The Impact of the Psychiatrist on the Life Care Plan

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A life care plan is a tool that is used for medical treatment planning and management purposes in many settings, including legal and forensic applications. This article summarizes the life care planning process and emphasizes the role of the psychiatrist in establishing a strong medical foundation for the plan. The psychiatrist's expertise in determining the nature and extent of the evaluee's psychiatric illness, prognosis, need for and likely benefit from treatment, and costs of care inform the life care planning process. Advising life care planners on these matters is a natural extension of the work of psychiatrists and forensic psychiatrists, who are accustomed to providing medical opinions to the courts. There are specific challenges when the psychiatrist creates recommendations for the life care plan; they include determining long-term prognosis, devising treatment plans, and identifying malingering. These questions are explored to assist the psychiatrist in providing the foundation for a life care plan.

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Life care plans (LCPs) are the most objective and accurate method to convey the full scope of morbidity and economic burden of catastrophic illness or chronic health care needs.[1] Life care planning emerged in the 1980s and developed from the fields of rehabilitation planning and case management.[2,3] The life care planning process was conceptualized as a way to determine damages in civil litigation and was first published in a legal text.[4] Thereafter, life care planning was introduced to the health care industry.[5] LCPs are prevalent in many settings in the United States, including workers compensation claims, Medicare set-aside plans, civil litigation, mediation, reserve setting for insurance companies, estate planning, discharge planning, and federal vaccine injury fund cases.[1,6,7] The LCP continues to be the standard documentation for the management of catastrophic injuries or complex health care needs in the medical-legal setting.[7]

A LCP is defined as "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" (Ref. 7, p 5).

LCPs are prepared for individuals who have a serious illness or significant morbidity. A few examples of catastrophic injuries and chronic diseases for which LCPs have been created are spinal cord injury, acquired brain injury, amputation, burn, birth injury such as hypoxic ischemic encephalopathy, chronic pain, cancer, and impaired vision.[7,8] LCPs are created for these catastrophic injuries and chronic diseases to convey the full scope of morbidity and the economic burden for courts, insurers, and other third parties.

The psychiatrist is often included on the multidisciplinary treatment team and the LCP because catastrophic injuries are strongly associated with psychiatric comorbidities.[9] Conditions commonly comorbid with catastrophic injury are depressive disorders, anxiety disorders, trauma-based disorders, substance-use disorders, impulse-control disorders, dissociative disorders, somatic symptom disorders, sleep-wake disorders, and neurocognitive disorders.[7,10] The psychiatrist's expertise allows the life care planner to create a strong medical foundation for the evaluee's mental health care needs.[11,12] A LCP must have a strong medical foundation to be effective, especially in the legal setting.[13-15]

The emphasis of this article is on the psychiatrist as a medical expert and consultant for the life care plan-

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ner in a legal setting. Specific challenges that the psychiatrist may face when creating recommendations for the LCP include determination of long-term prognosis, developing enduring treatment plans, and detection of malingering. The goal of this article is to assist the psychiatrist in making recommendations for the LCP by summarizing the methodology and challenges. To our knowledge, this is the first article in the psychiatric literature addressing the role of the psychiatrist in the LCP.

Training of the Life Care Planner

As an aid to effective collaboration, it is helpful for the psychiatrist to know the common types of training and qualifications possessed by life care planners. Life care planning is a transdisciplinary specialty practice made up of health care professionals, such as rehabilitation counselors, nurses, social workers, physical therapists, occupational therapists, speech pathologists, psychologists, and physicians. The discipline of life care planning was first standardized in a training program in 1992.[7] Currently, there are training programs for obtaining education in this specialized field through several institutions.[16-18] There also are organizational affiliations and professional codes of ethics for the practitioner.[19-22] The field of life care planning is sustained by a network of organizations with roles for continuing education, publications, and research.[23,24]

Components of the LCP

The LCP must address a wide range of categories related to future needs, as delineated in Table 1.[7] Specifically, the LCP must address the extent of injury or disease, impairments, prognosis, likely benefit from treatment, and costs of future needs. Furthermore, projected elements of medical care must be considered, including preventing secondary complications, enhancing functional outcome due to impairments and disability, reducing suffering, and improving quality of life. Additionally, the long-term consequences of living with a catastrophic medical condition must account for the impact of the aging process. Each category of the LCP must be assessed, and the details of each recommendation must include the frequency and duration of each item over the course of a lifetime. This requires an estimation of the evaluee's life expectancy, a specialized activity usually performed by non-psychiatrists (e.g., physiatrists).[25]

