



Routine Violations of Medical Privacy in Article 81 Guardianship Cases: So What or Now What?

By Joseph A. Rosenberg

Introduction

Each day in courtrooms throughout New York State, and indeed the United States, judges are asked to decide whether to appoint a guardian for an alleged incapacitated person (AIP) with the power to make decisions about the AIP's property management and personal needs.¹ In New York, the standard for appointing a guardian under Article 81 of the N.Y. Mental Hygiene Law (MHL) requires clear and convincing evidence of two main elements: that a guardianship is necessary to provide for a person's personal needs and property management, and the person either consents to the appointment or is found to be incapacitated.² Medical evidence is not necessary to prove that a person is incapacitated and needs a guardian.³ Although medical information can be an important piece of the guardianship "puzzle," it may be prejudicial and obscure the primary inquiry under Article 81: what are the functional capacities of the person alleged to need a guardian, and does the person have functional limitations that he or she does not fully understand or appreciate, and as a result place the person at risk of harm?⁴

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Anecdotal evidence suggests that many, if not most, guardianships are resolved in a generally decent manner, with genuine care and concern for the person who is alleged to be incapacitated and in need of a guardian. However, the “loose use” of medical information creates the risk that medical privacy rights are routinely violated. This is not only a cause for concern in that unauthorized disclosure of private health-related information is unlawful and damaging to a person, but it also may shift the predominant frame of a guardianship from a functional assessment to a medical diagnosis. Excessive reliance on medical evidence can result in a court order that appoints a guardian without a full exploration of less restrictive alternatives that may be available and sufficient. Consider the following scenarios:⁵

- Adult Protective Services (APS) filed a petition to appoint a guardian for a single woman in her mid-80s, based on an investigation conducted by an APS psychiatrist. The petition alleged that the woman could not make decisions about her property or personal needs, including health care decisions. At the beginning of each visit, the APS psychiatrist allegedly obtained the woman’s consent to meet. The discussion leading to the patient’s “consent” was brief and the psychiatrist did not advise her that the information he was gathering might be used in a guardianship petition and at a hearing. Although the APS psychiatrist testified that the person was incapacitated and needed a guardian, the petition was dismissed because the court found that the person had the capacity to execute advance directives and had an adequate informal support system. The testimony of the psychiatrist was permitted and the psychiatric affidavit remained part of the public record.

- A hospital filed a petition for a guardian to be appointed for a man in his 60s who was brought to the hospital by his family when he became disoriented while shopping at a local supermarket. In support of the petition, the hospital included medical information relating to alleged psychiatric issues and substance abuse. The hospital also alleged that the person could not be safely discharged to his home and asked for a guardian with the power to sell his residence in the community and place him permanently in a nursing home. The court found the person had the capacity to consent to the appointment of a guardian, but only with limited powers for a limited period of time, and required that the guardian facilitate a discharge back to his home in the community with appropriate home care and case management.

- A nursing home filed a petition to have a guardian appointed for a woman in her 80s who had been living at home in an apartment. After a mild stroke required the woman’s hospitalization and rehabilitation in a nursing home, the petitioner alleged that the woman needed a guardian due to her dementia and psychiatric issues. The petition asked that the guardian be granted the power to relinquish the AIP’s apartment and keep her in the nursing home. The court appointed a guardian with the power to

release the person’s apartment and place her permanently in the nursing home.

- A parent filed a petition to be appointed guardian for his 21-year-old daughter, whose struggles with psychiatric issues required her to reside in a residential school. The school provided medical information that was used to support the petition, and the daughter’s psychiatrist submitted an affidavit that was attached to the petition. The petition requested a guardianship with full powers and for an unlimited duration. Although the daughter’s functional capacity was relatively high and she may have been able to function independently over time, the court appointed the parent as guardian with broad powers for an unlimited duration.

These cases represent a microcosm of those decided pursuant to Article 81 of the MHL. This statute, which was enacted in 1983, has been justifiably lauded as a pioneering piece of legislation because it moved the focus of the need for a guardian from a medical model to a functional model and looks at the capacity of the person to make decisions and perform activities of daily living.⁶

The adult guardianship population in New York and the United States is rapidly becoming more diverse, and demographic patterns point to substantial increases in the number of people who may need a guardian due to mental health issues, age-related diseases that affect cognition (e.g., Alzheimer’s disease and other dementia-related conditions), mental illness, and/or developmental disabili-

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ties.⁷ The case vignettes described above reflect this diversity. Petitioners can include government agencies, hospitals, nursing homes, or family members – and the statute also authorizes any other person or entity concerned with the welfare of the person alleged to need a guardian to file a petition. Those people alleged to need a guardian represent a diverse group: the elderly woman, who became the subject of an APS investigation, who had an adequate support system in place; the older person who had a history of financial problems and substance abuse being forced out of his residence and into a nursing home; the elderly woman whose guardian was authorized to release her apartment and place her in a nursing home; and the young adult who

appointment of a guardian is clear and convincing evidence. The pleadings must include a plain-English notice to the AIP; the court must hold a hearing at which the AIP must be present, unless the court dispenses with this requirement; and the court must appoint a court evaluator or an attorney for the AIP. The rules of evidence apply in contested hearings. Courts are required to consider alternatives to a guardianship before appointing a guardian. The statute requires particular findings of fact and provides for a variety of arrangements that include limited guardianships – both in scope and duration.¹¹

Yet, even under Article 81, routine disclosures of medical information create a dual risk. One is that a

The concept of the least restrictive alternative is central to the rights of people who are subjected to guardianship proceedings; it is codified in Article 81.

suffered from mental disease and a lack of maturity. The reasons for bringing a guardianship proceeding are also illustrative: protection against possible financial exploitation; discharge to a nursing home; sale of a residence in the community and permanent placement in a nursing home, and assurance that a parent would have legal authority to make all major decisions for a child beyond the age of 21. Despite their variety, these cases have two commonalities: (1) medical information was included as part of the petition and used in ways that violated the medical privacy of the person alleged to need a guardian, and (2) all of the cases could have been resolved without filing a petition for guardianship.

In recent years, a great deal of attention has been paid to the “back end” of guardianships.⁸ This phase of a guardianship relates primarily to the duties of a guardian, the duration of the guardianship, and the filing of initial, annual and final reports which are reviewed by court examiners and approved by the guardianship part or court. In addition, judicial oversight is crucial to assure that the powers being exercised remain appropriate and necessary, and that the person is residing in the least restrictive setting reasonable under the circumstances.⁹

However, relatively less attention has been paid to issues at the “front end” of guardianships, which is the point at which unnecessary guardianships can be avoided.¹⁰ These issues include the standard for appointing a guardian, pleading requirements, possible alternatives to a guardianship, the nature and quality of notice to the AIP and interested parties, circumstances under which an attorney must be appointed, the scope of the court evaluator’s role, and the use of medical information to support a petition to appoint a guardian – whether in the form of medical affidavits, records, or testimony.

Article 81 is a functional statute that includes important components of due process. The standard for the

person’s medical privacy will be violated, and the other is that the statutory mandate to view the case through a functional and least-restrictive-means framework will be subordinated to a medical diagnosis. These violations may occur throughout the various phases of a guardianship case, including the “front end” in pleadings, during the pre-hearing investigation stage when the parties prepare their evidence, and while the neutral court evaluator assesses the allegations and prepares recommendations to the court. These violations may continue at the hearing and, if a guardian is appointed, throughout the “back end” of the guardianship, in the guardian’s initial and annual reports. These violations may be relatively benign and in reality few people may see, know, or care about the private medical information that remains in court files and digital records for many years. But the failure to adequately safeguard and protect private medical and health care related information might not only violate the dignity and privacy rights of the AIP but also result in a guardianship that is unnecessary.

The question is not whether medical evidence should ever be part of a guardianship case. Indeed, if it is relevant, probative, material, and admissible, then it may very well help a judge, and possibly a jury, make a decision. Rather, the real questions concern whether there are sufficient safeguards to prevent violations of a person’s medical privacy rights and under what circumstances, if any, should medical information be disclosed and admitted into evidence during the various phases of an Article 81 guardianship. In addition to violating a person’s medical privacy rights, the loose use of medical information may help perpetuate vestiges of the *medical* model of guardianship, which has been repudiated over the course of the last quarter century in numerous reports and studies.¹² Medical information and diagnosis may potentially be detrimental to the person alleged to need a guardian

in that it may enable a petitioner (and the court) to relegate a *functional* assessment and potential alternatives to a guardianship¹³ to a secondary consideration. Thus, health care facilities (i.e., hospitals and nursing homes) and government agencies (i.e., APS) may file a guardianship proceeding instead of exploring meaningful support services, such as case management and discharge planning, resulting in unnecessary guardianships that further strain the resources of the guardianship system.¹⁴

In addition, and perhaps more important, to have a guardian appointed to make decisions is to experience a “civil death.” It deprives a person of the fundamental rights that define our personhood. It deprives a person of the right to forge an individual path in the world, however flawed and imperfect, as part of a larger community. It is those precious and fundamental rights that are essential for human growth and development.

The Tension Between Functional and Medical Evidence

Guardianship deprives a person of fundamental liberties that are protected by the Due Process Clause of the Fourteenth Amendment to the U.S. Constitution.¹⁵ The United Nations Convention and Optional Protocol on the Rights of Persons With Disabilities (UN Convention) also includes far-reaching provisions and a framework for protecting fundamental human rights for people with disabilities.¹⁶ A guardianship should be used only as a last resort when less restrictive alternatives have been exhausted. If a court decides that a guardian is necessary, the U.S. Constitution and Article 81 require that the guardian be granted only the minimum powers that are necessary. Article 81 provides for an array of due process protections, including:

- detailed notice and pleading requirements;
- a functional framework that does not require medical information;
- the appointment of a neutral court evaluator or attorney for the person, in every case;
- consideration of less restrictive alternatives to a guardianship;
- a mandatory hearing;
- the right to invoke the Fifth Amendment protection against self-incrimination;¹⁷
- clear and convincing evidence of the need for a guardian and the person’s consent or incapacity;
- required findings of fact; and
- tailored guardianships that are monitored after 90 days and annually.

