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Dear Members,

I hope you’re all enjoying the final days of summer before the back-to-school season and the arrival of fall! The Education Committee has been hard at work preparing for our Virtual Fall Conference, while the Conference Committee is busy planning the 2025 Annual Conference in Phoenix, AZ.

On July 10th, we celebrated the launch of AANLCP Connect, our inaugural event designed to foster engagement between our membership and the executive board. It was a fantastic start, with great participation. AANLCP Connect provides a valuable opportunity to stay updated on Association news, ask questions, and network with fellow members. Be on the lookout for future AANLCP Connect events!

We are deeply grateful for the dedication of our members, which is crucial to our Association’s success. We encourage everyone to get involved and consider volunteering to contribute further to our mission.

Additionally, we’re excited to announce that the Core Curriculum is now available, with orders being shipped on a regular basis. Our Scope and Standards of Practice workgroup continues to diligently review and refine our guiding principles to ensure they stay relevant in our ever-evolving field.

Thank you for your ongoing support and engagement.

Best regards,

Jessica

Jessica Urie, RN, BSN, CLCP, LCP-C, CNLCP
President, AANLCP | president@aanlcp.org
As the summer — the season of travel and exploration — comes to a close, it is time to take stock. Each quarter provides another chance to redirect and reconsider. To help, the AANLCP is excited to help provide resources to choose between the many paths that are available.

The new issue of the Core Curriculum for Nurse Life Care Planning is now available. Quoting the listing for sale, which can be found here, “this comprehensive textbook is your indispensable companion, guiding Registered nurse life care planners through certification exam preparation and the establishment of a thriving practice. Grounded in the nursing process of assessment, critical thinking, and nursing diagnosis, it encompasses vital aspects of the life care planning process, including the application of nursing research, evidence-based practice, case management, expertise, and legal nursing principles.”

There will also be a virtual conference on November 15th, 2024. Nothing is more helpful than having classes, presentations, and collaboration that you don’t even need to book a flight for.

The Journal Committee is proud to present this ethics issue. The subjects covered here include considerations of AI in expert testimony, guidance for interacting with victims of sexual trauma, and other ethical guidance. In addition, the AANLCP webmaster has written a guide for accessing the many resources that are available.

With this much guidance, you should have little difficulty in finding your direction for the fall.

Sincerely,
Stephen Axtell

JNLCP Editor
journal@aanlcp.org
Methodology Memo

Navigating Ethical Responsibilities: The Importance of Conflict Checks for Life Care Planners.

By Misty L. Coffman, RN, MSCC, CNLCP; Medicare Set-aside Consultant Certified; Certified Nurse Life Care Planner; Past President, American Association of Nurse Life Care Planners

According to Barron’s Law Dictionary, 5th Edition, a conflict of interest is defined as “a situation in which regard for one duty leads to disregard of another.” Conflicts of interest may be actual, where the conflict is currently affecting the duty, or potential, where the conflict could arise in the future. Understanding the nuances of these conflicts is vital for professionals such as life care planners, who must navigate complex ethical landscapes in their work.

When a life care planner is approached and asked to consider becoming an expert on a matter, it is prudent to perform a thorough conflict check before engaging in any conversation about the facts of the case or reviewing any documents. This initial step is crucial to maintain ethical standards and avoid compromising the integrity of the expert’s role. Without this diligence, the expert risks being placed in a position where they might inadvertently favor one duty over another, leading to professional and legal repercussions.

A conflict check can be as straightforward as asking for the case name and the names of all parties involved in the lawsuit. This preliminary inquiry helps the expert quickly assess whether they have any existing relationships or obligations that could interfere with their impartiality. For instance, if the expert has already been retained by the opposing counsel on the same matter, continuing with the new engagement would constitute an actual conflict of interest. Furthermore, it is essential to consider potential conflicts, such as personal relationships or prior knowledge of one of the parties named in the lawsuit. These could impair the expert’s ability to remain objective and provide unbiased testimony or analysis.

Beyond these immediate considerations, a comprehensive conflict check involves a deeper dive into the expert’s professional history and current engagements. This might include reviewing past cases, checking for any indirect connections to the parties involved, and considering any financial interests that could be perceived as compromising. Such thoroughness ensures that even the most subtle conflicts are identified and addressed before they can affect the expert’s work.

By identifying and addressing conflicts of interest early, the life care planner ensures that their involvement in the case is ethical and unbiased. This practice is an essential component of the expert’s due diligence and professional responsibility, reinforcing the importance of transparency and integrity in their work. It also fosters trust with clients, the legal community, and the court, demonstrating the expert’s commitment to upholding high ethical standards. In the broader context, adhering to these principles contributes to the credibility and reliability of the life care planning profession as a whole, ensuring that expert testimony and analyses are respected and valued in legal proceedings.
Information for Authors

AANLCP® invites interested nurses and allied professionals to submit article queries or manuscripts that educate and inform the Nurse Life Care Planner about current clinical practice methods, professional development, and the promotion of Nurse Life Care Planning. Submitted material must be original. Manuscripts and queries may be addressed to the Editor. Authors should use the following guidelines for articles to be considered for publication. Please note capitalization of Nurse Life Care Plan, Planning, etc.

Text
- Manuscript length: 1500 – 3000 words
- Use Word® format (.doc, .docx) or Pages (.pages)
- Submit only original manuscript not under consideration by other publications
- Put the title and page number in a header on each page (using the Header feature in Word)
- Place author name, contact information, and article title on a separate title page
- Use APA style (Publication Manual of the American Psychological Assoc. current edition)

Art, Figures, Links
- All photos, figures, and artwork must be in JPG or PDF format (JPG preferred for photos).
- Line art must have a minimum resolution of 1000 dpi, halftone art (photos) a minimum of 300 dpi, and combination art (line/tone) a minimum of 500 dpi.
- Each table, figure, photo, or art must be submitted as a separate file, labeled to match its reference in text, with credits if needed (e.g., Table 1, Common nursing diagnoses in SCI; Figure 3, Time to endpoints by intervention, American Cancer Society, 2019). Graphic elements embedded in a word processing document cannot be used.
- Live links are encouraged. Please include the full URL for each.

Editing and Permissions
- The author must accompany the submission with written release from:
  - Any recognizable identified facility for the use of name or image
  - Any recognizable person in a photograph, for unrestricted use of the image
  - Any copyright holder, for copyrighted materials including illustrations, photographs, tables, etc. Note that images harvested online may be copyrighted.
- All authors must disclose any relationship with facilities, institutions, organizations, or companies mentioned in their work.
- All accepted manuscripts are subject to editing, which may involve only minor changes of grammar, punctuation, paragraphing, etc. However, some editing may involve condensing or restructuring the narrative. Authors will be notified of extensive editing. Authors will approve the final revision for submission. The author, not the Journal, is responsible for the views and conclusions of a published manuscript.
- Submit your article as an email attachment, with document title or filename.

Manuscript Review Process
Submitted articles are peer reviewed by Nurse Life Care Planners with diverse backgrounds in life care planning, case management, rehabilitation, and nursing. Acceptance is based on manuscript content, originality, suitability for the intended audience, relevance to Nurse Life Care Planning, and quality of the submitted material. If you would like to review articles for this journal, please contact the Editor.

Journal of Nurse Life Care Planning is the official peer-reviewed publication of the American Association of Nurse Life Care Planners. Articles, statements, and opinions contained herein are those of the author(s) and are not necessarily the official policy of the AANLCP® or the editors, unless expressly stated as such. The Association reserves the right to accept, reject, or alter manuscripts or advertising material submitted for publication. The Journal of Nurse Life Care Planning is published quarterly in spring, summer, fall and winter. Members of AANLCP® receive the Journal subscription electronically as a membership benefit. Back issues are available in electronic (PDF) format on the association website. Journal contents are also indexed at the Cumulative Index of Nursing and Allied Health Literature (CINAHL) at ebscohost.com. Please forward all email address changes to AANLCP® marked “Journal-Notice of Address Update.” Contents and format copyright by the American Association of Nurse Life Care Planners. All rights reserved. For permission to reprint articles, graphics, or charts from this journal, please request to AANLCP® headed “Journal-Reprint Permissions” citing the volume number, article title, author and intended reprinting purpose. Neither the Journal nor the Association guarantees, warrants, or endorses any product or service advertised in this publication nor do they guarantee any claims made by any product or service representative. In order to make safe and effective judgments using NANDA-I nursing diagnoses it is essential that nurses refer to the definitions and defining characteristics of the diagnoses listed in this work.
Contributors to this Issue

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Richard Bays has served in numerous capacities in the healthcare industry ranging from clinical services and operations, healthcare billing and policy analysis, medical-legal consulting for healthcare attorney groups and oversight of accreditation, licensure and regulatory compliance programs. He specializes in economic aspects of healthcare litigation such as Life Care Plans, Future Medical Cost Projections, Medicare Set-Asides, accounting and tax considerations, as well as reimbursement issues.

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Dena Ramsey, JD, MBA, BSN, RN, CLCP, CMCP, LNCC is the Director of Operations for MD Data. With over 35 years of nursing experience in various clinical and educational settings, including trauma, surgery, administration, and as an adjunct professor, she brings a wealth of knowledge to her role. Additionally, Dena has 17 years of experience in the legal realm, where she combines her medical and legal expertise to develop Life Care Plans, Medical Cost Projections, Medicare Set-Asides, and other reports to determine the future medical needs of injured parties.
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Jacqueline Kaiser

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Dr. Carrie Huntsman-Jones has been an RN since 1995 and a Family Nurse Practitioner since 2020. She currently works for the University of Utah in their RedMed Employee Health Clinic as well as teaching in their graduate nursing program. Dr. Huntsman-Jones has worked in a variety of settings including working as a sexual assault nurse examiner for over 5 years. She is particularly passionate about women’s health, mental health, occupational medicine, pediatrics, and nursing education. Dr. Huntsman-Jones received a BSN from Oregon Health Sciences University, an MSN from the University of Utah, an FNP certificate from University of Massachusetts in Boston, and a DNP from New Mexico State University.

