Despite her many professional accomplishments, Nancy Snyderman, MD—head and neck surgeon, network medical correspondent for nearly 25 years—might best be remembered for the take-out soup incident of 2014.

Snyderman was caught violating her self-imposed 21-day quarantine after returning from reporting on the Ebola epidemic in Liberia for NBC News in October. She was spied waiting in a car while a companion ducked into a New Jersey restaurant to pick up a to-go order of soup (http://nydn.us/1e1MEhY). Snyderman apologized and resumed reporting in December, but she departed NBC in March.

"Covering the Ebola epidemic last fall in Liberia, and then becoming part of the story upon my return to the US, contributed to my decision that now is the time to return to academic medicine," Snyderman said in a statement (http://bit.ly/1A09RuJ).

When she resigned, however, Washington Post media critic Erik Wemple conceded the incident was blown out of proportion. In his blog post entitled, “Yes, we did overreact to Dr. Nancy Snyderman's Ebola screwup,” Wemple wrote that she might have been a victim of the hype and hysteria in the United States about Ebola's threat.

Snyderman is among several high-profile physician broadcasters criticized recently for becoming “part of the story,” as she put it. CNN's Sanjay Gupta, MD, was called out for exploiting victims of the 2010 Haiti earthquake and violating their privacy by treating them in front of a camera.

Gupta prompted similar ethical concerns after the network aired footage of him treating victims of the recent Nepal earthquake (http://bit.ly/1FfYDYn). Columbia University cardiologist Mehmet Oz, MD, MBA, and his eponymous syndicated show spurred 10 physicians to write in April to Columbia University College of Physicians and Surgeons Dean Lee Goldman, MD, calling for Oz's dismissal as vice chair of surgery. Oz "has repeatedly shown disdain for science and for evidence-based medicine," the physicians wrote (http://bit.ly/1IgY9NX).

These situations highlight what 1 journalist, who also is a physician, calls the potential "minefield" of navigating 2 professions that have different ethical standards and goals.

"I think it's really important for physician-journalists to define their role," Tom Linden, MD, director of the medical and science journalism program at the University of North Carolina (UNC) at Chapel Hill, said in an interview. As a psychiatrist who couldn't shake journalism's pull, Linden spent 3 years in the mid- to late 1980s as a morning reporter for a local NBC affiliate in California and saw patients in the afternoon. "I had very strict rules. I would never see a [new] patient who called and said, 'I saw you on TV,'" he said. "I would also never use one of my pa-
patients in a TV report. I tried to keep the 2 worlds very distinct.”

Linden left medical practice in 1989 for stints at CNBC, the Financial News Network, and television stations in San Francisco and Los Angeles. “When I was doing television reporting, I was a journalist first and a physician second,” he noted. Besides his current position at UNC, Linden serves as a medical anchor for Journal Watch Audio for the Massachusetts Medical Society.

Ethical Perils

Linden maintained a firm identity as a journalist, but he said that’s not always the case with physician reporters. “I think others see journalism as almost an extension of their medical practice,” he noted. And that may set them up for what at least appear to be improprieties. Some physician-reporters may promote themselves, their colleagues, or their hospital without realizing that such reporting is biased, Linden said.

“We are turning over the responsibility for independently vetting evidence to people who either have not established that expertise or have not established the interest or ability to present it in a balanced manner,” Gary Schwitzer, a former CNN medical reporter who is not a physician, said in an interview. In his blog on HealthNewsReview.org, which he publishes, Schwitzer is one of the more outspoken critics of physicians reporting on network news shows.

Tensions over ethical reporting and network self-promotion came to a head during coverage of the 2010 Haiti earthquake, when Gupta and other physician-journalists from the networks treated victims on camera, Linden said.

“The Hippocratic Oath mandates that physicians ‘do no harm or injustice’ to their patients and ‘keep secret’ what they ‘see or hear in the lives’ of their patients,” Linden wrote a few years ago (Linden T. Virtual Mentor. 2011;13[7]:490-493). But, he wrote, “journalists generally do the opposite—they disseminate information to the public in the services of what the Society of Professional Journalists calls ‘public enlightenment.’” In US health care settings, patient privacy is protected by the Health Insurance Portability and Accountability Act, but disaster survivors treated on camera may be exposed to a worldwide audience.

Granted, physician-journalists assigned to cover natural disasters or war zones might, like any journalist, feel compelled to help victims, Linden acknowledged. “When that’s the case, the medical professional should perform health care duties as he or she sees fit,” he wrote in a 2010 essay. “However, it’s usually inappropriate for medical professionals to report about their own health care efforts. In most cases, this type of first-person journalism is self-centered and simply bad journalism” (Linden T. Electronic News. 2010; 4:60-64).

The Haiti coverage prompted the Association of Health Care Journalists, a professional organization, to convene a committee, on which Linden served, that drew up guidelines for physician-journalists. “Do not exploit vulnerability for gain or glory,” the association advised physician-journalists in a statement (http://bit.ly/1lCQrlq).

But it doesn’t take a disaster to give rise to conflicts of interest, Schwitzer noted.

In 2011, Schwitzer criticized Jennifer Ashton, MD, then a CBS News medical correspondent, for wearing the stylized Susan G. Komen for the Cure pink ribbon while interviewing Nancy Brinker, founder and then chief executive officer of the Komen organization, about breast cancer screening (http://cbns.ws/IOW2Nlc). Although the US Preventive Services Task Force (USPSTF) recommends that women at average risk get screening mammograms every 2 years beginning at age 50 years (http://bit.ly/IPRtxVs), Komen recommends annual screening beginning at age 40 years (http://sgk.mn/1HNbcpY).

