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The Dementia Crisis

Special Issue for Attorneys, Their Loved Ones and Their Clients

By Robert Abrams, Editor

NEW YORK STATE BAR ASSOCIATION

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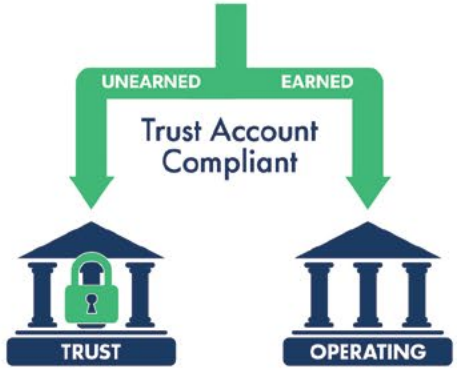

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EUGENE C. GERHART
(1912–2007)
Editor-in-Chief, 1961–1998

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BY ROBERT ABRAMS, EDITOR

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DEPARTMENTS

The *Journal* welcomes articles from members of the legal profession on subjects of interest to New York State lawyers. Views expressed in articles or letters published are the authors' only and are not to be attributed to the *Journal*, its editors or the Association unless expressly so stated. Authors are responsible for the correctness of all citations and quotations. Contact the editor-in-chief or managing editor for submission guidelines. Material accepted by the Association may be published or made available through print, film, electronically and/or other media.

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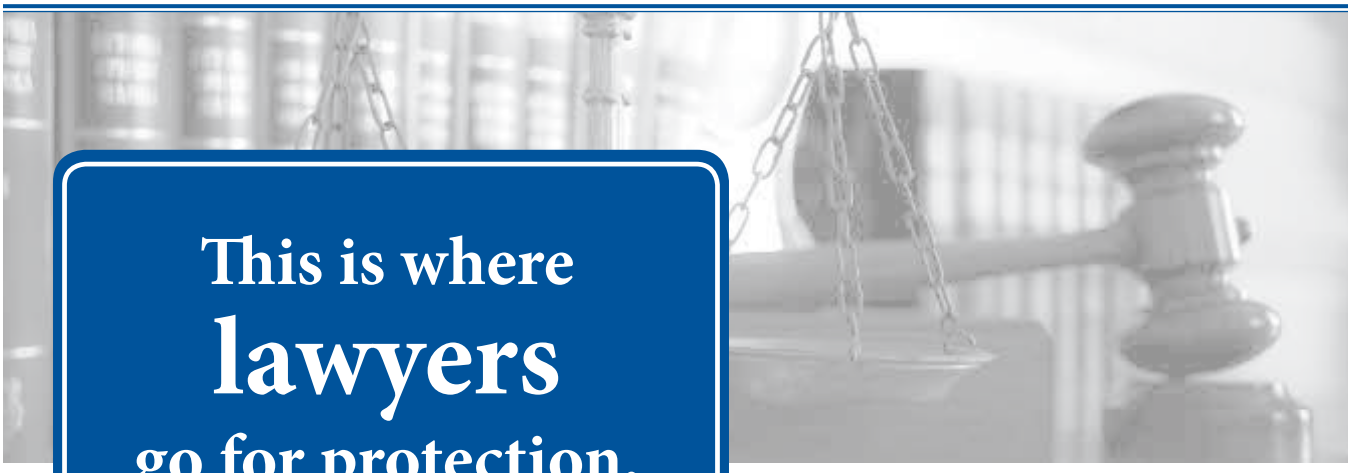

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CLAIRE P. GUTEKUNST

Connect Inspire Learn

"This is the power of gathering: it inspires us, delightfully, to be more hopeful, more joyful, more thoughtful: in a word, more alive."

– Alice Waters

Our Association's 140th Annual Meeting will be in New York City from January 23 to January 27, 2017. The theme is "connect, inspire, learn," and this year's CLE offerings, meetings and networking opportunities reflect the rich smorgasbord of the law and the knowledge and diversity of our members.

Connection is key. We too rarely come together in person, so it is particularly satisfying to shake hands and speak with a colleague known only through email. As much as we rely on electronic communication, meeting and engaging with colleagues in person has a power that resonates long after we return to our offices across the state, the country or the world.

That's the power of Annual Meeting, and we hope you join us. Our Sections, committees and staff have worked tirelessly to develop programs and events to educate and inspire you. If you cannot attend, please gather with us via our live-streamed programs: the House of Delegates meeting, career development programming and the Presidential Summit.

On Wednesday, it will be my privilege to host the Presidential Summit. One panel will discuss the impact of artificial intelligence on the legal profession, a hot topic for all members.

Combatting domestic violence is one of my priorities as president, and our other Summit panel addresses a new twist in this scourge. Advances in technology, the Internet and social media have made possible a form of abuse that involves threatening to or actually disseminating sexually explicit images of an intimate partner without consent, often (but mistakenly) referred to as "revenge porn." This wreaks havoc on victims' lives, causing shame, humiliation and trauma, and makes them vulnerable to harassment by those who view the images online. The panel will focus on the dynamics of intimate partner violence, the legal issues and options relating to e-exploitation, the current law in New York and whether laws specifically targeting this form of violence are needed.

Increasing diversity and inclusion is another of my priorities, and the Annual Meeting offers programs and events to advance that goal as well.

On Monday, the Committee on Diversity and Inclusion celebrates diversity in the bar – beginning with the Constance Baker Motley Symposium, followed by presentation of the Diversity Trailblazer Award and capped off with a reception. At the Symposium, this year's Trailblazer, Second Circuit Court of Appeals Judge Denny Chin, will join past Trailblazers to discuss what progress has been made toward achieving diversity in the legal profession in the 10 years since the award's inception.

Tuesday's Committee on Women in the Law program will help you "step up your game," with a panel discussing leadership and presentation skills. Another panel will address the importance of women in the judiciary, including their impact on the legal community and on women litigants and parties. The Committee also will present an award honoring a woman who has advanced the professional development of women attorneys, and will host a networking reception after the program.

On Thursday, the Committees on Civil Rights and Diversity and Inclusion will co-host a program on disrupting implicit bias, offering practical steps to "interrupt" your own unconscious biases (and deal with a colleague's), in situations from hiring and mentoring, to interviewing a witness or client, to picking a jury.

At Friday's House meeting, we will discuss a proposal to incorporate diversity and inclusion and elimination of bias credits into the existing biennial MCLE requirement. I urge you to watch the debate on the House floor.

You can live stream some events, and many Section CLEs will be available online after the Annual Meeting, but you gain the most by joining us in person. "The power of gathering: it inspires us." Chef Alice Waters may have had sharing a meal in mind when she wrote this but, clearly, the power is in coming together – not the food. That is the power of the Annual Meeting. Gathering together, we connect, inspire, and learn. ■

CLAIRE P. GUTEKUNST can be reached at cgutekunst@nysba.org.

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"Moments in History" is an occasional sidebar in the Journal*, which will feature people and events in legal history.*

Moments in History

The Social Security Act

In 1934, the nation lay mired in the Great Depression. A quarter of the workforce was unemployed. Many of the elderly and those who couldn't work or seek work lacked a steady income for survival. Voices for reform implored the federal government to provide the leadership that individual states could not. President Franklin Delano Roosevelt answered the call with an executive order establishing the Committee on Economic Security, which was directed to formulate an appropriate program of social insurance.

In August 1935, a modified version of the proposal that Roosevelt's team had submitted to Congress became law as the Social Security Act. It had four major elements: (i) a federal-state unemployment insurance system to be administered by the states and funded by a uniform nationwide tax on employers; (ii) federal grants for state welfare payments to needy populations; (iii) federal grants to states for a variety of public health programs; and (iv) "old-age insurance" to be funded by employers and workers through a payroll tax.

In 1940, Mrs. Ida May Fuller of Ludlow, Vermont, became the first recipient of a monthly Social Security retirement check in the amount of $22.54. By the time she died in 1975, she had received a total of $22,888.92. For the year 2012, 56.8 million Americans received monthly Social Security benefits totaling $775 billion.

Excerpted from *The Law Book: From Hammurabi to the International Criminal Court, 250 Milestones in the History of Law* (2015 Sterling Publishing) by Michael H. Roffer.

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The Dementia Crisis

By Robert Abrams, Editor

Dementia, of which there are over 100 types, including, but not limited to, Alzheimer's disease,[1] vascular dementia,[2] dementia with Lewy bodies[3] and frontotemporal dementia,[4] is a:

> syndrome – usually of a chronic or progressive nature – in which there is deterioration in cognitive function (i.e. the ability to process thought) . . . It affects memory, thinking, orientation, comprehension, calculation, learning capacity, language and judgment. . . . The impairment in cognitive function is commonly accompanied, and occasionally preceded, by deterioration in emotional control, social behavior, or motivation.[5]

Approximately 47 million people have dementia worldwide,[6] over 20 percent of whom reside in the United States.[7] By 2050, 135 million people worldwide are projected to have dementia[8] and similar growth of this disease is expected to increase proportionately in the United States.[9]

None of us are immune from this debilitating and deadly disease, which, according to the U.S. Centers for Disease Control (CDC), is now the sixth leading cause of death in the United States. The World Health Organization (WHO) has called dementia a "global epidemic."[10] Victims of dementia include famous people such as President Ronald Reagan, Senator Barry Goldwater, the husband of Supreme Court Justice Sandra Day O'Connor, Civil Rights leader Rosa Parks, sports legend Sugar Ray Robinson, as well as many entertainment icons including Rita Hayworth and Robin Williams, who was believed to have had Lewy Body Dementia.[11] Most of dementia's victims, however, are everyday people, no different from those of you reading this article.

The financial and business devastation caused by dementia not only affects the victims but also the victims' loved ones, co-workers, neighbors, communities, and business partners. Cognitive decline is not only emotionally painful but often simultaneously requires one or more family members to participate in providing care.[12] As the dementia progresses, basic care, such as bathing, dressing, toileting and eating, may need to be provided. Providing such care is physically and mentally challenging, and may require other family members to forgo responsibilities such as work and familial obligations.[13]

Robert Abrams (babrams@abramslaw.com) is a founding member and Executive Partner of Abrams, Fensterman, Fensterman, Eisman, Formato, Ferrara & Wolf, LLP. He is an adjunct professor at and co-founder of Touro Law Center's Aging and Longevity Law Institute. A former Chair of both the Elder and Health Law Sections of the New York State Bar Association, he has edited and/or written numerous books and articles for NYSBA, including the treatise *Guardianship Practice in New York State; The Legal Manual for New York Physicians*, and the *New York State Public Health Legal Manual*. In 1995, he created Health Decision Making Day (renamed the Mitchell Rabino National Healthcare Decision Day), which has successfully informed tens of thousands of people throughout New York and the United States about the importance of advance directives.

In addition to the personal toll on the individual with dementia and his or her loved ones, there is also a substantial financial cost. The average per-person cost of care for an individual with dementia is estimated to be tens of thousands of dollars each year.[14] New Yorkers requiring nursing home or other specialized care may incur annual costs in excess of $200,000.[15] The financial challenges to provide care and a safe environment for an individual with dementia can result in serious financial hardship and possible impoverishment for the individual and his or her family.

Further, the societal costs of dementia are staggering and growing. According to a 2013 study conducted by the RAND Corporation Center for the Study of Aging, "[t]he monetary cost of Dementia in the United States ranges from $159 billion to $215 billion dollars annually, making the disease more costly to the nation than either heart disease or cancer."[16] The Alzheimer's Association believes the cost of dementia care is even higher than that reported by RAND and projects that by the year 2050, Alzheimer's disease will cost the United States over $1 trillion.[17]

Not surprisingly, the personal, financial and business costs of dementia have serious and, in some cases, potentially catastrophic legal consequences. While we in the legal profession cannot prevent the occurrence of this destructive and deadly disease, we can empower our clients to prepare for and/or minimize the legal challenges they may face if they, a loved one or business partner have dementia.

In this light, the Honorable A. Gail Prudenti[18] urges the legal professional to address the dementia crisis in a swift, professional and sensitive manner:

> The dementia epidemic has forced the legal profession to re-think and re-focus on how it will address the cares and concerns of our rapidly aging population and families in crisis. As they have with every other broad societal issue, lawyers must be prepared to meet their rightful burden by counseling their clients in a professional, caring manner with information and advice to both protect and to guide affected families through a myriad of difficult situations.
>
> What exacerbates this problem even further is the large number of people who will be afflicted with or affected by dementia. The numbers of those with dementia is simply staggering and is forecast to explode exponentially in the years to come. We have an obligation to meet the concerns of clients who look to us for strength, assistance and knowledge at the worst times in their lives. In order to meet its duty, the bar must prepare now – tomorrow is too late!

As evidenced by the contributions made by judges, lawyers and law students in this special issue of the *Journal*, I have no doubt that New York's legal community will respond to Judge Prudenti's call for action.

Examples of the commitment of New York's judges and attorneys can be found in the articles, *Dementia in the Courtroom* and *Perspectives on Dementia, the Legal Profession and the Law*. Our colleagues who authored these articles acknowledge our collective desire to fulfill our respective professional obligations in a manner that is understanding of and sensitive to the special needs of individuals with dementia, their loved ones and those who provide them with care. Such an understanding requires legal professionals to have the skills to distinguish between *Dementia, Mental Illness and Other Causes of Decline,* as well as provide immediate and timely assistance, to the extent possible, to individuals "recently diagnosed with early-stage dementia."

The personal, financial and business costs of dementia have serious and, in some cases, potentially catastrophic legal consequences.

As noted in the articles *Dementia and the Law* and *Proving Your Client's Diminished Mental Capacity Post-Death*, there are many laws that address the consequences of diminished mental capacity both prior and subsequent to death. These laws vary in their scope and effectiveness. They also fail to establish a coordinated legal framework that adequately addresses the legal implications of dementia in an efficient and comprehensive manner.

Even statutes such as Article 81 of New York's Mental Hygiene Law, which was specifically designed and enacted to address the legal and personal needs of individuals with diminished mental capacity, fail to adequately address critical substantive matters. Moreover, statutorily imposed time frames which were enacted to meet the needs of alleged incapacitated persons (AIP) are routinely ignored, causing delays which sometimes deprive the AIP of receiving the care and services they require and which almost always result in additional costs and undue stress to the AIP, family members and other participants in the proceeding.

The legal profession can and must do better to ensure that laws are properly developed and enforced. Moreover, we must continue our dialogue with representatives of other disciplines, most notably geriatricians, neurologists and other physicians; scientists with an expertise on dementia-related research; and health care professionals, particularly those familiar with how and where individu-

als with dementia and their family members access care and services. As Michael Miller, Esq. and Robert Freedman, Esq. remind us, we cannot cure or treat dementia, but we can minimize the legal and financial obstacles that further exacerbate this debilitating and deadly disease for our clients and our loved ones.

In this light, in cooperation with NYSBA, Touro Law Center's Aging and Longevity Law Institute and many of my colleagues throughout New York State, we will dedicate 2017 to providing the legal profession with information and resources that will help us meet the needs of individuals with dementia and their family members. Beginning in February, we will launch the Guardianship Quality Initiative which will be a 12-month collaboration between New York judges and attorneys. We will also finalize an update to the NYSBA treatise *Guardianship Practice in New York State*. Finally, in June 2017, we will present a special program on "Dementia, Science and the Law," which will review alternatives on how legal capacity should be determined.

Before closing, I'd like to thank the current and past leaders of NYSBA who have provided me with the opportunity to participate in various projects, like this special *Journal* issue, and my partners at Abrams, Fensterman, Fensterman, Eisman, Formato, Ferrara & Wolf, LLP who encourage and support my participation. I must also acknowledge David Wilkes, editor-in-chief of the *Journal*, Dan McMahon, director of Publications, Kate Mostaccio, in-house editor of the *Journal*, and Erin Corcoran, graphic designer, for their guidance, support and collegiality. I also extend my gratitude, appreciation and respect to the dedicated authors who have contributed their expertise to this historic issue of the *Journal*. Finally, I thank my wife, Linda, and my daughters, Dana and Tracey, who provide me with daily reminders that our greatest accomplishment is to love and be loved.

1. Alzheimer's disease is the "most common form of dementia" and is a "progressive disease beginning with mild memory loss possibly leading to loss of the ability to carry on a conversation and respond to the environment." *Healthy Aging Home, Health Information for Older Adults, Alzheimer's Disease*, CDC, www.cdc.gov/aging/aginginfo/alzheimers.htm.

2. "Vascular dementia is a decline in thinking skills caused by conditions that block or reduce blood flow to the brain, depriving brain cells of vital oxygen and nutrients. Vascular dementia is widely considered the second most common cause of dementia after Alzheimer's disease, accounting for 10 percent of cases." *Alzheimer's & Dementia, Vascular Dementia*, Alzheimer's Assoc., www.alz.org/dementia/vascular-dementia-symptoms.asp#symptoms.

3. "Dementia with Lewy bodies (DLB) is a type of progressive dementia that leads to a decline in thinking, reasoning and independent function because of abnormal microscopic deposits that damage brain cells over time." *Alzheimer's & Dementia, Dementia with Lewy Bodies*, Alzheimer's Assoc., www.alz.org/dementia/dementia-with-lewy-bodies-symptoms.asp.

4. "Frontotemporal dementia (FTD) describes a clinical syndrome associated with shrinking of the frontal and temporal anterior lobes of the brain. . . . As it is defined today, the symptoms of FTD fall into two clinical patterns that involve either (1) changes in behavior, or (2) problems with language." *Frontotemporal Dementia Information Page*, Nat'l Inst. Neurological Disorders & Stroke, www.ninds.nih.gov/disorders/picks/picks.htm.

5. *Media Center, Dementia, Fact Sheet April 2016*, WHO, www.who.int/mediacentre/factsheets/fs362/en/.

6. *Id*.

7. Approximately 10 million Americans have dementia. "An estimated 5.4 million Americans of all ages have Alzheimer's disease in 2016." Alzheimer's Assoc., 2016 Alzheimer's Disease Facts and Figures 17 (2016).

8. *Media Center, Dementia, Fact Sheet April 2016*, WHO, www.who.int/mediacentre/factsheets/fs362/en/.

9. *See* Alzheimer's Assoc., *supra* note 7, at 22. Some studies show that the ever-increasing rates of dementia may not be as extreme as publicized. Kara Gavin, *Dementia on the downslide, especially among people with more education, study finds*, Univ. of MI. Health Sys. Blog (Nov. 21, 2016), www.uofmhealth.org/news/archive/201611/dementia-downslide-especially-among-people-more-education.

10. WHO, The Epidemiology and Impact of Dementia: Current State and Future Trends 1 (2015).

11. Rebecca Robbins, *How Lewy Body Dementia Gripped Robin Williams*, Sci. American (Sept. 30, 2016), https://www.scientificamerican.com/article/how-lewy-body-dementia-gripped-robin-williams1/.

12. *Media Center, Dementia, Fact Sheet April 2016*, WHO, www.who.int/mediacentre/factsheets/fs362/en/.

13. *Id*.

14. Michael D. Hurd et al., *Monetary Costs of Dementia in the United States*, 368 New Eng. J. Med. 1326, 1329 (Apr. 2013).

15. MetLife, Market Survey of Long-Term Care Costs: The 2012 MetLife Market Survey of Nursing Home, Assisted Living, Adult Day Services, and Home Care Costs 19 (Nov. 2012).

16. *Cost of Dementia Tops $159* Billion Annually in the United States*, Rand Corp. (Apr. 3, 2013), www.rand.org/news/press/2013/04/03.html.

17. *See* Alzheimer's Assoc., *supra* note 7, at 56.

18. *Hon. A. Gail Prudenti*, Hofstra Law, http://law.hofstra.edu/directory/administration/prudenti/.

In Memoriam

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Dementia and the Law

By Rose Mary Bailly and Robert K.P. Cannon

When Robert (hereinafter "Bob") Abrams, Esq., suggested we write an article on the multitude of New York laws that impact older individuals with dementia and their families, he was eager to offer the following perspective and guidance:

> With few exceptions, America's system of legal jurisprudence is reactive in nature and often the product of compromise, monetary considerations, and an imbalance of political power. Our response to the legal implications of dementia is no different.
>
> A hodgepodge of laws were designed or repurposed, at least to some degree, to address legal issues confronted by individuals with dementia and their loved ones. These laws vary in effectiveness and collectively fail to create a coordinated response to this unprecedented public health emergency that affects tens of millions of Americans.
>
> As lawyers we must advocate for and counsel our clients within the confines of the legal system that our legislative leaders have created. While the current system can be frustrating for practitioners, it can be overwhelming and bewildering for individuals with dementia, in particular their loved ones who must navigate and overcome legal barriers as they struggle to adjust to their new reality.
>
> As members of the legal community, we lack the skill and training required to develop a cure or treatment

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for dementia. We can, however, help and comfort our clients by ensuring we act with sensitivity, efficiency, and a modicum of predictability, as we assist them in navigating the dementia-related legal maze.

While researching and writing this article, Bob's observations remained at the forefront of our minds. This article demonstrates that, although the legal system's approach to dementia has evolved as our knowledge and understanding of the disease has grown, the sheer breadth and complexity of law in this field present challenges to attorneys and laypersons. The purpose of this article is to provide the reader with a sampling of the many laws that not only address the issues facing the individual with dementia but also the laws designed to ease the burden on the family and society as a whole.

New York ranks among the top four states with the highest number of older adults, coming in just behind Texas with 2.9 million people age 65 and older.[1] In New York, the population of individuals 65 or older in 2015 represented 15 percent of the population,[2] and the aging of the Baby Boomers gives us every reason to believe the percentage will grow. New York has taken into account its older population, a significant portion of which suffers with dementia, by developing laws that protect individuals as they age.

Indeed, Governor Andrew Cuomo recently signed two new laws relating to caregiving for older adults, that affirm New York's continuing commitment to its aging population.[3]

The Caregiver Advise, Record, and Enable Act, Chapter 391 of the Session Laws of 2016,[4] amends the Public Health Law to require that "hospitals allow patients to formally designate a caregiver before they leave the hospital, or are transferred to another facility . . . [and] hospital workers to provide the caregiver with instruction or training on how to perform tasks for the patient at home, such as changing bandages or administering medication."[5]

Chapter 471 of the Session Laws of 2016 amends the Education Law to create a new job category known as Advanced Home Health Aides.[6] These individuals will receive additional training and, acting under the supervision of a licensed registered professional nurse, will carry out advanced tasks in a person's home. Thus, aging New Yorkers, including those with dementia, will be able to remain in their homes and their communities instead of institutional settings.

This article discusses some additional laws that protect New York's vulnerable population. This list is not exhaustive, but illustrates the variety of ways the public policy of the state is mindful of its aging citizens.

Civil

Recognition of an Aging Population

The state Office for the Aging was created to inform "the public, especially the elderly themselves, on subjects beneficial to the community which relate to the needs, abilities, resources, opportunities, rights, entitlements, and other issues affecting older people in New York state."[7] The activities of the office follow the requirements of the federal Older Americans Act of 1965, as amended.[8] Of special note is the New York State Legal Services Initiative, a collaboration facilitated by Bob, endorsed by Governor Cuomo, and run by the state Office for the Aging.[9] The initiative's purpose is to increase access to affordable legal assistance to three targeted population groups, including New York's older adults, with the ultimate aim being to ensure equal access to justice.[10]

Housing and Community Living

It is critical that the law encourages older individuals, including individuals with dementia, when appropriate, to remain in the community. This concept became an integral part of the law following the 1999 U.S. Supreme Court ruling in *Olmstead v. L.C.*,[11] wherein the court held that states must, in accordance with the Americans with Disabilities Act, provide community-based treatment for persons with mental disabilities.[12] In response, New York State developed the Olmstead Implementation Plan that addresses issues, including but not limited to, integrated housing, transportation, and community services to ensure individuals with disabilities, including older adults with dementia, receive services in the most integrated setting appropriate to their needs.[13] The following laws have been enacted to enhance the protections afforded to older individuals living in the community:

Discrimination. It is illegal to discriminate, in housing and public accommodations, on the basis of age, disability, familial status – having children under age 18, and other criteria.[14]

Other Tenant Protections. Tenants, or their spouses living with them, who are 62 years or older, or who will turn 62 during the term of their lease, may notify their landlord, in writing, of their intention to move and terminate the lease if they are certified by a physician as no longer able to live independently.[15] Moreover, persons who are 62 years of age or older and who live in buildings being converted to cooperatives or condominiums in New York City,[16] and Nassau, Rockland, and Westchester counties, and other municipalities are entitled to remain in their apartments without buying and may retain all rights of rent-regulated tenants.[17]

Naturally Occurring Retirement Communities (NORC). NORC programs for neighborhoods of single-family homes and low-rise apartment buildings that have become densely populated with older individuals help them "age in place" and prevent isolation and alienation. NORC funding makes possible health care aid, transportation, and other services that allow the occupants to live independently in their homes.[18]

The Enriched Housing Program. This program, licensed by the New York State Department of Health, offers

community living arrangements with supportive services primarily for people 65 years of age or older who are unable to perform some activities of daily living. Program services include assistance with personal care, meals, shopping, housekeeping, and a 24-hour, on-call emergency service.[19]

Access to Home Program. This program provides financial assistance to property owners to make homes accessible for low- and moderate-income persons with disabilities.[20]

Ability to Drive. Depending on where they reside, an older individual's ability to drive may have an enormous impact upon his or her ability to remain in the community. An individual's ability to drive is dependent upon the individual's mental and physical condition and ability to follow traffic laws and rules, not the individual's age. Pursuant to New York's Vehicle and Traffic Law § 506, if the commissioner of Motor Vehicles has reasonable grounds to believe that an individual is not qualified to drive, the commissioner may require such person to submit to an examination to determine his or her qualifications.[21]

It is critical that the law encourages older individuals, including individuals with dementia, when appropriate, to remain in the community.

