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Life Care Planner: Secretary, Know-It-All, or General Contractor? One Person's Perspective

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Introduction

Some professionals have criticized life care planners for the way in which they conduct the process of accumulating the data required for projecting future care of clients. For consistency in this article, the life care plan definition is as follows:

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. Source: Combined definition of the University of Florida and Intelicus annual life care planning conference and the American Academy of Nurse Life Care Planners (now known as the International Academy of Life Care Planners) presented at the Forensic Section meeting, NARPPS annual conference, Colorado Springs and agreed upon April 3, 1998 and cited in Weed, 1999 and available at www.internationalacademyoflifecareplanners.com.

Consistent with the definition of life care planning, standards of practice, ethics and procedures have been developed over the years to assure effective elucidation of client needs and published in peer reviewed journals (McCollom & Weed, 2002; Weed 2002). How one accomplishes this task has been refined to the extent that certified life care planners (CLCP) have been trained to review medical records, depositions, and all other available information, conduct interviews where possible, contact treating professionals when accessible, or otherwise obtain a foundation for the entries in the plan (such as hiring consultants to provide recommendations within their scope of practice and expertise or relying upon research). It is recognized that many life care planners are consultants in litigation, assist insurance companies to set reserves in workers' compensation or health insurance cases, or work in other settings where they may not have access (either direct or indirectly) to the treating professionals involved in the client's care, and alternative approaches have been developed to assure accurate assessment of client needs. For purposes of this article, the focus will be on litigation related plans.

Two Apparent Self-Serving Views

Varying criticism has been launched by some with regard to procedures used by life care planners for obtaining recommendations. This short article is intended to address two well-

known criticisms. The first is the rehabilitation consultant who stated in testimony that the life care planner's role is essentially one of a "secretary." The professional meets with the doctor or others and simply writes down their opinions, researches costs and then publishes a report with the entries. The person presenting this assertion portrays the life care planner as merely a conduit for information. (It should be noted that the individual making this assertion is not a CLCP but was criticizing a life care plan – not this author's, by the way. Reportedly, at least one CLCP has also presented this opinion.)

The second argument is by the professional who has "been there, done that" and based on his/her experience expresses that they do not need to consult anyone about projected needs. These individuals contend that a review of the records and perhaps an interview is all that is necessary to develop a comprehensive and accurate care plan for an individual with a catastrophic injury. Within this argument, several depositions reviewed reveal that these individuals believe their nursing degree uniquely qualifies him/her, or the CRC credential or Ph.D. degree is adequate for him/her to complete a life care plan. Conferring with physicians or treating professionals (if available) is deemed unnecessary because, at least implicitly, "they know it all" or alternatively ipse dixit (loosely interpreted as "I said it so it must be true"). Also, the representation that one group of healthcare professionals is superior or more "uniquely qualified" to develop life care plans (assuming they have the credentials to seek certification) smacks of prejudice which sets up a foundation for conflict and strife (not unlike diversity bias). In fact, rehabilitation practice is built upon the foundation of teamwork to maximize outcomes.

A Critical Review of Educational Requirements

After reviewing various cases in litigation, workers' compensation and other disability related treatment venues, there seems to be a rather clear picture of what is acceptable with regard to developing an expert opinion that is "valid." The "secretary" view can be easily dismissed since it is incumbent on the qualified life care planner to:

- Know and understand medical terminology, basic anatomy, physiology, and the functional meaning of a diagnosis.
- Know what questions need to be asked of providers in order to get appropriate information regarding future needs.
- Know how to work within the medical system and access the needed information.
- Know which specialties and specialists should be included in care plans.
- Know how to conduct relevant research about medical conditions and costs.
- Be able to critically analyze and synthesize information from a variety of sources.
- Know when information received is not credible or the professionals providing the information are not adequate.
- Know when consultation by a specialist or specialists is indicated.
- Know how to identify qualified specialists and coordinate the consultation.
- Offer opinions within his/her professional expertise as a part of the overall plan.0
- Other... (For more information on role and function studies for life care planners, see www.CDEC1.com and www.internationalacademyoflifecareplanners.com).

Like a secretary, life care planners use the telephone and often the computer to author letters and reports. However, "secretarial" work is a minor part of the process. Indeed, Master's degree students in rehabilitation counseling at Georgia State University must develop a com-

prehensive rehabilitation plan with a "real" client as part of their program. Even with specialized instruction, it is rare that a student can offer a professional quality product until they have gained real world experience. In fact, students have available to them example projects as well as a textbook with step-by-step procedures yet most need "hand holding" throughout the semester in order to complete the project. The point to the above is to underscore that the job of accumulating future care data for a person with a catastrophic injury or complex health problems cannot be delegated to someone who does not have specialized knowledge and training.