The concept of the least restrictive alternative is central to the rights of people who are subjected to guardianship proceedings; it is codified in the opening legislative findings and purpose section of Article 81:

The legislature finds that it is desirable for and beneficial to persons with incapacities to make available to them the least restrictive form of intervention which

assists them in meeting their needs but, at the same time, permits them to exercise the independence and self-determination of which they are capable . . . in a manner tailored to the individual needs of that person, which takes in account the personal wishes, preferences and desires of the person, and which affords the person the greatest amount of independence and self-determination and participation in all the decisions affecting such person’s life.¹⁸

The stakes of a guardianship proceeding are extremely high. The outcome of a guardianship directly affects the AIP’s right to make decisions about fundamental aspects of life such as where to live,¹⁹ health care and medical treatment,²⁰ social environment,²¹ and management of finances and property.²² The right to live independently, with appropriate support, is essential for a person to be fully recognized as such under the law. In Article 81 cases, the question often arises whether a person should continue living at home in the community, return to a community residence from a hospital or nursing facility, or continue to reside in a health care facility or other institutional setting. Article 81 mandates that a person under a guardianship be given the opportunity to remain living in, or return to, the community provided it is reasonable.²³

The right of people with disabilities to live independently in the community was recognized by the U.S. Supreme Court in *Olmstead v. L.C. by Zimring*.²⁴ In *Olmstead*, the Court held that under the Americans With Disabilities Act (ADA), individuals with disabilities have a right to “the benefits of community living” if the placement is appropriate, it is not opposed by the “affected” individual, and the placement could be reasonably accommodated without a fundamental altering of the program providing the services.²⁵ Under the ADA, the segregation of individuals with disabilities within institutions constitutes discrimination, and the ADA’s “integration regulation” requires reasonable accommodations in a community-based setting.²⁶

The right to independent living under Article 19 (“Independent living and being included in the community”) is also a key provision of the UN Convention. The UN Convention focuses on a person’s legal capacity and rejects substitute decision making and guardianship in favor of a support model of decision making.²⁷ There is a symbiotic relationship under the UN Convention between the Article 19 mandate for independent living and Article 12, which provides that persons with disabilities shall have equal recognition before the law and be entitled to the support necessary to “exercise legal capacity.”²⁸

The standard for appointing a guardian has evolved along with societal notions of incapacity, the understanding that disability is as much a social construct as a personal challenge, our knowledge that the capacity to make decisions is local and not global, and the value we place on autonomy over protection. The concept of disability has, and continues to be, defined under a variety

of rubrics, not all of which are mutually exclusive. Medical, legal, and functional needs are all accepted “prisms” through which a person’s capabilities can be assessed. The “support of legal capacity” model under Article 12 of the UN Convention situates all people along a continuum of support.²⁹

The medical evidence dilemma reflects the tension between autonomy and protection that is at the core of guardianship cases and also illuminates the larger, evolving movement away from a medical model to a functional framework, which may ultimately culminate in the support model envisioned by Article 12 of the UN Convention. A requirement that medical evidence must

The functional capacity framework of Article 81 looks primarily at the person’s capacity to manage activities of daily living.

be offered to establish incapacity or disability may violate a person’s civil rights and result in an erroneous determination that does not reflect the functional ability and capacity of the person. In contrast, appointing a guardian based merely on factual evidence that is anecdotal may risk ignoring or minimizing medical conditions that are causing the person’s limitations and that might be temporary or responsive to treatment.³⁰

When the evidence presented to prove the need for a guardian involves both a person’s psychiatric condition and history, two main problems arise. First, admission of this evidence “[p]oses a significant risk of unfair prejudice to the plaintiff in light of the persistent and evasive stigmatizing effects of psychiatric diagnoses.”³¹ Second, “[f]act finders are likely to misuse psychiatric evidence, particularly when offered through expert witnesses, because they have few tools to independently evaluate such evidence and thus may overvalue the significance of psychiatric diagnoses for the resolution of factual questions.”³²

The functional capacity framework of Article 81 looks primarily at the person’s capacity to manage activities of daily living, including decisions about finances and health care. The standard for appointing a guardian under Article 81 has two essential components: The guardianship must be necessary, and the person must either consent or found to be “incapacitated.”³³ A court must not appoint a guardian if there are adequate alternatives that are less restrictive and adequately meet the person’s needs, which would make the guardianship unnecessary.³⁴ Under the statute, the term “incapacitated” means the person (1) has limitations that interfere with activities and decisions of daily living, (2) does not

understand the nature and consequences of his or her limitations, and (3) is therefore at risk of harm.

Although Article 81 has many of the positive attributes of the functional approach, the inappropriate use of medical evidence creates the risk of violating the medical privacy rights of the person alleged to need a guardian. The consequences of these violations may depend in large part on the context of the case and the circumstances of the person. Greater awareness of medical privacy would help Article 81 fully realize its stated intent to base guardianship on a person’s functional capacity and reinforce respect for the complete legal recognition of each person’s rights, dignity, and legal capacity.

Protections Against Disclosure of Medical Information That Affects the Guardianship Population

Privacy is of great value in our society, and medical privacy in particular enjoys multi-layered levels of protection under various laws that govern disclosure by health care entities and individual providers. These include the right to medical privacy, protection against disclosures by entities under the federal Health Insurance Portability and Accountability Act (HIPAA) and the MHL, as well as evidentiary privileges such as the physician-patient privilege.³⁵

Medical Privacy Rights Under the U.S. Constitution and State Constitution Apply to Individuals Alleged to Need a Guardian

The U.S. Supreme Court has recognized a right of informational privacy under the Due Process Clause of the Fourteenth Amendment to the U.S. Constitution.³⁶ Two broad categories are recognized within the right to privacy: the right to autonomy, which protects personal choices from unwarranted interference from the government; and the right to maintain the confidentiality of private information.³⁷ In *Whalen v. Roe*,³⁸ the Court held that although there was a constitutional right of privacy, a computerized record of prescriptions for controlled substances maintained by the State of New York did not violate those rights, as it contained adequate protection against disclosure and did not affect an individual’s decision to obtain a prescription.

Federal courts in the Second Circuit have held that this constitutional right “[i]n avoiding disclosure of personal matters” applies to the medical information of a person with HIV,³⁹ a prisoner with HIV who is a transsexual,⁴⁰ and a person with sickle-cell anemia.⁴¹ Although courts agree that determining if a person’s medical privacy rights have been violated under the Constitution requires a case-by-case analysis, in *Matson v. Board of Education of the City School District of New York*,⁴² the Second Circuit held that the standard requires that the person have a serious medical condition that, if disclosed, would bring “opprobrium,” such as disgrace, discrimination, and intolerance.⁴³ *Matson* involved a

music teacher with fibromyalgia who was investigated by the Board of Education of the City of New York (BOE) for potential abuse of its sick leave policy. In the course of its investigation, the BOE posted her condition on its website, and the *New York Times* ran an article about her situation. The court held that her privacy rights were not violated in that fibromyalgia was not fatal, did not involve a psychiatric disorder, was not the kind of condition that if disclosed would result in societal stigma and discrimination, and that any adverse consequences the teacher suffered were due to her abuse of the sick leave policy, not her medical condition. The dissent in *Matson* criticized the majority for imposing an unduly restrictive standard, particularly in the procedural posture of deciding a motion to dismiss the complaint.⁴⁴

Assuming a particular medical condition is sufficiently serious and subject to societal discrimination, the question of whether disclosure is reasonable requires analysis of the government's interest in public health and whether action was taken to minimize the disclosure of private information.

Although not specifically mentioned in the New York State Constitution, New York courts have held that the scope of the right to privacy protected under the state constitution is broader than the U.S. Constitution.⁴⁵ The N.Y. Court of Appeals has not specifically ruled on the question of disclosure of medical records, although it has upheld the requirement under New York City law that the name and address of a person obtaining an abortion be included on the pregnancy termination document filed with the Department of Health, as it furthered a governmental interest in maternal health and made it easier for government officials to retrieve a person's health records.⁴⁶

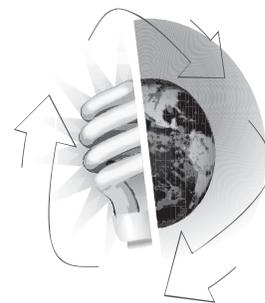
Applying these standards to guardianship cases, the requirement that a condition be "serious" would appear to be satisfied if a case involved the disclosure of medical information supporting a finding of incapacity and that a guardianship was necessary. To the extent that particular medical conditions relate to a person's mental capacity to make decisions, disclosure could trigger the required level of disgrace, discrimination, and intolerance required by *Matson*. For example, if a medical affidavit accompanies a guardianship petition and includes information related to a condition such as Alzheimer's disease, Parkinson's disease, or a history of substance abuse, a person suffering from these potentially disabling conditions is protected from discrimination under the ADA. Each of these is serious, potentially fatal, and if revealed could subject a person to discrimination and intolerance. A person's reasonable expectation of privacy should not diminish or disappear merely because a government agency or health care facility files a petition for guardianship, or a court decides the person is incapacitated and appoints a guardian.

HIPAA and the MHL Limit the Circumstances Under Which Covered Entities May Disclose Protected Health Care Information in Guardianship Proceedings

The release of medical records is subject to the requirements of HIPAA,⁴⁷ which preempts state law unless the state law provides greater privacy protection to health-related information than HIPAA. For example, prior to HIPAA, a person who brought a medical malpractice action was deemed to have placed his or her medical condition at issue, and therefore impliedly consented to the disclosure of medical information to the defendant's attorney. However, HIPAA's provisions require separate authorization by the plaintiff before a defendant's attorney is permitted to obtain protected health-related information. Otherwise, the information is not admissible.