Financial Assistance with Housing

Real Property Tax Credit. This state tax credit program assists eligible elderly and moderate-income homeowners and renters.[22]

Real Property Tax Exemption. This exemption, known as the circuit-breaker, allows tax exemptions to homeowners aged 65 and older if they meet certain requirements.[23]

STAR Property Tax Exemption. This exemption offers couples over the age of 65 who own their home or co-op apartment and meet residency and income guidelines an "enhanced" school tax rebate under the STAR program.[24]

Senior Citizen Rent Increase Exemption (SCRIE). This exemption grants certain exemptions from rent increases to tenants who are senior citizens. If a tenant or tenant's spouse is 62 years of age or older living in a rent-regulated apartment, with a combined household income at or below the income eligibility level and paying at least one-third of their disposable income toward their rent, they may qualify.[25]

Sharing a home. The law permits tenants to share their apartments with a roommate who is not on the lease, thus allowing older adults on fixed incomes to share living expenses.[26]

Health Care

The rights of a patient in a hospital or nursing home include, among others, the right to autonomy, disclosure of information, and privacy.[27] In addition, all patients in New York State hospitals have a right to receive a written discharge plan before they are discharged from the hospital. The plan should describe the arrangements for health care services required upon a patient's discharge, which must be secured or reasonably available to the patient prior to discharge.[28] Patient privacy in health care facilities is largely governed by the Health Insurance Portability and Accountability Act (HIPAA).[29]

Decisions by Surrogates. An individual, known as the principal, can execute a health care proxy appointing an agent to make health care decisions on the principal's behalf, in the event the principal is unable to make such decisions.[30] In the absence of a validly executed health care proxy, a surrogate from a prioritized list may make medical decisions for a patient in the event the patient lacks capacity to make such decisions personally, and did not previously make such decisions.[31]

The Attorney General Medicaid Fraud Control Unit investigates and prosecutes individuals and companies responsible for improper or fraudulent Medicaid billing schemes committed by hospitals, nursing homes, pharmacies, doctors, dentists, nurses, and other health care entities billing the Medicaid program.[32]

Financial Planning

It is critically important for individuals of all ages, in particular older adults, to implement a plan to ensure that their financial needs, and the financial needs of their family and loved ones, are protected in the event the individual can no longer handle his or her affairs. As practitioners, it is important to be cognizant of the potential financial impact that a dementia diagnosis can have not just on the victims and their loved ones but also upon their employees, co-workers, and business partners. For that reason, laws have been enacted to ensure that financial devastation can be avoided for the individual who plans ahead.

Joint Bank Accounts. Individuals may hold money in their accounts jointly with another individual, and each person has full access to the account with the right of survivorship in the proceeds of the account.[33]

Joint Bank Account for Convenience Only. The owner of this type of account adds another individual's name to the account for purposes of convenience only, i.e., check writing, bill paying, transfers, and withdrawals. The individual listed for convenience does not own the money in the account.[34]

Totten Trust Account. The owner of this type of account directs that the amount remaining in the account at the time of the owner's death be paid to a named beneficiary.[35]

Powers of Attorney. An individual can create a power of attorney for financial and estate planning thereby appointing an agent to manage the individual's financial affairs without court intervention; however, the agent can be required by the court to account for the management of the individual's affairs.[36]

Wills and Trusts. These documents are used to protect and preserve and distribute property during lifetimes or at death.[37]

Protection of Rights and Protection Against Abuse and Exploitation

A critical function of government is ensuring the rights of its citizen body are protected. Arguably, this function is most frequently put to the test when preserving the rights of vulnerable populations. As many commentators have observed, the manner in which a government treats its most at-risk populations is a true measure of society. The final sections of this article address a variety of New York laws that have been enacted to ensure that the basic rights of older persons, including those with dementia, are protected.

Private Right of Action Against Residential Health Care Facility. A patient of a residential health care facility who suffers injuries as a result of being deprived of any right or benefit may maintain a private right of action. The N.Y. Public Health Law defines the right or benefit as one that is "created or established for the well-being of the patient by the terms of any contract, by any state statute, code, rule, or regulation or by any . . . federal statute, code, rule, or regulation."[38] Injuries include, but are not limited to, "physical harm to a patient; emotional harm to a patient; death of a patient; and financial loss to a patient."[39] The remedies provided by the statute are in addition to and cumulative with any other remedies available to a patient, at law or in equity or by administrative proceedings, including tort causes of action, and may be granted regardless of whether such other remedies are available or are sought.[40] Damages recovered will not impair Medicaid eligibility.[41] Exhaustion of administrative remedies is not required prior to the commencement of any action, and any waiver, by a patient or legal representative, of the right to commence an action under this section, is null and void.[42]

Witnesses' Testimony. Testimony can be preserved if a party or a key witness is not expected to survive the time period necessary to commence an action and seek the disclosure in the context of it.[43]

The Right to Vote. An individual's right to vote is a cornerstone of American democracy and, for many, one of few opportunities to engage in politics. However, despite protection at both federal and state level, the right to vote is not absolute. The National Voter Registration Act of 1993 authorizes states to remove registrants from official lists of eligible voters "by reason of criminal conviction or mental incapacity."[44] Pursuant to New York Election Law, "no person who has been adjudged incompetent by order of a court of competent judicial authority shall have the right to register for or vote at any election in this state unless thereafter he shall have been adjudged competent pursuant to law."[45]

In a recent NAELA article titled, *Voting Under Guardianship: Individual Rights Require Individual Review*, Michele J. Feinstein and David K. Webber propose that no state should revoke an individual's right to vote, even if that person has been declared incapacitated, "without an individualized inquiry into whether the person truly lacks the capacity to understand and participate in the electoral process."[46] Despite the obvious importance of voter rights, there appears to be no published New York case law addressing an incapacitated person's right to vote.

The following is an overview of some of the protections afforded to older adults against abuse and exploitation, including guardianships.

Protecting an Incapacitated Person. *Parens patriae* is a Latin term meaning "parent of his or her country."[47] Black's Law Dictionary defines the term as the legal doctrine by which the state is regarded "as a sovereign; the state in its capacity as provider of protection to those unable to care for themselves."[48] The state's *parens patriae* is a critical legal doctrine that authorizes the state to intervene in matters affecting individuals unable to care for themselves and forms the basis for New York's guardianship laws, including Article 81 of the N.Y. Mental Hygiene Law (MHL). A court can appoint a guardian to meet the personal or financial management needs of an individual who either consents to the appointment or is found by the court to be unable to care for his or her self, is at risk of harm because of that inability, and fails to understand or appreciate that risk.[49] Unlike its predecessors and the more inflexible Article 17-A of the Surrogate's Court Procedure Act, MHL Article 81 allows courts to fashion orders of appointment tailored to the specific needs of a particular incapacitated person.[50] Moreover, it requires that all guardians take into account the incapacitated person's personal wishes, preferences, and desires.[51]

Annulment of a Marriage of a Spouse Who Is Incapacitated or Has a Mental Illness and Protecting an Estate. An action can be maintained by any relative of a person with a mental illness to annul a marriage on the ground that one of the parties had a mental illness at the time of the marriage.[52] Moreover, a husband or wife is not considered a surviving spouse for purposes of asserting the right to an elective share against the deceased spouse's will if the court determines that a valid "final decree or judgment of divorce, of annulment or declaring the nullity of a marriage or dissolving such marriage on the ground

of absence . . . was in effect when the deceased spouse died."[53]

Adult Protective Services. Adult Protective Services responds to reported concerns about individuals in the community, without regard to their income, who have no one willing or able to assist them and who may have mental or physical impairments that render them unable to: (1) manage their own resources; (2) carry out the activities of daily living; or (3) protect themselves from physical abuse, sexual abuse, emotional abuse, active, passive or self-neglect, financial exploitation, or other hazardous situations.[54]

The Long-Term Care Ombudsman Program. The program, maintained by the Office for the Aging, advocates for residents by: (1) investigating and resolving complaints made by or on behalf of residents; (2) promoting the development of resident and family councils; and (3) informing government agencies, providers, and the general public about issues and concerns impacting residents of long-term care facilities.[55]

Disclosure of Information to Investigators. Banking organizations are authorized to disclose an individual's financial information to social services officials and the Department of Social Services investigating financial exploitation.[56]

Order of Protection. A court can issue an order of protection for any spouse, former spouse, parent, child, or member of the same family or household[57] or to protect an incapacitated individual or an individual alleged to be incapacitated.[58]

Mandatory Reporting of Abuse and Neglect in a Facility. Certain individuals are required to report abuse or neglect of a resident in a health care facility. Such individuals include the operator or employee of such facility, any person under contract to provide patient care services in such facility, and any nursing home administrator, physician, medical examiner, coroner, physician's associate, specialist's assistant, osteopath, chiropractor, physical therapist, occupational therapist, registered professional nurse, licensed practical nurse, dentist, podiatrist, optometrist, pharmacist, psychologist, licensed master social worker, licensed clinical social worker, speech pathologist, or audiologist.[59]

Criminal

Older adults, in particular those who suffer with dementia, are extremely susceptible to abuse, including, but not limited to, physical, psychological, emotional abuse, and financial exploitation. Such abuse is perpetrated not only by strangers but by family members and professionals. It is the government's role to reduce the rates of abuse and ensure that criminal acts committed against older adults and those that suffer with dementia are prosecuted. To that end, New York County – and other counties throughout New York – has established Elder Abuse Units to address the needs and concerns of older crime victims and to enforce laws designed to protect older adults.

Older adults, in particular those who suffer with dementia, are extremely susceptible to abuse, including, but not limited to, physical, psychological, emotional abuse, and financial exploitation.

The state's criminal laws recognize that older adults can fall victim to crime and punish the perpetrators of criminal acts, such as fraud and identity theft,[60] offenses that endanger the welfare of vulnerable elderly and incompetent persons,[61] and hate crimes, where the perpetrator intentionally commits a crime against an individual who is 60 years of age or older.[62]

Conclusion

Although this article focuses on the bigger picture and provides an overview of some laws enacted to protect older individuals, we as lawyers must be cognizant of what we can do on an individual level to ensure the protection of one of society's most vulnerable populations. We must recognize the need for sensitive and expert advice to assist our clients and their families as they navigate through this "legal maze." As we serve this vulnerable population, we must strive to further our knowledge and understanding not just of the laws referenced in this article but also of the other professional services available to older adults, especially those suffering with dementia. As such, an interdisciplinary approach to this field must be encouraged to ensure older adults and their families receive all the services and support they require. ■

1. Admin. on Aging et al., A Profile of Older Americans: 2015, p. 6, https://aoa.acl.gov/aging_statistics/Profile/2015/docs/2015-Profile.pdf. California (5.0 million); Florida (3.8 million); and Texas (3.1 million).

2. *Quick Facts New York*, U.S. Census Bureau, http://www.census.gov/quickfacts/table/PST045215/36 (last visited Dec. 7, 2016).

3. *Governor Cuomo Signs Legislation to Support Family Caregivers*, N.Y. State (Oct. 27, 2015), https://www.governor.ny.gov/news/governor-cuomo-signs-legislation-support-family-caregivers [hereinafter "N.Y. State"].

4. N.Y. Pub. Health Law Art. 94-cccc (McKinney 2016).

5. N.Y. State, *supra* note 3.

6. Press Release, N.Y. State Dep't of Health, *New York State Authorizes Advanced Home Health Aides, Enabling More New Yorkers to Live in Their Homes and Communities* (Dec. 2, 2016), https://www.health.ny.gov/press/releases/2016/2016-12-02_advanced_home_health_aides.htm.

7. N.Y. Elder Law § 201 (McKinney 2004).

8. 9 N.Y.C.R.R. § 6651.2(f) (1987).

9. Press Release, Governor Andrew M. Cuomo, *Governor Cuomo Announces Statewide Partnership to Improve Access to Legal Services for Vulnerable New Yorkers* (Sept. 12, 2012), https://aging.ny.gov/LivableNY/LegalServices/PressRelease.pdf.

10. New York State Legal Services Initiative: Description of Initiative, N.Y. State Office for the Aging, https://aging.ny.gov/LivableNY/LegalServices/DescriptionOfInitiative.pdf.

11. 527 U.S. 581 (1999).

12. *Id.* at 607.

13. *Olmstead: Community Integration for Every New Yorker*, N.Y. State, https://www.ny.gov/programs/olmstead-community-integration-every-new-yorker.

14. N.Y Civ. Rights Law § 40-c (McKinney 2003); N.Y. Exec. Law § 292(21) (McKinney 2016); *see also* Andrew Schere & David Robinson, *Housing Law*; Elder Law Handbook 9:3.1 (Supp. 2010).

15. N.Y. Real Prop. Law § 227-a (McKinney 1999).

16. N.Y. Gen. Bus. Law § 352-eeee (McKinney 1988).

17. N.Y. Gen. Bus. Law §§ 352-eee (McKinney 1988).

18. N.Y. Elder Law § 209 (McKinney 2016).

19. N.Y. Soc. Serv. Law § 461 (McKinney 1984).

20. N.Y. Priv. House. Fin. Law, Art. XXV.

21. N.Y. Veh. & Traf. Law § 506(1) (McKinney 1973).

22. N.Y. Real Prop. Tax Law § 467 (McKinney 2016).

23. N.Y. Tax Law § 606(e) (McKinney 2016).

24. N.Y. Real Prop. Tax Law § 425 (McKinney 2016).

25. N.Y. Real Prop. Tax Law § 467-b (McKinney 2016).

26. N.Y. Real Prop. Law § 235-f (McKinney 1985).

27. N. Y. Pub. Health Law § 2803 (McKinney 2016), amended by 2016 Sess. Law Ch. 450 (A.7714-C); 10 N.Y.C.R.R. art. 3 (1991).

28. 10 N.Y.C.R.R. § 405.9 (2013).

29. Pub. L. 104-191, 110 Stat. 1936 (1996).

30. N.Y. Pub. Health Law, Art. 29-C.

31. N.Y. Pub. Health Law, Art. 29-CC (the "Family Health Care Decisions Act").

32. *Medicaid Fraud Control Unit*, N.Y. State Office of the Attorney Gen., http://www.ag.ny.gov/bureau/medicaid-fraud-control-unit.

33. N.Y. Banking Law § 675 (McKinney 2011).

34. N.Y. Banking Law § 678 (McKinney 2011). Under NY property law, an account for convenience technically carries the presumption of survivorship, because most banks do not have such a designation as "convenience." Due to that reason, most persons end up creating joint bank accounts, whereby the pre-deceasing joint tenant needs to make his intention clear on whether the account was actually supposed to be joint or an account for "convenience."

35. N.Y. Est. Powers & Trusts Law 7-5.1–7-5.8 (McKinney 1993).

36. N.Y. Gen. Oblig. Law, Art. 5, Tit. 15.

37. N.Y. Est. Powers & Trusts Law, Arts. 3, 7 & 8 (wills & trusts) (McKinney 1993).

38. N.Y. Pub. Health Law § 2801-d(1) (McKinney 2009).

39. *Id.*

40. *Id.* at (4).

41. *Id.* at (5).

42. *Id.* at (4), (7).

43. CPLR 3102(c) (McKinney 2011).

44. 42 U.S.C. § 1973gg-6(a)(3)(B)(2000).

45. N.Y. Elec. Law § 5-106(6) (McKinney 1976).

46. Michele J. Feinstein and David K. Webber, *Voting Under Guardianship: Individual Rights Require Individual Review*, 10 Naela J. 125, 126 (2014).

47. Black's Law Dictionary 1287 (10th ed., 2014).

48. *Id.*

49. N.Y. Mental Hyg. Law § 81.02 (McKinney 1992).

50. *In re Maher*, 207 A.D.2d 133, 139 (2d Dep't 1994).

51. N.Y. Mental Hyg. Law § 81.01 (McKinney 1992).

52. N.Y. Dom. Rel. Law § 140(c) (McKinney 1978).

53. N.Y. Est. Powers & Trust Law 5-1.2(a)(1) (McKinney 1993).

54. N.Y. Soc. Services Law, Art. 9-B.

55. N.Y. Elder Law § 218 (McKinney 2016).

56. N.Y. Banking Law § 4 (McKinney 2007).

57. N.Y. Fam. Ct. Act § 842 (McKinney 2013).

58. N.Y. Mental Hyg. Law § 81.23 (McKinney 2004).

59. N.Y. Pub. Health Law § 2803-d (McKinney 2004).

60. N.Y. Penal Law, Art. 190 (McKinney 2016).

61. N.Y. Penal Law, Art. 260 (McKinney 2016).

62. N.Y. Penal Law, Art. 485 (McKinney 2016).

My Doctor Said … So My Attorney Said

The Legal Challenges for Recently Diagnosed Individuals

By Cora A. Alsante and Ellyn S. Kravitz

On a daily basis, regardless of our profession, each of us multitask. The proverbial "Where are my glasses?" when they are resting on your head to "What did I come into this room for?" does not discriminate by age.

Our memory changes as we get older. So how do we know if we are just aging or have signs of the onset of dementia?

The Alzheimer's Association provides 10 warning signs of Alzheimer's disease:

1. Memory loss that disrupts daily life;
2. Challenges in planning or solving problems;
3. Difficulty completing familiar tasks;
4. Confusion with time or place;
5. Trouble understanding visual images and spatial relationships;
6. New problems with words in speaking or writing;
7. Misplacing things and losing the ability to retrace steps;
8. Decreased or poor judgment;
9. Withdrawal from work or social activities; and
10. Changes in mood and personality.[1]

People go to doctors on a frequent basis when any physical symptoms arise. Yet, when it comes to memory or cognitive issues, individuals are less willing to seek medical attention.

An individual with a diagnosis of the onset of dementia can camouflage his or her actions in a variety of ways.

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Betty, for example, is 72 years old. She has become a little forgetful. She can't remember where she put her keys or what she ate for dinner last night. She plays bridge once a month with friends, and most recently she could not follow the game. She blames it on doing too many things at the same time. After her last card game, she became extremely frustrated and finally decided to see her primary-care physician. Betty explains to her doctor what she has been experiencing lately and her doctor recommends some neurological testing. At her follow-up appointment, her doctor gives her the diagnosis: the onset of dementia. Betty's doctor suggests that she consider getting her legal affairs in order.

While the doctor's suggestion is a good one, an elder law attorney knows that there is more involved than the execution of legal documents. An attorney must recognize and be sensitive to the emotional aspects of the diagnosis on the client, the family dynamics, and the challenges that result from such a devastating diagnosis.

After Betty has had some time to process the diagnosis, she decides that she should consult with an attorney to get her affairs in order for both personal decision-making and property management as she expects that her mental status will decline.

For some of our clients, like Betty, an initial meeting with an attorney to discuss long-term care issues is their first exposure to the legal world. These clients are apprehensive and untrusting. It takes a skilled elder law attorney to listen, understand and present options and recommendations in a clear and concise manner.

Rather than instill panic, an elder law attorney can assist with the creation of a plan to assure clients that their wishes will be met. Once the plan is in place, clients can concentrate on the activities that they enjoy most.

As elder law attorneys, we know that with a diagnosis of the onset of dementia, individuals will gradually lose the ability to think clearly. Their ability to participate meaningfully in the decisions regarding their finances and health care is likely to deteriorate. It is important for people in Betty's position to clearly state his or her wishes and make well-informed decisions *now* about his or her person and finances.

So what would an elder law attorney recommend to help Betty put her affairs in order? At the initial meeting, we can begin with a discussion of advance directives, such as a Health Care Proxy,[2] Living Will and Power of Attorney.[3] These types of documents allow individuals to appoint another trusted individual to step into his or her shoes and act on his or her behalf if he or she becomes incapacitated. These documents afford a certain amount of peace of mind and security to the client, assuring the client that his or her wishes and desires are clear.

Health Care Decision-Making

A Health Care Proxy allows an individual, the principal, to appoint another individual, the agent, to make health care decisions on his or her behalf in the event that he or she is unable to do so.[4]

New York State law provides that an adult is presumed competent to execute a Health Care Proxy and appoint an agent unless he or she is declared incompetent by a court and a guardian has been appointed pursuant to Article 78 of the Mental Hygiene Law or Article 17-A of the Surrogate's Court Procedure Act.[5]

The New York State Department of Health's website provides a sample form that is recognized by hospitals and physicians. Once the form is complete, it must be signed by the principal before two disinterested witnesses. The capacity threshold to appoint an agent under a Health Care Proxy is a low one. The statute, however, does not set forth a standard of capacity to execute such a document.

Even with a Health Care Proxy, Betty can continue to make her own health care decisions until a determination is made by her physician that she lacks the capacity to make decisions. The Health Care Proxy does not expire and continues to be valid even when she becomes incapacitated.

We will also recommend that Betty sign a Living Will, which is a written declaration of her wishes concerning medical treatment, such as life-sustaining treatment. The Living Will will be honored in any state, unlike the Health Care Proxy, which we can only guarantee will be recognized in New York State.

We also explain to Betty that she should consider completing a Medical Orders for Life-Sustaining Treatment (MOLST) form with her doctor, which will outline her wishes for treatment as her dementia progresses.

Financial Decision-Making

For property management, we will recommend a Power of Attorney under N.Y. General Obligations Law Article 5, Title 15, where Betty can appoint an agent to manage her business and financial affairs.[6] Betty must be very careful in choosing her agent, as he or she can act on Betty's behalf even while she is able to act on her own. The attorney must remind Betty that in order for the Power of Attorney to be effective, her agent must acknowledge his or her appointment and sign the document as well.

While clients are typically apprehensive about signing documents and giving control to others, it is important to remind them that without such documents in place the alternative is a time-consuming and costly court proceeding as set forth in Article 81 of the Mental Hygiene Law. Most important, the client may not have the ability to select his or her guardian.

An individual with a diagnosis of dementia may still possess the capacity to execute a Power of Attorney. The determination of capacity should be on a case-by-case basis, taking into account a variety of factors, including the individual's familiarity with his or her assets and family members.

Last Will and Testament

While advance directives work during the client's lifetime, we, as elder law attorneys, must impress upon our clients that they have the ability to control the disposition of their assets at the time of their passing.

The threshold for establishing testamentary capacity is extraordinarily low. It is less than what is required to sign a Power of Attorney or conduct any other legal transaction. The testator must:

1. Understand the nature and consequences of making a Will.
2. Know the nature and extent of his or her property.
3. Know the natural objects of his or her bounty and relations with them.[7]

In our example, Betty must be able to identify family members, demonstrate an understanding of her assets and be able to articulate how she wants these assets distributed at her death.

Trusts

Elder law attorneys often recommend Trusts to their clients, whether revocable or irrevocable. It is important for clients to understand the difference between these Trusts as a revocable trust will not provide the asset protection that an irrevocable Trust will provide after a period of time. The capacity standard for executing a Trust is higher than that of a Will, which is similar to that required to enter into a contract.[8]

Long-Term Care Costs

In addition to legal documents, clients with a diagnosis of the onset of dementia will be concerned about financing their long-term health care costs. Dementia is a chronic disease and individuals with dementia can live a long life. An individual with the onset of dementia may not require any assistance with his or her activities of daily living at the time of the diagnosis. However, as the disease progresses, medical needs will increase. Individuals will look to Medicare,[9] Medicaid,[10] veterans' benefits,[11] and long-term care insurance to pay these costs.[12]

Often clients believe that Medicare will cover the cost of all of their medical care. Who is eligible for Medicare? All U.S. citizens or permanent residents can enroll in Medicare when

1. they attain age 65.[13]
2. they are under age 65 and certified disabled or certified blind.[14]
3. they are any age with End Stage Renal Disease or ALS.[15]

Medicare is divided into four parts: Part A – Hospital and Skilled Nursing Benefits; Part B – Doctors and Durable Medical Equipment; Part C – Managed Care; and Part D – Prescription Plan.[16] There are deductibles and co-insurances to the Medicare program.[17] Those who are enrolled in the Medicare program should also purchase a Medigap policy which covers deductibles and co-insurances.[18]

The most important thing for clients to realize is that Medicare only provides benefits for skilled nursing care and for limited periods of time. Typically, a client with dementia requires assistance with their activities of daily living (ADLs),[19] which is considered custodial care, not skilled nursing care. The only public-sponsored insurance program that provides caregiver benefits for someone who requires custodial care is Medicaid.

Medicaid is a federal program administered through state and county agencies. It is a means-tested program for clients who are elderly, blind or disabled. In New York State, there are various types of Medicaid programs. Clients can receive care at home or in a hospital/nursing home. The eligibility requirements vary for each program. Clients with dementia may be eligible to enroll in the Medicaid program to cover the cost of their home health aides provided that they are financially eligible to apply.

While long-term care insurance can offset the cost of care, a diagnosis of the onset of dementia prevents an individual from purchasing such a policy. As such, these policies need to be considered before any diagnosis. Long-term care insurance policies may provide benefits to someone living at home, in an assisted living setting and/or in a skilled nursing facility. They are beneficial in that they provide a source of payment to allow the individual to remain at home as long as possible.