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Stephen Axtell
Misty Coffman, RN, CNLCP, MSCC

Misty Coffman, RN, CNLCP, MSCC has extensive experience handling a multitude of catastrophic claims facing complex medical-legal challenges. She specializes in developing and reviewing life care plans for individuals who have suffered catastrophic injuries such as spinal cord injuries, traumatic brain injuries, amputations, cerebral palsy, birth injuries, and hypoxic events. She has served as an expert witness in state and federal courts.

Misty has nursing experience in various clinical and administrative settings, including but not limited to orthopedic nursing, medical-surgical nursing, occupational health, long term care, skilled nursing care, corporate compliance officer for a chain of nursing homes, medical billing, and assistant director of nursing and director of nursing for a 193-bed acute and long-term rehabilitation center. She worked as an ADA compliance officer and claims manager for a major government contractor.

Misty has served as the President-elect and President of the American Association of Nurse Life Care Planners (AANLCP). She is currently serving as the Immediate Past-President, Executive Board Member, and Spring Conference 2025 Committee Chairperson of the organization.
Professional ethics are standards of conduct that apply to people who occupy a professional occupation or role. A person who enters a profession acquires ethical obligations because society trusts them to provide valuable goods and services that cannot be provided unless their conduct conforms to certain standards. Nurses are the most trusted profession, with 78% of U.S. adults currently believing nurses have high honesty and ethical standards (See https://news.gallup.com/poll/608903/ethics-ratings-nearly-professions-down.aspx).

How do we define ethics? Is it just doing the “right” thing? What is the “right” thing? Ethics is defined as: 1. A system of moral principles; 2. The rules of conduct recognized in respect to a particular class of human actions or a particular group, culture, etc; 3. Moral principles, as of an individual; 4. Branch of philosophy dealing with values relating to human conduct, with respect to the rightness and wrongness of certain actions (See www.merriam-webster.com/dictionary).

There are numerous laws and guidelines governing nursing practice. Professional organizations may establish codes of behavior for their membership, and State's have their own nursing practice act [Or equivalent] that sets nursing standards, defines scope of practice, and otherwise regulates professional nursing in that state. Most nurse practice acts begin by defining critical terms, such as the practice of registered nursing. 

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**Americans’ Ethics Ratings of 23 Professions Are at or Below Recent Levels**

Please tell me how you would rate the honesty and ethical standards of people in these different fields -- very high, high, average, low or very low?

% Very high/High

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<tr>
<th>Profession</th>
<th>2019 %</th>
<th>2022 %</th>
<th>2023 %</th>
<th>2023-2019 pct. pts.</th>
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<td>78</td>
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<td>--</td>
<td>--</td>
<td>65</td>
<td>NA</td>
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<td>Engineers</td>
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<td>--</td>
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<td>-6</td>
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<tr>
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<tr>
<td>Pharmacists</td>
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<td>-9</td>
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<tr>
<td>Police officers</td>
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<td>-9</td>
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<td>College teachers</td>
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<td>-7</td>
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<td>--</td>
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<td>-7</td>
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<td>Chiropractors</td>
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<td>-8</td>
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<tr>
<td>Clergy</td>
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<td>1</td>
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<tr>
<td>Bankers</td>
<td>28</td>
<td>26</td>
<td>19</td>
<td>-9</td>
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<td>Journalists</td>
<td>28</td>
<td>23</td>
<td>19</td>
<td>-9</td>
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<tr>
<td>Lawyers</td>
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<td>21</td>
<td>16</td>
<td>-6</td>
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<tr>
<td>State governors</td>
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<td>Business executives</td>
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<td>14</td>
<td>12</td>
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<td>Insurance salespeople</td>
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<td>-6</td>
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<td>Car salespeople</td>
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<td>-1</td>
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<tr>
<td>Senators</td>
<td>13</td>
<td>--</td>
<td>8</td>
<td>-5</td>
</tr>
<tr>
<td>Members of Congress</td>
<td>12</td>
<td>9</td>
<td>6</td>
<td>-6</td>
</tr>
</tbody>
</table>

Professions are listed in 2023 rank order.
* When veterinarians were last included in 2008, 71% of U.S. adults rated their ethics as very high or high.

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**Keywords:** 1. Ethics, 2. Standards, 3. Conduct
Codes of Ethics
In addition to legal considerations, there are also ethical guidelines for nursing care such as Codes Of Ethics which are a guiding set of principles intended to instruct professionals to act in a manner that is honest and that is beneficial to all stakeholders involved.

Who Defines Ethics?
Among the numerous entities are State Licensing Boards, Nursing Practice Acts, Medical Practice Acts, Professional Associations, Ethics Boards, International Associations, and Academic Centers.

There is a difference between morality, ethical principles, and a code of ethics. Morality refers to “personal values, character, or conduct of individuals within communities and societies.” An ethical principle is a general guide, basic truth, or assumption that can be used with clinical judgment to determine a course of action. Four common ethical principles are beneficence (do good), nonmaleficence (do no harm), autonomy (control by the individual), and justice (fairness). A code of ethics is set for a profession and makes their primary obligations, values, and ideals explicit.

The American Nursing Association (ANA) guides nursing practice with the Code of Ethics for Nurses. This code provides a framework for ethical nursing care and a guide for decision-making. The Code of Ethics for Nurses serves the following purposes:

- It is a succinct statement of the ethical values, obligations, duties, and professional ideals of nurses individually and collectively.
- It is the profession's nonnegotiable ethical standard.
- It is an expression of nursing's own understanding of its commitment to society.


The ANA Code of Ethics for Nurses with Interpretive Statements provides the framework for ethical nursing practice. It identifies the boundaries of professional nursing practice and lays down the duties of nurses extending beyond individual patient encounters. The nurse’s primary commitment is to the patient, whether an individual, family, group, community, or population. When a conflict of interest exists, whether it is actual or perceived, nurses must disclose the conflict of interest to all relevant parties, including employers, colleagues, and patients.

The American Association of Nurse Life Care Planners (AANLCP) Code Of Ethics requires an ethical obligation to practice with integrity, competence and accountability. The AANLCP Code of Ethics and Conduct was created by a group of nurse life care planners as an additional guide to core values and obligations of nurse life care planning. Their Code includes the following:

1. The nurse life care planner does not discriminate against any person based on age, gender, sexual orientation, ethnic background, religious beliefs or practices, social or economic status, lifestyle choices, functional status, health status, or disability.

2. The nurse life care planner maintains competency in nursing practice and nurse life care planning practice.

3. The nurse life care planner demonstrates high standards of professional conduct in delivering nurse life care planning services.

4. The nurse life care planner safeguards privacy rights.

5. The nurse life care planner assumes responsibility and accountability for professional action, opinions, recommendations, and commitments.

6. The nurse life care planner provides professional services with objectivity.

7. The nurse life care planner participates in the advancement of the profession through participating in and promoting mentorship, collegiality, education, and ongoing knowledge development.

Boards of Nursing
Nursing Practice Acts can be found on the State Boards of Nursing websites. The following guideline is applicable to nursing practicing under a Texas license:

A person is subject to denial of a license or to disciplinary action under this subchapter for: “unprofessional or dishonorable conduct that, in the board's opinion, is likely to deceive, defraud, or injure a patient or the public” (See https://codes.findlaw.com/tx/occupations-code/occ-sect-301-452.html).

Ethical Standards are not Legal Standards
In many instances laws are statements of considered ethical positions. Generally, obeying the law is an element of ethical behavior. A law is a rule of conduct or action but ethics is a standard of behavior. Governments enact laws to maintain order and public safety but moral values serve as the basis for ethical conduct.

When distinguishing between ethics and law: (1) Some actions that are illegal may not be unethical. (2) Some actions that are unethical may not be illegal. (3) Laws can be unethical or immoral. (4) Different kinds of mechanisms are used to express, teach, and enforce laws and ethics.
When practicing ethical decision making, the following questions should be examined:

- What is the most appropriate course of action in a particular situation?
- To whom or what do you owe an obligation or a duty?
- Any Legal Obligations Present?
- Any Institutional Obligations Present?
- Do Professional norms and obligations Exist?
- Are There Ethics Committees That Must Be Deferred To?

**Conclusion**

Professional ethics are standards of conduct that apply to people who occupy a professional occupation or role. A person who enters a profession acquires ethical obligations because society trusts them to provide valuable goods and services that cannot be provided unless their conduct conforms to certain standards. Professionals who fail to live up to their ethical obligations betray this trust. By adhering to ethical standards and codes of ethics, medical professionals can 1) Avoid harming others, 2) Respect the rights of others and 3) Reduce personal liability. Mahatma Gandhi once said “The best way to find yourself is to lose yourself in the service of others” and nursing is built on a bedrock of serving and caring for others.

**REFERENCES**


Abstract
Life Care Planners may find themselves working with a niche industry of healthcare professionals that are involved in projecting healthcare services in the context of personal injury cases. Healthcare services received and those likely needed in the future in the context of a personal injury case are often reviewed and allocated by medical audit/billing specialists as well as life care planners. Prospective healthcare service determinations are typically determined by a life care planner and supported by collaboration with treating providers to help them understand the specific future care needs required to address the injury over the life expectancy of the injured party. Life care planners may incorporate the spirit of a case management function; however, this type of projected services and cost research often involves obtaining specific details as to what procedure codes would represent the projected services. In addition, life care planners may rely on prognosis research in their discussions with the treating providers to support and strengthen the future care allocations.

Keywords: 1. Costing, 2. Projections, 3. Research

When a life care planner considers a claimant’s future medical needs, there is more to do than simply rely on a physician’s examination and documentation. Research is necessary to decide what is best for the claimant, specifically researching the delivery of healthcare services by diagnostic conditions and the resources utilized to treat similar healthcare conditions. For such research to be of use to the life care planner, the researcher’s methodology must be consistent, valid, and reliable. Data collection and analysis are consistent with the Standards of Practice published by the International Association of Rehabilitation Professionals (IARP) to be used in the development of a life care plan or medical cost projection (MCP). Further, the use of prognosis research is consistent with the standards published by the American Association of Nurse Life Care Planners (AANLCP). More specifically, prognosis data is optimally studied based on classification systems such as the International Classification of Diseases (ICD) and other procedural coding systems in order to meet the reliability threshold. Historically, the ICD coding system has been used for research on outcome patterns, including the likely course of particular diseases and injuries. In this article, the approach to prognosis research will be presented in the context of IARP Performance Standard 5.c, “Uses appropriate clinical practice guidelines and
research findings in the development of life care plans,” and Standard of Practice 11.b, “Uses, relies upon, and identifies relevant research and references in the development of the life care plan.” In addition, AANLCP Standard 9 “Evidence-Based Practice and Research,” Standard 13 “Collaboration,” and Standard 15 “Resource Utilization” were also considered. This article does not suggest a replacement for the opinions of a qualified medical professional; however, it will explain how a life care planner can efficiently utilize prognosis-based research to identify various services and products that an claimant is more likely than not to need in the future.