Table 1 Categories of the Life Care PLAN

Evaluations: neuropsychology, physical therapy, occupational therapy, speech therapy, nutrition, recreational therapy, vocational assessment, audiology, vision, swallow studies
Therapeutic modalities: neuropsychology, psychology, social work, physical therapy, occupational therapy, speech therapy, nutrition, recreational therapy
Educational assessment: special education, summer program
Vocational assessment: career guidance, career retraining, job coaching, supported work
Wheelchair needs: manual or power wheelchair, shower wheelchair
Aids for independent function: adaptive aids for the home, adapted clothing
Orthotics/prosthetics: brace, prosthesis
Orthopedic equipment needs: cane, walker, exercise equipment
Home furnishings and accessories: hospital bed, Hoyer lift, portable ramp
Medications: Prescription and nonprescription medications
Supplies: for the prosthesis, catheter, respirator, gastrostomy
Home care versus facility care: level of care determination
Medical care routine: multidisciplinary physicians (including psychiatry), labs, imaging
Medical care aggressive: hospitalization, invasive procedures
Architectural renovations: handicap accessibility
Transportation: adapted van, roadside assistance
Potential complications: risks that are present even with optimal medical and preventative care (This is included for information purposes and pricing is not generated for this category.)

Preparing a LCP is a multistep process that relies on comprehensive analysis, assessment, and research. The life care planner analyzes all available information, including medical records. The life care planner then directly assesses the evaluee and delineates diagnoses, prognosis, and recommended treatments. The life care planner must then review published standards of treatment and consult with physicians on the therapeutic team or medical experts.[13-15] Physicians from various disciplines are involved in LCPs for complex health care needs, often including a psychiatrist, a pain specialist, a physiatrist, a neurologist, and an orthopedist.[26] Furthermore, the life care planner must estimate lifetime costs of interventions and care, for which there are established methods.[7,19] Overall, a qualified life care planner must be an author and collaborator who creates a comprehensive, individualized, and multidisciplinary plan.[27-29]

When the LCP is to be completed for legal matters, the life care planner is often required to give sworn testimony regarding the development and content of the LCP. Similar to other evaluations

done in a legal or forensic setting, the individual for whom the LCP is written is referred to as the evaluee to make clear that, while medical expertise is being used, there is no provider–patient treatment relationship, the evaluation is objective, and the evaluation is not confidential.[30]

The Psychiatrist and the LCP

A psychiatrist is uniquely qualified to provide opinions for the LCP regarding mental health needs.[11,12,26] Through training, experience, and ongoing education, a psychiatrist often provides lifelong care to patients with mental health disorders who have sustained an injury or illness that results in permanent impairment and disability.[31] Furthermore, a psychiatrist routinely assesses the overall needs of patients; psychiatric care often overlaps with treatment by multiple other specialists. Consequently, a psychiatrist may be particularly well positioned to understand the holistic needs of medically compromised patients, providing valuable insight to the life care planner. Psychiatrists, in particular forensic psychiatrists, are familiar with the legal basis for expert testimony and the requirements for objectivity, clear and logical inferences, and adherence to the legal standards for scientific evidence. Given the qualifications and experience that psychiatrists have, life care planners often seek them out and develop professional relationships with them.

The scope of topics the psychiatrist can address as a retained expert and consultant to the LCP is summarized in Table 2. The psychiatrist employs the methodology that is normally used for creating psychiatric evaluations: records analysis, examination of the evaluee, diagnostic testing, referrals, and an assessment and long-term plan based on current scientific literature and published standards of practice.[12,32]

Chronic illness and trauma often cause a range of emotional difficulties and psychiatric illness. Areas of particular concern in this population over the long term are emotional responses to the new life situation; adjustment to disability; development of comorbid psychiatric disorders such as traumatic, mood, or neurocognitive disorders; exacerbation of prior psychiatric illness; and questions regarding malingering and secondary gain. Furthermore, the psychiatrist can address questions related to education, employment, functional limitations, disability, need for attendant care, and costs related to psychiatric diagnoses. In addition, the psychiatrist can determine if referrals are necessary for further evaluations as part of the multidisciplinary approach.[31]