Planning Options

At the initial meeting, the elder law attorney must also address asset preservation planning options. Often clients are uncomfortable with the idea of divesting their assets. Saving money for a rainy day did not take into account paying a home health aide and/or a nursing home.

We may suggest an irrevocable trust, a transfer of the client's home with a reservation of a life estate, outright gifting to family members, or simply adding a child to a bank account for convenience purposes. We must be careful, however, to counsel our clients about the legal consequences of these transfers to make sure they are in accordance with the client's life and testamentary plan.

For our clients with business or partnership interests, it is important to advise them that their interests will be considered resources for Medicaid eligibility and that transfers will need to be made now in order to protect those interests. We must also discuss transitioning any management role in these interests before capacity further diminishes. These are very difficult conversations to have but are critical to proper representation of our clients.

We will also need to advise clients with spouses that for Medicaid eligibility purposes, Medicaid will consider clients and their spouses as "units" and will allow the spouse to retain non-retirement resources of somewhere

between $74,820 and $119,220, a vehicle, an irrevocable burial account, life insurance with a face value not to exceed $1,500, and retirement accounts in payout status. They can also keep $2,980.50 of combined monthly income. In addition, clients can keep $14,850 in his or her own name and $50 in monthly income for incidentals and any excess monthly income will need to be paid to the nursing home.

We must also advise that clients with children who are certified disabled may transfer assets to that child without adversely affecting their eligibility for certain government benefits. They must, however, be mindful of any government benefits the child may be receiving so as not to jeopardize the child's benefits.

The Ambivalent Client

Often clients are overwhelmed with all the information and recommendations made by the attorney. The client may become paralyzed and unable to focus and prioritize the action needed to be taken. In certain situations, the attorney may require the input of other professionals, including but not limited to, accountants, financial planners and care managers. Care managers, in particular, can provide guidance regarding the diagnosis, access to required services and counseling. The care manager can also help clients identify and navigate their current needs and help them to see what their future care needs will be.

If clients are uncomfortable proceeding with any of the above, we advise that there are crisis planning options available if they decide to wait until a nursing placement is imminent.

As one can see, there is no cookie-cutter plan for a client with a diagnosis of the onset of dementia. The uniqueness of an elder law practice is that each client comes to the meeting with different needs, other illnesses and family issues. The totality of the circumstances must be taken into consideration by the attorney in order to make the appropriate recommendations.

Elder law attorneys must identify who their client is and determine if there are any conflicts of interest, especially a spouse or other family members who attend the meeting. The National Academy of Elder Law Attorneys (NAELA), in November 2005, adopted the Aspirational Standards for the Practice of Elder Law with Commentaries that was published in the *NAELA Journal*, Volume II.[20] These standards can serve as a guide for the elder law attorney.

It is important for clients to realize that a diagnosis of dementia may not prevent one from properly planning for the future. While these decisions may be overwhelming for our clients and they may initially resist, we, as elder law attorneys, must recognize the importance of putting our clients at ease with both their new diagnosis and the options available to them to put their "legal house" in order so that they can navigate the long road ahead. One of the goals of the elder law attorney is to become the trusted advisor to both the client with the diagnosis and those family members and/or friends that the client wants involved in the planning process. The ultimate goal of the elder law attorney is to promote dignity and quality of life for the clients that we represent. ■

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3. N.Y. Gen. Oblig. Law § 5-1501 (McKinney 2009) (GOL).
4. PHL art. 29-c.
5. PHL §§ 2981 (1), (2); (McKinney 2012).
6. GOL § 5-1501.
7. *In re Slade*, 106 A.D.2d 914 (4th Dep't 1984); *In re Estate of Kumstar*, 66 N.Y.2d 691 (1985).
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MEMBERSHIP TOTALS

New Regular Members 1/1/16-11/23/16	**8,028**
New Law Student Members 1/1/16-11/23/16	**2,984**
Total Regular Members as of 11/23/16	**6,421**
Total Law Student Members as of 11/23/16	**6,924**
Total Membership as of 11/23/16	**69,345**

Distinguishing Dementia from Mental Illness and Other Causes of Decline

By Carolyn Reinach Wolf, Jamie A. Rosen, Dorothea Constas and Hindi Mermelstein

I. Introduction

Whether an individual suffers from dementia, mental illness or another cause of cognitive impairment, these conditions cause symptoms that worry potential clients, family members and caregivers, to the point of leading them to seek the advice of an attorney with experience in this area. Though there may be several legal questions that arise, in the end, all roads lead to capacity or lack thereof. Attorneys must develop the skill set to assess whether a client (or a client's family member or loved one) has capacity in a variety of different situations according to various legal standards, and then advise that client as to how to best proceed to achieve his or her legal goal. The attorney must keep in mind his or her ethical obligations in representing a client with potential or actual diminished capacity. In cases where a client may be unable to make decisions on his or her own behalf due to some type of mental impairment (or where the client is a family member or loved one of a mentally impaired individual), that attorney must then develop a plan that may include executing appropriate legal planning documents or seeking intervention through the court system to protect the best interests of the individual.

Section II will discuss the common clinical syndromes causing clinical dysfunction, with an emphasis on the similarities and differences between them. Section III will explore the issue of capacity and how these various symptoms affect legal representation from the perspective of a privately retained attorney and from the viewpoint of a Mental Hygiene Legal Service attorney. Section IV provides a brief overview of several legal options for clients and/or family members with mental illness,

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dementia or cognitive decline including advance directives, guardianship, and inpatient hospitalization.

Throughout this article please refer to the following two case studies to guide the discussion.

Case Study #1

Maria, an 81-year-old woman, presents to your law office with her adult daughter, Anna, who encouraged her mother to meet with you. Anna gives you a history of her mother always being a "difficult person to communicate with" but says that they have a good relationship currently. Anna is an only child, is married and has three children. Anna's impression of her mother is that she is "very depressed most of the time." She is concerned that her mother may have early dementia. Anna describes her mother's symptoms as "paranoid, delusional, irritable with a lack of focus and increasingly poor ability to care for herself." She is worried that her mother could request to change her legal documents, such as her Health Care Proxy, Power of Attorney and Will, all of which appoint Anna. Anna is also concerned that due to her mother's increasing paranoia, she could disinherit her and her grandchildren. Anna admits that she had convinced her mother to see a geriatric psychiatrist who diagnosed her with "Rule-out Untreated Geriatric Depression, Severe; Rule-out Typical Dementia, Rule-out Medical Causes."

Case Study #2

Murray, an 85-year-old man, comes to your office seeking legal advice on drafting advance directives and a Will. He is mildly disheveled and there is something "off" about him which you cannot quite figure out early on in your meeting. As your consultation with Murray continues, it becomes increasingly clear that he cannot complete his thoughts, forgets what he has just asked, cannot recall the information you have just presented to him and spends much of the time looking behind him, staring at the lights above, asks about who else is in the office currently, and suggests the pictures on your wall have a special meaning.

II. Defining the Terms: Dementia, Mental Illness, and Cognitive Decline

In adults, particularly in the geriatric population, there are several conditions in the neurologic, psychiatric, and neuropsychiatric spectrum that can interfere with cognitive skills, impede functioning and cause symptoms that concern family members and may require attorney involvement. Among the most common are the dementias, depression/mood disorders and dementia "mimics." Each of these groups share basic elements with additional symptoms that track to specific disorders.

A. Dementia

Dementia is a grouping of neurological or neuropsychiatric conditions characterized by acquired, progressive, cognitive decline accompanied by loss of function.[1] Overall, all dementias cause cognitive dysfunction, can and, over time, often will, impair judgment, decision-making, affect communication, and impede or prevent independent living. Though the trajectory of illness is universally downward, the rate of progression is individual and the clinical symptoms are condition-specific.

The primary hallmark of dementia is the cognitive decline, usually involving memory and higher executive functioning, such as abstraction, attention, concentration, and planning or follow through. In Alzheimer's disease, the most common form of dementia, the memory impairment initially affects the most recent and progresses to the most remote. Individuals have the greatest difficulty with new information, its registration (learning), recall, retention (memory) and retrieval. Eventually, long-term memory is affected as well. In frontal-temporal dementia, the memory loss appears variable, almost unpredictable, with changes in personality, loss of social skills and even perceptual distortions such as hallucinations.[2]

Early in the course of dementia, there may be depression as people struggle with the loss and their fear of the future. Paranoia is not uncommon, as seen in an elderly man who accuses his wife of stealing his glasses after once again forgetting where he placed them. Together with the apathy that occurs mid-course, the affected person becomes less able to negotiate his or her world including relationships and roles.

From the medical expert perspective, the challenge is to determine the client's diagnosis and clinical status. For example, in early dementia, a person may not be able to handle a complicated computer program but can still manage his or her everyday affairs. In the early and middle stages, the impact on capacity remains situational and needs to be determined on a case-by-case basis. The unpredictable rate of decline as the illness progresses makes it virtually impossible to determine when someone who presents with early signs of dementia will no longer be able to handle his or her own affairs.

It is also important to be aware that older people have multiple medical illnesses that can cause, contribute to, and/or complicate the clinical picture of dementia.[3]

B. Mental Illness

The most common psychiatric conditions for the elderly population are the depressive and anxiety disorders which range from the "blues" to depression with psychotic features and from mild discomfort to full-blown panic attacks. As people age, the number of stressors grows over time with a concomitant loss of close family and friends. Together with any medical issues, there is an increase in risk for new onset or recurrent depressive disorders, worsening of chronic anxiety, intensification of longstanding family dysfunction, ongoing personality disorders as well as long-term sequelae of chronic psychotic illnesses.

The depressive disorders are a group of psychiatric conditions characterized by mood changes, dysphoria (depressed mood which when severe can morph into despair, hopelessness and helplessness) accompanied by loss of interest in usual activities, abnormal sleep or eating patterns, feelings of low self-worth, and sometimes psychotic symptoms or even suicidal ideation.[4] In late-onset depression, the loss of attention to dress, weight loss, delusional thinking and suicidal ideation can even mimic terminal illness and may require hospital admission. Decreased motivation and interest, poor concentration, low energy and demoralization can lead to pseudodementia, where individuals can appear to be cognitively impaired, even demented.

As with dementia, there are somewhat different symptoms to each subtype of depressive disorder, but overall, they are all marked by very low mood accompanied by other symptoms affecting how people feel about themselves and the world and potentially impacts their ability to function. However, unlike dementia, depressive disorders are most often acute (versus chronic) or episodic and tend to respond to treatment with attenuation, if not full remission, of symptoms. During acute depressive illness there may be impairment of judgment and disordered thinking so that capacity is affected (i.e., a patient who was so depressed she refused to give consent to surgery believing that God had given her a way to die), but once treated the symptoms remit and the person returns to, or close to, his or her pre-depressive baseline.

In addition, there are other conditions such as chronic mental illness, for example, schizophrenia, bipolar disorder or schizoaffective disorder, that may present with a lifelong impairment of judgment and cognitive symptoms accompanied by mood changes that worsen with age.

C. General Cognitive Decline or "Dementia Mimics"

In addition to dementia and depression there are several other conditions that impact cognitive skills, can impair functioning, and may be part of the client's presentation.

The most common of these is normal aging itself, which affects the way an individual processes information, his or her reaction times and the way he or she stores and retrieves short-term memory. A common manifestation is the "forgetting" of names only to recall them sometime later. People often overestimate the negative impact of these changes. The individual can become depressed or anxious, which if severe enough can impede the learning of new information.

A related condition is known as minimally impaired cognition (MIC), which falls between dementia and normal aging. Individuals suffering from MIC can do everyday things but have impairment of higher executive function affecting the management of their financial portfolios or even simple bank accounts. Even mild forms of MIC are amplified with additional stressors which may be physiological (e.g., lack of sleep), psychological (e.g., grief), or medical (e.g., heart failure). This may mean that in stressful situations, such as during a medical crisis, persons suffering from MIC may not be able to multitask or even fully grasp a complex situation. Hence, planning may be of particular benefit to this subset of the population, some of whom will remain with MIC, while a smaller proportion will progress to dementia of the Alzheimer's type.

In the medical units, a frequently encountered dementia "mimic" is delirium, which is characterized as a temporary global (affecting most components of our brains) brain dysfunction of sudden onset.[5] The symptoms of delirium can mimic dementia with the loss of attention and focus, confusion, day-night reversal or psychiatric illness with psychotic ideation, agitation, apathy or mood changes. It can have many triggers, and treating the underlying cause is the primary approach. However, the recovery can be prolonged and for those already suffering from dementia, so-called "double delirium," there is a high risk of worsening residual dysfunction.

Finally, there are medications and medical conditions that can affect any area of cognitive function. For example, many opioid-containing medications can impair focus, cognitive clarity and reaction time, which underlies the caution about driving or using heavy machinery. Severe impairments can occur in this setting but are generally mild to moderate, temporary and reversible, with little or no permanent changes.

In situations where there is uncertainty or even discomfort with the clients' clinical state, and an uncertainty about the correct diagnosis or prognosis and its impact on cognitive function, decision making, and judgment, a medical expert consultation can be very useful.

III. How Do These Diagnoses/Symptoms Affect Capacity and/or Legal Representation?

A. The Privately Retained Attorney

"Capacity" is a medical determination that is broadly used to describe a person's ability to act in a legal environment, as well as the level to which he or she is accountable or responsible for his or her actions. The incidence of cases in which capacity is an issue has grown substantially in the past few years because of the aging demographic and the increasing number of cases involving serious mental illness, drug and/or alcohol dependence/abuse, or other related mental health concerns. In civil matters, capacity issues arise as to contracts (e.g., is the party capable of entering into, or suing pursuant to a contract?), executing advance directives, such as a Health Care Proxy, Living Will, or Power of Attorney, in guardianship proceedings under Article 81 of New York's Mental Hygiene Law, and as to a patient's right to consent to and/or refuse medical treatment. As such, different statutes will define capacity as it is applicable to that particular area of law.

Attorneys must make capacity judgments in at least two aspects of representation. First, the attorney must determine whether the potential client even has the capacity to retain an attorney. A retainer agreement falls within the scope of contracts and is governed by contract principles. An individual lacks the mental capacity to retain counsel if he or she lacks sufficient mind and reason for a full and clear understanding of the nature and consequences of making the contract at the time the contract is made.[6] Then, the attorney must determine whether the potential client has the capacity to "carry out the specific legal transaction(s) under consideration."[7]

Model Rule 1.14 of the ABA Model Rules of Professional Conduct concerns clients with "diminished capacity" and suggests a duty to make informal capacity judgments in certain cases.[8] Rule 1.14 states:

> (a) When a client's capacity to make adequately considered decisions in connection with a representation is diminished, whether because of minority, mental impairment or for some other reason, the lawyer shall, as far as reasonably possible, maintain a normal client-lawyer relationship with the client.
>
> (b) When the lawyer reasonably believes that the client has diminished capacity, is at risk of substantial physical, financial or other harm unless action is taken and cannot adequately act in the client's own interest, the lawyer may take reasonably necessary protective action, including consulting with individuals or entities that have the ability to take action to protect the client and, in appropriate cases, seeking the appointment of a guardian ad litem, conservator or guardian.

In determining the extent of the client's diminished capacity, the lawyer should consider and balance such factors as: the client's ability to articulate reasoning leading to a decision, variability of state of mind and ability to appreciate consequences of a decision; the substantive fairness of a decision; the consistency of a decision with the known long-term commitments and values of the client; and the irreversibility of the decision.[9] In appropriate circumstances, the lawyer may seek guidance from a diagnostician.

Possible cognitive signs of incapacity may include: short-term memory loss; communication problems; comprehension problems; lack of mental flexibility; calculation problems; and/or disorientation. Possible emotional signs of incapacity may include significant emotional stress; emotional lability and/or emotional inappropriateness. Possible behavioral signs of incapacity may include delusions or beliefs that are unlikely to be true and/or poor hygiene.[10]

An attorney may be contacted by either the individual him or herself, a family member, or an otherwise concerned individual. In the first case study, the family member contacts the attorney. As the attorney, what are your prognostic issues and options? One issue is whether Maria has the capacity to revoke her legal documents, and if so, whether an Article 81 guardianship is appropriate to take control of her health care and financial decision-making. Looking at this first case study from the perspective of an attorney representing Maria herself, a potentially incapacitated individual, whose family members are involved as potential guardians, powers of attorney, and/or potential beneficiaries, the attorney is advised to consider the potential conflicts of interest, issues of confidentiality and goals of the representation.

In addition to dementia and depression there are several other conditions that impact cognitive skills, can impair functioning, and may be part of the client's presentation.

In the second case study, the potentially impaired individual consults with an attorney on his own behalf. As the attorney, you must consider and evaluate your ethical and legal obligations to him. Important questions to consider are whether he may be exhibiting signs of dementia, mental illness, or even side effects of a medical condition, and if so, whether any of these potential ailments affect his capacity to retain and direct counsel. Should the attorney make a referral to a geriatric psychiatrist? Should the attorney consider a voluntary/involuntary psychiatric hospitalization? Or should the attorney draft the documents requested and permit him to execute them, as it seems he can focus some of the time? Either way, the attorney has challenging legal and ethical decisions to make.

B. Mental Hygiene Legal Service

Another legal actor to consider is the Mental Hygiene Legal Service (MHLS). MHLS is a legal service organized under Article 47 of the Mental Hygiene Law to provide legal assistance to patients or residents of certain facilities within New York State.[11] MHLS derives its statutory authority to represent clients suffering from mental illness and/or diminished capacity as a result of mental illness and/or dementia through Article 47, Mental Hygiene Law Article 81[12] and the seminal case of *Rivers v. Katz*.[13] In a guardianship matter pursuant to Article 81, the court can appoint MHLS as counsel for the alleged incapacitated person (AIP), whether or not the individual resides in a facility, or as court evaluator.[14] The court is likely to consider the appointment of MHLS where the

AIP has minimal or no assets. If the AIP is institutionalized in a mental hygiene facility, then MHLS is entitled to notice of the proceeding, whether or not MHLS is actually appointed.[15]

MHLS, through its practice, recognizes that there are varying degrees of capacity and at times capacity can be improved and/or restored. The MHLS attorney must examine what is causing the diminished capacity, what is the extent of the diminished capacity, how the diminished capacity affects the client's ability to understand the options available, the ability to make reasoned decisions based on a risk/benefit analysis, and the ability to manage one's own affairs. The actual structure of the proposed "care plan" for each individual will be guided by the diagnosis and prognosis – for example, if a person has a dual diagnosis of mental illness and substance abuse, which is affecting his or her decision-making, enrollment in a day program that provides drug treatment and also psychiatric medications may allow that individual to live safely in the community. On the other hand, someone with dementia resulting in cognitive decline might need planning that incorporates the prognosis of dementia. That individual may need more help as time continues and the plan can be fashioned based on what we know occurs to someone suffering from that decline.

In representing the client, the attorney is driven by what would be the least restrictive form of intervention for the client.

In the case studies, MHLS would potentially become involved if either Maria or Murray were hospitalized or if a guardianship proceeding was initiated for either individual. If Maria were hospitalized for treatment of her symptoms such as paranoia, delusions, irritability, and poor self-care, or if Murray were hospitalized for treatment of his bizarre behavior, delusions, possible hallucinations, and lack of focus, as a patient in a mental health facility, they would be entitled to legal counsel through MHLS related to their care and treatment.[16] If Maria's daughter, for example, initiated a guardianship proceeding against her, MHLS could potentially become involved as court-appointed counsel for Maria or as the court evaluator.

In the context of representing a patient in a mental health facility, the role of the MHLS attorney is to first meet with the client and advise him or her of the procedures for admission and retention of patients, and to inform the patient of his or her rights, including the right to have a judicial hearing, to be represented by counsel and to seek an independent medical opinion.[17]

In the context of representing an AIP in a guardianship proceeding, the MHLS attorney would play a similar role in meeting with the client and advising him or her about the procedures for the appointment of a guardian, informing the client of his or her rights to have a judicial hearing and to be represented by counsel, among others. The MHLS attorney, just like any other court-appointed attorney for the AIP, would want to determine the client's wishes regarding the appointment of a guardian, his or her living arrangements, and daily life. The attorney would also want to evaluate the client's ability to function in terms of his or her personal needs and ability to manage finances.

In representing the client, whether in a mental hygiene facility or in a guardianship proceeding, the attorney is driven by what would be the least restrictive form of intervention for the client.[18] Any intervention should be tailored to the individual based upon whether that individual suffers from a mental illness, dementia, or another medical condition and his or her prognosis.

IV. Sample Legal Options for Clients/Family Members with Mental Illness, Dementia or Other Cognitive Decline

Family members, caregivers and the attorneys involved in the care of a mentally impaired individual must be familiar with the various "legal tools" designed to protect and support that individual. The legal system, working in tandem with the medical and/or mental health care system, can often offer assistance in the form of advanced directives, guardianship, and inpatient hospitalization, among others.

Advance directives are legal documents containing an individual's prior expressed wishes regarding financial affairs or medical treatment that must be executed while the individual has the requisite mental capacity.[19] A *durable* Power of Attorney allows the Principal to appoint an Agent (or Attorney-in-Fact) to make certain financial decisions when the Principal becomes unable to do so.[20] Under a Health Care Proxy, the appointed Agent has the power to make certain medical decisions when the Principal becomes unable to do so.[21] A Living Will can be used to provide medical treatment instructions to a doctor if the patient loses the ability to communicate.[22] Advance directives are relatively simple, inexpensive to draft and execute, and can be revoked when the Principal has the capacity to do so.

In the event that an individual has not executed any advance directives, has revoked any advance directives, or no longer has the capacity to execute advance directives, family members and caregivers managing the medical, social and financial issues of their loved one may come up against significant legal roadblocks. Guardianship is a legal proceeding by which a court appoints and oversees a legal decision maker, or "guardian," for another adult, who due to incapacity or other disability, is

unable to manage his or her own affairs.[23] The court can appoint a Personal Needs Guardian to make decisions such as consenting to medical care, choosing a place of abode, and determining whether the individual should travel and/or have a driver's license, among others. The court can grant the Guardian the power to access and disclose medical and confidential records that would otherwise be protected by state and federal privacy laws.[24] The court can also appoint a Property Management Guardian to manage the individual's financial affairs, such as paying bills, applying for New York State and/or U.S. government benefits, and handling Medicare or Medicaid applications and claims, among others.

It is important to note that, in a guardianship proceeding, counsel for the AIP, the court evaluator, or a cross-petitioner, for example, can request that the court appoint a medical physician or psychiatrist to perform an independent medical examination.[25] If the application for guardianship is based upon a diagnosis of dementia, for example, such a medical exam would confirm the diagnosis and speak to the very issue of capacity and functional limitations. The role of the appointed expert would include performing the evaluation,[26] interviewing family members and/or caregivers, reviewing medical records and other documentation, preparing a report for the Court and potentially testifying at the guardianship hearing.

Guardianships are commonly used for the elderly, mentally ill and developmentally disabled individuals, but are often regarded as a last-resort option, since they can be expensive, time consuming, and deprive an adult of significant personal rights.

If the individual requires immediate psychiatric intervention, hospitals offer a safe setting for such treatment including observation, diagnosis, therapy and medication management.[27] In New York, Article 9 of the Mental Hygiene Law sets forth the legal requirements for voluntary, involuntary and emergency admission to a hospital, as well as the retention of patients pursuant to a court order.[28] However, families and caregivers should not have to wait until the individual decompensates and becomes increasingly symptomatic and impaired before he or she can be evaluated and treated in a hospital. In New York, family and other concerned individuals can make an application to the court for a "Mental Health Warrant," an order for immediate evaluation in an emergency room not to exceed 72 hours.[29]

These legal tools are designed to assist family members, caregivers and the attorneys involved in the care of a mentally impaired individual while also protecting and supporting that individual.

V. Conclusion

Clients, family members, or loved ones come to the lawyer's office with legal queries, but often also bring with them their medical, neurological and psychiatric issues. Lawyers have a need to recognize dementia, depression and other causes of cognitive decline as it can impact the lawyer's work with the clients, drive the legal goals, dictate the plan and its execution and determine any additional components necessary to be decided on a case-by-case basis. In almost all cases involving cognitive dysfunction the most critical legal issues center around capacity. ■

1. Eitan Z. Kimchi & Constantine G. Lyketsos, *Dementia and Mild Neurocognitive Disorders*, *in* The American Psychiatric Publishing Textbook of Geriatric Psychiatry (177–242) (David C. Steffens et al. eds., 5th ed. 2015).

2. *Id*. at 177–242.

3. For example, poor glucose control in diabetes affects brain function and can exacerbate the lack of focus and distractibility of dementia.

4. Hindi T. Mermelstein & Lynna Lesko, *Depression in patients with cancer*, 1 Psycho-Oncology 199, 199–215 (1992).

5. Downing, L., Caprio, T., Lyness, J., Geriatric psychiatry review: *Differential diagnosis and treatment of the 3 D's – delirium, dementia and depression*, Current Psychiatry Review 2013 (6) 365–369.

6. *See* Restatement (Second) of Contracts § 15 (Am. Law. Inst. 1981); 22 N.Y. Jur. 2d Contracts § 26 (2016).

7. Assessment of Older Adults with Diminished Capacity: A Handbook for Lawyers, 13, Am. Bar Ass'n, www.americanbar.org/content/dam/aba/administrative/law_aging/2012_aging_capacity_hbk_ch4.authcheckdam.pdf.