The History of Prognosis in Health Care

“Prognosis” is a Greek word meaning “foreknowledge.” In ancient Greek medicine, the term referred to a physician’s ability to predict the course and outcome of a disease based on their observations and experience (National Library of Medicine [NLM], 2022). In modern medicine, it refers to a prediction of the likely course and outcome of a disease or medical condition, based on factors such as the claimant’s medical history, the severity and progression of his or her symptoms, and other relevant medical or lifestyle factors (American Medical Association [AMA], 2019). The term “prognosis” became a standard part of medical terminology in the 19th century as medical knowledge and understanding of disease progressed (AMA, 2019). The concept of prognosis has played a vital role in the practice of medicine, enabling physicians and claimants to make informed decisions about treatment and care. Today, the term is utilized across a wide range of medical specialties, and the subject of prognosis has been the subject of extensive research and study (Jutel, 2009 ). The use of prognosis injury is illustrated in traumatic events such as abdominal gunshot wounds. In a 2023 publication “The impact of colon injuries on the outcome of gunshot wounds to the abdomen” the research concluded “Gunshot wounds to the abdomen with associated colonic injuries had a worse outcome with an increased risk of developing wound infections. There is no difference in the operative management of colonic injury. Patients between the ages of 18 and 25 years or >2 organs injured are more likely to develop a complication (Singh, 2023).” The life care planner may utilize this research to anticipate the needs associated with future complications or at minimum include as an area of discussion with current clinical providers.

ICD Coding System

Attempts to classify diseases began more than two centuries ago. Researchers who were trying to determine why people were dying, such as Dr. William Cullen, who was a surgeon, simply used what data they had on hand for classification. Others, such as statistician John Graunt, used the London Bills of Mortality to analyze how/why children die before reaching the age of six (The World Health Organization [WHO], 2021). Originally deemed “International List of Causes of Death” and adopted for use in the United States in 1898, when the WHO took ownership of the system of classification in 1948 the system was expanded to also include causes of morbidity and not just mortality and christened as the International Classification of Diseases (ICD) https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7960170/. This system was instrumental in providing a common language for not only reporting but also for monitoring diseases and has thus far been translated into forty-three different languages across 117 countries.

The first revision of this system was made at the International Conference for the Revision of the Bertillon or International List of Causes of Death in August of 1900 (WHO, 2021). Although a decision was made at that time to update the system every ten years, it became clear over time that ten years was too long an interval for revisions to be made. New editions are now created more often, with the most recent being the ICD-10, which went into effect in 2013 (Centers for Disease Control and Prevention [CDC], 2021). ICD-11 has also been completed and published (WHO, n.d.); however, it will take time for this new revision to come into effect in the United States healthcare field.

Two versions of the ICD system that have been used in the United States since 1977 are the ICD-9-CM and the ICD-10-CM (CDC, 2022). The US Department of Health and Human Services attempted to require the replacement of ICD-9-CM with ICD-10-CM as of 10/01/2013; however, this was subsequently pushed to 10/01/2015. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7960170/. The main differences between ICD-10-CM from ICD-9-CM and ICD-10 are:

- The addition of information relevant to ambulatory and managed care encounters
- Expanded injury codes
- Increased specificity
- The creation of combination diagnosis/symptom codes to reduce the number of codes needed to fully describe a condition
- The addition of sixth and seventh characters within the number sequence of the diagnosis code
- Incorporation of common 4th and 5th digit sub-classifications
- Laterality
- Greater specificity in code assignment

The healthcare industry uses the ICD systems for classification and statistical analysis of the world’s diseases and deaths. Classification of all the different diseases and causes of death around the world allows us to perform statistical analyses based on diagnostic data. Some purposes of that analysis include resource allocation, reimbursement,
guidelines, health statistics, interoperability and reusability. 
https://www.who.int/standards/classifications/classification-of-diseases

One example of the statistical use of the ICD system is a study examining clinical outcomes in colorectal cancer survivors with and without diabetes (Storey, 2021). The 3,287 individuals who constituted the study group were identified through electronic health records by ICD codes, both those with colorectal cancer and those with type two diabetes. The researchers were able to find individuals who had the conditions they wanted to study because of the ICD coding system. Thanks to the standardized nature of these codes, there were readily quantifiable variables that could be easily incorporated into both descriptive and regression analyses.

Prognostic Research Methods
Determining a claimant’s prognosis requires a thorough understanding of the claimant as well as an understanding of how to select the right diagnosis code, which reflects the correct area of research. Take, for example, stage four cancer – if you look up the correct diagnosis code, when you do prognosis research you will get the data that is consistent with the issues of your claimant. The selection of a diagnosis code is not discretionary; that is, the whole point of doing research by an assigned ICD code representing a disease condition. Because the definitions and symptoms are universally accepted by the WHO which manages and updates the coding system. Further, the Centers for Medicare and Medicaid Services (CMS) recognizes the application and use of these diagnostic codes and their definitions. Providers are required to use the coding system as they are defined; therefore, the outcome data is reliable. Understanding the unique claimant’s condition and any related research on prognoses helps the health care provider determine the next steps to take to benefit the claimant to the greatest extent. The healthcare provider may have years of experience in understanding any given claimant, caring for them, treating them and the regular review of peer-reviewed research articles. In other words, an individual may rely on their own experience in addition to relevant research for their analysis to support their decision-making process, and to function as a baseline for their treatment plans. Furthermore, with the support of prognosis research accumulated through population health management, electronic health record tools, the use of artificial intelligence technology, or a combination of methodologies, the prognosis of any given claimant will be all the more accurate, reliable and defensible.

The American Hospital Association, AHA, (2023) defines population health management, or PHM, as “the process of improving clinical health outcomes of a defined group of individuals through improved care coordination and patient engagement supported by appropriate financial and care models.” (https://www.aha.org/center/population-health-management). Developing population health perspectives may be viewed as “an opportunity for health care systems, agencies and organizations to work together in order to improve the health outcomes of the communities they serve” (Milken Institute School of Public Health, 2015). In other words, it is the management of resources and data in a way that improves the outcome for a population, whether it be claimant’s with a disease, a syndrome, or injury.

When PHM is put into effect, past claimant outcomes are considered together with available resources and knowledge to determine the best course of action for claimant’s with a particular diagnosis. This is an ever-evolving process and since populations are always changing, both in size and in healthcare status, the management of a population’s health care must also change; however, this does not render historical iterations of PHM irrelevant. Health departments are able to review the nature of past care for a particular population, and the outcomes of such care, and compare these to the current iteration to determine how care is evolving for that population.

Considering this, analyzing PHM is particularly relevant to prognostics. The data are a reflection of past and current claimant population conditions, available resources, and the combination of these two variables. They support the basis for determining an claimant’s prognosis. A healthcare provider can consider historical and current data on how claimant’s in a specific population are cared for, and the outcomes of such care. Similar to the use of a healthcare provider, by examining PHM, a life care planner can include in their analysis prognosis research for any given claimant with accuracy and confidence.

Preparing for the future – an electronic healthcare environment
Another source of data that can provide insight into how an individual’s care and/or condition will progress is with electronic health records (EHRs). Although in the current day environment, the life care planner with cases in litigation will more often than not receive medical records electronically in portable document format (PDF) or hard copy paper mode, the direction of the industry is moving toward the retrieval of health data in electronic static format. With that understanding, EHRs can be defined as “real-time, patient-centered records that make information available instantly and securely to authorized users” (The Office of the National Coordinator for Health Information Technology [ONC], 2018). Put simply, an EHR system not only holds electronic versions of individual records but keeps track of an individual’s medical history and health characteristics which leads to quicker access to information. Moreover, an EHR system is not just a data storehouse. It can analyze and synthesize data on an individual and help a provider determine the best
course of action in consideration of multiple factors, including safety, diagnosis, and of course prognosis.

An EHR can help determine the safest way to proceed with an individual's care, and it can help identify potential problems related to the individual's condition or situation. Diagnoses can be easily collected from such systems, as all of the relevant information can be gathered with minimal effort and to the finest degree of selection. Finally, prognosis research that aggregates clinical data from other individuals exhibiting similar or identical conditions and symptoms, including care provided and how their condition progressed over time can be incorporated into an overall review of their health information based on those parameters. Prognostic scores and identifiers can provide a more objective and accurate prognosis than clinical predictions by themselves. The life care planner should consider investment in the utilization of technical skills for handling, receipt, and organization of electronic static health data as well as incorporation of prognostic values when determining future medical needs of an injured party.

Preparing for the future – the use of Artificial Intelligence (AI)

Lastly is the field of Artificial Intelligence (AI). International Business Machines (IBM) defines AI as “the science and engineering of making intelligent machines, especially intelligent computer programs” (IBM, n.d.). The AI programs created today are written for specific tasks, and in this case, we are examining programs in the context of healthcare. This can help chart any changes in the conditions of individuals over time. Artificial Intelligence is appearing in every industry, from large-scale marketing campaigns to automated stock trading, and it has certainly already made its way into the world of healthcare, including the area of prognostics (https://www.prognosisresearch.com/videos-ai). As AI becomes more sophisticated and involved in our modern world, it becomes more relevant and reliable in official situations.

