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Rational Life Care Planning

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I. Introduction

In serious injury cases, plaintiffs' life care plans often appear to be litigation driven and designed to make the potential damages as high as possible. This is probably more common in nonfire cases involving paralysis or head injury, but also occurs where fires are connected with significant personal injuries.

Similarly, the defense sometimes takes the opposite approach seeking the least costly services available.

Numerous cases and authorities discussing life care plans can help defense practitioners in both situations. They illustrate issues and approaches for challenging the overzealous plaintiffs' life care plan as well as pitfalls to avoid in the defense's own advocacy.

II. Fire Case

Bonin v. Ferrellgas, Inc., 2003 La. App. Lexis 2265 (La. App. 3 Cir. 2003), for example, involved a propane gas line fire seriously injuring six young adults. The plaintiffs submitted a life care planner's future medical costs projections. The appellate court reversed as "unreasonable" a jury defense verdict and calculated the damages based on the record.

The life care plans in *Bonin* may not have been litigation driven, and the court accepted many of the projections, but the issues were typical of concerns that defense counsel must address. The discussion showed why defense counsel must insist that plans actually fit with the treating doctors' recommendations and the actual care plaintiffs seek.

Bonin noted that defense counsel rebutted the treatment projections by pointing to recommendations the plaintiffs had not pursued from the time the plans were developed until trial. The court accepted the life care expert's explanation "concerning certain recommendations which he had not yet discussed with the Plaintiffs." *Id*. at 25. However, with other therapies the treating doctors continually recommended that plaintiffs had not pursued, the court found the plaintiffs were "not likely to incur these expenses in the future." *Id*. at 25. The therapy projections disallowed as "too speculative" included in-patient evaluations and programs earlier recommended, but not pursued. *Id*. Allowed in the projections were group and individual counseling plaintiffs previously sought; however, family counseling and biofeedback projections were disallowed since they had not previously been engaged in and there was nothing supporting the projection that plaintiffs would incur the costs. *Id*. at 26.

The court also found "case manager" projected costs "highly inflated." *Id*. The court's basis was that the plan called for plaintiffs to meet a case manager once a month, but the case manager (who was also the life care planner) testified they did not meet on a monthly basis. *Id*. The court found that two, not 12, case manager sessions were adequate. *Id*.

The court said evidence supported plaintiffs' lawn maintenance and housekeeping costs. *Id*. at 27. Further, since the treating plastic surgeon and an independent plastic surgeon corroborated the testimony, the court allowed future medical supplies and equipment, check-ups, and future surgery costs. *Id*.

Bonin illustrated that both the plaintiffs' plan and the defendant's response should fit with the actual care plaintiffs are receiving as well as how the treating doctors' and other medical testimony can influence the outcome. The opinion also emphasized how vital it is to pin down the bases (or lack of) for the life care projections as well as to seek a foundation for defendant's response.

Bonin disallowed items that probably were relatively minor compared with the cost projections allowed.

However, because the costs in life care plans often are projected over a life expectancy or at least over many years, even the minor items often add to a considerable total.

III. Plan's Purposes

Problems arising when either the plaintiff's life care plan is litigation driven or the defendant seeks recommendations of the least costly services available were recently discussed by Frank Woodrich and Jeanne Patterson in *Ethical Objectivity in Forensic Rehabilitation*, The Rehabilitation Professional, July/August/September 2003, 41–47 (hereinafter "Woodrich and Patterson"). Woodrich is a forensic consultant with considerable life care plan experience. Patterson directs the graduate program in rehabilitation counseling at the University of North Florida.

They quoted R.O. Weed, *Life Care Plan Development,* 7(4) Topics in Spinal Cord Injury Rehabilitation 5 (2002), for a life care plan's definition:

> A life care plan is a dynamic document based upon published standards of practice, comprehensive assessment, data analysis and research, which provides an organized concise plan for current and future needs with associated costs for individuals who have experienced catastrophic injury or have chronic, health care needs….

Woodrich and Patterson at 42. Their article noted that when life care plans are objective and unbiased, they can be very helpful to an individual with a disability, the attorneys, and the court. However, they stressed that when litigation driven by the plaintiffs' side, the plans "have one purpose—to place as high a dollar value as possible on the disability for litigation purposes." Similarly, as will be noted later in this paper, they also have similar cautions for the defense when seeking the least costly services available. *Id*.