8. Model Rules of Prof'l Conduct R. 1.14 (Am. Bar Ass'n 2006).

9. Model Rules of Prof'l Conduct R. 18 (Am. Bar Ass'n 2006); *see* Model Rules of Prof'l Conduct R. 1.14 cmt. 6 (Am. Bar Ass'n 2006).

10. Model Rules of Prof'l Conduct R. 14-16 (Am. Bar Ass'n 2006).

11. N.Y. Mental Hyg. Law Article 47 (MHL).

12. MHL Article 81.

13. *Rivers v. Katz*, 67 N.Y.2d 485 (1986).

14. *See* MHL § 81.09 (McKinney 2011).

15. MHL § 81.07(g) (McKinney 2009).

16. MHL § 47.03 (McKinney 2007).

17. *Id.*

18. *See, e.g.*, MHL § 81.03(d) (McKinney 2004).

19. For the purposes of signing an advanced directive, a person is deemed to have capacity unless proven otherwise. N.Y. Pub. Health Law § 2981(1) (McKinney 2012).

20. Without a *durable* power of attorney, family members or caregivers may have to go to court to get the authority to handle the individual's affairs should he or she lose capacity.

21. As with a guardian, in many states there are certain aspects of a person's care that may never be delegated to an agent such as the involuntary administration of psychiatric medication.

22. These treatments may include resuscitation, artificial nutrition and hydration, and mechanical ventilation, among others.

23. MHL § 81.02(a). In New York, incapacity refers to functional limitations rather than a mental or physical condition. MHL § 81.02(c) (McKinney 1992).

24. This specific power is often crucial when family members and/or caregivers need information about their loved one's medical and/or mental health care.

25. MHL § 81.09(c) (McKinney 2011).

26. Such an evaluation might include but is not limited to, cognitive tests, mental status examinations, MRI/CAT scans, laboratory tests, review of medications, and a review of medical and social history.

27. National Alliance on Mental Illness, http://www.nami.org/Find-Support.

28. *See* MHL §§ 9.13, 9.27, 9.37, 9.39 (McKinney 2016).

29. MHL § 9.43. At any time during the 72-hour period, the patient may, if appropriate, be admitted as a voluntary or involuntary patient. *Id* (McKinney 1989).

Proving Diminished Mental Capacity Post-Death

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I. Introduction

One of the most difficult tasks of a practitioner in the estate litigation field is attempting to prove capacity or lack thereof after the death of the decedent. Due to the low standard of capacity required to create a testamentary instrument, courts generally hold that a testator had capacity at the instrument's creation absent extreme or extenuating circumstances.[1] Attempting to prove or disprove capacity post-death poses special problems for litigators in the trusts and estates and elder law practice areas. This article will explore those special concerns in proving capacity post-death. Section II of this article will give a brief overview of the common causes of diminished mental capacity. Section III will delve into the ethical and professional responsibility considerations when entering into an attorney-client relationship with a client who may suffer from diminished mental capacity. Section IV will set forth the capacity continuum explaining the varying levels of capacity required for different functions. Finally, section V will clarify the common way of proving or disproving capacity for various transactions after the death of the decedent.

II. Common Causes of Diminished Mental Capacity

There are many different mental disorders that may cause a person's diminished mental capacity. It is important to know how these disorders may affect a person's decision-making and communication skills. These disorders range from several different kinds of dementia to depression. Professionals who are aware of the signs and symptoms of such disorders can detect whether the client's decision-making and communication skills have been compromised, and further, how to deal with such a situation if the client can no longer exercise his or her right of autonomy in the estate planning scheme.

A. Dementia

In general, dementia is an overall term to describe a "clinical syndrome characterized by generalized cognitive impairment and a normal level of consciousness."[2] The most common form of dementia is Alzheimer's disease, which affects 60 to 80 percent of all cases of dementia.[3] Each year more and more studies and reports project that the number of people affected by Alzheimer's disease will only continue to increase in the upcoming years.[4] The Alzheimer's Association attributes the increase to the number of baby boomers in the country and the "growth of the oldest-old population."[5] Alzheimer's can cause a person to forget recent conversations, names, and events. It can also impair one's ability to communicate, make judgments, and cause severe behavioral changes.[6] All of these symptoms can prospectively and retrospectively affect a person's estate plan if he or she suffers from Alzheimer's disease. The disease is caused by the accumulation of certain proteins inside and outside of the neurons in a person's brain, which are believed to be the culprit of memory loss and other symptoms of Alzheimer's.[7] The buildup of these proteins damages the neurons and interferes with communications between them, leading to the death of brain cells.[8] Those who suffer from a Mild Cognitive Impairment (MCI) are more likely to develop Alzheimer's because their brains are already susceptible to changes that affect thinking abilities.[9] A small percentage of people with genetic abnormalities may be prone to developing Alzheimer's at an age as young as 30.[10] Further, age and family history may also indicate a person's risk factor for developing Alzheimer's.[11] It is predicted that in 2016, between research, medical care, and caregiver's costs, Alzheimer's will cost the nation $236 billion.[12] Although MCI dementia can be detected early on and it is a slow-progressing brain disease, there still is no cure for it.[13]

Vascular dementia, dementia with Lewy bodies, mixed dementia, frontotemporal lobar degeneration, Parkinson's disease dementia, Creutzfeldt-Jakob disease, and normal pressure hydrocephalus are all other forms of dementia with symptoms that can also affect a person's mental capacity.[14] Impaired motor skills and judgment are a hallmark of all of these other types of dementia. These cognitive symptoms are all affected by changes and damage to vital parts of the brain that control behaviors, judgment-making, communication, and memory.[15]

B. Aphasia

Some people may suffer from Aphasia, which can be confused with dementia because Aphasia can be a symptom of dementia.[16] Aphasia is "a general term used to refer to deficits in language functions."[17] A diagnosis of Aphasia does not necessarily mean that the person's decision-making capacity has been compromised.[18] For example, Primary Progressive Aphasia (PPA) is a cognitive impairment that affects a person's language function.[19] People with PPA may appear to have a difficult time with common words while speaking or writing and often it is assumed that when elderly clients present this kind of behavior they are suffering from dementia.[20] Although the parts of the brain responsible for language begin to deteriorate, usually a person's memory, reasoning, and visual perception are not affected if they have Aphasia.[21] Therefore, people with PPA usually do not suffer from diminished capacity, but from difficulty in communicating with others.

Professionals must also remember that capacity is not a fixed condition.[22] A client's capacity can fluctuate throughout the day; it can be affected by the time of day, mood, medication dosage, and other external surrounding circumstances.[23] For instance, seniors are most familiar and comfortable within their own homes and may become irrational, agitated, and confused in a professional's office.[24] The National Academy of Elder Law Attorneys (NAELA) recommends that the elder law attorney "[a]dapts the interview environment, timing

of meetings, communications and decision-making processes to maximize the client's capacity."[25]

C. Depression

Another disorder that affects mental capacity is depression.[26] It is also a disorder that does not discriminate against any age group.[27] Across the country, as many as 16 million Americans suffer from some sort of depression, and 10 percent of those cases are people aged 65 or older.[28] Clients who suffer from depression may exhibit concerning symptoms such as loss of interest, diminished energy, low mood, slow thought and motor skill processing, agitation, and diminished concentration.[29] These symptoms can also be easily confused for dementia; however, depression can be treated with medication, which usually becomes effective within one to two months of use.[30]

Other cognitive impairments can be caused by chronic drug and alcohol abuse or temporary and permanent losses of cognitive functions, such as coma, minimally conscious states, and terminal illnesses.

Professionals must be educated and equipped to be able to determine whether the client suffers from any of the aforementioned conditions that may result in a lack of mental capacity. It is also important for the professional to know what conditions affect what parts of the brain that control decision-making, judgment-making, and other cognitive functions, and whether that condition can be cured. By learning how to identify a client's condition and knowing how to manage the situation, the professional can prepare a proper estate plan for the client, whether the client has the requisite capacity for certain functions.

III. Ethical Considerations When Counseling Clients Who Suffer from Diminished Mental Capacity

When determining the capacity of potential clients, there are ethical considerations that must be taken into account by the attorney before agreeing to representation. The New York Rules of Professional Conduct state that when dealing with clients with diminished capacity, whether it be because of minority, mental impairment, or another reason, the lawyer shall maintain a conventional attorney-client relationship with the client, as far as reasonably possible.[31] Attorneys are also required to act with "reasonable diligence and promptness in representing all clients, regardless of their capacity," and shall not neglect any legal matter they are entrusted with by a client.[32] However, this duty arises when a confidential attorney-client relationship is formed and may occur when: an attorney agrees to representation; an attorney is appointed to represent; or the client reasonably assumes the attorney is representing his or her interest.[33]

Issues often arise when a lawyer wishes to decline or terminate representation of a client with diminished capacity.[34] The rules provide that a lawyer may withdraw from representation when it can be done "without material adverse effects" on the client.[35] When withdrawal is permitted or even required, the lawyer is obligated to take steps to avoid "foreseeable prejudice to the client."[36] This includes delivering all the papers and files the client is entitled to and refunding any portion of the retainer that was paid in advance and not exhausted.[37]

It is possible to represent a client with diminished mental capacity provided that the client still satisfies the capacity requirement set by the New York Estates, Powers and Trusts Law, which is a lower capacity standard than the requisite capacity to contract.[38] There are also ethical considerations that arise during the course of litigation. When a lawyer reasonably believes a client with diminished capacity is at risk of substantial physical, financial or other harm and is unable to act in their own interest, the lawyer may take "reasonably necessary protective action, and in the appropriate cases, seeking the appointment of a guardian ad litem, conservator, or guardian."[39] Information relating to the representation of a client with diminished capacity is still subject to the confidentiality standards as provided by Rule 1.6.[40]

As the legal profession requires self-regulation, if a lawyer learns of conduct of another lawyer that violates the Rules of Professional Conduct, Rule 8.3 states that lawyer shall report such knowledge.[41] Thus, if a lawyer learns of another lawyer's disregard for these rules, especially when it comes to clients with diminished capacity, it is important that this neglect is reported to prevent harm to the client.

IV. New York's Standards of Capacity

The level of mental capacity fluctuates depending upon the advanced directive that is being executed. The levels of legal capacity are part of a spectrum developed through different state laws.[42] Testamentary capacity is on the lower end of the spectrum while the capacity to execute a power of attorney and contract is on the higher end of the spectrum.[43] The purpose of the legal concept of the different levels of requisite capacity is to determine when a state legitimately may take action to limit an individual's rights to make decisions about their own person or property, thereby exercising their *parens patriae* powers in relation to a person's due process constitutional rights.[44]

Testamentary capacity is on the lower end of the capacity spectrum. At common law, the court in *Greenwood v. Greenwood*[45] set forth four elements to determine testamentary capacity, commonly referred to as the *Greenwood-Baker* test.[46] The four elements are: (1) Did the testator understand the nature of the act he or she was performing; (2) Did the testator know the nature and extent of his or her property; (3) Did the testator know the identity of those who were the "natural objects of his or her bounty"; and (4) Did the testator understand the will's disposition of his or her property.[47] The *Greenwood-*

Baker test has been used widely across the country when determining testamentary capacity.

In New York, pursuant to EPTL 3-1.1, "every person eighteen years of age or over, of sound mind and memory" may dispose of real and personal property and exercise a power to appoint such property.[48] The N.Y. Court of Appeals reasoned in *In re Estate of Kumstar*[49] that the court must consider the *Greenwood-Baker* test in conjunction with the EPTL.[50] The Court of Appeals laid out a modified version of the *Greenwood-Baker* test.[51] The Court stated:

> [I]n a will contest . . . "the proponent has the burden of proving that the testator possessed testamentary capacity and the court must look to the following factors: (1) whether she understood the nature and consequences of executing a will; (2) whether she knew the nature and extent of the property she was disposing of; and (3) whether she knew those who would be considered the natural objects of her bounty and her relations with them."[52]

Oftentimes, litigation involving testamentary capacity has focused on factors such as the decedent's age, physical condition, and progressive mental illness, such factors, however, are not necessarily inconsistent with testamentary capacity, and may not necessarily be the appropriate inquiry. In *In re Estate of Hedges*,[53] the Second Department reasoned that the appropriate inquiry is whether the decedent was lucid and rational at the time the will was made.[54] Where there is conflicting evidence creating an issue of fact drawing possible inferences the issue of capacity is one for the jury, rather than for summary judgment.[55]

As a practical matter, the objectant will often be at a strategic disadvantage when seeking to defeat a motion for summary judgment regarding the decedent's alleged diminished capacity. This is the case as the proponent of a summary judgment motion must make a prima facie showing of entitlement to judgment as a matter of law, tendering sufficient evidence to demonstrate the absence of any material issues of fact.[56] Once this showing has been made, the burden shifts to the party opposing the motion for summary judgment to produce evidentiary proof in admissible form sufficient to establish the existence of material issues of fact which require a trial of the action.[57] In order to establish a material issue of fact with regard to diminished mental capacity, oftentimes the best evidence is medical records of the decedent. However, an objectant may not be in possession of these medical records or the medical records of the objectant may lack the proper foundation to enable their introduction in a legally admissible form.[58] When seeking to defeat a motion for summary judgment, it will quickly become apparent that there are several significant obstacles to obtain the relevant medical records from medical professionals and facilities. Accordingly, when seeking to establish there is a material question of fact related to the decendent's capacity, it is critical to obtain the necessary waivers and/or authority from the court early in the proceeding in order to have sufficient time to compel the production of medical records for the decedent in a legally admissible form.[59]

The capacity necessary to execute a power of attorney is higher than testamentary capacity on the mental capacity spectrum.[60] Many jurisdictions require a different level of capacity to execute a will versus a power of attorney, which requires the capacity to contract.[61] In order to have capacity to contract, the person must be able to understand the nature and consequences of the transaction and make a rational judgment concerning those consequences.[62] New York General Obligations Law § 5-1501B(1)(b) defines a power of attorney as a document "by which a principal with capacity designates an agent to act on his or her behalf."[63] The principal is deemed to lack the mental capacity to execute a valid power of attorney if he or she is unable to comprehend the nature and consequences of the act, any provision contracted within the act, or the authority of any person to act as an agent under a power of attorney.[64] The court will look to the principal's state of mind at the time the document was signed.[65]

Similar to the requisite capacity to execute a power of attorney, a higher level of capacity is required to execute a health care proxy.[66] The New York law provides that "every adult shall be presumed competent to appoint a health care agent unless such person has been adjudged incompetent or otherwise adjudged not competent to appoint a health care agent, or unless a committee or guardian of the person had been appointed for the agent."[67] Furthermore, pursuant to Pub. Health Law § 2980(3), capacity to make health care decisions means the ability to understand and appreciate the nature and consequences of health care decisions, including the benefits and risks of and alternatives to any proposed health care, and to reach an informed decision. This definition being very similar to that of General Obligation Law § 5-1501(c) would seemingly indicate that contractual capacity is the requisite to execute a health care proxy. However, in practice, a very low level of capacity is generally required.

Although there is some uncertainty, the standard of contractual capacity may be necessary since both the decision-making granted by a health care proxy and durable power of attorney lasts even after the principal has lost capacity.[68] This supports the theoretical spectrum of mental capacity because of the impact each of the advanced documents has on the principal or testator. A will only becomes effective upon the testator's death and, therefore, has no effect on the testator's life or financial well-being,[69] whereas a health care proxy and power of attorney are effective when signed, and set forth an agency-relationship between the principal and agent.[70]

V. Proving a Client's Capacity Post-Death

A. Proving Capacity in Testamentary Transactions

Under EPTL 3-1.1, every person over the age of 18 and "of sound mind and memory" may dispose of his or her property by will.[71] Nevertheless, the New York statute, similar to those statutes in other jurisdictions, fails to adequately set forth the meaning of "sound mind and memory," rather the determination has been developed by case law as applied to the particular circumstances of each case.[72] Generally, the capacity needed for executing a will requires the lowest form of capacity while the capacity needed for entering into a contract requires a more exacting level.[73] In a contested probate proceeding, the contesters are entitled to a jury trial; thus, unless the contesters wave a jury trial, the issue of capacity will be submitted to a jury when the evidence surrounding the testator's capacity is conflicting or there is a possibility of drawing different conclusions.[74]

Generally, the Surrogate's Court's determination of whether the testator had capacity is subject to great deference and will not be disturbed absent the great weight of the evidence to the contrary.

Customarily, the proponent of the will has the burden to establish by a preponderance of the evidence that the testator was "of sound mind and memory" when the will was executed.[75] However, there is a presumption of testamentary capacity where there are affidavits of the attesting witnesses, so long as the will was executed with the proper formalities under EPTL 3-2.1.[76] The existence of the attesting witness' affidavit is enough to shift the burden of proof on testamentary capacity to the party challenging the will.[77] The contestant is then required to show by a preponderance of the evidence that the testator lacked capacity by more than mere conclusory allegations.[78] Moreover, when attempting to prove capacity, there only needs to be a showing that the decedent had a "general, rather than a precise, knowledge of [his/her] assets."[79]

Notwithstanding these general burdens and the circumstances resulting in the shifting thereof, there are limited situations in which the burdens may be modified. For example, if the contestant alleges that undue influence was exhibited over the testator in the creation and/or execution of his or her will, the burden on undue influence may shift back and forth between the proponent and the objectant.[80] Generally, the objectant has the burden to prove undue influence. However, the burden may shift where there is a confidential relationship. The court in *In re Hayes' Estate*[81] held that where the testatrix drafted her will thereby leaving most of her estate to the scrivener, a presumption of undue influence arose based upon the confidential relationship with the scrivener and, thus, the burden shifted back to the proponent.[82] The proponent of the will was entitled to the initial presumption of capacity and due execution based upon the affidavits of the attesting witnesses, with the burden on the contestant to prove lack of testamentary capacity and undue execution.[83] However, the court held when the contestant can prove that the testatrix had a confidential relationship with a person who may have exhibited undue influence over the decedent and suspicious circumstances were present, the burden shifts back to the proponent to disprove undue influence.[84] A confidential relationship where an undue influence is asserted generally exists "when one person is dependent on and subject to the control of the other."[85] Some examples of confidential relationships are: a testator and the scrivener;[86] the testator and an attorney or doctor;[87] the testator and a nurse;[88] the testator and a psychologist;[89] the testator and a nursing home director;[90] the testator and a member of the clergy;[91] the testator and an accountant or financial advisor;[92] and the testator and an attorney-in-fact.[93] Examples of suspicious circumstances inlcude: "a fiduciary relationship; a change of testamentary intention; advanced age, and mental and physical condition of the decedent; the fact that the proponent was the drafter and principal beneficiary under the will and took an active part in procuring its execution; and that the testator acted without independent advice."[94]

Based upon the test set out in *Kumstar*, the relevant inquiry is whether the testator had capacity at the time the will was executed.[95] Due to the concept of freedom of disposition and that the testators intent should be given deference in most jurisdictions, courts generally lean toward finding capacity unless the contestant has demonstrated extenuating circumstances.[96] Although New York's statutory standard for testamentary capacity, which requires only "sound mind and memory" may seem to suggest a simplistic analysis, the Surrogate is charged with balancing all factors and determining whether the testator possessed the "task-specific functional capacity" at execution.[97] As the court in *In re Horton's Will*[98] stated,

> Each case depends on its own factual situation. But in general, a testator must have sufficient intelligence and capacity to understand the nature and consequences of his testamentary act, to know the nature and extent of his property, and those who may have just or natural claims upon his bounty in its disposition.[99]

For example, even documentary evidence supporting a finding that the testator suffered from Alzheimer's

is not sufficient alone to prove that a person lacked testamentary capacity because testamentary capacity is limited only to the moment in time when the testator executed his or her will.[100] It need only be shown that he or she had a lucid interval at the time of execution.[101] The court in *In re Chiurazzi*[102] held that despite the fact that the decedent suffered from "periods of confusion," the proponent of the will adequately satisfied the capacity threshold by establishing that the decedent was aware of the natural objects of her bounty and had a general idea of her property at the time of the execution of her will.[103] Similarly, the court in *In re Estate of Williams*[104] found the testator to be competent to execute a will despite the presence of medical records that showed that the testator had been diagnosed with permanent dementia and that his doctor indicated he did not always know the date.[105] The fact that the evidence showed that the testator was released from a hospital on the condition that he receive 24-hour care was not sufficient on its own to establish that the testator lacked capacity.[106]

Another potential problem for an objectant attempting to prove the testator's lack of capacity is the Dead Man's Statute, codified in CPLR 4519.[107] The Dead Man's Statute essentially renders parties and other interested persons incompetent to testify on their own behalf as to communications with the decedent.[108] New York's Dead Man Statute's three elements require:

> (1) [a]ny person "interested in the event," or a predecessor in interest of such person, may not testify in his or her own behalf or that of the successor in interest against; (2) certain protected persons with a specified relationship to the mentally ill person; and (3) concerning a transaction or communication with the decedent or mentally ill person.[109]

These elements are referred to as the disqualified witness, the person that may invoke the protection of its application, and the subject matter that is prohibited by its operation.[110]

As to the "disqualified witness" element, there are three types of witnesses that are disqualified: "(1) a party interested in the event; (2) a person interested in the event; and (3) a person from, through or under whom such a party or person derived his or her interest by assignment or otherwise."[111] All such persons who are witnesses are incompetent to either give testimony on their behalf or on behalf of a successor in interest to him or her.[112] Courts have construed the "event," as referred to in CPLR 4519, as a future occurrence, in which the person has either a pecuniary or fee interest.[113] Moreover, to fall within the purview of the statute, the interest itself must be "present, certain, and vested . . . and not an interest uncertain, remote, or contingent."[114] To be interested in the event, the witness must "either gain or lose by the direct legal operation and effect of the judgment, or . . . the record will be legal evidence for or against him in some other action."[115]

With respect to the second element, protected persons who can invoke the protection of the statute, fall into three categories: "(1) the executor or administrator of the decedent's estate or the guardian of the mentally ill person; (2) a 'survivor' of the decedent; and (3) a person deriving his or her title or interest from, through, or under the decedent or mentally ill."[116] There is a plethora of case law on the application of the statute regarding the executor or the administrator of the decedent's estate. The executor or the administrator may invoke the protection of the statute no matter if he or she is defending a claim against the estate or bringing a claim on behalf of the estate.[117]

Finally, once it is known who is disqualified and who may invoke the protection of the statute, you must determine what subject matter is prohibited by operation of the statute. The Court of Appeals in the seminal case of *Griswold v. Hart* held that an interested witness may not testify against members of the protected class "concerning a personal transaction or communication between the witness and the deceased person or [mentally ill person.]"[118] In addition, the application of the rule also prohibits the witness from giving "negative" testimony in relation to the things that the decedent did, said, or his or her failure to do things.[119] While the purpose of the Dead Man's Statute is to prevent witnesses from giving testimony against a deceased person who cannot controvert such testimony, the statute and its application causes a perplexing problem for practitioners as it may preclude the testimony of the person that is most likely to have knowledge of the cognitive capabilities of the decedent before his or her death.