A patient or the patient's authorized representative (e.g., a person named in a HIPAA release, a court-appointed guardian with the power to access health care information, or an agent under a health care proxy) must consent prior to the disclosure of medical records by a covered entity under HIPAA.⁴⁸ Exceptions to these requirements include disclosures required by law, which include but are not limited to requests made in the course of a judicial proceeding. Such disclosure may be in response to a subpoena, court order, or other process related to the proceeding.⁴⁹

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Although HIPAA includes a number of exceptions to its general rule of non-disclosure, the failure to follow the HIPAA procedures will result in the exclusion of the medical records or information, and potentially a fine. The N.Y. Court of Appeals has held that a hospital's release of medical records to a state agency in an Assisted Out-patient Treatment (AOT) proceeding pursuant to MHL § 9.60 (a.k.a. Kendra's Law) violated HIPAA, as the disclosure was not authorized by the person who was the subject of the proceeding, and there was no judicial process in the form of a court order or subpoena.⁵⁰ In *In re Miguel M.*, the records provided to the AOT administrator did not meet any of the exceptions recognized under HIPAA – that is, for purposes of treatment or pursuant to a court

the theory that “privilege in the courtroom will encourage disclosure in the sickroom.”⁵⁴ The physician-patient privilege protects information obtained by a physician who attends to a person in his or her professional capacity, whether the information is communicated to the physician or based on the physician's observations.⁵⁵ A physician-patient relationship is created when professional services are rendered and accepted by the patient pursuant to an express or implied contract.⁵⁶ The privilege applies regardless of whether the information is in the form of testimony or record.⁵⁷ And it is construed broadly, although there are exceptions for review of records by a court evaluator in an Article 81 case,⁵⁸ examinations related to employment (unless the physician

When the petitioner is a hospital, nursing home, or other covered entity, the practice of including medical information as part of the petition violates HIPAA.

order or other judicial or administrative process. The Court also held that the AOT program did not fall within the public health exception under HIPAA and the Privacy Rule, and moreover, that the records were not admissible, distinguishing the AOT context from a criminal context in which courts have admitted medical records to prove that a crime has been committed. In a subsequent case with virtually identical facts, a lower court held that *Miguel M.* applied retroactively, ruling that the medical records at issue were not admissible since they were disclosed without the patient's consent and without a court order or subpoena.⁵¹

Under Article 81, health care facilities that initiate guardianship proceedings routinely disclose medical information without the consent of the patient or an authorized representative. Such disclosure may occur at the very beginning stage of a guardianship proceeding, with the filing of the petition, in which case, the disclosure often continues throughout all stages of the guardianship. All the while, sensitive health care information is disclosed freely, without the AIP's consent or a court order.

Evidentiary Privileges Protect Disclosure and Admission of Medical Evidence in Guardianship Proceedings

Evidentiary privileges govern the relationship between a health care professional (and other disciplines such as social workers) and a patient/client/consumer.⁵² The physician-patient privilege did not exist at common law and New York was the first jurisdiction to enact a physician-patient statutory privilege in 1828. Although subject to some criticism, this privilege is firmly embedded in the public policy of New York.⁵³ The privilege safeguards disclosures by individual providers and entities under

affirmatively treats or recommends treatment),⁵⁹ cases involving guardianship or custody of abused or destitute children, reports made concerning suspected abuse and neglect of children, where the physical and mental condition of a decedent is at issue, and for certain public health purposes.⁶⁰

The privilege is not waived merely because a person has to defend against an action that places his or her medical or psychiatric condition at issue, even if the plaintiff or petitioner claims that the person's medical condition is “in controversy” and subject to discovery.⁶¹ This applies directly to Article 81 guardianships, where a person who is alleged to need a guardian is not making a claim or putting his or her medical condition at issue, at least initially, but is defending allegations made in the petition by a government agency, health care facility, person, or other entity.

Typically, a person who is alleged to need a guardian may interact with a variety of physicians and other health care professionals who initiate contact with the person in a therapeutic context and may be subject to an evidentiary privilege. This sort of involuntary physician-patient relationship can pose special challenges in a guardianship, as it may not fit neatly within the traditional conception of a treating physician.

The Use and Abuse of Medical Information in Guardianship Proceedings: A Double-Edged Sword

The disclosure of medical information in a guardianship case creates a risk that the person's medical privacy rights will be violated and the health-related information will be admitted into evidence that may not be causally connected to the person's functional capacity and might distort the need for a guardian based on a medical diagnosis.

Conversely, the use of medical evidence and testimony in guardianships may be necessary to assure that any possible determination of incapacity is not the result of side effects from medication, depression, or other conditions that if properly treated will resolve the problems causing the person's incapacity.⁶²

Under Article 81, a guardian can be appointed only if it is necessary and the person consents or is found to be incapacitated.⁶³ The element of necessity requires a finding that the person is at risk of harm if a guardian is not appointed. If alternatives to a guardian are available and sufficient, the guardianship may not be necessary, and the petition must be dismissed.⁶⁴ The secondary element of either consent or a finding of incapacity requires that the person either have the capacity to make an informed decision about the nature and consequences of having a guardian appointed or be found incapacitated. Incapacity is defined as a person's lack of awareness and understanding of how limitations that interfere with decisions about property and personal needs may put the person at risk of harm.⁶⁵ Notably, a finding of incapacity cannot be based, for instance, on inability to pay rent or provide for one's needs, or the questionable wisdom or even self-destructive nature of "bad" decisions. Rather, it must be based on the absence of a knowing or informed choice about the decisions that may lead to harmful consequences.⁶⁶ If a court finds that a guardianship is not necessary – e.g., if adequate alternatives exist or the person is not at risk of harm – the petition must be dismissed, even if the person is found to be incapacitated.

Article 81 requires that certain information be included in the petition, such as a "description of the [AIP's] functional level, including [the AIP's] ability to manage the activities of daily living, behavior, and understanding and appreciation of the nature and consequences of any inability to manage the activities of daily living."⁶⁷ Witnesses may be family members or friends, professionals that have come into contact with the person or health care personnel who may base their assessment on a medical diagnosis. Although this evidence can and should primarily be factual and anecdotal, medical information and diagnoses continue to have a significant, if not primary, role in Article 81 cases. However, medical evidence is not required, either as part of the petition or at the hearing.⁶⁸

The use of medical evidence depends in large part on the context, the reasons for its use, and the role of the person requesting access to those records. In an uncontested proceeding, courts may have the discretion to relax evidentiary rules, although that may still be problematic in that the privacy rights of a person may be violated. In a contested guardianship hearing, the full panoply of objections and evidentiary requirements apply, and courts will deny motions to admit medical records and testimony into evidence.⁶⁹ In some cases, a court will order that the hearing be closed to the public and the case record sealed.⁷⁰

Using Protected Medical Information in Support of the Petition May Violate HIPAA, the Physician-Patient Privilege, and Distort the Focus on Functional Capacity and the Least Restrictive Alternative

There is risk that the privacy rights of the AIP may be violated when the order to show cause and petition are filed. The petitioner may be a hospital or nursing home, and the petition may contain the AIP's medical information obtained from the facility's medical records or records of treating physicians at the facility. Although Article 81 explicitly states that medical information is not required to be included in the petition, the order to show cause must inform the person that the court evaluator may request a court order to inspect medical or psychiatric records and that the AIP has the right to object to this request.⁷¹ In this very common scenario, a court may strike a medical affidavit attached to the petition because it violates a person's medical privacy rights under HIPAA, the physician-patient privilege, or other applicable privacy laws.

When the petitioner is a hospital, nursing home, or other covered entity, the practice of including medical information as part of the petition violates HIPAA.⁷² In *In re Derek*,⁷³ a case decided under Article 17-A of the Surrogate's Court Procedure Act but directly applicable to Article 81, the court removed medical affidavits that were attached to the petition, as required by the statute. The court held that the affidavits violated HIPAA but denied the motion to dismiss as there was sufficient non-privileged information to state a cause of action.

If medical information from a treating physician is included as part of the petition, it may also violate the physician-patient privilege.⁷⁴ Even when the purpose of the petition is to secure an appropriate placement for a patient in a facility, medical records and the testimony of treating physicians are not admissible.⁷⁵ In *Tara X*,⁷⁶ a contested adversarial proceeding in which the privilege had been asserted, a daughter alleged in the Article 81 petition that her mother had various psychiatric conditions that made her incapacitated. She attached affidavits from a physician who had treated her mother during a prior hospitalization, and reports of "medical personnel" who had "attended" to the mother prior to that hospitalization. The court evaluator requested access to the AIP's medical records and permission to retain an independent physician to consult. The respondent AIP asked the court for a protective order to prevent admission of the medical records and also opposed the request of the court evaluator.

The court referred to the strong public policy in New York, which supports the physician-patient privilege, noting that the purpose is "[t]o encourage its citizenry to seek medical treatment for any physical or mental condition without fear of the public ridicule or disgrace that might result from a disclosure of any such condition."⁷⁷ Although the privilege is not absolute, there are

very limited exceptions, including the use of medical records by a court evaluator in guardianship matters to assist in the investigation of the case as well as potential disclosure under some circumstances.

The court in *Tara X* denied a motion by the court evaluator to discover medical records because it would reduce due process protection for the AIP to a level below that of other civil litigants and ordered that medical information attached to the petition be removed and sealed. The holding in *Tara X* affirmed the vitality of the physician-patient privilege and the duty of the court to honor the privilege.