IV. Defense Road Map

Woodrich and Patterson's article concerned life care plan ethical issues and was not a "how to do it" for practitioners. Looking at the article from a defense lawyer's perspective, however, there were many points in the article and the authorities cited that can help defense lawyers minimize some life care plans' litigation-driven tendencies and do a better job with their own advocacy. The following summary of the points provides a road map for investigations, discovery, and counteradvocacy when focusing on life care plans:

- Plans should have a factual basis and be within the provider's area of expertise and discipline (citing the International Association of Rehabilitation Professionals (IARP,n.d., http://www.rehabpro.org/standardsethics_nav_msie.html)).
- Plans should focus on both assets and barriers created by the disability; when only the limitations of an individual with a disability are emphasized, they can result in a self-fulfilling prophecy.
- Plans should include rehabilitation services or interventions attempting to restore the individual to a productive postinjury or postillness lifestyle; for example, life plans frequently exclude referral to vocational rehabilitation service providers, retraining, and placement services.
- Plans should avoid, when possible, excessive use of home care services, based on the medical model of nursing care, rather than on a consumer-based model of choice (citing Paterson, J., Patrick, A., & Parker R., *Choice: Ethical and Legal Rehabilitation Challenges*, 43 Rehabilitation Counseling Bulletin 203–08 (2000).
- "…recommendations for health care supports which foster dependency, with a plethora of 'high tech' equipment, primary reliance for personal care assistance by registered or licensed nurses or thera-

pists (except for supportive periodic review and the special care required by ventilator-dependent person), should be suspect as an inflationary ploy that is financially self-serving on behalf of those who have prepared, or are advocating these services of items." (quoting Reynolds, G., "Becoming Successful Healthcare Consumers." In *Aging with a Spinal Cord Injury*, eds. G.G. Whiteneck, S.W. Charlifue, KA. Gerhart, D.P. Lammertse, S. Manley, R.R. Menter, & K.R. Seedroft, 229, 236. New York: Demos, 1993.

- Plans should use service costs for the locale where the individual will receive services (citing Zasler, N.D., *A Physiatric Perspective on Life Care Planning*, 9 Nat'l Ass'n Rehabilitation Prof'ls Private Sector J. 57, 60 (1994)).
- Plans should not state "possibilities as probabilities" or make "probability predictions that are contrary to accepted fact and literature" (quoting Zasler at 60).
- Plans should not project higher costs to accommodate for attorneys' compromises (citing Zasler at 60).
- Plans should include the client's goal (citing Zasler at 60).
- Plans should not duplicate services (citing Gunn, L.D., *Life Care Planning: A Defense Perspective*, 9 Nat'l Ass'n Rehabilitation Prof'ls Private Sector J. 73–77 (1994). Examples are wheelchair accessible van for individuals with mobility impairments, not deducting cost of a standard automobile from a van cost since people with and without disabilities have transportation needs, or including the cost of building an entire home for people with disabilities without considering that everyone has housing needs and not all people become homeowners.
- Plans should exclude physician visits, diagnostic procedures, and medication costs for conditions predating the disability in question.
- Plans should not differ greatly for similar individuals with disabilities.

In addition to *Bonin*, cases have discussed issues similar to the points raised by Woodrich and Patterson. Issues discussed include the *Daubert*-expertise concerns regarding life care planners, the speculative nature of some projections, and debate about required and adequate attendant care

V. *Daubert* Expertise

Norwest Bank, N.A., v. Kmart Corp., 1997 WL 33479072 (N.D. Ind. 1997), extensively discussed its reasons for disallowing a life care planner to testify. In this slip and fall case, the injured person had brain damage, and the planner wanted to testify about the type and cost of future health care. After reviewing the planner's considerable experience in life care plans and as a brain injury clinic manager, the court called him an "expert." However, the court stressed he was not a medical doctor and unqualified "to predict the care and treatment [the injured person] needs today, or will need in the future." *Id.* at 2. The court said the life care planner's experience with neurologically impaired patients "qualifies him to state opinions of the costs of treatment, if the need for treatment is established by medical evidence, but the court does not believe [the planner] is qualified to provide the medical evidence." *Id.* The opinion stressed:

> …the court is unaware of any instance in which a witness with no education or licensure in medicine, osteopathy, dentistry, chiropractic or nursing has been found qualified, regardless of experience, to give an opinion on a person's medical condition and medical future based on a review of medical records an interview with the patient and her husband.

