The future of the Victorian Doctors Health Program:

A discussion paper prepared on behalf of the Australian Medical Association (Victorian Branch), the Medical Practitioners Board of Victoria and the Board of the Victorian Doctors Health Program February 2009

Executive summary

- The Victorian Doctors Health Program (VDHP) is an independently governed organisation jointly owned by AMA Victoria and the Medical Practitioners Board of Victoria and is fully funded by the Medical Practitioners Board. Its charter includes assisting doctors and medical students who are unwell to obtain appropriate care, and supporting education and research to improve the well being of doctors.
- The workload of VDHP has grown each year since it was established in 2000. In the last two years, VDHP has seen an increase in the number of medical students and young doctors in training seeking help and an increase in the proportion of participants seeking help with stress related problems. This has been associated with a marked "cultural" change in the approach taken by younger doctors to issues around their own well being.
- Under the planned national registration process, it is by no means clear that the Victorian Doctors Health Program will be able to continue to be funded and governed as it currently is. Indeed, its future may be in jeopardy.
- In all other Australian states and territories, Doctors' Health Advisory Services (DHAS) seek to provide immediate access to medical assistance for sick doctors. These services are generally unfunded voluntary organisations.
- In Victoria, the establishment of VDHP has not altered the statutory responsibilities of the Medical Practitioners Board which continues to use its Health Subcommittee to manage those doctors whose ill health is deemed to pose risks to the community.
- Programs similar to the VDHP have existed in the USA and Canada for many years. Forty six US states with physician health programs come together under the banner of the Federation of State Physician Health Programs and in Canada, programs in every province are linked under the Canadian Physician Health Network.
- Health issues of the medical profession are well documented. The problems identified include stress and 'burnout', drug and alcohol dependence, depression and suicide, delayed diagnosis of physical illness, and marital, social and family difficulties. One per cent of doctors become dependent upon narcotics and up to 10 per cent misuse mood altering prescription drugs. The incidence of alcohol abuse ranges from 10-17 per cent of doctors. Male doctors are twice as likely as other professionals to die by suicide while female doctors may be 4-6 times more likely to commit suicide than other female professionals. Most of these problems are preventable and/or treatable.
- The key questions are how to ensure that prevention measures and treatment strategies are accessed in a timely manner and how to avoid health related- impairment with associated risk to the community?
- We argue that a VDHP type of program or similar service is <u>essential</u> in all states and territories and that the cost should be borne by the entire medical profession. The simplest and most equitable means of achieving this is to use the Victorian funding model. If this was adopted nationally, each state and territory could be adequately funded to provide appropriate services. This would represent a modest investment for very good returns.

Funding and governance arrangements for the Victorian Doctors Health Program under the national medical board model

Introduction

With the introduction of a national system of medical registration for doctors (and other health professionals) likely to be in place by 2010, it is by no means clear that the Victorian Doctors Health Program (VDHP)will be able to continue to be funded and governed as it currently is. This discussion paper attempts to identify all the relevant issues surrounding the future of the VDHP and to provide options for consideration in the short and longer term.

A brief history of why the VDHP was established and how it has operated

The VDHP was established jointly by the Medical Practitioners Board of Victoria (MPBV) and AMA Victoria in 2000 in response to the observations of MPBV that doctors coming to the attention of the Board with health problems associated with possible impairment were often referred quite late in the evolution of their illness or substance dependence and that MPBV had no means of directing these doctors to appropriate high standard care, or to relevant rehabilitation or practice re-entry programs. Changes brought about by the new Medical Practice Act 1994, intended to make it less threatening for impaired doctors to approach the MPBV, did not improve this situation. The model chosen for VDHP was partly based on similar organisations already established in some US states and Canadian provinces, but with some noticeable differences (see below). The director of one such US program was invited to Victoria by MPBV and his presentations helped convince leaders of the medical profession beyond MPBV of the need for such a program in Victoria. In addition, the establishment of VDHP required convincing the State Health Minister of the day of the need to amend the Medical Practice Act to authorise the MPBV to allocate funds to this service.