Table 2 Scope of the Psychiatrist's Role in the Life Care Plan

Premorbid psychiatric disorders
Psychiatric disorders related to the injury or chronic illness
Personality traits and disorders
Prognosis of psychiatric illness
Psychosocial history and family dynamics
Psychosocial functioning and limitations
Vocational functioning and limitations
Psychological adjustment to disability
Educational and vocational needs
Attendant care or facility care
Psychiatric treatment: medications, psychotherapy, and higher levels of care such as intensive outpatient treatment or hospitalization
Interventional psychiatry: electroconvulsive therapy, transcranial magnetic therapy, intravenous ketamine
Psychiatric standard of care
Referrals to specialists
Costs of treatment

Common Diagnoses and Treatment Considerations

LCPs are created for a population that has suffered a range of catastrophic injuries or has chronic health care needs. Common psychiatric illnesses in this population consist of anxiety disorders, mood disorders, trauma-related disorders, neurocognitive disorders, and substance-use disorders. For example, the prevalence of major depression in the spinal cord injury cohort is estimated to be approximately 20 percent, more than double the prevalence in the primary care setting.[33] The prevalence of clinically significant depressive symptomatology for young and middle-aged adults with vision loss is 40 to 45 percent, whereas 20 percent exhibit moderate to severe anxiety symptoms.[34] Depression is a common neuropsychiatric consequence of stroke, with up to 55 percent of stroke victims experiencing depression.[35] The prevalence rates for depression in older patients with hip fractures was reported to be 9 to 47 percent.[36] Furthermore, studies have shown the incidence of new-onset psychiatric illness after a motor vehicle accident to be as high as 53 percent. The majority of illnesses consist of depression and posttraumatic stress disorder, which are often comorbid.[37] Up to 80 percent of people who sustain a traumatic brain injury suffer from a psychiatric disturbance at some point in their recovery period.[38] Of people experiencing a devastating disaster, 50 to 80 percent develop posttraumatic stress disorder.[39,40]

The comorbidity of such psychiatric disorders with chronic medical illness and trauma causes disability and reduced quality of life, and it interferes with rehabilitation outcomes.[41-43]Suicide is a significant concern. For example, it has been reported that patients with chronic pain have a 5 to 14 percent lifetime prevalence of suicide attempts and a suicide completion rate that is two to three times greater than that of the general population.[44] Thus, there is a significant role for the psychiatrist to assess, diagnose, and recommend treatment for the LCPs of this population.

When the psychiatrist prepares the recommendations for a LCP, all relevant modes of treatment should be considered. Psychotherapy modalities include a range of therapies, such as supportive therapy, cognitive behavioral therapy, psychodynamic therapy, biofeedback, hypnotherapy, family therapy, and group therapy. Psychopharmacology is often recommended in patients with catastrophic illness. Psychopharmacological interventions should be detailed and specific, including the rationale for the treatment approach and the predicted course of treatment. Side effects of psychotropic medications (e.g., cognitive, attentional, sexual, and metabolic) must be anticipated, as well as the need for interventions to address them.

If it is likely that invasive treatments such as electroconvulsive therapy will be required, they should be included in the LCP. The need for alternative interventional treatments, such as transcranial magnetic stimulation or ketamine infusions for medication-resistant depression, should be addressed where relevant. As alternative treatments gain FDA approval, they may be added to the treatment plan where indicated. For example, new expensive medications may become available and preferable, or old drugs may develop new indications, such as with ketamine infusions for treatment-resistant depression. The psychiatrist will advise the life care planner on frequency, duration, and the cost of these treatments. The psychiatrist can play a key role in developing a holistic, individualized, and comprehensive LCP.

Long-Term Prognosis and Treatment

One of the most challenging questions for the psychiatrist is determining the long-term prognosis of the evaluee. Because the LCP is a road map for the remainder of the evaluee's life expectancy, the psychiatrist must make medical determinations for the long term. This is very different from the clinical setting where the psychiatrist can have the patient return to the clinic as often as needed for evaluation and treatment modifications. Very few prospective life-long studies on mental health exist, one such study being the Harvard Study of Adult Development, a prospective study beginning at ages 11 to 19 and nearing 80 years of follow-up.[45] This study has yielded valuable insights, but the data are still being compiled and analyzed. The psychiatrist must, therefore, use knowledge, experience, and current medical guidelines and research to make the most reasonable long-term recommendations for the evaluee.