Id. The life care planner was not allowed to cast his opinion as a "forecast" rather than as a "prognosis" since the jury would not understand a distinction. *Id.* at 2–3.

Regarding *Daubert* principles, the court said the life care planner's opinions "may be correct," but the plaintiffs established no link between his opinions and a scientific principle as to the required care. *Id.* at 5. The court noted that no principle underlying the planner's medical needs opinions had been subject to peer review, or its error rate established. *Id.* at 6

As for the planner's cost valuations, the court said cost does not require medical expertise, and that the planner had the experience to give helpful cost opinions. However, disallowing those opinions, the court said there was no medical opinion that the care priced was needed. *Id*. at 7. The court noted the planner had not discussed the plan's components with the treating physicians, either before or after devising the plan. *Id.*

Norwest Bank focused on the qualification and expertise of a plaintiff's life care expert. However, many of the court's comments—requiring opinions be based on the requisite expertise and methodology—apply to both sides of a lawsuit. The opinion has advice for challenging the plaintiffs' expert, but also for strengthening the defense's position.

The opinion showed why it sometimes is necessary to seek a life care planner who is also a doctor and/or to have both life care and medical experts. It seems this may be particularly true for the defense since the plaintiff often can count on the treating doctors or have easier access to them.

Other decisions considering life care planner qualifications and expertise, with less discussion, allowed the testimony. See, *e.g., Theatre Mgmt. Group, Inc. v. Dalgliesh,* 765 A.2d 986 (D.C. 2001); *Vienne v. American Honda Motor Co*., 2001 U.S. Dist. Lexis 606 (E.D. La. 2001); *Bultema v. Caterpillar, Inc*., U.S. Dist. Lexis 6301 (N.D. Ill. 1999); and *Ballance v. Wal-Mart Stores, Inc.,* 178 F.3d 1282, (4th Cir. N.C. 1999). However, even in most of these cases, the courts looked at the planners' qualifications and whether their projections were based upon the medical evidence.

In *Dalgliesh*, for example, the appellate court, in upholding a decision allowing a rehabilitation nurse experienced as a life care planner to testify, noted that the trial judge "concerned about [the nurse's] qualification to project the kinds and duration of medical treatment [the plaintiff] would need (as distinct from her competency to price those services), painstakingly examined each component of the projections she proffered." *Dalgliesh* at 992. The court said the trial judge "could permissibly find" that a rehabilitation nurse had sufficient knowledge about wheelchair-related infirmities and the need for an in-home aide. *Id.* at 992–93. Further, the opinion said the nurse's physical therapy projection was based not solely on her experience, but on the treating doctor's recommendation. *Id*. at 993. The court observed a legitimate question about the nurse's expertise to opine on future psychological counseling, but noted the plaintiff already had some psychological treatment, was encouraged by others to seek it, and approvingly stressed the trial judge restricted the nurse to opining on only short term counseling. *Id.*

Norwest Bank, and even decisions such as *Dalgliesh* allowing the life care planner's testimony, make it clear the defense lawyer must carefully question the planner's qualifications, determine precisely the bases for the plan, and look at how it fits with the medical or treating physician's evidence. With some planners, depending upon these factors, a *Daubert*-type challenge may be appropriate. Similarly, these points apply to the defense's own experts or perspective on the life care issues.