VDHP is an incorporated not for profit entity registered with the Australian Securities and Investment Commission as a “public company limited by guarantee and not having share capital”. The shareholders in the company are MPBV and AMAV. VDHP has an independent and honorary Board of Directors; currently seven Directors are medical practitioners and the eighth is chartered accountant. Half the directors are nominated by AMA Victoria and half by MPBV. Directors serve for three years but are eligible for reappointment. Serving members of MPBV are ineligible for appointment. The chairperson of the Board is nominated by agreement between AMAV and MPBV. VDHP is funded entirely by MPBV according to a budget which is negotiated annually. The annual running costs of VDHP represent a contribution of a little over $25 per registered doctor in Victoria.

The constitution of VDHP lays down five objects including (a)to encourage the development of and to facilitate access to optimal services for the education and prevention, early intervention, treatment and rehabilitation, to ensure the wellbeing of medical practitioners and students, (b) to encourage and support research into the prevention and management of illness in medical practitioners and students, (c) to facilitate early identification and intervention for medical practitioners and students who are ill and at risk of becoming impaired, (d) to act as a referral and co-ordination service to enable access to appropriate support for medical practitioners and students who are ill, and their families and (e) to ensure access to high quality rehabilitation and encourage re-training and re-entry to the workforce.

The clinical program is presently staffed by two part time medical practitioners (one a psychiatrist and the other an addiction medicine specialist) and a psychologist. The VDHP Board monitors and supports the work of the clinical staff via two Board subcommittees, one for financial matters and the other for clinical audit. Board members have no access to the clinical records or identifying information of any participants in the Program but problematic cases are discussed anonymously at meetings of the clinical audit subcommittee.

The VDHP meets with the owners of the company (AMAV and MPBV) twice per year to keep those organisations abreast of VDHP activities. Under company law, VDHP is externally audited and holds an annual general meeting. There is in place a memorandum of understanding (MoU) between MPBV and VDHP which details the obligations of VDHP to its owners. The MoU specifically addresses the obligations of treating doctors to comply with Section 36 of the *Health Professions Registration Act 2005*; ie the reporting to MPBV of any doctor whose illness has seriously impaired the doctor's capacity to practise and is putting the public at risk. In addition, the VDHP constitution establishes a broad based consultative council which is convened at least once per year, bringing together nominees of the medical colleges, medical schools, medical defence organisations, medical student societies, and agencies that support doctors and students with health problems.

The workload of VDHP has grown each year. Particularly striking has been the increase in (a) the number of medical students and doctors in training seeking help from VDHP and (b) the increasing proportion of participants seeking help with stress related problems. It is reasonable to postulate that these changes represent earlier identification of potentially more serious health issues and reflect the impact of VDHP education programs on the attitude of younger doctors to managing their well being. If this is so, the importance of the work of VDHP towards the welfare and protection of the community, by preventing ill health and impairment in doctors should not be underestimated. The work of VDHP staff also includes giving advice and preliminary counselling by telephone. Some contacts result in the telephone caller being able to access appropriate assistance directly without the potential participant attending VDHP for assessment. Follow up support is done by a combination of telephone and face to face contact. Awareness of the services offered by VDHP continues to grow. Sudden peaks of referrals apparently in response to VDHP newsletters sent to all registered doctors suggest that VDHP does not yet always come to mind when a doctor is concerned about the health of a colleague or an employee.

VDHP does not provide direct treatment of participants but instead provides triage to ensure that health needs are met promptly and with the best available and appropriate resources. Participants who do not have their own general practitioner are expected and assisted to find one. Over time, the VDHP has built up a network of general practitioners and relevant medical specialists and clinical psychologists to whom participants can be referred. In addition, an agreement has been signed with a large private psychiatric hospital to facilitate referral and where necessary admission of participants whose needs are deemed to be urgent. It has also built up a strong referral base in that the advice and services of VDHP are increasingly relied upon by medical administrators in our public and private hospitals and by our medical schools when staff have concerns about the welfare of students.

A proportion of participants (those with substance dependency issues or mental ill-health) are asked to sign personally detailed care and ongoing monitoring agreements (including urine and

hair testing as appropriate)and are then supported and monitored closely by VDHP staff in collaboration with treating doctors and in some instances workplace monitors. The success of this aspect of the program in keeping doctors well and in the work force is reflected in the following statistics. In the years 2001-2008, 89 doctors with substance abuse problems signed such agreements. At the time of entry, a little over half of these doctors (47 or 53%) were not working, were suspended from work or were on sick leave, but within six months, 32 of this 47 were back at work. Of the participants who have now been followed up for five years or more since commencing the VDHP program, 81% (34 out of 42) remain well and in the workforce.

