Journal of Life Care Planning, Vol. 15, No. 3, (45-53)

Ethics Interface

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This column is the collaborative effort of Nancy Mitchell, Dorajane Apuna, Mary Barros-Bailey, Dianne Simmons-Grab, Sherry Latham, Ann Neulicht, and the Honorable Judith LaBuda. The author is grateful for their editorial support, wisdom and collective experience.

The column is meant to be an educational forum for life care planners. It is not designed to offer an authoritative opinion from the editor or editorial board of the *Journal of Life Care Planning*, the board of the International Academy of Life Care Planners, or the board of its parent organization, the International Association of Rehabilitation Professionals, nor is it designed to represent or replace official opinions from the certifying body or other organizations associated with the practice of life care planning.

Dilemma

I have been asked to evaluate the life care planning needs of a woman who is a member of a large local refugee community. Her rehabilitation physician is from the same ethnic community and practices functional medicine with medical recommendations that are very different from the consulting rehabilitation physician on the case. The consulting rehabilitation physician has made recommendations that are more consistent with what we learned in our LCP training from mainstream medical practices. I am struggling with how to be culturally sensitive to the needs of the evaluee and her rehabilitation physician as well as the recommendations of the consulting rehabilitation physician who will likely be representative of the kind of judge and jury who will hear this case. How do I address cultural issues in my life care plan?

Response

Our standards of practice direct us to recognize and embrace cultural differences. This is easy for most of us when our cultural practices align. The challenge comes when the other person's cultural beliefs and practices are not in tandem with our personal and professional way of thinking. Life care planners come from varied medical backgrounds, but our clinical training is typically rooted in Western medical practices.

Cultural views may shift over time and an injured person may come to adopt the medical practices of the new country … or not. The most prudent way to handle this is to provide both options in the life care plan, i.e., the practices and approaches of the rehabilitation professional from the refugee community as well as those of conventional medical practices. It will be important to fully disclose this approach to the injured person, the family, and your retaining attorney as appropriate to your role in the case. See the below relevant standards:

Relevant Organizational Standards

The International Academy of Life Care Planning Standards of Practice (2015)

II. PHILOSOPHICAL OVERVIEW / GOALS OF LIFE CARE PLANNING

The life care plan is a document that provides accurate and timely information which can be followed by the evaluee and relevant parties. It is a detailed document that can serve as a lifelong guide to assist in the delivery of health care services. The life care plan is a collaborative effort among the various parties, when possible, and reflects goals that are preventive and rehabilitative in nature. As a dynamic document, the life care plan may require periodic updating to accommodate changes and should have quality outcomes as its goal.

Goals of Life Care Plans:

In life care planning, the evaluee is defined as the person who is the subject of the life care plan.

A. To assist the evaluee in achieving optimal outcomes by developing an appropriate plan of rehabilitation, prevention, and/or reduction of complications. This may include recommendations for evaluations or treatment that may contribute to the evaluee's level of wellness or provide information regarding treatment requirements.
B. To provide health education to the evaluee and relevant parties, when appropriate.
C. To specify services and the charges for those services needed by the evaluee.
D. To develop likely alternatives for care that take into consideration developmentally appropriate and least restrictive options for the evaluee.
E. To communicate the life care plan and objectives to the evaluee and relevant parties, when appropriate.

III. STANDARDS OF PERFORMANCE

4. STANDARD: The life care planner considers cultural and linguistic factors that may influence the assessment, development, and implementation of the plan.

MEASUREMENT CRITERIA:

a. Recommends care that is culturally sensitive.
b. Considers multiple evaluee-centered factors including ethnic, religious, sexual identity, and geographic.

IV. STANDARDS OF PRACTICE

2. STANDARD: The life care planner must have skill

and knowledge in understanding the health care needs addressed in a life care plan.

MEASURMENT CRITERIA:

a. Consults with others and obtains education when the life care planner must address health care needs that are new or unfamiliar.
b. Able to locate appropriate resources when necessary.
c. Provides a consistent, objective, and thorough methodology for constructing the life care plan, relying on appropriate medical and other health related information, resources, and professional expertise for developing the content of the life care plan.