VI. Speculative Nature

Closely related to the qualification and expertise cases are those discussing the speculative nature of many life care plans. *Gourley v. Nebraska Methodist Health System,* 265 Neb. 918, 663 N.W.2d 43 (2003), a medical malpractice case with a brain-damaged infant, discussed that a life care planner must be "reasonably certain" the

plan projections are needed. *Gourley* found that "speculative" evidence wrongfully admitted did not affect the trial's result because the jury was instructed to consider only what the infant definitely needed, but stated:

> [The life care planner] admitted that he included information in the life care plan about items for which he was not reasonably certain [the infant] would need in the future. The context of his testimony makes clear that he was guessing that [the infant] might possibly need these items. An expert opinion which is merely speculation or conjecture is inadmissible. Here, the court erred by allowing [the planner] to testify about the items for which he admitted that he was not reasonably certain [the infant] would need in the future. Similarly, information about these items should have been redacted from the life care plan before it was accepted into evidence.

Id. at 932. The opinion noted that the life care planner treated items differently if he was not reasonably certain they were needed. The court's description of the plan is worth stating since it is typical.

The plan had two sections. First, a 28-page spreadsheet included items the infant needed, or might need, in horizontal rows. Spaces in each row allowed eight types of information about each item: (1) when the infant needed it, (2) how many years it was needed, (3) how often it was needed, (4) the purpose, (5) the likely vendor, (6) a range of *per* unit prices, (7) a range of *per* year prices, and (8) any additional explanation.

In this first section, if the planner was reasonably certain the item was needed in the future, there was an estimate in the range *per* year prices, but if not reasonably certain, that space was blank. *Id*. at 933.

The second section showed the cost of an item over the infant's life, and every item was listed. If the planner was not reasonably certain of an item's need, he would include only an estimate of the item's cost over the infant's life and would put a zero for the item cost. Ending the second section, there was a total sum for all items the planner was reasonably certain were needed.

An opinion finding "speculative" life care projections inadmissible was *Donaldson v. Ryder Truck Rental & Leasing*, 737 N.Y.S.2d 783, 189 Misc. 2d 750 (2001), a workers' compensation case where plaintiff was injured unloading a truck. The vocational rehabilitation specialist's future medical cost projections were found "clearly speculative" because the treating orthopedic surgeon's affidavit did not address the need for future medical procedures and their costs. The court stated:

> At the least, plaintiff should have submitted an affidavit from [the orthopedic surgeon] or other admissible evidence covering those subjects. [The vocational specialist's] projections in this report are beyond his qualifications. His opinion based on [the surgeon's] reports and records that have not been submitted in evidentiary or affidavit form and upon conversations with [the surgeon's] employees are clearly inadmissible. While a vocational specialist may give opinion testimony on employment opportunities based on a labor market survey conducted by telephone [citation omitted], that rule should not be extended to allow informal assessment of the need for and cost of future medical procedures as plaintiff suggests.

Id. at 754.

If defense counsel pins down the bases of life care projections, many may be excluded as speculative. This applies not only to future treatment, but also costs, life expectancies, required equipment, and other factors in plans. Of course, neither should the defense's position be susceptible to speculation claims.

The life expectancy used in the life care plan, for example, sometimes can be successfully challenged as speculative. Plaintiffs' experts often will use standard tables that do not consider studies showing that certain injuries or disabilities reduce life expectancy.

VII. Attendant Care

As discussed by Woodrich and Patterson, an injured person's attendant care can be a primary cost item in life care plans. *Elliott By and Through Elliott v. United States*, 877 F. Supp. 1569 (M.D. Ga. 1992), *aff'd. en banc*, 37 F.3d 617 (11th Cir. 1994), extensively discussed the proper level of attendant care. *Elliott* focused on many usual issues about such care and illustrated that a defendant may have difficulty challenging attendant care closely coordinated with the treating doctors' testimony. The opinion showed how the life care planners' respective experience and work can be persuasive.

In *Elliott*, a carbon monoxide poisoning case, the primary differences between the life care plans proposed by plaintiffs and defendant were the duration of needed therapies and of the attendant care level. As is common, both parties eventually agreed attendant care was necessary, with some disagreement about the hours *per* week, but primarily disagreeing about the type of attendant.