In addition to the clinical assessment and triage work of the Program as described above, the VDHP charter also calls for VDHP to seek to educate medical students and doctors about their own health; to take steps to prevent, or detect at an early stage, health issues leading to impairment; to foster rehabilitation and re-entry programs; and to foster research into such health problems. Rehabilitation programs are primarily delivered via other agencies. Re-entry to the workplace is facilitated in many instances by VDHP negotiating with workplaces on behalf of participants to ensure graduated re-entry and adequate support and oversight.

Education of the medical profession about health issues and about VDHP has been tackled on several fronts. A regular bulletin is sent to all registered doctors and medical students (courtesy of MPBV mail outs). A website has been established and bulletins and other material are posted there (www.vdhp.org.au) . Clinical staff give talks on doctors health matters and on the services of VDHP regularly to medical students, doctors in training, Divisions of General Practice, medical colleges and hospital grand rounds. VDHP now also holds a workshop each year to address significant health issues for the profession. The initial workshop in 2007 was on the topic of stress and distress in doctors in training. The topic for 2008 was on assisting doctors to become better equipped and more confident when asked to become a treating doctor for another doctor.

The existence of VDHP since 2000 and its role in education and promotion of interest in doctors' health matters has also contributed to other organisations in Victoria commencing programs for peer support and counselling services for doctors in distress, and promoted more general awareness that every doctor should have their own general practitioner.

The situation in other Australian states and territories

Structured help is available in all other states from a state based Doctors' Health Advisory Service (DHAS –see Table in attachment 1). These are predominantly voluntary organisations which seek to provide immediate access to medical assistance for sick doctors, whether the reporting is by self, spouse, family or colleagues. Advice can be sought anonymously and any subsequent action is totally confidential. The service is not linked to the state medical board, although in NSW, the Medical Board makes an annual contribution towards running costs. The addresses and contact numbers of the various Doctors' Health Advisory Services are provided below. These services meet together annually as the Australian Doctors Health Interest Group, recently renamed the Coalition of Doctors Health Services.

The advice of VDHP has been sought in the last eighteen months by at least one other medical board which has been considering establishing a similar service.

The role of the medical boards

All medical boards face the task of assessing doctors with health issues where there is alleged impairment and the community may be at risk because the impaired doctor is still practising. Impaired practitioners who may be putting the public at risk usually fall into one of three categories; psychiatric illness, drug or alcohol addiction, or illness leading to intellectual or physical impairment. Impairment coming to the attention of medical boards often involves loss of insight on the part of the doctor. Medical boards are informed of potential impairment of doctors by one of the following routes: concerned treating practitioners (mandatory in several states if the public is believed to be at risk), under statutory obligation by medical directors of scheduled psychiatric hospitals, notification by officers responsible for policing the drugs of dependence regulations, and referral from medical administrators in hospitals.

Most Medical Acts have statutory provisions that give medical boards the framework and the powers to handle notifications of possible impairment. Where a doctor is so impaired that the risk to the public is grave, most boards have the power to suspend the registration of the doctor forthwith, pending the outcome of assessment and/or inquiry. More commonly, the doctor is not suspended, but under statute is obliged to undergo medical assessment by one or more independent specialists. This report is used by the board to determine whether suspension or imposition of limitations or conditions on practice is required. The process by which this is achieved varies. In some states, the board receives the report and takes action, in others an impaired practitioners panel or subcommittee deals with the matter or a board member is delegated with the power to negotiate appropriate conditions on a voluntary basis, backed by the appropriate powers if voluntary agreement is not reached. The conditions imposed on doctors may include mandatory random urine testing and other requirements for oversight by the medical board, such as regular reports on progress from treating specialists. The processes involved have gradually changed in recent years in that the sick doctor is increasingly commonly dealt with by negotiation (with mandated suspension powers kept in reserve) and a greater emphasis is placed on assisting the doctor to recover and return to active practice.

In Victoria, the Medical Practitioners Board continues to use a Health Committee for this purpose and employs staff to oversight reporting and random urine testing requirements. The numbers of doctors under supervision in this way by MPBV has decreased since the establishment of VDHP. In 2000, MPBV had 46 new referrals to its Health Committee with 123 doctors under its supervision; by 2007, the respective numbers were 27 and 70. There remains an absolute need for the statutory powers of MPBV as they are required where an illness has led to loss of insight or where a doctor refuses to accept professional advice about his or her capacity to practise medicine safely.