Generally, the Surrogate's Court's determination of whether the testator had capacity is subject to great deference and will not be disturbed absent the great weight of the evidence to the contrary.[120] The Fourth Department in *In re Will of Buckten*[121] reversed the Surrogate's findings that the proponent failed to demonstrate "due execution" of the will.[122] The court reasoned that, generally, an appellate court will not disturb the determination of a Surrogate with respect to due execution and capacity.[123] However, when the great weight of the evidence shows to the contrary, the determination should be reversed.[124]

B. Proving Capacity for Contracts, Trusts, and Inter Vivos Transfers

The burden of proof for capacity for contracts, trusts, and inter vivos transfers differs from the burden of proof of proving capacity to make a will. The court will look to the transaction itself to determine what standard of proof should apply. A will is considered to be a unilateral transaction, but a trust is deemed to be a bilateral transaction that is consistent with a contract.[125] Therefore, the capacity to create a valid trust is the same as the capacity to make a valid contract.[126] The Surrogate's Court, in *In re Rosen*,[127] opined that the standard of capacity to make

a valid gift is the same as a trust.[128] Where the transfer is by gift, the donee bears the burden of proving, by clear and convincing evidence, that the gift was voluntary and knowingly made by the donor, uninfluenced by fraud, duress or coercion.[129]

a. Inter Vivos Transfers

In *Kirshtein v. AmeriCU Credit Union*,[130] the Appellate Division reviewed the Supreme Court's determination, which involved a dispute regarding capacity to make an inter vivos transfer of stock certificates.[131] The court instructed the jury that the contestant had the burden to prove by clear and convincing evidence that, at the time of the stock transfers, the decedent had lacked the mental capacity to enter into a contract.[132] The court reasoned that the burden of proof in will contests is different from the burden of proof in inter vivos transfers. More specifically, in an action to probate a will, the proponent of the will must establish the decedent's testamentary capacity by a fair preponderance of the evidence only once that capacity has been put in issue.[133] However, in an action involving an inter vivos transfer, the contestant has the burden of establishing the transferor's incapacity.[134]

The contestant in this case submitted evidence including a police report and hospital records indicating that the donor suffered from dementia.[135] The evidence further included testimony from an attorney who had drafted the decedent's will but ultimately determined the decedent did not have the capacity to execute the will; and testimony of an expert psychiatric witness, a nursing home physician, and an expert witness in geriatric medicine, who all maintained that the decedent did not have the capacity to understand the nature of the stock transfers.[136] The court subsequently held that the donor did not have the capacity to execute the inter vivos transfer.[137]

b. Trusts

The first case to address the issue of the capacity standard to execute a trust was *In re ACN*.[138] The Surrogate's Court found a unitrust to be analogous to that of a contract given its bilateral relationship between the settlor and the trustee.[139] The court followed the two-part test set forth in a decision rendered by the Court of Appeals in *Ortelere v. Teacher's Retirement Bd*.[140] The test involves (1) application of the *cognitive test* in which the focus is on whether an individual could understand the nature and consequences of the transaction and "be able to make a rational judgment concerning the particular transaction," and (2) the question of whether "*by reason of mental illness or defect*" the settlor is "unable to act in a reasonable manner in relation to the transaction."[141] Following the burden in *Kirshtein*, the court in *Ortelere* held that the contestant bears the burden to prove by clear and convincing evidence that the settlor lacked the requisite mental capacity to enter into a contract.[142]

In this case, the decedent was a savvy tax lawyer and executed a trust in which the decedent and his wife held life-time interests with a fee simple remainder to a charitable organization.[143] The court considered the creation of the trust to be that of a contract because there was a present property interest, which was surrendered in exchange for annual interest.[144] The court considered the testimony from longtime friends of the decedent; attorneys with whom he shared office space; family; a personal physician; an expert on unitrusts; the guardian ad litem appointed for the decedent during his conservatorship proceeding; and a forensic psychiatrist, who all supported the position that the decedent lacked mental capacity.[145] Based upon the totality of the evidence, the court found that a showing of "clear and convincing credible evidence" had been made on the part of the contestant.[146] The court reasoned that the settlor suffered from insane delusions and lacked the capacity to execute the trust, which satisfied the two-part test.[147]

c. Antenuptial Agreements

In *In re Will of Goldberg*,[148] the decedent executed a will releasing his wife from their antenuptial agreement and a dispute arose as to whether he had the capacity to do such through his will.[149] The court held that the requisite capacity for revoking the antenuptial agreement, even though it was effectuated in the decedent's will, was, in fact, higher than the capacity required for making and executing a will. The capacity to release the spouse from the antenuptial agreement was that of entering into a contract.[150] The decedent was diagnosed with organic brain syndrome resulting from two heart attacks and a stroke.[151] The court held the antenuptial agreement required a higher level of capacity because the "[decedent's] revocation . . . represented the surrender of his testamentary freedom in response to his wife's future needs," creating a bilateral transaction.[152] Proving incapacity involved many factors, including whether the decedent understood the revocation, whether his decision was guided by independent advice and most importantly, whether the transaction is one that a "reasonably competent person" would make.[153] The court subsequently held that the decedent did have the requisite mental capacity to execute such a release in his will.[154]

VI. Conclusion

The trusts and estates practice area, especially in the areas of estate litigation and elder law, poses unique problems for litigators. Generally, in other areas of litigation, the attorney has the benefit of the testimony of the aggrieved party to assist in carrying his or her client's burden and/or defending against a claim. In our realm of practice, a practitioner must rely on the testimony of others, which oftentimes is influenced by personal financial motivations, bias or may be barred entirely by operation of law. Accordingly, the court or the trier of fact is often left to draw inferences from the medical records and other pieces of documentary evidence, in addition to wading through self-serving sworn statements and testimonial evidence from interested parties. For the most litigating

attorneys, it can be a great challenge to marshal compelling evidence to establish the decedent possessed or lacked mental capacity. Practitioners, especially scriveners, should take special note of these concerns when attempting to assist clients with advanced directives and testamentary transactions as their contemporaneous correspondence, notes and records are often relied on to determine if the decedent possessed sufficient capacity to execute the challenged legal document. ■

1. *In re Estate of Kumstar*, 487 N.E.2d 271, 272 (1985). *See generally Horn v. Pullman*, 72 N.Y. 269 (1878); *Clarke v. Sawyer*, 2 N.Y. 498 (1849); *In re Will of Slade*, 106 A.D.2d 914 (4th Dep't 1984); *In re Beneway's Will*, 272 A.D. 463 (3d Dep't 1947); *In re Horton's Will*, 26 Misc. 2d 843 (Sur. Ct., Suffolk Co. 1960), *aff'd*, 13 A.D.2d 506 (2d Dep't 1961).

2. Robert P. Roca, *Determining Decisional Capacity: A Medical Perspective*, 62 Fordham L. Rev. 1177, 1180 (1994).

3. Informational Brochure, The Alzheimer's Ass'n, 2016 Facts and Figures (last visited Oct. 13, 2016), http://alz.org/documents_custom/2016-facts-and-figures.pdf (2016 Facts and Figures).

4. *Id.*

5. *Id.*

6. *Id.*

7. *Id.*

8. *Id.*

9. *Id.*

10. *Id.*

11. *Id.*

12. 2016 Facts and Figures Overview, The Alzheimer's Association (last visited Oct. 13, 2016), http://alz.org/facts/overview.asp.

13. Robert B. Flemming, *Representing the Elderly Client or the Client with Diminished Capacity*, 50 Fam. L.Q. 27, 28 (2016).

14. *See 2016 Facts and Figures, supra* note 3.

15. *Id.*

16. Informational Brochure, Nw. Univ. Feinberg Sch. of Med, What Is Primary Progressive Aphasia (last visited October 9, 2016) http://brain.northwestern.edu/dementia/ppa/index.html.

17. *Id.*

18. *Id.*

19. *Id.*

20. *Id.*

21. *Id.*

22. Walter T. Burke, *Ethical and Psychological Aspects of Representing the Elderly*, 13 Experience 5, 8 (2003).

23. *Id.*

24. *Id.*

25. A. Frank Johns & Bernard A. Krooks, *Elder Clients with Diminished Capacity: NAELA's Response to Specific Case Applications and Its Development of Aspirational Standards That May Cross Professional Organization Boundaries*, 1 Nat'l. Acad. of Elder L. Attorneys J. 197, 214 (2005).

26. Lindsay Holmes, *11 Statistics That Will Change the Way You Think About Depression*, The Huffington Post (Jan. 20, 2015, 8:21 AM), www.huffingtonpost.com/2015/01/20/depression-statistics_n_6480412.html.

27. *Id.*

28. *Id.*

29. Roca, *supra* note 2, at 1185.

30. *Id.*

31. N.Y. Rules of Prof'l Conduct Rule 1.14(a) (2015).

32. N.Y. Rules of Prof'l Conduct Rule 1.3(a)(b) (2015).

33. N.Y. Rules of Prof'l Conduct Rule 1.2 (2015).

34. N.Y. Rules of Prof'l Conduct Rule 1.6(a) (2015).

35. N.Y. Rules of Prof'l Conduct Rule 1.16(c)(1) (2015).

36. N.Y. Rules of Prof'l Conduct Rule 1.16(e) (2015).

37. *Id.*

38. *In re Ernest*, 271 A.D. 1059, 1059 (4th Dep't 1949).

39. N.Y. Rules of Prof'l Conduct Rule 1.14(b) (2015).

40. N.Y. Rules of Prof'l Conduct Rule 1.6(a) (2015).

41. N.Y. Rules of Prof'l Conduct Rule 8.3(a) (2015).

42. Lawrence A. Frolik, *Sufficient Capacity: The Contrasting Capacity Requirements for Different Documents*, 2 Nat'l. Acad. of Elder L. Attorneys J. 303 (2006).

43. *See generally In re Estate of Kumstar*, 487 N.E.2d 271 (1985); N.Y. Gen. Oblig. Law § 5-1501(c) (McKinney 2009).

44. Frolik, *supra* note 42, at 303.

45. 163 Eng. Rep. 930 (1790).

46. *Id.* at 931.

47. *Id.*

48. N.Y. Est. Powers & Trusts Law 3-1.1 (McKinney 1966).

49. 487 N.E.2d 271 (1985).

50. *Id.* at 272.

51. *Id.*

52. *Id.* (quoting *In re Slade*, 106 A.D.2d 914, 915 (4th Dep't 1984)).

53. 100 A.D.2d 586 (2d Dep't 1984).

54. *Id.* at 587.

55. N.Y. Est. Powers & Trusts Law 3-1.1 (McKinney 1966) (practice commentary) (Patrick Rohan Pg. 275).

56. *Alvarez v. Prospect Hosp.*, 501 N.E.2d 572, 573 (N.Y. 1986).

57. *Zuckerman v. City of New York*, 404 N.E.2d 718, 719–20 (N.Y. 1980).

58. *Joseph E. G. v. East Irondequoit Cent. Sch. Dist.*, 273 A.D.2d 835, 836 (4th Dep't 2000) (granting summary judgment as the uncertified, unsworn medical records were not in admissible form).

59. This is normally accomplished through certification of the medical records pursuant to CPLR 3122-a(c) and CPLR 4518(c).

60. *See generally* N.Y. Gen. Oblig. Law § 5-1501(c) (McKinney 2009).

61. *Id.*; 22 N.Y. Jur. 2d *Contracts* § 26 (2016).

62. 22 N.Y. Jur. 2d *Contracts* § 26 (2016).

63. N.Y. Gen. Oblig. Law § 5-1501(c) (McKinney 2009).

64. *Id.*

65. *In re Imre B.R.*, 40 Misc. 3d 1237(A) (Sup. Ct., Dutchess Co. 2013).

66. N.Y. Pub. Health Law § 2981 (McKinney 2012).

67. *Id.*

68. Frolik, *supra* note 42, at 303.

69. *Id.*

70. N.Y. Gen. Oblig. Law § 5-1501(c) (McKinney 2009).

71. N.Y. Est. Powers & Trusts Law 3-1.1 (McKinney 1966).

72. N.Y. Pattern Jury Instr. Civil § 7:48 (2015).

> Under our law a person of sound mind and memory is said to possess testamentary capacity and may dispose of (his, her) property by will. The question you must decide is whether the testator possessed these mental qualities at the time (he, she) executed this will. The law does not define any particular grade of mental ability necessary to qualify a person to make a will. Wills are made by all types of people, in every stage of life and condition of health; by persons of weak intellect and by those of great ability. The fact that a person is old, or uneducated, or sick, or lacking in business experience, does not prevent him or her from making a valid will. Testamentary capacity, therefore, must be judged by all the circumstances of the case, taking into consideration the particular testator and the particular will involved.

73. *In re Estate of Donaldson*, 38 Misc. 3d 841, 844–45 (Sur. Ct., Richmond Co. 2012); *In re Matter of Will of Goldberg*, 153 Misc. 2d 560, 565 (Sur. Ct., N.Y. Co. 1992).

74. *Id.*

75. *In re Donovan's Estate*, 47 A.D.2d 923, 924 (2d Dep't 1975). *See In re McCloskey*, 307 A.D.2d 737, 738 (4th Dep't 2003).

76. *In re Estate of Johnson*, 6 A.D.3d 859, 860–61 (3d Dep't 2004); N.Y. Est. Powers & Trusts Law 3-2.1 (McKinney 1974).

77. *Id.*

78. *Id.*

79. *In re Estate of Vosilla*, 121 A.D.3d 1489, 1491 (3d Dep't 2014).

80. *In re Hayes' Estate*, 49 Misc. 2d 152 (Sur. Ct., Bronx Co. 1966).

81. *Id.*

82. *Id.* at 153.

83. *Id.*

84. *Id.*

85. 2 Harris N.Y. Estates: Probate Admin. & Litigation 24:278 (6th ed. 2015).

86. *In re Putnam's Will*, 257 N.Y. 140 (1931).

87. *In re Burke*, 82 A.D.2d 260 (2d Dep't 1981).

88. *Petrie v. Chase Manhattan Bank*, 38 A.D.2d 206 (1st Dep't 1972).

89. *Estate of Reiner*, 86 Misc. 2d 511 (Sur. Ct., N.Y. Co. 1976).

90. *Estate of Arnold*, 125 Misc. 2d 265 (Sur. Ct., N.Y. Co. 1983).

91. *Estate of Eckert*, 93 Misc. 2d 677 (Sur. Ct., N.Y. Co. 1978).

92. *Will of Bartel*, 161 Misc. 2d 455 (Sur. Ct., N.Y. Co. 1994), *aff'd*, 214 A.D.2d 476 (1st Dep't 1995).

93. *Matter of Bach*, 133 A.D.2d 455 (2d Dep't 1987).

94. 2 Harris N.Y. Estates: Probate Admin. & Litigation § 24:278 (6th ed. 2015).

95. *Estate of Kumstar*, 66 N.Y.2d 691, 691 (1985).

96. Jesse Dukeminier & Robert H. Sitkoff, Wills, Trusts, and Estates 19 (Vicki Been et al. eds., 9th ed. 2013).

97. *See generally In re Will of Khazaneh*, 15 Misc. 3d 515 (Sur. Ct., N.Y. Co. 2006).

98. 26 Misc. 2d 843 (Sur. Ct., Suffolk Co. 1960).

99. *Id.* at 847 (citing *Delafield v. Parish*, 25 N.Y. 9 (1862); *In re Coddington's Will*, 281 A.D. 143 (3d Dep't 1952), *aff'd*, 120 N.E.2d 777 (1954)).

> One may be able to make a will though afflicted with a fatal disease. A will is not necessarily rejected because testator does not make it until near death, nor because he is ill or weak. [O]ne need not have perfect mind or memory[.] An elderly person may have good days and poor days. Testamentary capacity is not destroyed retroactively by events happening after execution. (citations omitted)

100. *In re Minasian*, 149 A.D.2d 511, 511 (2d Dep't 1989).

101. *In re Estate of Buchanan*, 245 A.D.2d 642, 645 (3d Dep't 1997).

102. 296 A.D.2d 406 (2d Dep't 2002).

103. *Id.* at 407.

104. 13 A.D.3d 954 (3d Dep't 2004).

105. *Id.* at 956–57.

106. *Id.*

107. CPLR 4519 (McKinney 1962).

108. *Id.* (practice commentary) (Vincent C. Alexander § C4519:1). CPLR 4519 provides in pertinent part:

> Upon the trial of an action or the hearing upon the merits of a special proceeding, a party or a person interested in the event, or a person from, through or under whom such a party or interested person derives his interest or title by assignment or otherwise, shall not be examined as a witness in his own behalf or interest, or in behalf of the party succeeding to his title or interest against the executor, administrator or survivor of a deceased person or the committee of a mentally ill person, or a person deriving his title or interest from, through or under a deceased person or mentally ill person, by assignment or otherwise, concerning a personal transaction or communication between the witness and the deceased person or mentally ill person, except where the executor, administrator, survivor, committee or person so deriving title or interest is examined in his own behalf, or the testimony of the mentally ill person or deceased person is given in evidence, concerning the same transaction or communication.

109. *Id.* (practice commentary) (Vincent C. Alexander § C4519:1).

110. *Id.*

111. *Id.*

112. *Id.*

113. *Tworkowski v. Tworkowski*, 181 Misc. 2d 1038, 1041 (Sup. Ct., Kings Co. 1999).

114. *Laka v. Krystek*, 261 N.Y. 126, 130 (1933).

115. *Id.*

116. CPLR 4519 (McKinney 1962) (practice commentary) (Vincent C. Alexander § C4519:3).

117. *De Laurent v. Townsend*, 243 N.Y. 130, 132–33 (1926).

118. 205 N.Y. 384, 387 (1912).

119. *Endervelt v. Slade*, 162 Misc. 2d 975, 980 (Sup. Ct., N.Y. Co. 1994), *aff'd*, 214 A.D.2d 546 (1st Dep't 1995).

120. *In re Chiurazzi*, 296 A.D.2d 406.

121. *Id.*

122. *Id.* at 981–82.

123. *Id.*

124. *Id.*

125. *In re ACN*, 133 Misc. 2d 1043 (Sur. Ct., N.Y. Co. 1986).

126. *Id.*

127. 17 Misc. 3d 1103(A) (Sur. Ct., Kings Co. 2007).

128. *Id.* at *5–6.

129. *Id.*

130. 83 A.D.3d 153 (4th Dep't 2011).

131. *Id.* at 155.

132. *Id.* at 159.

133. *Id.* at 158.

134. *Id.*

135. *Id.* at 156.

136. *Id.* at 156.

137. *Id.* at 161.

138. *ACN*, 133 Misc. 2d at 1043.

139. *Id.* at 1046–47.

140. *Id.* at 1047 (citing *Ortelere v. Teachers Retir. Bd.*, 25 N.Y.2d 196, 201–02 (1969)).

141. *Id.* at 1047 (emphasis added).

142. *Id.* at 1048.

143. *Id.* at 1044.

144. *Id.* at 1047.

145. *Id.* at 1046.

146. *Id.* at 1048.

147. *Id.*

148. 153 Misc. 2d 560 (Sur. Ct., N.Y. Co. 1992).

149. *Id.* at 561.

150. *Id.* at 565.

151. *Id.* at 561.

152. *Id.* at 565.

153. *Id.* at 566.

154. *Id.* at 567.

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Dementia in the Courtroom

By David Klein and Kyle Durante

I. Introduction

The Touro Law Center's Institute on Aging and Longevity Law, supported by a grant from the Jerry Stock Trust, Phyllis Dubrow, Esq., trustee, and in cooperation with the Dementia Spotlight Foundation, the New York State Office of Court Administration and members of the New York State Bar Association, sponsored a program titled "Dementia in the Courtroom," that featured Teepa Snow (hereinafter "Teepa").[1]

Teepa is a nationally recognized expert on dementia.[2] The purpose of her participation was to educate experienced attorneys and judges as to the important role they have in helping to improve quality of life for individuals living with the disability of dementia. Not one to mince words, Teepa challenged the program attendees: If the legal profession doesn't protect and advocate for people with dementia, "Who the hell will?"

With the input of judges and attorneys, most notably Fern Finkel, Esq., Ira Salzman, Esq., and Louis Levenson, Esq., Teepa began the program with a series of role-play segments, which identified common behaviors exhibited by persons with dementia in their homes and in court settings. She highlighted that those victim to dementia sometimes, knowingly out of fear or involuntarily due to the effects of the disease, are able to disguise their cognitive decline. This would be difficult to discern in a courtroom setting and might come in the form of confabulation,[3] isolation or through aggressive and combative behaviors or interactions with those trying to help.

II. Teepa's Emphasis on Dementia Demographics[4]

Teepa explained that dementia is not a normal part of aging, notwithstanding that with an increase in age comes an increase in the prevalence of dementia. Teepa gave us the good and bad news of living a long life: "If we all make it to 85, 50 percent of us will have it. As a matter of fact, right now, somewhere between five to 15 years before you show the signs of it, you already have it. It's already in your brain. It's already cooking. It's already changing."

She also explained that often with dementia, the person affected is also likely to suffer from comorbidities.[5]

> For every person who has dementia, they have on average three other health conditions going on. It's not just a dementia. . . . The most common will be a physical ailment and the most common of those are arthritis, hypertension, diabetes, and blood supply, oxygenation, and energy supply issues. Arthritis results in pain, which controls how you move and what you think is happening.
>
> Then you have emotional or mental health conditions, which are very common in people suffering from diminished mental capacity. The two most common are anxiety and depression . . . 50 percent will have clinical signals and symptoms that actually have a clinical diagnosis of anxiety or depression. Some people have both. Some people have neither.
>
> And the last condition that most people have, the third condition will be a sensory thing. A vision change, a

> hearing change, or a movement or balance/coordination thing. So it's due to Parkinson's, it's due to things like diabetes. They have diabetic retinopathies; they have visual problems. The most common being cataracts. Cataracts, macular degeneration. Hearing, they can't hear high-pitched sounds.

Once the disease starts it cannot be stopped. Once again, without mincing words, Teepa reminds us, "The disease literally kills your brain."

Teepa explained that before dementia kills its victims, in late stages of the disease progression,[6] an individual will lose awareness of hunger and thirst and when actively dying will refuse to be fed for this reason. Some dementia patients may suffer from the side effects of medication and/or from other seemingly non-related medical conditions and they may be no longer able to wake/sleep on a regular pattern.

Also palpable during Teepa's presentation was the undeniable fact that lawyers and judges are just as likely as all other Americans, regardless of professional status and wealth, to be disabled by dementia themselves, as are their loved ones, elderly parents, spouses, and children. It was impossible for the attendees not to wonder about their own morbidity and mortality as Teepa focused on the real-life consequences caused by the current and growing epidemic of dementia.

III. Judicial Perspectives

As evidenced by the following commentaries of Hon. Charles Troia and Hon. Tanya R. Kennedy, two Article 81 guardianship judges, Teepa's presentation provided invaluable insight:

Hon. Charles M. Troia

Judge Troia (Sup. Ct., Richmond Co.) believes this program has "provided [him with the] tools for communicating with and easing the fears of individuals suffering from dementia as they are before the court." Judges commonly have difficulty accessing the functional limitations and the severity of a person's illness because they do not thoroughly understand the diseases. Court evaluators in an Article 81 proceeding are there to help bridge a gap between the alleged incapacitated person (AIP) and the courtroom; however, if they don't sufficiently understand the illness, a gap will still exist.

This program has "educated [members of the judiciary] on the various forms and symptoms of dementia and provided [them] with means of accessing whether someone is suffering from dementia" and has "provided an understanding of the limitations and fears of individuals suffering from their dementia." It is a common occurrence that untrained people will see an elderly person act out-of-character and assume they are suffering from Alzheimer's, or hear that a person has dementia and automatically assume that it is Alzheimer's. However, what people fail to realize is that there are numerous forms of dementia, all of which have different effects on the AIP's capabilities.

In order for a judge to be able to adequately determine the form of intervention that is necessary for the AIP, they need to understand exactly what the individual is suffering from and how the illness might affect the AIP. This program has "[p]rovided [judges with] an understanding of the development of the disease [assisting them in] understanding how the needs of those afflicted by the [illness] will continually change."

Finally, the program "[p]rovided an in[-]depth view of how the illness affects the family members." While a judge in an Article 81 proceeding is supposed to take into consideration the capabilities of the AIP, they must also take other factors into consideration, including family members' abilities to handle the functional limitations of the AIP. Judges in Article 81 proceedings prefer to allow a family member to serve as a guardian when it is permissible. However, a judge must thoroughly understand the toll that this may take on the family member and must be able to assess how this illness may affect family members to be sure that the AIP is adequately protected.

Hon. Tanya R. Kennedy

Judge Kennedy (Sup. Ct., N.Y. Co.) believes this program "informed [her] about the various forms of dementia and how they manifest" and "informed her about the tests used to diagnose dementia and the misconceptions about the disease." One of the most difficult issues in the area of aging and dementia is actually determining whether the person is suffering from diminished mental capacity and if so, determining what the illness is and what can be expected. There are numerous methods used to attempt to diagnosis the different types of dementia. Only with the proficient usage of these tools can the judiciary adequately determine what the appropriate needs of the AIP currently are and what they might be in the future.

This program provided "greater insight regarding the reasons why AIPs display certain behaviors in the courtroom and that may be perceived as disruptive." A judge must be capable of understanding the functional limitations of the individual and their ability to understand the proceeding before them. Often, an AIP will have outbursts in the courtroom, but that is not because they are purposely trying to be disruptive, rather their body is responding to what is before them because they are unsure of what is going on. This program provided practitioners with insight on how to approach the AIP and explain the procedures to them.

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This program equipped members of the judiciary with "greater insight and sensitivity as to how AIPs perceive language set forth in the Order to Show Cause." The standard form for an Order to Show Cause is large, bolded language in the center of the cover, in an attempt to notify the person receiving such that they need to respond. While a person that is not suffering from diminished mental capacity may be able to adequately and appropriately receive that information, a person suffering from diminished mental capacity may not be able to understand the language. There are ways in which practitioners can ease the process for AIPs, which starts with the forms they use. Instead of using white paper with large, bolded black lettering, they should use black paper, with white, large bolded lettering. White lettering on black paper is easier for persons with poor eyesight or poor cognitive function to read and comprehend.

Finally, this program informed judges of the "greater sensitivity as to how the courtroom's physical environment impacts the AIP." There are many AIPs that come before the court that may have never set foot in a courtroom in their entire life. There is also the common misconception of the person living with dementia, that due to the communication and comprehension limits of their disease progression, when they come to court, they believe they are either "in trouble" or someone is going to impede upon their rights. Practitioners need to understand that it is extremely stressful for a dementia disabled AIP to attend court. It is stressful for most people to attend court who have limited knowledge of the court system and do not suffer from diminished mental capacity. This program clarified for practitioners the best ways to approach an AIP and that a judge may wish to lessen the formalities in order to reduce stress, get an accurate representation of the AIP, and hopefully be better equipped to direct outcomes on that person's behalf. Judges can lessen the formalities by meeting around a conference table, instead of traditional benches, or not wearing their robe, for example. Judges should be lenient and flexible with the AIP due to their changing disability, as it is necessary to get an accurate representation of the limitations of the AIP.

IV. Conclusion

As evidenced by the comments of Judge Troia and Judge Kennedy, we in the legal profession must address and recognize the legal, financial, and medical challenges that impact millions of Americans who have and will be diagnosed with dementia. Inevitably these individuals, their family members, business colleagues, and neighbors will reach out to the legal profession for assistance, which requires lawyers and judges to more thoroughly understand and be prepared for the ever-growing dementia crisis. ■

1. Teepa Snow, www.teepasnow.com.
2. Teepa Snow, www.teepasnow.com/about/about-teepa-snow.
3. R. Morgan Griffin, *What It's Like to Have Dementia,* WebMD, www.webmd.com/alzheimers/features/understanding-dementia-symptoms.
4. This portion of the article is based on transcripts from the event. The transcripts are on file with the author.
5. Fact Sheet, Ctrs. for Disease Control and Prevention, www.cdc.gov/arthritis/data_statistics/comorbidities.htm (last updated May 27, 2015).
6. Angela Morrow, *What's it Like to Die of Dementia,* VeryWell, https://www.verywell.com/what-is-it-like-to-die-of-dementia-1132331 (April 27, 2016). *See also* Fact Sheet, Ctrs. For Disease Control and Prevention, www.cdc.gov/nchs/fastats/alzheimers.htm (last updated October 6, 2016).