Elliott noted that plaintiff's doctor and life care planner testified plaintiff would require assistance during the day and, to a reduced degree, around the clock. The plaintiff's experts also concurred the attendant should be more than a sitter, as the defendant advocated. The plaintiff's experts said the attendant should be an ablebodied person, who could lift, move, and transfer plaintiff, take blood pressure, pulse, and temperature, and have a working knowledge of fundamental medical procedures. The court noted that such a person "is generally described as a medical assistant or someone who has worked with the disabled or in a rehabilitation hospital or nursing home." *Id.* at 1582. The court said a plaintiffs' doctor described this individual as an orderly, nurse, or aide, but concurred that a R.N. (registered nurse) or L.P.N. (licensed practical nurse) was not needed. The plaintiff's life care planner gave an estimate of the cost. The defendant also had a physician expert and a life care planner. The court noted that defendant's plan was based on its physician expert's three-day evaluation and review of medical records. The defendant's witnesses both testified that less expensive care would be adequate.

The court found it "pertinent" that defendant's medical expert testified that defendant's original life care plan did not include attendant care. Only after being deposed, the court noted, did the defendant's medical doctor determine attendant care was needed. *Id*. The court said it "takes particular note of the fact" that defendant's life care planner agreed that usually the attending physician probably has a better opportunity to observe and make recommendations about attendant care. *Id*. The court observed the treating doctors long cared for plaintiff and "presumed" they were in a better position to provide more accurate information on the attendant care level than the defendant's medical expert. *Id.* The court followed the treating doctors' recommendations on future therapies. *Id*.

The court accepted the plaintiff's life care plan based on the treating doctors' testimony, and the experience and work of plaintiff's life care planner. The court noted that plaintiff's life care planner, who previously prepared and implemented several hundred complex plans, reviewed the records, visited two medical facilities for an extended time, and met with staff and visited the plaintiff and his spouse at home. The court said defendant's life care planner had been in the profession for a short time, this was his fifth plan, and he had never implemented a plan. The court said "[e]qually as important," the defendant life care planner testified he agreed with the plan proposed by plaintiff's life care planner. *Id.* at 1583.

Elliott not only illustrated many attendant care issues, but has more subtle suggestions for defense counsel. Although attendant care is a major item in many plans, and the defense ideally would like to exclude it, experts on both sides often agree that some type of attendant care is needed. There may be issues about the care's type and duration—for example, whether at home, in an institution if available in an appropriate locality, 24 hours a day, seven days a week, or for lesser periods, and from a trained nurse (provided by a service or working independently) or less skilled caregiver—but some type of care is often needed. The defense may sometimes make a major strategic mistake by arguing no attendant care of any type is needed or by appearing unreasonable or

unsympathetic. What the facts, motivation, or strategy were in *Elliott* are unclear, but the court's specific references to defendant's medical doctor changing his opinion after his deposition and defendant's life care planner endorsing plaintiff's plan are typical of problems the defense may have in deciding the best way to handle attendant care.

Some life care planners, even testifying for the defense, for example, are hesitant to support care in a healthcare facility as opposed to attendant care at home (although the facility care may be less expensive due to reduced individual equipment and personal supervision needs) unless the family situation (for example, no family care giver, domestic problems or neglect) justify it. The expert may admit this hesitancy under cross-examination, and the plaintiffs' counsel inevitably will argue the defendant "heartlessly" wants to institutionalize the plaintiff. Further, if advocating a facility, the defense needs to ensure that for this individual's condition, a facility is reasonably close and accessible to family and friends unless the defendant wants to appear unsympathetic. A counter to arguments about "institutionalizing" is that some experts believe certain individuals with a disability benefit from an environment providing peer socialization.

VIII. Defense Experts

Elliott has another example of why defendants should be concerned not only with challenging plaintiff's projections, but also with speculation by defense experts. The court expressly denied the defendant's argument for a credit for medical expenses the Veteran Administration "may" provide in the future. *Id*. at 1582.

Woodrich and Patterson in their article cautioned defense attorneys about not letting litigation goals affect their experts' objectivity:

> Similarly, defense attorneys, in their efforts to minimize the damage total for their clients, often seek to get their experts to recommend the least costly services available.

Woodrich and Patterson at 45 (citing Weed, R.O., *Ethical Issues in Expert Opinions and Testimony*, 43 Rehabilitation Counseling Bulletin 215–18 (2000); Zasler). They also suggested the defense may mistakenly seek their experts to opine that state and federal programs effectively meet all the individual's needs, and they stressed that such programs' limitations and benefits must be understood. *Id*.