Some information about doctors' health programs in North America

Led by the American Medical Association, physician health programs were established in nearly all US states during the 1970s and 1980s. Most programs were set up by state medical societies (i.e. the equivalent of state branches of the Australian Medical Association) at "arms-length" from the state medical board. A common early theme was the treatment and monitoring of physicians with substance addiction problems. It was also quite common that the new programs took over (by agreement) the entire role previously played by the medical boards in conducting regular urine testing, monitoring physician progress and advising when a physician was fit to return to work. This aspect of the work

became to be known as “diversion” and was held to be an important means of encouraging physicians to seek help on a voluntary basis. [NOTE: The VDHP is **not a diversion program** as the Medical Practitioners Board continues to oversight those doctors deemed to be a risk to the community, conducting urine and hair testing and other monitoring using the Board’s statutory powers].

In California, which had one of the largest and oldest such diversion programs, consumer concern that the program was failing to adequately protect the public has resulted in the Californian program being closed by the Californian Medical Board in 2008 (http://www.bonnebridges.com/pdf/BB_brief_Jul08_P7.pdf). Debate is continuing as to what type of service should replace it (http://www.medbd.ca.gov/diversion_summit_summary.pdf).

Forty six states with physician health programs come together under the banner of the Federation of State Physician Health Programs (http://www.fsphp.org/) . The Federation website provides a very full picture of the services provided by each state program as well as information about funding and governance arrangements (see attachment 2).

In Canada, all provinces have physician health programs, mostly originating from the provincial medical association but with working agreements with the provincial medical registration authority. The programs unite under the Canadian Physician Health Network and more information can be found on the network’s website (http://www.cma.ca/index.cfm/ci_id/25567/la_id/1.htm).

The scope of health problems faced by doctors

The full extent of psychological and physical health problems of doctors may not be known because of the tendency to denial, but available evidence is worrying. The problems found include stress and ‘burnout’, drug and alcohol dependence, depression and suicide, delayed diagnosis of physical illness, and marital, social and family difficulties. Published studies show that one per cent of doctors become dependent upon narcotics and that up to 10 per cent misuse mood altering prescription drugs (1,2). The incidence of alcohol abuse ranges from 10-17 per cent of doctors (1-3). These figures may be understated as more objective data derived from statistics concerning deaths from cirrhosis show that there is a threefold over-representation of doctors from such deaths in the United Kingdom (1). Male doctors are twice as likely as other professionals to die by suicide while female doctors may be 4-6 times more likely to commit suicide than other female professionals (4-6). This suggests that serious depression in doctors is going unnoticed or is denied, and thus remains untreated. Doctors often treat themselves, self-prescribe for more than minor conditions and are uncomfortable at taking on the role of being a patient. When they do attend another doctor, that doctor is frequently not skilled in caring for a fellow doctor.

The demands of busy clinical practice have been repeatedly described as contributing to marital discord and psychological difficulties for the doctor and his or her family (1,7,8). These difficulties may be linked to stress, depression or substance abuse. It is generally accepted that medical practice is stressful and probably becoming more so (9-16). Medical students also report that their experiences are stressful and studies have shown that inappropriate coping mechanisms may begin in the undergraduate years (17,18). There is evidence also that the personality of some individuals who choose a career as a doctor make them vulnerable to the adverse effects of stress.

Such personality traits may also make them more empathic doctors. Without insight, support or professional help, such doctors under stress may choose maladaptive responses leading to emotional withdrawal, denial and social isolation (19).

The only optimistic data about the health of doctors is that the incidence of physical disease as judged by standardised mortality rates is lower than for the population generally (20). This data is counterbalanced by the tendency of doctors to deny possible illness, to delay seeking help, and to experience under treatment from colleagues (21). Many doctors, especially male doctors, do not regularly use the services of an identified general or family practitioner and do not encourage their spouses and children to attend an independent general practitioner (22-24).

Most importantly, in the context of this discussion paper, many of the above health problems in doctors and medical students are preventable or treatable (25,26). The key questions thus are (a) how to ensure that prevention measures and treatment strategies are accessed in a timely manner and (b) how can the incidence of impairment with associated risk to the community be best reduced? Success in both areas will also have an impact on keeping doctors in the workforce.