4. STANDARD: The life care planner uses a consistent, valid and reliable approach to research, data collection, analysis, and planning.

MEASUREMENT CRITERIA:

c. Considers appropriate criteria for care options such as admission criteria, treatment indications or contraindications, program goals and outcomes, whether recommended care is consistent with standards of care, duration of care, replacement frequency, ability of the evaluee to appropriately use services and products, and whether care is reasonably available.

6. STANDARD: The life care planner uses a planning process.

MEASUREMENT CRITERIA:

d. Develops recommendations for content of the life care plan cost projections for each evaluee and a method for validating inclusion or exclusion of content.

The International Commission on Health Care Certification (2015)

Principle 2 - Evaluee and ICHCC Certificants Relationship

ICHCC Certificants shall respect the integrity and protect the welfare of people and groups with whom they work. The primary obligation of the certificant is to the evaluee outside of independent medical examinations and independent review of plans in which no physician/patient relationship exists.

R2.4 ICHCC Certificants' primary obligation and responsibility is to the catastrophically or non-catastrophically disabled person for whom assessment, evaluation, medical and vocational and rehabilitation needs are being applied and/or determined.

Principle 3 – Advocacy:

ICHCC Certificants shall serve as advocates for fair and balanced reporting regardless of the referral source, with the health, care and safety of people with disabilities not to be compromised as a result of a submitted respective report.

R3.1 The ICHCC certificants shall further use his or her specialized knowledge and skills to do no harm to the "disabled" individual with regards to the summary and conclusions of reporting, regardless of the referral source.

Principle 4 - Professional Relationships

ICHCC Certificants shall act with integrity in their relationships with colleagues, other organizations, agencies, institutions, referral sources and other professions as to facilitate the contributions of all specialists.

Rules of Professional Conduct:

R. 4.1 ICHCC Certificants shall ensure that there is a mutual understanding of the evaluation by all parties involved.

R 4.2 ICHCC Certificants shall collaborate as a team with allied professionals in formulating reports when applicable.

R 4.3 ICHCC Certificants shall not commit the recipient of the case to any prescribed course(s) of action, which may be specified in the report.

R4.4 ICHCC Certificants shall obtain from other professionals essential medical records and evaluations for report development or evaluating function and impairment.

R4.5 ICHCC Certificants shall not discuss with evaluee and/or referral source reputations and/or competency of colleagues in a disparaging manner, nor will they provide judgments to the evaluees regarding quality and appropriateness of treatment they may have received from other professionals.

R4.8 ICHCC Certificants possessing knowledge of any rule violation of this Code of Professional Ethics is obligated to reveal information to the International Commission on Health Care Certification unless the information is protected by law.

Principle 9 - Competence

ICHCC Certificants shall establish and maintain their professional competencies as mandated by their standards of practice.

Rules of Professional Conduct:

R9.1 ICHCC Certificants shall function within the limits of which they are professionally qualified and competent.

R9.2 ICHCC Certificants shall continuously strive through reading, attending professional meetings and taking course instruction to keep abreast of new developments, concepts, and practices that are essential to providing the highest quality of services to their evaluees.

The Commission for Case Manager Certification Code, Professional Conduct for Case Managers for Standards, Rules, Procedures, and Penalties (2015)

Scope of Practice For Case Managers

Case management is a professional, collaborative and inter-disciplinary practice. Board certification indicates that professional case manager possesses the education, skills, moral character and experience required to render appropriate services based on sound principles of practice.

Certified Case Managers (CCMs) will practice only within the boundaries of their role and competence of their education, skills and appropriate professional experience. They will not misrepresent their competence to clients. They will not represent the possession of the CCM credential to imply a depth of knowledge, skills and professional capabilities greater than those demonstrated by achievement of certification.