A petitioner who seeks disclosure of medical records by subpoena subsequent to filing the petition implicates a variety of protections against disclosure of medical information. In granting a motion to quash the subpoena served on a local agency of NYSARC Inc., the court noted that this was a case of first impression. As the New York State Office of People with Developmental Disabilities certified the local agency, the records were protected under MHL § 33.13. As a covered entity, the local ARC agency was subject to HIPAA, which requires that medical records be held confidential unless the patient consents to or a court orders disclosure. The court also held that the records were protected under the physician-patient privilege. Notably, the court emphasized that medical evidence is not required in an Article 81 proceeding, and there was ample non-privileged information to prove the need for a guardian.⁷⁸

Using medical information in the petition potentially violates laws protecting medical privacy and may also have the effect of allowing the petitioner to minimize or ignore the statutory requirement to provide information about the person's functional capacity and to fully explore whether alternatives to a guardianship are available.⁷⁹ In turn, this frames the guardianship in terms of medical diagnosis, enabling the petitioner to avoid taking responsibility for meaningful discharge planning or a case management plan that meets the needs of the person, without the appointment of a guardian. Even if a guardianship is necessary, medical information substitutes for a description of the person's capacity to perform activities of daily living and make decisions. Instead of guardianship being a last resort, it becomes a means for providing case management and discharge planning, often to the detriment of the person.

Disclosure of Medical Records to the Neutral Court-Appointed Investigator: A Sound Practice That Balances the Need for Relevant Information and Privacy Concerns

Under Article 81, the court evaluator plays a pivotal role in the proceeding and has broad-ranging powers, including the duty to protect the property and interests of the person alleged to need a guardian.⁸⁰ As the neutral "eyes and ears" of the court, the court evaluator is in a unique position to shape how the case unfolds. It is critical that

the court evaluator attempt to limit unnecessary disclosures of medical information, fully explore the availability of less restrictive alternatives, promote the use of evidence related to functional capacity and, if it is necessary to appoint a guardian, recommend that the court grant only those powers that are necessary and appropriate.

Article 81 strikes a balance between the court evaluator's possible need to review medical records and the importance of protecting the medical privacy rights of the person alleged to need a guardian.⁸¹ A court evaluator may request a court order to review medical records, and if the court issues an order, it is only for the limited purpose of assisting the court evaluator in his or her investigation.⁸² The court may order the disclosure of these records to the court evaluator, notwithstanding the physician-patient privilege, the psychologist-patient privilege, or the social worker-client privilege provisions of the CPLR.⁸³ However, the authority of the court may be limited by federal and state laws that impose different standards for the disclosure of particular kinds of records, such as records of patients in alcoholism and substance abuse facilities, HIV-related information, and records of patients in mental hygiene facilities.

Article 81 draws an important distinction between the use of medical records to assist the court evaluator and their admissibility as evidence in court.⁸⁴ This recognizes that while medical records might be helpful in a court evaluator's assessment, they are not always essential and should not be disclosed unnecessarily or automatically be deemed admissible. The court evaluator should initially only disclose relevant records to the court in-camera. Unless the court directs otherwise, the court evaluator should discuss medical-specific diagnoses and medications only in a separate addendum to the court evaluator report.

If the court orders that medical records be disclosed to the court evaluator, the court may also direct such further disclosure of those records upon the request of the petitioner or the attorney for the person alleged to need a guardian.⁸⁵ This disclosure may be limited to pre-hearing discovery, as with Article 31 of the CPLR, or extend to admission as evidence at the hearing.⁸⁶ Although the court evaluator's report may be admitted into evidence if the court evaluator is subject to cross examination, that does not mean medical records and information obtained by the court evaluator are similarly admissible.⁸⁷ The court evaluator can apply to the court to retain an independent medical expert where it is necessary and appropriate,⁸⁸ which may be necessary in order to avoid a breach of the AIP's physician-patient privilege. If insufficient medical information is available and the court evaluator needs that information, an independent medical expert may help determine if the AIP is incapacitated. A court may deny a request by the court evaluator for an order that grants access to medical records on the basis that it would deny the AIP constitutionally protected due process rights.⁸⁹

The court is also authorized, in uncontested proceedings and for good cause shown, to relax the rules of evidence. This discretion, as noted by the court in *Tara X*, reflects the balance between the more traditional “best interests” approach to guardianship and the “adversarial” approach embodied in modern guardianship statutes that provide enhanced protection of the rights of the person alleged to be incapacitated. However, relaxing the rules of evidence may create a potential

need a guardian has interacted with physicians and other health care professionals who serve in a variety of roles. The testimony of a non-treating physician is not subject to the privilege and is admissible provided it is material, relevant, and probative and not excludable on other grounds. In *In re Marie H.*,⁹⁶ a case involving a psychiatrist who was part of a mobile emergency response team, the AIP moved to strike the testimony of the psychiatrist on the basis of the physician-patient privilege. The psychia-

Article 81 draws an important distinction between the use of medical records to assist the court evaluator and their admissibility as evidence in court.

problem for a person who needs, and does not object to, a guardian. If the person has the capacity to consent to the appointment of a guardian, a court may appoint one based on a finding of necessity and consent. This makes a finding of incapacity unnecessary and medical evidence and testimony would not be required. Concerns about medical privacy are equally present in an uncontested proceeding, if private medical information is part of the proceeding and remains in the court file as a public record.

Testimony by Physicians and Other Health Care Professionals to Support the Appointment of a Guardian

The physician-patient privilege and other similar evidentiary privileges apply in contested Article 81 cases.⁹⁰ Under Article 81, medical testimony is not required in all cases and may not be admissible unless the person waives the physician-patient privilege or places his or her medical condition at issue.⁹¹ For example, a person placed her mental condition at issue when she included a doctor’s report in her motion to dismiss the Article 81 petition, notwithstanding her assertion that the sole purpose of the report was to rebut the allegations of her examining physician.⁹² A person does not waive the physician-patient privilege by failing to object to the testimony of a physician who treated the person in the hospital if the physician relies on his or her notes and not the person’s medical records.⁹³

If the privilege has not been waived, the testimony of a treating physician should be excluded.⁹⁴ Functional evidence alone can be sufficient to meet the statutory standard for appointing a guardian. Even if the testimony of the treating physician is not admissible, the court may appoint a guardian based on the testimony of, say, the person’s children that their mother could not manage her medical, personal, and financial needs.⁹⁵

The traditional confines of the physician-patient privilege may not adequately protect disclosures of private medical information when the person alleged to

trist was acting pursuant to a statutory “Comprehensive Psychiatric Emergency Program,” which authorized participating psychiatrists to involuntarily commit a person who was found to need immediate care and treatment and who posed a danger to herself or others due to a psychiatric condition. The court analyzed the nature and responsibilities of the psychiatrist’s role and found that it was closer to that of a police officer making an arrest than a treating physician. This decision was supported by statutes that created a relatively well-defined role for the psychiatrist acting within the scope of emergency circumstances with specific protocols and remedies. The psychiatrist was acting to protect the safety and well-being of the person, serving as part of the rescue component of a structured response that included treatment by other psychiatrists and providers at the institution to which the person was taken.

The Special Case of the APS Psychiatrist as Investigator and Witness: A Treating Physician Subject to Evidentiary Privilege or a “Guardianship Specialist” Fulfilling the Agency’s Protective Function?

Federal law requires states to provide Adult Protective Services.⁹⁷ APS is generally responsible for providing information, referrals, and assurance that services are available to individuals who are unable to manage their property or personal care. The agency works to provide for vulnerable individuals’ personal needs and protect them from dangerous circumstances arising from neglect or abuse, particularly those who have no one able or willing to provide needed assistance.⁹⁸ Adult protective services have a legal duty to provide necessary care and services to eligible adults.⁹⁹

APS must provide an array of support services designed to assist vulnerable adults who are at risk of harm to remain in the community and avoid institutionalization. Additionally, APS is required to prevent or resolve cases of neglect, exploitation or abuse by enhancing the person’s capacity to function independently. It

may investigate allegations or provide services to a vulnerable person,¹⁰⁰ and decide that it is necessary to file a guardianship petition. When a psychiatrist employed by APS is part of the investigation, roles may be blurred. Information gathered from the AIP in an arguably therapeutic context may later be used as evidence in a guardianship proceeding. The methods by which APS obtains this information, and its use in guardianship cases, raises issues related to medical privacy and the scope and application of the physician-patient privilege.

Two significant practices involving APS raise serious concerns as to violations of the liberty interests and medical privacy rights of vulnerable elders. When APS is unable to gain access to a person, perhaps because the person does not want to cooperate for fear of being placed in an institution or having a guardian appointed, APS may utilize an *ex parte* process that culminates in an order granting access to the vulnerable elder's residence. The purpose of this visit is ostensibly limited to assuring that the person is not in danger. It is improper for APS to use evidence obtained as part of this *ex parte* process in a guardianship case.

*In re Eugenia M.*¹⁰¹ involved a 95-year-old woman whose landlord contacted APS and reported *inter alia* that her cooperative apartment was in need of repairs. A psychiatrist for APS met with Ms. M in March 2007. In early 2008, the City of New York Department of Social Services, the parent agency of APS, initiated an Article 81 guardianship proceeding and a hearing was scheduled for February 8, 2008. Ms. M thought the hearing was scheduled for February 6, in part because the return date was "faint" on the order to show cause, and traveled to the courtroom alone by public transportation, despite the winter cold.

The hearing was adjourned, and after several months, the petitioner requested that the matter be further adjourned as Ms. M refused to allow the APS caseworker into her home. The additional adjournment would allow APS to obtain an "Order to Gain Access" to Ms. M's apartment, which in turn would allow the APS psychiatrist to evaluate Ms. M. The court denied the request because the Order to Gain Access is intended to be used only to assess a person's need for protective services, which APS had already done. It is also appropriate only if there is no other opportunity to observe and evaluate the person. Here, Ms. M left her apartment on a daily basis to shop, which would afford APS a sufficient opportunity to interact with her.

Ms. M's court-appointed attorney argued that APS was using the adjournment and possible Order to Gain Access as a pretext to gather additional evidence to support its guardianship petition because the nine-month delay had rendered APS's evidence stale. After the court denied the motion for an adjournment, the petitioner commenced its case with one witness, the APS psychiatrist, who testified based on the single meeting with Ms. M. The psychiatrist testified that Ms. M's apartment needed some repairs,

some of which had not been done because Ms. M reported that she had previously been overcharged for repairs, further noting that Ms. M had food in the refrigerator, her grooming was "passable," and that she told him that she paid her own bills, did her own banking, shopping, and cooking, and had health insurance. The court dismissed the petition, finding that the evidence established that Ms. M's only functional limitation was an unsteady gait, and that the threat of a future eviction did not support the appointment of a guardian.