The issues at stake

From the VDHP viewpoint (and AMA Victoria and the Medical Practitioners Board of Victoria's), the key issue at stake is the survival of the current program which serves the doctors and medical students of Victoria very well. The move to a single national medical board puts the funding and governance arrangements of VDHP at jeopardy.

However, at this point of moving to national medical registration, there is a bigger issue at stake which deserves national attention; viz the desirability of all doctors and medical students having access to equitably funded health programs in every state and territory.

How should such services be funded?

First, it should be noted that every registered doctor in Victoria presently contributes approximately $25 per annum (via annual renewal of medical registration fees) to the running of VDHP. While the medical profession in Victoria should be aware of this arrangement, individual members of the profession were not consulted about this impost in the negotiations that took place between AMA Victoria and MPBV in the late 1990's and the cost of VDHP is not identified as a "levy" or separate payment when registration is renewed each year.

It seems highly unlikely that the new national medical board will be willing or able to continue to fund VDHP in the same manner as, without establishing similar services in all jurisdictions, this would effectively mean that doctors in the other jurisdictions would be subsidising the costs of the VDHP. It may be possible to add a separate compulsory "VDHP levy" to the registration renewal fee of doctors resident in Victoria. Given the above evidence regarding denial of vulnerability to health problems, it is highly likely that some members of the profession would object to such a payment and lobby successfully against it.

Presuming that there is professional, government, and community support for the continuation of the VDHP, this then raises the broader question of whether there are other ways by

which VDHP should be funded. Is this something that the medical profession alone must fund or is it in the community's interest that government might contribute? Despite the statistics quoted above about the health of doctors and the role of a service like VDHP helping to keep doctors in the workforce, it seems highly unlikely that government of any persuasion could be convinced that a special case could be made out for the taxpayer to fund the VDHP, in part or in whole.

It might be possible to seek funding from a combination of sources made up of organisations which hold a stake in maintaining a healthy medical workforce, including employers (ie state departments of health), medical indemnity organisations and professional associations (ie the AMA). As only approximately 60% of doctors are members of the AMA, its membership is unlikely to be willing to subsidise the other 40% of the profession. With the exception of possible employer contributions, the main source of funding under this model would still be from the medical profession. Negotiating adequate funding on an annual basis with more than one funding provider would be complex and may well break down.

We would thus argue that the cost of a VDHP type service should be borne by the entire medical profession and that the simplest means of achieving this is to continue to use the Victorian funding model. If this were to be adopted nationally, each state and territory could be adequately funded to provide appropriate services, services which are currently provided on an honorary basis, other than in Victoria.

What should be the governance model?

It is unlikely that the new national medical board would welcome the prospect of taking over the existing role played by MPBV in the governance of VDHP – although this would be the simplest model, and could be done on an interim basis. It may be necessary for AMAV and MPBV to agree on an interim governance model to cover any gap between the cessation of MPBV and the establishment of a national approach to doctors' health matters.

This submission is otherwise silent on what type of governance arrangements might be desirable in the future as this cannot be addressed until the nature of any ongoing program (s) is agreed (see below).

What should be the service model(s)?

The Victorian model has been described above. However, there are other models that could be considered. This question needs to be resolved with input from existing services, existing medical boards, the national registration implementation task force and the yet to be appointed national medical board.

Should any program focus solely on doctors?

The health issues that doctors face, the problem of many doctors tending to deny or delay the need for attending to their own health care, and the risks to the community when doctors become impaired and refuse to stop practising, have a particularity that suggests it would be unwise at this point in time to attempt to combine doctors' health programs with a service for other health professionals. Combined programs do exist in North America and VDHP has been approached by two other health professions for assistance. Thus, in due course a multi-profession program might

become the preferred model, but to consult upon and debate such an additional issue now with so many additional stakeholders is likely to be cumbersome and unrewarding.

Some possible ways forward

NOTE: Although being partly based on longer standing models in the USA and Canada, VDHP does NOT see its present service and governance model as being the only model suitable for Australia. However, it is a model that should be carefully examined.