I. Underlying Values

- Belief that case management is a means for improving client health, wellness and autonomy through advocacy, communication, education, identification of service resources, and service facilitation.
- Recognition of the dignity, worth and rights of all people.
- Understanding and commitment to quality outcomes for clients, appropriate use of resources, and the empowerment of clients in a manner that is supportive and objective.
- Belief in the underlying premise that when the individual(s) reaches the optimum level of wellness and functional capability, everyone benefits: the individual(s) served, their support systems, the health care delivery systems and the various reimbursement systems.
- Recognition that case management is guided by the ethical principles of autonomy, beneficence, nonmaleficence, justice and fidelity.

Selected Definitions

Advocacy: The act of recommending, pleading the cause of another; to speak or write in favor of. (CMSA Standards of Practice 2010, p. 24)

Assessment: The process of collecting in-depth information about a person's situation and functioning to identify individual needs in order to develop a comprehensive case management plan that will address those needs. In addition to direct client contact, information should be gathered from other relevant sources (patient/client, professional caregivers, non-professional caregivers, employers, health records, educational/military records, etc.). (CCMC Certification Guide, p. 7)

Autonomy: Agreement to respect another's right to self-determine a course of action; support of independent decision making. (Beauchamp, T.L., Childress, J.F., Principles of Biomedical Ethics, 6th Ed. 2009, NY, NY; Oxford University Press, pp 38-30).

Beneficence – Compassion; taking positive action to help others; desire to do good; core principle of client advocacy. (Beauchamp, T.L., Childress, J.F., Principles of Biomedical Ethics, 6th Ed. 2009, NY, NY; Oxford University Press, pp 38-30).

Fidelity – The ethical principle that directs people to keep commitments or promises (Cottone, & Tarvydas, 2007).

Standards for Professional Conduct

S 1 - The Client Advocate

Board Certified Case Managers will serve as advocates for their clients and perform a comprehensive assessment will identify the client's needs; they will identify options and provide choices when available and appropriate

S 6 – Conflict of Interest

Board Certified Case Managers will fully disclose any conflict of interest to all affected parties and will not take unfair advantage of any professional relationship or exploit others for personal gain. If after full disclosure, an objection is made by an affected party, the Board-Certified Case Manager will withdraw from further participation in the case.

S 10 - Description of Services

Board Certified Case Managers (CCMs) will provide information to educate clients to make informed decisions. At minimum. At a minimum, information provided by Certificants to clients about case management services will include a description of the services, possible benefits, significant risks, alternatives and the right to refuse services. Where applicable, Board Certified Case Managers will also provide the client with information about the cost of case management services prior to initiation of such services.

S24 –Research: Legal Compliance

Board-Certified Case Managers (CCMs) will plan, design, conduct and report research in a manner that reflects cultural sensitivity; is culturally appropriate; and is consistent with pertinent ethical principles, federal and state laws, host institution regulations, and scientific standards governing research with human participants.

The CDMS Code of Professional Conduct (2015)

RPC 1.13 – Human Relations

A. Discrimination

Certificants shall:

1. demonstrate respect for clients with diverse populations regardless of age, color, culture, disability, ethnicity, gender, gender identity, race, national origin, religion/spirituality, sexual orientation, marital status/partnership, language preference, or socioeconomic status.
2. develop and adapt interventions and services to incorporate considerations of individual client's cultural and/or religious perspectives and recognition

of barriers external to clients that may interfere with achieving effective outcomes.

3. not condone or engage in discrimination based on age, gender, gender identity, race, ethnicity, culture, national origin, religion/spirituality, sexual orientation, disability, language or socioeconomic status.

The Commission on Rehabilitation Counselor Certification, *Code of Professional Ethics for Rehabilitation Counselors* (2012)

Preamble: Rehabilitation counselors provide services within the Scope of Practice for Rehabilitation Counseling. They demonstrate beliefs, attitudes, knowledge, and skills to provide competent counseling services and to work collaboratively with diverse groups of individuals, including clients, as well as with programs, institutions, employers and service delivery systems and provide both direct and indirect services.

The primary obligation of rehabilitation counselors is to the clients, defined as individuals with or directly affected by a disability, functional limitation(s), or medical condition and who receive services from rehabilitation counselors. In some settings, clients may be referred to by other terms such as not limited to consumers and service recipients. Rehabilitation counseling services may be provided to individuals other than those with disabilities. Rehabilitation counselors do not have clients in a forensic setting. The subjects of the objective and unbiased evaluations are evaluees. In all instances, the primary obligation remains to clients or evaluees and adherence to the Code is required.