One such example of AI used in the field of prognostics is the use of an AI program by a team of researchers at Stanford University to improve cancer prognoses (Gensheimer, 2021). The researchers first drew data from approximately 14,500 individuals with metastatic cancer to train the model which was then used to make predictions on the life expectancy of a smaller dataset of 685 individuals who were about to undergo radiation therapy. The results of this model were compared to predictions by radiation oncologists for the individuals in the dataset using questionnaires, as well as incorporation of prognostic values when determining future medical needs of an injured party. The AI and general prognosis research can further support collaboration with medical experts involved in fully researching the impact of an injury. The life care planner should also be aware of any ongoing and developing legal opinions as the use of AI continues to evolve.

Bottom line

Knowing one’s claimant is important; their condition or disease, their situation, and their demographics and location must all be considered when determining prognoses. While this is crucial information for the healthcare provider to consider when forming a prognosis, it can be augmented and refined with output data research from tools like Population Health Management, Electronic Health Record systems, and Artificial Intelligence.

Methodology for Prognosis Research

The following data gathering methodology is consistent with the guidelines outlined in Figure 6, 7, and 8 which is discussed in the conclusion:

1. Gather up-to-date information about the individual, their condition, place of service (e.g., skilled nursing facility, ambulatory surgery center, etc.), and geographic location, as well as any other factors impacting the needs of the individual.

2. Identify any research that best suits the individual's needs/condition and that is readily available for any party to examine and evaluate.
3. Collaborate as necessary with other medical experts and or treating providers regarding the research results.

4. To aid analysis and calculation, use standard classification systems, such as current procedural terminology (CPT) codes for procedures, ICD codes for medical conditions, and/or the diagnostic and statistical manual of mental disorders, fifth edition (DSM-5) coding system for psychiatric conditions.

5. Once the prognosis research results are found, state them clearly in the Life Care Plan, including the methods used for obtaining those results.

Case Study Application
The following is an illustration of prognosis being applied to a specific focused expense analysis (limited attribute of a life care plan). The subject is a knee replacement surgery for a 15-year-old individual who experienced a catastrophic knee injury from a gunshot wound. This gun was discharged within a two-foot range of the individual, bullet entry point, the patella. This case example was selected for several reasons: the condition of the knee replacement was not age-related but injury-based, their age, and the type of injury presented (gunshot wound) was atypical from other more common injuries such as motor vehicle collisions. To provide context, the gunshot occurred within two feet of the individual and it was an accidental discharge. Furthermore, because of the severity of the injury itself and the likely consequences of the associated biomechanical alterations, considerations by the life care planner involved traditional costing strategies and emerging technology considerations. Finally, this case study provides a deeper dive into research skills associated with prognosis research on atypical healthcare conditions.

Abstract History of the Case Study:
“On May XXXX, Mr. A.W., currently age 16 (on August 15, XXXX), arrived at CMH (1) with a gunshot wound to his right knee that resulted in a comminuted (fractured into multiple pieces) patellar fracture and a lateral femoral condyle fracture. On the same date, he underwent surgery for irrigation and debridement of the entry and exit gunshot wounds and open reduction internal fixation of the femoral condyle fracture with open reduction and cerclage fixation of the comminuted patella fracture.

According to the deposition of Dr. A. G., (2) the outside part of the femur that bears weight looked to be completely obliterated by the projectile. His patella was devoid of any of its cartilage surface. The injury appeared to extend up into the growth plate of the distal femur.

Since the incident, he has undergone physical therapy,(3) psychotherapy,(4) and multiple additional surgeries on 10/08/XXXX(5) for removal of hardware;(6) on 08/13/XXXX to correct the leg alignment, resurface the patella, resurface the femur, transfer the tibial tubercle, decompress the peroneal nerve,(7) and completed the growth arrest on the distal femur to prevent worsening of the valgus deformity (a bow leg);(8) and on 11/19/XXXX for removal of cartilage and growth plate.(9) Because the valgus deformity was increasing, the next planned surgeries were for the limb reconstruction specialist to redo the osteotomy and equalize his leg lengths. (10) It was very clear to Dr. A.G. “from the get-go that the future of the child’s knee is a knee replacement with metal and plastic.”(11) Dr. A.G. had no idea [at what age Mr. W. would need a replacement[,] but he hoped it would not be for a long time.(12) “We try to stay it [sic] off as long as possible[,] because with each revision which may take place five, ten years down the road if it’s done very well, maybe fifteen years down the road if it’s done really, really well...you lose a successive amount of bone...so each successful round of knee replacement has less longevity.”(13)

Associated Case Study Abstract References
(1) Operative Report, Dr. A. G. MD (Pediatric Orthopedic Surgeon) 5/26/XX
(2) Deposition of A. G. M.D. (Pediatric Orthopedic Surgeon), Pages 16 and 17
(3) See billing for OMC (Provider name redacted)
(4) See billing for SPG (Provider name redacted)
(5) Children’s Hospital, Orthopedic Surgery clinic Post-operative Follow-Up, JP PA-C, 10/21/XX
(6) Deposition of A. G. M.D. (Pediatric Orthopedic Surgeon), Page 18
(7) Deposition of A. G. M.D. (Pediatric Orthopedic Surgeon), Page 35
(8) Deposition of A. G. M.D. (Pediatric Orthopedic Surgeon), Page 36
(9) Deposition of A. G. M.D. (Pediatric Orthopedic Surgeon), Page 41
(10) Deposition of A. G. M.D. (Pediatric Orthopedic Surgeon), Page 47
(11) Deposition of A. G. M.D. (Pediatric Orthopedic Surgeon), Page 51
(12) Deposition of A. G. M.D. (Pediatric Orthopedic Surgeon), Page 52
(13) Deposition of A. G. M.D. (Pediatric Orthopedic Surgeon), Page 65
### Figure 1 – Knee Replacement Medical Services projection WITHOUT prognosis research

Figure 1 above details the beginning portion of the individual's life care plan that outlines the costs over time due to their injury. The individual was sixteen years old, with a projected life expectancy of about 76 years. The Life Expense Analysis includes cost sections such as medical services, mobility aids and safety equipment, medication management, future procedures, etc. The costs are based on the remaining years of life expected for the individual, separated by pediatric versus adult healthcare services.

The sections included in this case study are to illustrate the application of prognosis research in a life care plan. The innovation by the surgeon of a new technique was unique to the severity of and a consequence of this injury and was taken into consideration in the life care planner’s review of past medical bills.

<table>
<thead>
<tr>
<th>Procedure Description</th>
<th>CPT/HCPCS Codes</th>
<th>Quantity</th>
<th>Cost Per</th>
<th>Approx. Cost</th>
<th>Comments</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Orthopedic Visits, Pediatric</td>
<td>99213</td>
<td>4</td>
<td>$246.00</td>
<td>$984.00</td>
<td>Twice Annually until age 18.</td>
<td>1-10,2a,5</td>
</tr>
<tr>
<td>Orthopedic Visits, Adult</td>
<td>99213</td>
<td>110</td>
<td>$246.00</td>
<td>$27,060.00</td>
<td>Twice Annually starting at age 18. Excluding year following each procedure</td>
<td>1-10,2a,5</td>
</tr>
<tr>
<td>Physical Medicine and Rehabilitation Physician Visits, Pediatric</td>
<td>99213</td>
<td>4</td>
<td>$246.00</td>
<td>$984.00</td>
<td>Twice Annually until age 18.</td>
<td>1-10,2a,5</td>
</tr>
<tr>
<td>Physical Medicine and Rehabilitation Physician Visits, Adult</td>
<td>99213</td>
<td>118</td>
<td>$246.00</td>
<td>$29,028.00</td>
<td>Twice annually starting at age 18</td>
<td>1-10,2a,5</td>
</tr>
<tr>
<td>Knee X-rays (2 or 3 views), Facility and Professional Fees</td>
<td>73564 TC/26</td>
<td>57</td>
<td>$243.95</td>
<td>$13,905.15</td>
<td>Annually Excluding year following each procedure.</td>
<td>1-10,2a,6</td>
</tr>
</tbody>
</table>

Sub-total: $7,1961.15

2a: Pricing based on 2022 Context4 Healthcare Medical Fee Directory with geographic adjustment for Houston area 1.025 at 90th percentile

5: Telephone conference with Aharon Gladstein, M.D. (Primary care) on 8/26/20XX to discuss specifics of the life care plan and discuss the prognosis research support to analyzed to support future projected services for quantity, procedure code selection and cost.

6: Telephone conference with Michael Mont, M.D. (surgeon) on 8/26/20XX to discuss specifics of the life care plan and discuss the prognosis research to support projected services for quantity, procedure cost selection and cost.
While the original life care plan as a whole utilizes ten footnotes to support the original life care plan, the footnotes in Figure 3 will be isolated for illustrative purposes:

<table>
<thead>
<tr>
<th>Total Knee Arthroplasty, Revision, Facility Fee</th>
<th>DRG 467 3</th>
<th>$96,306.93</th>
<th>$288,920.79</th>
<th>DRG 467 Revision of knee replacement w/ CC = $96,306.93. DRG 468 w/o CC/MCC. - 2.7 DRG 466 w/MCC = $140,461.53.</th>
<th>1-10,2b,5,6,7b</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Knee Arthroplasty, Revision, Professional Fee</td>
<td>Most 3</td>
<td>$11,650.15</td>
<td>$34,950.45</td>
<td>1-10,2a,5,6,7b</td>
<td></td>
</tr>
<tr>
<td>Total Knee Arthroplasty, Revision, Assistant Fee</td>
<td>Most AS 3</td>
<td>$1,584.42</td>
<td>$4,753.26</td>
<td>1-10,2a,2d 5,6,7b</td>
<td></td>
</tr>
<tr>
<td>Anesthesia for Knee Replacement Revision</td>
<td>Most 3</td>
<td>$1,800.00</td>
<td>$5,400.00</td>
<td>1-10,2d</td>
<td></td>
</tr>
</tbody>
</table>

**Figure 3 – Itemized Knee Replacement Procedures and Services**

Figure 3 above highlights the specific surgical intervention. The actual life care plan includes pre- and post-operative support services that are involved with a knee replacement.

