Guardianship Quality Initiative

Live Program # 1: The Aging Process: What Guardianship Judges and Lawyers Need to Know About the Actual and Perceived Physical and Mental Consequences of Aging

Friday, June 19, 2015, 8:30 a.m. – 3:00 p.m. | Touro Law Center
# Program Agenda

**Friday, June 19, 2015**

**The Aging Process: What Guardianship Judges and Lawyers Need to Know About the Actual and Perceived Physical and Mental Consequences of Aging**

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<td>9:30 a.m. – 11:00 a.m.</td>
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12:40 p.m. – 1:20 p.m.       **Lunch**

1:20 a.m. – 2:10 p.m.       **The Positive and Negative Implications of the Significant Use of and Reliance on Prescription Medication and Over-the-Counter Drugs by Older Persons**

Speakers: Robert Cannon, Esq., Coordinator
Aging and Longevity Institute (ALLI), Touro Law Center

Kenneth Cohen, PharmD, Ph.D., MS
Associate Professor, Touro College of Pharmacy

2:10 a.m. – 3:00 p.m.       **Judges and Lawyers Must Look Beyond a Person’s Age, Diagnosis and Appearance**

Speakers: Fern Finkel, Esq.
Law Offices of Fern Finkel, Esq.

Joan Lensky Robert, Esq.
Kassoff, Robert & Lerner, LLP

Ira Salzman, Esq.
Goldfarb Abrandt Salzman & Kutzin, LLP

3:00 p.m.         **Closing Remarks**
Roberto Cannon, Esq., Coordinator
Aging and Longevity Institute (ALLI), Touro Law Center
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I. Introduction

Touro College Jacob D. Fuchsberg Law Center, in collaboration with New York Medical College and Touro College of Pharmacy, welcomes you to the inaugural live Guardianship Quality Initiative (“GQI”) continuing legal education program.

The program will highlight the need for judges and lawyers involved in the guardianship process to work with and learn from colleagues in the medical profession. World class faculty will discuss key facets of the aging process and address the challenges of ensuring older individuals and individuals with diminished mental capacity are treated with the utmost respect and sensitivity. Speakers will demonstrate how knowledge, patience, and collaboration can promote individual rights and ensure the integrity of the guardianship process.

As always, please do not hesitate to email any questions or comments you might have regarding these materials to Alli-info@tourolaw.edu.

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Cases are cited in accordance with the Style Manual used by the New York State Law Reporting Bureau.
II. Touro Law Center’s Aging and Longevity Law Institute

The Aging and Longevity Law Institute ("ALLI") is designed to provide members of the bench and bar, law students, professionals from other disciplines and members of the community with the information, tools and resources required to address the legal needs of the approximately 100 million Americans that are 50 years of age and older.

ALLI, which is housed at the Touro Law Center, will provide cutting edge, interdisciplinary training and research to the legal community as well as to students. Offering intensive training, encouraging and preparing attorneys to become compassionate and vigorous advocates for their clients, ALLI will foster a commitment to civic engagement on matters affecting the aging community. In addition to significant curricular enhancements, including a concentration in Aging & Longevity Law, Touro Law Center is proud to be partnering with other schools in the Touro community to offer a continuum of professional development through a unique interdisciplinary collaboration.

ALLI recognizes that the study and practice of law is a fluid and organic process. Therefore, with guidance from our Advisory Board, we will work with our community to identify and implement the most effective way to share information and resources. Studies and reports issued by ALLI will identify problems in the law and highlight possible solutions. ALLI will partner with other advocates for the elderly to promote legal changes that enhance healthy, stable, respectful and contented aging both for seniors and those who care for them.

ALLI intends to be at the forefront of innovative thinking on legal issues affecting aging and will publish articles and commentary at the vanguard of academic exploration. Institute publications will offer a venue for the widest exchange of thoughtful discussion on the legal consequences and challenges of aging and longevity.

Under the leadership of ALLI’s founder and chairperson, Robert (“Bob”) Abrams, ALLI will offer a series of advanced continuing legal education programs addressing many of the substantive topics in Aging and Longevity Law. The programs will enrich the educational opportunities for lawyers who will benefit from the unique perspectives of program faculty which shall comprise judges, lawyers, court personnel and other professionals.
As evidenced by the Guardianship Quality Initiative, in addition to providing a valuable educational and practical program for attorneys, ALLI intends to provide program participants with an opportunity to help shape their own educational experience by encouraging a greater level of collaboration through our interactive content management system.

ALLI is led by Professor Marianne Artusio, the Founding Director. Professor Artusio is an Associate Professor of Law at Touro Law Center and is Director of Touro’s Elder Law Clinic which she started in 1993. Professor Artusio has taught courses in Elder Law, Consumer Law and Professional Responsibility. Professor Artusio has lectured widely to professional audiences, seniors and their families on issues affecting the aging population and the growing epidemic of financial, psychological and personal abuse of the elderly. Robert Cannon, Esq., is ALLI’s Coordinator. In addition, Bob Abrams, Founder of ALLI and co-founder of Abrams, Fensterman, Fensterman, Eisman, Formato, Ferrara & Wolf, LLP has been appointed Chair of ALLI’s Advisory Board. Touro Law students will assist in the Institute’s efforts.
III. The Guardianship Quality Initiative

The Guardianship Quality Initiative is a unique program for attorneys and judges designed to address every aspect of a Mental Hygiene Law article 81 guardianship proceeding.

Millions of Americans are victims of Alzheimer’s disease or other diseases or conditions that cause diminished mental capacity. The Alzheimer’s Association predicts that by the year 2050, the number of people 65 years of age and older with Alzheimer’s disease will triple, from 5.1 million to 13.8 million. In addition, tens of thousands of older New Yorkers will suffer with other physical or mental health, personal or financial challenges which will require legal assistance, including, for some, the protection of the Guardianship Courts.

The Guardianship Quality Initiative (“GQI”) was created by Robert "Bob" Abrams, co-founder of Touro Law Center’s Aging and Longevity Law Institute (“ALLI”). GQI’s goal is to assess and address the legal needs of these vulnerable individuals as well as to inform and educate the legal community about the medical, societal, personal, legal, and non-legal issues that affect individuals with diminished mental capacity, their loved ones and their communities.

In cooperation with the New York State Office of Court Administration, prominent judges, experienced practitioners, government representatives, healthcare professionals, and members of academia, ALLI has created a comprehensive program that includes valuable and practical resources for New York judges, lawyers, court personnel and all guardianship stakeholders.

GQI is an historic initiative that will improve the quality and delivery of legal services to older New Yorkers. The GQI endeavors to provide lawyers, judges, and court personnel with the information, tools, and resources necessary to meet the needs of individuals with diminished mental capacity and their families. A series of online continuing legal education ("CLE") programs and several live CLE programs will address How to Humanely and Competently Assess, Litigate, and Adjudicate Matters Involving Individuals with Diminished Mental Capacity.

Click here to access the Guardianship Quality Initiative Brochure.

Please click here to go directly to the Guardianship Quality Initiative Registration Page.
PROGRAM MATERIALS
IV. The Actual and Perceived Physical and Mental Consequences of Aging

Questions & Answers

1. What is the difference between a chronic health condition and an acute health episode?

Chronic Health Conditions, also known as Noncommunicable diseases, are diseases of long duration and generally slow progression.¹ Common chronic conditions include cancer, chronic respiratory diseases, diabetes, and heart disease.² According to the Centers for Disease Control and Prevention (“CDC”), seven out of ten deaths in the United States are caused by chronic disease.³ The United States spends 86% of its health care dollars on the treatment of chronic diseases.⁴ Chronic disease is the leading cause of death and disability in the United States.⁵ The following chronic disease facts and statistics, as well as many more, are located on the CDC website:

- As of 2012, about half of all adults—117 million people—have one or more chronic health conditions. One of four adults has two or more chronic health conditions.⁶

- Seven of the top 10 causes of death in 2010 were chronic diseases. Two of these chronic diseases—heart disease and cancer—together accounted for nearly 48% of all deaths.⁷

According to the New York Department of Health’s website, more than 40% of New York’s adults suffer from a chronic disease and six out of every ten deaths in New York are caused by chronic diseases.⁸ However, New York’s Department of Health Division of Chronic Disease Prevention offers innovative public health strategies to reduce the incidence and burden of chronic diseases and related conditions, including the Preventing Chronic Diseases Action Plan.⁹ For more information on chronic diseases and New York’s strategic plans, visit the Department’s website.

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² Id.
⁴ Id.
⁵ Chronic Disease Prevention and Health Promotion: Chronic Disease Overview, CDC http://www.cdc.gov/chronicdisease/overview/index.htm#ref1 (last visited June 17, 2015).
Unlike chronic conditions, acute health conditions occur over a short period of time and symptoms appear, change, and worsen rapidly.\(^\text{10}\) Examples of acute illnesses include colds, flu, bronchitis, and infections.

2. **What are the leading causes of death in the United States?**

According to the National Center for Health Statistics, the leading causes of death in 2011 were:

1. Diseases of heart
2. Malignant neoplasms (cancer)
3. Chronic lower respiratory diseases
4. Cerebrovascular diseases
5. Accidents (unintentional injuries)
6. Alzheimer’s disease
7. Diabetes mellitus.\(^\text{11}\)

However, according to the Rush Institute Study, Alzheimer’s disease is vastly underreported and could be as high as third on the list.\(^\text{12}\) On Friday, June 20, 2014, Touro Law Center hosted the “Aging in Place Conference”. Eric Sokol, Vice President of Public Policy at the Alzheimer's Foundation, discussed the "Impact of Alzheimer's Disease and the Policy Responses to this Challenge." Among the numerous facts and statistics cited by Mr. Sokol during his presentation, the following are particularity noteworthy:

- The total number of people with Alzheimer's Dementia in the United States in 2050 will be 13.8 million, up from 4.7 million in 2010;
- According to the Rush Institute Study, Alzheimer's disease is the third (3) leading cause of death in the United States.\(^\text{13}\)
- In 2012, the direct costs of caring for people with Alzheimer's disease to American Society totaled an estimated $200 billion, including $140 billion in costs to Medicare and Medicaid.

Please click [here](http://www.nlm.nih.gov/medlineplus/ency/article/002215.htm) to view Mr. Sokol, his PowerPoint presentation is available to view.

3. **What is the role and availability of geriatrician’s to evaluate and treat individuals as they age?**

Geriatric medicine is a sub-specialty of internal medicine concerning the health and well-being of older adults.\(^\text{14}\) Geriatricians can play a pivotal role in diagnosing, treating, and managing


\(^{13}\) Id.

\(^{14}\) *Geriatrics*, AM. COL. PHYSICIANS,
diseases and conditions affecting older populations.\textsuperscript{15} Unfortunately, despite an aging population, the number of certified geriatricians in the US decreased by 25% between 1996 and 2010.\textsuperscript{16}

4. **Define the following terms: custodial care, home health care, inpatient hospital care, long-term care, skilled nursing care, hospice care, and respite care.**

The following definitions are taken directly from the Medicare.gov website.\textsuperscript{17}

- **Custodial care** – non-skilled personal care, like help with activities of daily living like bathing, dressing, eating, getting in or out of a bed or chair, moving around, and using the bathroom. It may also include the kind of health-related care that most people do themselves, like using eye drops. In most cases, Medicare doesn’t pay for custodial care.

- **Home health care** – health care services and supplies a doctor decides you may receive in your home under a plan of care established by your doctor. Medicare only covers home health care on a limited basis as ordered by your doctor.

- **Inpatient care** – health care that you get when you’re admitted to a health care facility, like a hospital or skilled nursing facility.

- **Long-term care** – services that include medical and non-medical care provided to people who are unable to perform basic activities of daily living, like dressing or bathing. Long-term supports and services can be provided at home, in the community, in assisted living, or in nursing homes. Individuals may need long-term supports and services at any age. Medicare and most health insurance plans don’t pay for long-term care.

- **Skilled nursing care** – care like intravenous injections that can only be given by a registered nurse or doctor.

- **Hospice care** – a special way of caring for people who are terminally ill. Hospice care involves a team-oriented approach that addresses the medical, physical, social, emotional, and spiritual needs of the patient. Hospice also provides support to the patient’s family or caregiver.

- **Respite care** – temporary care provided in a nursing home, hospice inpatient facility, or hospital so that a family member or friend who is the patient’s caregiver can rest or take some time off.

\textsuperscript{15} Id.
\textsuperscript{16} Id.
\textsuperscript{17} Glossary, MEDICARE.GOV, \url{http://www.medicare.gov/glossary/a.html} (last visited June 17, 2015).
5. What is the prevalence of alcohol and substance abuse among older persons and can such addictions affect mental capacity?

Alcohol Abuse
According to The State of Aging & Health in America 2013, a Center for Disease Control and Prevention publication, excessive alcohol use, including binge drinking, accounted for more than 21,000 deaths of individuals 65 years of age or older in the United States.\(^\text{18}\) Excessive drinking increases a person’s risk of developing the following ailments:

- High blood pressure;
- Liver disease;
- Certain cancers;
- Heart disease;
- Stroke; and
- Many other chronic health problems as well as an increased risk of falling, being in a car crash, and being involved in a violent crime.\(^\text{19}\)

Further, excessive alcohol can impact prescribed and over-the-counter medications by negating their impact or potentially worsening the underlying condition.\(^\text{20}\)

Drug Abuse
Drug abuse is not simply a problem for the young. This issue will be explored in the section titled, “The Positive and Negative Implications of the Significant Use of and Reliance on Prescription Medication and Over-the-Counter Drugs by Older Persons.”

6. Are older persons at greater risk of injury due to a loss of balance and “falls”?

For a variety of reasons, individuals 65 years of age and older face a far greater likelihood of being injured as a result of falling and, depending on the severity of the fall, it can have an enormous impact on an older person’s life.

Approximately 350,000 Americans fall and break a hip every year.\(^\text{21}\) Of the 350,000, 40% end up in a nursing home and 20% can never walk again.\(^\text{22}\) The main risk factors for falling are poor balance, taking more than four prescription medications, and muscle weakness.\(^\text{23}\)

The following facts and statistics relating to falls are on the Center for Disease Control and Prevention website:

- One out of three older adults (those aged 65 or older) falls each year but less than half


\(^{19}\) Id.

\(^{20}\) Id.

\(^{21}\) GAWANDE, Supra note 16 at 40 & 269 (2014).

\(^{22}\) Id.

\(^{23}\) Id.
talk to their healthcare providers about it.\textsuperscript{24}
\begin{itemize}
\item In 2013, 2.5 million nonfatal falls among older adults were treated in emergency departments and more than 734,000 of these patients were hospitalized.\textsuperscript{25}
\item In 2013, about 25,500 older adults died from unintentional fall injuries.\textsuperscript{26}
\item In 2013, the direct medical costs of falls, adjusted for inflation, were $34 billion.\textsuperscript{27}
\end{itemize}

The New York Times article, \textit{A Tiny Stumble, A Life Upended},\textsuperscript{28} provides a stark insight into the painful reality seniors and their loved ones face after a fall.

7. \textbf{How does poor nutrition impact the aging process?}

The nutritional needs of individuals as they age are critical, particularly when recuperating from acute and chronic health problems.\textsuperscript{29} Further, a diet rich in fruit and vegetables can reduce the risk of cancers and chronic diseases, including diabetes and heart disease.\textsuperscript{30} Fruits and vegetables provide essential vitamins, minerals, fiber and other substances important for good health.\textsuperscript{31} The New York State Office for the Aging’s Plan on Aging provides a helpful insight into some of the programs and services offered to encourage older New Yorkers to improve many aspects of their lives, including nutrition and well-being, by utilizing the services on offer.\textsuperscript{32}

\begin{quote}
Nutrition Services strive to prevent or reduce the effects of chronic disease associated with diet and weight; strengthen the link between nutrition and physical activity in health promotion for a healthy lifestyle; improve accessibility of nutrition information, nutrition education, nutrition counseling and related services, and healthful foods.\textsuperscript{33}
\end{quote}

Unfortunately, it is often those most in need of a balanced daily diet that are least able to maintain their nutritional well-being.\textsuperscript{34} “Malnutrition has been found to affect one out of four older Americans living in the community and is a factor in half of all hospital admissions and readmissions of older people.”\textsuperscript{35}

\begin{itemize}
\item \textit{Home & Recreational Safety, Falls Among Older Adults: An Overview}, CDC,\texttt{http://www.cdc.gov/HomeandRecreationalSafety/Falls/adultfalls.html} (last visited June 17, 2015).
\item \textit{Id.}
\item \textit{Id.}
\item \textit{Id.}
\item \textit{The State of Aging and Health in America 2013 supra note 18 at 20.}
\item \textit{Id.}
\item \textit{Id. at iv.}
\item \textit{Id. at 8.}
\item \textit{Id. at 9.}
\end{itemize}
8. Does smoking adversely affect older persons?

Smoking harms nearly every organ in the body. As reported by the Centers for Disease Control and Prevention, smoking causes many diseases and is the leading cause of preventable death in the United States, accounting for more than 480,000 deaths, or one of every five deaths, each year. In excess of 16 million Americans live with a smoking-related disease.

**Articles, Books, & Resources**

**Articles**


**Books & Resources**

**ATUL GAWANDE, BEING MORTAL** (2014).


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37 *Id.*
Centers for Disease Control and Prevention

New York State Office for the Aging
http://www.aging.ny.gov/

New York State Department of Health
https://www.health.ny.gov/

MedlinePlus
V. The Relevance and Consequences of Diminished Mental Capacity

There are a variety of causes of diminished mental capacity including, but not limited to, the following:

- Alzheimer’s Disease and other types of dementia;
- Strokes and other neurological related conditions;
- Environmental factors and personal behavior, including:
  - Accidents;
  - Alcohol abuse and abuse of prescription, over-the-counter and recreational drugs;
  - Placement in healthcare settings; and
  - Depression and/or other mental health issues.

Lawyers need to be familiar with the etiology of diminished mental capacity for a variety of reasons. In the first instance, capacity issues can be temporary, intermittent, and/or may be triggered by external or mental health factors that can be controlled or monitored.38 As discussed in the next section, capacity can be affected by medications and/or a combination of medications or by failure to take medication in the prescribed manner.

Moreover, the impact on an individual’s cognitive ability may vary based on the underlying problem or stage of the disease.39 Alzheimer’s disease, for example, affects its victims in different ways and at different stages.40 Victims in the early stage may be able to make most, if not all, of their legal decisions. As the disease progresses, however, legal capacity to make some or most decisions may be compromised. Ultimately, Alzheimer’s disease and/or other dementias may hasten death.

As discussed in greater detail in the section “Judges and Lawyers Must Look Beyond a Person’s Age, Diagnosis and Appearance” a person’s physical appearance is not determinative of that person’s cognitive ability. Attorneys and professionals working with individuals suffering from certain disease, including Aphasia, must be cognizant of this.

Further, individuals may be born with conditions or diseases that permanently impact decision-making capacity and therefore diminished mental capacity can affect children and young adults.41

Diminished mental capacity can adversely affect your life and may even cause your death. Given its prevalence and devastating impact, lawyers must encourage their clients - as well as their

38 Dementia: Causes, MAYO FOUND. FOR MED. EDUC. & RES.,
39 Id.
40 Seven Stages of Alzheimer’s Disease, ALZHEIMER’S ASS’N,
http://www.alz.org/alzheimers_disease_stages_of_alzheimers.asp (last visited June. 17, 2015); Alzheimer’s Stages: How the Disease Progresses, MAYO FOUND. FOR MED. EDUC. & RES.,
41 Younger/Early Onset Alzheimer’s & Dementia, ALZHEIMER’S ASS’N,
loved ones and themselves - to plan for the possibility of diminished mental capacity.\textsuperscript{42}

Questions & Answers

1. Approximately how many Mental Hygiene Law article 81 guardianships are commenced in New York State in any given year?

Unfortunately, at both a State and national level, accurate data as to the number of “active” guardianships is lacking.\textsuperscript{43} A lack of data hampers the efforts of courts, policy makers, advocates, and others to address the many issues facing New York’s guardianship system. However, given the vast number of individuals with Alzheimer’s disease, and other forms of diminished mental capacity, it is unsurprising that anecdotal evidence suggests a large number of guardianship proceedings. It is important to note, an Alzheimer’s disease diagnosis in and of itself is not determinative of an individual’s need for a guardian.\textsuperscript{44} Further, the absence of cognitive impairment diagnosis does not necessarily obviate the need for a guardian.\textsuperscript{45} Nonetheless, the number of individuals’ suffering with Alzheimer’s sheds some light – on the number of guardianships in New York. According to the Alzheimer’s Association, approximately 320,000 New Yorkers suffered from Alzheimer’s in 2010 and, according to their projections, by the year 2025 that number will rise to 350,000.\textsuperscript{46}

The Article 81 Guardianship proceeding is an essential tool for protecting the growing section of our population who lack the ability to protect themselves from abuse (physical, emotional, or financial) and self-neglect.

2. What do guardianship attorneys and judges need to know about Alzheimer’s disease?

Alzheimer’s disease is an irreversible, progressive brain disease that slowly destroys memory and thinking skills and, eventually even the ability to carry out the simplest tasks of daily living. In most people with Alzheimer’s, symptoms first appear after age 60. Alzheimer’s disease is the most common cause of dementia among older people.\textsuperscript{47}

According to the Centers for Disease Control and Prevention, in 2013, approximately five million people suffered with Alzheimer’s disease, the overwhelming majority of whom were 65

\textsuperscript{42} Robert Abrams, \textit{Are You a Planner or a Gambler?}, 83 N.Y.St.B.A. J. 6 (2011).
\textsuperscript{44} \textit{Matter of Jacobs}, 167 Misc 2d 766 [Sup Ct, Ontario County 1995].
\textsuperscript{45} \textit{Matter of Ehmke}, 164 Misc 2d 609 [Sup Ct, Queens County 1995] ("An individual’s intelligence is not a deciding factor in an article 81 proceeding.” (615)).
\textsuperscript{46} Alzheimer’s Ass’n, 2013 \textit{Alzheimer’s Disease Facts and Figures}, Table 2, page 24 available at http://www.alz.org/downloads/facts_figures_2013.pdf

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years of age or older.\textsuperscript{48} In addition to the facts and statistics cited above, guardianship attorneys and judges should note the following:

- Although less common, younger people can get Alzheimer’s Disease;\textsuperscript{49}
- The incidence of Alzheimer’s disease doubles every five years beyond the age of 65;\textsuperscript{50}
- Involves parts of the brain that control thought, memory, and language;\textsuperscript{51}
- Can seriously affect a person’s ability to carry out activities of daily living.\textsuperscript{52}

As referenced earlier, Eric Sokol, Vice President of Public Policy at the Alzheimer’s Foundation, presented at a prior Institute event during which he discussed the "Impact of Alzheimer's Disease and the Policy Responses to this Challenge” and provided the following statistics:

- Alzheimer’s disease is the \textbf{third leading cause of death in the US}
  - Alzheimer’s disease vastly underreported
  - CDC reports only 90,000 deaths a year attributable to Alzheimer’s disease (this would make it the 6\textsuperscript{th} leading cause of death)
  - \textbf{Study indicates more than 500,000}
- Alzheimer’s disease \textbf{Only growth category in the top ten causes of death in the US}
- Alzheimer’s disease \textbf{Only condition with no cure or treatment to reverse or slow its progression.}

For information on warning signs, diagnosis, symptoms, and much more, please visit the Alzheimer’s Foundation of America website at \url{http://www.alzfdn.org/index.htm}

As emphasized in \textit{Matter of Nimon},\textsuperscript{53} a change in environment can have serious detrimental effects on Alzheimer’s patients and should be avoided. (See case summary on page 31.)

\textbf{3. Is the number of American’s who fall victim to Alzheimer’s disease expected to increase?}

Yes, unless a cure is found, the number of individuals suffering with Alzheimer’s will increase in line with the aging of the country’s population. According to the Centers for Disease Control and Prevention website, beginning at 65, the risk of developing Alzheimer’s doubles every five years and, by age 85 and older, between 25 and 50 percent of people will exhibit signs of Alzheimer’s disease.

\textsuperscript{48} \textit{Healthy Aging: Alzheimer’s Disease}, CDC, \url{http://www.cdc.gov/aging/aginginfo/alzheimers.htm}
\textsuperscript{49} \textit{Younger/Early Onset Alzheimer’s & Dementia}, supra note 41.
\textsuperscript{50} \textit{About Alzheimer’s Disease: Statistics}, ALZHEIMER’S FOUND. AM., \url{http://www.alzfdn.org/AboutAlzheimers/statistics.html} (last visited June 17, 2015).
\textsuperscript{51} \textit{Healthy Aging: Alzheimer’s Disease} supra note 48.
\textsuperscript{52} \textit{Id}.
\textsuperscript{53} 15 AD3d 978, 979 [4th Dept 2005].
By 2050, the number of Americans suffering with Alzheimer’s disease is expected to more than double due to population aging.55

4. In addition to Alzheimer’s disease, what other types of dementia should guardianship attorneys and judges be familiar with?

Alzheimer’s disease is the most common type of dementia and, according to the Centers for Disease Control and Prevention, accounts for 50 to 70 percent of dementia cases.56 Other types of dementia include vascular dementia, mixed dementia, dementia with Lewy bodies, and frontotemporal dementia.57

The following information is from the Alzheimer’s Association website.58

- Vascular Dementia: Previously known as multi-infarct or post-stroke dementia, vascular dementia is less common as a sole cause of dementia than Alzheimer’s, accounting for about 10 percent of dementia cases.

- Dementia with Lewy bodies (DLB): People with dementia with Lewy bodies often have memory loss and thinking problems common in Alzheimer's, but are more likely than people with Alzheimer's to have initial or early symptoms such as sleep disturbances, well-formed visual hallucinations, and muscle rigidity or other parkinsonian movement features.

- Mixed dementia: In mixed dementia abnormalities linked to more than one type of dementia occur simultaneously in the brain. Recent studies suggest that mixed dementia is more common than previously thought.

- Frontotemporal dementia: Includes dementias such as behavioral variant FTD (bvFTD), primary progressive aphasia, Pick's disease and progressive supranuclear palsy.

There are various other types of dementia referenced on the Alzheimer’s Association website, including Normal pressure hydrocephalus, Huntington’s disease, and Wernicke-Korsakoff Syndrome.59 The most common cause of Wernicke-Korsakoff is alcohol misuse.60

5. How does New York’s Mental Hygiene Law article 81 define mental incapacity?

A court will appoint a guardian for an alleged incapacitated person (AIP) if it determines that such appointment is necessary to provide for the “personal needs of that person . . . and/or to

55 Id.
56 Health Aging: Caregiving for Alzheimer’s Disease or other Dementia, CDC, http://www.cdc.gov/aging/caregiving/alzheimer.htm (last visited June 17, 2015).
57 Id.
59 Id.
60 Id.
manage the property and financial affairs of that person”. The AIP must either agree to the appointment or the court must find the AIP to be incapacitated pursuant to §81.02(b). A court shall base its capacity determination on clear and convincing evidence and a determination that the AIP is “likely to suffer harm because: 1. the person is unable to provide for personal needs and/or property management; and 2. the person cannot adequately understand and appreciate the nature and consequences of such inability.”

6. During the course of an article 81 proceeding, what situations may arise that will force the court to consider the alleged incapacitated person’s capacity to perform certain acts?

- Although unusual, an individual can petition for guardianship for himself. Does than individual have the capacity to do so?

- The alleged incapacitated person (“AIP”) may refuse the services of the court appointed counsel instead opting to retain counsel of his or her own choice. The court must consider whether the AIP has the capacity to retain an attorney.

- An alleged incapacitated person can consent to the appointment of a guardian and can nominate a guardian of his or her choosing. How can the court determine whether the AIP has the capacity to make these decisions and what standard does the court employ?

- At times, medical evidence will be introduced either at the outset of a guardianship proceeding and/or during the hearing itself. An alleged incapacitated person can waive his or her right physician-patient privilege during the course of a proceeding either affirmatively or by affirmatively placing his or her medical condition in issue. The following potential issues raised by the aforementioned scenario:
  
  - o Does the AIP have the capacity to waive this privilege?
  
  - o Does the AIP know not to affirmatively place his medical condition in issue and/or how to avoid doing so?

(Note: these standards will be explored in far greater depth in later subject areas)

7. What are the standards for mental capacity in other New York State statutes?

Capacity is situational because different degrees of capacity are required for different tasks and transient because individuals can

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61 N.Y. MENTAL HYG. LAW §81.02(a) (1).
62 N.Y. MENTAL HYG. LAW §81.02(a) (2).
63 N.Y. MENTAL HYG. LAW §81.02(b) (1), (2).
64 N.Y. MENTAL HYG. LAW §81.17.
65 N.Y. MENTAL HYG. LAW §81.10(a).
66 Id.
67 Supra note 64.
69 Matter of Goldfarb, 160 Misc 2d 1036 [Sup Ct, Suffolk County 1994].
have both periods of relative lucidity and confusion. At any given point in time, capacity may also be influenced by external forces, such as lack of sleep or medication.\footnote{U.S. Senate Special Comm. on Aging, Guardianship for the Elderly: Protecting the Rights and Welfare of Seniors with Reduced Capacity 13 (Dec. 2007) available at http://www.guardianship.org/reports/Guardianship_Report.pdf.}

**Marriage & Divorce**

Pursuant to New York Domestic Relations Law (“DRL”) §7, a marriage is considered void from the time a court of competent jurisdiction declares that either party to the marriage was, inter alia, “incapable of consenting to a marriage for want of understanding”.\footnote{N.Y. Dom. Rel. Law §7 (2).} DRL §10 provides that so far as its validity in law is concerned, marriage is a civil contract and it is essential that parties are capable of consenting.\footnote{N.Y. Dom. Rel. Law §10.} Pursuant to Mental Hygiene Law (“MHL”) §81.29 (d), once a guardianship court has determined that a person is incapacitated, the court has the authority to, inter alia, revoke any contract made by the incapacitated person prior to the appointment of a guardian if said contract was executed at a time when the person was incapacitated.\footnote{N.Y. Mental Hyg. Law §81.29(d).} Please see the following MHL article 81 cases (detailed summaries of these cases can be found in the case summary section):

- **Matter of Dot E.W.,** 172 Misc 2d 684, 693 [Sup Ct, Suffolk County 1997]

  a marriage constitutes a contract within the meaning of Mental Hygiene Law §81.29 (d). As such it is subject to revocation by the court on the grounds that a party thereto for whom a guardian has been appointed was incapacitated at the time it was contracted rendering such party incapable of consenting thereto by reason of want of understanding.

- **Matter of Kaminester v. Foldes,** 51 AD3d 528, 529 [1st Dept 2008] - The alleged incapacitated person lacked the capacity to enter into the marriage and engage in financial transactions and “based on the medical reports and the hearing testimony, the IAS court properly found evidence of cognitive deficits,” which the “respondent failed to rebut” with medical evidence of her own.

- **Matter of Schmeid,** 88 AD3d 803, 803-804 [2d Dept 2011] – the court directed the annulment of decedent’s marriage to his former nurse.

**Execute an Advance Directive**

**Power of Attorney**

To execute a valid power of attorney in New York, a principal must have the required capacity. Pursuant to New York General Obligations Law § 5-1501 (2)(c), capacity is the “ability to comprehend the nature and consequences of the act of executing and granting, revoking,
amending or modifying a power of attorney, any provision in a power of attorney, or the authority of any person to act as agent under a power of attorney." Please see the following MHL article 81 cases (detailed summaries of these cases can be found in the case summary section):

- **Matter of K.R.C.,** 4 Misc 3d 1004 [A], 2004 NY Slip Op 50660 [U] *3 [Sup Ct, Tompkins County 2004] – “The power of attorney was signed at the bank at the suggestion of a bank official. The notary who notarized KRC’s signature read and explained the document to her.” However, the power of attorney was improper because the AIP “undoubtedly lacked the capacity to understand the significance of a power of attorney. She cannot read, write more than her name, or do math.”

**Health Care Proxy**

- **Matter of Mildred M.J.,** 43 AD3d 1391, 1392 [4th Dept 2007] - Petitioner failed to meet her burden of showing the alleged incapacitated person (“AIP”) lacked the capacity to execute a power of attorney and health care proxy. The AIP’s physician and nurse practitioner testified that the AIP “would have been able to understand questions such as whom she would like to make her health care decisions if she were unable to do so and whether she would like her grandson to handle her financial affairs.” Testimony from the attorneys present at the execution revealed the AIP “was capable of understanding the nature of the transactions she was authorizing.”

**Testamentary Capacity**

Although New York’s Estates Powers and Trusts Law (EPTL) provides that “every person eighteen years of age or over, of sound mind and memory, may by will dispose of real and personal property and exercise a power to appoint such property”, it offers no guidance as to the definition of “sound mind and memory”. Therefore, we must look to case law to determine the standard commonly referred to as testamentary capacity, in particular, the oft cited New York Court of Appeals case, **Matter of Kumstar,** 66 NY2d 691 [1985] and the following portion of the court’s opinion:

> It is the indisputable rule in a will contest that “[t]he proponent has the burden of proving that the testator possessed testamentary capacity and the court must look to the following factors: (1) whether she understood the nature and consequences of executing a will; (2) whether she knew the nature and extent of the property she was disposing of; and (3) whether she knew those who would be considered the natural objects of her bounty and her relations with them“ (*Matter of Slade*, 106 AD2d 914, 915; *see also, Matter of Delmar*, 243 NY 7). (692)

Please see the following MHL article 81 cases all of which address testamentary capacity

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74 N.Y. GEN. OBLIG. LAW § 5-1501 (2) (c).
75 N.Y. EST. POWERS & TRUSTS LAW §3-1.
76 Matter of Kumstar, 66 NY2d 691 [1985].
(detailed summaries of these cases can be found in the case summary section).

- **Matter of Colby**, 240 AD2d 338, 338 [1st Dept 1997] - an incapacity finding pursuant to Mental Hygiene Law article 81 is based upon “different factors than those involved in a finding of testamentary capacity.”

- **Matter of Vosilla**, 121 AD3d 1489, 1491 [2nd Dept 2014] - The court evaluator opinioned that at the time she met decedent – one to two months prior to the will execution – decedent possessed testamentary capacity as she was aware of her substantial assets and of the natural objects of her bounty.

**Execute a Contract**

- **Buckley v Ritchie Knop, Inc.**, 40 AD3d 794, 795 [2d Dept 2007] - As a general rule, a party’s competence is presumed, and in order to set aside a transfer of property on the ground of lack of capacity, it must be established that the party did not understand the nature of the transaction at the time of the conveyance as a result of his or her mental disability (see Crawn v Sayah, 31 AD3d 367 [2006]; Whitehead v Town House Equities, Ltd., 8 AD3d 367 [2004]; Feiden v Feiden, 151 AD2d 889 [1989]; Lopresto v Brizzolara, 91 AD2d 952 [1983]).

- **Matter of Doar (Brunson)**, 28 Misc 3d 759, 761 [Sup Ct, Queens County 2009] - Justice Thomas held the alleged incapacitated to have been “incapable of handling her financial affairs and from understanding the nature of the reverse mortgages entered into in 2001 and 2003 and their long-term implications.”

**Capacity to Execute a Trust**

1) **Revocable Trust** – testator must have testamentary capacity;

2) **Irrevocable Trust** – varies depending on the testator’s reasons for creating the trust
   a. Irrevocable Trust as a gift – testator must have testamentary capacity and understand effect the gift will have on his/her future financial security and security of his/her dependents.
   b. If irrevocable trust is part of a negotiated settlement or adversarial transaction – testator must possess capacity to contract.

- **Matter of Donaldson**, 38 Misc 3d 841, 843-844 [Sur Ct, Richmond County 2012] - However, in order to determine the mental capacity standard, this Court must first determine whether the documents executed are more comparable to a will, therefore requiring a minimal mental capacity, or whether they are more similar to a contract and, therefore, requiring a higher mental capacity. (Matter of ACN, 133 Misc.2d 1043, 509 N.Y.S.2d 966; Matter of Rosen, 17 Misc.3d 1103(A), 851 N.Y.S.2d 61, 2007 WL 2792153). It is abundantly clear after reviewing the documents executed by the Decedent that they are more comparable to a contract and therefore require a higher mental capacity than that of a will.

**Drive**

An individual’s ability to drive is dependent upon the individual’s mental and physical condition and ability to follow traffic laws and rules *not the individual’s age*. Pursuant to New York’s Vehicle and Traffic Law §506, if the commissioner of Motor Vehicles has reasonable grounds to believe that an individual is not qualified to drive, the commissioner may require such person to submit to an examination to determine his qualifications. 77

**Vote**

The right to vote is a cornerstone of American democracy and for many, one of few opportunities to engage in politics. However, despite protection at both federal and state level, the right to vote is not absolute. The National Voter Registration Act of 1993 authorizes states to remove registrants from official lists of eligible voters “by reason of criminal conviction or mental incapacity.” 78

Pursuant to New York Election Law, “no person who has been adjudged incompetent by order of a court of competent judicial authority shall have the right to register for or vote at any election in this state unless thereafter he shall have been adjudged competent pursuant to law.” 79

In a recent NAELA article titled, *Voting Under Guardianship: Individual Rights Require Individual Review*, Michele J. Feinstein and David K. Webber propose that “no state should revoke a person under guardianship’s right to vote without an individualized inquiry into whether the person truly lacks the capacity to understand and participate in the electoral process.” 80 Currently, New York is one of eleven States in which the right to vote is automatically revoked “upon an adjudication of mental incapacity or guardianship, with no individualized inquiry.” 81 The other ten states are Alabama, Mississippi, Montana, Nebraska, New Mexico, Rhode Island, South Carolina, Virginia, West Virginia, and Wyoming. 82 The authors made the following conclusions about these eleven states:

Except for Virginia, none appear to satisfy the procedural due process requirement for notice to the proposed ward that they may lose their right to vote. And because many people under guardianship actually have the mental capacity to vote, these states are likely disenfranchising many voters who are fully capable of understanding the electoral process and making informed decisions about voting. 83

77 N.Y. VEH. & TRAF. LAW §506(1).
79 N.Y. ELEC. LAW §5-106(6).
81 Id. at 133-134.
82 Id. at 134.
83 Id.
In addition to an in-depth analysis as to the constitutional requirements, the article divided the various state requirements with respect to the right of incapacitated individuals to vote into five distinct groups: Automatic Revocation, Limited Guardianship Only, Automatic Revocation with Reinstatement, Revocation after Individual Inquiry, and No Restrictions.84

Despite the obvious importance of voter rights, there appears to be no New York case law addressing an incapacitated person’s right to vote.