With regard to the "know-it-all" professional, in this author's experience the individual commonly is not a CLCP. Two recent depositions reviewed were by nurses who admitted in deposition to never having any training in life care planning but, none-the-less, offered opinions for the plaintiff without the benefit of physician or therapist participation or endorsement of recommendations. The nurses claimed that their nursing education and experience was sufficient as the foundation for opinions. Three others, two of which held doctorates and one Master's level CRC, opined that his/her experience was adequate to express opinions, with one stating that his/her rehabilitation counselor training was essentially equivalent to the CLCP. In an attempt to survey these assertions more closely, the accreditation agencies for nursing (National League for Nursing Accreditation Commission, www.nlnac.org) and rehabilitation counselor training (Council on Rehabilitation Education, www.core-rehab.org) were contacted.

First, according to a survey of accredited rehabilitation counselor Master's degree programs, 54% offer some training specifically in life care planning and all are required to offer training in case management skills (Countiss & Deutsch, 2002). Other required curriculum include medical aspects of disability (including anatomy and physiology), psychosocial aspects of disability, functional capabilities of people with disabilities, assistive technology, counseling and helping skills, vocational and career development, assessment, job development, research, and foundations of rehabilitation counseling.

Nursing programs require education in anatomy and physiology, theoretical & clinical applications, nursing theory, nursing process, critical thinking, health assessment, technical skills, health promotion/disease prevention, concepts of illness & disease management, nursing research, nursing role, leadership/management, health systems and policy, and trends & issues in community based, acute care, and long term care settings. A baccalaureate nursing curriculum typically includes courses on medical surgical nursing, obstetrics/women's health, pediatrics, gerontology, psychiatry, and community health. There are other liberal arts courses with an emphasis in the sciences included, which is similar to the baccalaureate programs the rehabilitation counselors must accomplish before embarking on a graduate degree.

The bottom line: Although both education curriculums include a foundation for working within the medical system, both have strengths and weaknesses. Nurses generally have more in-depth medical education than most rehabilitation counselors and may have some case management training but certainly are not trained as physicians or therapists. Rehabilitation counselors generally have more education and a broader perspective with medical case management, rehabilitation planning, and vocational planning training but likewise are not trained as physicians or therapists either. In addition, rehabilitation counselors with doctorates have more than twice the higher education than nurses and have additional specific rehabilitation training with a heavy emphasis on research. In this author's view, all life care planners must have an adequate foundation for expressing medical or other expert opinions and just knowing what degree they possess is not enough. Indeed, many physicians will defer to other physicians when opinions are outside of his/her specialty area, so the non-physician offering

recommendations that are, in effect, prescriptions seems well outside his/her scope of practice.

It should be recognized that this article does not address the training of the many other health care related professionals who author life care plans, but many of the points are relevant to them as well.

In summary, the life care planner who portrays him or herself as able to identify the details of lifetime needs of clients who require a physiatrist, neurologist, orthopedist, gastroenterologist, ophthalmologist, internist, neuropsychologist, occupational therapist, physical therapist, speech/language therapist, as well as nursing care, diagnostic studies, vocational needs, case management, etc. is not credible. Even if the life care planner is a physician, he or she is not qualified to address many of the areas listed above (for example case management and vocational needs) (Deutsch, 2002). The punch line of this discussion is that in order for the life care planner, retained as an expert witness, to offer a well-founded plan, he/she must rely upon many sources (medical records, literature, as well as solicited medical recommendations) for his/her opinions.

A Third View – By Analogy

An alternative comparison might be encapsulated in the analogy of the general contractor. In this author's experience, general contractors come from a wide variety of educational and experiential backgrounds. The range of training includes engineering and architecture, as well as the person with a GED who worked up through the ranks by building homes. However, it is a rare person who knows every specialty. Think about some of the tasks that go into building a quality home: Architectural design, drafting, site preparation, foundation planning and forming, framing, electrical, plumbing, sheet rock, roofing, security systems, cabinetry, tile, brick laying, wallpapering, flooring, painting, heating/air conditioning, landscaping, irrigation planning and installation, deck building, budgeting, and facilitating the permit process.