Two paths forward offer themselves:

(1)Seek via the new national registration process to equitably fund a health program in each jurisdiction and invite each jurisdiction to develop its own model (within broad parameters laid down by the national medical board, after consultation with stakeholders), or

(2) Seek to establish an Australian Doctors Health Program with offices in every capital city.

Proposal (1) has the advantage of allowing for differences (political, geographic, population, current services etc) between the jurisdictions and thus should be more readily accepted by the jurisdictions. Proposal (2) for a single uniform national program would bring an enormous boost to research capacity and has the practical advantage of "bureaucratic neatness", and consistency with the aims of the national registration process. Neither proposal is likely to be agreed upon quickly and put in place promptly. The viability of the VDHP may be at risk while such proposals are being debated. Given the considerable funding provided by COAG to establish the new national registration process, Victoria (via its Health Minister ideally) might wish to seek bridging funding for the VDHP until a national approach to doctors health services is agreed and in place.

The existing state and territory doctors' health advisory services meet annually under the banner of the Australian Doctors Health Interest Group/ Coalition of Doctors Health Services to discuss issues of mutual interest. These meetings are unlikely to provide the best venue for deciding on a nationally consistent approach. However, singly and collectively, its membership should be engaged in the development of an agreed national approach.

Are there risks involved in this submission?

Yes, there are some risks which are difficult to assess. If any changes are to be made to the existing arrangements in regard to doctors' health services, it is unlikely this could be achieved without some public discussion. This might have unintended consequences, especially if the media is involved, as it is likely that there would be undue emphasis on the ill health of doctors and the risks this might pose to the community. This could lead to the type of outcome which has occurred in California, even though the MPBV and VDHP processes are not based on, or closely related to, the Californian diversion program.

Given the level of denial of health problems by many doctors, there is also a risk that a concerted campaign could be mounted by sections of the medical profession in favour of a "user pays" principle rather than a model where the costs are shared across the entire medical profession.

It is also possible, depending upon the experience and backgrounds of the people appointed to the new national medical board, that the new board will at the least be very nervous about

supporting a program that could be seen to avoid the desired scrutiny of all program participants by the board, and might thus "turn the clock back" many years.

Some of these risks can be managed by ensuring that leaders of the medical profession (from AMA, colleges, divisions of general practice, the existing medical boards etc) are informed and involved in the process. Equally importantly, there should be engagement with health ministers and proactive engagement with the medical press and the general media.

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Attachment 1

Table: Names, addresses and telephone numbers of Doctors' Health Advisory Services

State	Address	Telephone
New South Wales Doctors' Health Advisory Service	P.O. Box 422 St Leonards 1590	(02) 94376552 (helpline) (02) 9902 8135
Victoria Doctors' Health Program	27 Victoria Parade, Fitzroy 3065	(03) 9495 6011 (helpline)
Queensland Doctors' Health Advisory Service	PO Box 123 Red Hill 4059	(07) 3833 4352 (helpline) (07) 3872 2222
South Australia Doctors' Health Advisory Service	Parkland Medical Practice, Hughes Plaza, University of Adelaide 5005	(08) 8273 4111 (helpline) (08) 8303 5050
Western Australia Doctors' Health Advisory Service	PO Box 604 Leederville 6007	(09) 321 3098 (helpline)
Tasmania Doctors' Health Advisory Service		(03) 6223 2047 (helpline)
Northern Territory Doctors' Health Advisory Service	PO Box 41046 Casuarina 0811	(08) 8927 7004
Australian Capital Territory Doctors' Health Advisory Service	PO Box 560 Curtin 2605	0407 265 414 (helpline) (08) 6270 5410

Attachment 2.

Some information about doctors' health programs in North America

The information below was extracted from the web site http://www.fsphp.org/ (on Jan 2, 2009):

Governance: Twenty-two are conducted by the state medical society, 18 are run as independent organisations, 3 are run by the state medical board and 3 are run jointly by the medical board and the medical society. Thirty - four of the programs have contracts or agreements with the state medical board.

Funding: Thirty-two programs receive funding from multiple sources (usually including the medical society and medical indemnity organisations). Eight are funded to at least 80% or more by the state medical board and one program (in Michigan) is funded entirely by government.

Professional groups served: Fourteen programs provide services only to doctors (and medical students in some instances). In the remainder, the coverage varies from extending just to dentists or veterinarians in a few instances, to a large range of health professionals, and even lawyers, in others.