Consent to Medical Treatment
- Matter of B., 190 Misc 2d 581, 587 [County Ct, Tompkins County 2002] - B had “sufficient capacity to give informed consent” to undergo a tubal ligation procedure.

Other
- Matter of Baird, 167 Misc 2d 526 [Sup Ct, Suffolk County 1995] - the alleged incapacitated person did not have the capacity to renounce her interest in decedent’s estate.

- Matter of Mattei, 169 Misc 2d 989, 994 [Sup Ct, Nassau County 1996] - the incapacitated person “lacked the requisite mental capacity to exercise the right of election herself and will not likely regain such capacity in the foreseeable future (see, Mental Hygiene Law §81.21[d] [1], [2]).”

- Cheney v. Wells, 23 Misc 3d 161, 166 [Sur Ct, NY County 2008] - The court observed defendant and found her to be “incapable of managing the instant litigation . . . [and] unable to appreciate the consequences of that incapacity.”

- Matter of Willner (F.G.), 45 Misc 3d 1222 [A], 4, 2014 NY Slip Op 51675 [U] [Sup Ct, Bronx County 2014] - although “[a] person of unsound mind but not judicially declared incompetent may sue or be sued in the same manner as any ordinary member of the community” (Huber v. Mones, 235 A.D.2d 421, 422 [2nd Dept.1997] ), it does not sit well with this court that the Hebrew Home was so bold as to sue the person for unjust enrichment and breach of contract despite the fact that, as the person's social worker testified, their own doctor evaluated the person and found her to lack capacity to make financial decisions.

The Applicability of the Rules of Professional Conduct When Providing Legal Services to Involving Individuals with Diminished Mental Capacity

A single search on Google such as “ethical issues for elder law attorneys” will result in over a million links. Common themes include:

- Who is the client?
• Who has authority to act?
• Does the client have the capacity to retain counsel?
• Are there any conflicts of interest?
• Did the client waive confidentiality?
• Is someone exerting undue influence over the client?

In 2008, New York State adopted the Rules for Professional Conduct. Several rules, including but not limited to the following, provide direction for attorneys who are involved in matters that include one or more individuals with diminished mental capacity:

• **Rule 1.14. Client with Diminished Mental Capacity:**
  o (a) When a client’s capacity to make adequately considered decisions in connection with a representation is diminished, whether because of minority, mental impairment or for some other reason, the lawyer shall, as far as reasonably possible, maintain a conventional relationship with the client.
  o (b) When the lawyer reasonably believes that the client has diminished capacity, is at risk of substantial physical, financial or other harm unless action is taken and cannot adequately act in the client’s own interest, the lawyer may take reasonably necessary protective action, including consulting with individuals or entities that have the ability to take action to protect the client and, in appropriate cases, seeking the appointment of a guardian ad litem, conservator or guardian.
  o (c) Information relating to the representation of a client with diminished capacity is protected by Rule 1.6. When taking protective action pursuant to paragraph (b), the lawyer is impliedly authorized under Rule 1.6(a) to reveal information about the client, but only to the extent reasonably necessary to protect the client’s interests.

• **Rule 1.6. Confidentiality of Information:**
  o (a) A lawyer shall not knowingly reveal confidential information, as defined in this Rule, or use such information to the disadvantage of a client or for the advantage of the lawyer or a third person, unless:
    ▪ (1) the client gives informed consent, as defined in Rule 1.0(j);
    ▪ (2) the disclosure is impliedly authorized to advance the best interests of the client and is either reasonable under the circumstances or customary in the professional community; or
    ▪ (3) the disclosure is permitted by paragraph (b).
    “Confidential information” consists of information gained during or relating to the representation of a client, whatever its source, that is (a) protected by the attorney-client privilege, (b) likely to be embarrassing or detrimental to the client if disclosed, or (c) information that the client has requested be kept confidential. “Confidential information” does not ordinarily include (i) a lawyer’s legal knowledge or legal research or (ii) information that is generally known in the local community or in the trade, field or profession to which the information relates.
(b) A lawyer may reveal or use confidential information to the extent that the lawyer reasonably believes necessary:

- (1) to prevent reasonably certain death or substantial bodily harm;
- (2) to prevent the client from committing a crime;
- (3) to withdraw a written or oral opinion or representation previously given by the lawyer and reasonably believed by the lawyer still to be relied upon by a third person, where the lawyer has discovered that the opinion or representation was based on materially inaccurate information or is being used to further a crime or fraud;
- (4) to secure legal advice about compliance with these Rules or other law by the lawyer, another lawyer associated with the lawyer’s firm or the law firm;
- (5) (i) to defend the lawyer or the lawyer’s employees and associates against an accusation of wrongful conduct; or
  - (ii) to establish or collect a fee; or
- (6) when permitted or required under these Rules or to comply with other law or court order…

- **Rule 1.0(j). “Informed consent”** denotes the agreement by a person to a proposed course of conduct after the lawyer has communicated information adequate for the person to make an informed decision, and after the lawyer has adequately explained to the person the material risks of the proposed course of conduct and reasonably available alternatives.

- **Rule 1.7. Conflicts of Interest: Current Clients:**
  - (a) Except as provided in paragraph (b), a lawyer shall not represent a client if a reasonable lawyer would conclude that either:
    - (1) the representation will involve the lawyer in representing differing interests; or
    - (2) there is a significant risk that the lawyer’s professional judgment on behalf of a client will be adversely affected by the lawyer’s own financial, business, property or other personal interests.
  - (b) Notwithstanding the existence of a concurrent conflict of interest under paragraph (a), a lawyer may represent a client if:
    - (1) the lawyer reasonably believes that the lawyer will be able to provide competent and diligent representation to each affected client;
    - (2) the representation is not prohibited by law;
    - (3) the representation does not involve the assertion of a claim by one client against another client represented by the lawyer in the same litigation or other proceeding before a tribunal; and
    - (4) each affected client gives informed consent, confirmed in writing.

- **Rule 1.9. Duties to Former Clients:**
  - (a) A lawyer who has formerly represented a client in a matter shall not thereafter represent another person in the same or a substantially related matter in which that
person’s interests are materially adverse to the interests of the former client unless the former client gives informed consent, confirmed in writing.

○ (b) Unless the former client gives informed consent, confirmed in writing, a lawyer shall not knowingly represent a person in the same or a substantially related matter in which a firm with which the lawyer formerly was associated had previously represented a client:

□ (1) whose interests are materially adverse to that person; and
□ (2) about whom the lawyer had acquired information protected by Rules 1.6 or paragraph (c) of this Rule that is material to the matter.

○ (c) A lawyer who has formerly represented a client in a matter or whose present or former firm has formerly represented a client in a matter shall not thereafter:

□ (1) use confidential information of the former client protected by Rule 1.6 to the disadvantage of the former client, except as these Rules would permit or require with respect to a current client or when the information has become generally known; or
□ (2) reveal confidential information of the former client protected by Rule 1.6 except as these Rules would permit or require with respect to a current client.

- **Rule 8.3. Reporting Professional Misconduct:**
  - (a) A lawyer who knows that another lawyer has committed a violation of the Rules of Professional Conduct that raises a substantial question as to that lawyer’s honesty, trustworthiness or fitness as a lawyer shall report such knowledge to a tribunal or other authority empowered to investigate or act upon such violation.
  - (b) A lawyer who possesses knowledge or evidence concerning another lawyer or a judge shall not fail to respond to a lawful demand for information from a tribunal or other authority empowered to investigate or act upon such conduct.
  - (c) This Rule does not require disclosure of:
    □ (1) information otherwise protected by Rule 1.6; or
    □ (2) information gained by a lawyer or judge while participating in a bona fide lawyer assistance program.

Moreover, attorneys may also receive guidance from a variety of legal organizations that have issued ethical opinions and/or position papers based on matters that involved individuals with DMC:

- National Academy of Elder Law Attorneys [https://www.naela.org/Public](https://www.naela.org/Public)
- New York State Bar Association;
- New York City Bar Association;
- American Bar Association Center for Professional Responsibility;

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87 Center for Professional Responsibility, AM. Bar Ass’n.
Many organizations, including the New York City Bar Association ((212) 382-6663), provide attorneys with an emergency ethics hotline.

In closing, a good rule of thumb for attorneys dealing with individuals who have DMC is that if they think they may have an ethical issue, they probably do and should access the aforementioned available resources for guidance.

Statutes

Mental Hygiene Law

§81.29 Effect of the appointment on the incapacitated person

(a) An incapacitated person for whom a guardian has been appointed retains all powers and rights except those powers and rights which the guardian is granted.

(b) Subject to subdivision (a) of this section, the appointment of a guardian shall not be conclusive evidence that the person lacks capacity for any other purpose, including the capacity to dispose of property by will.

(c) The title to all property of the incapacitated person shall be in such person and not in the guardian. The property shall be subject to the possession of the guardian and to the control of the court for the purposes of administration, sale or other disposition only to the extent directed by the court order appointing the guardian.

(d) If the court determines that the person is incapacitated and appoints a guardian, the court may modify, amend, or revoke any previously executed appointment, power, or delegation under section 5-1501, 5-1505, or 5-1506 of the general obligations law or section two thousand nine hundred sixty-five of the public health law, or section two thousand nine hundred eighty-one of the public health law notwithstanding section two thousand nine hundred ninety-two of the public health law, or any contract, conveyance, or disposition during lifetime or to take effect upon death, made by...
the incapacitated person prior to the appointment of the guardian if the court finds that the previously executed appointment, power, delegation, contract, conveyance, or disposition during lifetime or to take effect upon death, was made while the person was incapacitated or if the court determines that there has been a breach of fiduciary duty by the previously appointed agent. In such event, the court shall require that the agent account to the guardian. The court shall not, however, invalidate or revoke a will or a codicil of an incapacitated person during the lifetime of such person.

**Estates Powers and Trusts Law**

§ 3-1.1 *Who may make wills of, and exercise testamentary powers of appointment over property*

Every person eighteen years of age or over, of sound mind and memory, may by will dispose of real and personal property and exercise a power to appoint such property.

**Domestic Relations Law**

§ 7. *Voidable marriages*

A marriage is void from the time its nullity is declared by a court of competent jurisdiction if either party thereto:

1. Is under the age of legal consent, which is eighteen years, provided that such nonage shall not of itself constitute an absolute right to the annulment of such marriage, but such annulment shall be in the discretion of the court which shall take into consideration all the facts and circumstances surrounding such marriage;

2. Is incapable of consenting to a marriage for want of understanding;

3. Is incapable of entering into the married state from physical cause;

4. Consent to such marriage by reason of force, duress or fraud;

5. Has been incurably mentally ill for a period of five years or more.
§ 10. Marriage a civil contract

Marriage, so far as its validity in law is concerned, continues to be a civil contract, to which the consent of parties capable in law of making a contract is essential.

General Obligations Law

§ 5-1501. Application and definitions

2. As used in this title the following terms shall have the following meanings:

(c) “Capacity” means ability to comprehend the nature and consequences of the act of executing and granting, revoking, amending or modifying a power of attorney, any provision in a power of attorney, or the authority of any person to act as agent under a power of attorney.

§ 5-1501A. Power of attorney not affected by incapacity

1. A power of attorney is durable unless it expressly provides that it is terminated by the incapacity of the principal.

2. The subsequent incapacity of a principal shall not revoke or terminate the authority of an agent who acts under a durable power of attorney. All acts done during any period of the principal's incapacity by an agent pursuant to a durable power of attorney shall have the same effect and inure to the benefit of and bind a principal and his or her distributees, devisees, legatees and personal representatives as if such principal had capacity. If a guardian is thereafter appointed for such principal, such agent, during the continuance of the appointment, shall account to the guardian rather than to such principal.

§ 5-1510. Special Proceedings

2. A special proceeding may be commenced pursuant to this section for any of the following additional purposes:

(a) to determine whether the power of attorney is valid;

(b) to determine whether the principal had capacity at the time the power of attorney was executed;
(c) to determine whether the power of attorney was procured through duress, fraud or undue influence;

§ 5-1511. Termination or revocation of power of attorney; notice

1. A power of attorney terminates when:

(h) a court order revokes the power of attorney as provided in section 5-1510 of this title or in section 81.29 of the mental hygiene law.

Election Law

§5-106. Qualifications of voters; reasons for exclusion

6. No person who has been adjudged incompetent by order of a court of competent judicial authority shall have the right to register for or vote at any election in this state unless thereafter he shall have been adjudged competent pursuant to law.

Vehicle & Traffic Law

§506. Reexamination of licensees

1. If the commissioner has reasonable grounds to believe that a person holding a license issued pursuant to this article is not qualified to drive a motor vehicle, the commissioner may require such person to submit to an examination to determine his qualifications.

Cases

The following cases deal with specific capacity determinations within the context of article 81 guardianship proceedings. In other words, in addition to a determination as to the alleged incapacitated person’s (“AIP”) need for a guardian, each case addresses whether the AIP had the requisite capacity to perform an act performed prior to the guardianship determination or whether, despite the appointment of a guardian, the AIP can perform an act subsequent to the hearing.

In light of their inclusion in this section, the cases have been summarized with this subject area in mind and therefore, certain aspects of the decisions may have been omitted. If there are any significant cases dealing with this subject area that we have failed to include, please do not hesitate to email us at Alli-info@tourolaw.edu.
Case List

**Matter of Nimon**, 15 AD3d 978 [4th Dept 2005]

**Capacity to Execute Advance Directives**

**Matter of Chase**, 264 AD2d 330 [1st Dept 1999]

**Matter of Rose S.**, 293 AD2d 619 [2d Dept 2002]

Matter of K.R.C., 4 Misc 3d 1004 [A], 2004 NY Slip Op 50660 [U] [Sup Ct, Tompkins County 2004]

**Matter of Mildred M.J.**, 43 AD3d 1391 [4th Dept 2007]

**Testamentary Capacity**

**Matter of Colby**, 240 AD2d 338 [1st Dept 1997]

**Matter of McCloskey**, 307 AD2d 737 [4th Dept 2003]

In re Wonneberger, 2009 NY Slip Op 30573 [U] [Sur Ct, Nassau County 2009]

Matter of B.C., 33 Misc 3d 1221[A], 2011 NY Slip Op 52048 [U] [Sup Ct, Bronx County 2011]
Matter of Curtis, 40 Misc 3d 1233 [A], 2013 NY Slip Op 51417 [U] [Sur Ct, Dutchess County 2013]

**Matter of Vosilla**, 121 AD3d 1489 [2nd Dept 2014]

**Non-Article 81 Cases (no summaries provided)**

**Matter of Coddington**, 281 AD 143 [3d Dept 1952]; **Matter of Kumstar**, 66 NY2d 691 [1985];
**Matter of Khazaneh**, 15 Misc 3d 515 [Sur Ct, NY County 2006]

**Capacity to Execute/Revoke Trusts**

Matter of Banks, 11 AD3d 307 [1st Dept 2004]

**Matter of Joos**, 24 Misc 3d 980 [Sup Ct, Kings County 2009]

**Matter of Donaldson**, 38 Misc 3d 841 [Sup Ct, Richmond County 2012]

**Financial Decisions, Including the Conveyance of Real Property**


**Matter of Mattei**, 169 Misc 2d 989 [Sup Ct, Nassau County 1996] – Right of Election
Matter of Jenkins v Stephenson, 293 AD2d 612 [2d Dept 2002]

Matter of Margaret S., 2006 NY Misc LEXIS 2833 [Sup Ct, Richmond County 2006]

Buckley v Ritchie Knop, Inc., 40 AD3d 794 [2d Dept 2007]

Matter of Doar (Brunson), 28 Misc 3d 759 [Sup Ct, Queens County 2009] – Reverse Mortgage

JPMorgan Chase Bank N.A v Haedrich, 29 Misc 3d 1215 [A], 2010 NY Slip Op 51838 [U] [Sup Ct, Nassau County 2010] - Mortgage


Non-Article 81 Case (no summaries provided)


Capacity to Marry/Divorce

Matter of Dot E.W., 172 Misc 2d 684 [Sup Ct, Suffolk County 1997]

Matter of Kaminester v. Foldes, 51 AD 3d 528 [1st Dept 2008]

Matter of Schmeid, 88 AD3d 803 [2d Dept 2011]

K.A.L. v R.P., 35 Misc 3d 1211 [A], 2012 NY Slip Op 50625 [U] [Sup Ct Monroe County 2012]

Matter of Doar (L.S.), 39 Misc 3d 1242 [A], 2013 NY Slip Op 50988 [U] [Sup Ct Kings County 2013]

Non-Article 81 Cases (no summaries provided)

Matter of Berk, 71 AD3d 883 [2d Dept 2010]; Campbell v Thomas, 73 AD3d 103 [2d Dept 2010]

Capacity to Commence/Appear in a Lawsuit, Stipulate & Retain Counsel


Matter of Bernice B., 176 Misc 2d 550 [Sur Ct, NY County 1998]

Parras v Ricciardi, 185 Misc 2d 209 [Civ Ct, Kings County 2000]

Cheney v. Wells, 23 Misc 3d 161 [Sur Ct, NY County 2008]
400 W.59th St. Partners, LLC v Edwards, 28 Misc 3d 93 [1st Dept 2010]

Matter of Willner (F.G.), 45 Misc 3d 1222 [A], 2014 NY Slip Op 51675 [U] [Sup Ct, Bronx County 2014]

Matter of Caryl S.S (Valerie L.S.), 45 Misc 3d 1223[A], 2014 NY Slip Op 51697 [U] [Sup Ct, Bronx County 2014]

See also, Arthur Mgt. Co. v Zuck, 19 Misc 3d 260 [Civ Ct, Kings County 2008]; 1234 Broadway LLC v Feng Chai Lin, 25 Misc 3d 476 [Civ Ct, NY County 2009]; Berrios v. NYCHA, 564 F3d 130 [2d Cir 2009].

Non-Article 81 Cases (no summaries provided)

East 10th St. LLC v Garcia, 37 Misc.3d 1224 [A], 2012 NY Slip Op 52152 [U] [Civ Ct, NY County 2012];

Medical Decisions

Matter of B., 190 Misc 2d 581 [County Ct, Tompkins County 2002]


Other

Matter of Penson, 289 AD2d 155 [1st Dept 2001]

Non-Article 81 Cases (no summaries provided)


Case Summaries

In Matter of Nimon, 15 AD3d 978 [4th Dept 2005], pursuant to a 2002 Supreme Court decision, two of the incapacitated person’s (“IP”) daughters were appointed co-guardians of the AIP’s person and property. (978) The Supreme Court ordered the IP, an Alzheimer’s disease patient, to spend six months a year in a Pennsylvania facility near one daughter, petitioner, and the remaining six months in a Massachusetts facility near the other daughter, respondent. (Id.)

In 2004, petitioner and her brothers sought an order modifying the 2002 order so as to establish one residence and one guardian. (978-979) The motion was supported with letters from medical professionals “explaining the serious detrimental effects that changes in environment have on Alzheimer’s patients” as well as observations about the IP’s physical and psychological decline following her return to the Pennsylvania facility in 2003. (979) (Emphasis added.)
The Supreme Court, recognizing that all four children wanted the IP to reside in one facility, ordered the IP reside in the Massachusetts’ facility. (Id.) The court modified the Supreme Court’s decision which failed to “properly consider the best interests of the IP in determining that she should be transferred to the facility in Massachusetts and reside there year-round.” (Id.) The record established that the “trauma of leaving a stable environment and readjusting to a different environment has serious deleterious effects on Alzheimer’s patients in general, and specifically on the IP at issue herein.” (Id.) It was in the IP’s best interests to remain in the Pennsylvania facility and to appoint petitioner as sole guardian of the IP’s person. (Id.)

Capacity to Execute Advance Directives

In Matter of Chase, 264 AD2d 330 [1st Dept 1999], the Supreme Court appointed a non-family member as guardian of the alleged incapacitated person (“AIP”) but, contrary to Mental Hygiene Law §81.15, failed to include any factual findings in the order. (331) Further, the Supreme Court erred in accepting the court evaluator’s conclusions regarding the AIP’s daughter’s (“Ms. Chase”) inability to care for the AIP and that her financial interests were adverse to his. (Id.)

The court addressed whether a conflict of interest existed between Ms. Chase and her father. (332) The bank accounts in question were transferred five months before the AIP’s stroke and were effectuated pursuant to a power of attorney executed by the AIP on the day of the transfer in the presence of the bank’s assistant vice-president and crucially, “the evidence does not show that he [the AIP] was legally incompetent at the time he executed the power of attorney (see, Mental Hygiene Law §§ 81.12, 81.29; see also, Gala v Magarinos, 245 AD2d 336)”. (332-333) Further, the transfers were in line with the AIP’s wishes. (333)

The transfers were “not nefarious and certainly not of a character to preclude Ms. Chase from serving as her father’s guardian” and, contrary to the Supreme Court’s decision, the AIP’s daughter is the “appropriate and, in fact, preferred, choice as the guardian of her father’s person and property.” (332)

In Matter of Rose S., 293 AD2d 619 [2d Dept 2002], the Supreme Court erred in upholding the validity of the health care proxy executed by Rose S. (620) Although “every adult is presumed competent to appoint a health care agent (see Public health Law §2981 [1] [b]) . . . where there is medical evidence of mental illness or a mental defect” the burden of proving competence shifts to the other party “to prove by clear and convincing evidence that the person executing the document in question possessed the requisite mental capacity (see Hubbard v Gatz, 130 AD2d 622, 623; see also Matter of Shapiro, NYLJ, Apr. 19, 2001, at 25, col 1).” (Id.) Here, the testimony failed to establish Rose’s competency at the time she signed the health care proxy and there was “no evidence that either of the witnesses to the health care proxy attempted to determine whether Rose was competent prior to witnesses the health care proxy.” (621)

In Matter of K.R.C., 4 Misc 3d 1004 [A], 2004 NY Slip Op 50660 [U] [Sup Ct, Tompkins County 2004], it was agreed by all parties, including the alleged incapacitated person (“AIP”), that she needed help with her finances and personal affairs. (*1)
According to the Court Evaluator’s Report, KRC has an IQ of 50 which places her in the range of mild mental retardation. Although the AIP is able to express her wishes to a limited extent, it is clear from the testimony, the Court Evaluator’s Report and this Court’s own observations of her that she is incapacitated and in need of a guardian. \textit{(Id.)}

The Court Evaluator recommended the appointment of the AIP’s sister and brother (hereinafter “LAL” and “RAC”) as guardians. \textit{(Id.)} Justice Peckham expressed concern over the AIP’s execution of a power of attorney which was executed at the behest of LAL and RAC at a time when the AIP was incapacitated. \textit{(*2-3)} LAL and RAC “utilized a Power of Attorney obtained from KRC [AIP] to withdraw $50,000 from accounts of KRC’s and deposit it in an account in the name of RAC [sister] alone.” \textit{(*2)}

During testimony, RAC insisted the money was transferred to protect it and that it would be returned to the AIP upon the appointment of a guardian. \textit{(Id.)} The power of attorney was executed at the bank at the suggestion of a bank employee and was improper because the AIP “undoubtedly lacked the capacity to understand the significance of a power of attorney”. \textit{(Id.)}

However, Justice Peckham was satisfied LAL and RAC acted out of a desire to help the AIP and their actions were consistent with the AIP’s wishes. \textit{(*3)} The siblings were appointed co-guardians of the person and property and all Powers of Attorney were revoked. \textit{(*3-5)}

In \textit{Matter of Mildred M.J.}, 43 AD3d 1391 [4th Dept 2007], the Supreme Court dismissed the guardianship petition, ordered petitioner to pay the court evaluator’s fees, and upheld the validity of the alleged incapacitated person’s (“AIP”) power of attorney and health care proxy. \textit{(1392)} The “Supreme Court properly determined that petitioner failed to meet her burden of showing that the AIP lacked capacity when she signed the 2004 power of attorney and the 2004 health care proxy.” \textit{(Id.)} During the hearing, the AIP’s physician and nurse practitioner testified that the AIP “would have been able to understand questions such as whom she would like to make her health care decisions if she were unable to do so and whether she would like her grandson to handle her financial affairs.” \textit{(Id.)} Testimony from the attorneys present at the execution revealed the AIP “was capable of understanding the nature of the transactions she was authorizing.” \textit{(Id.)} Further, petitioner “failed to establish that respondents had a confidential relationship with the AIP, and she failed to establish that respondents exercised undue influence in connection with the AIP’s authorizations of the 2004 power of attorney and the 2004 health care proxy.” \textit{(1393)}

\textbf{Testamentary Capacity}

In \textit{Matter of Colby}, 240 AD2d 338 [1st Dept 1997], petitioner’s successful efforts to have herself appointed decedent’s guardian months before decedent executed the first of three codicils did “not collaterally estop her from arguing that decedent possessed testamentary capacity at the time he executed the codicils”. \textit{(338)} The court reasoned that an incapacity finding pursuant to Mental Hygiene Law article 81 was based upon “different factors than those involved in a finding of testamentary capacity \textit{(compare, Matter of Maher, 207 AD2d 133, 140, lv denied 86 N.Y.2d 703, with Matter of Kumstar, 66 N.Y.2d 691, 692).}” \textit{(Id.)} Although susceptible to undue
influence, petitioner was not involved in the drafting of the codicils and the burden to demonstrate freedom from undue influence never shifted to her. *Id.* Mere opportunity for undue influence is not sufficient (*Matter of Bobst*, 234 AD2d 7). (339)

In *Matter of McCloskey*, 307 AD2d 737 [4th Dept 2003], the court reversed the Surrogate’s Court’s decision denying probate of decedent’s will. (738) The Surrogate’s Court had determined the will proponents failed to establish by a preponderance of the evidence that decedent possessed sufficient testamentary capacity on the day the will was executed. *(Id.)*

The attorney draftsperson testified that decedent had contacted him because a family member had commenced a Mental Hygiene Law (“MHL”) article 81 guardianship proceeding seeking to have a guardian appointed for decedent. *(Id.)* The attorney draftsperson testified that decedent was "well versed" as to the nature and extent of her assets and instructed the attorney as to her estate’s distribution. *(Id.)* Further, the attorney reviewed the will’s contents with decedent before execution and decedent read and understood the will. *(Id.)*

Objectants to the probate of decedent’s will presented decedent’s physicians who testified as to decedent’s various psychological disorders months after the will execution but none claimed decedent lacked testamentary capacity. *(Id.)* In addition, objectants presented testimony from the court evaluator appointed at the outset of the MHL article 81 proceeding. (739) The court evaluator testified that she interviewed decedent three days before the will execution and, in her opinion, decedent lacked testamentary capacity. (739) “The court evaluator admitted, however, that she did not know the criteria for determining testamentary capacity” and went on to say that the “decedent knew the amount of her income and assets, that she knew who her relatives were, and that she knew what a will was.” *(Id.)*

the evidence presented at trial by the objectants does not establish that decedent was "suffering from an insane delusion which directly affected her decision not to leave anything to [the objectants]" (*Matter of Zielinski*, 208 AD2d 275, 277 [1995], lv dismissed 86 NY2d 861 [1995], rearg granted and lv dismissed 87 NY2d 944 [1996]), nor does it refute the evidence presented by the proponents that decedent possessed testamentary capacity at the time that she executed the will. . . . we find that the objectants also failed to establish the existence of undue influence (*see Matter of Buckten*, 178 AD2d at 983). *(Id.)*

*In re Wonneberger*, 2009 NY Slip Op 30573 [U] [Sur Ct, Nassau County 2009], Surrogate Riordan addressed testamentary capacity:

The proponent has the burden of proving testamentary capacity. It is essential that a testatrix understand in a general way the scope and meaning of the provisions of her will, the nature and condition of her property and her relation to the persons who ordinarily would be natural objects of her bounty (*see Matter of Kunstar*, 66 NY2d 691 [1985]; *Matter of Bustanoby*, 262 AD2d 407 [2d Dept...
A testatrix must understand the plan and effect of the will, and less mental faculty is required to execute a will than any other instrument (see Matter of Coddington, 281 App Div 143 [3rd Dept 1952], affd 307 NY 181 [1954]). Mere proof that the decedent suffered from old age, physical infirmity and progressive dementia is not necessarily inconsistent with testamentary capacity and does not preclude a finding thereof (see Matter of Fiumara, 47 NY2d 845, 847 [1979]; Matter of Hedges, 100 AD2d 586 [2d Dept 1984]) as the relevant inquiry is whether the decedent was lucid and rational at the time the will was made (see Matter of Hedges, 100 AD2d 586 [2d Dept 1984]). “When there is conflicting evidence or the possibility of drawing inferences from undisputed evidence, the issue of capacity is one for the jury” (Matter of Kumstar, 66 NY2d 691, 692 (1985)). (Emphasis added.)

In Matter of B.C., 33 Misc 3d 1221[A], 2011 NY Slip Op 52048 [U] [Sup Ct, Bronx County 2011], petitioner submitted a motion requesting the court deem the actions of B.C.’s guardian to be inconsistent with B.C.’s best interests. (*1) Petitioner alleged it was not in B.C.’s best interests for the guardian to have engaged the services of an attorney to draft and execute a will for B.C. without having made an application to the court. (*1-2) Petitioner requested the court deny the guardian’s request for nunc pro tunc approval of his payment of the drafting attorney’s fees, it surcharge the guardian, and that she be reimbursed for her expenses. (*1)

Petitioner was the petitioner in the underlying guardianship proceeding in which the court evaluator, Mario Biaggi, Jr., was appointed guardian. (*1-3)

Petitioner claimed the court should have been given the opportunity to assess the person’s testamentary capacity and that the execution of the will “has opened the door to potentially costly and protracted litigation post-mortem regarding [the person’s] testamentary capacity and/or his vulnerability to undue influence”. (Id.) Further, petitioner claimed the guardian violated NYCRR Part 36 by paying the attorney draftsperson without court approval. (Id.) The guardian claimed he had the authority to retain counsel without court approval. (*2-3)

the order and judgment specifically notes that the guardian should “afford the I.P. the greatest amount of independence and self determination with respect to property management...” (Exhibit A, p. 4). Mr. Biaggi asserts that he was empowered by the court in the order and judgment, to “retain or employ attorneys or other professionals to assist in the performance of the duties of the Guardian.” (Exhibit A, p. 5). (*3)

The guardian argued that the appropriate time to challenge the will execution was after the person’s death. (Id.) Contrary to petitioner’s claims, the guardian, when serving as court evaluator, “never opined that the person lacked mental or testamentary capacity and despite petitioner's request that this court make a finding that the person lacked testamentary and mental capacity, this court specifically declined to do so.” (Id.)
The guardian claimed:

because he was not subject to Part 36 rules, he made payment to Mr. Stein without seeking prior approval of the court. He acknowledges that he needed prior approval of the court before paying counsel’s fees and asserts that he was the one who brought his oversight to the court’s attention. He claims that a surcharge is inappropriate and that the fees were justified. (Id.)

Justice Hunter denied petitioner’s motion as her arguments were a “regurgitation of allegations she made in her petition for the appointment of a guardian for the person.” (*4)

This court found that the person required the appointment of a guardian of his person and property but in its decision after the hearing, dated December 10, 2009, this court noted that the court evaluator, “…believed that the guardian should keep the person involved in making decisions.” (Biaggi Exhibit C, para. 7). This court further ordered in its decision dated December 10, 2009 and in the order and judgment, that the guardian should afford the person the greatest amount of independence and self determination with respect to his property management and personal needs. (Id.)

The guardian was not subject to 22 NYCRR Part 36 and therefore, did not have to seek court permission to hire professionals when performing his duties. (Id.) Further, there was nothing in any prior court order or in any case law cited by petitioner “to support her position that the guardian was required to return to court for a determination to be made as to the person’s testamentary capacity prior to drafting a new will.” (Id.) Petitioner’s claim that drafting a will opened the door to costly and protracted post-mortem litigation was “purely speculative” and allegations of testamentary capacity and undue influence should be brought up “post-mortem and not at this time before this court.” (Id.)

Petitioner’s request to surcharge the guardian for paying the attorney draftsperson’s fee without court approval was rendered moot as the court had granted the guardian’s nunc pro tunc order. (Id.)

In Matter of Curtis, 40 Misc 3d 1233 [A], 2013 NY Slip Op 51417 [U] [Sur Ct, Dutchess County 2013], objectant requested dismissal of the probate petition on the grounds “decedent lacked testamentary capacity; the due execution requirements of EPTL §3-2.1 were not satisfied; and undue influence on the part of decedent's live-in home health aide, Leonora Smart [hereinafter “Smart”], the primary beneficiary of decedent's will.” (1)

Decedent received $10million in a structured settlement as a result of injuries sustained from “in utero exposure to toxic chemicals during her mother’s employment.” (Id.) Decedent was found to be incapacitated pursuant to Mental Hygiene Law (“MHL”) article 81 and co-guardians were authorized “to engage in Medicaid and estate planning” for decedent. (2) Objectant herein, by
order of this court dated May 11, 2010, was removed as co-guardian of decedent’s person. (Id.) Attorney Gifford and attorney Sullivan-Bisceglia were appointed guardians of decedent’s property and person respectively. (Id.)

Decedent died on July 20, 2012 leaving a last will and testament executed on January 1, 2012. (Id.) Objectant conducted depositions of the two named witnesses, attorney Rosenzweig and Van Duser. (Id.) Rosenzweig and Van Duser were employees of the law firm Van DeWater and Van DeWater, LLP. (Id.)

Van Duser, guardian Gifford’s secretary, testified that guardian Sullivan-Bisceglia requested a will be drafted for decedent. (Id.) Van Duser prepared a draft will based on Sullivan-Bisceglia’s recommendations and gave it to Rosenzweig for review. (Id.) As to the will execution, Van Duser testified as to those present and that decedent was attentive as to what was happening. (Id.)

Attorney-draftperson and witness, Rosenzweig, testified that “decedent appeared focused and attentive during the process” and before execution, Rosenzweig reviewed the will with decedent, asked decedent if she understood the contents, and whether it reflected her intent. (Id.) After decedent’s affirmative response, Rosenzweig witnessed decedent sign the will and proceeded to sign the witness affidavit. (Id.) Surrogate Pagones addressed each of the challenges to probate:

Testamentary Capacity

for the decedent to possess testamentary capacity she is required to “know the contents of the will and appreciate the disposition of property made by it” (2 NY PJI 2d 7:48). Nonetheless, it is clear that less capacity is required to execute a will than a contract or any other legal document (see In re Coddington’s Will, 281 AD 143 [3rd Dept 1952], aff’d 307 NY 181 [1954]). (3)

Objectant argued that due to decedent’s cognitive impairments, which she suffered from her entire life, she would have been unable to understand the will. (Id.) Further, objectant referred to the finding of incapacity in the article 81 proceeding. (Id.) However, Surrogate Pagones noted that “a finding of incapacity under Mental Hygiene Law Article 81 is based upon different factors from those involved in a finding of testamentary capacity (see Matter of Colby, 240 AD2d 338 [1st Dept 1997] leave appeal denied 91 NY2d 801 [1997]).” (Id.)

The witnesses to the will . . . clearly indicate that Candace understood the nature and consequences of executing a will; knew that she was disposing all her property and the nature thereof via the will; and knew those who would be considered the natural objects of her bounty and her relations with them (see Matter of Kumstar, 66 NY2d 691 [1985] rearg denied 67 NY2d 647 [1985]). The affidavit of the guardian, Susan Sullivan-Bisceglia, Eq., indicates that objectant and Candace had at best what could be described as a strained relationship, thus the lack of a bequest to the objectant under the will would further indicate the strength of decedent's testamentary capacity in the formation and execution of the will. (3-4)
Decedent possessed the requisite capacity to execute a will. (4)

Execution Requirements

Based on witness testimony, the attestation clause, and the fact the execution ceremony was “supervised and witnessed by the attorney-draftsperson”, Justice Pagones held that the will was “properly executed and witnessed as required by EPTL §3-2.1.” (5)

Undue Influence

To meet the burden of undue influence, objectant must “proof motive, opportunity, and the actual exercise of undue influence tantamount to a moral coercion which restrained independent action and destroyed free will (see Matter of Walther, 6 NY2d 49 [1959]).” (Id.) Objectant outlined Smart’s relationship with decedent, the bequests to Smart, decedent’s isolation from her maternal family, and Smart’s role in “drafting” the will. (Id.) However, objectant’s “conclusory assertions” were “unsupported by evidence, circumstantial or otherwise.” (Id.)

The objections were dismissed and the will was admitted to probate. (Id.)