Rehabilitation counselors are committed to facilitating the personal, social, and economic independence of individuals with disabilities. In fulfilling this commitment, rehabilitation counselors recognize diversity and embrace a cultural approach in support of the worth, dignity, potential, and uniqueness of individuals with disabilities within their social and cultural context. They look to professional values as an important way of living out an ethical commitment. The primary values that serve as a foundation for this Code include a commitment to:

- Respecting human rights and dignity;
- Ensuring the integrity of all professional relationships;
- Acting to alleviate personal distress and suffering;
- Enhancing the quality of professional knowledge and its application to increase professional and personal effectiveness;
- Appreciating the diversity of human experience and culture; and,
- Advocating for the fair and adequate provision of services.

These values inform principles. They represent one important way of expressing a general ethical commitment that becomes more precisely defined and action-oriented when expressed as a principle. The fundamental spirit of caring and respect with which the Code is written is based upon six principles of ethical behavior:

Autonomy: To respect the rights of clients to be self-governing within their social and cultural framework.

Beneficence: To do good to others; to promote the well-being of clients.

Fidelity: To be faithful; to keep promises and honor the trust placed in rehabilitation counselors.

Justice: To be fair in the treatment of all clients; to provide appropriate services to all. Nonmaleficence: To do no harm to others.

Veracity: To be honest.

Although the Code provides guidance for ethical practice, it is impossible to address every possible ethical dilemma that rehabilitation counselors may face. When faced with ethical dilemmas that are difficult to resolve, rehabilitation counselors are expected to engage in a carefully considered ethical decision-making process. Reasonable differences of opinion can and do exist among rehabilitation counselors with respect to the ways in which values, ethical principles, and ethical standards would be applied when they conflict. While there is no specific ethical decision-making model that is most effective, rehabilitation counselors are expected to be familiar with and apply a credible model of decision-making that can bear public scrutiny. Rehabilitation counselors are aware that seeking consultation and/or supervision is an important part of ethical decision-making.

The Enforceable Standards within the Code are the exacting standards intended to provide guidance in specific circumstances and serve as the basis for processing complaints initiated against certified rehabilitation counselors.

Each Enforceable Standard is not meant to be interpreted in isolation. Instead, it is important for rehabilitation counselors to interpret standards in conjunction with other related standards in various sections of the Code. A brief glossary is located after Section L to provide readers with a concise description of some of the terms used in the Code.

Autonomy: To respect the rights of clients to be self-governing within their social and cultural framework.

A.2. Respecting Diversity

a. Respecting Culture. Rehabilitation counselors demonstrate respect for the cultural background of clients in developing and implementing rehabilitation and treatment plans, and providing and adapting interventions.

b. Nondiscrimination. Rehabilitation counselors do not condone or engage in discrimination based on age, color, race, national origin, culture, disability, ethnicity, gender, gender identity, religion/spirituality, sexual orientation, marital status/partnership, language preference, socioeconomic status, or any basis proscribed by law.

A.3. Client Rights in the Counseling Relationships

c. Developmental and Cultural Sensitivity. Rehabilitation counselors communicate information in ways that are both developmentally and culturally appropriate. Rehabilitation counselors provide services (e.g., arranging for a qualified interpreter or translator) when necessary to ensure comprehension by clients. In collaboration with clients, rehabilitation counselors consider cultural implications of informed consent procedures and, when possible, rehabilitation counselors adjust their practices accordingly.

B.1. Respecting Client Rights

a. Cultural Diversity Considerations. Rehabilitation counselors maintain beliefs, attitudes, knowledge, and skills regarding cultural meanings of confidentiality and privacy. Rehabilitation counselors hold ongoing discussions with clients as to how, when, and with whom information is to be shared.