Outside the *ex parte* context, a similar practice that raises medical privacy and evidentiary privilege concerns is the use of APS psychiatrists to obtain information to be used in a guardianship petition. Usually, the APS caseworker is familiar with the AIP, having worked on his or her case. Next the APS psychiatrist becomes the primary investigator, assesses the person's need for guardianship, and ultimately becomes the primary witness for the petitioner. The APS petition will routinely recite that the person voluntarily consented to be interviewed by the psychiatrist. Ironically, the information obtained from the voluntary interview becomes the basis of the psychiatrist's testimony that the person who provided "informed consent" needs a guardian with broad powers, including those related to medical and health care decisions. A person may have the capacity to consent to a meeting with an APS psychiatrist but not have the capacity to make decisions about property management and personal care, but the nature of consent is actually fairly complex. This casts doubt as to whether such consent is truly informed, knowing, and voluntary.

As a threshold matter, it is doubtful that the psychiatrist provides sufficient information to the AIP for the AIP to form the predicate for an informed decision. The psychiatrist is employed by APS, and APS is charged with protecting those in need, including diagnosing and improving their circumstances. The psychiatrist will not only perform an assessment and evaluation for those purposes, but the information obtained may also be the basis for bringing a guardianship proceeding, in part for precisely those decisions relating to the informed consent that the APS psychiatrist is trying to obtain. Even if the APS psychiatrist does provide that information, a truly informed consent would require that the person understands the role of the psychiatrist within APS, the mandate of APS, and the nature and scope of a guardianship proceeding.¹⁰²

The extent to which the APS practice of using a psychiatrist as a "guardianship specialist" violates medical privacy depends, at least in part, on a number of factors. Assuming there is a constitutional right of medical privacy, does the person have a reasonable expectation of privacy when meeting with an APS psychiatrist in an arguably therapeutic context? Can the APS psychiatrist be characterized as a "treating physician" subject to the physician-

patient evidentiary privilege or, alternatively, does the psychiatrist owe a duty of confidentiality to the person?

Generally, the existence of a privilege favors the “exclusion of the evidence.”¹⁰³ “[T]he decision as to what values to recognize through the law of privileges is a difficult one.”¹⁰⁴ Conventional wisdom holds that due to the narrow scope of the physician-patient privilege, the APS psychiatrist is an “examining” physician to whom the privilege does not apply. However, a closer examination of the APS mandate suggests that the role of the APS psychiatrist may be within the scope of the evidentiary privilege that attaches to treating physicians. Consider the following characterization of the APS role:

The Commissioner is likewise charged with arranging for medical and psychiatric services to evaluate and whenever possible to safeguard and improve the circumstances of adults with *serious impairments*.¹⁰⁵

The psychiatrist “visiting” Ms. M on behalf of APS was charged with carrying out the APS mandate to evaluate, safeguard, and improve Ms. M’s circumstances. A treating physician is defined as one who provides diagnosis or medical treatment pursuant to an explicit or implicit agreement.¹⁰⁶ Although the APS psychiatrist is not providing services under a standing order from a physician, pursuant to the agency’s statutory mandate, the psychiatrist is both diagnosing and attempting to remediate the person’s medical condition. Although APS is required to conduct an investigation upon receiving a report of a vulnerable person at risk, in the guardianship context, the psychiatrist often, if not always, seeks to obtain consent to meet with the person.

It is therefore arguable that the APS psychiatrist should honor the person’s expectations of privacy and also be subject to the physician-patient privilege, at least to the extent that the psychiatrist is involved in diagnosis and any kind of therapeutic relationship. Unlike a personal injury case, in the context of a guardianship proceeding, the person alleged to be incapacitated is not placing her own medical condition at issue. The case is brought “against” the person, and the petitioning party in New York has the burden of proving that the guardianship is necessary and the person either consents or is incapacitated as defined by the statute. A distinction between the APS psychiatrist’s interaction with a potential AIP and a more conventional relationship between a psychotherapist and patient is that, typically, a conventional patient consults the psychotherapist for diagnosis and treatment, whereas APS initiates contact with an AIP pursuant to a statutory mandate.¹⁰⁷

The privilege that attaches to communications between patient and physician or psychiatrist is subject to a number of exceptions, including when it occurs for reasons other than treatment.¹⁰⁸ The intended protective function of APS may require that a petition for guardianship be filed if the person is having difficulty providing for his or her needs,

although guardianship should be only a last resort after sufficient efforts have been made to provide necessary services to the person. The purpose of the guardianship would ostensibly be to prevent harm to the vulnerable person and assure that he or she receives and continues to receive sufficient services. Assuming that alternatives to a guardianship have been fully explored, but to no avail, these arguments would support the view that the APS psychiatrist is not subject to the physician-patient privilege.

Yet there remains something quite troubling about this relationship and the medical professional’s use of information obtained during the course of the APS investigation. Under Article 81, medical evidence is not necessary, and non-privileged evidence that is relevant and material to a person’s functional capacity and the standard for appointing a guardian is sufficient and favored by the statute. The rationale for using a psychiatrist to obtain information for APS is therefore weaker, and at least requires that diagnostic and other medical information obtained by the psychiatrist be excluded. A better alternative would be to rely on testimony from the APS caseworker regarding the AIP’s functional capacity.

Recommendations to Prevent, Manage, and Resolve Violations of Medical Privacy in Article 81 Guardianships

Although Article 81 is a “functional capacity” statute, it falls short of the emerging support model envisioned by Article 12 of the UN Convention that recognizes a person’s full legal capacity regardless of disability. The support model would replace the guardianship incapacity framework with a “co” or “facilitated” structure for supportive decision making. Article 81 includes many provisions that respect a person’s autonomy and protect due process, privacy, and liberty interests that are at stake for individuals who are alleged to need a guardian. However, the permissive use of medical information perpetuates the medical model of guardianship and creates the risk that medical privacy rights are routinely violated. Consequently, it may also impede a full exploration of functional capacity and alternatives to guardianship.

The following recommendations are intended to improve Article 81 through a combination of proposed amendments and suggested “best practices.” The ultimate goal of these recommendations is to move Article 81 closer toward a completely functional framework that utilizes a support model, which ultimately will replace the notion of incapacity and guardianship with the model of “partnered” or “facilitated” decision making required under Article 12 of the UN Convention.

1. Prior to filing an Order to Show Cause and Petition, attorneys for petitioners should conduct a complete investigation in order to fully assess the person’s functional capacity and determine whether alternatives to a guardianship are available and sufficient. They should thoroughly assess the need for a guard-

ian and determine to the greatest extent possible if the person has the capacity to make decisions. This assessment should focus on the statutory standard, explore potential alternatives to a guardianship, highlight the person's functional abilities rather than medical diagnoses, and use the statutory powers as a checklist.¹⁰⁹

2. When drafting the petition, the attorney for the petitioner should include as much of the statutorily required information as possible. Under § 81.08(a), the petition is supposed to include specific information, including the following most relevant to these recommendations:
 - Describe the person's functional capacity based on his or her ability to manage activities of daily living.
 - Include specific information about events, actions, or occurrences that create a risk of harm, and indicate that the person does not appreciate or understand the limitations that interfere with his or her ability to provide for personal needs or property management.¹¹⁰
 - Explicitly connect the person's needs and functional capacities to the powers sought.¹¹¹
 - Identify and describe resources that may be available as alternatives to the guardianship.¹¹² If none exist, describe specific actions taken by the petitioner that would constitute due diligence in exploring these potential alternatives.
 - Include any other information that would help the court evaluator.¹¹³ This existing statutory requirement implicitly requires that the petitioner view the petition from the perspective of the court evaluator, at least with respect to making sure that a guardianship is necessary and there are no sufficiently reliable alternatives available.
 - Do not include medical information without a court order. Medical information is not required to be included with the petition. The statute's emphasis on functional capacity and medical privacy protections suggest, and may require, that medical information not be included with the petition.
3. Suggested "best practices" for judges:
 - Do not sign the Order to Show Cause if the petition does not include the required elements described above.
 - Prior to accepting a petition that includes protected or privileged medical information, require the petitioner's attorney to submit an affirmation explaining the need for medical information, explain why evidence of functional capacity is not available or sufficient, and formally request a court order to include medical information with the petition.
 - As part of an order granting the request to use medical information (whether made by the petitioner or the court evaluator), require the protect-

ed or privileged information to be in a separate document, perhaps as a "medical information rider" to the petition, or an addendum to the court evaluator report, so that it may easily be separated and sealed from the publicly available case documents.