In Matter of Vosilla, 121 AD3d 1489 [2nd Dept 2014], respondent appealed from the Surrogate’s Court decision granting petitioner’s motion for summary judgment and denying respondents’ motion to reopen the SCPA 1404 hearing. (1490)

Following decedent’s death, petitioner filed a probate petition which respondent objected to by challenging decedent’s testamentary capacity and alleging petitioner unduly influenced decedent. (Id.) A 1404 examination was conducted with the attorney draftsperson (“Finn”) and the other witness (“Morin”). (Id.) After the examinations, petitioner moved for, and was granted, summary judgment. (Id.) The court affirmed the Surrogate’s Court decision and noted

While rare, summary judgment in a contested probate proceeding is appropriate where a petitioner establishes a prima facie case for probate and the objectant does not raise any factual issues regarding testamentary capacity, execution of the will, undue influence or fraud (see Matter of Stafford, 111 AD3d at 1217; Matter of Colverd, 52 AD3d at 972; Matter of Nofal, 35 AD3d 1132, 1133 [2006]; see also Matter of Cioffi, 117 A.D.2d 860, 860–861 [1986]; cf. Matter of Paigo, 53 AD3d 836, 838 [2008] ). (Id.)

The court addressed decedent’s testamentary capacity. (Id.) In response to respondent’s claim, petitioner provided self-proving affidavits which “constituted prima facie evidence of the facts attested to and created a presumption of testamentary capacity Matter of Prevratil, 121 AD3d at 141; see Matter of Walker, 80 AD3d at 866).” (1491) In addition, Finn provided a separate affidavit confirming decedent’s testamentary capacity and both Finn and Morin testified to that effect during their respective 1404 examinations. (Id.)

Petitioner provided an affidavit from Robin Depuy-Shanley (“Depuy-Shanley”), an attorney who had been appointed court evaluator in an article 81 guardianship proceeding in which petitioner
had petitioned for the appointment of a property management guardian for decedent. (Id.) The guardianship proceeding was commenced two months prior to the will execution. (Id.) The proceeding was commenced as a result of decedent’s concerns that she lacked the experience to manage the significant inheritance she was due to receive following her mother’s death. (Id.) The guardianship proceeding was subsequently withdrawn when it became clear that a trust would be “better suited to protect decedent and her assets.” (1491 n.1) As court evaluator, Depp-Shanley had prepared a report in which she concluded decedent required assistance with her property management needs. (1491) Nonetheless, in her affidavit, Depp-Shanley opined that at the time she met decedent – one to two months prior to the will execution – decedent possessed testamentary capacity as she was aware of her substantial assets and of the natural objects of her bounty. (Id.) Petitioner also submitted an affidavit from attorney, Schwarzenegger, who petitioner initially contacted to draft decedent’s will, in which she confirmed decedent’s testamentary capacity. (1492)

The foregoing, together with additional proof proffered by petitioner in support of the motion, constituted prima facie evidence of decedent’s testamentary capacity (see Matter of Prevratil, 121 AD3d at 141; Matter of Walker, 80 AD3d at 866), shifting the burden to respondent to demonstrate a triable issue of fact (see Matter of Prevratil, 121 AD3d at 141). (Id.)

Respondent argued decedent had a history of medical and psychological problems and that the guardianship petition brought by petitioner was sufficient to raise questions as to decedent’s testamentary capacity. (Id.) However, as the evidence clearly established, the guardianship petition was brought in an attempt to safeguard decedent’s assets and was not determinative of testamentary capacity. (Id.) Respondent failed to raise an issue of fact regarding decedent’s testamentary capacity and the Surrogate’s Court “properly granted summary judgment dismissing the objection on that ground”. (1492-1493)

As for respondent’s claim that decedent was subjected to petitioner’s undue influence, the record revealed petitioner’s close relationship with decedent which was illustrated during the guardianship proceeding during which decedent “spoke favorably about petitioner” and “proclaimed her trust for him and stated that she wanted him to be her guardian.” (1493) This was echoed by Depp-Shanley who observed a “genuine fondness” between decedent and petitioner. (Id.) The court found “respondent's speculative and conclusory allegations of undue influence . . . insufficient to raise a question of fact (see Matter of Stafford, 111 AD3d at 1219) that would preclude an award of summary judgment dismissing this objection.” (1494)

**Capacity to Execute/Revoke Trusts**

In Matter of Banks, 11 AD3d 307 [1st Dept 2004], Justice McCooe had appointed coguardians of the person and property of the incapacitated person (“IP”) but had “rejected appellants family members’ requests to set aside the incapacitated person’s transfer of certain condominium apartments to a trust for the ultimate benefit of respondent companion.” (307-308) The court affirmed Justice McCooe’s findings. (308)
Evidence that the incapacitated person executed the trust after having suffered a stroke and also while suffering from Alzheimer's disease does not, by itself, satisfy appellants' burden of showing that the incapacitated person was incompetent at the time of the trust's creation (see *Harrison v Grobe*, 790 F Supp 443, 447-448 [1992], *affd* 984 F2d 594 [1993], citing, *inter alia*, *Feiden v Feiden*, 151 AD2d 889 [1989], and *Matter of Ford*, 279 App Div 152 [1951], *affd* 304 NY 598 [1952]). *(Id.)*

There was ample third-party testimony offered by respondent which demonstrated the IP’s “lucidity up until the week before the hearing”, the IP and respondent had been companions for 30 years, the “trusts transfer of the subject apartments to respondent was conditioned” on respondent living with the IP for the rest of the IP’s life, and the trust was “entirely consistent with the longstanding relationship between the incapacitated person and respondent.” *(Id.)*

In *Matter of Joos*, 24 Misc 3d 980 [Sup Ct, Kings County 2009], following Ms. Joos’ death, her court-appointed guardian, Connors, moved to judicially settle his final account and sought an order granting his commission and attorney’s fees. *(981)* The Guardianship clerk’s office was unsatisfied with the final account and brought the following issues to the court’s attention:

(1) Was the newly formed revocable trust properly revoked? Had the guardian exceeded his authority when he revoked the trust? Had he acted improvidently in marshaling the trust assets into the guardianship account? (2) Was there possible overreaching and excessive fees taken by the guardian in the various fiduciary capacities? (3) Did the guardian act improperly by mislabeling the trustee commissions he took as court ordered, when they were in fact not court ordered? *(982)*

Justice Barros reviewed the case’s procedural history. *(Id.)* Petitioner, Ms. Joos’ former son-in-law expressed concern as to Ms. Joos’ physical and financial well-being and on August 13, 2002, commenced an article 81 proceeding. *(Id.)* In March 2002, concerned with Ms. Joos’ welfare, petitioner contacted the law firm that had represented Ms. Joos in the past. *(983)* The firm refused to speak with petitioner and petitioner filed the guardianship petition. *(Id.)*

In response, the firm filed an affirmation in opposition. *(985)* The affirmation stated that the firm had represented Ms. Joos for 11 years and Ms. Weiss had cared for Ms. Joos for many years and was her health care proxy and attorney-in-fact. *(Id.)* According to the affirmation, in March of 2002, Ms. Joos called the firm to inform them she was unhappy with the manner in which Weiss was exercising the power of attorney and requested that Connors, a partner at the firm, manage her finances and health care decisions. *(Id.)* The affirmation did not reference petitioner’s call to the firm. *(Id.)*

Ms. Joos established a revocable trust naming Connors as trustee, Connors was appointed as Ms. Joos attorney-in-fact pursuant to a newly executed power of attorney, and an associate at the firm was named Ms. Joos’ health care proxy. *(Id.)*
The affirmation outlined the reasons why the appointment of a guardian was inappropriate, namely the existence of advance directives which “secured Ms. Joos in her property and person”. (986) The court evaluator recommended that either Connors be appointed guardian or the revocable trust continue thereby negating the need for the appointment of a guardian. (987)

A settlement was reached wherein the objection was withdrawn on the condition there be no finding of incapacity and that Connors be appointed guardian of the person and property. (987-988) Connors was appointed guardian. (988)

At no point during the pendency of the matter did Connors and Sullivan ever mention the estate savings to be generated by the trust or the detrimental financial consequences of undoing the trust. In the negotiated settlement, Connors and Sullivan never addressed the need for specific provisions to preserve the trust and insure its attendant financial benefits to Ms. Joos' estate. (Id.)

The order and judgment was entered on February 13, 2003 and on July 10, 2003, Connors filed his bond and oath and designation but failed to obtain his commission. (988-989)

Petitioner moved for his attorney’s fees, which Connors opposed. (989) During oral argument on the fee issue, “the court began to question whether it had erred in appointing Mr. Connors as guardian and made inquiry as to whether the estate plan he designed for Ms. Joos inappropriately benefitted himself or his law firm.” (Id.) Pursuant to the court’s direction, Connors filed an affirmation in which he stated that neither he nor anyone related or affiliated to him was a trust beneficiary. (Id.) However, “despite being a court appointee, obligated to be transparent in answering the court’s concerns about his ward’s finances and estate planning, Mr. Connors failed to disabuse the court of its notion that the trust still existed.” (Id.) The court was unaware of the financial benefits due Connors and the firm in the event the trust was revoked. (Id.)

On December 31, 2003 Ms. Joos died and Connors moved for judicial settlement of his final account. (Id.) Connors claimed Ms. Joos had revoked the trust and provided the court with a copy of the revocation. (990) Justice Barros raised the following concerns about the manner in which Connors executed his obligations as guardian/trustee:

- the acknowledgment of the revocation originally dated March 28, 2003 was crossed out to read February 18, 2003.
- the trustee/guardian withdrew trust assets on February 13, 2003 and February 16, 2003, that is, before February 18, 2003, the date the revocation document is signed and acknowledged.
- The trustee/guardian on February 6, 2003, paid himself $12,431.89 in trustee commissions, well before either the trust's one-year anniversary which would have been March 22, 2003, or the date the trust was purportedly revoked February 18, 2003. Taking
Exiting trustee commissions before the revocation of a trust is improper and taking annual commissions before the anniversary of the trust is also improper.

The trust paid the trustee's law firm $600 per month to pay Ms. Joos' bills and to supervise her agency-provided home care. Any portion of the $600 per month allocated to bill paying services appears to be double billing.

The trustee/guardian's assertion that the trust was revoked is belied by the fact that Ms. Joos' house remained a trust asset until it was sold by Mr. Connors in his capacity as trustee/executor approximately a year after her death.

Mr. Connors likewise disregarded requirements contained in the order and judgment appointing him guardian. For instance, Mr. Connors marshaled all of Ms. Joos' liquid assets into a guardianship account(s) several months prior to obtaining his bond and without ever receiving his commission to act. (990-991)

Had the trust not been revoked, Ms. Joos’ estate would have avoided “nearly all of the $74,000 in executor's commissions and legal fees in the probate proceeding.” (991) Connors “never attempted to prevent the estate planning fiasco that occurred when the trust was revoked, and in fact began to undo his client's estate plan even before the trust revocation was signed.” (Id.) Nonetheless, Connors sought full guardianship commissions and legal fees. (Id.)

Connors argued Ms. Joos had never been determined incapacitated and therefore was free to revoke the trust and had the capacity to do so. (991) Justice Barros described the claim that Ms. Joos independently and knowingly revoked the trust as “incredible.” (991-992) The record supported the conclusion that “Ms. Joos neither sought to revoke the trust, nor had the requisite understanding of the financial consequences triggered by executing the revocation.” (992) Connors’ claim that the order and judgment appointing guardian required revocation of the trust was “baseless.” (Id.)

The court refused to award Connors his commission given the fact he had already received trustee fees, planning and booking fees, and a full executor’s commission. (996) Further, he “failed to preserve his ward’s assets, failed to preserve her trust, failed to file an initial report, filed his bond some five months after the order and judgment was entered, and failed to obtain his commission.” (Id.) Connors’ request for legal fees for his counsel was denied. (997)

In Matter of Donaldson, 38 Misc 3d 841 [Sur Ct, Richmond County 2012], petitioner moved for summary judgment declaring the trust and deed transfer (hereinafter “trust documents”) executed by her mother (hereinafter “decedent”) void on the basis decedent lacked the capacity to execute said documents. (841-842)
Respondent, one of decedent’s seven children, contacted attorney Ted Parnese, Esq. (“Parnese”) who drafted the trust documents. (842) Although Parnese went to decedent’s home to explain the trust documents and to have her execute them, he “did not meet with the decedent nor speak to her privately prior to drafting the trust documents”. (Id.) Instead, he relied on respondent’s statements and a letter written by decedent’s treating doctor addressing decedent’s mental capacity. (Id.) The letter read, "Mrs. Muriel Donaldson was seen by me. She is a very independent minded person. She is noted to be in an acceptable mental status to help coordinate her care and is competent to direct her family and/or aides for her personal or financial needs." (Id.) The trust documents were executed 61 days before decedent died, there were family disputes regarding decedent’s bank accounts, and petitioner had discussed a potential Mental Hygiene Law article 81 guardian for decedent. (842-843)

Justice Gigante first addressed the capacity required to execute the trust documents in question:

in order to determine the mental capacity standard, this Court must first determine whether the documents executed are more comparable to a will, therefore requiring a minimal mental capacity, or whether they are more similar to a contract and, therefore, requiring a higher mental capacity. (Matter of ACN, 133 Misc.2d 1043, 509 N.Y.S.2d 966; Matter of Rosen, 17 Misc.3d 1103(A), 851 N.Y.S.2d 61, 2007 WL 2792153). It is abundantly clear after reviewing the documents executed by the Decedent that they are more comparable to a contract and therefore require a higher mental capacity than that of a will. The controlling standard in evaluating decedent's capacity is not the lower standard for a testamentary instrument, but is rather the higher contract standard of capacity, which focuses on whether the person was able to understand the nature and consequences of a transaction and make a rational judgment concerning it (Matter of Goldberg, 153 Misc 2d 560 [1992]). (843-844)

Justice Gigante noted that “unlike testamentary capacity”, the burden of proving incapacity with a trust document of this nature is “on the one who asserts it (Matter of Goldberg, 153 Misc 2d 560 [1992], citing Matter of Obermeier, 150 AD2d 863 [1989]).” (844) Justice Gigante reviewed the facts surrounding the execution of the trust document. (844-845)

during the doctor's deposition, he was asked hypothetically whether he thought the decedent would be able to read and understand a contract of sale and the reply was "I don't think so." . . . Dr. Banerji performed neither a mental status test the day he drafted the letter, nor a complete neurological exam. The drafting attorney, Ted Parnese, Esq., relied solely on the letter drafted by Dr. Banerji to determine the decedent had the requisite mental capacity to execute the transfer documents. Mr. Parnese did not meet with the decedent, nor did he speak to her prior to executing the documents (Ted Parnese EBT, June 18, 2012, at 5, lines 16-
20). He received his instructions on the drafting of the trust and deed transfer from the respondent, Diane Morelli (Ted Parnese EBT, June 18, 2012, at 10, line 20 through 11, line 10). Mr. Parnese did not perform any type of cognitive exam to determine the decedent's mental capacity. (844-845)

The decedent did not have the mental capacity to execute the trust documents and the documents were voided. (Id.)

**Financial Decisions, Including the Conveyance of Real Property**

In *Matter of Baird*, 167 Misc 2d 526 [Sup Ct, Suffolk County 1995], a dispute arose as to whether a property management guardian should be given authority to renounce part of her incapacitated person’s (“IP”) interest in the decedent’s estate. (528) The partial renunciation was “intended to provide sufficient funds to pay for the IP’s nursing home costs during a Medicaid “penalty” period, while allowing the remaining funds to pass to her sons.” (Id.) The Nassau County Department of Social Services (“NCDSS”) objected to the renunciation. (Id.)

Although Justice Luciano agreed with the philosophical themes underpinning NCDSS’ opposition, Justice Luciano was “compelled to grant the guardian the requested authority”. (530) Justice Luciano concluded, “to deny an incapacitated person a statutory right available to another person, similarly situated except to the extent of having the capacity personally to make property management decisions would bear implications of denial of equal protection of the laws.” (531) (Emphasis added.)

Justice Luciano addressed Mental Hygiene Law (“MHL”) §81.21(d) and concluded the IP did not have the capacity to make the renunciation herself (MHL §81.21 [d] [1]), would be unlikely to regain capacity to do so (MHL §81.21 [d] [2]), and she had no dependents that would be adversely affected by the renunciation (MHL §81.21 [d] [3]). (532) Finally, renunciation was not inconsistent with the IP’s testamentary plan. (MHL §81.21 [d] [4]). (Id.)

In *Matter of Mattei*, 169 Misc 2d 989 [Sup Ct, Nassau County 1996], the incapacitated person’s (“IP”) husband, Anthony (“decedent”), established a revocable trust (the “trust”) naming his daughter, petitioner herein, sole beneficiary. (990) The trust was funded by the family home and decedent’s assets. (Id.) Petitioner was the sole beneficiary in decedent’s will. (Id.)

The IP suffered with senile dementia and probably Alzheimer’s disease and resided at the family home. (Id.) Decedent filed for Medicaid for the IP and executed “spousal refusal” before moving the IP into a nursing home on March 4, 1994. (Id.) The Medicaid application was granted retroactively to December 1, 1993. (Id.) Decedent died on August 3, 1995. (Id.) Decedent’s will was not probated because his assets passed outside the will either through the trust or joint accounts. (Id.) The Suffolk County Department of Social Services (“DSS”) were notified and requested the IP’s nursing home commence an article 81 guardianship proceeding over the IP to ensure the IP exercised her right of election pursuant to EPTL 5-1.1-A (c) (3) (e). (Id.)
Petitioner commenced a Mental Hygiene Law article 81 proceeding but did not request the authority to exercise her mother’s right of election. (Id.) DSS cross-petitioned for the appointment of an independent guardian with authority to exercise the right of election. (Id.)

The IP was determined to be incapacitated and petitioner was appointed personal needs and property management guardian. (991) The basis for DSS’ cross-petition was its regulatory obligation to pursue potential available resources. (Id.) DSS believed the IP’s right of election was an asset and, “whether exercised or not”, would render the IP ineligible for Medicaid for up to a year making her unable to pay her nursing home bills. (Id.)

The critical question was not the court’s authority to authorize a guardian to renounce an IP’s right of election rather; “the consequences of such inaction . . . irrespective of its legality.” (993) The current law concerning Medicaid is “consistent with the principles that Medicaid should be limited to needy and that need will not be found where created by refusing available resources (See, Matter of Molloy v Bane, supra, at 174, 176; Matter of Flynn v Bates, supra; Matter of Tutino v Perales, 153 AD2d 181, 186, appeal dismissed 75 N.Y.2d 1004, lv denied 76 N.Y.2d 705; Matter of Harrington v Blum, 117 Misc 2d 623, 624-625.” (Id.)

the courts have authorized the use of Medicaid planning for the benefit of incapacitated persons where such planning is intended by applicable law. We should not go beyond that and permit incapacitated persons to do, via guardians, what competent persons cannot do contrary to the provisions and intent of said law. (Id.) (Emphasis added.)

Petitioner’s attempt to distinguish right of election from inheritance failed because “both are assets and the transfer thereof results in ineligibility (see, Social Services Law § 366 [5] [d] [1], [3]).” (993-994) The IP can be “ineligible for Medicaid because of her right of election and that without the exercise thereof she would be without funds to make up the loss of Medicaid benefits.” (994) Based on the nature of the IP’s condition and the underlying incapacity determination, Justice Rossetti concluded that the IP “lacked the requisite mental capacity to exercise the right of election herself and will not likely regain such capacity in the foreseeable future (see, Mental Hygiene Law §§81.21[d][1],[2]).” (Id.) Justice Rossetti found by clear and convincing evidence that “the subject right of election should be exercised to the extent necessary to provide for the period of Medicaid ineligibility resulting therefrom, and for permitted Medicaid funds.” (995)

(See also, Matter of Street 162 Misc 2d 199 [Sur Ct, Monroe County 1994])

In Matter of Jenkins v Stephenson, 293 AD2d 612 [2d Dept 2002], a proceeding was commenced to set aside deeds to real property. (612) The court reversed the Supreme Court’s decision and set aside the “deed to the subject property from Sally Mae Jenkins . . . and the [subsequent] deed from Stephenson to Legend Home Sales, Inc.” (613)
By deed dated December 24, 1996, Sally Mae Jenkins “purported to convey title to real property . . . to Dorine Stephenson, without consideration.” (Id.) In June 1997, a Mental Hygiene Law article 81 proceeding was commenced during which Sallie Mae Jenkins was determined to be an incapacitated person (“IP”) and in need of a guardian. (Id.) Petitioner, Emma Jenkins, was appointed co-guardian and learned of the property transfer from the District Attorney. (Id.) Petitioner sought to void the deed to Stephenson and, on November 24, 1997, filed a notice of pendency. (Id.) The same day, Stephenson conveyed title to Legend Home Sales, Inc. (“Legend”). (Id.) The Supreme Court held that the IP was indeed incapacitated at the time of the transfer which was a result of undue influence and fraud however, since Legend was a bona fide purchaser, the deeds could not be voided. (614) The Supreme Court erred in holding Legend a bona fide purchaser as “Legend failed to record the deed prior to the filing of the notice of pendency, and, therefore, is bound to the same extent as Stephenson by the judgment determining that Sallie Mae Jenkins did not have the capacity to deed the property.” (Id.)

In Matter of Margaret S., 2006 NY Misc LEXIS 2833 [Sup Ct, Richmond County 2006], a written stipulation was entered into wherein it was agreed that the alleged incapacitated person (“AIP”) was incapacitated. (*1) Peter, the AIP’s son and cross-petitioner, was to be appointed temporary co-guardian of the AIP’s person along with an independent co-guardian. (*1-2) Patricia C., the AIP’s daughter and petitioner herein, was to be appointed temporary co-guardian of her mother’s property along with an independent co-guardian. (*2) Petitioner claimed the AIP had lacked the capacity to convey property to cross-petitioner on October 8, 2003 claiming the conveyance was a product of undue influence. (Id.)

Justice Giacobbe had to determine whether to modify, amend or revoke the challenged conveyance pursuant to Mental Hygiene Law § 81.29 and whether petitioner, cross petitioner, or a third party should be appointed permanent guardian. (2-3) Cross-petitioner had resided with the AIP for over 30 years and the AIP had executed a Power of Attorney and Health Care Proxy in favor of cross-petitioner. (*3-4)

5. On October 8, 2003, Mrs. S. transferred title to the premises to Peter and his wife, Ann, subject to her life estate. The deed was executed in the presence of the AIP’s treating physician, Dr. Donna S., the attorney who prepared the deed, John G., Esq., the transferees, Peter and Ann S., and a neighbor.

6. Later in the day on October 8, 2003, Mrs. S. executed a Last Will and Testament, also prepared by John G., Esq., wherein she provided for the distribution of her residuary estate to her two remaining children, Patricia C. and James S., "as she had already provided for Peter during her lifetime." . . .

12. The AIP stated to Dr. S. on October 8, 2003 that she wanted Peter to take care of her and help make decisions, and that she wanted to give her house to Peter and not to her other children.
13. Eight months later, at the time of her evaluation by Dr. L., the AIP did not recall signing the deed to Peter and Ann, but continued to express her wish that Peter be her beneficiary and make decisions for her if she was unable to do so. She further stated to Dr. L. that she was willing to sign her home over to Peter as a gift because she is very close to him and he assists her on a daily basis. (*4-6)

Although the validity of the AIP’s will was not before the court, Justice Giacobbe noted that “a finding of incapacity under Mental Hygiene Law article 81 is based upon the consideration of different factors from those determinative of testamentary capacity (see Mental Hygiene Law § 81.29[b]; Matter of Colby, 240 A.D.2d 338, 660 N.Y.S.2d 3 [1st Dept 1997], lv denied 91 N.Y.2d 801, 669 N.E.2d 533, 689 N.E.2d 533, 666 N.Y.S.2d 563).” (*4-5)

Justice Giacobbe determined that the AIP’s best interests would be served by the appointment of cross-petitioner as personal needs guardian and petitioner as property management guardian. (*13) The AIP clearly expressed a preference for her son, the cross-petitioner to continue to care for her person by assisting her, as he had done for many years, with her activities of daily living. (*13-14) Mindful of the animosity between petitioner and cross-petitioner, Justice Giacobbe appointed independent co-guardians of the person and property. (*15-16)

Justice Giacobbe addressed the disputed conveyance by first dealing with cross-petitioner’s alleged exertion of undue influence over the AIP:

regardless of which burden-shifting analysis is applied to the claim of undue influence, the Court finds that the close family ties between Peter, Ann and Margaret S. resulting from the AIP's dependency upon her son and daughter-in-law due to her declining health and mental condition, are alone insufficient to establish that the AIP was the subject of undue influence by either of them. Moreover, the trial transcript contains clear and convincing evidence that Mrs. S.’s expressed desire to give her house to Peter was not the result of undue influence or control but rather was the natural product of her gratitude to her son for the care she has received and expects to receive from him in the future (see Mandell v. Finkel, 298 A.D.2d 365, 751 N.Y.S.2d 235 [2nd Dept 2002]; see also Matter of Walther, 6 N.Y.2d 49, 54, 159 N.E.2d 665, 188 N.Y.S.2d 168). (*17)

Justice Giacobbe addressed whether the AIP had the capacity to convey the property noting that the fact someone is suffering from a disease such as Alzheimer’s is not, in and of itself, proof of that person’s inability to convey property. (Id.)

The AIP’s physician, Dr. S., who was present at the conveyance and who had performed a physical examination and a mental evaluation of the AIP prior to the conveyance testified. (*18) Dr. S.’s testimony regarding the AIP’s lucidity at the time of conveyance was “afforded great
weight in view of the longstanding doctor-patient relationship between herself and the AIP, as well as her extensive experience in the field of geriatrics.” (*Id.)

Dr. S.’s testimony was “not negated by the contrary report and testimony of Dr. James L., which were wholly dependent upon a single evaluation of the AIP conducted eight months after the transfer.” (*19) Further, Dr. James L.’s testimony regarding the “alleged inadequacy of the so-called "mini mental status exam" administered by Dr. S. “was largely theoretical in nature and unpersuasive.” (*Id.) Further, “the doctor's opinion that "lucid intervals" do not exist in cases of dementia conflicts with controlling case law in the State of New York (see Matter of Lee, supra, citing e.g. Gala v. Magarinos, supra).” (*20) Further, the testimony of the drafting attorney regarding the AIP’s capacity was credible and consistent with Dr. S.’s testimony. (*Id.)

Justice Giacobbe denied the motion to modify, amend, or revoke the conveyance and

notwithstanding the AIP's uncontroverted affliction with a degree of senile dementia of the Alzheimer's type, petitioner has failed to meet her burden of rebutting the presumption of competency or overcoming the proof of lucidity at the time of the challenged transfer (see Matter of Waldron, supra at 508; Feiden v. Feiden, supra at 890). In sum, the AIP has not been proven to be "so affected by her condition as to render [her] wholly and absolutely incompetent to comprehend and understand the nature of the transaction or unable to control her conduct" at the point of execution (Whitehead v. Town House Equities, 8 A.D.3d 367, 369, 780 N.Y.S.2d 15 [2nd Dept 2004], citations and internal quotation marks omitted). (*22–23)

In *Buckley v Ritchie Knop, Inc.*, 40 AD3d 794 [2d Dept 2007], Robinson commenced an action to set aside the conveyance of a property by his mother, Ethel, to defendant, Ritchie Knop, on the basis Ethel was in cognitive decline at the time of the transfer and defendant paid $280,000 less than fair market value. (794–795) After the commencement of the action, Robinson’s sister sought the appointment of a guardian for Ethel pursuant to Mental Hygiene Law article 81. (795) The Supreme Court determined Ethel to be incapacitated and appointed her children as guardians. (*Id.*) Defendant moved for summary judgment and the guardians cross-moved “to amend the caption to reflect that she [Ethel] had been adjudicated incompetent, and they had been appointed her guardians.” (*Id.*) The Supreme Court denied defendant’s motion to dismiss except as to the forgery claim. (*Id.*)

As a general rule, a party’s competence is presumed, and in order to set aside a transfer of property on the ground of lack of capacity, it must be established that the party did not understand the nature of the transaction at the time of the conveyance as a result of his or her mental disability (*see Crawn v Sayah, 31 AD3d 367 [2006]; Whitehead v Town House Equities, Ltd., 8 AD3d 367 [2004]; Feiden v Feiden, 151 AD2d 889 [1989]; Lopresto v Brizzolara, 91 AD2d 952 [1983]). Although persons suffering from a disease such
as Alzheimer’s are not presumed to be wholly incompetent (see Matter of Rose S., 293 AD2d 619 [2002]; Matter of Waldron, 240 AD2d 507 [1997]), the evidence submitted by Robinson and Teresa in opposition to the motion, which included medical testimony presented at the competency hearing, was sufficient to raise an issue of fact as to whether Buckley was competent on the date of the conveyance (see Sepulveda v Aviles, 308 AD2d 1 [2003]; Inman v Inman, 97 AD2d 864 [1983]). (795-796)

In Matter of Doar (Brunson), 28 Misc 3d 759 [Sup Ct, Queens County 2009], petitioner sought the appointment of a guardian for Ms. Brunson, an alleged incapacitated person (“AIP”). (760) At the time of hearing, the AIP’s home was in foreclosure. (Id.) The foreclosure action was stayed during the pendency of the guardianship proceeding. (Id.) Petitioner sought to establish the AIP “lacked the capacity to (1) execute the deed transferring the property to her brother Joseph, and (2) to enter into mortgage agreements with Financial Freedom Senior Funding Corp. (“Financial Freedom”) signed in December 2001 and June 2003.” (Id.) Financial Freedom claimed the AIP had capacity at the time of execution and, even if she did not, the mortgage proceeds were used for the AIP’s benefit. (Id.)

Based upon testimony from the AIP’s physician at the time of the transfer and mortgage agreement and from the AIP’s sister, Justice Thomas determined that the AIP “suffered from a mental illness which, from the time of her hospitalization in the year 2000, rendered her incapable of handling her financial affairs and from understanding the nature of the reverse mortgages entered into in 2001 and 2003 and their long-term implications.” (Id.) Justice Thomas addressed Mental Hygiene Law §81.29(d):

If the court determines that the person is incapacitated and appoints a guardian, the court may modify, amend, or revoke any previously executed . . . contract, conveyance, or disposition during lifetime or to take effect upon death, made by the incapacitated person prior to the appointment of the guardian if the court finds that the previously executed . . . contract, conveyance, or disposition . . . was made while the person was incapacitated. (762)

In cases involving a mortgage contract, a mortgagee must have

“knowledge of the mortgagor’s incapacity before the contract which is otherwise voidable could be voided. In order to void a contract which is voidable because of incapacity, the mortgagor must establish that the mortgagee had knowledge of the “incapacity and were . . . not bona fide mortgagees for value.” (See Weisberg v DeMeo, 254 AD2d 351, 351 [1998].)” (Id.)

Justice Thomas addressed the legislative history of reverse mortgages in particular the Department of Housing and Urban Development’s “concern about the intricacies of a reverse mortgage and the need to insure that elderly individuals not risk their hard earned equity by
entering into a reverse mortgage unless they fully understand the terms and significance of the mortgages to which they are agreeing.” (762-763)

Since reverse mortgages are available only to individuals over a certain age, “a greater obligation is appropriately placed on the mortgagee than in an otherwise arm’s length transaction.” (763) Therefore, “the burden of knowledge which had been placed on the proponent seeking to void the contract due to lack of capacity of a party . . . must be shifted to the mortgagee when dealing with a reverse mortgage.” (Id.) To that end, when contracting for reverse mortgages, “the mortgagee is entrusted with the responsibility of conducting an inquiry of the applicant’s understanding of the mortgage agreement.” (Id.) The counseling served dual purposes neither of which Justice Thomas believed were met in the instant case. (Id.) Firstly, the mortgagor should be aware of his or her rights under the mortgage contract and secondly, the mortgagor must demonstrate to a reviewing court that the legislative intent was met and the statutory regulations enforced. (Id.)

There was no evidence Ms. Brunson understood the mortgage terms or the counseling certificate she signed. (764) Justice Thomas voided the two mortgages as the AIP was “incapable of understanding the agreements” however, to the extent the AIP used the funds for her own benefit, Financial Freedom was to be compensated from the monies paid out to the AIP. (Id.)

In JPMorgan Chase Bank N.A v Haedrich, 29 Misc 3d 1215 [A], 2010 NY Slip Op 51838 [U] [Sup Ct, Nassau County 2010], movant was appointed personal needs and property management guardian of Mr. and Mrs. Haedrich in 2005. (*2) As of June 1, 2008, neither movant nor Mr. and Mrs. Haedrich paid the required monthly mortgage payments and the instant foreclosure action was commenced by JP Morgan Chase. (Id.) Movant, in his capacity as guardian of Mr. Haedrich, Mrs. Haedrich having died, moved to vacate “all judgments of foreclosure, mortgages, notes and consolidation agreements and for an order saying the pending foreclosure proceeding.” (*1)

Movant argued that when the relevant mortgage documents were executed in 1999 and 2003, both Mr. and Mrs. Haedrich suffered from “mentally debilitating conditions, including dementia, which deprived them of their capacity to understand the substance of the documents they signed, as well as the consequences emanating therefrom.” (*2) Movant submitted a letter from Dr. Mervin Sakowitz wherein he stated that Mrs. Haedrich was his “patient for one visit in 1990” and “probably had atypical Mycobacterium Avium Cellulare infection in her lungs” . . . he did not see Mrs. Haedrich “until 2004” at which time she had “chronic Mycobacterium Pneumonia” (Id.)” (Id.). Dr. Sakowitz stated that he first saw Mr. Haedrich in 2004 at which point he “gave a history of Alzheimer’s Disease”. (Id.) Further, movant referenced testimony allegedly provided by psychiatrist, Dr. Lipschutz, during the article 81 hearing as further evidence. (Id.)

Counsel argues that due to the dementia of Mr. and Mrs. Haedrich, coupled with the Chronic Mycobacterium Avium Cellulare of Mrs. Haedrich, JP Morgan Chase, as the lender seeking to enforce the subject instruments, bears the burden of demonstrating that it had no knowledge of Mr. and Mrs. Haedrich's incapacity at the time the subject transactions were executed (Id., ¶7). In so arguing, counsel relies upon The Matter of Hermina Brunson, NYLJ
January 7, 2010. The Court notes that the proper title of this case is
In re Doar and the proper citation thereto is 28 Misc 3d 759 [Sup Ct, Queens Co., December 18, 2009, Thomas, J.]. (Id.)

Justice Phelan referenced Mental Hygiene Law §81.29 and the court’s authority to revoke any contract executed by the incapacitated person prior to the appointment of a guardian if the contract was made at a time when the person was incapacitated. (Id.) However, evidence provided by movant was “patently insufficient” to show that either “Mr. or Mrs. Haedrich were “incompetent or that the lender “knew or was put on notice” of the purported incapacity with which Mr. and Mrs. Haedrich were afflicted (Orterlere v. Teachers’ Retirement Board of the City of New York, 25 N.Y.2d 205).”(*3)

Disregarding the fact Dr. Sakowitz’s letter was “not in admissible form (CPLR § 2106)”, and even if the assertions within the letter are accurate, said assertions fail to establish that at the time of the mortgage transactions “Mr. and Mrs. Haedrich were “incapable of comprehending the nature” of the documents they signed or that by virtue of mental disease “were unable to control [their] conduct” (Horrell v. Horrell, 73 A.D.3d 979, 900 N.Y.S.2d 666 [2d Dept 2010] ). (Id.)

Further, even assuming there was competent medical evidence that in 2004 Mr. Haedrich indeed suffered from Alzheimer's Disease, it has been held that “one suffering from Alzheimer's disease is not presumed to be wholly incompetent” and “rather, it must be demonstrated that, because of the affliction, the individual was incompetent at the time of the challenged transaction” (Gala v. Magarinos, 245 A.D.2d 336, 337, 665 N.Y.S.2d 95 [2d Dept 1997]). (*4)

Finally, counsel's reliance upon the case of In re Doar is unavailing. Unlike the facts as adduced herein, in Doar there was a confirmed diagnosis of chronic paranoid schizophrenia from which the alleged incapacitated person suffered at the very time the challenged mortgage documents were executed (In re Doar, 28 Misc.3d 759, 900 N.Y.S.2d 593 [Sup Ct, Queens Co., December 18, 2009, Thomas, J.]). Additionally, the mortgage in issue in Doar was a “reverse mortgage” (Id.). In the instant matter, there is no indication that the loan in issue was in the form of a reverse mortgage. (Id.)

The motion for an order vacating all judgments of foreclosure, mortgages, notes and consolidation agreements and for an order staying the pending foreclosure proceeding was denied. (Id.)

In Matter of Willner (F.G.), 45 Misc 3d 1222 [A], 2014 NY Slip Op 51675 [U] [Sup Ct, Bronx County 2014], an article 81 proceeding was commenced by the Hebrew Home for the Aged (hereinafter the “Home”). (*1)
The AIP was admitted to the Home in January 2013 however, despite completing rehabilitation, could not be discharged due to the lack of a safe discharge plan. (*2) The AIP’s assets consisted of a bank account with approximately $240,000 and a cooperative apartment. (Id.) The AIP received neither social security nor Medicaid however, as of March 2014, the New York City Human Resources Administration had taken up her care costs. (Id.)

The hearing was held at the AIP’s bedside. (Id.) The AIP, the Home’s Social Worker, the Home’s Assistant Controller of Resident Accounts, the court evaluator, and the AIP’s former Power of Attorney and Healthcare Proxy gave testimony. (Id.)

The Home’s Social Worker, Anne Weisbrod (“Weisbrod”), testified that in March 2013, the AIP underwent tests and evaluations and it was determined that she lacked the capacity to make financial decisions. (Id.) In June 2014, the AIP underwent further tests and it was again confirmed that she lacked the capacity to make financial decisions and further, her condition was worsening. (*3) Weisbrod also testified that the AIP had executed a health care proxy in 2011 and a power of attorney in 2004 both naming Barbara Lissner, Esq. (“Lissner”) as her agent and attorney in fact. (Id.)