B.5. Responsibility to Minors or Clients Lacking Capacity to Consent

b. Responsibility to Parents and Legal Guardians. Rehabilitation counselors inform parents and legal guardians about the role of rehabilitation counselors and the confidential nature of the counseling relationship. Rehabilitation counselors are sensitive to the cultural diversity of families and respect the inherent rights and responsibilities of parents/guardians over the welfare of their children/charges according to law.

D.2. Cultural Competence/Diversity

a. Interventions. Rehabilitation counselors develop and adapt interventions and services to incorporate consideration of cultural perspective of clients and recognition of barriers external to clients that may interfere with achieving effective rehabilitation outcomes.

b. Nondiscrimination. Rehabilitation counselors do not discriminate against clients, students, employees, supervisees, or research participants in a manner that has a negative effect on these persons.

G.1. Informed Consent

b. Recipients of Results. Rehabilitation counselors consider the welfare of clients, explicit understandings, and prior agreements in determining who receives the assessment results. Rehabilitation counselors include accurate and appropriate interpretations with any release of individual or group assessment results. Issues of cultural diversity, when present, are taken into consideration when providing interpretations and releasing information.

G.4.Competence to Use and Interpret Tests

c. Recommendations Based On Results. Rehabilitation counselors are responsible for recommendations involving individuals that are based on assessment results, and have a thorough understanding of educational, psychological, and career measurements, including validation criteria, assessment research, and guidelines for assessment development and use. In addition to test results, rehabilitation counselors consider other factors present in the client's situation (e.g., disability or cultural factors) before making any recommendations, when relevant.

G.5. Test Selection

c. Culturally Diverse Populations. Rehabilitation counselors are cautious when selecting assessments for use with individuals from culturally diverse populations to avoid the use of instruments that lack appropriate psychometric properties for those client populations.

G.7. Test Scoring and Interpretation

b. Cultural Diversity Issues in Assessment. Rehabilitation counselors use caution with assessment techniques that were normed on populations other than that of the client. Rehabilitation counselors recognize the effects of age, color, race, national origin, culture, disability, ethnicity, gender, gender identity, religion/spirituality, sexual orientation, marital status/partnership, language preference, socioeconomic status, or any basis proscribed by law on test administrations and interpretations, and place test results in proper perspective with other relevant factors.

I.3. Reporting Results

a. Accurate Results. Rehabilitation counselors plan, conduct, and report research accurately. They provide thorough discussions of the limitations of their data and alternative hypotheses. Rehabilitation counselors do not engage in misleading or fraudulent research, distort data, misrepresent data, or deliberately bias their results. They explicitly mention all variables and conditions known to the investigator(s) that may have affected the outcome of studies or interpretations of data. They describe the extent to which results are applicable for diverse populations.

<u>The Standards of Practice, The American Occupational Therapy Association (2015)</u>

Principles and Standards of Conduct

The Principles and Standards of Conduct that are enforceable for professional behavior include (1) Beneficence, (2) Nonmaleficence, (3) Autonomy, (4) Justice, (5) Veracity, and (6) Fidelity. Reflection on the historical foundations of occupational therapy and related professions resulted in the inclusion of Principles that are consistently referenced as a guideline for ethical decision making.

Beneficence

Principle 1. Occupational therapy personnel shall demonstrate a concern for the well-being and safety of the recipients of their services.

Beneficence includes all forms of action intended to benefit other persons. The term beneficence connotes acts of mercy, kindness, and charity (Beauchamp & Childress, 2013). Beneficence requires taking action by helping others, in other words, by promoting good, by preventing harm, and by removing harm. Examples of beneficence include protecting and defending the rights of others, preventing harm from occurring to others, removing conditions that will cause harm to others, helping persons with disabilities, and rescuing persons in danger (Beauchamp & Childress, 2013).

Principle 2. Occupational therapy personnel shall refrain from actions that cause harm.