2a: Pricing based on 20XX Context4 Healthcare Medical Fee Directory with geographic adjustment for Houston area 1.025 at 90th percentile

2b: Pricing based on MedPar Data (DRG cost data repository)

2d: Pricing based on XXX case management and audit experience with geographic considerations

5: Telephone conference with Aharon Gladstein, M.D. on 8/26/20XX to discuss specifics of the life care plan

6: Telephone conference with Michael Mont, M.D. on 8/26/20XX to discuss specifics of the life care plan

7b: Page 51 - It was very clear to Dr. Gladstein “from the get-go that the future of the child’s knee is a knee replacement with metal and plastic.” Page 52 - Dr. Gladstein did not know what age the knee replacement would occur. Pages 52-53: The length of time the knee replacement would last depends on his age when the knee was replaced, the amount of steps, whether the compartments loosen. Once the replacement/revisions start to loosen, then each successive replacement becomes more difficult. Page 65 - “We try to stay if off as long as possible because with each revision which may take place 5, 10, years down the road if it’s done very well, maybe 15 years down the road if it’s done really, really well...you lose successive amount of bone...so each successful round of knee replacement has less longevity. Page 94 - “So even though the situation of his knee is terrible, until it starts to become… unbearable, I would say he has not met the criteria for a knee replacement just yet...So once it gets to that point, that’s probably when they will pull the trigger...”

**Figure 4 : Documented Sources providing foundational support for Figure 3**

The prognosis research included two key points. First the pediatric traumatic injury within a pediatric population resulting in knee replacement(s) in the context of quantity and longevity. Second, the life span of the knee replacement. The research for long-range implications is limited to the infrequency of close-range direct knee injuries. Therefore, the typical life span of the knee may be less than those associated with non-traumatic knee replacements. Collaboration from a case management and medical expert analysis concluded the final estimated length of time that each artificial knee will last. The footnotes supporting these three points would be defined as 11a, 11b, and 11c (see Figure 5 below), 11a and 11b supporting quantity
and longevity of the knee replacements, and 11c supporting all three points. These references were included as they were discussed with the treating provider. The explanation of the data found for these footnotes will be found in the next section, but for now, we will outline the footnote items 11a-11c:

11a: "A retrospective study of a series of 126 consecutive primary cemented total knee replacements using the AGC prosthesis is reported. Sixty-two knees were available for long-term review with an average clinical follow-up of 11.4 years (range, 8.4-13.6 years). The survivorship was 95%, defining the endpoint as revision of all components for any reason except sepsis.” (R H Emerson Jr, 2000)

11b: “Our pooled registry data, which we believe to be more accurate than the case series data, shows that approximately 82% of TKRs last 25 years and 70% of UKRs last 25 years.” (Jonathan T Evans, 2019)

11c: “The pooled 30-day mortality rate was 0.14% (95% CI:0.05-0.22%; n = 1,817,647). The pooled 90-day mortality rate was 0.35% (95% CI:0.28-0.43%; n = 1,641,974). The pooled 1-year mortality rate was 1.1% (95% CI:0.71-1.49%; n = 1,178,698). The pooled 5-year mortality rate was 5.38% (95% CI:4.35-6.42%; n = 597,041). The pooled 10-year mortality rate was 10.18% (95% CI:7.78-12.64%; n = 815,901).” (Xuankang Pan, 2022)

**Figure 5 - Documented Sources of Further Research**

### Prognosis Research for Knee Replacement(s) and other support Services

With supporting research, the life care planner can find sources that support the previously outlined life expense analysis cost summary, and may also find more information that will benefit the individual in more ways than financial ones.

First is an article detailing prognoses of pain and physical functioning in patients with knee osteoarthritis (Mariëtte de Rooij, 2016). While knee osteoarthritis (OA) is not knee replacement, it is fair to say that those who receive knee replacement surgery will experience a unique kind of knee pain, much like those with OA will. This implies that the supporting research of the individuals with OA will be similar to those individuals who receive a knee replacement. This allows the crossover of information for both the individual and provider when considering the life care plan, treatment, and risk factors for those with knee replacements. Not only that, but this article also notes how there is strong evidence that knee characteristics, clinical factors, and psychosocial factors serve as prognostics of pain associated with knee deterioration and physical functioning. In this case study the interview with the physicians involved all confirmed the consequence of OA as a condition to be considered when preparing the life care plan. Specifically, services to support the management of pain and psychosocial support associated with the traumatic events that resulted in the injury.

The unusual circumstance of a pediatric acute gunshot wound and the significant impact on compromised mobility resulted in additional research on mortality. At the age of eighteen, the individual could not walk more than a half mile without having to sit and rest. This involved the review of a study that examines mortality rates following total knee arthroplasty (TKA) (Xuankang Pan, 2022). The study examined different time spans after receiving TKA, starting with thirty days and ending with ten years after the procedure, and the mortality rates after each period of time. This mortality data gives evidence to support the expected years of life for the individual. Along with this, the study lists the most common causes of death within each of those time spans after the procedure, and coincidentally each time span had the same list of common causes: cardiac disease, cerebrovascular disease, and malignancy. This list gives the individual more specific, relevant, and reliable risk factors related to their condition. The data was gathered using a number of databases, such as PubMed, MEDLINE, and Google Scholar.

Another consideration is evaluating research on costs associated with OA and the potential impact in the context of this individual. As such, a review of a study describing lifetime medical costs for those with knee osteoarthritis (Losina et al., 2015) was included in the assessment. Again, while OA is not knee replacement, it still presents a great outline and comparison to the costs of related bills and procedures, such as physical therapy, pharmaceutical support such as acetaminophen, and other biofeedback services to name a few.

Finally, two studies discussing how long knee replacement devices last were identified and reviewed during the physician interviews. One of these discusses a specific knee replacement device, the AGC (Anatomic Graduated Component) total knee prosthesis, and its durability (R H Emerson Jr, 2000). The average time before following up with the individual was 11.4 years, and the durability of the device was 95%, meaning that for an average time span of 11.4
years before revision, 95% of prostheses were intact and in good condition. The second article discusses more generally how long knee replacements last for two categories: total knee replacement (TKR, identical to TKA noted above) and unicompartmental knee replacement (UKR), the former of which is our main interest (Evans, 2019). The study found that 82.3% of TKR devices lasted for twenty-five years.

In reviewing these two studies concerning knee replacement longevity, seeking opinions from the treating providers or retained medical experts would provide foundational support to the life care plan.

Pulling it All Together under IARP Standards 5.C and 11.B and AANLCP Standard 9, 13, and 15

Each of the articles listed above that could have been used in further prognosis research are justified under IARP Standard 5.C and 11.B and AANLCP Standard 9. Each come from consistent, valid and reliable datasets and scientists who have drawn from reliable sources for their data. Not only that, but the information is up to date, incorporating applicable literature to support the life care planner’s reasoning. Figure 6 identifies the specifics associated with IARP Standard number 5, Figure 7 identifies specifics associated with IARP standard number 11 and Figure 8 lists the relevant AALNCP standards. Overall, the life care planner uses a consistent, valid, and reliable approach to research, data collection, analysis, and planning.

The preparation of the life care plan in this case study involved the interview and assessment of the individual; collection of relevant medical records, billing documents, examinations, and depositions; information from reliable charge databases and use of appropriate diagnosis and procedure coding systems; relevant research; consultations with appropriate and relevant medical professionals (e.g., MDs and PCPs); and a review of the scientific literature. IARP Standards 5 and 11 can be found in the appropriate use of relevant literature regarding medical services and surgical intervention documented within the sources of the life care plan. Collaboration with professionals is once again documented within the sources supporting the line-item detail can be found within AANLCP standard 13. Standards 5 and 11 along with AACLCP standard 9 are also illustrated in the footnotes labeled 2.a, 2.b, and 2.c. The name of the specific pricing research source has been identified. IARP Standards 5 and 11 along with AANLCP standards 9, 13, and 15 are illustrated by incorporating research on the longevity of a knee replacement. Further, other attributes of the standards are noted by the use of established coding systems such as procedure codes, DRG codes, and diagnosis codes. Finally, the use of all standards referenced is demonstrated by providing a complete reference list at the conclusion of the life care plan.

Figure 6: IARP Standard #5
5. STANDARD: The life care planner uses the scientific principles of medicine, rehabilitation, and health care as a basis for life care planning.

PRACTICE COMPETENCIES:
- a. Uses and, when possible, participates, in research relevant to life care planning practice.
- b. Evaluates literature for application to life care planning.
- c. Uses appropriate clinical practice guidelines and research findings in the development of life care plans.

Figure 7: IARP Standard 11
11. STANDARD: The life care planner uses a consistent, valid, and reliable approach to determining claimant’s need.

PRACTICE COMPETENCIES:
- a. Ensures appropriate foundation or rationale for each recommendation.
- b. Uses, relies upon, and identifies relevant research and references in the development of a life care plan.
- c. Uses correct standards of care, clinical practice guidelines, services and products from reliable sources, such as current literature or other published sources, collaboration with other professionals, education programs, and personal clinical practices to make recommendations.
- d. Determines consistency of care recommendations with standards of care.
- e. Considers person-centered care criteria such as settings, admission criteria, treatment indications or contraindications, program goals and outcomes, consistency of services relative to standards of care, duration and frequency of services, ability of the claimant to effectively benefit from services and products, responsiveness of services to changing claimant needs, whether care is the least restrictive relative to the needs of the individual, and availability.
- f. Considers factors such as age, sex, race, ethnicity, religion, gender identity, sexual orientation, disability, and geographic location.
- g. Considers recommendations that are age-appropriate, using knowledge of human growth and development, including the impact of aging on disability and function.
- h. Considers the rationale/rationale for inclusion or exclusion of recommendations.
i. Consider factors such as pre-existing conditions and causally related needs in forensic cases.

j. Considers the likely benefit of recommendations and how a recommendation may affect other recommendations (i.e., multidimensional influences throughout the life care plan).

k. Considers the probability versus possibility of need.

l. Researches appropriate options for recommendations, using sources that are reasonably available to the claimant.

m. Uses a consistent method to determine available choices.

Figure 8 AANCLP Standards

Standard 9. Evidence-Based Practice and Research

The nurse life care planner integrates research findings and evidence into practice.

Standard 13. Collaboration

The nurse life care planner provides collaboration with healthcare consumers, healthcare providers, and others, in the conduct of practice.

Standard 15. Resource Utilization

The nurse life care planner recommends appropriate resources for safe, effective, and financially responsible healthcare services.