The Home’s Assistant Controller of Resident Accounts, Rosemary Pignone (“Pignone”), testified as to the AIP’s accounts, including, as of June 2014, an overdue balance of $279,348.25. (Id.) Further, Pignone testified that in May 2013, the AIP signed a $50,000 check to the Home which the home deposited and applied towards the AIP’s balance. (Id.)

Justice Hunter noted that the $50,000 transaction occurred two months after the Home concluded that the AIP lacked the capacity to make financial decisions. (Id.) When the AIP refused to make further payments and prohibited Lissner from doing likewise, the Home “shockingly” commenced a lawsuit against the AIP for breach of implied contract and unjust enrichment. (Id.)

Once the Home believed the AIP’s liabilities exceeded her assets, it filed a Medicaid application on the AIP’s behalf and the New York City Human Resources Administration took up the AIP’s care costs retroactively beginning March 2014. (Id.) However, the AIP’s status remains “conditional” because the Medicaid application was less than 50% complete. (Id.)

The AIP’s attorney in fact and agent, Lissner, testified that she assisted the AIP from the 1990s until the AIP entered the home. (Id.) Lissner testified that she contacted the AIP “offering her a retainer agreement to assist her after her apartment fire” however, the AIP did not sign the agreement and refused Lissner’s assistance. (Id.) Neither the power of attorney nor the health care proxy were revoked. (Id.)

The AIP testified that she did not need a guardian, referenced the $50,000 check, did not recall signing a power of attorney, and that she had no preference as to potential guardians. (Id.)

The court evaluator, Anup Kaur, Esq., (“Kaur”), visited the AIP on three separate occasions and on the second and third occasions the AIP did not remember Kaur or what was discussed. (Id.) Kaur testified that the AIP’s financial documents “were strewn around her room in such a way that any one entering her room would be able to see their contents.” (Id.) Further, according to Kaur, the AIP was unable to manage her personal and property needs due to confusion and
forgetfulness and was unable to complete the necessary paperwork to obtain Medicaid or other benefits and was unwilling to consent to having another party act on her behalf. \(\text{Id.}\)

The court evaluator testified that in her experience, nursing homes routinely look through sensitive financial documents that are left out in residents' rooms. She further stated that, once a nursing home ascertains that a particular resident has funds, they allow that resident to write checks for nursing home payments while fully aware of the resident's incapacity. Despite having knowledge of this practice, the court evaluator's report did not make mention of the two evaluations that found the person lacked capacity, the $50,000.00 check, nor the civil suit that the Hebrew Home commenced against the person after one psychiatrist found her lacking the capacity to make financial decisions. The court evaluator recommended that the court appoint a guardian of the person and property from the Part 36 fiduciary list. \(\text{Id.}\)

In his opinion, Justice Hunter outlined what he described as the “unsettling facts and actions by the Hebrew Home” that occurred in connection with the instant application namely, “a questionable payment of $50,000.00 by check to the Hebrew Home after the person was found to lack capacity by a psychiatrist; the Hebrew Home commencing a civil suit against the person, again, after she was found to lack capacity”. \(\text{Id.}\) Justice Hunter criticized the actions of the attorney in fact and health care agent, Lissner, before he concluded that it “would be an understatement to declare that this court is outraged by the behavior exhibited by the interested parties - parties who were supposed to protect the person, but who have all unabashedly demonstrated through their actions in connection with the person that they are only interested in getting paid.” \(\text{Id.}\)

Justice Hunter cited \textit{Matter of G.S.}, 17 Misc 3d 303 [Sup Ct, Bronx County 2007] in support of the proposition that a guardianship proceeding brought for the purpose of ensuring a nursing home is paid for care provided to an AIP “was not the legislature’s intended purpose”. \(\text{*3-4}\) Justice Hunter also raised the possibility that once appointed, the guardian might, pursuant to Mental Hygiene Law §81.43(a), commence a turnover and discovery proceeding in order to recover the $50,000. \(\text{*4}\) Justice Hunter addressed whether or not a person who lacks capacity, can sue or be sued:

Furthermore, although “[a] person of unsound mind but not judicially declared incompetent may sue or be sued in the same manner as any ordinary member of the community” (Huber v. Mones, 235 A.D.2d 421, 422 [2nd Dept.1997] ), it does not sit well with this court that the Hebrew Home was so bold as to sue the person for unjust enrichment and breach of contract despite the fact that, as the person's social worker testified, their own doctor evaluated the person and found her to lack capacity to make financial decisions. Although the Hebrew Home did not move for a default judgment after the person failed to appear and despite the
fact that the time for such a motion has expired, it nevertheless appears that this lawsuit may not have been proper. (*Id.*)

Justice Hunter authorized the guardian to defend the civil action commenced by the Home and to investigate the facts and circumstances surrounding the $50,000 check payment to the Hebrew Home and the commencement of a lawsuit against the person by the Hebrew Home for any evidence of financial exploitation and, with prior court approval, refer the matter to the Office of the Bronx County District Attorney and the Office of the New York State Attorney General for investigation. (*Id.*)

**Capacity to Marry/Divorce**

In *Matter of Dot E.W.*, 172 Misc 2d 684 [Sup Ct, Suffolk County 1997], Justice Prudenti addressed whether the alleged incapacitated person’s (“AIP”) post-petition marriage could be revoked and annulled by the court pursuant to Mental Hygiene Law (“MHL”) §81.29(d). (685)

Petitioners commenced the guardianship proceeding seeking their appointment as coguardians of the person and property of their aunt, the AIP (686) Following the action’s commencement, but prior to the adjourned return date, William B. – the person with whom the AIP resided – married the AIP in a civil ceremony before a retired Justice. (*Id.*) William B. (hereinafter “Mr. B.”) filed a cross-petition seeking his appointment as the AIP’s personal needs guardian and the appointment of an independent property management guardian. (*Id.*)

Petitioners, by supplemental order to show cause, were authorized to serve a supplemental petition seeking, inter alia, “a judgment “revoking and anulling” the July 14, 1996 marriage contract” between the AIP and Mr. B. pursuant to MHL §81.29 (d) on the basis the AIP was “incapacitated on the date of the marriage and thus lacked the mental capacity to understand the nature and consequences of the marriage.” (*Id.*)

At the hearing, which cross-petitioner did not attend, petitioner called ten witnesses, including the AIP’s current physician, a psychiatrist retained as a medical expert by petitioners, home health care providers, a banker, and the AIP’s relatives. (687) The AIP, although present, was unable to meaningfully participate. (*Id.*)

Testimony focused on the period between the death of the AIP’s husband – of nearly 60 years – and the commencement of the action during which, the AIP deteriorated physically and mentally and, according to petitioner’s witnesses, Mr. B. “began to engage in a course of conduct which isolated Ms. W. [AIP] from her friends, family and property.” (687-688) This conduct included disconnection of the AIP’s phone service, non-admittance of health care aides, cancellation of skilled nurse services, and attempts to gain financial control over the AIP, including the revocation of a previously executed power of attorney and the execution of new power of attorney in Mr. B.’s favor. (688)
The AIP was determined incapacitated and petitioners were appointed coguardians of the AIP’s person and property. (688-689)

Justice Prudenti reviewed cases in which AIPs were unable to participate in proceedings due to the severity of their incapacity and noted that, in such cases, “the advocacy approach to guardianship gives way to the traditional best interests approach. Such approach is deeply rooted in the parens patriae power of the State from which the court’s jurisdiction over incapacitated persons and their property is derived.” (690)

Justice Prudenti reviewed the provisions within article 81 that fostered the “best interests” approach to guardianship, including the court’s ability to “revoke any previously executed power, delegation, or any contract, conveyance or disposition if it appoints a guardian and finds that the individual was incapacitated when it was made (Mental Hygiene Law § 81.29 [d]).” (690-691)

Upon a reading of article 81 in its entirety, this court finds that it is an affirmative, positive statute, remedial in nature, the enactment of which was intended for the protection of persons under disability and the public at large. As such, it is entitled to a liberal construction by this court (McKinney’s Cons Laws of NY, Book 1, Statutes §§ 34, 35, 321, 323). (691)

Turning to whether or not to revoke and annul the marriage, Justice Prudenti provided that such relief could only be granted if:

(1) a marriage contract constitutes a contract within the meaning of Mental Hygiene Law § 81.29 (d); (2) by empowering the court to revoke any contract the Legislature intended to create a statutory right or action in favor of parties to an article 81 proceeding pursuant to which the court may annul a marriage; and (3) that the granting of such relief in the context of an article 81 special proceeding is not precluded by existing statutes or decisional law nor inconsistent with the requirements for the granting of existing remedies provided thereunder. (Id.)

After reviewing “precedents, current statutes . . . and upon a liberal reading” of MHL §81.29(d) and Domestic Relations Law §10, Justice Prudenti held that “a marriage constitutes a contract within the meaning of Mental Hygiene Law §81.29 (d)’ and therefore, “subject to revocation by the court on the grounds that a party thereto for whom a guardian has been appointed was incapacitated at the time it was contracted rendering such party incapable of consenting thereto by reason of want of understanding.” (693)

Justice Prudenti noted that the court, although authorized to revoke and annul the marriage, was “without any proof regarding the economic issues contemplated” by DRL §236 (B)(5) “and was thus precluded from issuing judgment as to party rights regarding marital property.” (695)
In *Matter of Kaminester v. Foldes*, 51 AD 3d 528 [1st Dept 2008], the Supreme Court “properly issued a declaratory finding . . . that the AIP lacked the capacity to enter into the marriage and engage in financial transactions.” (529) The court addressed the Supreme Court’s authority to revoke transactions pursuant to Mental Hygiene Law §81.29(d):

Where there is medical evidence of mental illness or defect, the burden shifts to the opposing party to prove by clear and convincing evidence that the person executing the document in question possessed the requisite mental capacity (*Matter of Rose S.*, 293 AD2d 619, 620 [2002]). Based on the medical reports and the hearing testimony, the IAS court properly found evidence of cognitive deficits, and respondent failed to rebut that finding with medical evidence of her own. Annulment of marriage is also an available remedy in an article 81 proceeding (*Matter of Joseph S.*, 25 AD3d 804, 806 [2006]; *Matter of Dot E.W.*, 172 Misc 2d 684, 693-694 [1997]). (Id.)

In *Matter of Schmeid*, 88 AD3d 803 [2d Dept 2011], decedent bequeathed his entire estate to his former nurse who was 43 years younger than decedent. (803) Decedent married his former nurse on March 28, 2003. (Id.) Prior to his death, an article 81 proceeding was commenced seeking the appointment of a property management and personal needs guardian for decedent. (Id.) In a judgment dated November 25, 2005, the petition was granted, the court determined decedent had been incapacitated since February 1, 2001, coguardians were appointed for decedent’s person and property, and the court directed the annulment of decedent’s marriage to the former nurse. (803-804) The court affirmed the incapacity determination and the annulment. (804) The court addressed EPTL §5-1.4 which was

enacted to prevent a testator’s inadvertent disposition to a former spouse where the parties’ marriage terminated by annulment or divorce and the former spouse is beneficiary in a testamentary instrument which the testator neglects to revoke (see Turano, 1999 Supp Practice Commentaries, McKinney's Cons Laws of NY, Book 17B, EPTL 5-1.4, 2011 Pocket Part, at 51-52; *Matter of Knospe*, 165 Misc 2d 45 [1995]).The statute creates a conclusive and unrebuttable presumption that any provisions in a will for the benefit of a former spouse are revoked by divorce or annulment (see *Matter of Knospe*, 165 Misc 2d at 50; Turano, 1999 Supp Practice Commentaries, McKinney's Cons Laws of NY, Book 17B, EPTL 5-1.4, 2011 Pocket Part, at 51-52). (Id.)

Since petitioner’s marriage to decedent was annulled, the bequest to her and her nomination as executor under decedent’s will were correctly revoked. (804)

In *K.A.L. v R.P.*, 35 Misc 3d 1211 [A], 2012 NY Slip Op 50625 [U] [Sup Ct, Monroe County 2012], plaintiff sought to annul defendant’s marriage to plaintiff’s deceased father. (*1) The surviving spouse, defendant, sought to dismiss on the grounds plaintiff lacked standing to annul
the marriage and failed to state a cause of action for “either physical or mental incapacity or fraud or duress to void the marriage under New York's Domestic Relations Law.” (Id.)

Decedent lived in Florida until May 2011 at which point he discovered he had stage-four lung cancer. (Id.) Decedent moved to Rochester, New York, to live with defendant until his death on September 13, 2011. (*1-2) On or around August 26, 2011, decedent was told he had two weeks to live, palliative hospice care was ordered, pain medication was tripled, and all other medication was ended. (*2) 13 days before decedent died, he married defendant and signed a codicil to his will. (Id.)

Plaintiff objected to the marriage claiming decedent was receiving substantial pain medication and did not recognize members of his family. (Id.) Decedent signed the will in front of three witnesses and decedent swore he was “acting freely and voluntarily and was of “sound mind” and “under no constraint or undue influence.” (*3)

All three witnesses to the codicil were present in the room in the defendant's house, presumably for some amount of time. The witnesses included decedent's son-in-law, the husband of the plaintiff. A second witness was a close friend of the decedents for 60 years. The witnesses signed an attestation clause in the codicil, affirming that to the best of their knowledge, the decedent was of sound mind and under no constraint or undue influence. The attorney notarized their signatures. (Id.)

Justice Dollinger found there to be “no dispute that the decedent was of sound mind and free from any constrain or undue influence at the time of the execution of the codicil – which, based on the undisputed facts, was all – but simultaneous with his marriage.” (Id.) Plaintiff and defendant disputed decedent’s mental status at the time of his marriage however, neither provided medical or expert testimony regarding decedent’s heath. (*4)

The wife argues that the presiding judge at the wedding and the attorney overseeing the codicil are, by their participation, evidence that the husband was competent to marry her, even though there is no sworn statement from either professional before the court. The daughter's counsel, at oral argument, informed the court that the daughter was not able to obtain medical records for her father because she lacked a medical release form under Health Insurance Portability and Accountability Act (“HIPPA”). The wife's counsel did not dispute that the records had not been made available to the daughter. (Id.)

Justice Dollinger addressed defendant’s claim that plaintiff lacked standing to bring the claim by addressing New York Domestic Relations Law (“DRL”) §140 (c) which allows an interested relative of a person who lacked capacity to enter into a marriage to bring an action to annul the marriage. (*5) There are three requirements under DRL §140(c), “the plaintiff must allege that her father was “mentally ill,” that she is a relative and she has an “interest to avoid the
Although, a “relative”, defendant failed to offer an express allegation the father was “mentally ill” and there was no competent evidence he was mentally ill on the day in question. (*6) Plaintiff failed to demonstrate her interest in the matter as there was “no allegation that her personal finances or any other matter will be impacted by granting the suggested relief.” (Id.)

Justice Dollinger noted that marriages that are invalid for reasons of incapacity and fraud “are voidable as of the time the nullity is declared by the court. NY DOM. REL. LAW. §7” however, there is no retroactive effect. (Id.)

Under New York’s Estate Powers & Trusts law, the wife is the surviving spouse unless a judgment of annulment is “in effect when the deceased spouse died.” NY E.P.TL. §5-1.2(a)(1). This court can not annul the marriage effective on the date of the husband’s death: at best, this court, under Section 140(c), can only annul the marriage effective only on the date that a judgment of annulment is entered with the court clerk. Bennett v Thomas, 38 AD2d 682 (4th Dept. 1971). Therefore this court can not nullify the decedent’s marriage to defeat the wife’s right of election as it exists under New York law. As one New York commentator noted:

Un fortunately, any efforts by a relative of friend to annul a voidable marriage may be futile because voidable marriages are valid unless and until they are attacked in an annulment proceeding. New York is one of the few states where after-death challenges are permitted, yet this status change has no effect on the property rights to the decedent’s estate because of the specific requirement within the disqualification statute that an annulment or declaration that the marriage was a nullity must have been in effect when the deceased died. A voidable marriage may be annulled after death, but the “surviving spouse” would still be able to take an elective share of the decedent’s estate. Ratigan, The Right of Election and Fraudulent Marriages in New York, LEXIS 2011 (*6-7)

Justice Dollinger addressed whether plaintiff had a cause of action under §81.29(d). (*7) However, the statute requires the appointment of a guardian which did not occur here. (Id.) Further, in order for the marriage to be annulled pursuant to MHL, the incapacity must be “so marked as to show an inability to comprehend the subject of the marriage contract” or “a diagnosis after the wedding that a spouse was incompetent before the wedding, although having some weight, is not conclusive on the issue of the sanity of the allegedly mentally incapable spouse on the wedding day.” Scampone v. Scampone, NYLJ, July 28, 1992, p.25 (Sup. Ct. Westchester County 1992), citing Wilson v Mitchell, 10 Misc 2d
The aforementioned cases differed in that there was no suggestion decedent was insane or mentally incapable. \((Id.)\) Justice Dollinger cited \textit{In re Berk}, 71 AD3d 883 [2d Dept 2010] in which the doctrine of equitable estoppel was invoked “to void a marriage ab initio and defeat a much younger spouse’s right to an elective share. \textit{In re Berk}, 71 AD3d 883 (2nd Dept. 2010); \textit{Matter of Atriam}, 83 AD3d 1055 (2nd Dept. 2011). \((Id.)\) Justice Dollinger declined to follow \textit{In re Berk} noting that in that case, the wife “knowing that a mentally incapacitated person [was] incapable of consenting to a marriage, deliberately [took] unfair advantage of the incapacity by marrying that person for the purpose of obtaining pecuniary benefits that become available by virtue of being that person’s spouse, at the expense of that person’s intended beneficiaries.” \((Id.)\)

The complaint failed to state a cause of action to annul the marriage. \((*10)\)

In \textit{Matter of Doar (L.S.)}, 39 Misc 3d 1242 [A], 2013 NY Slip Op 50988 [U] [Sup Ct, Kings County 2013], Justice Barros highlighted the all too common scenario of an elderly individual falling victim not only to the ravages of dementia but to the clutches of a manipulative and dishonest individual:

\begin{quote}
This guardianship case highlights the predation and exploitation that face the aged and incapacitated. In the case at bar, the predator, through seduction and feigned concern for him gained the incapacitated person’s total co-operation in her scheme to convert of all his assets to herself. His doctors at the VA hospital, suspicious of his recent marriage and aware of his dementia failed to report their concerns, his banking institutions failed to act in a timely manner so as to thwart her scheme, and his appointed agent failed to intercede effectively. Law enforcement has done nothing to protect the incapacitated person or to restore his funds. The only shelter afforded this victim came in the context of this civil proceeding, an intervention that unfortunately came much too late. \((*1)\)
\end{quote}

Petitioner, Adult Protective Services (“APS”), commenced an article 81 proceeding for the appointment of a guardian for respondent, an alleged incapacitated person (“AIP”). \((*2)\) APS was prompted to file following allegations of financial exploitation of the AIP by his wife, the AIP’s former aide (hereinafter “cross-petitioner”). \((Id.)\)

During the AIP’s hospitalization in a VA facility, he met cross-petitioner and, upon his discharge in 2008, at a time when the AIP was becoming increasingly cognitively impaired, cross-petitioner became his part-time home attendant. \((*4-5)\) Cross-petitioner informed Brian, the AIP’s friend and attorney-in-fact that she was looking after the AIP’s finances and that Brian was no longer needed. \((*5)\) Cross-petitioner took the following actions:
In November 2009, cross-petitioner became the POD designee on the AIP’s accounts;

In October 2010, without Brian’s knowledge, the AIP revoked the prior power of attorney and appointed cross petitioner as his attorney-in-fact pursuant to a new power of attorney; and

In April 2010, cross petitioner and the AIP married. (*Id.)

During cross-petitioner’s testimony, she failed to explain “why she and the AIP had drained the accounts, nor of how the money was spent . . . how she would provide for her husband now that he was destitute” and admitted she had given no thought to the AIP’s tax filings. (*5-6)

Dr. Speken, an expert in adult psychiatry and an APS employee, testified as to his findings following an interview with the AIP and a review of the AIP’s medical records:

Dr. Speken found the AIP’s short term and long term memory significantly impaired, as evidenced by the AIP's inability to recall fundamental milestones in his life . . . Dr. Speken also diagnosed the AIP as delusional . . . Dr. Speken further pointed out that during the interview, the AIP engaged in “Witzelsucht” - inappropriate humor to cover up memory failure - a behavior characteristic of individuals with frontal lobe disease.

Overall, Dr. Speken found the AIP's memory, judgment, and insight impaired and rendered a diagnosis of rapidly advancing Alzheimer's disease. He determined the onset of the disease to have occurred back in 2009. . . . Dr. Speken's findings were supported by a neuropsychological assessment made nearly one year prior to his own evaluation, which found the AIP's executive functioning ”globally impaired “ and his ability to verbalize, recall, and recognize severely impaired. Both evaluations reveal that the AIP's compromised mental state existed for a number of years prior to this proceeding.

Dr. Speken found the AIP vulnerable and susceptible to exploitation and easily influenced due to his dementia and opinioned that the AIP did not possess the requisite mental capacity to consent to marriage at the time the marriage purportedly occurred . . . In sum, Dr. Speken concluded that the AIP is incapable of making an informed judgment on how to handle his estate, whom to trust and whom to marry. (*7)

According to the court evaluator, the AIP’s entire estate of between $350,000 and $450,000 was gone. (*Id.) The extent of cross-petitioner’s “withdrawals grew commensurate with the degree of the AIP’s dementia” and “after the marriage she took the remainder of the AIP’s life savings, leaving him pauperized and with credit card debt.” (*8) Justice Barros found cross-petitioner to
be “disingenuous, manipulative and neglectful as a spouse and care-taker” and gave her testimony no credit. (*9)

The court evaluator’s investigation revealed that Brian had reported cross-petitioner’s financial exploitation to the District Attorney’s (“DA”) office and an investigation was initiated. (*8) However, the investigation was ended once the cross-petitioner and the AIP married. (*Id.)

Justice Barros found the AIP to be incapacitated and that “through a steady course of seduction and isolation, and veiled in the cloak of marriage”, cross-petitioner exploited the AIP “with impunity.” (*9) As a result, “the AIP in all likelihood, can no longer be safely maintained in the community as he had once envisioned.” (Id.) Justice Barros noted that “although the relief sought in this Article 81 petition does not include dissolution of this marriage, the facts elicited at trial support an application for such relief.” (*7 n15)

Justice Barros addressed the prevalence of elder abuse:

Efforts to redress elder abuse are still in their infancy. However, similar challenges have been met and tremendous strides made in “difficult to prosecute” cases such as domestic violence, child abuse and sexual offenses. If our community is serious about protecting its most vulnerable adults, new initiatives and coordinated strategies must likewise be developed and implemented. (*10)

A protocol requiring financial institutions, health care providers, licensed home care providers, banks, hospitals, doctors, and designated agents to report suspected abuse to Adult Protective Services and to law enforcement should be implemented. For example, such as mandatory reporting of suspected financial elder abuse, banking alert systems, adequately staffed and trained police units to investigate elder abuse and new prosecutorial approaches including special laws with enhanced penalties for the exploitation and endangerment of the impaired, would foster greater protection of vulnerable seniors. (Id. n22)

Non-Article 81 Cases (no summaries provided)

*Matter of Berk, 71 AD3d 883 [2d Dept 2010]; Campbell v Thomas, 73 AD3d 103 [2d Dept 2010]*

Capacity to Commence/Appear in a Lawsuit, Stipulate & Retain Counsel

In *Matter of Huber v Mones*, 235 AD2d 421 [2d Dept 1997], the court rejected appellants’ contention that “petitioner lacked the requisite mental capacity to commence this special proceeding against them”. (421) “A person of unsound mind but not judicially declared incompetent may sue or be sued in the same manner as any ordinary member of the community
(Sengstack v Sengstack, 4 NY2d 502; Pisecki v Rashib, 203 AD2d 443).” (422) The fact that after petitioner commenced the action there was a determination that petitioner was in need of the appointment of a special guardian to manage her property “did not prohibit the Surrogate from concluding that the petitioner had the mental capacity to bring this proceeding.” (Id.)

In Matter of Bernice B., 176 Misc 2d 550 [Sur Ct, NY County 1998], the issue before the court was whether a party (“KB”) in a probate proceeding for whom a guardian ad litem (“GAL”) had been appointed, can be bound by the GAL’s consent to settlement over her objections. (551) KB was not “incapacitated” pursuant to Mental Hygiene Law (“MHL”) article 81. (Id.) The court described the situation as one involving “the appearance of a party who seems to function on her own, but who is nonetheless as a practical matter so mentally or emotionally disabled as to be a hazard to her own interests in the litigation, and those of the other parties, as well as to the orderly administration of the court.” (Id.)

During the probate proceeding, KB’s sister petitioned for the appointment of a personal needs and property management guardian pursuant to MHL article 81. (552) The court evaluator recommended the appointment of a GAL in the probate proceeding to “minimize KB’s disruptions to the proceeding and to help restrain KB from triggering the in terrorem clause.” (Id.) Shortly thereafter, the will proponents formally moved for the appointment of a GAL. (Id.) KB was determined to be an ‘incapacitated person’ pursuant to Surrogate’s Court Procedure Act (“SCPA”) 103(25) (Id.) The court evaluator in the guardianship proceeding was appointed as KB’s GAL. (Id.) Following an SCPA 1404 examination, the GAL negotiated a settlement which provided that the will was to be modified to give KB the trust income. (553) However,

KB protested the GAL’s proposed settlement and . . . tried to file objections to probate. Her failure to do so is the result of this court’s order dated June 17, 1997, designed to control the flood of frivolous, threatening submissions by KB, which directs court personnel to refuse to accept any filing from KB unless joined in by her GAL. If KB files objections to probate and loses the will contest (which is likely), the in terrorem clause would be triggered, resulting in her disinheritation. (Id.)

The question before the court was whether the court may authorize the GAL to enter into the proposed settlement on KB’s behalf over KB’s objection and without an adjudication of incapacity pursuant to MHL article 81. (Id.) The “GAL cannot bind her adult ward to a settlement of which the ward disapproves unless the ward’s incapacity to participate in the litigation (or in its settlement) has been established under the special procedural safeguards afforded by the Mental Hygiene Law.” (Id.) The court considered SCPA 401:

the sense of the statute would seem to remain clear: any adult party has the right to participate in a court proceeding unless and until she has been adjudicated to be mentally unfit to do so under procedures specially designed to determine the issue of such fitness. (554)
Further, courts have recognized that both the GAL and the ward can appear concurrently and are not mutually exclusive:

On the one hand, the GAL's appearance is designed to serve as a safety net for such a ward in the proceedings (Matter of Palestine, 151 Misc 100, 104; Wurster v Armfield, 175 N.Y. 256, 261). On the other hand, the GAL's role — to identify and promote her ward's "best interests" — may fall short of advancing the ward's personal views in the litigation (Matter of Aho, supra). (Id.)

The finding of incapacity made in this case was “not the equivalent of the adjudicative process that the law requires in order to deny a party such as KB an element of her constitutional right to appear, namely, her right to exercise a veto over a settlement that would be binding on her.” (Id.) The court directed the parties to appear at a later date for a trial on the issue of KB’s need for a guardian pursuant to MHL article 81. (Id.)

In Parras v Ricciardi, 185 Misc 2d 209 [Civ Ct, Kings County 2000], the tenant was 90 years old, mentally incompetent, and resided in a nursing home. (212) Although the landlord was aware his tenant resided in a nursing home, the landlord’s counsel sought “a judgment and warrant upon the tenant’s default in responding to “nail and mail” service at the tenant’s apartment.” No attempt had been made to serve the tenant at the nursing home, as required by RPAPL 735. (Id.)

The court holds herein that RPAPL 735 (1) (a) also by extension requires that a default may not be entered against a tenant when the tenant is not served at his or her other residence address even where the petitioner does not learn of the other residence until the investigator discovers the tenant's whereabouts in connection with preparing the affidavit of investigation. In no other way can we avoid accidentally evicting people who are temporarily in a hospital, convalescent home or nursing home, or temporarily living with a relative or friend in order to recuperate from an illness. (212-213) (Id.)

Further, when a landlord is aware of a tenant’s mental incompetence “even service at the nursing home would not be sufficient to obtain a judgment and warrant on the respondent’s default.” (213)

It is the petitioner's obligation to bring the respondent's possible mental incompetency to the court's attention, to permit the court to determine whether a guardian ad litem should be appointed to protect such respondent's interests. Failure to do so will result in a default judgment that will be set aside, even after, for example, a foreclosure and subsequent sale to a third party. (Oneida Natl. Bank & Trust Co. v Unczur, 37 AD2d 480 [4th Dept 1971].) (Id.)
Justice Silber addresses the public policy objectives undertaken to ensure the “rigorous protection of the rights of the mentally infirm.” (215-216)

In Scherer, Residential Landlord-Tenant Law in New York § 7:116 the authors make it crystal clear that “[i]f an attorney representing a landlord has reason to believe that the respondent is in need of a guardian ad litem, the attorney has an obligation to bring that fact to the court’s attention, so that the court can make a suitable inquiry into whether appointment of a guardian is necessary. [Citations omitted.] This is especially important in cases in which the tenant defaults.” (216)

Justice Silber offered guidance as to the actions the landlord could have taken:

The landlord's attorneys could have contacted the tenant's attorney, whose name they had notice of, or contacted the nursing home to see if they would bring a guardianship proceeding under article 81 of the Mental Hygiene Law (a common practice), or whether the tenant has assets that could pay the rent arrears, if someone has power of attorney for the tenant and could pay her rent, whether she has a chance of returning home or is too ill, and whether she has any known relatives who could move her possessions if she does not intend to return to the apartment. But, the reality is that the landlord's attorneys were not obligated to do any of these things. They were obligated, however, to serve the tenant at the nursing home. (217)

In *Cheney v. Wells*, 23 Misc 3d 161 [Sur Ct, NY County 2008], Surrogate Glen addressed the court’s and counsel’s obligations when a defendant in a civil matter appears to lack capacity to participate in their own defense. (162) Defendant’s counsel (“movant”) sought to withdraw. (Id.)

The instant action was brought by defendant’s now deceased mother against defendant on 11 separate causes of action. (Id.) The case was transferred to Surrogate’s Court as it had jurisdiction over the pending contested probate proceeding involving defendant’s challenge to the validity of her mother’s will. (163)

Defendant had been represented by four separate sets of counsel. (Id.) Surrogate Glen observed defendant and found her to be “incapable of managing the instant litigation . . . [and] unable to appreciate the consequences of that incapacity.” (166) According to Surrogate Glen, defendant’s situation was “precisely the situation” addressed by article 81. (Id.)

Article 81 begins with the presumption that every adult is fully capacitated, and then permits appointment of a guardian only for those areas in which a person "is likely to suffer harm because" she "is unable to provide for personal needs and/or property
management; and ... the person cannot adequately understand and appreciate the nature and consequences of such inability” (Mental Hygiene Law § 81.02 [b] [1], [2]). Article 81 guardianships are intended to be "closely tailored" to an individual's incapacity, and to replace her autonomy only to the extent necessary to protect her from harm with regard to such incapacity. (166-167)

An article 81 proceeding was commenced with defendant’s consent. (167) The question before the court was who should commence the proceeding and “whether counsel may or should commence a guardianship proceeding for an allegedly incapacitated client.” (Id.)

Since defendant was unable to act in her own interest and there was “no other practical method available to protect her interest” (See Restatement § 24, Comment e.) the attorney, Kupferman, was permitted to commence an article 81 proceeding to “appoint a limited guardian to litigate and defend the instant action.” (171) After reviewing the then proposed rule 1.14 of the Code of Professional Responsibility, Surrogate Glen found there to be no ethical impediment to Kupferman bringing a limited guardianship proceeding for the defendant. (172)

In 400 W.59th St. Partners, LLC v Edwards, 28 Misc 3d 93 [1st Dept 2010], the landlord commenced a nuisance holdover proceeding against the tenant which was resolved pursuant to a stipulation entered into between the landlord’s attorney, tenant’s attorney, and the tenant herself. (94) Less than a year after the stipulation was executed, the landlord claimed the tenant breached the stipulation and moved to restore the nuisance holdover proceeding. (Id.) The tenant cross-moved to vacate the stipulation on the ground “she lacked the mental capacity to enter into a binding contract.” (Id.) The court affirmed the Civil Court’s denial of tenant’s cross motion:

Tenant failed to carry her burden of proving that she lacked the mental capacity to enter into the stipulation (see generally Weissman v Weissman, 42 AD3d 448 [2007]). As Civil Court aptly noted, tenant's papers in support of her cross motion contained neither competent medical evidence supporting tenant's claim nor an affidavit from tenant herself. Moreover, the hearsay affirmation of tenant's counsel did not provide competent evidence of tenant's incapacity claim (see generally Mohrmann v Lynch-Mohrmann, 24 AD3d 735 [2005]; Torsiello v Torsiello, 188 AD2d 523 [1992]). (95)

The fact that a Mental Hygiene Law article 81 guardian was appointed for the tenant six months after the stipulation was executed “did not, standing alone, raise a triable issue as to tenant's mental capacity at the time the parties entered into the stipulation.” (Id.)

Matter of Willner (F.G.), 45 Misc 3d 1222 [A], 2014 NY Slip Op 51675 [U] [Sup Ct, Bronx County 2014] (See case summary on page 51.)

In Matter of Caryl S.S (Valerie L.S.), 45 Misc 3d 1223[A], 2014 NY Slip Op 51697 [U] [Sup Ct, Bronx County 2014], the alleged incapacitated person’s (“AIP”) daughter, petitioner herein,
sought the appointment of a personal needs and property management guardian for the AIP. (*1) The AIP suffered a stroke in January 2014 after which petitioner alleged Williams, the AIP’s son (hereinafter “Williams”), made questionable transfers of the AIP’s property. (Id.)

The AIP retained counsel, Coyle, who informed the court that she would be moving to dismiss the petition and requested an adjournment. (Id.) Coyle was advised that the matter would not be adjourned, that the AIP should appear on the hearing date, and that she should make her motion to dismiss by Order to Show Cause returnable on the return date of the petition. (Id.) Said Order to Show Cause was supported by an affidavit of the AIP dated November 19, 2014. (Id.)

The AIP’s affidavit contained a detailed recitation of the first meeting between the AIP and Coyle, “that the AIP did not want a guardian appointed, and that she was happy with the care provided by her son, in whose favor she had executed both a health care proxy and a power of attorney.” (Id.) Further, the court should disqualify petitioner’s counsel due to the fact she had represented the AIP in the transfer of the AIP’s home to petitioner as joint tenant, a later deed which transferred the AIP’s remaining interest in the home to the petitioner with a life estate to the AIP, and also prepared a will for the AIP. (Id.)

Justice Aarons disqualified petitioner’s counsel due to her inherent conflict of interest. (*2) Justice Aarons conducted a home visit of the AIP to “ascertain her status and condition” and to “determine if in fact the AIP had retained Ms. Coyle as her counsel.” (Id.) The proceeding was re-convened at the AIP’s home with all parties present. (Id.)

Justice Aarons asked the AIP a number of questions, including whether or not anyone had talked to her about the proceeding. (Id.) In her written opinion, Justice Aarons reported her conclusions:

. . . it became clear at the commencement of the hearing that the AIP had no recollection of discussing the filing of the facts of the present case with her retained counsel. Further inquiry by the Court immediately established, from the commencement of the hearing, that the AIP had very little comprehension that she had retained counsel. (Id.)

The AIP testified, and it is undisputed, that she had no prior relationship with Ms. Coyle in any way. . . She clearly did not recall discussing the case with her attorney, other than it was her son who had brought her. (*3)

Further inquiry demonstrated that the AIP did not recall any of the alleged conversations with Ms. Coyle which preceded the Court’s inquiry. (Id.)

The AIP also did not understand the nature and object of the present proceeding: (Id.)
The AIP had no recollection of signing the affidavit, even though it was executed only two days previously. (*4)

The AIP gave compelling testimony as to the influence of her son on her decision-making process. (Id.)

The AIP confirmed her desire to continue to have Coyle represent her. (Id.) Coyle confirmed on the record that the AIP’s son contacted her regarding representation of his mother. (Id.) She stated that she asked questions listed in the affidavit to establish the AIP’s state of mind and “that she was clear-headed at the time.” (Id.) Coyle claimed she was surprised at the AIP’s confusion. (Id.) However, “she insisted that it was not unusual for relatives to secure counsel for the AIP, and that the AIP was “competent” and “had capacity” when she retained her.” (Id.)

Justice Aarons referenced MHL §81.10 (a):

“Any person for whom relief under this article is sought shall have the right to choose and engage legal counsel of the person’s chose. In such event, any attorney appointed pursuant to this section shall continue his or her duties until the court has determined that retained counsel has been chosen freely and independently by the alleged incapacitated person.” (Id.)

Given the nature of the proceedings, Justice Aarons believed the court was “constrained to ascertain if, indeed, Ms. Coyle should represent the AIP” particularly in light of the fact the litigants anticipated the proceeding to proceed in the AIP’s absence. (*5)

The AIP clearly, based on her statements and the observations of the Court, did not retain Ms. Coyle. Her confusion at the hearing was manifest . . . her short and long-term memory loss; her lack of comprehension as to the purpose of the present proceeding and the role of her counsel; and her inability to recall her prior counsel, the name of her present counsel, or the events in this litigation which occurred only days earlier. (Id.)

Justice Aarons expressed her concern at the fact Coyle had been “brought into the case by the AIP’s son, who is alleged to have exerted undue and improper influence over the AIP” and that “[w]hile it may not be unusual for an attorney to be contacted or selected by a relative, it is unusual when that relative is a person charged with exerting undue influence, and with using his agency powers improperly for his own gain.” (Id.) The AIP’s “memory deficits” and “evident confusion” support the conclusion that she “did not act freely and independently, but merely acquiesced in the selection of counsel made by her son”. (Id.)