“Just imagine a White House reporter... wearing a ‘Vote Obama’ button,” Schwitzer said. Who’s the Expert?

Ashton is not the only television physician who’s drawn Schwitzer’s ire over cancer screening recommendations. In 2013, he criticized urologist and prostate surgeon David Samadi, MD, for saying on the “Today” show that no complications arise from prostate cancer screening and that men should get a baseline prostate specific antigen (PSA) test at age 40 years (http://bit.ly/tj9u809).

However, the USPSTF recommends against routine PSA screening for men at average risk of any age (http://bit.ly/1fJANpa), while the American Urological Association guidelines note that its greatest benefit appears to be in the 55- to 69-year age group, although even those men should discuss the pros and cons with their doctors before deciding whether to proceed (http://bit.ly/IKKW6J3).

“I’ve been very clear about PSA screening,” Samadi, chief of robotic surgery at New York’s Lenox Hill Hospital, said in an interview. “PSA is one of the only screening tools we have. To wait for everyone to [reach] the age of 55 to do screening... that’s going to cause a lot of metastases.” He said that conclusion was “my own personal take of everything that I’ve read.”

For the past 5 years, Samadi has appeared weekly on the Fox News show “Sunday Housecall.” If prostate cancer screening comes up on the show, Samadi said, he feels comfortable giving his opinion. “I don’t find it a conflict of interest.”

Robert Bazell, PhD, would disagree. “I think there is a danger with physicians on television seeming to be an expert on everything, as opposed to being a journalist looking at both sides of the issue.”—Robert Bazell, PhD
practice at the University of Pennsylvania, "I've come across virtually every malady you could think of," he said in an interview.

But if he's working on a story outside his area of expertise, he'll run his report by a colleague in the relevant specialty. For example, he said, "if one of the Phillies has an orthopedic injury, I know what I'm going to say, but I will fact-check with an orthopedist just to make sure."

Crossing the Line?
As Samadi sees it, Oz has crossed the line into entertainment. "Mehmet Oz is trying hard to give good medical information, but good medical information sometimes can be boring," said Samadi, adding that he knows Oz from his time at Columbia. "Is he purposely trying to deceive the public? I highly doubt it. But it's the nature of TV.... Do I think he's made mistakes? I think there have been some cases where he's probably exaggerated more than he should."

Christina Korownyk, MD, and colleagues at the University of Alberta in Canada wondered how much of what television physicians such as Oz recommend is supported by evidence.

"We had so many patients asking us about recommendations they had seen on different shows," Korownyk, a family medicine physician, said in an interview. So she and her coauthors, mostly primary care physicians, randomly selected 40 episodes of "The Dr. Oz Show" and 40 of "The Doctors," another popular TV show that features 6 physician co-hosts, and identified and evaluated recommendations made on each program.

They found at least 1 case report or stronger evidence to support 46% of the recommendations in the Oz show and 63% of the recommendations in "The Doctors" (Korownyk C et al. BMJ. 2014;349:g7346). They also found evidence that contradicted 15% of the Oz show recommendations and 14% of "The Doctors" recommendations. And they found no evidence related to the rest of the recommendations on the shows.

Although a large portion of their recommendations lack supporting evidence, no one has formally assessed how many viewers actually follow them, Korownyk noted.

For Love, Not Fame and Fortune
Cirigliano has no network aspirations, and with a busy practice closed to new patients, he's not on television to attract business. "This is just a part-time little hobby," he said of his 2-minute "Dr. Mike" segments, for which he typically spends an hour preparing, "I do it because it's fun and I love it."

His television segments provide a creative outlet that he finds medicine lacks, said Cirigliano, a trumpet player who majored in music and intended to teach and perform until volunteering in a hospital emergency department steered him toward medicine.

"In my opinion, [reporting on television] has made me a much better doctor. I'm familiar with every new study that comes out even before it comes out," Cirigliano said, referring to the fact that journals often share embargoed copies of studies with reporters so they can prepare their stories.

Like Cirigliano, Samadi said he doesn't do television for the money or the publicity it generates. "It's a great way to educate the public."

The JAMA Forum
Learning About Competition From the UK's National Health Service
Austin B. Frakt, PhD

The United Kingdom's National Health Service (NHS) is a nationalized health care system—meaning its physicians are employed by the government. From that familiar fact, many conclude that the United States—with its competitive, private market-based delivery system—has nothing to learn from the NHS. That's wrong.

What's wrong with this thought is that it equates "competition" with "private." In fact, competition can exist even in a nationalized health system, and it does among NHS hospitals. Moreover, studies of NHS hospital competition illustrate just how important it is, leading to better management, higher quality, and lower mortality.

Since 2006, NHS general practitioners have been required and paid to ensure that their patients are aware of 5 choices of hospital. Hospital quality data are available to patients to help them make this choice. Those choices affect hospital revenue because the government's diagnosis-based payments follow the patient. This encourages hospitals to compete for patients on quality. The only way for a hospital to thrive is to improve its attractiveness to patients. Hospital managers who do so can receive higher pay. Those who don't might be fired. And failing hospitals are at heightened risk of closure.

In a study published in the American Economic Journal: Economic Policy in 2013 (http://bit.ly/ICBeckG), researchers found that this 2006 policy increased competition among hospitals, changed where patients chose to receive care, and decreased length of stay and mortality. They estimated that a 10% decrease in hospital market concentration would result in a 2.3% reduction in length of stay (the baseline mean length of stay was 1.2 days) and a decrease of 2.9% in 30-day mortality after