IX. Conclusion

Because plaintiffs' life care plans may be litigation driven, defense counsel need to know questions involving such plans and to give them and the planners careful scrutiny. The points in Woodrich and Patterson's article provide a roadmap of issues to consider and the discovery and investigation that can help.

The planners' qualifications and expertise are always important and may give rise to *Daubert*-type motions. Further, it is vital to pin down the bases for the planner's projections and to compare them with the care being given and the treating doctors' prognoses. Issues sometimes can be raised about the plans' speculative nature. Attendant care is always a major factor and questions can be raised regarding its duration, frequency, and level.

Defendants may consult, or use as a witness, a defense life care planner, or a medical expert. However, it is a mistake to seek more from the defense experts than is reasonable based on the evidence, and the defense also must consider the actual care and the treating doctors' prognoses.

Many Woodrich and Patterson points about plaintiffs' life care plans are applicable to the defense's own medical or life care experts and strategy in responding to the plaintiff. Attendant care, for example, is a major life care issue where the defense looks carefully at what plaintiff is projecting, but also makes careful decisions about its own position.

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Reaction to Rational Life Care Planning

Jeanne B. Patterson, Ed.D., and Frank Woodrich, Ph.D.

Kreuscher (2003) identified 11 points from our article (Woodrich & Patterson, 2003) that he believed could serve as a "road map" for defense attorneys. We agree, but a review of the points indicates that they are applicable equally to defense and plaintiff attorneys.

As we noted in our article, "given the diversity of credentials of professionals working in forensic rehabilitation (e.g., physiatrists, rehabilitation counselors, nurses, psychologists), the field encompasses a variety of licenses, certifications, and memberships, each with its own code of ethics and standards of practice." It is noteworthy that changes (e.g., a new section – F: Forensic and Indirect Services) in the recently revised *Code of Professional Ethics for Rehabilitation Counselors* (hereafter referred to as the Code, Commission on Rehabilitation Counselor Certification [CRCC], 2009) support Kreuscher's statement "the defense lawyer must carefully question the planner's qualifications, determine precisely the bases for the plan, and look at how it fits with the medical or treating physician's evidence." Standard F.2.b of the Code states:

> "rehabilitation counselors have an obligation to present to the court, regarding specific matters to which they testify, the boundaries of their competence, the factual bases (knowledge, skill, experience, training, and education) for their qualifications as an expert and the relevance of those factual bases to their qualifications as an expert on the specific matters at issue." (p. 18)

The issue of qualifications for those providing expert testimony can be troubling. In his discussion of attendant care, Kreuscher cited Elliott, where the court stated that the expert had limited time in the field, "this was his fifth plan and he had never implemented a plan" (p. 58). It appears the real issue was that the defendant's expert agreed with the plaintiff's expert. Every professional has had a "fifth" situation (e.g., surgery, hearing, lecture) and few, if any, experts have ever implemented a life care plan. Most have never served as case managers following a settlement or verdict. Their role is to use their unbiased, objective expertise. The Code, Standard F.1.c states: "… rehabilitation counselors do not provide direct services to evaluees whom they have previously provided forensic services in the past except under the conditions noted in A.5.f, (added: "…changing from a forensic to a primary care role, or vice versa; [or] changing from a non-forensic evaluative role to a rehabilitation or therapeutic role, or vice versa); or government statute" (p. 17).

Another issue related to qualifications is the proliferation of certifications that are used by attorneys to imply that one expert witness is more qualified than another. Or, as Johnson (2009) noted:

> I see a wide array of qualified individuals with a multitude of credentials within the Life Care Planning community. I would hate to see the community of life care planners be disrupted by one certifying body competing against another and

> ultimately excluding those who do not possess "X" or choose not to add even more letters after their name. I fear this is the direction in which we are going" (p. 155).

A list of acronyms following one's name may prove impressive to those who lack knowledge of what the certification actually means, but all certifications do not reflect similar standards. For example, CRCC is accredited by the National Commission for Certifying Agencies (NCCA), as is the Commission for Case Management Certification and the Certified Disability Management Specialist. The Institute for Credentialing Excellence (ICE) (2009) includes a number of groups (e.g., agencies, consumer groups, certifying organizations) with an interest in credentialing. However, as ICE notes: "Membership in ICE does not mean that ICE has approved, endorsed, or accredited an organization or its certification program(s). ICE's accrediting arm, the National Commission for Certifying Agencies (NCCA), is responsible for accreditation of individual certification programs" (p. 1).