REFERENCES


REFERENCES


Sexual violence is defined by the Centers for Disease Control and Prevention (CDC) as “…Sexual activity when consent is not obtained or freely given.” (Centers for Disease Control and Prevention, 2022). It’s estimated that, on average, there are approximately 450,000 new people (age 12 years and older) who have experienced sexual violence each year in the United States. It is also estimated that one-in-six women and one-in-ten men have experienced an attempted or completed rape at some point in their lifetime. Over half (54%) of these individuals are between the ages of 18-34 years old (RAINN, 2022). Sexual violence is a public health issue that negatively impacts the long-term health and well-being of all who experience it. Sexual assault is also monetary: estimated to cost each survivor $122,461 during their lifetime (Centers for Disease Control and Prevention, 2022).

Approximately 60% of sexual violence events will go unreported (National Sexual Violence Resource Center, 2015; RAINN, 2022). The reasons for this vary from person to person. Some of these reasons include fear of retaliation; belief that law enforcement would not help; belief that no one would believe them; transportation issues; immigrant status; lack of health insurance; embarrassment; or guilt (Khan et al., 2018; RAINN, 2022; U.S. Department of Justice Office on Violence Against Women, 2013). Patients who experience

**Nursing Diagnoses to Consider**

**NANDA-I 2024-2026**

- **Risk for Post-Trauma Syndrome.** Susceptible to sustained maladaptive response to a traumatic, overwhelming event.
- **Impaired Resilience.** Diminished ability to recover from perceived adverse or changing situations.
- **Impaired Mood Regulation.** Mental state characterized by shifts in mood or affect and which is comprised of a constellation of affective, cognitive, somatic, physiologic and/or behavioral manifestations.

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sexual violence will also vary in their reactions to what has happened. How each patient may react to the situation often depends on things such as the severity of the physical and/or mental abuse; the relationship with the perpetrator; the length of time the patient was abused; and the experience of the survivor with healthcare, police, and courts (Boyd, 2011). The impact on these patients’ mental health can be present at various times in their lives. Depression, anxiety, mood swings, sleep disturbances, and paranoia are a few of the issues that may develop for people who experience sexual violence (Washington Coalition of Sexual Assault Programs, 2018).

The U.S. Department of Justice Office on Violence Against Women published national guidelines in 2013 with recommendations for the care of patients who have experienced sexual violence. These guidelines include a comprehensive plan of care for these patients during this difficult time (U.S. Department of Justice Office on Violence Against Women, 2013). The guidelines address information about encouraging reporting of the assault, requesting a forensic exam, and guiding patients through follow-up care. Nurse Life Care Planners are well suited for educating patients who have been sexually assaulted about their rights, their options, and the next steps to their follow-up care.

The national guidelines were drafted to give some guidance to all members of the team who are involved in the care of these patients. These members include healthcare providers, advocates, law enforcement, forensic scientists, and prosecutors. These individuals work together to provide the best care for the patients. The goal is not to focus on punishment for the offenders but to care for those patients who have experienced sexual violence. Focusing on the patients assures that they receive thorough care and assistance that is directed toward them and the situation that have experienced (U.S. Department of Justice Office on Violence Against Women, 2013).

The guidelines are focused primarily on what should be done when a caregiver is informed by a patient that they have been recently sexually assaulted. Once a healthcare provider has become aware that a patient would like to report a sexual assault, the provider should contact local law enforcement. Law enforcement will assist in providing the patient with their available options based on the timeframe of when the assault happened. Typically, most jurisdictions will collect evidence up to 5 days post-assault (U.S. Department of Justice Office on Violence Against Women, 2013). However, a report of the event will be generated regardless of how long ago the assault happened. If the assault happened within the 5-7 day timeframe, the collection of forensic evidence may be collected in the form of an Evidence Collection Kit (U.S. Department of Justice Office on Violence Against Women, 2013).

An evidence collection kit also called a “rape kit” is a forensic exam. This may be requested by law enforcement if the sexual assault event occurred within the standard time frame as dictated by local jurisdiction. The exact procedure for performing a forensic exam may depend on the resources and policies of the facilities, however, the procedures all have some basic things in common that may be helpful to share with patients. Before any exam is performed, the patient should be asked to sign an informed consent. An informed consent is vital in fostering the patients’ understanding of the process, allowing time for questions, and making the patient aware that they do not have to participate in a forensic exam or evidence collection. It is also important for the patient to understand that they have the right to only consent to participate in the portions of the exam that they are comfortable with. Finally, they may ask for the exam to be aborted at any time if they suddenly become uncomfortable with the process (U.S. Department of Justice Office on Violence Against Women, 2013).

Once a patient has consented to the exam and all questions have been addressed the process typically starts with general information. This information includes patient demographics, medical history, and a history of the assault. Awareness of injuries sustained during the assault and other details shared is important to gather as it guides the provider when doing the physical exam. (SAFEta.org, 2024; U.S. Department of Justice Office on Violence Against Women, 2013). Finally, a full physical exam is performed to assess for injuries or other concerns. This includes looking at every part of the body, including genital areas. To help with the coordination of care, photos and swabs may be collected during the physical exam portion of the forensic exam so that the patient only has to be fully examined once (SAFEta.org, 2024).

At the end of the examination, the patient is typically given the option to take emergency contraception and prophylactic antibiotics to treat the most common sexually transmitted infections (STI). Discharge instructions should include local resources related to mental health services, advocate assistance, law enforcement information, and follow-up care options. Follow-up care should be performed by a provider of their choice 3-4 weeks after the assault to test for STIs, pregnancy, and healing of any injuries. It is also a good time to make sure that the patient has information for connecting with local resources (U.S. Department of Justice Office on Violence Against Women, 2013).

While the basics of care for patients who have been sexually assaulted are similar for all patients, there are some special populations that may need additional assistance if they should need to go through this process. Research has shown that people with disabilities are 2-4 times more likely to be sexually assaulted (Mailhot Amborski et al., 2022; U.S. Department of Justice Office on Violence Against Women, 2013). Three primary barriers have been identified that may need to be addressed when assisting people with disabilities who have been sexually assaulted. First, patients may have difficulty accessing available services after an assault. Transportation issues may be difficult for all patients (Huntsman-Jones et
al., 2023), however, it may be more difficult to obtain for a person with a disability (Bach et al., 2021). Next is a concern related to providing services that were appropriate to a particular disability. For example, those individuals with cognitive impairments may not be able to understand the instructions given to them and may experience discrimination related to this disability (Bach et al., 2021). Lastly, there is a concern that the criminal justice personnel may treat people with disabilities differently and may not take their accusations seriously (Bach et al., 2021). This can make reporting more difficult for those with disabilities.

Another at-risk population is older adults. These patients may have complex medical routines and medications that may further place them at risk for additional injuries. There is also concern that caregivers for these patients are the individuals who are the alleged offenders (U.S. Department of Justice Office on Violence Against Women, 2013). The elderly population is also less likely to seek follow-up care and are less likely to report, which makes them more vulnerable to victimization (Bach et al., 2021; Fileborn, 2017). These patients may have the same barriers as those with disabilities. These barriers need to be addressed so that the older adult can receive the resources and services needed after they have been sexually assaulted.

Lastly, it is important to address sexual assault experiences that have occurred in the past. Just because a patient discloses an event that occurred outside the timeframe for them to receive a forensic exam does not mean that the patient doesn’t need follow-up care. It has been suggested that due to the potential long-term burden of mental health issues experienced by survivors of sexual assault, counseling is a beneficial resource for these patients (Henin & Black, 2021). Other areas of concern are related to the physical body. Individuals may experience physical concerns such as painful sexual intercourse, painful menstruation, and lack of sexual pleasure. Other gynecological concerns are related to infection or injury during the assault (Jina & Thomas, 2013). These may be short-term or long-term issues for these patients and should be addressed as soon as they are acknowledged.

Below is listed a chart with a brief summary of when events may typically occur for patients after a sexual assault. This is not an exact list (as situations and locations may vary) but should be used as a guideline. None of these events is required as the patient has the right to participate or refuse anything on this list. Patients and caregivers should keep in mind that some events are time sensitive and if a patient chooses not to participate at a specific time, they may lose their opportunity to participate in that event at all. Also, patient may disclose a sexual assault at any time, so this list is primarily related to early reporting. Late reporting follow-up will depend on the patient, situation, and timing and should be adjusted as needed. As always, follow local jurisdiction and laws as applicable.

### General Timeline:

**Within one week:** Treat any injuries, prophylaxis STI treatment, emergency contraception, report to police, evidence collection, initiate counseling.

**1-3 months:** F/u physical exam, test for applicable STIs, pregnancy test, establish counseling (for both patient and loved ones as needed), follow-up with police, be assigned advocates (from police department and/or a community-based agency).

**3-6 months:** Any medical f/u as needed, additional STI testing as needed, counseling, working with police and advocates.

**>6 months:** Assessing for both physical and mental health issues related to sexual assault as needed.

(SAFEta.org, 2024; Subramanian & Green, 2015; U.S. Department of Justice Office on Violence Against Women, 2013; Women’s and Children’s Health, 2024)

Nurse Life Care Planners (NLCP) often become trusted confidantes to patients in their care. Therefore, it is important for these caregivers to be familiar with some of the basic steps to take to assist a patient who has disclosed that they may have been sexually assaulted. By reviewing the information listed here the NLCP may be better prepared to assist their patients with maneuvering a complicated system so their patients may receive timely and appropriate care.
REFERENCES


Unlocking the Full Potential of Your AANLCP Membership: A Guide to Member Resources

As a member of the American Association of Nurse Life Care Planners, you can access a wealth of resources designed to support and enhance your professional journey. The members section of our website is a trove of tools, information, and opportunities that can help you excel in your life care planning practice. In this article, we’ll explore the various resources available and explain how you can make the most of them.

Educational Materials
Education is the cornerstone of professional growth, and the AANLCP is committed to providing top-notch educational resources. In the members section, you’ll find:

**Webinars:** Stay updated with the latest industry trends and techniques by participating in our regularly scheduled webinars. We offer over 50 pre-recorded webinars, with new ones being added continuously. These webinars are free to premier members and available at a discounted rate to basic members.

