's Message:**

### **The Pediatric Information Crisis: Choose Your Sources Wisely**

In pediatrics, the source of information matters.

Perhaps that statement sounds obvious. However, in an era when medical advice can be generated, amplified, and disseminated to millions of people within minutes, it has become increasingly important to ask not simply, What is being said? But who is saying it, what evidence supports it, and does that evidence actually apply to children?

This is particularly important because children are not simply small adults. Their physiology, developmental stages, immune responses, pharmacokinetics, nutritional requirements, and vulnerabilities are distinct. Evidence generated in adults cannot automatically be extrapolated to infants, children, or adolescents. Even evidence generated in one pediatric population may not be applicable to another. (1-3) The consequences of getting this wrong can be substantial.

We have witnessed the proliferation of anti-vaccination claims, unproven therapeutic strategies, questionable nutritional recommendations, and other medical assertions promoted through social media, podcasts, online communities, and, increasingly, artificial intelligence. Some of these claims may appear sophisticated. Others may be presented with compelling anecdotes, impressive graphics, or seemingly authoritative references. Appearance is not evidence.

Artificial intelligence presents a particularly interesting challenge. AI can be an extraordinary tool for education, synthesis, and discovery, but it does not inherently distinguish reliable medical evidence from misinformation. It can reproduce unsupported assertions, cite inappropriate sources, misunderstand the population being studied, or present uncertainty with unwarranted confidence. The fact that an answer is articulate does not make it correct. (4, 5)

This places an important responsibility on pediatricians. We must choose our sources carefully.

Peer-reviewed and appropriately referenced literature should be the minimum standard, not the endpoint. We need to ask whether the study population resembles our patient. Was the research conducted in children? Was the sample adequately representative? Are the outcomes clinically meaningful? Has the finding been replicated? Is there a reasonable biological and epidemiological basis for applying the findings to the child in front of us?

Evidence-based medicine has never meant unquestioningly accepting a published paper. It means critically evaluating evidence and integrating it with clinical expertise and the patient's and family's circumstances, values, and needs.

We must also be particularly cautious about authority without expertise.

The public sphere increasingly rewards confidence, controversy, and certainty. A person with a large following can have greater influence than an experienced pediatrician or researcher simply because that person has mastered the mechanics of social media. A prominent title, celebrity

status, political position, business interest, or enormous online audience does not constitute medical expertise. Nor should a forceful personality substitute for evidence. (6)

There is a growing tendency to confuse visibility with credibility. Someone who repeatedly states an assertion, particularly from a position of power or influence, can create the impression that the assertion has been established simply through repetition. This is especially dangerous when the individual lacks relevant professional qualifications, has no meaningful expertise in pediatrics, or has a vested interest in promoting a particular narrative. (7)

Pediatricians should not be intimidated by the volume of misinformation. Our responsibility is not to compete with every social media personality on their own terms. Our responsibility is to provide families with something more valuable: trustworthy information, appropriate context, intellectual honesty, and the willingness to say, "We do not yet know." (8)

Medicine advances because we recognize uncertainty and investigate it. Good clinicians do not need to manufacture certainty where none exists. We should be willing to acknowledge limitations in the evidence, distinguish established knowledge from emerging hypotheses, and explain why one source deserves greater confidence than another.

We also need to recognize that parents and families are navigating an extraordinary information environment. They are often not deliberately seeking misinformation. They are searching for answers. When medical information is difficult to understand or access, confident voices offering simple explanations can fill the gap. (9)

Our response should therefore be neither dismissive nor condescending. Instead, we should teach families how to evaluate information.

Ask: What is the source? What are the qualifications of the person making the claim? What evidence supports it? Was the evidence actually conducted in children? Has it been peer reviewed? Can the findings be independently verified? Are reputable pediatric organizations and experts reaching similar conclusions? Is the person selling something, promoting something, or using fear and outrage to gain attention?

These questions are not about restricting discussion. They are about protecting children.

Pediatricians have a professional obligation to remain vigilant not only about the information we provide, but also about the information we consume. We should model critical appraisal for our trainees, our colleagues, our patients, and their families. We should use social media and artificial intelligence thoughtfully while recognizing their limitations. Moreover, we should never allow popularity, political influence, professional stature outside medicine, or sheer volume of repetition to substitute for evidence.

The pediatric information ecosystem is now part of the clinical environment. Our examination rooms are no longer the only places where medical advice is delivered. Families arrive after watching videos, reading posts, consulting online communities, and asking artificial intelligence

systems questions about their child's health. Some of that information will be useful. Some will be wrong. Much of it will fall somewhere in between.

Our job is not merely to know the literature. It is to help families navigate the information landscape surrounding it.

**Be careful. Be skeptical. Be evidence-based. Above all, be vigilant about the sources you trust.**

When the subject is a child, credibility should never be determined by who speaks the loudest. The quality of the evidence should determine it, its relevance to children, and our willingness to put the child's well-being ahead of personalities, platforms, politics, and popularity. (4-6)

### References:

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