Many of the acronyms following a vocational expert's name reflect a certificate program that has not undergone a review by an accrediting body such as the NCCA. The International Association of Rehabilitation Professionals (2010) lists 54 "certifications", although there is redundancy in the list, which include certifications, organizations, and occupations (e.g., Career Development Professional, American Board of Professional Counselors, Legal Nurse Consultant Certification). For example the American Board of Vocational Experts (ABVE) (2010) has as its mission "to promote the highest standards of forensic competency and integrity, to promote accountability though standards enforcement, to provide a 'bench marked' credentialing process that includes knowledge testing and peer review of forensic work products" (p. 1). ABVE certifies individuals as Associate, Fellow, or Diplomate status, with the primary difference the number of years of documented experience as a vocational expert, after one initially has achieved a passing score on the ABVE examination and submitted forensic work products for review. To be a Diplomate, an individual must have 7 years of experience and demonstrate "distinguished performance or recognition" through publications, leadership positions, presentations at professional conferences, "and/or [emphasis added] sitting on study groups or legislative committees to enhance the professionalism of an organization" (ABVE, 2010). Obviously there is wide variation in what constitutes distinguished performance. NCCA does not list ABVE as a member that has undergone review by an external body. Even the International Commission on Health Care Certification (ICHCC, 2009), which has procedures for an individual to become a "Certified Life Care Planner," is not listed as a member of NCCA.

A number of universities are embarking on life care planning programs. Minnesota State University – Mankato (2010) offers an on-line graduate certificate program in Forensic Vocational Rehabilitation and George Washington University (2010) will offer a "12 credit online program [that] can be completed in one year and is designed for busy working rehabilitation professionals. The program will provide the forensic training and experience required to become a consultant or expert witness." Kaplan (2008) advertises the profession of Life Care Planner: "In 12 months or less, you could be on your way to a more rewarding career in life care planning" and "the Life Care Planning Certificate program is designed for registered nurses and other health and human services professionals who would like to pursue a career in life care planning, specifically: occupational therapists, physical therapists, rehabilitation counselors, case managers, social workers, psychologists, medical doctors, chiropractors, nurse practitioners, special education professionals, licensed speech pathologists, and professional counselors" (p. 1). Each of these professional groups has its

own Code of Ethics, which may or may not address forensic issues and though an exam may be provided, the examination has not been rigorously reviewed by an external organization.

Regardless of the profession from which the life care planner comes, years of actual experience in working with people with disabilities is the foundation for understanding and learning how to meet their needs through an ethical and rational plan of care. Such experiences cannot be substituted by a "12 month or less" certificate program in life care planning.

We do concur with Kreuscher that expert witnesses for either the plaintiff or defense should base needs and projections on medical evidence. Attorneys are advocates for the clients, but it is up to the expert witness to provide the balanced, unbiased view. Both of us (Woodrich and Patterson) have found ourselves in the position of stating to an attorney, be it plaintiff or defense, "I don't think you will find my testimony helpful to your case." The Code (F.3.1) states:

> While all rehabilitation counselors have the discretionary right to accept retention in any case or proceed within their area(s) of expertise, they decline involvement in any case when asked to take or support predetermined positions, assume invalid representation of facts, alter their methodology or process without foundation or compelling reasons, or where there are ethical concerns about the nature of the requested assignments" (p. 16).

In conclusion, we approve of Kreuscher's title, "Rational Life Care Planning," but we believe that the ethical component is critical and that life care planners should be held to the highest standards. Moreover, there would be far more agreement between life care plans developed rationally and ethically by professionals actually experienced in evaluating and working with individuals with disabilities, rather than by people seeking certification just "for a more rewarding career." The result could yield more productive mediation outcomes, reduced litigation, and life care plans that are actually developed to meet the primary needs of the person with a disability and not the attorney's and expert's involved in the litigation process.

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