

EDITORIAL ESSAY

Editor's Message

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Rather than write my final Editor's Message, I want to use this space to revisit how our specialty practice of life care planning began. Understanding this history matters — not just where the practice originated, but how it has evolved — especially given the ongoing debate about who is qualified to prepare life care plans. Few things cut through confusion like hearing directly from the people who built this field. That is what you will see here. In June 2026, Dr. Roger Weed and Ms. Julie Kitchen graciously agreed to share their reflections on the early days of life care planning. Both played a foundational role in shaping this specialty, and decades later continue to offer their knowledge and guidance to those of us carrying the work forward.

Question 1. What do you remember most about the early days of life care planning?

Julie Kitchen: I began with Paul M. Deutsch and Associates (PMDA) in 1979, initially working with the worker's compensation population in Florida, where rehabilitation was mandated. In approximately 1980, PMDA was asked by an insurance company to provide a dollar figure for their financial exposure, for goods and services that would be expected over a lifetime for a child born with significant brain trauma. To accomplish this task, we pulled together members of each professional field for which services would be needed throughout this child's life. In-depth discussions ensued as to what would be needed. This consultation process became known as a life care plan.

In the early stages, there really were not the "scientific" protocols in place but with time and as testimony was accomplished, protocols were put into place to justify and support the recommendations in the life care plans. It is important to note the collaborative process between Paul M. Deutsch and Associates and economist Fred Raffa, Ph.D. This collaboration undertook to develop the 18 subsections of the life care plan which followed the specific economic growth trends of each section. For example, Projected Allied Health Evaluations grew at a different economic rate than Projected Allied Health Therapies did. Similarly, Medical Evaluations economically grew at a different rate compared to Allied Health Evaluations, etc. so there was a specific and well- thought-out methodology to the 18 different sections of the life care plan.

I think, looking back on history, we can all trace our roots to the foresight and creativity that Paul M. Deutsch initially developed. He saw a need and he and his team developed a niche area of practice that thrives today and has

been so important to thousands of people.

Dr. Roger Weed: Perhaps a little history will help. I was the only masters-level, CRC certified rehabilitation consultant in Alaska for several years and I regularly searched for answers for opining on vocational and other damages related topics for workers compensation and personal injury venues. During my search, I discovered a new organization, the National Association of Rehabilitation Professionals in the Private Sector (NARPPS), was forming (now known as the International Association of Rehabilitation Professionals [IARP]). The inaugural national conference was held in Dallas, Texas in 1981, which I attended as a charter member. One of the speakers was Timothy Field, Ph.D., who, at the time, was a professor at the University of Georgia (UGA). His presentation offered a structured – pre-computer - way to assess transferable skills – Vocational Diagnosis of Residual Employability (VDARE). I was hooked and wanted to know more....much more! At the time, there were very few educational resources while working in Alaska. Keep in mind that traveling from Anchorage to Seattle was about as far as traveling from Seattle to Atlanta, so attending the first NARPPS conference in Dallas required considerable time and money.

Fast forward several years.... I decided that pursuing the doctorate would be the best route for becoming thoroughly educated in my chosen profession, which also required leaving Alaska temporarily (though we never returned to live there). Dr. Field agreed to be my advisor, so I sold my 50% partnership in 1984, my wife resigned her position, and we moved to Athens, Georgia where I attended UGA. At age 40, I was older than most of my “cohort”, but I knew what path I intended to pursue. The mantra for the doctorate was “get in, get out, get on with your life” with my intention being to return to Alaska.

While in the UGA program in 1986, I was selected to speak at the regional rehabilitation educators’ annual *Critical Issues in Rehabilitation* conference, at Jekyll Island, Georgia. Paul Deutsch was also a speaker introducing life care planning concepts. By that time, vocational assessment and planning were well in hand for me but a comprehensive detailing of litigation damages was imprecise. Life care planning was the missing link! I stayed after Paul’s talk to learn more and we began a long relationship. (Fun fact — we enjoyed several work history similarities as well as being pilots.) I *knew* at the conclusion of the conference that life care planning was a major enhancement to complicated injury case evaluations.

2. *Was there a specific moment when you knew the field had genuinely arrived and would be lasting?*

Dr. Roger Weed: There are two notable timeframes. The first occurred in 1992 after planning two conferences limited to 100 people – one on the west coast and another on the east coast. The east coast conference was sold out before the brochures reached the west coast. The planning committee,

consisting of Richard Bongilio, MD, Susan Riddick Grisham, RN, and rehabilitation consultants Paul Deutsch Ph.D., Julie Kitchen, CDMS and me and we tasked ourselves with standardizing minimum knowledge areas. The curriculum consisted of eight “tracks” later leading to a certificate of completion from the University of Florida. This predated life care planning certification.