- Exclude medical information and evidence from the hearing, unless there is insufficient evidence related to the person's functional capacity, or the medical information is necessary and appropriate in order to make the required findings and decisions, assure that the person's medical diagnosis and medication regimen is accurate and therapeutic, or for any other reason that would be helpful to the court or to the person. The goal is to more sharply focus the hearing on the person's functional capacity, potential alternatives to a guardianship, and the least restrictive alternative.
 - Disseminate rules for court evaluators regarding the use of medical information. These rules would emphasize that the assessment is a functional one and not a medical diagnosis. The rules would also require a court order for the court evaluator to obtain medical information and disclose it to other parties. In addition, the court evaluator would be permitted to include medical diagnoses, medications, treatment, and other protected information only in a separate addendum to the court evaluator report, unless otherwise ordered by the court or the court record is sealed.
4. A party seeking to introduce medical evidence that may infringe on a person's medical privacy rights should be required to make a proffer of necessity. The court may either rule on the proffer as part of a pre-hearing written motion or hear oral argument on the issue prior to the hearing or on the hearing date.
 5. Require APS to focus more on functional capacity in its guardianship assessment and petition process, rather than basing its assessment, petition, and testimony too much on medical diagnosis.
 - Clarify the role of physicians, psychiatrists, psychologists, and social workers employed by APS who provide services to a person, and when they are acting in their professional capacity as an APS service provider, subject them to their profession's evidentiary privileges. Prior to a decision by the Department of Social Services or other "parent" agency of APS to file a petition for guardianship, these professionals should follow a protocol to obtain informed consent, which specifically states the purpose of the meeting (i.e., Is it a therapeutic relationship that gives rise to an evidentiary privilege or is the purpose

to assess the person's capacity to determine whether a guardianship is warranted?). If the purpose is assessing the need for a guardian, and the person does not fully understand the nature and consequences of the consent, the APS professional must terminate the meeting and may not gather information that may be used "against" the person in a guardianship proceeding. The goal would be to encourage these professionals to work with the person to achieve the statutory goals of APS, rather than gather evidence for a guardianship case from an unsuspecting person who is vulnerable and may not understand the nature and consequences of the APS employee's role. If the professional who may be subject to an evidentiary privilege is assessing the need for a guardian (i.e., acting as a "guardianship specialist" rather than a medical, psychological, or social work professional), the person should be permitted to testify only in that capacity, rather than as a professional who can diagnose and opine as to appropriate treatment of the person.

- When an APS investigation involves an APS-employed psychiatrist or other professional who may potentially infringe on the person's medical privacy or be subject to evidentiary privileges, the professional must obtain meaningful informed consent from the person. If the professional does not believe that the person has the capacity to understand the potential consequences of providing information to the professional, no further discussion should be allowed. If the psychiatrist or health care professional is truly acting as a "guardianship specialist" for APS rather than in his or her capacity as a medical professional, that person should be precluded from testifying at the hearing as a medical expert or about medical information. A better alternative would be to have APS fully explore services that may avoid the need for a guardianship. If a guardianship petition is filed as a last resort, APS should have a caseworker, not a psychiatrist, testify about the AIP's functional capacity.
6. Amend the last clause of § 81.07(b)(3), by replacing "the court shall not require that supporting papers contain medical information" with "the petition, and any supporting papers, shall not include medical information without a court order."
 7. Amend Article 81 terminology generally to more precisely reflect a focus on a person's legal capacity, rather than her incapacity or deficiency.¹¹⁴ Throughout the statute, replace the term "alleged incapacitated person" with "person alleged to need a guardian" and replace the term "incapacitated person" with "person with a guardian."

Conclusion

Article 81 should continue moving toward becoming a fully functional capacity statute that emphasizes functional capacity, requires that alternatives to a guardianship be fully explored prior to appointing a guardian, and raises the threshold for including medical information with the petition and at the hearing. If a court determines that medical evidence is necessary, there should be uniform procedures to ensure that a person's medical privacy rights are protected. Ultimately, both the medical and functional models of guardianship based on a person's incapacity should be replaced by a support model that recognizes the full legal capacity of the person, and identifies areas in which assistance is needed, without a finding of incapacity. ■

1. Under Article 81 of the MHL, the person is initially referred to as an "Alleged Incapacitated Person" (AIP) and if a guardian is appointed, an "Incapacitated Person" (IP). If the person consents to the guardianship, the court order will generally refer to the person as a "person in need of a guardian" (PING).
2. MHL § 81.02(a)(2).
3. See, e.g., *In re Ardelia R.*, 28 A.D.3d 485 (2d Dep't 2006) (testimony established that frail 82-year-old woman did not understand or appreciate the consequences of her limitations where APS found her at her home without running water, food, electricity, or heat, she was diagnosed with dementia, hypertension, and coronary artery disease, could not cook, wandered from home, did not know her income, where she banked, and despite substantial savings, was behind on her utility bills).
4. The statute states that "'[f]unctional level' means the ability to provide for personal needs and/or the ability with respect to property management." MHL § 81.03(b).
5. The facts have been altered in these composite cases to protect privacy, although all of the facts and documents in these and virtually all Article 81 cases are matters of public record, available for anybody to see, unless the case file is sealed under MHL § 81.14.
6. Although Article 81 can be used to appoint a guardian for any person who is found to need a guardian, regardless of his or her particular functional capacity or medical condition, Article 17-A of the N.Y. Surrogate's Court Procedure Act (SCPA) is an alternative guardianship statute that follows a medical model and is limited to people with developmental disabilities, autism, traumatic brain injuries, and other enumerated conditions. SCPA 1750-a. Article 17-A was initially enacted in 1969 primarily for parents of children with developmental disabilities who were reaching the age of majority, and has not been amended in any significant way. Article 17-A lacks most, if not all, of the due process protections of Article 81, as well as its flexibility, powers, and nuances. Courts have borrowed from the framework of Article 81 to fashion remedies that would pass constitutional muster or that are otherwise permitted under Article 81. See, e.g., *In re Mark C.H.*, 28 Misc. 3d 765 (Sur. Ct., N.Y. Co. 2010) (in a case involving guardianship for person whose medical diagnosis was belied by his functional capabilities, court discussed history of Article 17-A within constitutional and international human rights framework, and imposed monitoring requirements to assure that the person's needs were being met by a guardian and by a substantial trust established for his benefit); *In re Yvette A.*, 27 Misc. 3d 945 (Sur. Ct., N.Y. Co. 2010) (court held that under Article 17-A terms and restrictions in best interests of person can be imposed on guardian and imposed initial and annual reporting requirements on guardian of the person). Although the focus of this article is on Article 81, my analysis applies with equal force to Article 17-A.
7. Naomi Karp & Erica F. Wood, *Guardianship Monitoring: A National Survey of Court Practices*, 37 *Stetson L. Rev.* 143, 150 (2007) (noting that guardianship population will grow and be more diversified, and that approximately 7-8 million individuals have intellectual disabilities, affecting 10% of families).
8. See, e.g., Naomi Karp & Erica Wood, *Guarding the Guardians: Promising Practices for Court Monitoring* (AARP 2007); Pamela B. Teaster et al., *Wards of*

the State: A National Study of Public Guardianship, 37 Stetson L. Rev. 193 (2007) Sally Balch Hurme & Erica Wood, *Guardian Accountability Then and Now: Tracing Tenets for an Active Court Role*, 31 Stetson L. Rev. 867 (2002).

9. A guardian appointed under Article 81 must complete and file an initial 90-day report and subsequent annual reports, which are reviewed by a court examiner and approved by a judge. MHL §§ 81.30, 81.31. If the guardian is a family member or “lay” guardian, it is likely that an attorney will be required to assist with reporting, or the court examiner will have to provide assistance or at least review corrected reports. If the guardian is a “professional” appointed from the Part 36 fiduciary list of appointees, that person may not be available for another case that may involve greater need. Finally, when a guardian is appointed, payment for the petitioner’s attorney, the court evaluator, the attorney for the person under the guardianship (if any), and the court examiner must be made from the assets of the person.

10. There have been three major guardianship “summits” in the United States, each resulting in findings and recommendations. The 1988 and 2001 Wingspan Conferences gathered together a multi-disciplinary group of experts and produced comprehensive recommendations. See Comm’n on the Mentally Disabled & Legal Problems of the Elderly, Am. Bar Ass’n, *Guardianship: An Agenda for Reform*, 13 Mental & Physical Disability L. Rep. 274 (1989) (summarizing substance and recommendations of Wingspread Conference); A. Frank Johns & Charles P. Sabatino, *Wingspan – The Second National Guardianship Conference*, 31 Stetson L. Rev. 573 (2002); Marshall B. Kapp, *Reforming Guardianship Reform: Reflections On Disagreements, Deficits, and Responsibilities*, 31 Stetson L. Rev. 1047 (2002) (noting the presence of widespread disagreement among Wingspan participants, mostly revolving around the tension between adversarial and therapeutic approaches). The National Guardianship Network organized the “Third National Guardianship Summit: Standards of Excellence” at the University of Utah S.J. Quinney College of Law in Salt Lake City on October 12–15, 2011. The conference focused on “post-appointment guardian performance and decision-making.” See Guardianship Summit <http://www.guardianshipsummit.org>.

11. The functional model represents an improvement over the traditional medical model, which relied primarily on medical diagnosis as the basis for appointing a guardian. Although it has many positive aspects, to the extent that a functional model of guardianship requires a finding of incapacity, promotes the role of courts, and focuses on limitations and deficits, it falls short of the nondiscriminatory aspirations of the support model of the United Nations Convention and Optional Protocol on the Rights of Persons with Disabilities. 46 ILM 443 (2007), at <http://www.un.org/esa/socdev/enable/rights/convtexte.htm> (last visited Apr. 9, 2012) (UN Convention). The UN Convention was signed by President Barack Obama on July 24, 2009, 74 Fed. Reg. 37923 (July 24, 2009), but has not yet been ratified by the U.S. Senate. Nevertheless, the UN Convention and other international treaties and documents are relevant when analyzing potential human rights violations that may arise in guardianship cases. For a fuller discussion of the international framework within the context of an SCPA Article 17-A case, see *In re Mark C.H.*, 28 Misc. 3d 765, 783–88 (Sur. Ct., N.Y. Co. 2010).

12. See, e.g., A.B.A. Comm’n on Law and Aging, *Guardianship Law & Practice*, at http://www.americanbar.org/groups/law_aging/resources/guardianship_law_practice.html (last visited Apr. 9, 2012).

13. Alternatives to guardianships include various supports such as home health aides, visiting nurses, adult day care, and senior centers and advance directives such as a power of attorney for property decisions, a health care proxy or living will for health care decisions. MHL § 81.03(e).