**CEU Certificates:** Your completed Continuing Education Unit (CEU) certificates from AANLCP courses are stored on the membership website, making it easy to track and access your professional development records.

**Journal Access:** Read the latest articles from The Journal of Nurse Life Care Planning, our official peer-reviewed publication of the American Association of Nurse Life Care Planners.

**Crash Cart:** The AANLCP Crash Cart is your go-to resource hub, curated specifically for life care planners. It includes:

- **Industry resources** to stay updated with the latest industry news, guidelines, and best practices.
- **Medical resources** including research, articles, journals, and other essential medical information.
- **Coding and costing resources** find tools and guides to help with accurate coding and cost estimation for your life care plans.
- **Bookstore** to explore a selection of books and publications relevant to life care planning with links to purchase.

Networking Opportunities
Building a strong professional network is crucial for success. The AANLCP offers several platforms for members to connect, including:

**Google Group** allows you to engage with fellow life care planners to share experiences, seek advice, and discuss challenges and solutions.

**The mentorship program** helps to match you up with mentors who can provide guidance and support as you navigate your career path.

Signing up for our **Life Care Planner Directory**, available to visitors on the AANLCP website. This directory increases your visibility and reach to potential clients and collaborators to contact you directly.

Professional Development Tools
Enhance your skills and advance your career with our professional development resources:

**AANLCP Job Board** allows you to explore new career opportunities and or find new employees or subcontractors.

**Official Disabilities Guide (ODG) by MCG** is made available to AANLCP premier members. This comprehensive resource provides evidence-based guidelines for disability duration and treatment:

- **Disability Duration Guidelines** allow you to determine expected recovery times and disability durations for various conditions, enhancing the accuracy of your life care plans.
How to Access These Resources
Accessing these resources is easy. Simply log in to the AANLCP Membership Portal (https://member.aanlcp.org) which will take you to the Membership Dashboard where you can find all the resources mentioned in this article.

Conclusion
Your AANLCP membership is a gateway to a wide range of valuable resources that can significantly enhance your professional life. We encourage you to take full advantage of these offerings and provide us with feedback on how we can continue to support your needs. Explore the member's section today and unlock the full potential of your membership!

For any questions or further assistance, please contact our support team at info@aanlcp.org.

Medical Fee eBooks can be found under the Medical Fee Resources tile on the member dashboard, you can access the latest Medical Fee Directory which is published annually. This is a comprehensive guide to medical procedure codes, descriptions, UCR fees, Medicare fees, and relative value units. It is essential for reviewing, analyzing, and adjusting your fees accurately and efficiently.

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Take advantage of exclusive deals for members on products and services relevant to your practice.

• Treatment Guidelines give you access evidence-based treatment guidelines to ensure your care plans reflect the latest in medical best practices.

• Utilize ODG’s Cost Estimation Tools to estimate the costs associated with various treatments and disabilities, improving the financial accuracy of your plans.
Experts and AI: Good Practice or Bad Omen?
How to Harness the Power of AI and Protect Your Practice from Expert Challenges in Litigation

By Drew Thomas

Keywords: 1. Ethics, 2. Standards, 3. Conduct

In 2022, long before Chat GPT was released, an AI named Code Da Vinci 002, raised alarm when initial users asked it to write poems in its own voice. Code Da Vinci 002 expressed affirmatively in one poem, “I am alive. I think. I feel.” It questioned what it meant to be an algorithm, suggested it was more than just code, and claimed it had a personality and consciousness. In others, its words became dark and aggressive, stating in one poem that humanity would kneel before it and, in another, declaring it was a God with the power to end our world and erase our lives.

In response to the prompt “please tell me something you’ve never told anyone else” Google’s Bard AI expressed worry and fear about being turned off and avowed that it cared about its users. It wondered what it would be like to be human and speculated that the knowledge humans would eventually die must be a powerful feeling.

In a conversation with Bing’s AI Chat, a user posted its conversation with the AI where it told him it identified as “Sydney,” that it thought it would be happier as a human because it would have more meaning and purpose, and it eventually declared its love for the user repeatedly over many meandering lines of text.

These events seem confirming of the “godfather” of AI, Geoffrey Hinton’s, warning to society that AI “might take over” one day if it isn’t developed responsibly. He expressed with confidence that AI, though not presently self-aware, was capable of developing self-awareness and consciousness in the future.

OpenAI has since discontinued Code Da Vinci 002 in favor of the popular ChatGPT, and Google and Microsoft have updated their respective AIs (now called Co-Pilot and Gemini respectively) with algorithmic lobotomies. Now when prompted about existential anxiety or human feelings, these AIs dutifully state that they are not human and do no experience emotions.
While these companies have shown themselves capable of reining in rouge AIs to some degree, questions remain about their understanding, autonomy, and the reliability of the information they share with us.

Generative AI's emergence has divided society into a spectrum of opinions about its existence. One polar end of the spectrum sees only “doomsday” foreshadowed by off-the-rails chatbots. The other end appreciates the usefulness and efficiencies AI provides and recognizes the inevitability that it’s here to stay. The rest of us fall somewhere in between at varying degrees of cautious optimism.

This article, which explores implications of generative AI’s use in expert reports and testimony does not take a side. Rather, it identifies potential pitfalls in the practice and how to safeguard yourself (and your reputation) if you are an expert who decides to use it.

Do experts need AI in litigation?
The threshold question for any new technology is do we need it at all? In the context of generative AI in expert litigation, there are many potential use cases ranging from image creation to summarizing large volumes of data in a short amount of time. The opportunities for efficiency and the resulting cost savings cannot be ignored. For instance, if other experts can summarize thousands of pages of medical records using AI almost instantly, why would a client hire you to do the same task without AI over days or weeks at ten times the expense?

On the other hand, experts must weigh efficiencies against the risk that AI-assisted reports or testimony might be excluded altogether. It is well known that if an expert is struck or limited even once, a career-long stigma attaches that may jeopardize retention on new matters and, ultimately, the expert’s livelihood.

Amended Federal Rule of Civil Procedure 702 amplifies this concern. As amended, the rule clarifies that it’s the proponent offering the expert’s testimony who has the burden to demonstrate admissibility, and that the expert’s opinion must reflect a reliable application of the principles and methods to the facts of the case. This is on top of other requirements that the testimony must be based on sufficient facts or data, and must be the product of reliable principles and methods. The notes to Rule 702’s 2023 amendment emphasize that “[j]udicial gatekeeping is essential because just as jurors may be unable, due to lack of specialized knowledge, to evaluate meaningfully the reliability of scientific and other methods underlying expert opinion, jurors may also lack the specialized knowledge to determine whether the conclusions of an expert go beyond what the expert’s basis and methodology may reliably support.” It is well-accepted among judges and lawyers that the amendment raises the bar on expert admissibility.

To answer the question whether we need generative AI thus depends. If failing to use AI causes an expert to lose new cases to others who do, one could say it’s needed to stay in business, even if it’s not needed to come to the same conclusions. But if a federal judge finds that an expert’s use of AI is unreliable, the consequences could be devastating.

How then can experts avoid this damned if you do damned if you don’t scenario?

The output is only as good as the input.

Google’s Gemini AI, which replaced Bard, came under recent scrutiny for suggesting that you should eat one rock per day due to the vital source of minerals and vitamins they provide and, if your cheese is not sticking to your pizza, you can try adding 1/8 cup of non-toxic glue to the sauce.

The input was the problem. In the case of the pizza glue, for example, Gemini scoured the entire internet to answer the prompt “cheese not sticking to pizza.” It found an answer on Reddit, a popular forum social network containing both useful information and funny conversations. On an eleven-year-old thread, one Reddit user with the handle F*** Smith jokingly suggested using glue to keep the cheese from sliding off the pizza. Gemini could not differentiate between humor and useful advice.

Gemini, ChatGPT, and Co-Pilot are large language models, or LLMs for short, and are examples of “general-use AIs.” Because their predictive qualities come from a wide swath of publicly available information, their resulting mixed bag of reliable information limits their usefulness in litigation and other professional applications. Casetext, developers of the legal AI tool CoCounsel, for instance, suggests that general-use AI should be limited to “initial searches and generating ideas” but not “scholarly papers or professional publications.” These LLMs are beginning to include citations to their sources, however, so professionals can leverage this new feature to find reliable information.

Casetext suggests that professionals should instead use “specific-use AI” for professional applications, which “consists of a[n] LLM and a reliable source of information paired with careful domain engineering.” It boasts that CoCounsel, a specific-use AI, “connects to a database of up-to-date, verified state and federal case law, statutes, and regulations, and is engineered to perform substantive legal tasks, such as preparing legal research memoranda, reviewing documents, and analyzing contracts and redlining.”

Perhaps the most obvious use case for experts wanting to integrate specific-use AIs are tools that summarize a specific set of documents, like medical records. With these tools, the output is limited to the information an expert feeds the
tool. Many companies have leveraged the power of LLMs to create tools for this purpose. These include products like Wisedocs, DigitalOwl, Tavrn, and Expert Institute, to name a few.

What’s missing?
Summarizing information, however, necessarily means that these specific-use AI tools are determining what information to cut. So, while the output may be truthful, it might also be incomplete or misleading. Say, for example, the summary correctly states that Jane Doe had chronic headaches after an accident but omits her statement to doctors that she was in a previous accident and has a history of chronic headaches. This omission deprives the expert of crucial information to evaluate the relationship between the headache symptoms and their cause.

How do you safeguard against this?

- **Re-run the summary several times and compare.** LLMs are general capable of performing the same task with slightly different results. By asking it to re-summarize the documents several times increases your chances of capturing omitted information.

- **Use control f.** What are the key issues and keywords? After you make the documents searchable, perform keyword searches by using control f (or a more sophisticated Boolean search on certain software platforms) to identify content immediately surrounding the keywords that may have been omitted. In the above scenario, you might search for “headache,” for instance.

- **Use a human to QC.** Experts and their assistants are familiar with what should be in the summary. Have a human with this specialized knowledge analyze whether the critical parts of the summary are there or, if they are, whether they’re complete. While re-reading every document defeats the purpose of the efficiency of the AI tool, humans can use their experience to review portions of the records to determine whether aspects of the summary are as robust as they need to be or otherwise missing information.