Nonmaleficence "obligates us to abstain from causing harm to others" (Beauchamp & Childress, 2013, p. 150). The Principle of Nonmaleficence also includes an obligation to not impose risks of harm even if the potential risk is without malicious or harmful intent. This Principle often is examined under the context of due care. The standard of due care "requires that the goals pursued justify the risks that must be imposed to achieve those goals" (Beauchamp & Childress, 2013, p. 154). For example, in occupational therapy practice, this standard applies to situations in which the client might feel pain from a treatment intervention; however, the acute pain is justified by potential longitudinal, evidence-based benefits of the treatment.

Principle 3. Occupational therapy personnel shall respect the right of the individual to self- determination, privacy, confidentiality, and consent.

The Principle of Autonomy expresses the concept that practitioners have a duty to treat the client according to the client's desires, within the bounds of accepted standards of care, and to protect the client's confidential information. Often, respect for Autonomy is referred to as the self-determination principle. However, respecting a person's autonomy goes beyond acknowledging an individual as a mere agent and also acknowledges a person's right "to hold views, to make choices, and to take actions based on [his or her] values and beliefs" (Beauchamp & Childress, 2013, p. 106). Individuals have the right to make a determination regarding care decisions that directly affect their lives. In the event that a person lacks decision-making capacity, his or her autonomy should be respected through involvement of an authorized agent or surrogate decision maker.

Principle 4. Occupational therapy personnel shall promote fairness and objectivity in the provision of occupational therapy services.

The Principle of Justice relates to the fair, equitable, and appropriate treatment of persons (Beauchamp & Childress, 2013). Occupational therapy personnel should relate in a respectful, fair, and impartial manner to individuals and groups with whom they interact. They should also respect the applicable laws and standards related to their area of practice. Justice requires the impartial consideration and consistent following of rules to generate unbiased decisions and promote fairness. As occupational therapy personnel, we work to uphold a society in which all individuals have an equitable opportunity to achieve occupational engagement as an essential component of their life.

Principle 5. Occupational therapy personnel shall provide comprehensive, accurate, and objective information when representing the profession.

Veracity is based on the virtues of truthfulness, candor, and honesty. The Principle of Veracity refers to comprehensive, accurate, and objective transmission of information and includes fostering understanding of such information (Beauchamp & Childress, 2013). Veracity is based on respect owed to others, including but not limited to recipients of service, colleagues, students, researchers, and research participants.

In communicating with others, occupational therapy personnel implicitly promise to be truthful and not deceptive. When entering into a therapeutic or research relationship, the recipient of service or research participant has a right to accurate information. In addition, transmission of information is incomplete without also ensuring that the recipient or participant understands the information provided.

Concepts of veracity must be carefully balanced with other potentially competing ethical principles, cultural beliefs, and organizational policies. Veracity ultimately is valued as a means to establish trust and strengthen professional relationships. Therefore, adherence to the Principle of Veracity also requires thoughtful analysis of how full disclosure of information may affect outcomes.

Principle 6. Occupational therapy personnel shall treat clients, colleagues, and other professionals with respect, fairness, discretion, and integrity.

The Principle of Fidelity comes from the Latin root fidelis, meaning loyal. Fidelity refers to the duty one has to keep a commitment once it is made (Veatch, Haddad, & English, 2010). In the health professions, this commitment refers to promises made between a provider and a client or patient based on an expectation of loyalty, staying with the patient in a time of need, and compliance with a code of ethics. These promises can be implied or explicit. The duty to disclose information that is potentially meaningful in making decisions is one obligation of the moral contract between provider and client or patient (Veatch et al., 2010).

Whereas respecting Fidelity requires occupational therapy personnel to meet the client's reasonable expectations, the Principle also addresses maintaining respectful collegial and organizational relationships (Purtilo

& Doherty, 2011). Professional relationships are greatly influenced by the complexity of the environment in which occupational therapy personnel work. Practitioners, educators, and researchers alike must consistently balance their duties to service recipients, students, research participants, and other professionals as well as to organizations that may influence decision making and professional practice.

A response to another ethical dilemma will be published in the next issue of the *Journal of Life Care Planning*. The *Journal of Life Care Planning* welcomes the submission of real world ethical dilemmas. Submissions will be altered to promote confidentiality and be kept in strict confidence. Please send submissions via email to nancymitchell4574@yahoo.com.

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