The Court made clear during this hearing that the present inquiry does not involve any criticism of the conduct, ability, or integrity of Ms. Coyle. . . . However, the unusual events which transpired, involving the son’s refusal to allow the Court Evaluator to speak
with the AIP, combined with the failure to bring the AIP to Court despite a clear direction to do so, certainly warranted that the Court undertake immediate action to determine the relevant facts and circumstances of the AIP’s situation. (Id.)

Coyle was removed as the AIP’s counsel and the court appointed counsel for the AIP. (Id.)

Medical Decisions

In Matter of B., 190 Misc 2d 581 [County Ct, Tompkins County 2002], a petition was filed seeking to modify the court’s order appointing a personal needs and property management guardian for B which specified that “no decision shall be made with respect to the permanent sterilization of said B, by tubal ligation or otherwise, nor shall any such permanent sterilization be carried out, without further order of this Court, after hearing and appointment of a law guardian for said B.” (582)

The instant petition sought to grant B permission to undergo tubal ligation. (Id.) Counsel was appointed for B, MHLS was appointed court evaluator, and an independent psychological examination of B was ordered “to determine her capacity to give informed consent to the proposed procedure.” (Id.) B performed most activities of daily living but did not control her medications and finances. (Id.)

B testified that she was sexually active and that she wanted to undergo the procedure because she did not want to have a baby and testified as to the reasons why. (Id.) B’s gynecologist’s testimony revealed that although B was capable of having a baby, there was a 50% chance B’s child would be born disabled due to B’s chromosome problems.” (Id.)

Justice Peckham addressed whether B had the capacity to decide whether or not to undergo the tubal ligation. (Id.) According to testimony from B’s gynecologist, psychiatric social worker and her mother, B understood the significance of the procedure and was capable of consenting to it. (583) The independent psychologist appointed by the court was the only witness who testified to the effect that B was not competent to make a decision regarding tubal ligation. (Id.)

Justice Peckham addressed whether the court could “authorize B’s mother as her article 81 guardian to consent to the tubal ligation on behalf of her daughter.” (Id.) Both the case law and Mental Hygiene Law (“MHL”) §81.22(a) authorized B’s mother, as B’s guardian, to consent to the procedure. (583-584)

The court applied the standards set forth in Matter of Nilsson, 122 Misc 2d 458 [Sup Ct, Livingston County 1983], and determined it was in B’s best interests to authorize the tubal ligation procedure. (585) MHL §81.22 authorizes a guardian to “consent to or refuse generally accepted routine or major medical . . . treatment” and that the decision shall be made “in accordance with the patient’s wishes.” (583-584)

B had “sufficient capacity to give informed consent” to the procedure. (587) Further, if B was unable to provide informed consent, it was in B’s best interests to authorize the procedure. (Id.)
If any medical provider or insurance provider required it, the court authorized B’s mother, as B’s guardian, to consent to the tubal ligation of her daughter pursuant to MHL article 81. (Id.)

In Matter of Rhodanna C.B. (Pamela B.), 36 AD3d 106 [2d Dept 2006], in reversing the Supreme Court’s decision, the court held that a personal needs guardian appointed pursuant to Mental Hygiene Law (“MHL”) article 81 should not be granted the authority “to consent in perpetuity to the administration of psychotropic medication to their ward, over her objection and without any further judicial review of approval.” (107) Such authority is “inconsistent with the due process requirements of Rivers v Katz (67 NY2d 485 [1986]). (Id.)

No medical testimony or expert evidence was provided during the brief hearing before the Supreme Court rendered a judgment which, inter alia, authorized the guardians “to consent to the administration of psychotropic drugs or electroconvulsive therapy” to the alleged incapacitated person (“AIP”) over the AIP’s objections “without any durational limitation on that authority or judicial review” of the AIP’s capacity or the “propriety and necessity of the proposed medical treatment.” (Id.)

The court reviewed Rivers v Katz before it noted that pursuant to MHL § 81.22(a) (8), a court can authorize a personal needs guardian to “consent to or refuse generally accepted routine or major medical or dental treatment” which, the court acknowledged, “by definition includes “the administration of psychotropic medication or electroconvulsive therapy” (Mental Hygiene Law § 81.03[i])” (108-109) However,

since such an approach does not provide for an automatic judicial reassessment of the mental capacity of an incapacitated person who objects to treatment at the time the treatment is proposed, and does not require that any judicial assessment of the necessity and propriety of the proposed treatment ever be conducted, the grant of this authority fails to comport with the multiple-step inquiry designed to safeguard the rights of the incapacitated person as set forth in Rivers v Katz. (109)

The court reviewed the procedures set forth in MHL article 81 and agreed with the Supreme Court that when an individual petitions for the appointment of a personal needs guardian for an AIP, the court “conducts a constitutionally adequate inquiry into the mental capacity of the person when it follows the procedures set forth in the article.” (Id.)

under Mental Hygiene Law § 81.02 (b), a finding of incapacity must be based on clear and convincing evidence that the person is unable to provide for his or her own personal needs and cannot adequately understand and appreciate the nature and consequences of such inability. (Id.)

The court analyzed article 81 safeguards, including the appointment of a court evaluator, the AIP’s right to counsel, the requirement that the court hold a hearing, and the requirement that the court make specific findings on the record, before it concluded that the “initial determination as
to capacity in a Mental Hygiene Law article 81 proceeding comports with the due process requirements set forth in Rivers v Katz.” (109-110)

However, the court was wary of the indefinite nature of the authority granted to the guardian. (110) It considered such authority contrary to Rivers v Katz, specifically, the component of the Rivers decision that “mandates that a new determination as to capacity be made each time that a medical provider seeks to administer a new treatment to an objecting patient.” (Id.)

To hold, as the Supreme Court did, that the single determination of lack of capacity made in this Mental Hygiene Law article 81 guardianship proceeding may forever after deprive Rhodanna of an automatic judicial reassessment of her capacity in the event that such extraordinary medical therapies are proposed against her will in the distant future, affords her far less due process protection than an involuntarily-committed patient who has no guardian at all. (111)

The court found “little solace” in either MHL §§81.30, 81.31, and 81.36 (a)(1) or in Matter of Conticchio, 182 Misc 2d 205 [Sup Ct, Nassau County 1999]. (Id.)

While Mental Hygiene Law §§81.30, 81.31 provide for the filing of periodic reports with the court regarding the condition of the incapacitated person and the management of her property, there is nothing in those statutes, or in the judgment appealed from, mandating an assessment of the person’s current or prospective ability to consent to the narrow categories of extraordinary medical intervention under discussion here at the time they are proposed. (Id.)

The court addressed MHL §81.36 (b) which permits “a guardian, the incapacitated person, “or any person entitled to commence a proceeding under this article” to apply to the court to “discharge a guardian or modify his or her powers” if it can be shown that “the incapacitated person has become able to exercise some or all of the powers necessary to provide for personal needs . . . which the guardian is authorized to exercise.” (Id.) The burden of proof is on the “person objecting to such relief” (Mental Hygiene Law § 81.36[d]). (Id.)

MHL §81.36 failed to “provide a constitutionally satisfactory substitute for the procedures outlined in Rivers v Katz . . . for ensuring the timely judicial review of the incapacitated person's ability to make her own decisions regarding treatment with psychotropic drugs or electroconvulsive therapy.” (112) Contrary to the Supreme Court’s reasoning in Matter of Conticchio, the court found it unlikely that a guardian would seek to limit his/her powers and believed it “unrealistic” to expect an incapacitated person “to be aware of an exercise this right, especially when she is mentally ill, is not represented by counsel, and may already be laboring under the effects of drug therapy.” (Id.)
The court considered the second requirement established in *Rivers v Katz*, namely, that a court must “ascertain whether the proposed treatment is narrowly tailored to recognize the liberty interest of the patient, taking into account the patient’s best interests, the potential benefits and adverse side effects associated with it, and any less intrusive alternative regimens.” (*Id.* The court found this inquiry to be “glaringly absent from Mental Hygiene Law article 81 and from the judgment in this case.” (*Id.*) Although an appointing court must consider:

the dignity and uniqueness of every person, the possibility and extent of preserving the person’s life, the preservation, improvement or restoration of the person's health or functioning, the relief of the person's suffering, the adverse side effects associated with the treatment, any less intrusive alternative treatments, and such other concerns and values as a reasonable person in the incapacitated person's circumstances would wish to consider” (Mental Hygiene Law § 81.22 [a] [8]),

the statute “permits the guardian to consent to such therapy without the court ever conducting any inquiry into the nature, efficacy, or necessity of the treatment.” (113)

The decision addressed Justice Luciano’s dissenting opinion which relied upon *Matter of Conticchio*, specifically, that “when a guardian has been appointed for an incapacitated person, the guardian rather than the court may apply the requisite factors and make such treatment decisions.” (114) The majority disagreed and expressed concern that “a genuine danger exists that the guardian will merely “rubber stamp” the treatment recommendation.” (*Id.*) Further,

when a court [and not a guardian] is the arbiter of the propriety of the proposed treatment, the issues are fully explored in the context of an adversarial proceeding in which the parties are represented by counsel, medical evidence and other proof may be presented on both sides of the issue, witnesses may be subjected to the crucible of cross-examination, the court may appoint independent and disinterested experts to aid it in evaluating the incapacitated person's true condition and the overall efficacy of the proposed treatment, and the propriety of the treatment must be demonstrated by clear and convincing evidence (see *Matter of Paris M. v Creedmoor Psychiatric Ctr.*, 30 AD3d 425 [2006]; *Matter of Mausner v William E.*, 264 AD2d 485 [1999]). Similarly, the court acts as an impartial decision maker, unfettered by the personal interests and concerns which could influence the treatment decision made by a guardian. (114-115)

The court concluded, “a guardian is not an adequate substitute for a court in making such decisions.” (115) The court ordered that the judgment be reversed and a provision added “directing the petitioners not to authorize the administration of psychotropic medication or electroconvulsive therapy to Rhodanna C.B. without her consent or a further order of the court following a hearing.” (120)
Other

In *Matter of Penson*, 289 AD2d 155 [1st Dept 2001], the Supreme Court restored respondent to capacity status. The record established that respondent lived independently with his wife in Florida, understood his limitations, and sought the advice and assistance from an attorney and financial professionals about securing a plan for his future. (*Id.*) Respondent was now given “a degree of self-determination and participation in the decisions affecting his life.” (*Id.*) The interim guardian supported discharge, the respondent was questioned by the court under oath, appellants were given, but refused, the opportunity to ask respondent questions and appellants were given the opportunity to express their views. (*Id.*) The court ruled that the Supreme Court hearing met the minimum threshold vis-à-vis the hearing requirement (Mental Hygiene Law 81.36(c)). (*Id.*) The court then addressed the level of medical testimony provided at the hearing:

Further detail about respondent’s limitations that medical testimony might have provided could not have altered the basic finding that respondent is no longer incapacitated and is able to manage his financial affairs under the plan he proposed (*see*, Mental Hygiene Law § 81.01) (155-156)

Articles & Resources

Articles

Testamentary Capacity


Driving


Voting


**Miscellaneous**


**Resources**

DMV's Driver Re-evaluation Program, Department of Motor Vehicles  
[http://dmv.ny.gov/org/driver-license/dmv-driver-re-evaluation](http://dmv.ny.gov/org/driver-license/dmv-driver-re-evaluation)

“Request for Driver Review” form (DS-7)  

AARP’s Driving Resource Center  

New York State Office for the Aging  
[www.aging.ny.gov/ReportsandData/Index.cfm](http://www.aging.ny.gov/ReportsandData/Index.cfm)

Medical Terminology  
[www.medterms.com](http://www.medterms.com)

Alzheimer’s Association  
[www.alz.org](http://www.alz.org)
VI. The Positive and Negative Implications of the Significant Use of and Reliance on Prescription Medication and Over-the-Counter Drugs by Older Persons

Prescription and over-the-counter medications may help treat or even cure various medical diseases/conditions, but may also cause, exacerbate, or irritate an existing or dormant disease or illness, including conditions that cause diminished mental capacity. Research and anecdotal evidence demonstrate that older persons may experience adverse reactions to certain types of medications as well as from ingesting contraindicated medications.\(^{91}\) Contraindication is a specific situation in which a drug, procedure, or surgery should not be used because it may harm the patient.\(^{92}\)

Moreover, individuals who experience mild to extreme memory loss often fail to take their medication as prescribed.\(^{93}\) They may also take the incorrect dosage, ingest medication that has expired, or fail to refill prescriptions because they are costly.\(^{94}\)

Medication errors, or adverse drug events, may result in serious medical conditions, including diminished mental capacity. The impact may be minor and temporary or very serious with long-term or deadly implications.\(^{95}\) According to the Centers for Disease Control and Prevention, each year adverse drug events cause over 700,000 emergency room visits.\(^{96}\)

When confronted with an individual who appears to have cognitive deficits, especially individuals without a history of diminished mental capacity, it may be appropriate for counsel to inquire about an individual’s medication regimen and history. With the help of a knowledgeable physician, pharmacist, or other healthcare professional, a simple check of dosage and/or medication may reveal that an individual’s sudden onset of diminished mental capacity may be drug related.

Moreover, patients in hospitals, nursing homes, and other inpatient settings exhibiting signs of diminished mental capacity, psychiatric illness and/or behavioral issues may be at risk for adverse drug events upon the administration of medication.

Lawyers and other professionals must be aware of and sensitive to the impact drugs can have.


\(^{92}\) Id.


Questions & Answers

1. Do older persons generally take more prescription drugs than younger people?

As people age, it is more likely that they will be prescribed more medications. Adults 65 years of age and older are twice as likely as others to visit emergency departments for adverse drug events (over 177,000 emergency visits each year) and are nearly seven times more likely to require hospitalization following the emergency room visit.

2. What do guardianships judges and attorneys need to understand about drugs that are contra-indicated?

When confronted with an individual who appears to have cognitive deficits, especially individuals without a history of diminished mental capacity, counsel may wish to inquire about the individual’s medication regimen and history.

Research and anecdotal evidence demonstrate that older persons may experience adverse reactions to certain types of medications as well as from ingesting contraindicated medications. A contraindication is where a drug, procedure, or surgery should not be used because it may harm the patient. Medication errors, also known as adverse drug events, may also result in serious medical conditions, including DMC. The impact may be minor and temporary or very serious with long-term or deadly implications. According to the Centers for Disease Control and Prevention, each year adverse drug events cause over 700,000 emergency room visits.

3. How do older persons generally pay for their prescription medications?

Older persons generally pay for their prescription medications through Medicare, specifically Part D. Medicare offers prescription drug coverage to everyone with Medicare. For more information on Medicare Part D, please visit the Medicare.gov website at https://www.medicare.gov/part-d/index.html

4. What percentages of nursing home residents are prescribed psychotropic medications?

Approximately 40% of nursing home residents who suffer from some type of dementia, for example, are administered psychotropic medications. Notwithstanding the fact that

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97 Id.
98 Id.
102 “Twenty-six percent of all nursing home residents are on antipsychotic medications. Use is substantially higher (40 percent) among those with cognitive impairments and behavioral symptoms.” Administration on Aging, FY 2011 Report to Congress, 45 (2011), available at
psychotropic medications are inherently dangerous, even if properly prescribed, psychotropic medications administered to dementia patients may cause additional serious side effects that result in further medical complications, accelerate confusion and/or have fatal consequences.  

The following cases are a few examples outlining why attorneys should possess a degree of understanding as to medications:


Articles & Resources

Articles and Books Referenced in Dr. Cohen’s PowerPoint Presentation


APPLIED CLINICAL PHARMACOKINETICS 50 (Larry A. Bauer, 2001).

Chapter 3 - Drug Dosing in Special Populations: Renal and Hepatic Disease, Dialysis, Heart Failure, Obesity, and Drug Interactions.


Lisa C. Hutchinson & Catherine E. O’Brien, Changes in Pharmacokinetics and


103 “Inappropriately prescribed antipsychotic drugs, when prescribed for elders with dementia, can have serious medical complications, including death, loss of independence, over-sedation, confusion, and falls.” Id. at 45; see also, David A. Casey, MD, Colleen Northcott, MD, Keith Stowell, MD, Lina Shihabuddin, MD, & Mercedes Cguez-Suarez, MD, Dementia and Palliative Care, Clinical Geriatrics, Vol. 20, No. 1 (January 2012) available at http://www.clinicalgeriatrics.com/articles/Dementia-and-Palliative-Care.

Other Articles


Resources

AMERICAN PSYCHIATRIC ASSOCIATION, PRACTICE GUIDELINE FOR THE TREATMENT OF PATIENTS WITH ALZHEIMER’S DISEASE AND OTHER DEMENTIAS (2nd ed. 2007).

American Society of Consultant Pharmacists (ASCP), ASCP Fact Sheet https://www.ascp.com/articles/about-ascp/ascp-fact-sheet


Centers for Medicare and Medicaid Services: National Partnership to Improve Dementia Care exceeds goal to reduce use of antipsychotic medications in nursing homes: CMS announces new goal:

Centers for Medicare and Medicaid Services: New data show antipsychotic drug use is decreasing in nursing homes nationwide:
VII. Judges and Lawyers Must Look Beyond a Person’s Age, Diagnosis and Appearance

Questions & Answers

Diminished mental capacity comes in all shapes and sizes, is immune to cultural and racial differences and although many of its victims are 60 years of age or older, capacity issues can affect individuals of all ages.

There are individuals who due to one or more medical conditions, diseases and/or syndromes such as Aphasia, Parkinson’s disease, ALS, cerebral palsy, multiple sclerosis, among others, appear to be physically compromised and unable to communicate. Notwithstanding the fact that the physical appearance of these individuals may appear different and/or “abnormal,” many of these individuals do not suffer with cognitive deficits.

Attorneys, judges, and other professionals must take time to communicate with these individuals rather than assume they lack capacity. Our time is important but not compared to our individual and societal commitment to respect and honor an individual’s right to fully express his/her thoughts. Do not be too quick to judge individuals based on a first impression.

1. What do guardianship attorneys and judges need to know about aphasia?

The following Aphasia facts are taken from the National Institute of Neurological Disorders and Stroke website.  

- Aphasia is a neurological disorder caused by damage to the portions of the brain responsible for language.
- Signs of the disorder include:
  - Difficulty expressing oneself when speaking;
  - Trouble understanding speech, and
  - Difficulty reading and writing.
- Aphasia is not a disease, but a symptom of brain damage.
- Most common in adults who have suffered a stroke, it can also be caused by a brain tumor, infection, head injury, or dementia that damages the brain.
- Approximately one million Americans suffer with aphasia.

Although individuals suffering with Aphasia may be unable to communicate due to difficulty with speech and writing, it is critical that attorneys and judges display patience and understanding. Aphasia suffersers may be forced to communicate in an alternative manner such as, sign language, through an electronic communication board, or by using other new technologies that facilitate communication. Notwithstanding their inability to communicate, many of these individuals are not cognitively impaired.

In 2013, the National Aphasia Association (“NAA”) filed a discrimination complaint against a

Sacramento judge who ruled that a 75-year-old rape victim was incompetent to testify. Though her communication skills were compromised because she suffered from aphasia, the NAA argued the victim was able to competently testify if provided with the reasonable accommodations as required by the Americans with Disabilities Act. The “reasonable accommodations” for someone with expressive aphasia include having the individual answer yes/no questions, use gestures or point to pictures. Without providing these accommodations to the victim at her competency hearing, the NAA argues, the court violated the victim’s rights and discriminated against her.

- **Matter of Kurt T.**, 64 AD3d 819, [3d Dept 2009] – the alleged incapacitated person suffered with “expressive aphasia and dysarthria.” According to the decision, respondent’s condition affected his “ability to retrieve and articulate words, but he remains able to understand anything asked of or said to him.” (820)

While petitioner places great emphasis upon respondent's inability to explain the details of certain financial transactions, respondent's testimony in that regard is entirely consistent with his diagnosis of expressive aphasia and dysarthria. The record establishes, however, that respondent does not suffer from any condition that affects his ability to comprehend information. (822) (Emphasis added.)

2. What do guardianship attorneys and judges need to know about Parkinson’s disease?

The following Parkinson’s disease facts are taken from the National Institute of Neurological Disorders and Stroke website.  

- Parkinson’s disease is a motor system disorder. Motor system disorders are caused by a loss of dopamine producing brain cells.
- The four primary symptoms of PD are
  - tremor, or trembling in hands, arms, legs, jaw, and face;
  - rigidity, or stiffness of the limbs and trunk;
  - bradykinesia, or slowness of movement; and
  - postural instability, or impaired balance and coordination.
- As symptoms become more pronounced, patients may have difficulty walking, talking, or completing other simple tasks.
- Parkinson’s disease usually affects people over the age of 50.

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105 Andy Furillo, Sacramento County Judge Violated ADA Rights, Complaint Says, THE SACRAMENTO BEE (July 31 2013) available at [http://www.sacbee.com/2013/07/31/5610398/sacramento-county-judge-violated.html#mi_rss=Our%20Region](http://www.sacbee.com/2013/07/31/5610398/sacramento-county-judge-violated.html#mi_rss=Our%20Region)


3. What is ALS and do individuals with ALS suffer with diminished mental capacity?

Also known as Lou Gehrig’s disease, Amyotrophic lateral sclerosis ("ALS") is a progressive disease that attacks the nerve cells that control voluntary movement. Unfortunately, it is unclear what causes ALS and there is no cure. Guardianship attorneys and judges should note the following:

The presentation of ALS varies from person to person. Some people with ALS will never develop changes in thinking or behavior. For others with ALS, there will be mild changes in how they think or behave but they are still able to function independently and make informed decisions about their care. Finally, for some people with ALS, changes in thinking and behavior are quite significant and severe such that these people are challenged to make informed decisions about their care and activities and require others to act on their behalf.

... with approximately 25% of those people with ALS developing a full blown dementia.

4. Does an individual with serious language and/or communication challenges require the appointment of a guardian pursuant to article 81?

A court’s power to appoint a guardian for an alleged incapacitated person ("AIP") is contained within Mental Hygiene Law (MHL) §81.02. A court may appoint a guardian for an AIP if it determines such an appointment is necessary to provide for the “personal needs of that person . . . and/or to manage the property and financial affairs of that person". The AIP must either agree to the appointment or the court must find the AIP to be incapacitated pursuant to §81.02(b). A court shall base its capacity determination on clear and convincing evidence and a determination that the AIP is “likely to suffer harm because: 1. The person is unable to provide for personal needs and/or property management; and 2. The person cannot adequately understand and appreciate the nature and consequences of such inability.”

A court, in reaching its determination, shall give primary consideration to the AIP’s functional level and functional limitations, including an assessment of activities of daily living, and other factors as outlined in MHL article 81. When determining whether the appointment of a guardian is necessary, a court must, among other things, consider the “sufficiency and reliability of

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109 Id.
111 N.Y. MENTAL HYG. LAW §81.02(a) (1).
112 N.Y. MENTAL HYG. LAW §81.02(a) (2).
113 N.Y. MENTAL HYG. LAW §81.02(b) (1), (2).
available resources.”114 The statute offers several examples of what constitutes an available resource, including “visiting nurses, homemakers, home health aides, adult day care and multipurpose senior citizen centers, powers of attorney, health care proxies, trusts, representative and protective payees, and residential care facilities.”115

If an individual with serious language and/or communication problems requires assistance with certain aspects of their lives, that individual may still have the capacity to execute advance directives and/or hire individuals to assist in activities of daily living. Attorneys and judges must display patience and understanding. Notwithstanding their inability to communicate, many of these individuals are not cognitively impaired. Attorneys, judges, and other professionals must take time to communicate with these individuals rather than assume they lack capacity.

Cases


*Matter of Doe*, 181 Misc 2d 787 [Sup Ct, Nassau County 1999]

*Matter of Shah (Helen Hayes Hosp.),* 711 NYS2d 824 [2000]

*Matter of Kurt T.*, 64 AD3d 819 [3d Dept 2009]

*Matter of John D.*, 25 Misc 3d 940 [Sup Ct, Cortland County 2009]

In *Matter of Maher*, 207 AD2d 133 [2d Dept 1994], the proceeding was converted from a conservatorship proceeding to one for the appointment of a property management guardian pursuant to Mental Hygiene Law (“MHL”) article 81. (137) Francis E. Maher Jr., (hereinafter “appellant”) sought the appointment of a guardian for his father, Francis E. Maher (hereinafter “respondent”). (135)

The court reviewed article 81 in light of the deficiencies in MHL former articles 77 and 78. (138)

Mental Hygiene Law former article 78, the committee statute, required a finding of complete incompetence. That statute provided no guidance regarding what constituted incompetence, no standard governing the type of proof required to establish incompetence, and no specification respecting the range of powers assumed by a "committee of the person”. However, a finding of incompetence resulted in a complete loss of civil rights and the accompanying stigma of total incapacity. Because of this stigma and loss of civil

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114 N.Y. MENTAL HYG. LAW §81.02 (a) (2).
115 N.Y. MENTAL HYG. LAW §81.03(e).
rights, the judiciary became increasingly reluctant to invoke article 78. This reluctance, together with the statutory preference for a conservator which appeared in both Mental Hygiene Law former articles 77 and 78, resulted in the virtual abandonment of the committee procedure (Koppell and Munnelly, The New Guardian Statute: Article 81 of the Mental Hygiene Law, 65 NY St BJ [No. 2] 16 [Feb. 1993] [hereinafter Koppell and Munnelly]).

Mental Hygiene Law article 77, the conservatorship statute, enacted in 1972, allowed for the appointment of a conservator for property only. While certain language in article 77 regarding the "personal well-being" of the conservatee suggested the possibility of using conservators of the property to exercise authority over the person of the individual, the needs of the population to be served by guardianship statutes proved so varied that the relief ostensibly offered by article 77 simply did not in fact afford either the authority or the flexibility necessary to address them all (Koppell and Munnelly, op. cit.).

On April 30, 1991, the Court of Appeals decided Matter of Grinker (Rose) (77 N.Y.2d 703), holding, inter alia, that Mental Hygiene Law article 77 did not authorize a court to grant to a conservator the power to commit the conservatee to a nursing home. Such power to so significantly displace personal liberty, the Court explained, can be granted only pursuant to Mental Hygiene Law article 78, the committee statute, "with its full panoply of procedural due process safeguards" (Matter of Grinker [Rose], supra, at 710). That decision, although it clarified the respective reaches of articles 77 and 78, reinstated the courts' earlier dilemma. It further left without recourse the majority of incapacitated individuals who, although somewhat handicapped, were not hopelessly incompetent, and who, notwithstanding their need for varying degrees of assistance with their personal affairs as well as with property management, were not prepared utterly to relinquish in exchange therefor a lifetime's investment in integrity, autonomy, and dignity (see, Mental Hygiene Law § 81.01). (138-139)

In an attempt to cure the deficiencies in articles 77 and 78, the New York Law Revision Commission proposed new legislation based on the concept of the least restrictive alternative — one that authorizes the appointment of a guardian whose authority is appropriate to satisfy the needs of an incapacitated person, either personal or financial, while at the same time tailored and limited to only those activities for which a person needs assistance. The standard for appointment under this new procedure focuses on the
decisional capacity and functional limitations of the person for whom the appointment is sought, rather than on some underlying mental or physical condition of the person. The proposal encouraged the participation of the allegedly incapacitated person in the proceeding to the greatest extent possible" (Koppell and Munnelly, op. cit., at 17). (139) (Emphasis added)

The court stressed, “even if all the elements of incapacity are present, a guardian should be appointed only as a last resort, and should not be imposed if available resources or other alternatives will adequately protect the person.” (Id.)

The court affirmed the Supreme Court’s decision to dismiss the petition as the evidence established that although responded suffered from “certain functional limitations”; he had effectuated a plan for the management of his affairs “by granting a power of attorney . . . and by adding his wife as a signatory on certain of his bank accounts.” (141) These actions demonstrated that the AIP “appreciated his own handicaps.” (Id.)

In Matter of John XX., 226 AD2d 79 [3d Dept 1996], the original order and judgment granted the property management guardian the “power to make reasonable family gifts.” (81) The guardian sought the court’s approval, pursuant to Mental Hygiene Law (MHL) §81.21(b), to transfer funds from the Incapacitated Person (IP) to the IP’s two daughters, respondents herein, the purpose of which was “a Medicaid and estate-planning device to shield the bulk of John’s assets from a potential Medicaid lien for the cost of nursing facility services and other medical services.” (Id.) The transfer would leave the IP with $150,000 of assets, his pension, and social security income to live off during the 36-month Medicaid look-back period. (81-82) After the look-back period, the IP would rely on “Medicaid for the cost of medical care in excess of his income.” (82) The Broome County Department of Social Services (DSS) and the Ideal Senior Living Center opposed the application. (Id.) The Court granted the petition without a hearing. (Id.) DSS appealed. (Id.)

The court held the Supreme Court did not err in granting the petition without a hearing. (Id.) Firstly, since the original guardianship hearing was conducted only one-year prior, it was evident that the IP “lacked the capacity to affect the transfer and was unlikely to regain such capacity.” (Id.) Secondly, the IP was certain to exhaust his assets on medical care and “it cannot be reasonably contented that a competent, reasonable individual in his position would not engage in the estate and Medicaid planning proposed in the petition”. (83) Finally, there is no evidence that the IP had previously manifested “any intention inconsistent with the proposed transfer.” (Id.)

The court was not persuaded by appellants argument that the “proposed transfer constitutes a fraud on the Department, as a potential future creditor.” (Id.) Although the court accepted that the “Medicaid program was not designed to provide medical benefits to those who render themselves “needy” through estate plans, “the simple fact is that current law rewards prudent Medicaid Planning”. (Id.) The court acknowledged that article 81 gave statutory recognition to the common-law doctrine of “substituted judgment”’ which allows a guardian to be granted the power to:
make gifts . . . to convey or release contingent and expectant interests in property or power held by the incapacitated person . . . or to renounce or disclaim interests in estates . . . the authority to effect transfers of assets for the purpose of rendering incapacitated persons Medicaid eligible (see, e.g., Matter of Baird, 167 Misc 2d 526, 529-530; Matter of Daniels, 162 Misc 2d 840; Matter of Klapper, NYLJ, Aug. 9, 1994, at 26, col 1 [Sup Ct, Kings County, Leone, J.]).

In view of the Legislature's express grant of these powers, we agree with the conclusion of a number of lower courts that, subject to the provisions of Mental Hygiene Law § 81.21, guardians have the authority to effect transfers of assets for the purpose of rendering incapacitated persons Medicaid eligible (see, e.g., Matter of Baird, 167 Misc 2d 526, 529-530; Matter of Daniels, 162 Misc 2d 840; Matter of Klapper, NYLJ, Aug. 9, 1994, at 26, col 1 [Sup Ct, Kings County, Leone, J.]). As correctly reasoned by those courts, a contrary conclusion would have the effect of depriving incapacitated persons of the range of options available to competent individuals (see, supra). (83-84) (Emphasis added.)

In Matter of Doe, 181 Misc 2d 787 [Sup Ct, Nassau County 1999], petitioners sought the appointment of a guardian for their son (hereinafter “respondent”). (789) The court appointed counsel for respondent based on petitioner’s moving papers and the expectation respondent would oppose the relief sought. (Id.) The court dispensed with the appointment of a court evaluator. (Id.) The petition was dismissed as petitioner failed “to establish respondent’s incapacity and the necessity for the appointment of a guardian (see, Mental Hygiene Law §§81.02, 81.15, 81.16[a]).” (Id.) Justice Rossetti sought to discourage similar applications. (Id.)

Two months after his 18th birthday, respondent’s parents commenced the proceeding alleging their son was unable to manage his affairs due to “mental infirmity” (Id.) The “mental infirmity” referred to was respondent’s “attention deficit hyperactive disorder, oppositional defiant disorder, and polysubstance abuse.” (Id.) Justice Rossetti addressed article 81’s purpose:

While the primary impetus behind the enactment of Mental Hygiene Law article 81 was to provide a new, more individualized form of guardianship for the elderly, it is certainly usable for persons of any age, including young adults and even minors (see, 1 Abrams, Guardianship Practice in New York State, ch 6, § II, at 405-408). However, it is not some pro forma legal vehicle to be used merely to perpetuate parental control of an incorrigible child or as a parental tax planning device.

A guardianship, whether of a young adult or a senior citizen, involves limitations on those rights and a consequential loss of control over one’s life, to one degree or another . . . It is thus a
legal proceeding of considerable importance and should not be commenced lightly or without substantial cause and basis. (790) (Emphasis added.)

Petitioners had the burden to prove by clear and convincing evidence that the appointment of a guardian was necessary for respondent’s personal and property management needs and that respondent would suffer harm due to his inability to provide for himself and his failure to “adequately understand and appreciate the nature and consequences of his inability. (See, Mental Hygiene Law § 81.02 [a], [b].)” (791)

There is often an interrelationship between necessity and incapacity since the necessity for appointment generally arises from functional inabilities which make up incapacity. In making a guardianship determination, primary consideration is to be given to the functional levels and functional limitations of the alleged incapacitated person, and such consideration shall also include an assessment, inter alia, of any mental disability, alcoholism or substance dependence as defined in the Mental Hygiene Law (see, Mental Hygiene Law § 1.03 [3], [13], [41]; § 81.02 [c]). (Id.)

According to Justice Rossetti, the “disorders” alleged in the petition “seemingly can be distilled in laymen's terms to a rebellious youth with a short attention span. A bad attitude and a fickle nature may not make for an attractive personality, but they do not warrant the deprivation of constitutionally protected rights and liberty.” (Id.)

As to alcoholism and substance dependence, they are defined respectively as “a chronic illness in which the ingestion of alcohol usually results in the further compulsive ingestion of alcohol beyond the control of the sick person to a degree which impairs normal functioning,” and “the physical or psychological reliance upon a substance as defined in this section [see, Mental Hygiene Law § 1.03 (39)]”, arising from substance abuse” (Mental Hygiene Law § 1.03 [13”, [41”). All that petitioners have alleged is substance abuse (i.e., “the repeated use of one or more substances” [Mental Hygiene Law § 1.03 (40)]), and while it appears respondent has experimented with more than one illegal drug, it was not shown that he had a chronic compulsion to rely thereon or that it has resulted in an inability to function on an everyday basis. . . . As noted, the threshold issue and fundamental basis for an article 81 guardianship are functional limitations (see, Bailly, Practice Commentaries, McKinney's Cons Laws of NY, Book 34A, Mental Hygiene Law § 81.01, at 248; § 81.02, at 257-258). Although an abuser of drugs and/or alcohol may at some point develop such limitations and disability (particularly where such abuse exacerbates other problems or conditions), the mere use or even abuse by itself does not generally demonstrate the necessary
functional detriment, particularly in view of the high burden of proof required. (791-792)

Respondent may be immature, arrogant, irresponsible and subject to an unrealistic sense of entitlement, but such traits were not shown to rise to the level of a functional limitation. . . . Under the circumstances of this case and analogous proceedings, the granting of guardianship to the parents of an otherwise healthy and mentally competent child would be nothing more than a meaningless paper exercise. It has been said on numerous occasions that the courts should not be engaged in futile acts, and the judicial imprimatur sought by petitioners in this article 81 proceeding is not one which we believe was contemplated by the Legislature. (792)

Respondent had the capacity to understand his problems and did not require the appointment of a guardian. (793) The “appointment of a guardian is a drastic remedy which involves the invasion of the respondent’s freedom and a judicial deprivation of his constitutional rights . . . Before petitioning for such relief, careful and serious consideration should be given.” (Id.) (Emphasis added)

Justice Rossetti concluded that petitioners were “ill-advised” before determining to initiate the proceeding and their attorney “should have been cognizant of its ultimate failure before the hearing herein, if not before drafting the moving papers.” (794)

Justice Rossetti sealed the records as the “disclosure of medical and treatment information (see generally, CPLR 4504, 4507, 4508) would be potentially embarrassing and damaging to respondent, particularly with respect to his relationship with his parents and further treatment of his problems.” (Id.) In addition, there was no public interest in disclosure. (Id.)

In Matter of Shah (Helen Hayes Hosp.), 711 NYS2d 824 [2000], Justice Bellacosa, writing for the court, affirmed the decisions of the Appellate Division, Second Department in Matter of Shah (Helen Hayes Hosp.) and Matter of Shah v DeBuono. (152) Both decisions were the result of the following set of unfortunate events:

Bipin Shah lived in New Jersey with his wife, Kashmira, and their two children. On August 1, 1996, while at work in Suffolk County, New York, he was severely injured and lapsed into a coma. At first, he was hospitalized in Suffolk County. On September 29, 1996, at his wife's request, he was transferred to Helen Hayes Hospital in Rockland County, just across the border from the family home in New Jersey. His comatose condition is not expected to improve. He is almost 50 years of age. (Id.)

A little over three months after Mr. Shah’s transfer to Helen Hayes Hospital (hereinafter the “hospital”), the hospital advised Mrs. Shah (hereinafter, “petitioner”) that Mr. and Mrs. Shah’s private insurance benefits were nearly exhausted and, absent a successful Medicaid application,
the Shah’s would be personally responsible for the $1,600 a day payments. (153) Petitioner exercised her spousal right of refusal (“spouses may decline to make their income and resources available for the cost of the other spouse's care, without jeopardizing the needy spouse's ability to receive Medicaid benefits”), commenced a Mental Hygiene Law (MHL) article 81 proceeding, and filed a Medicaid application on Mr. Shah’s behalf. (Id.) Petitioner proposed that as guardian she would transfer her husband’s assets to herself as spouse enabling Mr. Shah to qualify for Medicaid. (Id.) The hospital and the Rockland County Department of Social Services (RCDSS) opposed the transfer. (Id.) The court was presented with the following two questions:

whether Mr. Shah is a resident of New York for purposes of determining eligibility to receive New York Medicaid benefits . . . whether a spouse, qualified as guardian, is permitted to transfer to herself, for purposes of Medicaid planning, the entire assets of her incapacitated spouse pursuant to Mental Hygiene Law § 81.21 (152)

After both the RCDSS and the Suffolk County Department of Social Services (SCDSS) denied Mr. Shah’s Medicaid application on the grounds of residency, petitioner requested a fair hearing. (153) In the meantime, petitioner was appointed guardian and was authorized to transfer all of her husband’s assets. (Id.) The hospital and RCDSS appealed. (Id.)