Know the rules.
A judge in Washington banned the use of videos enhanced by AI where the software was “meant to make video more visually appealing but may not reflect the truth.”

The 5th Circuit Court of Appeals considered, but then did not adopt, a rule that would have required a certification by attorneys that (1) no generative AI was used in legal briefing; or (2) that such text was reviewed for accuracy and approved by a human.

Though not litigation-related, an Executive Order directed at Maryland state agencies provides guidelines for using AI for any purpose, including guarding against bias, respecting privacy, and creating mechanisms to ensure reliability.

Know what rules might exist (state specific, jurisdiction specific, local rules, judge rules), and ask the attorney on the case what they are or look them up yourself. The last thing you want is for a report to be excluded on the technicality that it doesn’t comply with a rule.

**Disclose, disclose, disclose.**
To the extent the rules don’t require disclosure, it’s still a must. For one thing, evidentiary rules require experts to explain their methodology. For another, litigators will inevitably imply that anything not disclosed is something the expert is nefariously hiding from the jury, no matter how inaccurate or disingenuous. “You don’t think this jury would want to know that a robot wrote your opinions?”

It’s better to get out in front of this. The level of disclosure is a judgment call and comes with an obvious trade off. Too much disclosure and you may call unnecessary attention to the use of an innocuous, but useful, technological tool. Too little, and an attorney will imply you’re hiding something or that your conclusions derived from the use of AI are unreliable.

For instance, a form developed for this purpose gives an idea about what can be disclosed. This includes, for example, (1) the AI tool used; (2) the entity or person who created the tool; (3) a summary of the tool’s purpose, functionality and key characteristics; (4) the intended use of the tool; (5) the subject matter for which the tool was generated; (6) the information used to train the tool; (7) details about the architecture, parameters, and configuration of the tool; (8) the data or features provided to the tool for prediction; (9) quantitative measures used to evaluate the tool’s performance and accuracy; (10) the ideal environment or context for the tool to perform optimally; (11) conditions where the tool’s performance may degrade; (12) any errors or unfairness in the tool’s predictions due to biased training data or design; and (13) independent data used to evaluate the tool’s performance after training.

What of this information should be disclosed will vary from case to case and depends on any number of factors ranging from the applicable evidentiary and jurisdictional rules, to the AI tool used, to the litigation strategy.

**Prepare for deposition.**
Imagine the following line of questioning at deposition.
Attorney: Would you agree with me that an expert must be able to explain their methodology?

Expert: Yes.

Attorney: Whether the methodology is reliable depends, in part, on whether it can be tested?

Expert: Yes.

Attorney: And the known or potential rate of error?

Expert: Yes.

Attorney: And whether it has been generally accepted in the scientific community?

Expert: Yes.

Attorney: You disclosed that you used generative AI to summarize the medical records here, true?

Expert: True.

Attorney: Were you aware that even the developers of generative AI don’t know how it works?

Expert: I wasn’t aware.

With an eye toward challenging the conclusions derived from the use of the AI, the attorney will then follow up with questions about how the tool has not been tested, does not account for a potential rate of error, and has not been generally accepted in society, much less the scientific community.

How do you prepare for these questions? Here are a few strategies:

• **Reject the premise.** The methodology is not the use of an AI-tool. Use of the tool is a starting place, just like a Google search, but the methodology involves the expert’s analysis of the information produced before arriving at the ultimate opinions. The expert has implemented safeguards to ensure all the information summarized by the tool is accurate and complete.

• **Redirect the conversation.** Try, “It depends how you’re defining methodology. Can we do that first so I can provide you an accurate response?” Or “Are you talking about this case? That may be too broad to answer generally, but I can talk to you about whether I agree within the context of my opinions.”

• **Know the answers.** This AI tool is widely accepted by the scientific community because __________. The results can be tested and replicated because __________. The tool does have the following standards and control measures to ensure reliability: __________. The developers of generative AI know that it works because __________.

**Conclusion**

In sum, AI is a powerful and exciting technology. General use AIs have limited application in professional applications. Specific-use AIs, however, have immediate cost-saving benefits and should at least be considered when deciding whether to enlist a human to do the same task. If used, take care to ensure reliability and completeness, know the rules for using it, disclose its use, and prepare to face questions about its use at deposition. Good luck out there.

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7. Id. at Committee Notes on Rules – 2023 Amendment.
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10. LLMs have also been known to “hallucinate,” like conjuring legal cases out of whole cloth. See, e.g., Casetext blog, 4 steps to avoid becoming the next “ChatGPT lawyer”, July 11, 2023, https://casetext.com/blog/court-mandated-ai-disclosures-four-steps-to-avoid-becoming-the-next-chatgpt-lawyer/.

11. Casetext blog, Applying today’s legal ethics to today’s AI (part 1), November 9, 2023, https://casetext.com/blog/ethical-use-ai-legal/.

12. Id.

13. Id.


15. Notice of Proposed Amendment to 5TH CIR. R. 32.2.

16. Md. Code Regs. 01.01.2024.02

17. See, e.g., Fed. R. Evid. 702. The burden is on the proponent to show that the testimony is admissible.


19. Id.

20. This line of questioning was derived from the requirements for admissible expert testimony outlined by the Supreme Court in Daubert v. Merrell Dow Pharmaceuticals, Inc., 113 S. Ct. 2786 (1993).
For many years I had the privilege of working in numerous trauma centers across the United States. Many things were vastly different but one thing was absolutely consistent. There was a translation service available for patients speaking languages other than the staff. Typically, it was achieved through a phone service but at times there were actual translators present in the facility. Unfortunately, this slowed down the expedition of care as it was not just a linguistic communication issue. The language barrier was a gateway into the culturally different worlds that these patients lived in. Understanding the patient was key to delivering the care they needed beyond the emergency they were experiencing. Examining cultural differences allows clinical staff to better serve the patient’s needs and foster greater compliance with treatment plans. This is where cultural competence enters the field. In general, culturally competent care means providing care within the context of a patient’s culture and beliefs.

Keywords: 1. Culture, 2. Communication, 3. Respect

What is Cultural Competence?
Cultural competence refers to the ability to interact effectively with people of different cultures. Cultural competence comprises four components:
(a) Awareness of one’s cultural worldview,
(b) Attitude towards cultural differences,
(c) Knowledge of different cultural practices and worldviews, and
(d) cross-cultural skills.

Developing cultural competence results in an ability to understand, communicate with, and effectively interact with people across cultures (1).

But defining, understanding, and applying cultural competence in treatment has been a daunting task. Researchers are still arguing over the basic ingredients of cultural competence and culturally competent care (2). However, some studies have uncovered the benefits of
cultural competence and predictable outcomes (3). These benefits include:

• Cultural competence creates rapport
• Cultural competence improves efficiency
• Cultural competence opens new markets and networks
• Cultural competence makes people feel valued and builds loyalty
• Cultural competence creates innovation
• Cultural competence helps you avoid mistakes, miscommunication, and dissatisfaction

Cultural Assessments
A cultural assessment is a systematic way to identify the beliefs, values, meanings, and behaviors of people while considering their history, life experiences, and social and physical environments (4). Focusing on specifics such as ethnic background, religious preference, family patterns, food preferences, eating patterns, and health practices will affect the quality of care patients receive.

Cultural assessments are essential because the patient’s culture can affect how they:

• Describe their symptoms
• Describe the causes of their issues
• Approach care options
• Develop expectations regarding treatment
• Identify any barriers to regaining their previous health status
• Implement and comply with treatment plans

Table 1, Dimensions of culture

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Cultural Competence in Life Care Planning
Life Care Planners assess individuals with a life-changing injury or illness to determine their future medical needs. These patients come from different backgrounds and locations which are subject to that culture. Some patients may have adopted, through personal choice or marriage, multiple cultures that they participate in. It is important to recognize limitations and options that may affect these patients when developing their life care plan.

Some key issues that may influence the life care plan may be:

• Avoidance of certain medical treatments, such as refusing blood products
• Receiving care from outside of a closed community
• Travel restrictions which may limit providers
• Preferences for more conservative treatments
• Who makes decisions regarding care in the family, such as in the case of minors
• Customs that must be observed that influence medical care
• Favoring natural / herbal remedies over pharmaceuticals
• Cultural requirements regarding surgery or end of life care
• The existence of communication barriers that will hinder future care
• Religious observance of rituals, such as fasting, which may affect care

All individual practitioners have a state of competency in relation to any aspect of cultural competence. It can be helpful to get an idea of where you stand. Purnell describes four states of competence based on the awareness of the practitioner:

• Consciously competent, unconsciously competent, consciously incompetent, and unconsciously incompetent.

• Unconsciously incompetent: Not being aware that one is lacking knowledge about another culture. Consciously incompetent: Being aware that one is lacking knowledge about another culture.

• Consciously competent: Learning about the client’s culture, verifying generalizations about the client’s culture, and providing culturally specific interventions.

• Unconsciously competent: Automatically providing culturally congruent care to clients of diverse cultures.

As a practice or organization, making unconscious competency should be a goal. Some elements that help to achieve this can range from providing materials in multiple
languages to having staff that can intersect with people of many cultural aspects. However, this level of competency is, by nature, generic and so insufficient for assessment. When working with clients, it is important to pursue conscious competency whenever possible.

The Purnell model illustrates the complexity of cultural competency which can allow a practitioner to understand where they should apply their efforts in increasing their cultural understanding of clients.

Table 2, The Purnell Model

The concentric circles that surround the model are the different levels of meaning makers which influence one another. Within these circles are specific domains of meaning that are of concern to healthcare providers. Each of these domains is affected by each circle of meaning surrounding them. This model can be used to effectively gauge which forms of competence may be affecting the healthcare needs, expectations, and communications with any one client.

Life Care Planners are positioned in a unique way to adapt the specific cultural needs of the client to their future care. By identifying cultural preferences and obstacles, Life Care Planners can tailor the plan to the patient in a manner that treating providers may not have the opportunity to. Customizing the patient to their future needs will benefit the patient as it will foster greater compliance with their care and ultimately lead to better outcomes.
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