Experiential Wisdom

Insightful Perspectives on Dementia, the Legal Profession and the Law

By Robert Abrams

According to Michael Miller, Esq.[1], President-Elect Nominee of NYSBA:

> Lawyers serve on the front-lines of many compelling social issues, but few, if any, are more profound than those relating to dementia. Dementia poses extraordinary challenges for the individuals directly affected, as well as for their loved ones. Lawyers can't cure dementia, but those practicing in the areas of elder law and estate planning are uniquely qualified to help develop an effective financial and care plan. Whether representing individuals and family members facing this scourge for a fee or *pro bono*, lawyers play an important role in making the best of an extraordinarily difficult and frightening reality in the human drama.

Robert Freedman, Esq.[2] provides further insight as to why dementia has had a major impact on the legal profession and the law:

> There is a high correlation between aging and dementia. The field of elder law is burgeoning not just because of demographic growth but because of the epidemic of dementia that accompanies the increase in life expectancy in the US and across the world. The dual phenomenon of contemporaneous growth of dementia and longevity created a vital need for a legal community response.
>
> The disease is devastating. It destroys people and their families. There is no cure and no effective treatments. Nothing relieves the burden of the care that is needed. Family and informal caregiving takes a huge toll on the caregiver. Paid caregiving is enormously expensive, often wiping out a lifetime of savings. The burden on the family is enormous. There is very little that can be done. However, there is legal and financial planning that will ease the burden and make it better for the caregivers and the family. I tell my clients that I cannot help cure the patient or personally care for the patient, but I can give advice that will ease (not eliminate) the financial burden by explaining how to utilize Medicaid. I can provide legal documents like a HIPAA Medical Privacy Release, a Health Care Proxy and a Living Will to help the family deal with medical decisions. And I can provide legal documents like a Power of Attorney, Trusts and if necessary a Guardianship that will allow the caregivers to deal with the legal and financial issues that arise when the patient lacks the capacity to handle them. I cannot solve or ameliorate the burden of care and the pain of the disease as it destroys a loved one, but I can make it easier to deal with.

Robert Abrams, Esq., Abrams, Fensterman, Fensterman, Eisman, Formato, Ferrara & Wolf, LLP. Mr. Abrams thanks his colleagues Christopher Renke, Esq., Sara Clark and Meghan Ivory for their assistance.

> I will be the first to acknowledge that the people on the front line as caregivers, whether informal or paid, or as a support group leaders or participants have the more difficult roles, but I take comfort in the belief that I can contribute to make life a little bit easier for my clients and their families.

The Hon. Justice H. Patrick Leis, III,[3] who has presided over hundreds of guardianship matters and has written many seminal decisions, including *In re Buffalino (James D.)*[4] and *Christopher C. v. Bonnie C.*[5], shares Mr. Freedman's belief that lawyers and judges must be sensitive to and understanding of the unique challenges faced by individuals with dementia and their loved ones. In particular, Judge Leis urges his colleagues to be patient and observant in assessing and communicating with individuals who have dementia:

> Dementia is a condition effecting more and more people who enter our Guardianship courtrooms. What it means to the courts is that the usual and customary methods of communicating with an individual need to be reconsidered. Dementia not only affects the individual, it impacts the individual's family as well. This also must be recognized. For the family, it means taking on responsibilities previously handled by the individual which can often create resentment, impatience and fatigue.
>
> For the individual who has dementia, a gradual slip in memory and inability to be independent is terrifying and at times overwhelming. Dealing with this condition requires great patience, understanding and tolerance. People with dementia try to hide the fact that their memory is failing and they become anxious performing tasks that they used to do with ease. Anger and anxiety are a common reaction when they perceive what is happening to them, for make no mistake – they know something is happening to them. Accordingly, adjustments to the courts' interactions with them and the court system's response to their defensiveness and anger, must be made.
>
> We also need to recognize that in addition to the traditional forms of elder abuse – physical, emotional and financial – there is another form. This fourth form of abuse is the way that we as a society (including attorneys, judges and court staff) react to and look at a person who is suffering from a mental limitation.
>
> How to recognize the condition and serve the individual is an evolving task. Interacting in a kind and understanding manner is extremely helpful in opening a door of communication. All attorneys, judges and court staff need to look at the person with dementia or any other condition resulting in diminished mental capacity, with a non-judgmental, non-critical, caring eye in order to accurately evaluate the person's wishes and concerns. The stress of being in a new environment makes it very difficult for the court to be able to competently assess the mental capacity of a frightened, defensive and stressed individual and to assess the person's ability to communicate his/her needs and wishes.
>
> I have personally conducted a guardianship hearing in a nursing home where the initial recommendation of the court evaluator had been that the Alleged Incapacitated Person (AIP) was incapable of meaningfully participating in the hearing, but because of the use of a therapy/emotional support dog obtained by family members, the court was not only able to communicate with the AIP but also was able to discern the individual's needs and wishes.
>
> Being able to look into a person's eyes and see the essence that is not affected or limited by the particular mental or physical condition is a great help in relaxing that individual and enabling him or her to communicate. Even if the communication is the blink of an eye or the raising or lowering of the thumb, the communication has been made possible. Being able to imagine what it would be like to be in the shoes of a person with diminished capacity goes a long way in opening the door for understanding and communication. Empathy and compassion are indeed a universal language in and of themselves.

The legal community has and also needs to continue to partner with representatives of state government to ensure that the dementia-induced legal needs of all New Yorkers are met.

In addition to and in furtherance of the need for judicial sensitivity expressed by Justice Leis, the Hon. Thomas P. Aliotta[6] cautions the legal community that a person who is diagnosed with dementia may not automatically require the appointment of a guardian. If, however, a determination is made pursuant to Article 81 of New York's Mental Hygiene Law that the appointment of a guardian is necessary, the guardian must only be authorized to make decisions on behalf of the incapacitated person which constitute "the least restrictive form of intervention consistent with the person's functional limitations and the likelihood of harm because of the person's inability to adequately understand and appreciate the nature and consequences of such functional limitations."[7]

Judge Aliotta further reminds us that MHL § 81.29 specifically addresses the rights retained by an incapacitated person if a guardian is appointed:

> (a) An incapacitated person for whom a Guardian has been appointed retains all powers and rights

except those powers and rights which the Guardian is granted; [and]

(b) Subject to subdivision (a) of this section, the appointment of a Guardian shall not be conclusive evidence that the person lacks capacity for any other purpose, including the capacity to dispose of property by will.[8]

Therefore, pursuant to Article 81 and other New York statutes, every New York adult is presumed to have capacity and, if ultimately a court determines the person has diminished capacity and requires assistance, such assistance should be "tailored to the individual needs of that person, which takes into account the personal wishes, preferences and desires of the person, and which affords the person to the greatest amount of independence and self-determination and participation in all the decisions affecting such person's life."[9]

This legislative objective begs the question as to the competence of judges and attorneys to not only assess capacity but to truly appreciate the capacity continuum. Throughout this special issue on the dementia crisis, we have emphasized that there are more than 100 types of dementia and each type has its own unique set of consequences be it, *inter alia*, an assault on its victims memory, judgment, motor skills, behavior, appetite, sleep habits and/or activities of daily living. What training have most judges and lawyers participated in, if any, to truly understand the nature, nuances and extent of the dementia epidemic? Moreover, should judges and lawyers rely on anecdotal evidence of an alleged incapacitated person's need for assistance and/or on input from physicians and other health care professionals?

I discussed this dilemma with Harry Ballan,[10] Dean of the Touro College Jacob D. Fuchsberg Law Center. Dean Ballan and I discussed the need for the legal community to collaborate with other professionals including, but not limited to, scientists and physicians. As a result of our discussions, Touro Law Center's Aging and Longevity Institute plans to present a special program in June of this year titled "Dementia, Science and the Law: A Need for Mutual Collaboration."

Elkhonon Goldberg, Ph'D, ABPP-CN,[11] an internationally renowned neuropsychologist and cognitive neuroscientist, provided Dean Ballan and I with insight as to the importance of an inter-disciplinary collaboration:

> Increased longevity has resulted in profound demographic changes characterized by a large number of aging individuals with dementia in society. This has brought forth a host of unique legal issues requiring novel approaches and deeper understanding of the nature of the clinical conditions at hand. One set of issues involves the assessment of the elderly individual's competence to make testamentary, legal, medical, financial, and business decisions. Another set of issues relates to the diminished capacity of an elderly individual perpetrating a criminal act, e.g., traffic accident with grave consequences due to "driving while demented," shoplifting, or other antisocial behaviors due to dementia. Yet another set of issues relates to an accurate causal attribution of cognitive impairment (e.g., is it due to a medical procedure, an injury suffered in a fall, or due to a preexisting dementia).
>
> A casual reliance on courtroom "common sense" falls short in addressing these issues. An aging individual may have an intact bank of general knowledge, relatively intact memory, and even a rhetorical ability to answer questions whether it is OK to shoplift if you don't have enough money to buy what you want, to run a red light when in a hurry, or to trust total strangers with your money, yet be unable to make sound decisions and exercise sound judgment in real life. Such breakdown of judgment and decision making is caused by an impairment of so-called executive functions, which is among the earliest manifestations of dementia and can be quite elusive to the untrained eye of a lay person or a lawyer.
>
> To accurately address these and many other issues arising on the intersect of dementia and the law, special expertise and specialized procedures are often required. The field of neuropsychology offers such expertise, as well as specialized neurocognitive tests designed to be sensitive to cognitive impairment and to assess various aspects of cognition in a precise quantitative way. If this approach to diagnosis were to be adopted or even considered by the courts, the jurisprudence of capacity could be significantly, perhaps dramatically, altered. That could be a signal moment in reconciling legal and scientific concepts in the interest of justice and the fair administration of the law.

Both Dean Ballan and Dr. Goldberg recognize that the dementia epidemic requires a joint "medico-legal" partnership.

The legal community has and also needs to continue to partner with representatives of state government to ensure that the dementia-induced legal needs of all New Yorkers are met. In this light, I was able to facilitate the formation of New York State Legal Services Initiative, which is a collaboration of NYSBA, the New York State Office of Court Administration (OCA), the New York State Office for the Aging and other state agencies. According to Vera Propser, Ph'D,[12] who recently retired as the Initiative's director:

> The Initiative's Partnership was established in 2012 and is an effective collaboration at the policy level among the legal community, the court system, and the human services networks. Promoting this same type of collaboration at the community level is a major goal of the Partnership's activities.
>
> We have found that where such collaboration exists, everyone involved in a client's presenting problem understands how the social, health, legal, and familial factors shaping that problem are having an interac-

tive impact, and that addressing individual factors or issues in isolation often leads to repeated occurrences of the same problem. The Initiative's activities promote using a collaborative, holistic approach to more successfully effect a sustained resolution of a client's situation. Such an approach is particularly important when assisting caregivers, who, in addition to assuming responsibility for the problems and issues of the family member receiving the care, can experience their own physical and emotional stress, health decline, financial problems, job loss, marital or family discord, and other problems as a result of the caregiving responsibilities. The multiple impact of caregiving duties is exacerbated when the individual requiring care and assistance has Alzheimer's Disease, other forms of dementia, or a developmental and/or intellectual disability.

As best told by Greg Olsen,[13] acting director of the state Office for the Aging, the Legal Services Initiative is a collaboration that actually provides meaningful data and assistance:

> It became increasingly clear that significant numbers of older individuals, persons with disabilities and families could not find access to affordable legal help in civil matters. The intent of the State's Legal Services Initiative was to move from anecdote to science via 7 statewide surveys to understand in more depth the experiences of individuals, judges and lawyers and to use that data to set priorities and to develop actions and strategies that will enhance the availability of affordable legal assistance and help people gain access to this assistance.
>
> While the Initiative focused on the status of legal service for older adults, people of all ages with disabilities, and the unpaid caregivers of these two populations, the activities that the Initiative's Partnership is employing will have a positive impact across all community members. For example, "access" is affected by the quality of communication skills. As an activity to improve access, the Partnership is developing a CLE training course that is meant to improve the effectiveness of communication between attorneys from all legal disciplines and their clients, many of whom have various types of disabilities, or are experiencing aging-related physical and cognitive changes, or have limited English-speaking ability, or their cultural norms and expectations differ from other population groups. Another example is a program of community-based Learning Sessions that will be available to all community members. The intent is to increase understanding of legal topics (such as power of attorney, hospital observation status, understanding dementia), legal processes (such as guardianship, eviction, child custody), court room procedures, and alternative resources for affordable legal help. These learning sessions can help individuals and families better understand situations they encounter and can help prepare them for actively taking alternative actions before problems turn into crisis situations.

Acting Director Olsen and Dr. Prosper both mention the challenge for family members of individuals with dementia. Bob Lipp[14] provides insight regarding the practical and common non-legal challenges attorneys confront when meeting with an individual with dementia and family members:

> When the subject of the conversation concerns a family member who has been diagnosed with dementia, it requires a sensitivity and understanding that addresses a range of issues. These issues run the gamut, from the psychological impact, to discussing and dealing with a myriad of business, financial and legal matters. The attorney's ability to relate to and appreciate the possibility that the client may be hampered by various levels of denial, guilt, fear, or even greed, make it incumbent upon him or her to be a great listener and to rely on non-verbal communication to fully understand and relate to the concerns of the client. It's a burdensome challenge for an attorney who may find themselves caught up in dealing with a range of human emotions, while addressing practical and necessary realities.

Putting the practical realities and family dynamics aside, attorneys often experience serious ethical challenges as they must confirm "who" is the client – the individual with dementia and/or the one or more family members. The following is a sample of potential family conflicts that may arise:

> 1. A commencement of a divorce action by the well spouse. Such an action may be commenced to expedite the eligibility of the spouse with dementia for Medicaid and other government programs, prevent the financial impoverishment of the well spouse and/or simply to enable the well spouse to move on and not be responsible to pay medical bills or provide care.
>
> 2. Concerns by some family members that the cost of care will reduce if not eliminate a possible inheritance.
>
> 3. Disputes as to how, by whom, and how often care should be provided.
>
> 4. What family members have a right to reside in or make a claim of ownership of the personal residence of the family member with dementia.
>
> 5. Disputes between children of first marriage and current spouse of individual with dementia.
> 6. Family members who pressure a loved one with dementia to change their estate plan.

The list could go on and on. The stress of caring for a loved one with dementia combined with an array of related financial concerns, emotional entanglements and the fear of the unknown often results in familial upheaval. When such scenarios occur, the ability to serve as a family attorney is difficult and arguably inappropriate as the objectives of two or more family members may be in conflict.

Challenges of a different nature occur when an attorney represents a third party and/or entity that is at conflict with an individual with dementia. While the attorney's ethical duty to his or her client is clear, non-legal factors may force the attorney to recommend that his or her client exercise restraint and sensitivity beyond what the law requires.

For example, Lawrence DiGiovanna,[15] Esq., provides the challenges that exist for attorneys representing landlords:

> In the context of a multiple dwelling, particularly cooperatives and condominiums, the landlord, has an obligation to maintain a level of quiet enjoyment for the residents, especially with respect to common areas of the building or outdoor portion of the property. This can be particularly challenging when an individual with Dementia is a member of the community. Possible offensive behaviors can range from excessive noise, and/or hoarding which presents fire hazard, to abusive and aggressive conduct although, perhaps, not criminal, to a resident's failure to observe basic hygiene standards of both their person and dwelling. The landlord or other management body is obligated to take action to suppress the disruptive conduct. Of course, this should be balanced with a compassionate concern for the welfare of the offending individual who is part of the community. Often it is appropriate to consult with Adult Protective Service or a similar agency for a possible intervention and to determine whether that will stem the conduct. Sometimes, family members can intervene.

The challenge of balancing the rights and interests of an individual with dementia and the rights and interests of others places ethical and legal obligations on all counsel. In a litigation context, for example, the attorney for a plaintiff who commences an action against an *ex parte* defendant who appears to have diminished mental capacity must inform the court and request the appointment of a guardian ad litem.[16] The question for the attorney (and the judge) is at what point does the defendant meet the statutory definition of a guardian ad litem, i.e., that the party is "incapable of adequately prosecuting or defending his rights.[17]

Possibly even more troubling for attorneys are the potential ethical and/or malpractice consequences when a working partner or employee in their law firm appears to be experiencing a cognitive decline and/or dementia. Moreover, many of us have witnessed and in some cases, provided legal services to judges and lawyers who have dementia.

Deborah A. Scalise,[18] a partner in the firm of Scalise & Hamilton, LLP, which focuses its practice on the representation of professionals in professional responsibility and ethics matters, shares her approach to recognize dementia in colleagues, in hopes of avoiding embarrassment or disciplinary action:

> For lawyers who lack capacity, the newly enacted Rules for Attorney Disciplinary Matters, effective October 1, 2016, at 22 N.Y.C.R.R. § 1240.14 titled Attorney Incapacity, provide for a lawyer to be suspended if he or she lacks capacity. Judges with dementia retire or are removed based on their conduct.
>
> Very often, a lawyer or judge with an exemplary 30- to 40-year career and an unblemished reputation hits a certain age, usually between their 60s and 70s, and complaints about their behavior or lack of judgment are filed. These complaints may be indicative of dementia. The complaining party is a client, an adversary, a coworker, an employee/former employee, or a litigant. The complaints are initially made to the lawyer or judge, who assures the complaining party that he or she will address the issue. If there is no response and the lawyer or judge works with others, the complaints are next made to their partners or an administrative judge. And, finally, when the complaining party is frustrated, he or she complains to either a Grievance Committee or the Judicial Conduct Commission. This is where an attorney or an administrative judge may have to get involved. They have the delicate task of identifying the issues in order to defend the lawyer or judge to protect their individual interests while balancing the interests of a law firm and its clients, or the court, and the litigants.
>
> The first tool is intake. Our firm has a client fill out client intake forms that request information, including date of birth; year of admission; jurisdictions where admitted; the number of pending complaints; whether the client has any history of complaints or has ever been sanctioned by any court or in any jurisdiction; and whether he or she has been subject to malpractice actions. The intake form provides invaluable information and clues prior to the consultation. For instance, the following answers raise issues that need to be explored in the interview: the number of recent complaints, sanctions, and/or malpractice actions within the last five years, and the lack of a prior history in a career that spans decades. While everyday problems

Attorneys often experience serious ethical challenges as they must confirm "who" is the client – the individual with dementia and/or the one or more family members.

such as business partnership break-ups, marital issues, or caring for a sick relative may contribute to erratic conduct, there are occasions where the answers to the aforementioned questions are telltale signs of dementia. Thus, it is crucial for an in-person meeting.

The person handling the complaint should not delegate this to someone else because of the sensitive nature of the issues. This is especially so because the lawyer or judge who may have dementia (or other mental health issues) may be adept at covering his or her erratic behavior and/or may not even be aware that his or her behavior is erratic. And, I am sure that we can all agree that lawyers and judges are persuasive, so, in all likelihood, they will be on their best behavior to get the interviewer to like, agree with, and defend them. A seasoned lawyer or administrative judge should have the requisite experience to observe and scrutinize the lawyer's or judge's behavior.

Sadly, a few of us have even participated in guardianship matters where the incapacitated person was a former judge or lawyer who failed to plan.

At the beginning of the interview, the facts surrounding the complaint, including a chronological account of what happened, should be discussed with the lawyer or judge present, and in turn, the lawyer or administrative judge to observe. While the lawyer or judge may be upset by the complaint, his or her answers to the following questions are useful: does he or she have command of the facts and is his or her reasoning logical? Does he or she provide incomplete facts or lack recall of the facts? Are they missing documents? Is his or her reaction to the questions posed disproportionate to what is asked, such as a tirade in response to a simple factual question or giggling when you mention that they may be subject to discipline for their behavior? These are all telltale signs of dementia.

The following questions during the interview are also helpful in every case alleging misconduct. They allow us to determine whether outside factors are causing or contributing to the questionable behavior or judgment:

1. Have you been diagnosed with any medical issues over the past five years? If so, what are they, when were you treated and by whom?
2. Have you been treated for any emotional or other mental health issues, including addiction to drugs or alcohol, over the past five years? If so, what are they, when were you treated and by whom?
3. Are you taking any medication?
4. Have you participated in any 12-step programs like Alcoholics Anonymous, Narcotics Anonymous, or Gamblers Anonymous?
5. Have you ever been arrested or convicted of a violation, a misdemeanor or a felony?
6. Have you been involved as a caregiver for any family member for medical or psychological or addiction issues? If so, what were they diagnosed with?

I turn to the New York Rules of Professional Conduct (RPC) at 22 N.Y.C.R.R. § 1200 Rule 1.14 – Client with Diminished Capacity, which sets forth an attorney's obligations when dealing with clients whose capacity is questionable. Rule 1.14 has three sections that appear to permit the attorney to use reasonable judgment to determine whether the client has the "capacity to make adequately considered decisions in connection with a representation is diminished, whether because of minority, mental impairment or for some other reason . . . ." and "the lawyer shall, as far as reasonably possible, maintain a conventional relationship with the client." If the lawyer has done so and is unable to maintain the relationship, he or she looks to the next section, RPC 1.14(b), which provides,

> [w]hen the lawyer reasonably believes that the client has diminished capacity, is at risk of substantial physical, financial or other harm unless action is taken and cannot adequately act in the client's own interest, the lawyer may take reasonably necessary protective action, including consulting with individuals or entities that have the ability to take action to protect the client and, in appropriate cases, seeking the appointment of a guardian ad litem, conservator or guardian.

However, RPC 1.14(c) provides the following caveat:

> Information relating to the representation of a client with diminished capacity is protected by Rule 1.6. When taking protective action pursuant to paragraph (b), the lawyer is impliedly authorized under Rule 1.6(a) to reveal information about the client, but only to the extent reasonably necessary to protect the client's interests.

Therefore, lawyers dealing with a client with dementia must carefully navigate these issues to ensure they are protecting the client's interests and they may not substitute their judgment for that of the client. If it is necessary to contact a relative or request that the court appoint a guardian, the lawyer must abide by the client's directives, until someone can make decisions for the client. This issue is more difficult when the person with dementia is a lawyer or judge, because they, as officers of the court, are entrusted with protecting

> the interests of their own clients or the litigants who appear before the court.
>
> I submit that we, as a helping profession, should do our best to compassionately assist any lawyer or judge afflicted with dementia, who has had an exemplary career and who has well served the legal profession, to retire with his or her reputation intact.

Sadly, a few of us have even participated in guardianship matters where the incapacitated person was a former judge or lawyer who failed to plan. Timothy E. Casserly, Esq., CFP,[19] shares his experience:

> I've worked with a number of lawyers and judges on their estate plans, but it's surprising how many of those are in their 70s and 80s who had nothing in place until we met. Too often, it's the classic case of the shoemaker's kids going barefoot as these lawyers do not have a basic will, power of attorney or health care proxy.

Hopefully, this issue of the *Journal* will motivate all of us to plan for ourselves, family members and our clients and, as Joan Robert, Esq.[20] reminds us, allow us to meet the needs of our clients in a timely, sensitive and humane manner:

> Representing a client with diminished capacity presents ethical and practical dilemmas for the attorney. The ethical rules direct that as attorneys, we must maintain as normal an attorney-client relationship as possible. We must present the client's known wishes and advocate for his/her position. However, as human beings, we may wish to act in the best interest of the client, recognizing that the client's stated position may not be beneficial to him/her. When our client is no longer able to communicate, we must gauge the motivation and veracity of others furnishing us with information upon which we base our advice. In our practices, we must not lose sight of the fundamental ethical question: who is the client? Once we identify and remember whom we are representing, courts with the expertise and sensitivity to handle these matters should enable good outcomes to prevail. ■

1. Michael Miller, Esq., Law Office of Michael Miller; President Elect Nominee, New York State Bar Association.

2. Robert M. Freedman, Esq. is a partner at the law firm of Schiff Harden, LLP. In 2016, Mr. Freedman received a lifetime achievement award from NYSBA's Elder Law Section.

3. Honorable Justice H. Patrick Leis, III, Supreme Court, Suffolk County.

4. *In re Buffalino (James D.)*, 39 Misc. 3d 634 (N.Y. Sup. Ct., 2013).

5. *Christopher C. v. Bonnie C.*, 40 Misc. 3d 859 (N.Y. Sup. Ct., 2013).

6. Honorable Justice Thomas P. Aliotta, Supreme Court, Richmond County, is an experienced and respected Guardianship judge.

7. MHL § 81.15 (c)(7) (McKinney 2004).

8. MHL § 81.29 (a) and (b) (McKinney 2010).

9. MHL § 81.01 (McKinney 1992).

10. Harry Ballan, Dean of the Touro College Jacob D. Fuchsberg Law Center.

11. Elkhonon Goldberg, Ph'D, ABPP-CN, clinical professor of Neurology, NYU School of Medicine; to learn more about executive functions and their breakdown, see Elkhonon Goldberg, *The New Executive Brain: Frontal Lobes in a Complex World*, Oxford University Press, 2009.