The experienced general contactor probably has a "good idea" of what is involved in building a home but rarely knows all of the details especially when it involves trouble shooting, anticipating problem areas or knowing the latest in building techniques and materials in all subspecialty areas. Likely, the general contractor will rely upon the opinions of experts within the various specialties to attend to those details which he/she is not qualified to do. In commercial construction where a bid is required, the general contractor will usually solicit bids from subcontractors and then compile the estimates resulting in a proposal. The competent contractor knows who to hire, how to ask the "right" questions, or how to locate an expert in order to end up with a product that can be sold. However, we all know stories of failures in this industry where housing is not according to code or is substandard – not unlike some life care plans.

Conclusion

The qualified life care planner is neither a secretary nor all-knowing. He or she is more akin to a general contractor who has much to offer the healthcare industry in many settings. Like a general contractor, most states allow life care planners to hang out their shingle without anything other than a business license. However, most competent general contractors who build homes will join a local chapter of the Home Builders Association and agree to a set of ethics which adds a measure of comfort for the customer. Likewise, the foundation of a qualified life care planner is imbedded in the individual professional's education, related experience and personal history. Receiving training specific to life care planning, joining an organ-

ization specific to life care planning and achieving CLCP certification where standards and ethics are specific to the profession further supports that foundation and is the beginning to enhancing a valued profession. Since qualified life care planners are more alike than different and must rely on other professionals within his/her respective areas of expertise in developing a solid plan, it is incumbent upon all life care planning professionals to work together in this coordinated effort and to build consensus for uniformly accepted standards, ethics and purposes.

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Biography

Roger O. Weed, Professor and graduate rehabilitation counseling coordinator at Georgia State University, is a Licensed Professional Counselor, Certified Life Care Planner, Certified Rehabilitation Counselor, Certified Disability Management Specialist, Certified Case Manager, Fellow of International Academy of Life Care Planners, and Fellow of the National Rehabilitation Counseling Association. He has authored or co-authored approximately 100 books, articles and book chapters. He has been honored with several awards for his work including the 1997 and 1991 Outstanding Educator by the National Association of Rehabilitation Professionals in the Private Sector, the 1993 National Professional Services Award from the American Rehabilitation Counseling Association. In addition, he is listed in several Who's Who publications including the 2001 edition of Who's Who in the World.

He is also past- chair of the Georgia State Licensing Board for professional counselors, marriage and family therapists, and social workers, as well as past-president of the International Association of Rehabilitation Professionals (IARP) (previously known as the National Association of Rehabilitation Professionals in the Private Sector). Dr. Weed in chair of the ethics committee for the International Academy of Life Care Planners and maintains a nation-wide private consulting practice specializing in catastrophic rehabilitation and rehabilitation professional training. In addition, he holds adjunct faculty status with the Center for Rehabilitation Technology at the Georgia Institute of Technology and courtesy faculty at the University of Florida.

New Publications

Approaches to Estimating Lost Earnings: Strategies for the Rehabilitation Consultant (2002). Dillman, E., Field, T., Horner, S., Slesnick, F., Weed, R. (**B121**, 122 pp.,$20.00).

A presentation of papers presented at a national seminar on the general topic of estimating lost earnings. Presentations included: factors in estimating LEC (Slesnick), functional capacity assessment (Field), RAPEL (Weed), earnings capacity vs. expected earnings (Horner), and duration, base, inflation and discounting in LEC (Dillman). Choppa, Grimes and Jayne were process group leaders in a modified group process whereby information was solicited from all who attended the seminar. Results of the group process are included, in addition to a list of professionals who chose to be identified as contributors to the group process results.

Scientific vs. Non-Scientific and Related Issues of Admissibility of Testimony by Rehabilitation Consultants (2002). Field, T., Stein, D, and Babington, J., Caragonne, P., Growick, B., & Oldknow, P. (**B123**, @ 100 pp., $15.00).

This publication is a follow-up to a debate held by Drs. Field and Stein on scientific vs non- scientific testimony at a national conference in the Spring of 2002. The papers included in the booklet are: the admissibility of soft science testimony (Field), the importance of scientific testimony (Stein), a summary of cases admitted/not admitted under Daubert/Kumho, the concept of peer review (Caragonne), a reaction to Caragonne (Growick, a journal editor), and Oldknow (Daubert and the legal nurse consultant).

Court Decisions Involving the Americans with Disabilities Act: A Resource Guide for Rehabilitation Professionals (2002). Vierling, L. (**B122**, @ 100 pp., $20.00).

The ADA law has been in the news this past year as several federal court cases seek to clarify relevant issues related to interpretation. Vierling presents an excellent overview of the ADA law and how it differs from other related disability laws. Discussion of cases is presented (many of them being addressed by the US Supreme Court) involving private employers, the definition of disability, and several related aspects to the application of the law in the workplace. This resource in a must for any professional working with clients or cases related to the ADA.

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