

How Pediatric Hospitalists Must Contend With the Expert Halo Effect

Jared P. Austin, MD,^a Byron A. Foster, MD, MPH^{a,b}

In 2015, the American Board of Medical Specialties approved the petition of a group of pediatric hospitalists to make pediatric hospital medicine its own board-certified subspecialty.¹ Over the ensuing 4 years, standards for fellowship training and “grandfathering” were developed, and in 2019, the first certifying examination will be offered.² Although debate exists within the pediatric hospitalist community as to the utility and necessity of obtaining subspecialty status,³ many pediatric hospitalists, especially those at academic centers, will be compelled to become board certified. In so doing, they will assume a title long derided within the community for its association with dogmatic views: subspecialist.⁴ With this title and the mantle of respect it commands comes the possibility of relying more on expert opinion rather than evidence to settle debates and set policy. Specifically, there is the danger that the expert halo effect^{5,6} (the assumption of infallibility to an expert) may affect the subspecialty, leading to suboptimal decision-making. Addressing this potential effect and maintaining the core value of the field (practice supported by evidence) is our purpose for this article.

The expert halo effect, embedded within the science of heuristics and cognitive biases^{5–11} and recently described as a frequent contributor to wilderness tragedies,¹² is a form of bias that confers undue authority on group-identified experts. Similar to, but distinct from, the halo effect,^{8,9} the expert halo effect could be considered a nuanced form of authority bias,^{10,11} in which the authority is granted by virtue of possessing or being presumed to possess certain expertise or specialized knowledge in a particular area. This effect is exacerbated by power structures within health care that favor subspecialists and procedure-based specialties at the expense of generalists and cognitive-based specialties.¹³ Pediatric hospital medicine has a rich tradition of challenging the dogma of specialists and has been at the forefront in conducting studies in which dogmatic practices are tested, establishing evidence to better guide decision-making and reduce wasteful testing and treatment.¹⁴ Indeed, rather than developing into a subspecialty around an organ system, patient age, or disease process, pediatric hospital medicine is unique in that it has developed around systems-based practices, application of evidence, the science of quality improvement, and, yes, the challenging of expert halos. To suddenly join the ranks of the subspecialties while still clinging to the roots of generalism seems jarring and requires that those within the field remember and hold to its founding principles.

As acolytes (or disciples, take your pick) of evidence-based medicine, pediatric hospitalists have leveraged a range of methods, most notably quality improvement, comparative effectiveness, and systematic reviews, to examine and challenge previously accepted practices.¹⁵ For example, using quality improvement methodology, hospitalists have played a central role in changing the way neonatal opioid withdrawal is managed, resulting in considerable

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Address correspondence to Jared P. Austin, MD, Department of Pediatrics, Oregon Health & Science University, Mail Code: CDRC, 707 SW Gaines St, Portland, OR 97239-2998. E-mail: austinja@ohsu.edu

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^aDepartments of
Pediatrics and
^bDermatology, Oregon
Health & Science
University, Portland,
Oregon

improvements in length of stay, cost, and excess drug exposure.¹⁶ Using comparative effectiveness methodology, hospitalists helped to overturn the dogma that neonatal urinary tract infections, osteomyelitis, and septic arthritis required prolonged treatment courses of intravenous antibiotics.^{17,18} Using systematic reviews and meta-analyses, hospitalists have been key in shifting the practices around the management of bronchiolitis and the composition of maintenance fluids.^{19,20} These triumphs of evidence over dogma have only been possible because the field of pediatric hospital medicine has placed a premium on evidence and has challenged traditional arguments that are based largely on mechanistic explanations or expert opinion, with the understanding that patients and patient-derived data must drive decision-making. In developing pediatric hospital medicine fellowship program requirements, the Accreditation Council for Graduate Medical Education recognized this important aspect of the field and listed several areas of evidence-based medicine as core to the curriculum, including “the economics of health care and current health care management issues, such as cost-effective patient care, practice management, preventive care, population health, quality improvement, resource allocation, and clinical outcomes.”²¹ This trend in educational training, clinical practice, and research is encouraging and reveals that the field will continue to serve as a driving force in the area of evidence-based medicine for the foreseeable future, thus keeping the expert halo effect, both within and outside the field, safely in check.

Although typically viewed negatively, the expert halo effect could also be harnessed to improve care. For example, within complex health care systems, rallying support to implement multitiered interventions requires bringing diverse stakeholders to the negotiating table and crafting solutions. For subspecialists with additional professional clout, this role may become easier to accomplish. Within the realms of policy and granting agencies, obtaining subspecialty status may also make these positions more attainable, thus increasing the influence of the field within

high-level decision-making bodies. As long as decision-making within these realms is based on evidence or generates evidence to guide further practice, using the expert halo effect in this regard could improve care at both the individual and population level. If, however, decision-making trends toward opinion and abandons evidence, this opportunity will be lost. Pediatric hospitalists, and all physicians (and politicians) for that matter, would be wise to adopt the philosophy of Dr Otis Brawley in this regard: “Say what you know, what you don’t know and what you believe—and label it accordingly.”²² In situations in which evidence is lacking and decisions must be based on experience and intuition, these decisions should be labeled as opinions, and the appearance that these decisions have more evidence base than they actually do should be avoided.

The field of pediatric hospital medicine has seen considerable change in the past 20 years and will likely encounter equally great change as it transitions to a subspecialty. By continued adoption, advancement, and promulgation of the principles of evidence-based medicine and by harnessing the positive aspects while recognizing the negative aspects of the expert halo effect, pediatric hospitalists can ensure that this transition serves to improve the quality of care for children who are hospitalized.

Nota bene: A supplemental table revealing incidents of the near demise of both authors of this article, secondary to the expert halo effect, is available on request.

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