12. Vera Prosper, Ph'D, Former Director, New York State Legal Services Initiative, New York State Office for the Aging.

13. Greg Olsen, Acting Director, New York State Office for the Aging.

14. Bob Lipp, founder of Communication Masters, www.communication-masters.net.

15. Lawrence DiGiovanna, Esq., Abrams, Fensterman, Fensterman, Eisman, Formato, Ferrara & Wolf, LLP.

16. CPLR 1201 provides the statutory circumstances under which a guardian ad litem is authorized or required in a civil action. More specifically, CPLR 1201 states, in relevant part, "[a] person shall appear by his guardian ad litem . . . if he is an adult incapable of adequately prosecuting or defending his rights." The procedure for the appointment of a guardian ad litem is provided in CPLR 1202.

17. CPLR 1201, 1203; *see* Practice Commentaries on CPLR 1203; *1234 Broadway LLC v. Feng Chai Lin*, 25 Misc. 3d 476, 483 (Civ. Ct., N.Y. Co. 2009); *see, e.g.*, *Mills v. Mills*, 111 A.D.3d 1306, 1307 (4th Dep't 2013); *see also* Stedmans Medical Dictionary 437900 (defining mental impairment as "a disorder characterized by the display of an intellectual defect, as manifested by diminished cognitive, interpersonal, social, and vocational effectiveness and quantitatively evaluated by psychological examination and assessment").

18. Deborah A. Scalise, Esq., is the immediate past Chair of the NYSBA CLE Committee and a member of the NYSBA Committee on Attorney Professionalism. She has served as Vice President of the Women's Bar Association of the State of New York (WBASNY), where she also serves as the Co-Chair of the Professional Ethics Committee. She is a Past Presi-dent of the Westchester Women's Bar Association and the White Plains Bar Association. She is the former Deputy Chief Counsel to the Departmental Disciplinary Committee for the First Judicial Department.

19. Timothy E. Casserly, Esq., CFP, Burke & Casserly, P.C.

20. Joan Robert, Esq., Kassoff, Robert & Lerner.

BY DAVID PAUL HOROWITZ

David Paul Horowitz (david@newyorkpractice.org) is a member of Geringer, McNamara & Horowitz in New York City. He has represented parties in personal injury, professional negligence, and commercial cases for over 26 years. In addition to his litigation practice, he acts as a private arbitrator, mediator and discovery referee, and is now affiliated with JAMS. He is the author of *Bender's New York Evidence* and *New York Civil Disclosure* (LexisNexis), as well as the most recent supplement to *Fisch on New York Evidence* (Lond Publications). Mr. Horowitz teaches New York Practice at Columbia Law School and lectured on that topic, on behalf of the New York State Board of Bar Examiners, to candidates for the July 2016 bar exam. He serves as an expert witness and is a frequent lecturer and writer on civil practice, evidence, ethics, and alternative dispute resolution issues. He serves on the Office of Court Administration's Civil Practice Advisory Committee, is active in a number of bar associations, and served as Reporter to the New York Pattern Jury Instruction (P.J.I.) Committee.

"Object, Reject, . . . & Move?"

Introduction

October's column promised a sequel to "I Gotta Guy For That." Alas life, in this case the Court of Appeals' October 20, 2016, unanimous decision in *Rivera v. Montefiore Med. Ctr.*,[1] upended that plan. So, for now, the sequel must wait.

Readers of this column may remember the last time *Rivera* made an appearance: two years ago (to the day) in "You Better Object . . . Now!"[2] The facts then, as now, were that a jury returned a verdict in favor of the plaintiff for the wrongful death of Wilbur Rodriguez, 44, who arrived at Montefiore Medical Center's ER with respiratory distress at 15 minutes before midnight, was admitted to a unit without continuous patient monitoring with a working diagnosis of pneumonia, and died in the hospital between 4 and 4:40 early the next morning.

Rivera in the Supreme Court

At trial, plaintiff moved to preclude any testimony by defendant's medical expert "regarding any possible causes of the decedent's death as defendant's expert exchange did not comply with the requirements of CPLR § 3101(d), in that, it was not specific." At oral argument, "[d]efendant opposed the application as untimely because, plaintiff previously objected to the expert exchange as it did not contain information about the expert's residency (which the parties resolved), but failed to reject the expert exchange as not being specific." The court denied plaintiff's motion, the defendant's expert testified about the cause of death, and a verdict was returned for the plaintiff.

Both sides made post-trial motions, and the trial court denied plaintiff's post-trial motion seeking, *inter alia*, an order "striking from the record all testimony that the decedent died from sudden cardiac arrest:"[3]

> Admission of an expert's testimony is at the trial court's discretion. The facts upon which the expert's testimony is based must be established or "fairly inferable" from the evidence, rather than based on speculation or guessing. Here, plaintiff's motion to strike defendant's expert opinion regarding the cause of death as sudden cardiac arrest is denied as it was untimely made at the time of trial.[4]

Rivera in the First Department

On appeal, the First Department affirmed:

> We reject plaintiff's challenge to the aspect of the order that declined to strike the testimony of defendant's expert, Dr. Marc Silberman, in which he asserted that the cause of the decedent's death was a sudden, unexpected cardiac arrhythmia. Plaintiff's in limine application during trial to preclude Dr. Silberman's testimony was properly denied as untimely. Plaintiff's argument at trial for precluding Dr. Silberman's testimony was based on the lack of specificity of defendant's CPLR 3101(d) statement. The statement recited, with regard to the causation of the decedent's death, that defendant's expert would "testify as to the possible causes of the decedent's injuries and contributing factors . . . [and] on the issue of proximate causation"; also included in its formulaic recitation was the assertion that "the grounds for the expert's opinion will be said expert's knowledge and experience . . . and [the] trial testimony."[5]

After reciting the requirements for expert disclosure, the court stated "upon receipt of this 3101(d) statement, the only objection that plaintiff voiced was that the expert's qualifications failed to include the dates of his residency, which deficiency defendant then cured. Plaintiff neither rejected the document nor made any objection to the lack of specificity regarding the cause of death."[6]

The court concluded:

> Having failed to timely object to the lack of specificity in defendant's expert disclosure statement regarding the cause of the dece-

dent's death, plaintiff was not justified in assuming that the defense expert's testimony would comport with the conclusion reached by the autopsy report, and plaintiff cannot now be heard to complain that defendant's expert improperly espoused some other theory of causation for which there was support in the evidence.[7]

Rivera in the Court of Appeals

The Court of Appeals framed, and answered, the question on appeal:

> The issue on this appeal is whether the trial court abused its discretion as a matter of law in denying as untimely plaintiff's motion to preclude the testimony of defendant's expert on the grounds that the CPLR 3101 (d) disclosure statement was deficient. We hold that it did not.[8]

After chronicling the prior decisions, the Court reviewed the broad discretion trial courts possess to supervise expert disclosure: "'A determination regarding whether to preclude a party from introducing the testimony of an expert witness at trial based on the party's failure to comply with 3101(d) (1) (i) is left to the sound discretion of the court' (citations omitted)."

The Court concluded:

> Plaintiff made her motion mid-trial immediately prior to the expert's testimony. Plaintiff argues that at the time of the expert exchange, she had no reason to object to the disclosure statement because the statement gave no indication that defendant would challenge plaintiff's theory of decedent's cause of death. Assuming defendant's disclosure was deficient, such deficiency was readily apparent; the disclosure identified "causation" as a subject matter but did not provide any indication of a theory or basis for the expert's opinion. This is not analogous to a situation in which a party's disclosure was misleading or the trial testimony was inconsistent with the disclosure. Rather, the issue here was insufficiency.
>
> The trial court's ruling did not endorse the sufficiency of the statement but instead addressed the motion's timeliness. The lower courts were entitled to determine, based on the facts and circumstances of this particular case, that the time to challenge the statement's content had passed because the basis of the objection was readily apparent from the face of the disclosure statement and could have been raised – and potentially cured – before trial. Accordingly, there was no abuse of discretion as a matter of law.[9]

Other Decisions

In *Dedona v. DiRaimo*,[10] a First Department decision following, and citing, the First Department decision in *Rivera*, a trial court precluded the plaintiff from presenting evidence, including expert testimony, against the defendant, based upon the defendant's *in limine* motion made after jury selection but before opening statements.

The First Department reversed, reinstated plaintiff's complaint, and ordered a new trial:

> The trial court improvidently exercised its discretion in granting the motion and in dismissing the complaint based on the preclusion of evidence. Defendants' argument that they had no notice of plaintiffs' theory and were unfairly surprised is unavailing. The theory concerning vascularization of decedent's left leg was adequately disclosed in plaintiff's original and supplemental bills of particulars. Further, while CPLR 3101(d)(1)(i) does not require a party to retain an expert at any particular time, here plaintiff served the CPLR 3101(d) expert disclosure notice about eight months before trial, which was sufficient notice. Furthermore, during that period, defense counsel were present at several pretrial conferences and raised no objections to the expert disclosure, nor did they reject the notice.[11]

Rivera is cited for the final proposition, *to wit*, that there was a waiver by the defendant of an objection to the plaintiff's expert exchange, in part, because the defendant did not object at the pretrial conferences conducted in the case.

So, under *DeDona*, it appears incumbent upon counsel to now advise their adversaries, at pretrial conferences (where there is generally no record of the proceedings), of the assorted shortcomings in their case, or risk having waived the right to object when the evidence is ultimately offered at trial.

In *Fermas v. Ampco Sys. Parking*,[12] defendant sought to amend its answer to assert an affirmative defense that plaintiff failed to use an available seatbelt. The trial court had initially denied the motion on procedural grounds, but on the second application, granted the motion:

> To that end, plaintiff can claim neither surprise nor prejudice. Plaintiff was aware of the existence of this defense as early as it was interposed by codefendants in January 2013. Moreover, moving defendants' expert witness disclosure clearly indicated that the expert was to be "expected to testify that plaintiff failed to mitigate all injuries she did or would have suffered by failing to make use of the seatbelts available to her in the vehicle in which she was traveling." It is of particular significance that plaintiff made no objection in response to this CPLR 3101 (d) exchange.[13]

In *Fermas*, the trial court uses *Rivera* to impose a burden on the plaintiff to object to defendant's expert disclosure because it advanced a defense theory not asserted in the defendant's answer. Plaintiff is penalized for not objecting to an expert disclosure for what is, in essence, a pleading defect.

What to Do Now?

I volunteered the following advice in my 2015 column on *Rivera*:

> Upon receipt, object to the expert exchange (making certain to

object to each and every potential defect and/or inadequacy in the exchange)?;

Upon receipt, reject the expert exchange?; and

Upon receipt, make a motion *in limine*?[14]

Two years on, I offer the same advice, with the understanding that the motion is, for now, a strategic option to be considered by counsel on a case–by-case basis.

Conclusion

When my sons were in elementary school their classes were visited by the local fire department and each came home excitedly instructing my wife and I that, in the event we found ourselves on fire (more likely to happen to me since I go to court regularly), we should "stop, drop, and roll." When each of you arrives home tonight, you can excitedly tell family and friends that, in the event they are served with an inadequate expert response, they should "object, reject, and (maybe) move."

Next month, the saga of the "guy" continues, unless another seismic legal (as opposed to political) event occurs. Until then, I hope 2017 is off to a good start and remember, though it doesn't feel like it today, as you read this column the days are already getting longer. ■

1. 2016 N.Y. Slip Op. 06854 (2016).
2. David Paul Horowitz, *"You Better Object . . . Now!"* N.Y. St. B.J. (January 2015) p. 18.
3. *Rivera v. Montefiore Med. Ctr.*, 2012 N.Y. Slip Op. 33671(U), *1 (Sup. Ct., Bronx Co. 2012).
4. *Id*. at *4 (citations omitted).
5. 123 A.D.3d 424, 425 (1st Dep't 2014).
6. *Id*. at 426.
7. *Id*.
8. *Rivera*, 2016 N.Y. Slip Op. 06854, *1–2.
9. *Id*. at *3.
10. 137 A.D.3d 548 (1st Dep't 2016).
11. *Id*. at *1–2 (citations omitted).
12. 2016 N.Y. Slip Op. 32096(U) (Sup. Ct., Queens Co. 2016).
13. *Id*. at *5 (citing *Rivera*, 123 A.D.3d 424 (1st Dep't 2014)).
14. Such a motion would, since it pertains to disclosure, require a good-faith affidavit pursuant to 22 N.Y.C.R.R. § 202.7.

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List as of November 23, 2016

ATTORNEY PROFESSIONALISM FORUM

To the Forum:

I have a new client that is a party to a number of related actions with many parties. My client's prior attorney was a solo practitioner and she recently passed away unexpectedly. My client relied on the prior attorney implicitly, doesn't have any of the voluminous files for the litigation, and believes that the attorney was holding money in her escrow account pending the resolution of the litigation. I have been in communication with the prior attorney's husband, who is attempting to wind up the law office. It is clear, however, that in addition to being completely distraught about the loss of his wife, he is not an attorney and doesn't have any idea what to do. He is so concerned that he is going to turn over the wrong files to the wrong person, or turn over files without having collected all of his wife's fees, that he just refuses to turn anything over. He isn't sure if he is going to try to sell the practice or just dissolve it. It doesn't seem like he will be able to resolve this quickly. Meanwhile, I am having a very difficult time moving forward with my client's cases without her file, and the client and remaining parties are beginning to lose patience.

Although I am sympathetic to the husband's dilemma, my client is beginning to suffer from the delays. I am worried that I am not doing enough to convince the former attorney's husband to assist me in getting the files and turn over the escrow funds. In our last conversation, he even asked me, "Do you have any thoughts about whether I should dissolve the practice or try to sell it? Would you be interested in purchasing it?" When I asked my client if he had fully paid the prior attorney's fees, the client told me he thought he might owe some fees, but due to the recent delay, he believed that he no longer had to pay them.

Is there anything I can do to encourage the prior attorney's unrepresented husband to turn over the file and escrow funds? Should I be concerned that I am trying to get the file even though the prior attorney may not have been fully paid by my client? I have also been thinking about the offer to buy the practice. Here, it would kill three birds with one stone: I would get the file for my client, help out the prior counsel's husband, and expand my practice. Would I create a conflict of interest with my client by performing due diligence and negotiating to purchase the practice? What if I wasn't buying the practice, but just offering to assist in dissolving the practice?

Sincerely,
Somewhat Conflicted

Dear Somewhat Conflicted:

Your dilemma is a cautionary tale for all solo practitioners who have not created a plan in the event that they should unexpectedly pass away or become disabled and unable to practice law. Rule 1.3(b) of the New York State Rules of Professional Conduct (RPC) states that a "lawyer shall not neglect a legal matter entrusted to the lawyer." Comment 5 to RPC 1.3 addresses the ramifications of an attorney who suddenly is unable to practice: "To avoid possible prejudice to client interests, a sole practitioner is well advised to prepare a plan that designates another competent lawyer to review client files, notify each client of the lawyer's death or disability, and determine whether there is a need for immediate protective action." Similarly, the American Bar Association has stated that "[t]o fulfill the obligation to protect client files and property, a lawyer should prepare a future plan providing for the maintenance and protection of those client interests in the event of the lawyer's death." ABA Comm. on Ethics and Prof'l Responsibility, Formal Op. 92-369 (1992). The New York State Bar Association (NYSBA) publishes an excellent tool to assist in creating such a plan entitled, *NYSBA Planning Ahead Guide: How to Establish an Advance Exit Plan to Protect Your Clients' Interest in the Event of Your Disability, Retirement or Death*. This free guide is available online and is highly recommended for any solo practitioner or practice that has not prepared an exit plan. *See* www.nysba.org/PlanningAheadGuide2016. Unfortunately, it appears that your client's prior counsel did not prepare such a plan and that you and your client are now left to unravel the difficult ramifications from that oversight.

As a general matter, Rule 321(c) of the N.Y. Civil Practice Law and Rules (CPLR) protects parties where their attorney unexpectedly passes away in that it prohibits further proceedings against the party, "without leave of the court, until thirty days after notice to appoint another attorney has been served upon that party either personally or in such manner as the court directs." However, it appears that you have already been substituted as new counsel and your client may no longer be entitled to this statutory protection. While we would hope that both opposing counsel and the judge on the matter would be sympathetic to your client's situation, and that you have explained your efforts to obtain the file, we are cognizant that opposing counsel similarly faces a diligence burden for their clients under RPC 1.3.

The Attorney Professionalism Committee invites our readers to send in comments or alternate views to the responses printed below, as well as additional hypothetical fact patterns or scenarios to be considered for future columns. **Send your comments or questions to: NYSBA, One Elk Street, Albany, NY 12207, Attn: Attorney Professionalism Forum, or by email to journal@nysba.org.**

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As we read your question, you are trying to obtain your client's files and escrowed funds in an expedited manner from the deceased lawyer's husband, a non-lawyer and unrepresented party, and there is a reasonable possibility that your client has conflicting interests with the deceased lawyer's estate due to your client's intent to contest legal fees owed to the estate.

As an initial matter, we note that RPC 4.3 governs your communication with the former attorney's husband because he is unrepresented. *See* RPC 4.3. It provides that an attorney "shall not give legal advice to an unrepresented person other than the advice to secure counsel if the lawyer knows or reasonably should know that the interests of such person are or have a reasonable possibility of being in conflict with the interests of the client." *Id*. Moreover, RPC 4.3 prohibits you from stating, or even implying, to the prior lawyer's husband that you are disinterested in his situation and, if you should reasonably know that the husband misunderstands your role in the matter, you must take reasonable efforts to correct the misunderstanding. *See id*. Therefore, it goes without saying that you should not assist him in dissolving the practice or otherwise. Indeed, if you have not done so already, you should make clear to the deceased lawyer's husband that you cannot provide him with advice concerning his wife's estate or law practice, other than to recommend to him that he hire counsel immediately to advise him on the various issues he is confronting as a result of his wife's death. *See id*.

With respect to the husband's refusal to turn over the files, we note that while the files belong to the client and the delays caused by his refusal may be problematic, the husband's position is not entirely unreasonable. The NYSBA Planning Ahead Guide states that "[c]are should be taken to safeguard against improper access to client files and information by unauthorized persons, *e.g.*, non-attorney family members." *NYSBA Planning Ahead Guide: How to Establish an Advance Exit Plan to Protect Your Clients' Interests in the Event of Your Disability, Retirement or Death* (2015), www.nysba.org/PlanningAheadGuide2016, at 7. The guide also states that if the "executor [of the solo practice] is not an attorney, it is important that he or she avoid inappropriate access to client files and information and rely instead on an attorney or office staff to attend to these matters." *Id.* at 9. These risks may be avoided if the husband were to retain counsel to review the files to make sure that only the appropriate files are turned over.

This analysis applies even if you are engaged in discussions to potentially buy the deceased attorney's practice. Indeed, RPC 1.17(b) specifically restricts the information that a seller may disclose to prospective buyers providing that only certain information about clients may be disclosed, such as the identity of the clients, the status and general nature of the matters, material available in public court files, and the financial terms and payment status of the clients' accounts. *See* RPC 1.17(b)(2). Absent the informed consent of the client, the seller is prohibited from revealing confidential information or information that would cause a violation of the attorney-client privilege under RPC 1.6. *See* RPC 1.17(b)(1), (5). While RPC 1.17 does not explicitly state that a non-lawyer is prohibited from providing prospective buyers with information as to individual clients, an attorney is clearly needed to review the files to assess which materials are confidential and protected by attorney-client privilege.

The husband's concern about releasing the funds held in the practice's escrow account is similarly a legitimate one. As a non-lawyer, the husband is prohibited from being an authorized signatory to the escrow account. *See* RPC 1.15(e) ("Only a lawyer admitted to practice law in New York State shall be an authorized signatory of a special account."); NYSBA Comm. on Prof'l Ethics, Op. 693 (1997) ("[I]t is clear that only a lawyer may control the lawyer's client escrow account and be a signatory of it"). RPC 1.15(g) identifies the procedure regarding control of escrow accounts where the sole signatory attorney on the escrow account passes away. It requires an application to the Supreme Court of the State of New York for an order designating a successor signatory for the escrow account who is a member of the bar and admitted to practice in New York. *See* RPC 1.15(g)(1). This application may be made by, among others, a legal representative of the deceased lawyer's estate or any person who has a beneficial interest in the funds in the escrow account, such as your client. *See* RPC 1.15(g)(2). The New York Supreme Court can then designate a successor signatory and direct the disbursement of escrowed funds where appropriate. *See* RPC 1.15(g)(3).

In light of the foregoing ethical considerations, if you find that the husband is not inclined to retain an attorney for the estate, or is not acting expeditiously to hire one, your best option here may be to move before the appropriate court for an order directing that the files be turned over and appointing a successor signatory to the escrow bank accounts pursuant to the procedure set forth in RPC 1.15(g). *See In re Hickey*, 142 A.D.3d 753, 754 (3d Dep't 2016) (application made by Tompkins County Bar Association for the appointment of one or more attorneys as custodian of the files of a law office of a solo practitioner who died without a plan for his practice after his death and for the appointment of a successor signatory to decedent's law office and escrow bank accounts under RPC 1.15(g); granting bar association's motion to become a limited custodian of the law office files, but denying the motion for appointment of a successor signatory on the escrow account, without prejudice, because the motion failed to comply with procedure set forth in RPC 1.15(g)(2).) A motion would circumvent any conflicts that may arise from any direct communications with the husband, and may also ultimately encourage the husband to retain an attorney to review the files and make determinations as to which files should be turned over. Even if the husband chooses not to retain counsel once you have filed your motion and

proceeds *pro se*, at that point, a judge is likely to appoint a custodian of the law firm's files and successor signatory to the attorney's escrow account in order to protect the deceased lawyer's clients' funds.

The decision to make such a motion and have a successor signatory appointed is not without risks to your client. If an attorney is appointed by the court as a successor signatory, the outstanding legal fees issue is likely to be brought to the forefront since the successor signatory will likely review the file, and any outstanding charged fees, before releasing any escrowed funds or your client's files for that matter. Even though you may have replaced the former attorney as counsel of record in the litigation, the estate may claim a retaining lien and retain the file until the estate has been paid. *See* RPC 1.8(i)(1) (a lawyer may "acquire a lien authorized by law to secure the lawyer's fee or expenses"); *see, e.g.*, *Roe v. Roe*, 117 A.D.3d 1217, 1218–19 (3d Dep't 2014) ("A retaining lien . . . permits the discharged attorney to retain the contents of the client's file until such time as the attorney has been paid or 'the client has otherwise posted adequate security ensuring [the] payment [there] of'") (internal citation omitted); *Sec. Credit Sys., Inc. v. Perfetto*, 242 A.D.2d 871, 871 (4th Dep't 1997) ("Plaintiff submitted no proof that defendant was discharged for cause. Thus, defendant was entitled to reimbursement for his disbursements before returning the files to the client."). In any event, this may nevertheless be the best option to get what you need.

With respect to your interest in potentially purchasing the deceased lawyer's practice, we see two issues: (1) the husband may not be in a position at this time to make decisions regarding the sale of the practice unless he has been appointed as a legal representative of the deceased lawyer's estate; and (2) you should know that you will not be able to pick and choose which cases you want and do not want to take over from the practice. The estate's sale of the law practice is controlled by RPC 1.17, and provides that the personal representative of a deceased lawyer "may sell a law practice, including goodwill, to one or more lawyers or law firms, who may purchase the practice." RPC 1.17(a). According to Professor Roy Simon's annotation on RPC 1.17(a), this section "will not come into play unless a court appoints a legal representative" for the deceased lawyer. Roy Simon, *Simon's New York Rules of Professional Conduct Annotated*, at 983 (2016 ed.). Moreover, the rule "requires that the seller's *entire* practice be sold" and that "[t]he buyers are required to undertake all client matters in the practice subject to client consent." RPC 1.17 Comment 6. The purpose of this rule is to protect the clients whose matters are less lucrative and might have a hard time finding other counsel. *See id.* Accordingly, unless a court has already appointed the husband as the legal representative for his wife's estate, he may not even be able to sell the practice at this point and he certainly cannot sell off certain cases.

But even if a legal representative has been appointed for the estate, and that legal representative approaches you about a potential sale offer, a conflict of interest may exist here with your current client, which may prevent you from purchasing the practice unless certain conditions are met. Specifically, RPC 1.7(a)(1) prohibits representation of a client if a reasonable lawyer would conclude that "the representation will involve the lawyer in representing different interests." RPC 1.7(a)(1). Comment 10 to RPC 1.7 notes that, "[t]he lawyer's own financial, property, business or other personal interest should not be permitted to have an adverse effect on representation of a client." *Id*. If you are seeking to have the seller turn over litigation materials and escrowed funds for your client at the same time you are negotiating the purchase price of a solo practice for your personal benefit, your client's needs could become a source of leverage in the sale negotiation thereby creating a significant conflict of interest between you and your client. Professor Simon examines a similar risk in his discussion of payments to non-lawyers after an attorney's death under RPC 5.4(a)(2). *See* Simon, *Simon's New York Rules of Professional Conduct Annotated*, at 1424 ("The drafters [of the RPC] may have believed that there would be too great a risk that a widow, child, or relative of a deceased lawyer would seek to influence the handling of a particular pending matter in order to increase or expedite the payment of the deceased lawyer's share."). You may be able to avoid the conflict by resolving the file, escrow, and attorney fee issues to your client's satisfaction before considering the sale offer and then obtaining the informed consent of your current client in writing (*see* RPC 1.7(b, d)).