14. Guardianship courts play an important and largely constructive role in assuring that vulnerable individuals brought before them, and their constitutional rights, are protected. Occasionally, the protective function of the court comes at the expense of the person’s rights of self-determination and autonomy. A guardianship can be expensive and utilizes scarce judicial resources. Guardianships also provide a source of compensation for court-appointed guardians and court examiners, and fees are generally paid from the assets of the person for whom a guardian has been appointed. Compensation and appointments are governed by “Part 36 Rules,” N.Y. Comp. Codes R. & Regs. tit. 22, pt. 36, which became effective on June 1, 2003 and were enacted in response to two reports issued by the Office of Court Administration in 2001 that verified the need for reform (the Inspector General’s Report on Fiduciary Appointments in New York and the Report of the Commission on Fiduciary, referred to as the “Birnbaum Commission”). Another report that described the impact of the new appointment regime under Part 36, Development of a New Fiduciary Appointment System, was issued on February 9, 2004 by the Office of Court Administration, Guardian and Fiduciary Services. The text of the rules and reports are at <http://www.nycourts.gov/ip/gfs> (last visited Apr. 10, 2012).

15. See, e.g., *In re Grinker*, 77 N.Y.2d 703 (1991) (holding that predecessor statutes to Article 81 lacked protection for fundamental liberty interests protected under the U.S. Constitution); *In re Fisher*, 147 Misc. 2d 329 (Sup. Ct., N.Y. Co. 1989) (describing constitutional infirmities of conservator and committee statutes that preceded Article 81); *In re Doe*, 181 Misc. 2d 787 (Sup. Ct., Nassau Co. 1999).

16. 46 ILM 443 (2007), at <http://www.un.org/esa/socdev/enable/rights/convtexte.htm> (last visited Apr. 9, 2012). Among the key provisions in the UN Convention are Article 12, “Equal recognition before the law,” Article 19, “Living independently and being included in the community,” and Article 22, “Respect for privacy.”

17. *In re A.G.*, 6 Misc. 3d 447 (Sup. Ct., Broome Co. 2004).

18. MHL § 81.01.

19. See MHL § 81.22(a)(9).

20. See MHL § 81.22(a)(8); see also N.Y. Pub. Health Law art. 29-CC (authorizing guardian to make health care decisions as surrogate with power to make decisions to refuse or withdraw life-sustaining treatment).

21. MHL § 81.22(a)(2).

22. See MHL § 81.21 (authorizing a wide array of property management powers, including the power to make transfers, gifts, and establish trusts). See also *Helen Hayes Hosp. v. DeBuono (In re Shah)*, 95 N.Y.2d 148 (2000) (Article 81 guardian has power to engage in Medicaid planning, including transfers of assets to herself).

23. MHL § 81.22(a)(9).

24. *Olmstead v. Zimring*, 527 U.S. 581 (1999).

25. *Id.* at 599.

26. 28 C.F.R. § 35.130(d).

27. UN Convention, at <http://www.un.org/esa/socdev/enable/rights/convtexte.htm> (last visited Apr. 9, 2012). The U.S. Department of Justice is actively seeking to enforce the requirements of *Olmstead*. See <http://www.ada.gov/olmstead/index.htm> (last visited Apr. 2, 2012). See also *Disability Advocates, Inc. v. N.Y. Coalition for Quality Assisted Living, Inc.*, 675 F.3d 149, 154 (2d Cir. 2012) (holding that plaintiff lacked standing to bring action under the “integration mandate” of the ADA to challenge failure of New York State officials to place residents of adult homes who had serious mental illnesses in the community).

28. UN Convention.

29. Under Article 12 of the UN Convention, the person retains capacity as a legal matter and the support structure is designed, as is Article 81, to promote decisions by the person. Any “co” or “facilitated” decision would be based on the person’s preferences, wishes, and values. Article 81 comes close to Article 12 in its functional approach, mandate to explore alternatives to a guardianship, and requirement that the guardian make decisions based on a subjective understanding of the person’s wishes, and only utilize a best interests approach if the person’s wishes are not known or ascertainable.

30. See, e.g., Robert P. Roca, *Determining Decisional Capacity: A Medical Perspective*, 62 Fordham L. Rev. 1177 (1994) (explaining the critical role a psychiatrist can play in identifying the existence of a medical condition that may be causing cognitive impairment and recognizing when interventions such as adjusting medication may alleviate problems, for example when depression is an underlying cause). The assessment of incapacity by judges, lawyers, and health care professionals may be unreliable due to pretext and “sanism.” See Michael L. Perlin, “Half-Wracked Prejudice Leaped Forth”: *Sanism, Pretextuality, and Why and How Mental Disability Law Developed as It Did*, 10 J. Contemp. Legal Issues 3 (1999).

31. Deirdre M. Smith, *The Disordered and Discredited Plaintiff: Psychiatric Evidence in Civil Litigation*, 31 Cardozo L. Rev. 749, 753 (2010).

32. *Id.*

33. MHL § 81.02(a).

34. MHL § 81.02(a)(2); see, e.g., *In re May Far C.*, 61 A.D.3d 680 (2d Dep’t 2009) (appointment of guardian reversed where person made sufficient arrangements for meeting her needs, including executing a power of attorney).

35. Liability under tort law for invasion of privacy is another layer of potential protection, but beyond the scope of this article. These “privacy torts” include intrusion upon another’s seclusion and public disclosure of private facts. A physician or other health care professional in a confidential relation-

ship may incur tort liability through an unauthorized disclosure of confidential information.

36. See, e.g., *Whalen v. Roe*, 429 U.S. 589 (1977) (computer record of prescriptions for controlled substances); *Nixon v. Admin. of Gen. Serv.*, 433 U.S. 425 (1977) (presidential papers). The U.S. Supreme Court has also found a broader right to privacy in a variety of other contexts. See, e.g., *Lawrence v. Texas*, 539 U.S. 558 (2003) (right to consensual sexual contact between people of the same sex); *Roe v. Wade*, 410 U.S. 113 (1973) (right to choose abortion); *Grissold v. Conn.*, 381 U.S. 479 (1965) (right to obtain contraception).

37. *O'Connor v. Pierson*, 426 F.3d 187 (2d Cir. 2005) (holding that Board of Education did not have legitimate interest in demanding private medical records from teacher with a serious illness in matter involving sick leave, explaining that when a "legislative burden" infringes on privacy rights, the court will apply intermediate scrutiny and only permit it when the government has a substantial interest that outweighs the privacy interest).

38. 429 U.S. 589 (1977).

39. *Doe v. City of N.Y.*, 15 F.3d 264, 267 (2d Cir. 1994).

40. *Powell v. Schriver*, 175 F.3d 107, 110 (2d Cir. 1999).

41. *Fleming v. State Univ. of N.Y.*, 502 F. Supp. 2d 324 (E.D.N.Y. 2007).

42. 631 F.3d 57 (2d Cir. 2011).

43. *Id.* at 66. Prior to *Matson*, the standard for finding a right of medical privacy had only required a "serious medical condition." See *O'Connor*, 426 F.3d 187.

44. *Matson*, 631 F.3d at 72–73 (Straub, J., dissenting).

45. See e.g., *Rivers v. Katz*, 67 N.Y.2d 485 (1986); 1-12 New Appleman New York Insurance Law § 12.06.

46. *Schulman v. N.Y. City Health & Hosps. Corp.*, 38 N.Y.2d 234 (1975).

47. 42 U.S.C. § 1320d; 45 C.F.R. pts. 160–164 (the entire privacy rule is at <http://www.hhs.gov/ocr/hipaa>). Under HIPAA, the release of medical records and information is authorized, *inter alia*, pursuant to a court order or to a personal representative who is defined as a person with the legal authority to make health care decisions. For a summary of HIPAA, see U.S. Dep't of Health & Human Services Office of Civil Rights Privacy Brief, *Summary of the HIPAA Privacy Rule*, at www.hhs.gov/ocr/privacy/hipaa/understanding/summary.pdf. Note that other federal statutes govern matters related to medical privacy, including the Privacy Act, 5 U.S.C. § 552a (federal agencies); see *FAA v. Cooper*, 132 S. Ct. 1441 (2012) (holding that definition of "actual damages" under the act is limited to pecuniary damages), and the Americans with Disabilities Act; see 42 U.S.C. § 12101 (no federal employees).

48. See, e.g., *In re Mougianis*, 25 A.D.3d 230 (2d Dep't 2005) (court held that court appointed guardian was a qualified person under HIPAA, but that health care agent was authorized only to obtain records related to duties as agent).

49. 45 C.F.R. §§ 164.508, 164.512(e).

50. *In re Miguel M.*, 17 N.Y.3d 37 (2011). Protections similar to HIPAA that apply to facilities operated by the Office of Mental Health and the Office of People with Developmental Disabilities can be found at MHL § 33.13.

51. *In re Dolan (Lisa O.)*, 33 Misc. 3d 870 (Sup. Ct., Nassau Co. 2011).

52. See, e.g., CPLR 4507, 4508.

53. *Dillenbeck v. Hess*, 73 N.Y.2d 278.

54. *People v. Sinski*, 88 N.Y.2d 487 (1996) (in criminal prosecution against person involving prescription drugs, court discussed purposes and exceptions to physician-patient privilege and held that it excluded information from doctors who provided the prescriptions to the defendant).

55. *Sinski*, 88 N.Y.2d at 491 (citing Alexander, Practice Commentaries, McKinney's Cons Laws of NY, Book 7B, CPLR C4504:1, at 628 (1992)).

56. *Heller v. Peekskill Cmty. Hosp.*, 198 A.D.2d 265 (2d Dep't 1993).

57. *Dillenbeck*, 73 N.Y.2d at 284.

58. MHL § 81.09(d).

59. *Heller*, 198 A.D.2d 265.

60. See *Sinski*, 88 N.Y.2d 487.

61. *Dillenbeck*, 73 N.Y.2d at 280–81 (plaintiff in personal injury case sought medical records of defendant from hospitalization on day of car accident to determine blood alcohol level, but court held protected by physician-patient privilege).