After the fair hearing, the New York Department of Health upheld the decisions of the county departments and petitioner challenged their determination. (153-154)

The Appellate Division, Second Department found in favor of petitioner in both matters and Justice Bellacosa, in the instant opinion, quoted the following text from Matter of Shah (Helen Hayes Hosp.):

“it is, or should be, clear that Mr. Shah, who had the unrestricted right to give his assets to his wife, or to his children, or to anyone else for that matter, at all times up to the moment of his terrible injury, did not, on account of that injury, lose that fundamental right merely because he is now incapacitated and financial decisions on his behalf must necessarily be made by a surrogate. The relief granted pursuant to Mental Hygiene Law article 81 is designed to permit an incapacitated person to do, by way of a surrogate, those essential things such a person could do but for his or her incapacity”. (Matter of [Kashmira] Shah, 257 AD2d 275, 282). (154)

The New York Court of Appeals granted the hospital and RCDSS leave to appeal on both matters. (Id.)

Justice Bellacosa first addressed the residency issue for which “the Federal regulations set forth a straightforward definition of residency for Medicaid eligibility purposes and that, pursuant to that definition, Mr. Shah qualifies as a New York resident.” (155) The definition referred to was contained within 42 CFR 435.403[i][3] which provided that “For any institutionalized individual
who became incapable of indicating intent at or after age 21, the State of residence is the State in which the individual is physically present, except where another State makes a placement” (42 CFR 435.403 (i) (3) [emphasis added]).” (157) Since Mr. Shah was institutionalized, became incapacitated after turning 21, and was physically present in New York, “the State of New York is his residence, plain and simple for the operational purposes of 42 CFR 435.403(i)(3.)” (Id.)

As for the second question, the court confirmed that “a guardian spouse is permitted to effectuate this kind of Medicaid planning on behalf of an incapacitated individual pursuant to Mental Hygiene Law article 81” after a consideration of the factors contained within MHL §81.21[d] and [e]. (159-160)

The specifically enumerated potential powers of the New York guardian are unlimited and certainly not contingent on the particular purpose for the transfer--the guardian can make gifts, provide support for dependents and, simultaneously, apply for government benefits (see, Mental Hygiene Law § 81.21 [a]). The only “limitation” is that of the doctrine of substituted judgment--the guardian's actions must “take[ ] in account the personal wishes, preferences and desires of the [incapacitated] person” (Mental Hygiene Law § 81.01; see also, NY Law Rev Commn Comments, McKinney's Cons Laws of NY, Book 34A, Mental Hygiene Law § 81.21, at 376). (160)

The spousal right of refusal is recognized at a Federal level and by New York State (but not New Jersey) and provides that Medicaid must be made available to an institutionalized spouse “who meets eligibility requirements even if the community spouse has income or resources in excess of the community spouse resource allowance, as long as the State may seek recovery of the cost of medical assistance from the community spouse (42 USC § 1396r-5 [c] [3]; Social Services Law § 366 [3] [a]).” (161) In addition, there is no look-back period with respect to asset transfers between spouses. (Id.) In the following paragraphs, Justice Bellacosa provides a perfect summation of the court’s decision, the difference between this decision and Matter of John XX., and a revealing quotation from the Appellate Court:

the interplay of these provisions allows an institutionalized spouse, through guardianship authorization, to transfer all of that spouse's assets to a community spouse; the latter may simultaneously refuse to have those assets included in the calculation of income and resources available to the institutionalized spouse for Medicaid assistance (compare, Matter of John XX., 226 AD2d 79, supra [only a partial asset transfer was made by a guardian to the incapacitated person's children because the look-back period had to be taken into consideration]). (Id.)

“The complexities [of the law] ... should never be allowed to blind us to the essential proposition that a man or a woman should normally have the absolute right to do anything that he or she
wants to do with his or her assets, a right which includes the right to give those assets away to someone else for any reason or for no reason. ... We would only amplify this by saying that no agency of the government has any right to complain about the fact that middle class people confronted with desperate circumstances choose voluntarily to inflict poverty upon themselves when it is the government itself which has established the rule that poverty is a prerequisite to the receipt of government assistance in the defraying of the costs of ruinously expensive, but absolutely essential, medical treatment” (Matter of [Kashmira] Shah, 257 AD2d 275, 282-283, supra). (162-163)

In Matter of Kurt T., 64 AD3d 819 [3d Dept 2009], following a stroke, the alleged incapacitated person (hereinafter “respondent”), suffered with “expressive aphasia and dysarthria.” (820) Respondent’s condition affected his “ability to retrieve and articulate words, but he remains able to understand anything asked of or said to him.” (Id.)

Prior to his stroke, respondent appointed his cousin, petitioner herein, as attorney-in-fact pursuant to a power of attorney and made her the sole beneficiary of his sizeable estate. (Id.) Following his stroke, petitioner began acting as respondent’s health care proxy (Id.) However, in 2006, respondent revoked the advance directives and replaced petitioner with his long-term neighbor. (Id.) Petitioner commenced a Mental Hygiene Law article 81 proceeding seeking the appointment of a personal needs and property management guardian for respondent. (Id.)

The Supreme Court issued a stay prohibiting the neighbor from exercising the authority granted to her by the power of attorney. (Id.) Although originally on board with the idea of the appointment of a guardian, respondent indicated “he no longer consented to the appointment of a guardian” and the Supreme Court dismissed the petition, lifted the stay, and ordered respondent to “pay 80% of the total combined costs of his court-appointed counsel fees, the court evaluator's fees and petitioner's counsel fees, and that petitioner be financially responsible for the balance of those fees.” (821) Both parties appealed. (Id.)

The court upheld the Supreme Court’s decision to dismiss the case as petitioner failed establish the respondent’s incapacity (see Mental Hygiene Law § 81.12 [a]). (Id.) The court acknowledged respondent’s functional limitations but crucially, the record lacked “clear and convincing evidence that respondent is likely to suffer harm as a result of these limitations or that he is incapable of understanding and appreciating his limitations.” (Id.)

While petitioner places great emphasis upon respondent's inability to explain the details of certain financial transactions, respondent's testimony in that regard is entirely consistent with his diagnosis of expressive aphasia and dysarthria. The record establishes, however, that respondent does not suffer from any condition that affects his ability to comprehend information. Indeed, his social worker testified that he is aware of his assets, willing to seek the assistance of an attorney in managing those assets and that he
would not be harmed if a guardian were not appointed. (822)
(Emphasis added.)

Petitioner failed to show “by clear and convincing evidence the need for the appointment of a guardian (see Matter of Maher, 207 AD2d at 141-142; cf. Matter of Karen P., 254 AD2d 530, 531-532 [1998]). (Id.)

In Matter of John D., 25 Misc 3d 940 [Sup Ct, Cortland County 2009], despite a finding that the alleged incapacitated person (“AIP”) was not incapacitated, Justice Peckham, pursuant to Mental Hygiene Law (“MHL”) §81.16(b), appointed a monitor to oversee the AIP’s financial affairs. (941)

Justice Peckham reviewed the events that lead to the guardianship proceeding. (Id.) The AIP was hospitalized for severe depression and underwent electroshock therapy in 2007. (Id.) The therapy resolved the AIP’s depression but caused hypomania resulting in “excessive and irrational spending.” (Id.) The AIP’s wife began a divorce action and obtained a protective order against the AIP which was twice violated. (941-942)

At the time of the guardianship hearing, the AIP “testified rationally and coherently about his mental illness”, that he felt good, and had recovered from depression and hypomania. (942) The AIP’s doctors advised that there was “at least a 30% chance of a relapse.” (Id.) The AIP made his own financial decisions in consultation with a Merrill Lynch account executive and opposed the appointment of a guardian on the basis he believed it to be unnecessary. (Id.)

The court evaluator recommended against a long-term guardianship but recommended the appointment of a guardian and that the guardian’s role “be limited to protecting a certain amount of the principal and that John D. continue to have the right to participate in making investment decisions.” (Id.) Justice Peckham emphasized the important role the principle of the least restrictive form of intervention plays in article 81 proceedings and noted that in furtherance of this principle:

Mental Hygiene Law § 81.16 (b) provides for protective arrangements. The section provides the court may “ratify any transaction or series of transactions necessary to achieve any security, service, or care arrangement meeting the foreseeable needs of the incapacitated person.” . . . (Id.)

The leading treatise on guardianship in New York states in regard to this provision: “The court has a very broad selection of alternatives in addressing the case before it. It may . . . (b) fashion a protective arrangement without appointing a guardian.” (Abrams, Guardianship Practice in New York State, ch I, § III [E] [3], at 24 [1997].) (942-943)

Despite finding that the AIP was not incapacitated, Justice Peckham emphasized the AIP’s history of depression and hypomania and the possibility of a relapse which might result in “irrational expenditures which would be detrimental to his wife’s claim for equitable distribution
in the divorce action.” (943) Justice Peckham noted that MHL §81.16(b) “enjoins the court to consider in any protective arrangement the rights of creditors and dependents.” (Id.)

Justice Peckham determined a protective arrangement was “necessary to monitor and oversee John’s financial activities and medical needs and appointments in light of the possibility of relapse” and that such an appointment constituted the least restrictive form of intervention. (Id.) (Emphasis added.) The court evaluator was appointed as the AIP’s monitor with the authority to inter alia, “review and approve or disapprove any financial transaction in excess of $50,000.” (Id.) The appointment was for one year although the monitor was authorized to apply for an extension, on notice to the AIP, after one year. (Id.) The AIP and any financial institution holding the AIP’s assets were “restrained from transferring, releasing or paying to John or any other person or entity any amount of $50,000 or more” without the monitor’s written approval. (943-944)

**Articles & Resources**


- This article discusses a Massachusetts case where the lower court refused to provide accommodations to allow a person with aphasia to communicate effectively when testifying.


VIII. PowerPoint Presentations

A. Wilbert S. Aronow

B. Sheila Shea, The Relevance and Consequences of Diminished Capacity

C. William H. Frishman

D. Kenneth R. Cohen, Geriatric Pharmacotherapy

Conflict of Interest Statement

Wilbert S. Aronow, MD, FACC, FAHA, FACP, FCCP, AGSF, FGSA, Professor of Medicine at Westchester Medical Center/New York Medical College, has no conflicts of interest

Prevalence of Hypertension

- Without treatment, approximately 30% of adults in the United States have hypertension
- Prevalence of hypertension increases markedly with age
- The age-adjusted prevalence of hypertension in the United States is 64% of elderly men and 78% of elderly women

Pathophysiology of Hypertension in Elderly

- Multiple changes occur in the arterial media with aging, including reduced elastin content with increases in non-distensible collagen and calcium causing arterial stiffening
- Age-associated arterial stiffening increases systolic blood pressure and decreases diastolic blood pressure
- Flow-mediated arterial dilation, primarily mediated by endothelium-derived nitric oxide, decreases markedly with aging

Pathophysiology of Hypertension in Elderly

- The neurohormonal profile of older hypertensive adults is characterized by increased plasma norepinephrine, low renin, and low aldosterone levels
- Many so-called "normal aging changes" in arterial structure and function are blunted or absent in populations not chronically exposed to high sodium/high calorie diets, low physical activity levels, and high rates of obesity
Arterial Stiffening With Aging

- Arterial stiffening increases systolic blood pressure and decreases diastolic blood pressure, reducing coronary blood flow, causing myocardial ischemia.
- Arterial stiffening increases pulse wave velocity, increasing aortic impedance and left ventricular (LV) afterload, leading to LV hypertrophy, myocardial ischemia, increased left atrial size, atrial fibrillation, decreased early diastolic LV filling rate, and increased late diastolic LV filling rate.

Hypertension as a Risk Factor

- Hypertension is present in 69% of pts with a first myocardial infarction, in 77% of pts with a first stroke, and in 74% of pts with chronic HF.
- Hypertension is present in 60% of pts with peripheral arterial disease.

Aronow WS et al: Am J Cardiol 2009; 103: 130-135
Hypertension as a Risk Factor

Hypertension is also a major risk factor for a dissecting aortic aneurysm, sudden cardiac death, angina pectoris, atrial fibrillation, diabetes, the metabolic syndrome, chronic kidney disease, thoracic and abdominal aortic aneurysms, LV hypertrophy, vascular dementia, Alzheimer’s disease, and ophthalmologic disorders

Aronow WS et al: J Am Coll Cardiol 2011; 57:2037-2114

Cardiovascular Changes in Elderly

• There is a decrease in the number of cardiomyocytes
• There is a decrease in elasticity and an increase in stiffness of the arterial system
• Number and function of sinoatrial pacemaker cells are decreased and atrioventricular conduction abnormalities are increased

Aronow WS: Brocklehurst Textbook of Geriatric Medicine and Gerontology, Chapter 30, 6th ed
Cardiovascular Changes in Elderly

• Calcification of the aortic valve cusps and of the mitral valve annulus may develop
• Age-associated decreases in maximal heart rate and in peak exercise left ventricular contractility are due to decreased beta-adrenergic responses with aging
• Left ventricular end-diastolic and end-systolic volumes increase with peak exercise during aging

Cardiovascular Changes in Elderly

• Duration of left ventricular contractility and of relaxation is prolonged with aging
• Decrease in muscle mass with aging plays a role in age-associated decrease in systemic arteriovenous oxygen difference and in maximum VO2 at peak exercise
Cardiovascular Disease in Elderly

Elderly women and men have an increased prevalence of coronary artery disease, stroke, peripheral arterial disease, congestive heart failure, valvular heart disease, atrial fibrillation, and pacemaker rhythm.

Coronary Artery Disease

- Coronary artery disease is the most common cause of death in the elderly.
- Persons older than 65 years comprise 12% of the population and 60% of hospital admissions for acute myocardial infarction.
New Coronary Events

Prior myocardial infarction increased the incidence of new coronary events 1.72 times in older men and 1.91 times in older women.

Aronow WS, Ahn C: Am J Cardiol 77:864, 1996

New Coronary Events

Age increased the incidence of new coronary events 1.04 times for each 1-year increase in older men and 1.03 times for each 1-year increase in older women.

Aronow WS, Ahn C: Am J Cardiol 77:864, 1996
Cigarette Smoking

At 40-month follow-up of 664 older men and 48-month follow-up of 1,488 older women, cigarette smoking increased the incidence of new coronary events 2.2 times in men and 2.0 times in women

Aronow WS, Ahn C: Am J Cardiol 77:864, 1996

Smoking Cessation Program

The American College of Cardiology/American Heart Association guidelines recommend a smoking cessation program to reduce cardiovascular mortality and all-cause mortality

Passive Smoking

Passive smoking aggravates angina pectoris


Passive Smoking

Passive smoking causes an excess risk of fatal coronary heart disease

Hypertension

At 40-month follow-up of 664 older men and at 48-month follow-up of 1,488 older women, hypertension increased the incidence of new coronary events 2.0 times in older men and 1.6 times in older women

Aronow WS, Ahn C: Am J Cardiol 77:864, 1996

Antihypertensive Therapy

Antihypertensive drugs have been shown to reduce cardiovascular morbidity and mortality in older men and in older women

Aronow WS et al: J Am Coll Cardiol 57: 2037, 2011
Treatment of Hypertension

- Adults with coronary artery disease younger than 80 years with hypertension should have their blood pressure reduced to 130-139/80-89 mm Hg
- Adults with coronary artery disease aged 80 years and older with hypertension should have their systolic blood pressure reduced to 140-145 mm Hg if tolerated

Aronow WS et al: J Am Coll Cardiol 57: 2037, 2011

Serum Total Cholesterol

At 40-month follow-up of 664 older men and at 48-month follow-up of 1,488 older women, an increase of 10 mg/dL of serum total cholesterol increased the incidence of new coronary events 1.12 times in men and 1.12 times in women

Aronow WS, Ahn C: Am J Cardiol 77:864, 1996
Serum LDL Cholesterol

In 547 older men and 1,246 older women, an increase of 10 mg/dL of serum low-density lipoprotein cholesterol increased the probability of coronary artery disease 1.28 times.

Aronow WS, Ahn C: Am J Cardiol 73:702, 1994

Heart Protection Study

At 5-year follow-up, simvastatin 40 mg daily reduced all-cause mortality, vascular death, major coronary events, coronary or noncoronary revascularization, and any major vascular event regardless of initial levels of serum lipids, age, or gender in 20,536 patients with coronary artery disease, cerebrovascular disease, peripheral arterial disease, diabetes, or treated hypertension.

Lancet 360:7, 2002
Prospective Study

• In an observational prospective study of 922 women and 488 men, mean age 81 years, with a prior myocardial infarction, 48% were treated with statins
• At 36-month follow-up, use of statins was associated with a 50% independent reduction in the incidence of new coronary events

Aronow WS, ahn C: Am J Cardiol 89: 67, 2002

2013 ACC/AHA Lipid Guidelines

• Arteriosclerotic cardiovascular disease (ASCVD) is coronary artery disease, stroke, transient ischemic attack or peripheral arterial disease
• Give high-dose statins to pts ≤ 75 years with ASCVD unless contraindicated
  Reasonable for moderate- or high dose statins to patients with ASCVD >75 years if tolerated
2013 ACC/AHA Lipid Guidelines

Patients ≥21 years of age with a serum low-density lipoprotein cholesterol (LDL-C) ≥ 190 mg/dL should be treated with high-dose statins

2013 ACC/AHA Lipid Guidelines

- For primary prevention in diabetics 40-75 years of age and LDL-C 70-189 mg/dL, use moderate- dose statins
- For primary prevention in diabetics 40-75 years of age, an LDL-C 70-189 mg/dL, and 10-year risk of ASCVD ≥ 7. 5% use high-dose statins
- For diabetics <40 or >75 years and LDL-C 70-189 mg/dL, consider statins
2013 ACC/AHA Lipid Guidelines

Lifestyle modification with adherence to a healthy diet, regular exercise, avoidance of tobacco, and maintenance of a healthy weight is a critical for health promotion and ASCVD risk reduction both prior to and in concert with use of cholesterol-lowering drug therapy.

Diabetes Mellitus

At 40-month follow-up of 664 older men and at 48-month follow-up of 1,488 older women, diabetes mellitus increased the incidence of new coronary events 1.9 times in men and 1.8 times in women.

Aronow WS, Ahn C: Am J Cardiol 77:864, 1996
Obesity

Obesity was an independent risk factor for new coronary events in older men and women in the Framingham Study

Vokonas P, Kannel WB: Chapter 8, Cardiovasc Dis in Elderly Patient, 2nd ed, 1999

Physical Inactivity

Physical inactivity is associated with dyslipidemia, obesity, hypertension, and hyperglycemia
Physical Inactivity

Lack of moderate or vigorous exercise increased 5-year mortality in older men and women in the Cardiovascular Health Study


Exercise Training Programs

Exercise training programs prevent coronary artery disease and improve endurance and functional capacity in older persons after myocardial infarction

Wenger NK: Cardiovasc Dis in Elderly Patient, 1999
Family History

A history of premature coronary artery disease before age 55 in a father or brother or before age 65 in a mother or sister is a risk factor for coronary artery disease.

Hypothyroidism

Hypothyroidism is a risk factor for coronary artery disease.

HERS Trial

Data from the Heart and Estrogen/Progestin Replacement Study (HERS) in which 2,763 postmenopausal women with coronary artery disease were randomized to hormonal replacement therapy or placebo and followed for 6.8 years showed that estrogen/progesterone should not be given to postmenopausal women with coronary artery disease.


Women’s Health Initiative Study

- This study of 16,608 postmenopausal women without cardiovascular disease randomized to estrogen plus progesterone or to placebo was stopped at 5.2-years because absolute excess risks per 10,000 person-years attributable to estrogen plus progesterone were 7 more coronary artery disease events, 8 more strokes, 8 more episodes of pulmonary embolism, and 8 more invasive breast cancers.

JAMA 2988: 321, 2002
Age and Stroke

The incidence of stroke in men and women increases with age

Wolf PA, Kannel WB: Diagnosis and Management of Stroke and TIAs, 1981

Cigarette Smoking

At 42-month follow-up of 664 older men and at 48-month follow-up of 1,488 older women, cigarette smoking increased the risk of stroke 1.5 times in men and 1.9 times in women

Hypertension

At 42-month follow-up of 664 older men and at 48-month follow-up of 1,488 older women, hypertension increased the risk of stroke 2.2 times in men and 2.4 times in women


Antihypertensive Treatment

Treatment with antihypertensive drugs significantly reduces the incidence of stroke in men by 34%, in women by 38%, in elderly persons by 36%, in persons older than 80 years by 34%, and in those with a history of stroke or transient ischemic attack by 28%

Aronow WS, Frishman WH: Curr Cardiol Reports 6:124, 2004
Prevention of Stroke

The overall data suggest that reduction of stroke in pts with hypertension is related more to a reduction in blood pressure than to the type of antihypertensive drug used.

Aronow WS, Frishman WH: Curr Cardiol Reports 6:124, 2004

Treatment of Hypertension

- Adults with a stroke younger than 80 years with hypertension should have their blood pressure reduced to 130-139/80-89 mm Hg.
- Adults with a stroke aged 80 years and older with hypertension should have their systolic blood pressure reduced to 140-145 mm Hg if tolerated.

Aronow WS et al: J Am Coll Cardiol 57: 2037, 2011
Heart Protection Study

At 5-year follow-up of 20,536 high-risk pts (5,806 aged 70-80 years), compared with placebo, simvastatin significantly reduced stroke 25%

Lancet 360:7, 2002

New Stroke

At 36 month follow-up of 922 women and 488 men, mean age 81 years, with prior myocardial infarction, stroke developed in 14% of patients treated with statins (48% of group) versus 26% of patients treated with no lipid-lowering drug (52% of group) (p<0.0001), with a 60% significant independent reduction in stroke in patients treated with statins

New Stroke After Statins

- LDL C <90 mg/dl: 7%
- LDL C 90 to 99 mg/dl: 16%
- LDL C ≥100 mg/dl: 20%

p<0.0001 by Cochran-Armitage test

Diabetes Mellitus

At 29-month follow-up of 529 patients, mean age 79 years, with diabetes and a prior myocardial infarction, use of statins (53% of group) caused a 37% significant independent decrease in new coronary events and a 47% significant independent decrease in new stroke.

Diabetes and Stroke

After adjustment for other risk factors, the relative risk for stroke mortality and morbidity associated with diabetes in pts aged 50 to 79 years was 1.8 in men and 2.2 in women.


Diabetes Mellitus

At 42-month follow-up of 664 older men and at 48-month follow-up of 1,488 older women, diabetes increased risk of new stroke 1.5 times in men and 1.5 times in women.

Framingham Study

- Increased body weight was a weak risk factor for stroke, with obese women more at risk than obese men
- Multivariate analysis indicated that the association between obesity and stroke was chiefly due to higher blood pressures and blood sugars in obese pts

Wolf PA, Kannel WB: Diagnosis and Management of Stroke and TIAs, 1981

Alcohol

- Heavy alcohol intake increases incidence of stroke
- The effect of light and moderate drinking on stroke is unclear

**HERS Trial**

At 4.1-year follow-up of 2,763 postmenopausal women, mean age 67 years, with coronary artery disease, compared with placebo, oral conjugated equine estrogen plus medroxyprogesterone acetate insignificantly increased the incidence of new nonfatal stroke 18% and of new fatal stroke 61%.


---

**Women’s Health Initiative**

At 5.2-year follow-up of 16,608 postmenopausal women without cardiovascular disease, compared with placebo, estrogen plus progestin caused an absolute excess of 8 strokes per 10,000 person-years.

JAMA 288:321, 2002
Prior Stroke

At 42-month follow-up of 664 older men and at 48-month follow-up of 1,488 older women, prior stroke increased risk of new stroke 2.6 times in men and 2.9 times in women


Prior Myocardial Infarction

Prior myocardial infarction is a risk factor for stroke

Framingham Study

The relative risk of stroke in pts with atrial fibrillation compared with sinus rhythm was increased:

- 2.6 times in pts aged 60-69 years
- 3.3 times in pts aged 70-79 years
- 4.5 times in pts aged 80-89 years


Prevalence of Atrial Fibrillation in 2,101 Older Pts

- 5% in pts aged 60-70 years
- 14% in pts aged 71-80 years
- 13% in pts aged 81-90 years
- 22% in pts older than 90 years

New Stroke in 2,101 Older Pts

- The 3-year incidence of thromboembolic stroke was 38% in patients with atrial fibrillation vs 11% in patients with sinus rhythm.
- The 5-year incidence of thromboembolic stroke was 72% in patients with atrial fibrillation versus 24% in patients with sinus rhythm.


Treatment of Atrial Fibrillation

Older patients with chronic or paroxysmal nonvalvular atrial fibrillation at high risk for stroke (CHA2DS2-VASC score of ≥1 in men and of ≥2 in women) without contraindications to anticoagulant therapy should receive long-term warfarin in a dose to achieve an INR between 2.0 to 3.0 or dabigitran, rivaroxaban, or apixaban.

Men with a score of 0 and women with a score of 1 do not require oral anticoagulant therapy.

Lip GYH, Lane DA: JAMA 313: 1950, 2015
The Relevance and Consequences of Diminished Mental Capacity

- Formulations of Capacity Under New York Law
- Health Care Decision Making
  - "Decision-making capacity" means the ability to understand and appreciate the nature and consequences of proposed health care, including the benefits and risks of and alternatives to proposed health care, and to reach an informed decision.
- Public Health Law Sections 2980, 2994-a
The Relevance and Consequences of Diminished Mental Capacity

- Mental Hygiene Law Section 80.03 (c)
- Surrogate Decision Making
  - c) "Lack of ability to consent to or refuse major medical treatment" means the patient cannot adequately understand and appreciate the nature and consequences of a proposed major medical treatment, including the benefits and risks of and alternatives to such treatment, and cannot thereby reach an informed decision to consent to or to refuse such treatment in a knowing and voluntary manner that promotes the patient’s well-being.

The Relevance and Consequences of Diminished Mental Capacity

- General Obligations Law 5-1501(c)
- “Capacity” means the ability to comprehend the nature and consequences of the act of executing and granting, revoking, amending or modifying a power of attorney, any provision in a power of attorney, or the authority of any person to act as an agent under a power of attorney.
The Relevance and Consequences of Diminished Mental Capacity

• Testamentary Capacity
  • Requires the testator be capable of knowing her family members (traditionally referred to as the “natural objects of bounty”), the nature and extent of her property, and the nature and consequences of making the will (*Estate of Kumstar*, 66 NY2d 691 (1985)).
  • A will requires less capacity than any other instrument (*In re Will of Coddington*, 281 AD 143 (3d Dept 1952). The lower standard facilitates the execution of wills, a unilateral transaction, by people who may be sick or suffering from diminished capacity.
  • As a result, a person may have sufficient capacity to execute a will, even if a guardian has been appointed based upon a finding of incapacity (MHL Section 81.29[b]).

The Relevance and Consequences of Diminished Mental Capacity

• Clinical assessments of capacity will generally consider the individual’s ability to (1) express a choice, (2) understand relevant information, (3) demonstrate an understanding of the circumstances and consequences relevant to the current situation, and (4) rationally manipulate information to some degree, mainly as it relates to the situation at hand.

• A 2004 report from the U.S. Senate Special Committee on Aging stated that:

  • “Capacity is situational because different degrees of capacity are required for different tasks and transient because individuals can have both periods of relative lucidity and confusion. At any given point in time, capacity may also be influenced by external forces, such as lack of sleep or medication.”
The Relevance and Consequences of Diminished Mental Capacity

Courts have commented upon the "... Necessarily messy, contextual, indeterminate nature of our frequent efforts to determine the 'competence' or 'capacity' of a legal subject."

Hon. Kristen Booth Glen

*In re Will of Khazaneh*, 15 Misc 3d 515 (Surrogate Court, New York County 2006)

"Throughout most of our legal history, judges and litigants have utilized unitary concepts like 'competent' or 'incompetent,' 'sane' or 'insane.' Notwithstanding this apparently simple framework, the genius of the common law presaged a more 'functional' notion of capacity as legal standards or tests for capacity evolved differently in different areas of law ... It is only relatively recently, however, that the law has explicitly embraced the more nuanced view of modern psychology and psychiatry which recognizes that an individual may be perfectly 'competent' in one area, and 'incompetent' in another. Our legislature adopted this functional approach to determining capacity when it enacted Article 81 of the Mental Hygiene Law in the early 1990's."
The Relevance and Consequences of Diminished Mental Capacity

- In fact, in 1986, the Court of Appeals had held in Rivers v Katz, 67 NY2d 485, that:

- "We conclude however, that neither the fact that appellants are mentally ill nor that they have been involuntarily committed, without more, constitutes a sufficient basis to conclude that they lack the mental capacity to comprehend the consequences of their decision to refuse medication that poses a significant risk to their physical well-being. Indeed, it is well accepted that mental illness often strikes only limited areas of functioning, leaving other areas unimpaired, and consequently, that many mentally ill persons retain the capacity to function in a competent manner."

Mental Hygiene Law (MHL) Article 81 Functional Test of Capacity

The determination of incapacity shall be based upon clear and convincing evidence and shall consist of a determination that the person is likely to suffer harm because:

- The person is unable to provide for personal needs and property management, and

- The person cannot adequately understand and appreciate the nature and consequences of such inability.

- MHL Section 81.02 (b)
The Relevance and Consequences of Diminished Mental Capacity

In reaching its determination, the Court shall give primary consideration of the functional level and functional limitations of the person.

Such consideration shall include an assessment of that person’s:

1. Management of the activities of daily living;
2. Understanding and appreciation of the nature and consequences of any inability to manage the activities of daily living;
3. Preferences, wishes and values with regard to managing the activities of daily living; and
4. The nature and extent of the person’s property and financial affairs and his or her ability to manage them.

- MHL Section 81.02 (c)
The Relevance and Consequences of Diminished Mental Capacity

• The Court shall also consider:
  • The extent of the demands placed on the person by that person’s personal needs and by the nature and extent of that person’s property and financial affairs;
  • Any physical illness and prognosis of such illness;
  • Any mental disability, alcoholism and substance dependence;
  • Medications with which the person is being treated.
• MHL Section 81.02 (c)

The Relevance and Consequences of Diminished Mental Capacity

• The Diagnostic and Statistical Manual of Mental Disorders, with its fifth edition published in 2013 (DSM-5), provides a common language for communicating types of mental disorders and their criteria. DSM-5 organization employs a lifespan approach by grouping diagnoses that occur early in life, those that manifest in adolescence and young adulthood, and those that occur in adulthood and later in life.
• The science of mental disorders continues to evolve and there has been real and durable progress in such areas as neuroscience, brain imaging, epidemiology, and genetics.
• Because impairments, abilities and disabilities vary widely within diagnostic categories, the assignment or presence of a diagnosis does not imply a specific level of impairment or disability in an individual.
The Relevance and Consequences of Diminished Mental Capacity

• Diminished mental capacity may be a manifestation of a mental disorder or a physical disorder.

• Definitions:
  • “Mental Disorder” is a syndrome characterized by clinically significant disturbance in an individual’s cognition, emotion regulation, or behavior that reflects dysfunction in the psychological, biological, or developmental processes underlying mental functioning (DSM V, p.20)

The Relevance and Consequence Diminished Mental Capacity

• Compare DSM diagnosis with New York State statutory definition of Mental Illness which “means an affliction with a mental disease or mental condition which is manifested by a disorder or disturbance in behavior, feeling, thinking, or judgment to such an extent that the person afflicted requires care, treatment and rehabilitation” (MHL Section 1.03[20]).

• The clinical (mental disorder) and legal (mental illness) terms are broad and require contextual application in any particular case to appreciate and understand the cause of a person’s diminished mental capacity.
The Relevance and Consequences of Diminished Mental Capacity

- Diminished mental capacity may be a manifestation of:
  - Neurocognitive Disorders, including delirium and dementia;
  - A thought disorder such as Schizophrenia;
  - Neurodevelopmental Disorders;
  - Substance Related and Addictive Disorders

- Diminished mental capacity may also be caused by a medical condition.

- For example, individuals in a diabetic crisis may exhibit slurred speech, appear confused, and lose physical coordination. An individual with a seizure disorder may appear psychotic or report psychotic symptoms.

- Thus, the whole person should be considered when assessing functional impairments.
The Relevance and Consequences of Diminished Mental Capacity

- Neurocognitive disorders (NCD) begin with delirium followed by the syndromes of major NCD, mild NCD, and their etiological subtypes; including Alzheimer’s disease.

- Dementia is subsumed under the newly named entity *major neurocognitive disorder*, and is customary in use for degenerative dementias that affect older adults. Alzheimer’s is the most common type of dementia.

- The NCD category of disorders are those in which the primary clinical deficit is in cognitive function — *e.g.* thinking and memory — and that are acquired rather than developmental.

Demographic and Population Trends.

- Our population is not getting younger. The number of people with dementias will grow each year as the size and proportion of the US population age 65 and older continues to increase.

- By 2025, the total population of the United States is estimated to be 357,504,264. Of that total, 64,204,108 are projected to be 65 years of age and older; 28,015,838, 75 years of age; and older, and 7,373,320, 85 years of age and older (New York State Office of the Aging [www.aging.ny.gov/ReportsAndData/Index.cfm]).

- Over 5,300,000 people of all ages in the United States currently suffer from Alzheimer's Disease and the Alzheimer’s Association expects this number to nearly triple by 2050.
The Relevance and Consequences of Diminished Mental Capacity

- Delirium vs. Dementia

- Both conditions are alterations in mental status that impact the course of therapy and carry a poor prognosis.

- The onset of delirium is abrupt and has a fluctuating course, characterized by inattention, disorganized thinking and altered level of consciousness. Dementia is a chronic, progressive disease.

- Common scenario is for delirium to arise during the course of a hospital admission. In hospital settings, delirium may last about one week, but symptoms can persist.

The prevalence of delirium is highest among hospitalized older individuals and varies depending upon the individuals' characteristics, setting of care and sensitivity of the detection method.

- The prevalence of delirium at hospital admission ranges from 14% to 24%, and the incidence delirium occurring during hospitalization ranges from 6% to 56%. Delirium occurs in 15%-53% of older individuals post operatively and in 70%-87% of those in intensive care. Delirium occurs in up to 60% of individuals in nursing homes or post-acute care settings.
The Relevance and Consequences of Diminished Mental Capacity

- Why differential diagnosis important?
- Recognizing risk factors and intervening early can decrease the likelihood of delirium developing or shorten its course.
- Simple interventions to make a hospital environment less conducive to the onset of delirium:
- Keep familiar routines, particularly sleep patterns, check what might be missing (glasses, hearing aids, dentures), keep the individual moving, review medications, choose pain medications carefully.

For attorneys who are representing individuals in hospitals and nursing homes, recognizing the prevalence of delirium is important, as well.

- Attorneys may find it fruitful to meet with their clients on different occasions and during different times of day, to account for possible confusion. Engaging in topics of conversation that are familiar to the person, such as where he or she grew up, schools attended, military service, if any, and family relationships, may initiate a bond with the person and further representation.
The Relevance and Consequences of Diminished Mental Capacity

- "Dementia" v. "Mental Illness"

- Dementia (NCD) is a disorder in which the primary clinical deficit is in cognitive function.

- Although cognitive deficits are present in many if not all mental disorders (e.g., schizophrenia, bipolar disorders), only disorders whose core features are cognitive are included in the NCD category.

- The NCDs are unique, as well, among DSM-5 categories because they are syndromes for which the underlying pathology, and frequently the etiology, can potentially be determined.

The Relevance and Consequences of Diminished Mental Capacity

- "Mental illnesses" as commonly understood are descriptive diagnoses not based on laboratory tests.

- Clinical Disorders (old Axis I); e.g., Schizophrenia, Anxiety Disorders, Substance Related Disorders, Mood Disorders (mania, depression).

- Personality Disorders (old Axis II).
The Relevance and Consequences of Diminished Mental Capacity

- **Schizophrenia spectrum and other psychotic disorders** — defined by abnormalities in one or more of the following five domains: delusions, hallucinations, disorganized thinking (speech), grossly disorganized or abnormal motor behavior and negative symptoms.

- Two negative symptoms are particularly prominent in schizophrenia: diminished emotional expression and "avolition." Avolition is a decrease in motivated and self-initiated purposeful activities.

The Relevance and Consequences of Diminished Mental Capacity

- **Bipolar and Related Disorders**

- Individuals with bipolar and related disorders have fluctuations in their mood that are associated with disturbances in social and occupational functioning.

- Bipolar Disorder I — individual experiences episodes of major depression and mania.

- Bipolar Disorder II — individual has intermittent fluctuations in mood, consisting of one or more major depressive disorders and at least one hypomanic episode.
The Relevance and Consequences of Diminished Mental Capacity

- For people with mental illness it is important to understand that the presence of certain psychiatric signs and symptoms alone does not necessarily require a determination of capacity. For instance, a non-psychotic mood or anxiety disorder may have little or no impact on an individual's ability to perceive reality or recall past events. Psychotic symptoms, including, including hallucinations, are rarely constant and are often specific in nature. Psychotic delusions are also frequently discrete, specific to one area of a person's life, and do not necessarily affect a person's functional status generally.