As in other forensic medical testimony, the opinions provided by the psychiatrist should be stated to a "reasonable degree of medical certainty or probability." This language of probability enables the psychiatrist to make reasonable and appropriate recommendations, with the degree of certainty used in making clinical decisions.[46] The psychiatrist anticipates likely outcomes, determining, for example, whether depression will be characterized by eventual remission, episodic symptoms, or chronic severe symptoms. The recommendations for treatment, then, reflect the most likely course of the depression in the specific evaluee. When necessary, there is some opportunity for flexibility pertaining to prognosis and treatments in the LCP by providing a few options or giving a range of treatments. For example, in the case of major depression, several choices of selective serotonin reuptake inhibitors can be provided along with the associated costs of each of these. Short algorithms can be included, such as moving to a serotonin norepinephrine reuptake inhibitor if the evaluee does not respond to two different selective serotonin reuptake inhibitors. This makes the LCP more dynamic and allows it to be adapted to the individual over time.

The psychiatrist faces the challenge of balancing many variables when making holistic treatment recommendations for the LCP. The psychiatrist is opining on the mental health of the evaluee but must consider the entire clinical picture with comorbid diseases, socioeconomic factors, impairments, and disability. For example, although there are often indicated treatments of choice for a particular psychiatric diagnosis, the psychiatrist must determine whether that intervention can be used in the specific circumstance. Factors to consider are tolerability of

medication and ability to engage in treatment. Socioeconomic considerations play a vital role in health and community reintegration as well, such as culture, social supports, and return to work. These factors play a key role in health and rehabilitation and must be part of the psychiatrist's overall considerations for future treatment.

The psychiatrist should be aware that there are certain assumptions built into the recommendations for the LCP. One assumption is that the evaluee is entitled to have optimal medical care, which is neither excessive nor inadequate, but rather reasonable and appropriate. Another assumption is that treatment will help restore partial or complete health to the evaluee. The goals of the recommendation must assume that medical care is comprehensive and individualized. Consequently, a large part of the LCP consists of treatments that are intended to prevent secondary complications. For example, the psychiatrist will typically recommend an antidepressant and psychotherapy for major depression to optimize the evaluee's health, but also to avoid further deterioration with risk of hospitalization or suicide. These goals form the basis for the medical recommendations in the legal setting and originate from rehabilitation medicine and case management theory.[2-5]

Malingering

The psychiatrist is required to pay close attention to the possibility of malingering, symptom exaggeration, and dissimulation. In medical-legal contexts, conscious and unconscious motivations may affect the presentation of symptoms.[47] The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, defines malingering as "the intentional production of false or grossly exaggerated physical or psychological symptoms, motivated by external incentives" (Ref. 11, p 726). Although it appears to be a simple finding, malingering presents numerous challenges to physicians.[47] Potential secondary gains relevant to the setting of the LCP include financial reward, provision of medical care, medication seeking, and avoidance of familial, legal, or professional obligations. Unconscious motivations that may affect clinical presentation and lead to symptom exaggeration include the stresses of litigation, desire to correct a perceived injustice, and anxiety about providing financially for loved ones in the face of disability. Dissimulation or the minimizing of symptoms may also occur in the setting of a LCP, such as with a stoic plaintiff or one who has been reluctantly drawn into litigation by loved ones. The psychiatrist must bear in mind that malingering is not a diagnosis *per se* and should indicate when symptoms are inconsistent with known syndromes.[47]

Evaluations may at times be hampered by atypical presentations, poor effort, and nonadherence to treatment. The psychiatrist may use objective assessment screens to assist in the detection of malingering, such as the Structured Interview of Reported Symptoms (SIRS) or the Miller Forensic Assessment Symptom Test (M-FAST).[48] The SIRS questionnaire has a reported sensitivity of 80 percent and a specificity of 97.5 percent for evaluating malingering. M-FAST is a shorter questionnaire and has a reported sensitivity of 92 percent and specificity of 87 percent for detecting malingering.[48]These objective screening tools can be used by the psychiatrist to supplement clinical judgment for the most accurate assessment of the evaluee.

If cognitive impairment is part of the presentation, a referral for neuropsychological testing may be helpful.[49] Neuropsychological and psychological assessments utilize specific personality and emotional functioning measures, such as the Minnesota Multiphasic Inventory (MMPI-2), the Millon Clinical Multiaxial Inventory–IV (MCM-IV), and the Personality Assessment Inventory (PAI), to provide objective data for differential diagnosis and symptom severity. The neuropsychological evaluation also provides data about coping ability, survival strategies, resilience, and emotional resources. Thus, the neuropsychological evaluation is a valuable tool, especially pertaining to malingering and exaggeration. Ultimately, the psychiatrist would incorporate the results into the final recommendations for prescriptions and medical interventions for the LCP.