The second revelation came from publications. We tracked the number of life care planning related articles, chapters, books and legal citations. When the number topped 200, it became too challenging to keep up. These publications appeared in multiple health related disciplines as well as the legal literature. The value and longevity of the specialty practice became obvious.

Julie Kitchen: The practice of life care planning boomed with the increase in personal injury claims, almost guaranteeing a steady business flow. Word began to spread about life care planning, and a core group of people developed a curriculum for teaching the field, based on our collective experience. Initially, the curriculum planners included me, Paul Deutsch, Ph.D., Roger Weed, Ph.D., Richard Bonfiglio, MD, and Susan Riddick-Grisham, RN. (My sincere apologies if I have left out anyone...but recognize, that was at least 46 years ago). From that collaboration, the life care planning curriculum was developed, focusing on, I believe, eight different modules to teach the practice of life care planning. This was a long process, developed to ensure that life care planners possessed minimum competencies and skills in this specialty practice. Through these early efforts, Standards of Practice in life care planning were developed. Eventually, certification in life care planning was developed.

Since personal computers were just in their infancy, researching costs, recommendations, complications, etc., was accomplished through telephone calls, library research, textbook data, and physician/allied medical professional consultations. Each different city we visited to undertake an evaluation resulted in bringing back the yellow pages of a telephone book...I realize that a lot of you reading this might not even know what a telephone book is! In the 1990s, Randall Thomas, Ph.D., developed a useful computerized database program that allowed life care planners to “automate” the format and design of the actual life care plan, employing a format which was being widely used by life care planners throughout the United States and easily recognized by forensic economists and lawyers.

3. What challenge do you feel took the field longer than it should have to overcome?

Dr. Roger Weed: Standardizing life care planning methodology was, and perhaps in some ways, still is an issue. It seemed important to begin with a widely accepted definition of life care planning. It was my honor to lead the

workshop in 1998 where about 100 professionals from a variety of healthcare disciplines successfully gained consensus for a working definition that has stood the test of time.

Then, in April of 2000, I was moderator for the first Life Care Planning Summit where *numerous* consensus statements were reached on the following topic areas (Consensus =100% of the attendees agreed):

- Professional preparation
- Basic tenets and procedures for completing life care plans
- Ethics
- Reliability and validity of the life care plan
- Information dissemination

Speakers and representatives from several relevant organizations returned to their Boards seeking affirmation of the results. *All* Boards submitted letters of endorsement which were published along with detailed methods, process and results.

Following the Summit, the first Standards of Practice document was published in 2001.

Despite the above accomplishments, as well as certification, journals, chapters, articles, books, conferences, summits, etc. there were many who did not use, or even have awareness of ANY of the above but, nevertheless, held themselves out as life care planners. Before I retired at the end of 2011, I was a consultant or expert on several litigation cases where nurses, physicians, rehabilitation counselors, and others (including a part-time rehabilitation educator) claimed that they had the knowledge, skill, experience, training, and/or education to offer life care planning opinions without any of the above mentioned resources. One even claimed that there was no life care planning certification available nearly 15 years after the first certification, CLCP[®], was available. In short, life care planning had become a desirable practice and therefore “I are one,” unaware of, or ignoring the hard work of hundreds of *qualified* professionals.

4. Based on life care planning in its current form, what worries you most and what excites you most?

Dr. Roger Weed: Although retiring many years ago, I monitor IARP online discussion groups regarding general and forensic topics and scan related publications. Healthcare and political trends are disconcerting. Furthermore, AI will have a *significant* effect on the specialty practice. Maybe some effects are good and others maybe not so much. Time will tell. In my volunteer work, I regularly use the basics of AI, and I am sure that life care

planners are also. AI absolutely reduces research time and effort. As an aside, if not retired and still teaching, I wonder how students would be using AI in their coursework....

In the plus column, it is heartening to witness leadership (and emerging leaders) continuing to carry the life care planning torch, broadening horizons and improving the practice.

Julie Kitchen: Life care planning had changed significantly from the development stages in the 1979-1981 era until I retired in 2016. I think life care planning now is much more difficult/involved in terms of documentation and support. I suppose it would be correct to say that the life care plans of today are much more heavily documented, and “scientifically” supported in literature, consultation, Standards of Practice, etc.

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