- While a diagnosis can provide insight into the cause of diminished mental capacity, the legal consequences of diminished capacity will often depend upon a judicial adjudication of incapacity.

- E.g., the determination of capacity is a "uniquely judicial function" (Rivers v Katz, 67 NY2d 485 [1986] – forced administration of psychotropic medications to individuals involuntarily committed to psychiatric hospitals).

- E.g., the appointment of a legal guardian will depend upon a judicial determination as to whether the individual has functional limitations (MHL section 81.02).
The Relevance and Consequences of Diminished Mental Capacity

- Other remedies invoked to protect an individual alleged to be laboring under diminished capacity do not require a judicial finding that the individual is "incapacitated."

- *E.g.* civil admission to a psychiatric hospital under article 9 of the MHL.

- *E.g.* assisted outpatient treatment (MHL section 9.60; *Matter of KL*, 1 NY3d 362 [2004]- judicial finding of incapacity not required prior to court ordered implementation of AOT plan).

- *E.g.* entry of guardianship order upon consent (MHL section 81.15[a][2]).

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The Relevance and Consequences of Diminished Mental Capacity

- **Civil Rights:** Even if a patient is suspected to lack decisional capacity, his or her decisions must be respected, as required by PHL section 2994-c (6)

- **Priority of patient's decision.** Notwithstanding a determination pursuant to this section that an adult patient lacks decision-making capacity, if the patient objects to the determination of incapacity, or to the choice of a surrogate or to a health care decision made by a surrogate or made pursuant to section twenty-nine hundred ninety-four-g of this article, the patient's objection or decision shall prevail unless: (a) a court of competent jurisdiction has determined that the patient lacks decision-making capacity or the patient is or has been adjudged incompetent for all purposes and, in the case of a patient's objection to treatment, makes any other finding required by law to authorize the treatment, or (b) another legal basis exists for overriding the patient's decision.
The Relevance and Consequences of Diminished Mental Capacity

- **Civil Rights**

- An incapacitated person for whom a guardian has been appointed retains all powers and rights except those powers and rights which the guardian is granted (MHL section 81.29 [a][1]).

- *But see,* Election Law Section 5-106 (6) – “No person who has been adjudged incompetent by order of a court of competent judicial authority shall have the right to register to vote or vote at any election in this state unless thereafter he shall have been adjudged competent pursuant to law.”


Touro Law Center | Aging and Longevity Law Institute
The Relevance and Consequences of Diminished Mental Capacity

- Abuse of Vulnerable Elders

- A significant extra-judicial consequence of diminished mental capacity is the potential for elder abuse, generally defined as the mistreatment or exploitation of a person who is at least 65 years of age.


- See, Matter of Doar (L.S.) 39 Misc 3d 1242 [A] where Justice Barros of Supreme Court Kings County observed that “this guardianship case highlights the predation and exploitation of the aged and incapacitated.”

The Relevance and Consequences of Diminished Mental Capacity

- Summary and Review of the Impact Medications Have on Diminished Mental Capacity – Effects can be positive or negative.

- Antipsychotic medications may help to reduce psychotic symptoms; first generation (typical) e.g., Thorazine, Prolixin, Haldol; second generation (atypical) e.g. Clozaril, Zyprexa Risperdal, Abilify, Invega.

- Cognitive enhancers work to delay the progression of dementia, but cannot reverse any cognitive impairment that has already occurred e.g. Aricept.
The Relevance and Consequences of Diminished Mental Capacity

- **Drugs Associated with Cognitive Impairment**

- Taking a thorough drug history is one of the first steps that should be performed when assessing an order patient with changes in cognitive function.

- A simple mnemonic to help remember the drugs or classes of drugs that are associated with acute changes in mental status in older individuals is: ACUTE CHANGE IN MS.

- Antiparkinsonian, Corticosteroids, Urologic, Theophylline, Emesis, Cardiac, H2 blockers, Anticholinergics, NSAIDs, Geropsychotropics (antidepressants, antipsychotics, sedatives), Etoh, Insomnia meds, Narcotics, Muscle relaxants, Seizure Meds.

- See, Lisi, Definition of Drug-Induced Cognitive Impairment in the Elderly. Medscape.com

In conclusion and for attorneys, the Rules of Professional Conduct must be considered when representing a client with diminished mental capacity.


  (a) When a client’s capacity to make adequately considered decisions in connection with a representation is diminished, whether because of minority, mental impairment or for some other reason, the lawyer shall, as far as reasonably possible, maintain a conventional relationship with the client.
The Older Population is Growing Older

(1984) 28 Million persons 65 = 12% of U.S. population
(1980) 65-74 = 61% old
    75-84 = 30% old old
    85+ = 9% oldest old

By the year 2000, half of the elderly population will be 75+, 85+ population is fastest growing age group in country. Expected to triple in size 1980 – 2020
And increase seven – fold 1980 – 2050.
In general, elderly women now outnumber elderly men, 3:2
LIVING LONGER
U.S. life expectancy by race and gender.

THE 10 LEADING CAUSES OF DEATH
IN PERSONS ≥ 65 YEARS OLD:
U.S. 1979

<table>
<thead>
<tr>
<th>Cause of Death*</th>
<th>% of Total Deaths of Persons ≥ 65</th>
<th>Death Rate (per 100,000)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Heart Disease</td>
<td>44.6%</td>
<td>2,299</td>
</tr>
<tr>
<td>2. Malignant Neoplasms</td>
<td>19.5%</td>
<td>1,005</td>
</tr>
<tr>
<td>3. Cerebrovascular Disease</td>
<td>11.4%</td>
<td>588</td>
</tr>
<tr>
<td>4. COPD and Related Diseases</td>
<td>3.0%</td>
<td>155</td>
</tr>
<tr>
<td>5. Pneumonia/Influenza</td>
<td>2.9%</td>
<td>148</td>
</tr>
<tr>
<td>6. Atherosclerosis</td>
<td>2.2%</td>
<td>112</td>
</tr>
<tr>
<td>7. Accidental/Adverse Effects</td>
<td>1.9%</td>
<td>98</td>
</tr>
<tr>
<td>8. Diabetes</td>
<td>1.9%</td>
<td>97</td>
</tr>
<tr>
<td>9. Kidney Disease</td>
<td>0.9%</td>
<td>49</td>
</tr>
<tr>
<td>10. Chronic Liver Disease</td>
<td>0.7%</td>
<td>36</td>
</tr>
<tr>
<td>All Other</td>
<td>11.1%</td>
<td>570</td>
</tr>
</tbody>
</table>

* Based on 9th Rev International Classification of Diseases, 1975.
Source: America in Transition: An Aging Society, US Dept of Commerce Special Studies Series P-23, No. 120.
Cardiac Risk Factors: Still Important in the Elderly

Aronow W.S. Geriatrics. January 1990; Vol. 45, No. 1

BRONX AGING STUDY

488 STUDY VOLUNTEERS

-Mean age on entry 78.8 years
-Non-demented on entry
-Community – residing, ambulatory
-315 females; 173 male
-Model education 7-9 years
Entry and Annual Evaluations

1. Physical examination
2. Complete medical history
3. Psychological history
4. Family history
5. Current and past medical history
6. Electrocardiogram
7. 24 hour holter monitor
8. Complete biochemical, hematological and lipid profiles
9. Mental status examination
10. Neuropsychological evaluation

Health Self-Rating by a Cohort of Volunteers In Bronx Aging Study

<table>
<thead>
<tr>
<th></th>
<th>No.</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Excellent</td>
<td>45</td>
<td>(9.4)</td>
</tr>
<tr>
<td>Good</td>
<td>212</td>
<td>(44.4)</td>
</tr>
<tr>
<td>Fair</td>
<td>178</td>
<td>(37.3)</td>
</tr>
<tr>
<td>Poor</td>
<td>42</td>
<td>(8.8)</td>
</tr>
</tbody>
</table>

N = 477
ISH (Isolated Systolic Hypertension)

Systolic BP > 160 mm Hg when Diastolic BP < 90 mm Hg

SHEP

Systolic Hypertension in the Elderly Program
**SHEP Objective**

- To determine whether antihypertensive Drug treatment reduces total risk of stroke in men and women age 60 and older with ISH

- Definition of ISH (Isolated Systolic Hypertension):
  - SBP ≥ 160 - < 220 mm Hg
  - DPB < 90 mm Hg

**SHEP: Reduction of Stroke According to Age**

<table>
<thead>
<tr>
<th></th>
<th>N</th>
<th>Active Rx</th>
<th>Placebo</th>
<th>% Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>60-69</td>
<td>1964</td>
<td>3.9 %</td>
<td>5.2 %</td>
<td>-31 %</td>
</tr>
<tr>
<td>70-79</td>
<td>2122</td>
<td>5.4 %</td>
<td>8.5 %</td>
<td>-30 %</td>
</tr>
<tr>
<td>80+</td>
<td>650</td>
<td>7.5 %</td>
<td>14.0 %</td>
<td>-44 %</td>
</tr>
</tbody>
</table>

JAMA 1991: 265:3254-64
ISH (cont'd)

5-Year Absolute Benefits Found in Placebo-Controlled Endpoint Studies in ISH

<table>
<thead>
<tr>
<th>Event Type</th>
<th>SHEP 1</th>
<th>Syst-Eur 2</th>
<th>Syst-China 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stroke events</td>
<td>30</td>
<td>29</td>
<td>39</td>
</tr>
<tr>
<td>Major CV events</td>
<td>55</td>
<td>53</td>
<td>59</td>
</tr>
<tr>
<td>Deaths</td>
<td>---</td>
<td>---</td>
<td>55</td>
</tr>
<tr>
<td>Dementia</td>
<td>---</td>
<td>19$^4$</td>
<td>---</td>
</tr>
</tbody>
</table>

* With the therapy/regimen used in this study.


Bronx Aging Study Endpoint Events (n) to 12-31-89

<table>
<thead>
<tr>
<th>Event Type</th>
<th>Male</th>
<th>Female</th>
<th>Total</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deaths</td>
<td>69</td>
<td>103</td>
<td>172</td>
<td>6.1</td>
</tr>
<tr>
<td>Total MIs</td>
<td>36</td>
<td>75</td>
<td>111</td>
<td>3.9</td>
</tr>
<tr>
<td>Clinical MIs</td>
<td>22</td>
<td>39</td>
<td>61</td>
<td>2.2</td>
</tr>
<tr>
<td>Unrecognized MIs</td>
<td>14</td>
<td>36</td>
<td>50</td>
<td>1.8</td>
</tr>
<tr>
<td>CVAs</td>
<td>15</td>
<td>29</td>
<td>44</td>
<td>1.5</td>
</tr>
<tr>
<td>Dementia</td>
<td>29</td>
<td>63</td>
<td>92</td>
<td>3.3</td>
</tr>
<tr>
<td>SDAT</td>
<td>9</td>
<td>35</td>
<td>44</td>
<td>1.6</td>
</tr>
<tr>
<td>MID/MIX</td>
<td>10</td>
<td>19</td>
<td>29</td>
<td>1.0</td>
</tr>
<tr>
<td>Other</td>
<td>10</td>
<td>9</td>
<td>19</td>
<td>0.7</td>
</tr>
</tbody>
</table>
Bronx Aging Study
Dementia Rates by Baseline Blessed
to 12-31-89

<table>
<thead>
<tr>
<th>Blessed Errors</th>
<th>SDAT</th>
<th>Total Dementia</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-2</td>
<td>0.6</td>
<td>6.1</td>
</tr>
<tr>
<td>3-4</td>
<td>1.5*</td>
<td>3.4*</td>
</tr>
<tr>
<td>4-8</td>
<td>6.8**</td>
<td>11.1**</td>
</tr>
</tbody>
</table>

* Comparing 3-4 with 0-2 Blessed errors.
** Comparing 5-8 with 0-2 Blessed errors.

Rate of Dementia Related to Gender and MI Status

![Bar Chart]

- Prior MI
- No Prior MI

Women: p = 0.009
Men: p = 0.14

NS
MAJOR FINDING

An association exists between myocardial Infarction, both clinically recognized and unrecognized, and the development of all-cause dementia, especially in women.

HYPOTHESIS

Myocardial infarction and myocardial ischemia, both clinically recognized and unrecognized, are disease markers that predict dementia (PPD and vascular) in very old men and women.
Study Links Alzheimer’s and Heart Attacks

By Lawrence K. Alman

A decade of research with a surprise ending.
May 19, 1999 • One-Day, Pre-Conference Symposium

Hemodynamics and Cerebral Perfusion: New Evidence in the Pathology of AD

Mid-Conference Workshop — Thursday, May 28,

Cardiovascular Risk Factors in the Cause of Alzheimer's Disease: Could This Be an Underlying Key in the Pathology?
Is Elevated Serum Cholesterol Level a Risk Factor for Coronary Heart Disease In the Elderly?


Serum Lipids and Lipoproteins in Advanced Age Intraindividual Changes

William H. Frishman, MD, Wee Lock Ooi, DrPH, Melanie P. Derman, BA, Howard A. Eder, MD, Lewis I. Gidez, PhD, Devorah Ben-Zeev, BS, Peter Zimetbaum, MD, Mark Heiman, MD, and Miriam Aronson, EdD
### Myocardial infarction and men

<table>
<thead>
<tr>
<th>Variable</th>
<th>Beta</th>
<th>SE</th>
<th>P</th>
<th>Rate ratio</th>
<th>95% CI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Smoking</td>
<td>1.759</td>
<td>0.807</td>
<td>0.012</td>
<td>5.6</td>
<td>1.2-28.2</td>
</tr>
<tr>
<td>Health</td>
<td>-0.593</td>
<td>0.585</td>
<td>0.314</td>
<td>0.6</td>
<td>0.2-1.7</td>
</tr>
<tr>
<td>Hypertension</td>
<td>0.776</td>
<td>0.629</td>
<td>0.217</td>
<td>2.2</td>
<td>0.6-7.4</td>
</tr>
<tr>
<td>HDL-C Q-1, 2, 3</td>
<td>-0.528</td>
<td>0.769</td>
<td>0.489</td>
<td>0.6</td>
<td>0.1-2.7</td>
</tr>
<tr>
<td>HDL-C Q-4</td>
<td>2.079</td>
<td>0.578</td>
<td>0.006</td>
<td>7.9</td>
<td>1.8-35.4</td>
</tr>
</tbody>
</table>

Q = quartile  
HDL-C Q-4 = HDL-C < 30 mg/dL  
-Adapted from Frishman et al.

### Myocardial infarction and women

<table>
<thead>
<tr>
<th>Variable</th>
<th>Beta</th>
<th>SE</th>
<th>P</th>
<th>Rate ratio</th>
<th>95% CI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>0.164</td>
<td>0.067</td>
<td>0.014</td>
<td>1.2</td>
<td>1.0-1.3</td>
</tr>
<tr>
<td>Smoking</td>
<td>0.623</td>
<td>0.435</td>
<td>0.163</td>
<td>1.9</td>
<td>0.8-4.4</td>
</tr>
<tr>
<td>Body Mass Index</td>
<td>-0.113</td>
<td>0.061</td>
<td>0.060</td>
<td>0.9</td>
<td>0.8-1.0</td>
</tr>
<tr>
<td>HDL-C Q-1, 2, 3</td>
<td>-0.214</td>
<td>0.559</td>
<td>0.701</td>
<td>0.8</td>
<td>0.3-2.4</td>
</tr>
<tr>
<td>HDL-C Q-4</td>
<td>1.053</td>
<td>0.494</td>
<td>0.032</td>
<td>2.9</td>
<td>1.1-7.5</td>
</tr>
</tbody>
</table>

Q = quartile  
HDL-C Q-4 = HDL-C < 30 mg/dL  
-Adapted from Frishman et al.
### Risk Factors for Cardiovascular Mortality In the Elderly

1. Age  
2. Systolic Hypertension  
3. Diabetes Mellitus  
4. Increased LDL Cholesterol (women)  
5. Decreased HDL Cholesterol (men)  
6. Dementia  
7. History of Cigarette Smoking  
8. Left Ventricular Hypertrophy on ECG  
9. Old MI on ECG and/or MI History  
10. Prolonged PR Interval on ECG  
11. Paroxysmal Non-Sustained Ventricular Tachycardia on Ambulatory ECG  
12. Cardiomegaly on X-ray

### Findings Not Associated With Increased Cardiovascular Risk

1. Gender  
2. Total cholesterol  
3. Body surface area
THEORY

Short Life-Span → Risk Factors → Short Life Span

Short Life-Span Genes → Modify Risk Factors → Increase Longevity

Long Life-Span Genes → Risk Factors → Long Life, Increased Morbidity

Long Life-Span Genes → Modify Risk Factors → ? Long Life, Decreased Morbidity

Findings Not Associated With Increased Cardiovascular Risk

1. Most of the risk factors for cardiovascular morbidity and mortality described in middle age continue to operate in old age.

2. Treatment of risk factors (e.g. hypertension, hyperlipidemia) may impact favorably on cardiovascular morbidity and mortality in old age.
Checkmating Alzheimer’s
A 2 year multidomain intervention of diet, exercise, cognitive training, and vascular risk monitoring versus control to prevent cognitive decline in at-risk elderly people (FINGER): a randomised controlled trial

Tia Ngandu, Jenni Lehtisalo, Alina Solomon, Esko Levälahti, Satu Ahtiluoto, Riitta Antikainen, Lars Bäckman, Tuomo Hänninen, Antti Julia, Tiina Laatikainen, Jaana Lindström, Francesca Mangialasche, Teemu Paajanen, Satu Pajala, Markku Peltonen, Rainer Rauramaa, Anna Stigsdotter-Neely, Timo Strandberg, Jaakko Tuomilehto, Hilkka Soininen, Mia Kivipelto

The Lancet 380:12505-63, 2015
Geriatric Pharmacotherapy

Kenneth R. Cohen, Pharm.D., Ph. D., CGP
Board Certified Geriatric Pharmacist
Associate Professor of Pharmacy Practice
Touro College of Pharmacy

• “Medications are probably the single most important health care technology in preventing illness, disability, and death in the geriatric population.”

• J. Avorn, “Medication Use and the Elderly: Current Status and Opportunities.” Health Affairs, Spring 1995
• "Any symptoms in an elderly patient should be considered a drug side effect until proven otherwise”.

• “Thirty percent of hospital admissions in elderly patients may be linked to drug related problems or toxic effects.”

Seniors take more medications than any other age group. On average, seniors 65 to 69 years old have 13.6 prescriptions filled per year. Those 80 to 84 years old have 18.2 prescriptions filled per year.

www.seniorcarepharmacist.org
What is OLD?

- Chronologic age does not always reflect functional age
- Factors to influence functional age:
  - Nutrition
  - Smoking
  - Health status
  - Exercise habits
  - Living status

<table>
<thead>
<tr>
<th>Age Range</th>
<th>Designations</th>
</tr>
</thead>
<tbody>
<tr>
<td>65-75</td>
<td>Young-Old</td>
</tr>
<tr>
<td>75-85</td>
<td>Old</td>
</tr>
<tr>
<td>&gt;85</td>
<td>Old-Old</td>
</tr>
</tbody>
</table>

Geriatric Pharmacotherapy

- Elderly “walking well” patients take an average of 4.5 prescribed medications
- Geriatric patients in institutions typically take between 6-8 medications
- Older adults comprise approximately 13% of the populations but consume 30% of all medications
- Over The Counter medications and nutritional supplements, together with prescribed medications, greatly increase the risk of polypharmacy
Geriatric Pharmacotherapy

- Creatinine clearance (the measurement of kidney function) declines with an increase in age. This may necessitate dosage adjustment for renal excreted drugs.
- Aging is associated with an increase in the body fat component
- The water compartment decreases, which increases concentration of water soluble drugs.
- Gastrointestinal changes are not significant
- Albumin levels do not change with normal aging, but any decrease is a result of diseases such as liver disease.

Aging

- Multiple factors contribute to drug response in elderly person:
  - Physiological changes and decline in organ function
  - Concomitant drug therapy and co-morbid issues
  - Medication adherence
  - Atypical disease presentation
  - Functional impairment
  - Nutritional status
  - Physical frailty
Atypical Disease Presentation

- Hyperthyroidism
  - Eye findings and goiter may not be as evident
  - Elderly with milder and non-specific symptoms
- Depression
- Peptic Ulcer Disease
  - Anorexia, syncope, mental status changes
- Heart Attack
  - Less chest pain, more dyspnea, weakness, confusion
- Heart Failure
  - Less Shortness of breath more confusion, agitation, anorexia, weakness
- Infections, especially UTI ("change in mental status")

Chronic Conditions

- Most older persons have at least one chronic condition
  - Hypertension
  - Arthritis
  - Heart Disease
  - Cancer
  - Sinus problems
  - Diabetes
- Polypharmacy Issues
  - What is it?
  - 9 or more medications – OBRA
    - Nationwide standard in Long Term Care Facilities
Of all of the age-related changes of the pharmacokinetic process, absorption is the least altered, perhaps because most drugs are passively absorbed.

Warfarin (Coumadin) continues to present a significant challenge for older adults in medication management.
Why is there polypharmacy?

- Patient Age
- Multiple symptoms – in any age
- Multiple medical conditions – in any age
- Excessive prescription writing
- Multiple MDs in different specialties
- Lack of Primary MD
- Lack of coordination and communication between clinicians treating a patient
- Multiple pharmacies used
- Drug regimen changes (perhaps without d/c older meds)
- Hoarding of medications
- Self-treatment

Aging Research

- Few studies longitudinal in design documenting changes in pharmacokinetic parameters as people age
- Confounding characteristics of elderly population
  - Subclinical underlying disease often thought of as “normal aging”
  - Individual patient differences
  - Population differences
    - i.e. independent living vs. nursing home vs. assisted living
- FDA recommends, but does not require inclusion of elderly in clinical trials.
- Practice Guidelines not geriatric specific
The "Big Three" in geriatrics is:

- The ability to ambulate independently
- Successful management of bowel and bladder functions
- Maintenance of cognitive function

The loss of one or more of these abilities can often result in the loss of independent living.

Specific Medication Management Issues in Geriatrics

- How long do we treat?
- Do we treat differently based on age?
- Acceptable Time to benefit of treatment
- Quality of life
- Goals of Care
Pharmacokinetics

- Study of how the body handles a drug
  - Absorption
    - Passage of drug molecules through barriers to reach systemic circulation
  - Distribution
    - Passage of drug molecules from bloodstream into tissues and organs
  - Metabolism
    - Chemical conversion of drug molecules
  - Excretion
    - Irreversible removal of drug from the body


Absorption

- Changes in oral absorption of drugs due to age not clinically significant
- Age-related changes in the GI tract
  - Decreased gastric acid secretion
  - Delayed gastric emptying
  - Slowed intestinal transit time
  - Reduced gastrointestinal blood flow

What will affect Absorption

- More likely to affect oral absorption:
- Disease States
  - Congestive Heart Failure
  - Partial gastrectomy
- Concomitant drug ingestion
  - Drugs affecting pH
  - Drugs affecting gastric emptying and/or motility
- Nutritional Intake and Eating Habits
- Data on other routes other than oral limited
  - Elderly skin = dry with low lipid content

Distribution

- Physiologic changes in body composition
  - Total body water decreases 15% between ages 20 and 80
  - Total body mass decrease
    - 0.29kg/year ages 25 – 67 men
    - 0.12kg/year ages 25 – 67 women
  - Body fat increases by 10 - 20%
- Plasma protein concentration
  - Albumin
  - Alpha 1 acid-glycoprotein (AAG)
Distribution

- Water soluble drugs
  - Decrease Volume of distribution in elderly
    - Ex) ethanol, caffeine, lithium, ranitidine
- Lipid soluble drugs
  - Increase Volume of distribution in elderly
    - Ex) diazepam, carbamazepine, trazodone

Distribution

- Physiologic changes in plasma protein concentrations
- Albumin (4.0-4.5)
  - ↓ Due to normal aging, malnutrition, acute illness, hepatic disease, etc.
  - ↓ 4.2% in those with chronic illness
  - ↓ 10-20% between ages 20 and 90
Distribution

- Albumin is major binding site for acidic drugs
- ↓ serum albumin = ↑ free fraction of highly protein bound drugs
  - i.e. phenytoin, valproic acid, warfarin, salicylate
  - Dosage of medications should be titrated slowly to avoid risk of toxicity
- Alpha 1 acid-glycoprotein is major binding site for basic drugs
  - Concentration may be normal or moderately increased
  - ↑ in bound drugs
  - Ex: lidocaine, propranolol, imipramine, meperidine
  - Clinical significance unknown

Metabolism

- Major site = liver
- Normal aging associated with decreased liver mass and blood flow
  - Reduced first pass metabolism = higher systemic bioavailability
- Caution: high extraction ratio drugs
  - Will now have a higher systemic concentration
    - Nitrates, barbiturates, lidocaine, propranolol
Phase I Metabolism

- Phase I Metabolism reduced or unchanged in the elderly
- Anticipate a reduction in dosage of medications going through Phase I metabolism
- Hydroxylation
- Oxidation
- Reduction
- Demethylation
- Ex) diazepam, alprazolam, desipramine, phenytoin, ibuprofen, fluoxetine, propranolol

Phase II Metabolism

- Generally not affected by age
  - Glucuronidation
    - Lorazepam, Oxazepam, Temazepam
  - Acetylation
    - Isoniazid
  - Conjugation
    - Metronidazole
  - Sulfonation
Elimination

- Renal Excretion
  - Decline in kidney function in 2/3 of population

- Cockcroft-Gault formula most widely used
  \[
  \frac{(140-\text{age}) \text{ (weight in kg)}}{(72) \text{ (SCr mg/dL)}} \times (0.85) \text{ in women}
  \]


Elimination

- Blood Urea Nitrogen (BUN) and Serum Creatinine (SCr) useful markers of renal function, but ....
  - Malnourished – low BUN
  - Diminished muscle mass – low SCr
    - Increase serum creatinine to 1.0 in elderly patients when using Cockcroft-Gault formula
  - Renally excreted drugs
    - Digoxin, ranitidine, aminoglycosides, vancomycin

Beers Criteria

- 1991 – Developed by 12 clinicians, lead by geriatrician Dr. Mark Beers
  - Initially created to guide which medications should be avoided in nursing homes
- Updated in 1997 - Includes all seniors, regardless of residence
- Adopted by Centers for Medicare and Medicaid Services (CMS) in 1999 for nursing home regulation
  - Inappropriate medications met the criteria of:
    - Risk > benefit
    - Lack of efficacy
    - Better drugs available
- Updated again in 2003
- Updated again in 2012

New Beers Criteria Update

- Comprehensive systematic review and grading of evidence on drug-related problems and adverse drug events in older adults
- Support through American Geriatrics Society (AGS)
- 53 medications or medication classes in final criteria
  - Potentially inappropriate medications (PIMs) and classes to avoid in older adults
  - Potentially inappropriate medications and classes to avoid in older adults with certain diseases and syndromes that the drugs listed can exacerbate
  - Medications to be used with caution in older adults
STOPP/START

- Screening Tool of Older Person’s Prescriptions
  - Identifies potentially inappropriate prescribing
  - Accompanied by a concise explanation why prescribing practice potentially inappropriate
- Screening Tool to Alert Doctors to Right Treatment
  - Evidence based prescribing indicators for common disease encountered in older persons
- Red flags that require intervention

Potentially Inappropriate Meds

- Avoid use of PIMs to reduce medication related and ADEs in older adults
- Strong link between Beers medications and poor patient outcomes
- PIMs with limited effectiveness and increased risk of:
  - Delirium, GI bleed, falls, fracture
- Consider nonpharmacological therapy
  - Less is more approach
Adverse Drug Reactions (ADRs)

- Top five greatest threats to the health of seniors
- 28% of hospitalizations among seniors are due to ADRs
- 32,000 seniors suffer from hip fractures each year due to medication related falls
- Elderly account for 12.7% of population
  - Consume 34% of total prescriptions
  - 40-50% OTC
- Individuals aged 80-84 take an average of 18 prescriptions per year

Estimated Annual Cost of ADRs

- $76.6 billion among the ambulatory population
- $20 billion in acute-care facilities
- $7.6 billion in nursing facilities
- Total Annual Direct Medical Cost in United States:

- $104.2 billion
Classes of Medications Requiring Special Attention in the Elderly

- Analgesics
- Anticholinergics
- Anticoagulants
- Antipsychotics
- Antidepressants
- Hypnotics/Anxiolytics

- Digoxin
- Antihypertensives
  - Beta Blockers
  - Antidiabetics
  - H2 Antagonists/PPIs
  - OTCs

Analgesics

- NSAIDS/COX II Inhibitor
  - Not considered first line for osteoarthritis
  - Use cautiously in low doses
    - AVOID Aspirin 325mg
  - Side Effects
    - GI – increased risk for bleed
      - Those >75 or taking oral or parenteral corticosteroids
      - Indomethacin/Ketorolac with highest risk = AVOID
      - PPI/misoprostol does not decrease risk
    - Renal – decrease renal blood flow
    - Cardiovascular – increase BP, exacerbate heart failure and HTN
Analgesics

• Narcotic Analgesics
  • For Chronic or severe pain
    • Sedation
    • Constipation – be prepared with laxatives
  • Avoid long term use of meperidine
    • Renally eliminated – Delirium/seizures
  • Avoid Propoxyphene/APAP (Darvon)
    • No more effective than tylenol with identical side effects as narcotic analgesics
• Skeletal Muscle Relaxants
  • Poorly tolerated due to anticholinergic action, sedation, risk of fracture

GastroIntestinal

• Laxatives
  • First line:
    • Fiber, fluids, exercise
  • Avoid mineral oil
    • Aspiration risk, interferes with fat soluble vitamins, oil seepage
  • Always monitor for drug-induced constipation
• Metoclopramide
  • Can cause EPS and TD, risk greater in frail older adult
  • Avoid unless for Diabetic Gastroparesis
• Trimethobenzamide
Anticholinergics

- Adverse effects
  - Urinary retention
  - Delirium
  - Blurry Vision
  - Dry mouth
  - Constipation
  - Dry eyes

- Medications Include
  - Antimuscarinic agents used for overactive bladder
  - Antipsychotics
  - Antispasmodics
  - Antiparkinson agents
  - Tricyclic Antidepressants
  - Antiemetics
  - Antihistaminies
  - OTC sleep agents

Typical Response to Anticholinergic Medications

- Can’t See!
- Can’t Pee!
- Can’t Spit!
- Can’t Defecate!
- Can’t Think!
- This Stinks!
TABLE 1. Anticholinergic Drug Levels in 25 Medications Ranked by the Frequency of Their Prescription for Elderly Patients

<table>
<thead>
<tr>
<th>Medication</th>
<th>Anticholinergic Drug Level (ng/mL of atropine equivalents)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Procainamide</td>
<td>0.22</td>
</tr>
<tr>
<td>2. Digoxin</td>
<td>0.25</td>
</tr>
<tr>
<td>3. Diazoxide</td>
<td>0.08</td>
</tr>
<tr>
<td>4. Lanoxin</td>
<td>0.23</td>
</tr>
<tr>
<td>5. Hydralazine</td>
<td>0.00</td>
</tr>
<tr>
<td>6. Proneproanol</td>
<td>0.00</td>
</tr>
<tr>
<td>7. Salsalicylic acid</td>
<td>0.00</td>
</tr>
<tr>
<td>8. Dipyridamole</td>
<td>0.11</td>
</tr>
<tr>
<td>9. Theophylline anhydrous</td>
<td>0.44</td>
</tr>
<tr>
<td>10. Nitroglycerin</td>
<td>0.00</td>
</tr>
<tr>
<td>11. Insulin</td>
<td>0.00</td>
</tr>
<tr>
<td>12. Warfarin</td>
<td>0.12</td>
</tr>
<tr>
<td>13. Prednisolone</td>
<td>0.55</td>
</tr>
<tr>
<td>14. Alloprednisolone</td>
<td>0.00</td>
</tr>
<tr>
<td>15. Nifedipine</td>
<td>0.22</td>
</tr>
<tr>
<td>16. Insarbid citrate</td>
<td>0.15</td>
</tr>
<tr>
<td>17. Ibuprofen</td>
<td>0.00</td>
</tr>
<tr>
<td>18. Codeine</td>
<td>0.11</td>
</tr>
<tr>
<td>19. Clopidigron</td>
<td>0.06</td>
</tr>
<tr>
<td>20. Diluzem hydrochloral</td>
<td>0.00</td>
</tr>
<tr>
<td>21. Captopril</td>
<td>0.02</td>
</tr>
<tr>
<td>22. Atropine</td>
<td>0.00</td>
</tr>
<tr>
<td>23. Metoprolol</td>
<td>0.00</td>
</tr>
<tr>
<td>24. Timolol</td>
<td>0.00</td>
</tr>
<tr>
<td>25. Ranitidine</td>
<td>0.22</td>
</tr>
</tbody>
</table>

*At a 10⁻⁴ M concentration.

Anticoagulants and Antiplatelets

- Weigh risk-benefit
  - May prolong clotting time and elevate INR values or inhibit platelet aggregation, resulting in an increased potential for bleeding
- Check indications and length of treatment for each agent!
- Aspirin 81mg vs. 325 mg
  - Specific dosing guidelines
- Lack of evidence of benefit versus risk >80 for primary prevention
Anticoagulants and Antiplatelets

- Dabigatran – use with caution
  - Greater risk of bleeding than with warfarin in adults aged >75
  - Lack of evidence for efficacy and safety in individuals with CrCl < 30 mL
- Prasugrel – use with caution
  - Greater risk of bleeding in older adults; risk may be offset by benefit in highest-risk older adults (e.g., with prior myocardial infarction or diabetes mellitus)

Antipsychotics

- Very strict guidelines for antipsychotic use in elderly
- Potential to be used as chemical restraints
  - Dose reduction attempts at least once every 6 months
    - Attempt twice, then document clinical necessity
    - Document specific behaviors
- Use atypical antipsychotics first
  - Increased risk of stroke and mortality in persons with dementia
- Use very low doses
  - AE: weight gain, sedation, hyperglycemia, etc
FDA “Black Box Warning” for atypical psychotropic agents

- FDA approved uses for Risperdal include:
  - Schizophrenia
  - Bipolar mania
- Psychosis, agitation related to dementia, aggression and behavioral disorders are all off label uses (not approved by the FDA)
- “Black Box” Labeling on FDA approved packaging:
  - “Elderly patients with dementia-related psychosis treated with antipsychotic drugs are at increased risk of death. Risperidal is not approved for use in patients with dementia-related psychosis”

Evidence used by FDA

- 17 placebo controlled trials with 5106 elderly individuals suffering dementia-related behavioral disorders
- Data showed a 4.5% death rate as opposed to 2.6% in placebo group
- Causes included cardiovascular, heart failure or infectious conditions
2011 IG Report

- Half of Medicare claims for atypical antipsychotic drugs were outside the FDA indications
  - Contrary to above recommendations
- Prescribing and claims contrary to FDA findings
- CMS audits of LTC facilities should consider this “Unnecessary Drug Use” and cite facilities accordingly

Responses

- CMS felt that diagnosis is not a required data element on pharmacy billing transactions
- However, CMS was concerned about the risk/benefit of the use of these agents for dementia related agitation
- American Psychiatric Association includes atypical antipsychotics in its treatment guidelines for dementia

American Society of Consultant Pharmacists guidelines for psychotropic use in Nursing Facilities

- Use of non pharmacologic (Behavioral) intervention first
- An appropriate indication for its use
- A specific and documented goal for therapy
- Ongoing monitoring of the patient to evaluate medication effectiveness in achieving the stated goal of therapy
- Monitoring of drug induced adverse effects
- Use of medication only for the duration needed, at the lowest effective dose

CMS National Partnership to improved Dementia Care in Nursing Homes

- Designed to share strategies between health care organizations across the country
- Includes the Nursing Home Quality of Care Collaborative
- Reviews updates to surveyor guidance training
- Shares recent data
- Since inception 5 years ago, strategies have realized almost a 20% decrease in usage
Antidepressants

• All classes equally efficacious
• Choose agents based on side effects
• Avoid tertiary Tri-cyclic antidepressants
• Selective Serotonin Reuptake Inhibitors (SSRIs)
  • Most commonly used
  • Generally well tolerated
• Special Consideration:
  • Paroxetine (Paxil®)
  • Fluoxetine (Prozac®)
  • Mirtazapine (Remeron®)

Hypnotics/Anxiolytics

• Review Indication – avoid for treatment of insomnia, agitation, delirium
• Avoid long-acting Benzodiazepines
• Long half-lives in elderly – often days
  • Diazepam (Valium®)
  • Chlordiazepoxide (Libritabs®)
• Caution with short-acting Benzodiazepines
  • Lorazepam (Ativan®) >3mg
  • Oxazepam (Serax®) >60mg
  • Alprazolam (Xanax®) >2 mg
  • Temazepam (Restoril®) >15mg
  • Triazolam (Halcion®) >0.25 mg
Hypnotics/Anxiolytics

- Meprobamate
  - High rate of physical dependance; very sedating
- Nonbenzo hypnotics
  - Eszopiclone, zolpidem, zaleplon
  - Similar adverse events to those of benzodiazepines
    - Delirium, falls, fracture
    - Minimal improvement in sleep latency and duration
  - Avoid use >90 days

Digoxin (Lanoxin®)

- Review for proper indication
- Be alert for toxicity
  - Nausea, Anorexia, Visual disturbances, confusion
- Usual adult dose:
  - 0.125 – 0.250 mg /day
- Dose based on renal function
  - Higher doses put patient at risk for adverse effects!
    - No additional benefit – especially in heart failure
- Serum drug level needed
Antihypertensives

- Monitor for hypotension, falls, orthostasis
- Caution with alpha blockers
  - Terazosin, doxazosin used for Benign Prostatic Hypertrophy (BPH)
- Caution with alpha agonists
  - Clonidine – high risk of CNS side effects, bradycardia, orthostatic
  hypotension – not recommended for routine HTN treatment
- Favored agents:
  - Low dose diuretics, ACE inhibitors, ARBs, Calcium Channel Blockers
  - Avoid spironolactone >25mg/day
    - Avoid in heart failure or those with CrCl <30ml/min

Beta Blockers

- Many disease interactions
  - Mask tachycardia
  - Mask most symptoms of hypoglycemia
  - COPD/Asthma
  - Mental status
- Use for post-MI and HF patients
- Be patient specific when choosing an agent
- Ophthalmic beta blockers with systemic side effects
Antidiabetics

- Does patient have dexterity to administer insulin and check fingersticks?
- Complexity of dosing regimens
- Monitor patient for signs and symptoms of hypoglycemia
- Avoid long acting medications
  - Glyburide
  - Chlorpropramide
- Monitor renal function
  - Metformin
- Avoid Pioglitazone and rosiglitazone in HF

Sliding Scale Insulin

- AVOID!
- Beers Criteria says: Higher risk of hypoglycemia without improvement in hyperglycemia management regardless of care setting
H2 Antagonists/ Proton Pump Inhibitors

- Check Indication – often unclear or unnecessary!
  - Review dosing, length of treatment
  - Consider cost and alternatives
- Adjust dose based on renal function
- At risk of inducing or worsening delirium in older adults
- Monitor over the counter use
  - Prilosec OTC
  - Prevacid OTC
  - Tagamet – MANY interactions!