Legal Aspects of the LCP

Medical Reports

The psychiatrist prepares a report summarizing the recommendations for the LCP so that there are no errors in communication between the psychiatrist and the life care planner. This documentation reduces the opportunities to challenge the life care planner's testimony based on hearsay because the recommendations are provided orally and in writ-

ing.[7] In cases where the psychiatrist is retained as an expert witness beyond the role of consultant to the LCP, the report may be part of the legal record and the psychiatrist may be asked to provide sworn testimony. For example, the psychiatrist may offer an opinion on causation or standard of care, in addition to the long-term recommendations for the LCP. Therefore, the psychiatric report, just like the LCP, should be prepared as a legal document, and the psychiatrist should be prepared to give sworn testimony regarding the development and content of the report.

The LCP is often used in civil litigation for personal injury and medical malpractice, workers compensation claims, mediation, estate planning, and allocation of funds. The psychiatrist should understand the legislative and judicial pressure to reduce compensation and limit awards for pain and suffering. Therefore, providing evidence of the actual losses relating to ongoing medical and rehabilitative needs becomes increasingly important in litigation.[50,51] In litigated cases, the psychiatrist will educate the jury regarding the psychiatric lifetime needs of the individual with catastrophic injury or chronic illness. Damages must be quantified in a way that provides the economist or the jury with the necessary information to project costs over time.

Although it is suggested that the life care planner and psychiatrist have some knowledge or experience in providing expert testimony, this is not a requirement to be certified as an expert. According to legal precedent, an "expert witness is one who by reason of education or specialized experience possesses superior knowledge respecting a subject about which persons having no particular training are incapable of forming an accurate opinion or deducing correct conclusions" (Ref. 52, pp 428–9). This definition allows the life care planner to be named an expert in the legal setting. This definition emphasizes that while the life care planner is the author and collaborator of the LCP, the medical foundation for the LCP relies on physicians who have the education and experience to make medical determinations. The medical foundation for the LCP derives from the evaluee's medical records, standards of medical treatment, treating providers, and expert physician consultants on the multidisciplinary team.[7,14] The psychiatrist is, therefore, an essential part of the life care planning process.

Legal Standards for Scientific Evidence

In most jurisdictions, the psychiatrist who provides expert opinions and the life care planner who prepares the LCP must adhere to the *Daubert* standard.[31] The *Daubert* rule specifies that testimony in federal court offered by a scientific expert must be founded on a methodology that is scientifically valid. It is important that the theory or technique has been subjected to peer review and publication.[53,54] The test for whether expert testimony is admissible is whether it will be reliable and relevant. In determining admissibility of expert testimony, the court must assess, among other things, whether the expert's "theory or technique [. . .] can be (and has been) tested, whether it has been subjected to peer review and publication, its known or potential rate of error, and the existence and maintenance of standards controlling the technique's operation" (Ref. 53, p 594), as well as its general acceptance within a relevant scientific community.

The *Daubert* standard, however, emphasizes that these criteria must be applied flexibly to the expert testimony: "The inquiry envisioned by Rule 702 [in the federal rules of evidence] is, we emphasize, a flexible one. Its overarching subject is the scientific validity—and thus the evidentiary relevance and reliability—of the principles that underlie a proposed submission" (Ref. 53, pp 594–5). That is, no single criterion is dispositive of admissibility. The flexibility of the *Daubert* standard was further emphasized in *Kumho Tire Co., Ltd. v. Carmichael*,[55] which expanded the *Daubert* standard to all expert witnesses (e.g., technical experts), not just scientific experts.

LCPs have been found to meet the *Daubert* standard for admissibility in federal and state jurisdictions. For example, in a case in the southern district of West Virginia involving an injured worker, the defendant, which was a trucking company, filed a motion to exclude a LCP because the life care planner was not herself a medical expert. After finding that the *Daubert* standard, as expanded in *Kumho*, applied to the life care planner, the court ruled that in relying on medical experts to provide treatment recommendations and then applying her expertise in analyzing treatment costs, the life care planner followed a procedure that is reliable and relevant to the case, and her testimony was deemed admissible.[56]

In a case from the First Circuit Court of Appeals involving negligent obstetrical care, the appellant, a

medical center, argued that the trial court abused its discretion in admitting expert testimony by a life care planner.[57] The court noted that the life care planner based his findings on a review of records, a letter from the physician, and an interview of the family and caregiver. The court ruled that this methodology was sufficiently reliable for admissibility.