62. See *Roca*, *supra* note 30, at 1177.

63. MHL § 81.02(a).

64. See, e.g., *In re May Far C.*, 61 A.D.3d 680 (2d Dep't 2009) (reversing appointment of guardian where AIP made adequate arrangements for her affairs, including executing a power of attorney when she had sufficient capacity); *In re Nellie G.*, 38 A.D.3d 547 (2d Dep't 2007) (reversing appointment of independent guardian where daughter was agent under springing power of attorney, which was available resource rendering appointment of a guardian unnecessary, and allegation that daughter had engaged in questionable transaction involving AIP's real property was unfounded where daughter did not benefit and transaction did not adversely affect AIP's interests); *In re Mildred M.J.*, 43 A.D.3d 1391 (4th Dep't 2007) (petition dismissed where AIP had the capacity to execute advance directives and family relationship did not create presumption of undue influence nor a confidential relationship so as to shift burden of proof); *In re Isadora R.*, 5 A.D.3d 494 (2d Dep't 2004) (order appointing guardian reversed where agent appointed under health care proxy and power of attorney was properly carrying out plan for care of person and management of property); *In re Albert S.*, 286 A.D.2d 684 (2d Dep't 2001) (court refused to appoint guardian because health care proxy agents were acting consistently with provisions of living will, and court lacked authority to impose additional requirement for termination of life-sustaining treatment that was not contained in advance directives).

65. MHL § 81.02(b).

66. See, e.g., *In re David C.*, 294 A.D.2d 433 (2d Dep't 2002) (Commissioner of DSS petitioned for appointment of a guardian after an eviction proceeding initiated based on failure to pay rent and maintain the apartment properly, court reversed jury finding that person was incapacitated and held "[a] precarious housing situation and meager financial means do not, without more, constitute proof of incapacity . . ."); *In re Tait*, N.Y.L.J., May 31, 1994, p. 28 (Sup. Ct., N.Y. Co.) (even if a person is mentally ill, eccentric, has poor personal hygiene and lives in squalor, there must be clear and convincing evidence that the person is incapacitated as defined in the statute); *In re Presbyterian Hosp. (Early)*, N.Y.L.J., July 2, 1993, p. 22 (Sup. Ct., N.Y. Co.) (guardian not appointed for elderly woman who recognized the potential for harm if she refused placement in a nursing home or did not allow home care attendants to assist her).

67. MHL § 81.08(a)(3).

68. See, e.g., MHL § 81.07(b)(3); *In re Bess Z.*, 27 A.D.3d 568 (2d Dep't 2006); *In re Q.E.J.*, 14 Misc. 3d 448 (Sup. Ct., Kings Co. 2006); *In re Higgins (England)*, N.Y.L.J., Oct. 6, 1995, p. 27 (Sup. Ct. Suffolk Co.).

69. See, e.g., *In re Q.E.J.*, 14 Misc. 3d 448 (Sup. Ct., Kings Co. 2006).

70. MHL § 81.14; see *In re Astor*, 13 Misc. 3d 1203(A) (Sup. Ct., N.Y. Co. 2006) (court sealed medical, psychological, and nursing records, as well as court evaluator's reports, and documents that contained confidential information such as Social Security and financial account numbers; court proceedings concerning any confidential information would be closed to the public and press); *In re A.J.*, 1 Misc. 3d 910(A) (Sup. Ct., Kings Co. 2004) (on motion of court evaluator, court closed courtroom and sealed the record where husband and wife who were alleged to be incapacitated feared their son who had physically and financially abused them).

71. MHL § 81.07.

72. See *In re James B.*, 25 Misc. 3d 467 (Sup. Ct., Delaware Co. 2009) (agency certified by state agency to provide services for people with developmental disabilities).

73. 12 Misc. 3d 1132 (Sur. Ct., Broome Co. 2006).

74. See, e.g., *In re Goldfarb*, 160 Misc. 2d 1036, 1043–44 (Sup. Ct., Suffolk Co. 1994) (court held that affirmation of treating physician attached to petition would have violated physician-patient privilege, except that respondent placed her medical condition at issue).

75. *In re Q.E.J.*, 14 Misc. 3d 448.

76. *In re Tara X*, N.Y.L.J., Sept. 18, 1996, p. 27 (Sup. Ct., Suffolk Co.).

77. *Id.*

78. *In re James B.*, 25 Misc. 3d 467.

79. MHL § 81.08(a)(3); *In re Mary J.*, 290 A.D.2d 847 (3d Dep't 2002) (allegations in petition were sufficient where they described the alleged incapacitated person's physical problems, memory impairment, need for assistance in performing activities of daily living, and lack of understanding of the nature and consequences of her inability and limitations).

80. MHL § 81.09.
81. The AIP must be advised in the “legend” of the order to show cause that the court evaluator may be granted permission to inspect medical records and of the right to object by telling the judge that the court evaluator should not be given permission. MHL § 81.07(c). This right to object may only be meaningful if the AIP has retained an attorney, or has the right to be appointed an attorney under MHL § 81.10.
82. See, e.g., *In re Kufeld*, 51 A.D.3d 483 (1st Dep’t 2008) (affirming court’s decision to grant court evaluator’s request for order to access medical records as they would assist in investigation, especially in light of allegations by AIP’s nephew of duress and coercion against the AIP and AIP’s allegations of incapacity in self-petition).
83. MHL § 81.09(d).
84. MHL § 81.09.
85. MHL § 81.09(d).
86. *In re Goldfarb*, 160 Misc. 2d 1036, 1041–42 (Sup. Ct., Suffolk Co. 1994).
87. MHL § 81.12(b); *Goldfarb*, 160 Misc. 2d at 1043.
88. MHL § 81.09(c)(7).
89. *In re Tara X*, N.Y.L.J., Sept. 18, 1996, p. 27 (Sup. Ct., Suffolk Co.).
90. MHL § 81.09(d); *In re Goldfarb*, 160 Misc. 2d 1036.
91. *In re Rosa B.-S.*, 1 A.D.3d 355 (2d Dep’t 2003); *In re Bess Z*, 27 A.D.3d 568 (2d Dep’t 2006) (court excluded testimony of treating physician, but held that testimony established by clear and convincing evidence that the person was likely to suffer harm because she could not care for her medical, personal, and financial needs and did not understand the nature of her limitations).
92. *In re Goldfarb*, 160 Misc. 2d 1036.
93. *In re Maher*, 207 A.D.2d 133, 143 (2d Dep’t 1994).
94. See, e.g., *In re Bess Z*, 27 A.D.3d at 568 (testimony of AIP’s treating physician violated physician-patient privilege, but other evidence sufficiently clear and convincing to appoint guardian); *In re Seidner*, N.Y.L.J., Oct. 8, 1997, p. 25, col. 3 (Sup. Ct., Nassau Co.) (excluding medical evidence to which AIP objected based on physician-patient privilege and dismissing petition for lack of evidence).
95. *In re Rosa B.-S.*, 1 A.D.3d at 356.
96. *In re Marie H.*, 25 A.D.3d 704 (2d Dep’t 2006).
97. 42 U.S.C. §§ 1397–1397F.
98. N.Y. Social Services Law § 473(1) (SSL); N.Y. Comp. Codes R. & Regs. tit. 18, pt. 457 (N.Y.C.R.R.); see also <http://www.ocfs.state.ny.us/main/psa/>; 97 ADM-2.
99. See, e.g., *Dan R. v. Bane*, 199 A.D.2d 322 (2d Dep’t 1993) (local commissioner of Department of Social Services required as part of protective services to serve as representative payee for persons receiving SSI who are unable to manage their own finances).
100. Adult protective services are available to all adults who meet the following non-financial eligibility criteria: unable to provide necessary food, clothing, or medical care, access public and private benefits, or protect oneself from physical or mental injury, neglect, maltreatment, or financial exploitation. The person must be at risk and need protection from actual or potential harm. No other person or agency must be able or willing to provide the needed assistance. SSL § 473(1); 18 N.Y.C.R.R. § 457.1(c)(1), (2), (3); 90 ADM-40.
101. *In re Eugenia M.*, 20 Misc. 3d 1110(A) (Sup. Ct., Kings Co. 2008).
102. One court has called the practice of trying to assess on a case by case basis the validity of a waiver in this context a practice “fraught with peril and fallibility.” *In re Goldfarb*, 160 Misc. 2d 1036, 1040 (Sup. Ct., Suffolk Co. 1994).
103. Steven I. Friedland et al., *Evidence Law and Practice* 792 (3d ed. 2007).
104. *Id.* at 793.
105. *In re Eugenia M.*, 20 Misc. 3d 1110 (A); see SSL § 473(1)(b) (emphasis added).
106. *Heller v. Peekskill Cmty. Hosp.*, 198 A.D.2d 265 (2d Dep’t 1993).
107. See, e.g., *Jaffee v. Redmond*, 518 U.S. 1 (1996) (upholding claim of psychotherapist-patient privilege where police officer sought services from a clinical social worker subsequent to shooting in which he was involved). The client or patient of a social worker may invoke an evidentiary privilege under CPLR 4508.
108. See David P. Horowitz, 4-12 Bender’s New York Evidence – CPLR 4-12 (2012).
109. MHL § 81.02, § 81.02(a) (standard for appointing a guardian); § 81.03(e) (available resources that are alternatives to a guardianship); § 81.21 (property management); § 81.22 (personal needs).
110. MHL § 81.08(a)(4), (5).
111. MHL § 81.08(a)(6).
112. MHL § 81.08(a)(14).
113. MHL § 81.08(a)(15).
114. Article 81 made great strides by using “incapacity” and “incapacitated person” instead of the labels “incompetency” and “incompetent” that were used in the predecessor Article 78 “Committee” statute. However, in the ensuing two decades, societal awareness of the importance of language has increased, and it is time to update the statute and use language that does not reflect negatively on the person or suggest that the person’s legal capacity is not entitled to full recognition under the law. For example, New York has replaced the term “mental retardation” with “developmental disability” or “intellectual disability” in state agencies, statutes, and regulations.

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