Over-the-Counter Medications

- Must ask about during medication history
- Include Herbals, home remedies, vitamin and mineral use, teas, supplements – ANYTHING!!
- Many Rx products available OTC
  - Sleep aids
  - NSAIDS
  - PPIs
  - H2 Antagonists
  - Antihistamines
  - Pain relievers
Barriers to Effective Ambulatory Geriatric Care

- Having difficulty understanding labeled instructions relates to patient education and communication, which can be a common problem in interaction with the elderly. The others listed are all types of medication non-compliance that should be evaluated by the pharmacist.

Geriatric Syndromes

- Unique features of common health conditions on older adults that do not fit into discrete disease categories
  - Falls
  - Incontinence
  - Delirium
  - Frailty
  - Chronic Pain
  - Undernutrition/Anorexia
Falls

- Leading cause of accidental death in older adults
- In elderly population, 1 in 7 falls results in hip fracture
- Half of all mobile hip fracture patients unable to walk post fall and break
- Half of all hip fracture patients no longer able to live independently
- Interventions for fall-prevention
  - Review medication regimen
    - Alcohol, benzodiazepines, hypotension, hypoglycemia = all contribute to falls
    - Low dose, short half-life medications best
  - Calcium and Vitamin D Supplementation

Delirium

- Acute disturbance of consciousness marked by an attention deficit and a change in cognitive function
- Most often seen in acute care hospitals
  - Abrupt onset, varies throughout the day; “sundowning”
- Most frequently seen in:
  - Advanced age
  - Co-morbid conditions
  - Sleep deprivation
  - Dehydration
  - Pain
  - Transfer in setting
Incontinence

- Involuntary loss of urine
  - Leading to social and hygienic problems
- Treatment options
  - Behavioral therapy
  - Medication management
    - Review profile for medications/disease states causing incontinence
    - Initiate appropriate medications for incontinence

Frailty

- Decreased reserve; diminished resistance to stressors
- Resulting from cumulative decline across multiple physiologic systems
  - Increased vulnerability to adverse outcomes and high risk of death
  - 1. Ineffective of incomplete homeostatic response
  - 2. Multiple co-morbidities and polypharmacy
  - 3. Physical Disability
  - 4. Geriatric Syndromes
Medication Reconciliation

- When done correctly, can decrease medication error.
- Encourage patients to carry a medication record with them at all times.
  - List of CURRENT medications
  - Continuum of care

Medication Appropriateness Index

1. Is there an indication for the medication?
2. Is the medication effective for the condition?
3. Is the dosage correct?
4. Are the directions correct?
5. Are the directions practical?
6. Are there clinically significant drug-drug interactions?
7. Are there clinically significant drug-disease/condition interactions?
8. Is there unnecessary duplication with other medication(s)?
9. Is the duration of therapy acceptable?
10. Is this medication the least expensive alternative compared with others of equal utility?

Medication Non-Adherence

- Reasons
  - Attitudes/misconceptions
  - Lack of knowledge
  - Complicated regimen
  - Long duration of therapy
  - Inconvenience
    - Dosing schedule, cost
  - AE
  - Changes in functional status
  - Physiologic/psychologic dependence
  - Social/psychological problem

- Consequences
  - Side effects
  - Toxicity
  - Inadequate Treatment
  - Drug Interactions
  - Increased health care costs

Patient education will help

- Include family member/care giver
- Establish patient’s treatment goals with patient
  - Acceptance and understanding
- Detailed medication schedule
- Written and Verbal information
- Reassess at every opportunity
  - Knowledge and/or information does not equal adherence!
Those at increased risk for ADRs

- Polypharmacy
- Female Gender
- Small body size
- Hepatic or renal insufficiency
- Previous ADRs

Royal College of Physicians 1997

Compliance Aids

- Medication Calendar
  - List medications, check off as taken
- Pill boxes
- Electronic timers/beepers
- Helpful hints to form habits
- Organizers, reminders, safe medication aides:
  - zelco.com
  - medose.com
  - epill.com
  - medportinc.com
Geriatric Friendly Drugs

- Unique Dosage Forms
  - Nasal Sprays
  - Inhalers
  - Transdermal patches
- Sublingual tablets
- Liquid products
- Sustained release dosage forms
- Combination dosage forms*
- Increase availability of lower strengths of medication
  - Avoid splitting tablets

Pharmacist’s Role

- Properly assess medication regimens
- Assure doses are appropriate
- Assure patient is not experiencing side effects
- Evaluate compliance to medication regimen
- Properly counsel patient
- Provide compliance aids
  - Organizers, reminders, safe medication aides:
    - zelco.com
    - medose.com
    - epill.com
    - medportinc.com
Pharmacy Activities

- Brown Bag Days
- Senior Center Talks/Tables
  - Disease screening
  - Medication counseling
- Collect unwanted medications
- Community Support Groups
  - Pharmacist is often front line health care professional

THE GOLDEN RULE

- OF GERIATRIC PHARMACOTHERAPY ....

START LOW, GO SLOW,
DON’T STOP!
IX. Speaker Biographies

Patricia E. Salkin
Robert Abrams, Esq.
Honorable A. Gail Prudenti
Wilbert S. Aronow, MD
Ellyn S. Kravitz, Esq.
William H. Frishman, MD
Sheila Shea, Esq.
Robert Cannon, Esq.
Kenneth Cohen, PharmD, Ph.D.
Fern Finkel, Esq.
Joan Lensky Robert, Esq.
Ira Salzman, Esq.
Patricia E. Salkin

Prior to joining the Touro College Jacob D. Fuchsberg Law Center in the summer of 2012, Dean Salkin was the Raymond & Ella Smith Distinguished Professor of Law, as well as Associate Dean and Director of the Government Law Center of Albany Law School. Dean Salkin is co-chair of the NYS Bar Association’s Standing Committee on Legal Education and Admission to the Bar and she was a member of the City Bar’s Task Force on New Lawyers in a Changing Profession. She is a past chair of the American Association of Law School’s State & Local Government Law Section, and is the author of hundreds of books, articles and columns including a recent piece in the Journal of Legal Education on incorporating best practices into the teaching of land use law. She served two terms as an appointed member of the National Environmental Justice Advisory Council, a Federal Advisory Committee to the U.S. Environmental Protection Agency.

A member of the American Bar Association’s House of Delegates, Dean Salkin holds and has held many leadership positions within both the ABA and the New York State Bar Association including: Past Chair of the ABA State and Local Government Section and current member of the Standing Committee on Governmental Affairs (ABA); Past Chair of the NYSBA Municipal Law Section and Founding Member and Past Chair of the NYSBA Committee on Attorneys in Public Service; and she has chaired numerous NYSBA task forces including one focusing on: government ethics, eminent domain, and town and village justice courts.


She has served on the Board of Directors of the New York Planning Federation, and has been active in land use reform efforts including membership on the Land Use Advisory Committee of the NYS Legislative Commission on Rural Resources. She is a reporter for the American Planning Association's Planning & Environmental Law and on the Editorial Advisory Board for The Urban Lawyer produced by UMKC School of Law for the ABA. Dean Salkin continues to serve as the long-term chair of the American Planning Association's Amicus Curiae Committee. She has consulted on land use issues for many national organizations including: the American Planning Association, the American Institute of Certified Planners, the National Academy for Public Administration and the National Governor's Association.

Dean Salkin is committed to advancing the status of women in the legal profession. She is the editor of Pioneering Women Lawyers: From Kate Stoneman To Present, Editor (American Bar Association Press, 2008), and she has delivered speeches and earned recognition from womens'
bar associations, women's business organizations and non-profit organizations focused on women. She is a member of the Suffolk County Women's Bar Association, the National Association of Women Lawyers, and a former member of the Capital District Women's Bar Association. At Touro Law, Dean Salkin and her family have established two scholarships, one awarded to a rising 2L (F/T of P/T) or rising 3L (five-year PT) female student who shows commitment to women’s and/or diversity issues, and a second scholarship awarded annually to a law student who is either currently or was previously a K-12 teacher pursuing school while also raising a family; or someone raising a family who has expressed an interest in education law.
Robert Abrams (Bob) is the co-founder and an executive partner at Abrams, Fensterman, Fensterman, Eisman, Formato, Ferrara & Wolf, LLP, a law firm located in Lake Success, New York, with locations in Brooklyn, Manhattan and Rochester. A nationally recognized expert in Health and Elder Law, Bob has participated in many important matters in courtrooms, boardrooms and other venues.

Recognized for his substantive expertise and leadership skills, Bob has been called a “Pillar of Knowledge” and a “National Treasure.” Bob served as Chair of both the Elder and Health Law sections of the New York State Bar Association (NYSBA). Bob had the unique honor to serve as guest editor of the historic 2011 issue of the NYSBA Journal which was titled “Are You Prepared for the Elder Years?” Over 100,000 people have read this special issue of the NYSBA Journal.

Bob has twice been invited to participate in the once in a decade White House Conference on Aging (WHCoA), the first of which was hosted by President Bill Clinton in 1995 and the second hosted by President George W. Bush in 2005. At the 2005 Conference, Bob coordinated the first ever WHCoA Technology Exhibit which showcased technological initiatives designed to improve the quality of life for older individuals in America and throughout the world.

A prolific educator and writer, Bob has presented educational programs to attorneys, healthcare professionals and consumers throughout the United States. Bob has made presentations to many prestigious organizations including the American Healthcare Association; National Academy of Elder Law Attorneys; American Bar Association; Arizona Healthcare Association; Rhode Island Healthcare Association; California Association of Healthcare Facilities and the National Association of State Veterans Homes.

At the request of NYSBA, Bob has served as an Editor for the following legal resources: *Guardianship Practice in New York State*; a joint project with the New York State Medical Society titled: *The Legal Manual for New York Physicians*; and, at the direction of the Honorable Jonathan Lippman, Chief Judge of New York State, *The Legal Manual on Public Health Emergency Preparedness*.

In 2000, Bob co-authored *Boomer Basics*, which was published by McGraw Hill and which addressed personal, financial and health issues that affect Baby Boomers, their parents and children. In 2009, Bob wrote *Watered-Down Truth: A Flood of Lies More Deadly Than Hurricane Katrina*. This book received multiple accolades for providing a riveting and truthful account of how and why 35 patients drowned in their Nursing Home during Hurricane Katrina.

Bob’s latest book *Be a Planner, Not a Gambler: What You Need to Know and Do to Prepare for the Elder Years* has resulted in the creation of the “Be a Planner” phenomenon. Over 1,000,000 people throughout the United States are expected to be exposed to this movement which encourages Americans of all ages to prepare for life’s contingencies.
As an outgrowth of the “Be a Planner” movement, Bob created the Aging and Longevity Law Institute (“ALLI”) for the Touro Law Center. ALLI has been designed to provide attorneys and other professionals with the information and resources they need to serve the 100 million Americans who are 50 years of age or older. The Institute will address a wide variety of educational topics, including fragility of capacity, adult children with special needs, bankruptcy, confidentiality, emergency preparedness, estate planning and administration, financial planning, grandparents’ rights, mental health issues, retirement, taxes and many others. As the Institute grows, plans include a research agenda focused on law and public policy in the area of longevity and aging law.

As part of ALLI, Bob has begun an initiative to expand and transform the practice of elder law into a new area of law which would be called Aging and Longevity Law. Bob has defined Aging and Longevity law as follows:

A confluence of several substantive areas of law which individually and collectively address the diverse legal challenges and related life contingencies that impact many of the ever evolving and growing demographic of the 100 million Americans who are approximately 50 years of age or older.

Bob received his law degree from the evening division of New York Law School. While attending law school at night, Bob worked in an administrative capacity in a nursing home. He passed the New York State Nursing Home licensure test the same year he passed the Bar exam. He received a Master’s degree in Public Administration from New York University, which included course work completed at Fresno State University of the California University System. Bob graduated with honors from Brooklyn College where he received his bachelor’s degree in special education.

Bar Admissions

New York

Education

New York Law School, New York, New York
LL.B.

New York University
Master’s Degree
Major: Public Administration

Brooklyn College
B.A.

Published Works

Boomer Basics
Guardianship Practice in New York State

The Legal Manual for New York Physicians

The Legal Manual on Public Health Emergency Preparedness

Watered-Down Truth: A Flood of Lies More Deadly Than Hurricane Katrina

Be a Planner, Not a Gambler: What You Need to Know and Do to Prepare for the Elder Years

Classes/Seminars

Educational programs to attorneys, Healthcare Professionals and consumers throughout the United States, American Healthcare Association

Professional Associations and Memberships

National Academy of Elder Law Attorneys, Active Member

New York State Bar Association, Active Member
The Honorable A. Gail Prudenti was appointed Chief Administrative Judge of the Courts of New York State, by Chief Judge Jonathan Lippman effective December 1, 2011. As Chief Administrative Judge, she oversees the administration and operation of the statewide court system, with a budget of over $2.7 billion, 3,600 State and locally paid Judges and 15,000 non-judicial employees in over 350 court locations around the state.

Prior to her appointment as Chief Administrative Judge, she served as the Presiding Justice of the Appellate Division for the Second Judicial Department in New York State, the first woman to hold that position, having been appointed thereto, in February 2002, by then-Governor George E. Pataki. Before that, she was the first woman from Suffolk County to serve as an Associate Justice of the Appellate Division for the Second Judicial Department. Prior to ascending to the Appellate Division, Judge Prudenti was the Administrative Judge for the Tenth Judicial District (Suffolk County) for almost three years. At the time of her appointment as a District Administrative Judge, in February of 1999, Judge Prudenti was also the Surrogate of Suffolk County and was the first and only Surrogate in New York to hold the position of a District Administrative Judge.

In August 2011, then-Presiding Justice Prudenti was designated to serve as a Judge of the Court of Appeals for the hearing and determination of the appeal and any related motions in the case of Matter of World Trade Center Bombing Litigation.

Judge Prudenti’s judicial career began in 1991 when she was elected to the New York State Supreme Court where she served until 1995, at which time she began her term as the first woman elected Surrogate of Suffolk County. In 1996, during her tenure as Surrogate, Judge Prudenti was also designated as an Acting Supreme Court Justice and received the additional responsibilities of presiding over a dedicated Guardianship Part. After six years as the Surrogate, Judge Prudenti was reelected to the Supreme Court bench.

She earned her law degree from the University of Aberdeen, in Scotland, which also awarded her an honorary Doctorate of Laws in 2004 and an honorary appointment as Professor in the School of Law. She graduated from Marymount College of Fordham University of Fordham University with honors. Her first position was in the Suffolk County Surrogate’s Court where she was a Clerk and then a Law Assistant. For two years following her service in the Surrogate’s Court, she served as an Assistant District Attorney for Suffolk County. Over the next decade, she was a private practitioner specializing in trusts and estates and was special counsel to the New York City Patrolmen’s Benevolent Association’s Widows and Orphans Fund. She has had extensive litigation experience in all the Surrogate’s Courts in the metropolitan area.
Her legal writings are extensive. Over 1,000 of Judge Prudenti’s decisions have been published and she has contributed articles to many publications, such as “The New York Law Journal,” “Newsday,” “The Suffolk Lawyer” and “The Jurist.” She has also published handbooks for guardians ad litem and has written extensively on guardianship proceedings.

Additionally, Judge Prudenti has been a frequent lecturer throughout Suffolk County, Long Island, and the State, appearing at seminars and other functions sponsored by the Suffolk Academy of Law, the New York State Bar Association, the New York State Surrogate’s Association, the Office of Court Administration, the University of the State of New York at Stony Brook, Touro Law Center, the Diocese of Rockville Centre, and the Roman Catholic Diocese of Brooklyn, to name a few.

The judge is a member of the Advisory Panel of Judges of the New York State Lawyer Assistance Trust Program, a member of the Council of Chief Judges of the National Center for State Courts, a former chairperson of the Office of Court Administration’s Mental Health Curriculum Committee for Trial Judges, co-chair of the Chief Judge’s Task Force on Delay in the Courts, a member of the Chief Judge’s Commission on Public Access to Court Records, a former member of the Chief Administrative Judge’s Judicial Legislative Group and a member of the OCA’s Gender Bias and Anti-Discrimination Panel. In addition, the judge is a member of the Judicial Section of the American Bar Association, the former Presiding Member of the Judicial Section of the New York State Bar Association, a member of the New York State Trial Lawyers Association and the New York State Women’s Bar Association, a former co-chair of the Surrogate’s Court Committee of the Suffolk County Bar Association, a member of the Suffolk County Women’s Bar Association, which she helped found, and a member of the Board of Directors of the Suffolk County Columbian Lawyers Association.

Judge Prudenti is an accomplished administrator and an experienced supervisor of large-scale court operations, including one of the busiest appellate courts in the United States. As Presiding Justice, she served on the Judiciary’s primary decision-making body, the Administrative Board of the Courts, which provides direction and establishes statewide policies and practices for New York State’s Unified Court System. In her various leadership roles, the judge has developed innovative programs and instituted many initiatives to enhance the administration of justice and promote the public’s trust and confidence in the courts.

In her current role as Chief Administrative Judge, Judge Prudenti acts as the final authority on all administrative actions and services in the New York State Unified Court System, is the sole appointive authority for members of numerous statewide committees, and, in collaboration with the Presiding Justices, determines the annual assignment of over 3,300 justices and judges in the trial courts of the State of New York. She also serves as a member of the Oversight Board for Judiciary
Civil Legal Services Funds in New York, which grants annual awards totaling $25 million to legal services providers to the indigent throughout New York State, and as a member of the New York City Advisory Board for Administration for Children’s Services. She recently established the Annual Judicial Excellence Awards to acknowledge two outstanding jurists for their extraordinary contributions to New York’s judiciary and for their dedication and leadership in advancing the quality of justice.

While appreciative of the recognition and numerous awards she has received throughout the years from assorted groups and organizations, Judge Prudenti feels her greatest honor has been the opportunity to serve the people of the State of New York. The judge lives with her husband and fellow lawyer and former Suffolk County Attorney, Robert J. Cimino, in the Village of Bellport.

Information about Judge Prudenti is also available on the Executive Officers page and in the Judicial Directory.
Wilbert S. Aronow MD is Professor of Medicine at New York Medical College/Westchester Medical Center, Valhalla, NY, USA. Dr. Aronow received his MD from Harvard Medical School. He has edited 13 books and is author or co-author of 1,434 papers, 278 commentaries or Letters to the Editor, and 997 abstracts and is presenter or co-presenter of 1,355 talks at meetings. Dr. Aronow is a Fellow of the ACC, the AHA, the ACP, the ACCP, the AGS (Founding Fellow of Western Section), and the GSA. He has been a member of 108 editorial boards of medical journals, co-editor of 2 journals, deputy editor of 1 journal, executive editor of 3 journals, associate editor for 9 journals, and guest editor for 7 other medical journals. He has received each year from 2001-2014 an outstanding teacher and researcher award from the medical residents and also from the cardiology fellows at Westchester Medical Center/New York Medical College. He has received awards from the Society of Geriatric Cardiology, the Gerontological Society of America, New York Medical College including the 2014 Chancellor’s Research Award, the F1000 Faculty Member of the Year Award for the Faculty of Cardiovascular Disorders in 2011, 2013, and in 2014, the Walter Bleifeld Memorial Award for distinguished contributions to clinical research from the International Academy of Cardiology in July, 2010, and a Distinguished Fellowship Award from the International Academy of Cardiology in July, 2012. He has been a member of 4 national guidelines committees including being a coauthor of the 2010 AMDA guidelines for heart failure, co-chair and first author of the 2011 ACC/AHA expert consensus document on hypertension in the elderly, coauthor of the 2015 AHA/ACC/ASH scientific statement on treatment of hypertension inpatients with coronary artery disease, and is currently a member of the writing group of the ACC/AHA guideline for the management of patients with hypertension. He was a coauthor of a 2015 position paper from the International Lipid Expert Forum. He was a consultant to the ACP Information and Educational Resource (PIER) on the module of aortic stenosis. He is currently a member of the Board of Directors of the ASPC, and a member of the ACCP Cardiovascular Medicine and Surgery Network Steering Committee.
Ellyn S. Kravitz is a partner at Abrams, Fensterman, Fensterman, Eisman, Formato, Ferrara & Wolf, LLP. She concentrates her practice in elder law, special needs planning, estate planning, estate administration, guardianship, and veterans’ benefits. Ellyn is an authority on issues affecting adults and children with disabilities, and our senior population.

Ellyn holds the designation of a Certified Elder Law Attorney (CELA), awarded by the National Elder Law Foundation as accredited by the American Bar Association. There are fewer than 400 CELAs throughout the United States. Ellyn is also accredited by the U.S. Department of Veterans Affairs to present and prosecute claims for veterans’ benefits.

She was named as a “New York Super Lawyer” by Law & Politics magazine from 2009 through 2014 and was included in the list of Top Women Attorneys in the New York Metro Area for 2012, 2013 and 2014 in the New York Times Magazine. Further, she was selected by her peers for inclusion in the 21st edition of The Best Lawyers in America® in the practice area of elder law.

Ellyn is an active member of the New York State Bar Association where she is an active member of both the Elder Law and Special Needs Section and Trusts and Estate Sections. She is member of the Executive Committee of the Elder Law Section and serves as the current Co-Chair of the Guardianship Committee. Previously, she served as co-chair of the Estate and Tax, Legal Education and Health Care Committees. Ellyn is also a member of the Executive Committee of the Trusts and Estates section and serves as the Chair of its Elderly and Disabled Committee. She previously served as Co-Chair of the Elder Law Committee of the Westchester County Bar Association.

Ellyn is a member of the National Academy of Elder Law Attorneys (NAELA) and the New York State Chapter of NAELA. She is also a member of the Board of the Estate Planning Council of New York City, Inc.

Ellyn was former co-chair of the Long Island Alzheimer’s Foundation (“LIAF”) Legal Advisory Board. She serves on the Legal Advisory Committee of the Evelyn Frank Legal Resources Program of Selfhelp Community Services, Inc. She also serves on the Benefit Committee of the Kellner Family Pediatric Liver Disease Foundation.
She is a frequent presenter to both consumer and professional groups and has provided input to state and national programs addressing legal, financial and other related matters involving persons with disabilities and our senior population.

Ellyn received her Juris Doctor degree from the New England School of Law and her LL.M. in estate planning from the University of Miami. She received her undergraduate degree from the University of Michigan.

Certification

Elder Law Attorney, National Elder Law Foundation

Bar Admissions

New York, 1993

Education

University of Miami School of Law, Coral Gables, Florida
   LL.M.
   Honors: Estate Planning

New England School of Law, Boston, Massachusetts
   J.D.

University of Michigan
   B.A.

Honors and Awards

Super Lawyer, 2009 – Present
The Best Lawyers in America®, 2014 – Present
Top Women in Metro New York, Super Lawyers, 2014 – Present
Long Island Alzheimer’s Foundation

Professional Associations and Memberships

New York State Bar Association, Elder Law and Special Needs Section
   Executive Committee, Member
   Co-Chair of Guardianship Committee

New York State Bar Association, Trusts and Estates Section
   Executive Committee, Member
Chair of Elderly and Disabled Committee

National Academy of Elder Law Attorneys (NAELA), Member

New York Chapter of NAELA, Member

Estate Planning Council of New York, Member
Director of Law, 2013-2016

Selfhelp Community Services, Inc, Evelyn Frank Legal Resources Program
Legal Advisory Board, Member

Kellner Family Pediatric Liver Disease Foundation, Benefit Committee, Member

Long Island Alzheimer’s Foundation (“LIAF”) Legal Advisory Board, Co-Chair, 2005-2006
BIOSKETCH – WILLIAM H. FRISHMAN M.D.,
M.A.C.P.

Dr. William H. Frishman is currently The Barbara and William Rosenthal Professor of Medicine and Chairman of the Department of Medicine, as well as Professor of Pharmacology at New York Medical College, and Chief of Medicine at Westchester Medical Center, in Valhalla, NY. He previously served as Professor and Associate Chairman of the Department of Medicine at the Albert Einstein College of Medicine, and Chief of Medicine at the Weiler-Einstein College Hospital of the Montefiore Medical Center in the Bronx.

Dr. Frishman is a clinical cardiologist, cardiovascular pharmacologist, and internist. He is a graduate of the Boston University Six-Year Liberal Arts-Medicine Program. He completed his training in Internal Medicine at both Montefiore and Bronx Municipal Hospital Centers, and his cardiology training at New York Hospital-Cornell Medical Center.

A noted clinical investigator, Dr. Frishman has authored and co-authored over 1,100 original articles, reviews and book chapters related to cardiovascular pharmacology and clinical cardiology. He is the editor of the textbook Cardiovascular Pharmacotherapeutics (McGraw Hill, 1997; 2nd edition 2003; 3rd edition 2011). He was co-editor for 10 years of the Year Book of Medicine and is co-editor in chief of the journal Cardiology in Review. In addition, Dr. Frishman serves as supplements editor for The American Journal of Medicine.
Dr. Frishman has served as Principal Investigator and co-Principal Investigator of multiple NIH-funded cardiovascular drug trials including the Women's Health Initiative. He was the co-Principal Investigator of the NIH-funded Bronx Longitudinal Aging Study, the subject of today's presentation.

Dr. Frishman has also been recognized for his achievements as a medical educator, researcher and clinician having received the Teaching Scholar Award of the American Heart Association, the Preventive Cardiology Academic Award of the NIH-Heart Lung & Blood Institute, the Distinguished Teacher Award from the Association of American Medical Colleges, and the Humanism in Medicine Award. He served as a Lieutenant Colonel in the U.S. Army and is a recipient of the Army Commendation Medal for Meritorious Service and the Distinguished Service Cross.
Sheila Ellen Shea, Esq. is the Director of the Mental Hygiene Legal Service, Third Judicial Department, an agency of the Appellate Division of State Supreme Court which provides legal service and assistance to persons in mental hygiene facilities or those alleged to be in need of care and treatment in such facilities. Ms. Shea was appointed to the Service in 1987 and has served as its Director since 2007. She is a 1981 graduate of the University of Vermont and a 1986 graduate of the Albany Law School of Union University.

Ms. Shea is a member of the New York State Bar Association (NYSBA), its Elder Law Section and serves on the NYSBA Committee on Disability Rights. She edits the chapters on “Rights in Facilities” and “Individual Rights and Discrimination: The Deaf and Hard of Hearing” for the NYSBA publication, Disability Law and Practice. Ms. Shea is also the author of “The Mental Hygiene Legal Service at 50: A Retrospective and Prospective Examination of Advocacy for People with Disabilities” published by the NYSBA Government, Law and Policy Journal, (Winter 2012) and “Representing Clients With Mental Disabilities” published by the New York State Defender’s Association Public Defense Backup Center Report (January - April 2013).

Ms. Shea is the recipient of the 2013 Hodgson/Jacobs Law Award presented by the NYSARC Inc. for demonstrating outstanding commitment and dedication to improving the lives of people who have intellectual and other developmental disabilities and the 2014 Cerebral Palsy Associations of New York Public Service Award.
Robert Cannon, Esq. is the Coordinator of Touro Law Center’s Aging and Longevity Law Institute. The Institute is designed to provide members of the bench and bar, law students, professionals from other disciplines and members of the community with the information, tools and resources required to address the legal needs of the approximately 100 million Americans that are 50 years of age and older. As the Institute grows, plans include a research agenda focused on law and public policy in the area of longevity and aging law. Robert graduated from the University of Aberdeen Law School with an LL.B. in 2009 and a DLP in 2010. In 2012, he received an LL.M. from Benjamin N. Cardozo School of Law. Robert is admitted to the bar in New York.
Dr. Cohen has spent most of his career in clinical and administrative pharmacy practice in health care organizations and as a pharmacy educator in both the didactic and experiential programs. He has experience teaching in both traditional and distance learning. He has also been involved in the origination, accreditation, development and direction of ASHP accredited residency programs.

He has much experience in the utilization of evidence based medicine to guide health care systems in their decisions on how to use medication to treat disease. These presentations are utilized both at the group level and as individual patient and clinician consultations. His presentations involve demonstration of the value and well as the cost of drug therapy and the use of this information to provide input on formulary decisions as well as decisions on individual patient therapy.

Dr. Cohen has been involved in a number of publications and studies. These were done at the health care practice level. They demonstrate the impact of clinical pharmacist involvement with house staff, private primary care physicians, specialists, and hospitalists in a variety of disease states and in a variety of health care settings. These include inner city hospitals, suburban community hospitals and long term care. He has presented these studies at the national and international level.

Dr. Cohen has participated in a number of associations including the New York State Society of Health Systems Pharmacists, The American College of Clinical Pharmacy, the American Society of Health Systems Pharmacists and the American Society of Consultant Pharmacists.

**Education**

PharmD, Idaho State University College of Pharmacy  
PhD, California Coast University  
MS, St. John’s University College of Pharmacy  
BS, Arnold and Marie Schwartz College of Pharmacy

**Clinical Specialty**

Dr. Cohen is a board Certified Geriatric Pharmacist. Dr. Cohen has spent most of his career in clinical and administrative pharmacy practice in health care organizations and as a pharmacy didactic and clinical educator in both the campus based and health care organization based programs
Research

Demonstration of the impact of clinical pharmacist involvement with house staff, private primary care physicians, specialists, hospitalists and patients in a variety of disease states and in a variety of health care settings

Academic and Professional Honors

Clinical Faculty Preceptor of the Year: May 14, 2014
**Fern J. Finkel, Esq.** is an elder law attorney with her office in downtown Brooklyn. She has specialized in elder law and guardianship since 1998 and been in private practice since 1990. Prior to establishing her private practice, Fern was a litigator specializing in medical malpractice and personal injury at the law firm of Damashek, Godosky and Gentile.

Fern graduated with honors from New York University College of Business and Public Administration in 1981. She received her Juris Doctor Degree from Boston University School of Law in 1984.

As part of her private practice, Fern spends a significant amount of time working pro bono on behalf of the indigent elderly of Brooklyn. She has spearheaded the Legal Education and Assistance Project, known as LEAP, at the Brooklyn Bar Association Volunteer Lawyers Project, which she is a Board Member of. The LEAP project is dedicated to training attorneys to perform outreach at community and senior centers throughout Brooklyn, with a focus on assisting seniors to have their health care proxies and advance directives in place, avoiding the painful process of Guardianship which might otherwise result.

Fern is the Chair of the Foundation Law Committee of the Brooklyn Bar Association, the Vice Chair of the Elder Law Committee of the Brooklyn Bar Association, a delegate to the New York State Bar Association Elder Law Section where she serves as Vice Chair of the Guardianship Committee, and a board member of Legal Services New York City where she also serves on the executive board. Fern served for years as a volunteer certified mediator with Safe Horizons for community disputes, PINS cases and custody matters, as well as with the United States District Court, Eastern District. Fern lectures for various bar associations on topics including the Role of the Guardian, Role of the Court Evaluator, Role of the Attorney for the Alleged Incapacitated Person, Advance Directives and Guardianship. Since 2004 she has served as a mentor attorney at the Elder Law Clinic at New York Law School. She is a co-facilitator of the Working Model of Guardianship- WINGS [Working Interdisciplinary Network of Guardianship Stakeholders] and serves on the Committees on Character and Fitness for the Second Judicial Department.

Fern has won numerous awards for her pro bono service, including the Brooklyn Bar Association Frieda S. Nisnewitz Award for Pro Bono Service (1996), an Award of Merit from the National Center for Missing and Exploited Children (1997), the New York State Bar Association Pro Bono Award for the Second Judicial District (2003), the Women’s Bar Association of the State of New York Hanna S. Cohn Pro Bono Award (2004), the Brooklyn Bar Association Distinguished Service Award (2009) and (2013) and the Brooklyn Volunteer Lawyers Project Building Bridges Leadership Award (2013).
A tireless advocate for clients challenged by age and disability-related issues, Ms. Robert offers skilled, compassionate representation to those dealing with elder care matters.

JOAN LENSKY ROBERT is a member of KASSOFF, ROBERT & LERNER LLP, a law firm in Rockville Centre, New York practicing exclusively in the areas of elder law and disability law. Ms. Robert is a graduate of Skidmore College, where she was a member of Periclean, the Skidmore College Honor Society, the University of Pennsylvania, where she studied pursuant to a Ford Foundation Fellowship, and Touro College School of Law, summa cum laude, where she was the recipient of a Deans Fellowship and was valedictorian of the part time division. Prior to entering the practice of law, Ms. Robert taught French with the Valley Stream Central High School District.

9. Robert served as Chair of the New York State Bar Association Elder Law Section from 2003-2004 and served as Co-Chair of its Special Needs Planning Committee from 2006-2009. She is now Co-Chair of the Section's Mentoring program. She is a past member of the Committee of Persons with a Disability and of the Committee on Committees of the New York State Bar Association. She
is an attorney member of the Guardianship Advisory Committee formed by the Office of Court Administration. She received a Lifetime Achievement Award from the Elder Law Section in January, 2014. She has been named a Super Lawyer for 2014.

A past Director of the Nassau County Bar Association and a past chair of its Elder Law/Social Services/Health Advocacy Committee, Ms. Robert served as Dean of the Nassau Academy of Law. She served as a member of the Board of Directors of the Nassau County Bar Association and as a member of its nominating committee.

Ms. Robert is Past President of the New York Chapter of NAELA, the National Academy of Elder Law Attorneys and was a Co-Chair of the Special Needs Planning Summit sponsored by NAELA. She is a member of the Publications and Programs Task Force and is Co-Chair of the State Chapters Committee of NAELA. She received the NAELA award as outstanding member of the New York Chapter in 2012 and also received the Theresa Foundation Award for outstanding service and advocacy to persons with special needs, sponsored by NAELA.

Ms. Robert has been honored for outstanding service by the Long Island Alzheimer’s Foundation, Project Real and the National Multiple Sclerosis Society. She served on the Board of Editors of the Bill of Particulars, the publication of the New York State Trial Lawyers Association, which honored her as outstanding downstate speaker. She is a past Editor in Chief of the New York Elder Law and Guardianship Newsletter. She co-wrote the chapter on Special Needs Planning in the book Guardianship Practice in New York State and wrote the chapters on Medicaid liens and planning in Personal Injury Actions in New York published by the New York State Bar Association. The author of numerous articles for community groups and professional groups concerning elder law and disability law, Ms. Robert has been a faculty member at various Bar Association programs concerning Elder Law, Supplemental Needs Trusts and asset preservation, and has been an instructor at certified training programs for Guardians, Supplemental Needs Trust Trustees and Court Evaluators.

Ms. Robert and her husband, Charles, are the proud parents of Heather Robert Coffman, Esq. and Jay Robert, Esq., an associate at Kassoff, Robert & Lerner, LLP. They are the doting grandparents of Naomi Coffman and Leo Coffman, residents of San Francisco.
Ira Salzman is a partner in the law firm of Goldfarb Abrandt Salzman & Kutzin LLP. Ira is the former Chair of the Elder Law Committee of the New York County Lawyers' Association. He is currently a member of the Executive Committee of the Elder Law Section of the New York State Bar Association and the vice-chair of its Legislation Committee. He is the former co-chair of its Medicaid Committee and former vice-chair of its Guardianship subcommittee. Ira is a Fellow of the Brookdale Center on Aging. He is a member of the National Academy of Elder Law Attorneys and a former editor of its quarterly journal. He has written articles for the quarterly journal of the National Academy of Elder Law Attorneys, the Elder Law News (a publication of Little, Brown & Company), and for the Elder Law Attorney (published by the Elder Law Section of the New York State Bar Association). He is the co-author of the Guardianship Section of the New York Lawyer's Form Book (published by the New York State Bar Association). He is the author of the chapter on the responsibilities of the attorney for an alleged incapacitated person in Guardianship Practice In New York (published by the New York State Bar Association). Ira has lectured at numerous Office of Court Administration certified training programs for Court Evaluators and Guardians in New York County and Bronx County. In 1999 he received the Leonard Lerner Award for pro bono service from the New York County Lawyers' Association. In 2012 he received an award from the Elder Law Section of the New York State Bar Association in recognition of his work drafting a New York version of the Uniform Adult Guardianship and Protective proceedings Jurisdiction Act.