In a case involving product liability against Ford Motor Company in federal court in Utah,[58] the defendant sought to exclude the life care planner's testimony. In finding that the "method employed by [the life care planner] in reaching her conclusions is scientifically sound," the court ruled that "it is permissible for an expert [. . .] to rely on the reports or information of other experts . . . " (Ref. 58, p 1119).

State jurisdictions that follow *Daubert* have issued similar rulings. In a medical malpractice case in the Arizona Court of Appeals, the defendant/appellant challenged the admissibility of a LCP because the physician who reviewed the plan testified that he did not review it line by line.[59] The life care planner contradicted the physician, stating that he had reviewed it all or she would not have marked it as "reviewed." The court ruled the inconsistency between the physician and life care planner went to the weight (i.e., credibility) of the LCP, not its admissibility. In a case from Nebraska, the appellate court ruled against defendants who sought to exclude a LCP on the basis that parts of it were speculative.[60]

The case law cited indicates that federal and state courts admit LCPs under the stringent *Daubert* standard, even though the life care planner may not be a medical expert. The courts have found life care planners to have a distinct expertise in determining costs of lifetime health care needs. The courts have stipulated, however, that life care planners must rely on the opinions of medical experts, who themselves must also meet the *Daubert* standard. The psychiatric report that pertains to recommendations for the LCP must, therefore, be evidence-based. It is not enough to simply state diagnoses and treatments; rather, the evidence and reasoning for the diagnoses and treatments must be logically laid out to adhere to legal standards of scientific evidence.

In some jurisdictions, expert testimony is still defined more leniently according to *Frye* [61] as "generally accepted as reliable in the relevant scientific community" (Ref. 32, p 20). A review of the case law demonstrates that LCPs are admitted in *Frye* jurisdictions. For example, in a Maryland case involving a toddler who was rendered paraplegic when a waste container fell on her, the Court of Special Appeals found the life care planner's testimony admissible, noting, "It has long been accepted in Maryland, as a matter of common law, that an expert witness may express an opinion that is based, in part, on hearsay if the hearsay is of a kind that is customarily relied on by experts in that particular calling" (Ref. 62, p 524).

In a California Court of Appeal case, a trucking company found negligent at trial for an employee hitting and injuring the plaintiff sought on appeal to exclude the life care planner's testimony on the basis that the life care planner was a registered nurse, not a doctor. The defendant further argued that because the life care planner relied on the expert opinions of physicians who did not themselves testify at trial, there was no basis for her testimony regarding the plaintiff's future care needs. The trial court had overruled both objections, finding that a sufficient foundation existed based on the life care planner's reliance on her consultations with the plaintiff's doctors. The appellate court noted that the life care planner "testified that she is a registered nurse with a specialty in developing long-term treatment plans for patients, and that in doing so she regularly consults with the patient's physicians regarding the particular medical care that is anticipated for the patient" (Ref. 63, p19). In finding for the plaintiff, the appellate court cited case law, stating, "It is the long-standing rule in California that experts may rely upon and testify to the sources on which they base their opinions (Evid. Code, §§ 801, 802), including hearsay of a type reasonably relied upon by professionals in the field" (Ref. 63, p19).

In *Frye* and *Daubert* jurisdictions, LCPs are admitted into evidence and successfully withstand appeals attacking the methodology of life care planning. Regardless of the specific legal standard, recommendations for the LCP must be based on the best available medical evidence.

Conclusions

The life care planning field continues to grow and modify the scope of practice for catastrophic case management. Life care planning is currently the most effective case management method, particularly with regard to complex, medically challenging cases. Life care planning has been endorsed in the areas of allocation of funds for insurance companies, managed care organizations, workers compensation,

personal injury, estate planning, facility discharge planning, and government-funded vaccine injury programs. The psychiatrist is an integral medical expert and consultant to the life care planner in the legal setting. As part of a multidisciplinary rehabilitation team, the psychiatrist provides an expert opinion on psychiatric sequelae of catastrophic injury or chronic illness, recommendations for treatment, predictions about treatment course and complications, and an estimate of treatment cost. Given the psychiatrist's training, experience, and education, this medical specialist is uniquely qualified to contribute to the creation of a holistic, individualized, and comprehensive LCP.

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