The unexpected death or disability of an attorney will be devastating to family, coworkers, colleagues, and clients on a personal level and creates numerous issues particularly where there is no plan in place providing for the continuity of the law practice and maintenance and protection of client files and interests. The designation of an another attorney to manage or dissolve a solo practice in the event of death or disability, with basic written instructions and authorizations for the designated attorney, should be considered a bare minimum for all solo practitioners. In other words, it is wise to plan ahead for the benefit of your family and clients. For substituting counsel, your best option to retrieve your client's files and funds is to recommend to the unrepresented party that he retain counsel immediately and to communicate with the attorney assuming responsibility for the client files of the deceased lawyer. Alternatively, you should make a motion to the appropriate court seeking an order directing that the files and escrowed funds be turned over to you.

Sincerely,

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BECOMING A LAWYER

BY LUKAS M. HOROWITZ

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Contracts, Torts, and Property, Oh My!

What a semester it has been. Midterms, objective memos, unhealthy quantities of coffee, a presidential election, and, in the next two weeks, finals. The thought of finals brings to mind a line from one of my favorite childhood movies, "The Wizard of Oz." In the words of the Cowardly Lion, "Talk me out of it!" Feeling a bit like the Andrea Gail in "The Perfect Storm," I remind myself that all storms pass, and with every passing storm comes a new day.

Finals came so quickly, the first sign being the notification that the library, my home away from home, was extending its already generous hours. I have never spent so much time in a single place, and I know every ceiling tile above my study carrel. While I joke about it being a second home, I will enjoy the long holiday break from the library.

As I gear up for what I expect will be a difficult finals period, I cannot help but notice that I am quite the different 1L than I was three short months ago. While I am by no means proficient in the language of law, I have acquired a few key phrases. My uncle Brian once told me the most important thing to know in another language is to be able to ask, "Where is the bathroom?" Within the language of law, I am confident that I can, at the very least, navigate to the bathroom. The only thing different about the language of law is that the answer will probably be something along the line of "There are several possible bathrooms, and some of them are correct, however, one is the most correct."

I have been thinking quite a bit lately about how I have changed in the last three months, and ask myself from time to time: What is the most important take-away from my first semester at law school? Surprisingly, it sounds more physical than mental. Put simply, it is that I can work in a way I did not think possible in late August. Did I ever think that I could spend 60 hours a week working? Never! Read hundreds of pages a week, and describe it as, "Oh yeah, homework?" Impossible! I am actually capable of far more than I gave myself credit for.

So the rewards of choosing to attend law school, and pursue a career in law, have made up for the sleep deprivation, caffeine-heavy diet, and constant intestinal distress. Things just seem

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QUESTION FOR THE NEXT ATTORNEY PROFESSIONALISM FORUM

I am the managing partner in a 50-plus attorney firm. We are in the process of re-evaluating our document retention policies for closed litigation and transactional files. While some attorneys at my firm retain their files indefinitely, others destroy their client files 30 days after the representation has concluded. We would like to develop a firm policy, not only for consistency sake, but primarily to reduce the costs associated with the mounting volume of documents being stored in our records department, off-site and on our servers.

What are our ethical obligations to retain and preserve client files after the matter has concluded? After a litigation has been resolved, either through a settlement or judgment, must we continue to maintain the client's files, and if so, for how long? Are the rules the same for transactional matters? How long after a transaction has closed or been completed before we can destroy the client files for that representation?

I am also concerned about electronic files and emails, since I recently learned from one of my partners that he routinely deletes all emails after reading them and does not keep copies of "sent" emails. Do lawyers have an obligation to keep emails?

Does the firm have an obligation to notify our clients before destroying the files? One of our partners destroyed his copies of a client's transactional documents 30 days after the deal closed. The client called a year after that deal closed asking for the files and has threatened to sue the firm because those files were destroyed. The partner never contacted the client to tell him that he was disposing of the files. However, our engagement letter with that client expressly provides that we can dispose of the client's files upon the conclusion of the engagement. We understood that to be permissible but would appreciate your guidance.

Sincerely,

John Q. Manager

they create to realize the testator's intent.[15]

This is no easy task. Will drafting requires attention to detail, difficult and sensitive question asking, a thorough understanding of many EPTL and SCPA provisions, as well as, quite often, banking, real-property, tax, and business corporation, LLC, and partnership laws. The extraordinary number of reported and unreported decisions construing will terms and declaring parties' rights shows what happens when a will is unclear.

Identifying Beneficiaries

Perhaps most fundamental to will clarity is accurately and completely identifying the intended beneficiaries. Full names, including middle names or initials, and relationship to the testator are essential. If a name is common or if more than one person in a family shares a name, it's appropriate to include the address of the beneficiary when the will is drafted.

Another area of importance in identifying beneficiaries is to name charitable organizations. Charities might have similar names. Charities may have multiple offices and divisions, or be located in more than one country. Drafting clearly which branch of a charity the testator wishes to benefit is important to avoid litigation among charities or between divisions of the same charity.[16]

Revocatory Effect of Divorce

It's also important to identify a spouse by name. This is so especially when gifts or powers of appointment are made to prior spouses or to avoid any question of which spouse the testator desires to be buried or interred with. When it comes to anticipating divorce, EPTL § 5-1.4(a) provides that divorce or annulment has the effect of revoking any testamentary gifts to a spouse named in a will.[17] EPTL § 5-1.4(a) is one of the EPTL sections that contains a set of words to opt out of the statute.[18] In this case, the words in EPTL § 5-1.4(a) are "Except as provided by the express terms of a governing instrument. . . ." Thus, it's possible to draft a will making a testamentary gift to a former spouse if that's the testator's desire. The potential for litigation on this issue heightens the importance of drafting clearly, precisely, and specifically.

Divorce or separation also has the effect of revoking a nomination of a spouse as executor or trustee.[19] This revocation, however, doesn't apply to the spouse's family members.[20] It's important for the estate-planning attorney to discuss what the testator's wishes are concerning the in-laws in the event of a divorce so that the will can be drafted to contemplate what happens to appointments of in-law fiduciaries upon divorce. In *In re Lewis*, the Court of Appeals in dicta agreed with Surrogate's Court that even though the decedent divorced her husband in 2007, her nomination of her father-in-law in a 1996 document purported to be her last will and testament was not revoked by the divorce.[21] This might not necessarily be a clarity issue. Nevertheless, if the will had provided for the revocation of the appointment of the father-in-law upon divorce, the *Lewis* case might never have arisen.[22]

An area ripe with pitfalls concerns bequests of tangible personal property.

Identifying Who Gets What

Bequests must be written clearly.[23] Consider the following bequest: "I give the sum of $50,000 to my friend John D. Rockefeller and his wife, Laura." Does that mean John gets $50,000 and Laura gets $50,000? Do they share the $50,000? Who gets the $50,000 if John and Laura don't survive the testator? Do they both have to survive? Instead, assuming that the testator wants to give $50,000 each to John and Laura, it would be best to draft separate bequests for each of them: "I give the sum of $50,000 to my friend John D. Rockefeller, founder of Standard Oil, if he survives me. If he does not, then I give make this gift to his wife, Laura, if she survives me." Create a reciprocal bequest to Laura first and then contingently to John. So drafted, the bequests are clear, independent, and not subject to construction.[24]

Identifying the Property and the Bequest

An area ripe with pitfalls concerns bequests of tangible personal property. It's customary to draft will clauses giving specific items of the testator's tangible personal property to particular persons. For example, a testator might make a specific bequest as follows: "I give and bequeath my collection of vintage Libby glassware, regardless of what design, pattern or condition, wherever located, to Edward J. McLaughlin, if he survives me." Clear enough, but many cases demonstrate pitfalls for the unwary.

In *In re Estate of Phillips*, the decedent owned a house on a small lot and 88 acres of farmland adjacent to the lot the house was on. His will gave his "house and the plot of land appurtenant thereto" to his girlfriend and the residuary to his daughters. The Surrogate found that the preresiduary language unambiguously meant the house, the lot, and the farmland. On appeal, the Appellate Division ruled that it was impermissible to assume that the decedent knew what "appurtenant" meant and remitted the case to the Surrogate to consider extrinsic evidence.[25]

Once the specific bequests of "things" are drafted, or if there're no specific bequests, a clause giving the testator's tangible personal property is typical. It might read like this:

> I give my tangible personal property including without limitation, wearing apparel, personal effects, jewelry, furniture, furnishings, pictures, paintings, and other objects of art, silver, china, glassware, and other household effects, books, and automobiles to my children

who survive me, to be divided among them in substantially equal shares as they may agree. To the extent my children do not agree, my executor shall make a determination how to distribute or to sell the property and my executor's decision is final, absolute and unreviewable by any person interested or court of law.

Seems clear enough, but in *In re Estate of Rothschild*, the court found that a collection of stamps and coins worth millions of dollars wasn't part of the bequest of tangible personal property but rather investment property that passed to the remainder beneficiary, which was a charity.[26] This was so despite the words "without limitation" in the will.[27]

A contrary result was reached in *In re Estate of Faggen*,[28] in which the court found that a coin and medallion collection was part of the specific bequest of tangible personal property because that bequest contained the words "of every kind" and, the court reasoned, the testator clearly favored his spouse over the remainder beneficiary.

Digital Assets and RUFADAA

Perhaps one of the newest areas warranting clarity in drafting is accessing and controlling digital assets.[29] Nothing is new about disputes between executors and the service providers who act as gatekeepers and custodians of digital assets and accounts over who may access digital assets. The main area of contention has been whether the Terms of Service (TOS) agreement or a decedent's will controls who may have access to digital-asset accounts. After much negotiation with service providers, many states have adopted the Revised Uniform Fiduciary Access to Digital Assets Act (RUFADAA). It provides a three-tiered approach: (1) Directions given in an online tool on the Web site of the service-provider controls; (2) if none, or if no tool is available, then directions in the user's will or other document (*e.g.*, will or power of attorney) prevails; (3) absent either an online tool or the decedent's written direction, the TOS agreement controls. The legislature introduced New York's version of RUFADAA this year. On September 29, 2016, Governor Cuomo signed the bill into law.[30] It took effect immediately.

Conclusion

The topics in this column are but a few examples noting the importance of clear will drafting. The Legal Writer encourages readers to consult one of the several excellent treatises on New York will drafting and estate planning before drafting a will. ■

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1. A testator, most usually the client, is the living person who makes an oral declaration or puts in writing and declares the document to be the last will and testament. Once the testator dies, the testator is called the decedent.

2. Estates, Powers & Trusts Law (EPTL) § 1-2.19(a).

3. *See* Surrogate's Court Procedure Act (SCPA) § 1420(1-5). For some cases and an article on this topic, see *In re Estate of Bieley*, 91 N.Y.2d 520, 522, 695 N.E.2d 1119, 1120, 673 N.Y.S.2d 38, 39 (1998); *In re Estate of Sponholz*, N.Y.L.J., June 16, 2014, at 17, col. 3 (Sur. Ct. Kings Cnty); *In re Estate of Phillips*, 101 A.D.3d 1706, 957 N.Y.S.2d 778 (4th Dep't 2012); *In re Estate of Gourary*, 34 Misc. 3d 486, 932 N.Y.S.2d 881 (Sur. Ct. N.Y. Cnty 2011); *In re Estate of Faggen*, N.Y.L.J., Mar. 3, 2010, at 33, col. 3 (Sur. Ct. N.Y. Cnty); *In re Estate of Pease*, 50 A.D.3d 132, 850 N.Y.S.2d 312 (4th Dep't 2008); *In re Estate of Richard*, N.Y.L.J., July 7, 2003, at 20, col. 1 (noting that the goal of every construction proceeding is to "ascertain [the] decedent's intent in order that it may be effectuated"); 11 Linda B. Hershon, Andrew L. Martin, James D. Pagones, Eugene E. Peckham, C. Raymond Radigan & Joshua S. Rubenstein, *Warren's Heaton on Surrogate's Court Practice* § 187.01[4][a]-[b] (7th ed. 2016); Mary E. Mongioi. & Stephanie M. Alberts, *Draft Once, Proofread Twice: Take Extreme Care in Formulating Personal Property Bequests*, N.Y.L.J., Jan. 30, 2012, at S1.

4. *See* SCPA §§ 2205 & 2206; *In re Fabbri's Will*, 2 N.Y.2d 236, 238–39, 140 N.E.2d 269, 270, 159, N.Y.S.2d 184, 186 (1957) (determining how principal should be divided); *In re Estate of Chernik*, N.Y.L.J., Jan. 22, 2015, at 31, col. 3 (Sur. Ct. Suffolk Cnty) (construing tax clause); *Faggen*, N.Y.L.J, Mar. 3, 2010, at 33, col. 3 (accounting proceeding and tangible personal property).

5. New York is a solemn-probate jurisdiction. The person or bank named in a will is the nominated executor who'll become the executor only upon the court's issuing a decree admitting the will to probate and directing that letters testamentary issue to the executor. *See* Surrogate's Court Procedure Act (SCPA) §§ 1414(1), 1408(1) & 103(20).

6. An executor is a natural person who's eligible to receive letters as a fiduciary, SCPA § 707, or a financial institution authorized to act as a fiduciary, Banking Law (NYBL) §§ 100(4), 100-a(1), 131 & 201-b; SCPA § 103(20).

7. SCPA § 103(21).

8. *See Meinhard v. Salmon*, 249 N.Y. 458, 464, 164 N.E. 545, 546 (1928) ("A trustee is held to something stricter than the morals of the market place. Not honesty alone, but the punctilio of an honor the most sensitive, is then the standard of behavior."); *cf. In re Estate of Rothko*, 43 N.Y.2d 305, 320, 372 N.E.2d 291, 296–97, 401 N.Y.S.2d 449, 455 (1977) (applying *Meinhard* standard to executors).

9. Michael E. O'Connor *Estate Planning and Will Drafting* § 4.0, at 4-3. (N.Y. St. Bar Ass'n 2015).

10. Estate planning often involves will or testamentary substitutes, among which the most prominent is the revocable living trust. Jointly owned assets that pass by right of survivorship and contractual agreements with designated beneficiaries such as IRAs, 401k, pension and deferred-compensation plans, annuities, and life insurance are almost generally not "probate assets" unless there's no designated beneficiary or the estate is named as the beneficiary. Any further discussion of these topics exceeds the scope of this column.

11. *See, e.g.*, *In re Manufacturers & Traders Trust*, 42 A.D.3d 936, 937, 839 N.Y.S.2d 642, 643 (4th Dep't 2007); 11 Hershon et al., *supra* note 3, at §§ 187.01[2][a] & [4][a]-[b].

12. *E.g.*, *In re Estate of Cord*, 58 N.Y.2d 539, 544-45, 449 N.E.2d 402, 404–05, 462 N.Y.S.2d 622, 625 (1983); 11 Hershon et al., *supra* note 3, at § 187.01[5][a].

13. *See* EPTL § 1-2.19(a).

14. *E.g.*, *id.* § 5-1.4(a) ("Except as provided by the express terms of [the will]," a divorce, judicial separation, or annulment revokes bequests in the will to the former spouse, powers of appointment to the former spouse and nominations of the former spouse to serve in any fiduciary or representative capacity); SCPA § 806 (whenever an executor or testamentary trustee is appointed "who is required to hold, manage or invest real or personal property for the benefit of another, he shall unless the will provides otherwise, execute and file a bond"); EPTL § 11-1.2(b) ("Unless otherwise expressly provided by a will under which a disposition is made to or for the benefit of the surviving spouse. . . ."); EPTL § 2-1.8(c) ("Unless otherwise provided in a will or non-testamentary trust … (1) the [federal and state estate] tax shall be apportioned among the persons benefited in the proportion that the value of the property of interest received by each such person benefited bears to the total value of the property and interest received by all persons benefited. . . .").

15. O'Connor, *supra* note 9, at § 4.0, at 4-3.

16. *E.g.*, *In re Estate of Scale*, 38 A.D.3d 983, 985–87, 830 N.Y.S.2d 618, 620–22 (3d Dep't 2007) (finding

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that testator made a general bequest of cash to the Audubon Society of New York State but that two so-named societies were doing business in the New York).

17. EPTL § 5-1.4(a).

18. *Id.*

19. *Id.*

20. *In re Estate of Lewis*, 25 N.Y.3d 456, 459, 34 N.E.3d 833, 835, 13 N.Y.S.3d 323, 325 (2015) (remitting to Surrogate's Court to determine whether the 1996 instrument should be admitted to probate).

21. *Id.*, 34 N.E.3d at 835, 13 N.Y.S.3d at 325.

22. In 2015, legislation was introduced in both the New York Assembly and Senate that, if passed, will create a rebuttable presumption that dispositions and presumably nominations of fiduciary or representative capacity to relatives of ex-spouses are revoked. A.7638 & S.5684 (2015); Sharon L. Klein, NY's Latest Legislative Session: What Passed, What Didn't, What's Next, N.Y.L.J, Aug. 29, 2016, at S2, col. 1-6, S7, col. 1-3.

23. It's beyond the scope of this column to discuss at any length the different types of bequests. But there are general bequests ("I give $5000 cash to my son, Kenneth."); specific bequests ("I give my gavel collection to my daughter, Natalie."); demonstrative bequests ("I direct that my gavel collection be sold and the proceeds I give to my sister, Agnes."); and bequests of specific stock. For a thorough discussion of this topic, see O'Connor, *supra* note 9, at Chap. 4.

24. *See, e.g.*, *In re Estate of Levy*, N.Y.L.J., Dec. 18, 2009, at 34, col. 3 (Sur. Ct. N.Y. Cnty) (determining, in a trust that directed the trustee to pay the principal to the then-surviving issue of two grandchildren upon the two grandchildren's death, whether to pay principal upon the death of the first to die of the grandchildren or not until after all died).

25. *Phillips*, 101 A.D.3d at 1710, 957 N.Y.S.2d at 778. Similarly, in *In re Application of D'Elia*, the Surrogate found that when the will read that "I grant a life estate in the real property which I occupy as my primary residence at my death," the testator meant to give a life estate only for his upstairs apartment and not for the entire two-family home he owned when he died. 2005 N.Y. Slip Op. 51700(U), **2–3, 862 N.Y.S.2d 807, 2005 WL 2715662, at **1–2 (Sur. Ct. Kings Cnty).

26. N.Y.L.J., Oct. 28, 2014, at 22, col. 4 (Sur. Ct. Bronx Cnty).

27. *Id.*

28. N.Y.L.J., Mar. 10, 2010, at 36, col. 2 (Sur. Ct. N.Y. Cnty).

29. *See* Klein, *supra* note 22.

30. N.Y. Chap. L. 354 (Sept. 29, 2016).

Becoming a Lawyer
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less daunting now. Will I stress out over finals? Absolutely. Will I be able to control that stress and methodically move through my exams? I'll tell you in the next column.

And with that final note, I shift my attention away from this column, and back to my Federal Civil Procedure outline. I have my umbrella, boots, and rain jacket ready, and regard the approaching storm with guarded optimism. Come December 21 I am a (relatively) free man: and to make as dramatic a break as possible with law school I embark on a birthright trip to Israel on December 28 for 10 days. This is the light at the end of this dark tunnel they call finals. Wish me luck! ■

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BY GERALD LEBOVITS

Will of Fortune: New York | Will Drafting – Part 2

Part 1 of this two-part column, which appeared in the last edition of the *Journal*, outlined the basics of will drafting. This column is about the importance of clarity in will drafting.

It's impossible in a column of this length to address all the areas of writing a will. Will drafting is often complex and always detail-oriented. This column focuses, instead, on select will-drafting topics in which clarity is critical. We'll also include some pitfalls and solutions.

The purpose of a last will and testament is to wind up and settle the testator's[1] affairs and to communicate the testator's intent and instructions for the orderly and efficient distribution of the testator's assets.[2] Without clarity, as well as specificity and thoroughness, the likelihood that a will might accomplish these goals becomes merely aspirational. An unclear will can be the cause of time-consuming and expensive legal proceedings, most often in the form of a construction proceeding[3] or a contested accounting proceeding.[4]

A will is also the instrument by which a testator appoints one or more persons of trust and confidence to accomplish the purposes set forth in the will and to do so according to the testator's intent.[5] In New York, the person responsible for carrying out the testator's wishes is the executor.[6] If the testator wants to create one or more testamentary trusts, the person responsible for administering a trust is called a trustee. Executors and trustees are fiduciaries.[7] The responsibilities of fulfilling the testator's intentions and desires as expressed in a will are called fiduciary duties. Carrying out these fiduciary duties requires a high standard of behavior and undivided loyalty.[8] A will must provide clear directions to the fiduciary.

Although a will is the most basic of instruments to carry out a testator's intentions, a will is also "often the most important . . . estate planning document."[9] Estate planning can be complex. It involves understanding and addressing a host of topics. These include the nature and value of the testator's assets, family dynamics, earlier marriages and the children and grandchildren from those marriages, which family members have survived the testator, the quality of the relationships among the family members, the existence of preexisting planning devices (e.g., inter vivos trusts, earlier wills, contractual agreements such as IRAs, 401(k)s, pension and deferred compensation plans, annuities and life insurance),[10] loans by the testator, business relationships, and debt.

> Perhaps most fundamental to will clarity is accurately and completely identifying the intended beneficiaries.

The attorney draftsperson is charged with the responsibility of transcribing into a document the testators' intentions about settling their affairs and disposing of their assets, so that the final document accomplishes the testators' goals. The drafting attorney must gain detailed knowledge of the testators' affairs to draw a will that communicates clearly and with specificity the testators' intent and instructions for the orderly disposition of the estate. A court will determine the testator's intent from the four corners of a will if the will is unambiguous.[11] But a court will entertain extrinsic evidence if it finds that a disputed term in a will is ambiguous.[12] This opens the door to introducing documents the testator might not have wanted made part of the public record. For these and other reasons, clarity in will drafting is critical.

Because New York's Estates, Powers and Trusts Law (EPTL) both authorizes and governs wills in this state,[13] and because other laws, most prominently the Surrogate's Court Procedure Act (SCPA), also affect the drafting process, familiarity with these laws is crucial to draft a clear and concise will. The EPTL and SCPA establish many default provisions and rules. The EPTL and SCPA frequently contain a phrase emphasizing the importance of clarity in will drafting. That phrase is "unless the will specifies otherwise" or similar words to that effect.[14] It's up to the attorney draftsperson to be familiar with these opt-out provisions and to take advantage of the opportunities

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Nathaniel Elias Blood-Patterson
Matthew Neil Bobrow
Samuel Alexander Borland
Nora Lynne Brady
Melanie Francine Braverman
Luke Daniel Brindle-Khym
Walter James Bristow
Robert Donahue Broderick
Benjamin Pinchas Brookstone
Alexandra Bruno Carlo
Ngoc Quang Huy Bui
Jordan Lee Bunn
Arthur M.T. Burke
Steven Joseph Bushnell
Eugene Bykov
Alida Diane Camp
Christina Ann Campanella
Mariya Antonova Chakarova
Vishal Chanani
Sharon A. Cheren
Michelle Kay Chu
Lauren Giselle Citrome
Austin Cohen
James Hubert Coil
Olta Collaku
Mark E. Conrad
Micaela Conte
Sean F. Corrigan
Kelly Beth Cosby
John F. Coverdale
William Laurence Cranch
Nathaniel Adam William Crider
Nathaniel Desmons Cullerton
Connie Lee Dang
Eric Michael Daniel
Douglas J. Danzig
Debolina Das
Robert Bernard Davis
Matthew Ryan Deatley
Aaron Clyde Deditch
Luisanna Del Rosario
Cristina Rose Delise
Jennifer Audrey Depalma
Ryan Eschert Dibble
John Raymond Dillon
Justin Rivlin Druke
Zachary Daniel Dugan
Jaren Blake Dunning
Ana Maria Estrada Sierra
Matthew David Evans
Julia Valli Stark Feldman
Genevieve Xinxin Feng
Michael Brian Fingerhut
Noah Jordan Forrest
Michelle L. Fox
Sarah Hastings Fries
Naoki Peter Fujita
Jee-eun Jasmine Gahng
Danielle Garbi-etedgi
Ryan Harrison Gerber
Dana A. Gibber
Avery G. Gibson
Neil Gold
Levon Golendukhin
Jeffrey N. Gordon
Yass V. Grayeli
Steven Robert Green
Caroline Longenecker Greenwood
James Matthew Gross
Aaron Grunberger
Phara S. Guberman
Telisa Ann Gunter
Sumit Gupta
Lindsey Rae Gutierrez
Michael Robert Gynn
Henry Ha
Paul Hanft
Syed Shaheerul Haq
Bernard E. Harcourt
Drew Michael Harmon
Charles Lawrence Hauch
Thomas John Hennessey
Jillian Shafer Hewitt
Christopher Hilbert
Matthew Nathan Holbreich
Christopher Willis Holiman
William Patrick Hubbard
Elizabeth Huh
Leneer Lorraine Hutchinson
Shin Young Hwang
Sumiah Ashley Jaber
Noah Tom S. Jaffe
Alexandra Simpson James
Jennifer Jimenez
Nicholas Malino Joseph
Michael Ju
John Peter Kane
Rachel F. Katz
Mark William Kelley
Martha Lynn Kellogg
Susie Kim
Yoojin Lorelle Kim
James W. King
Leni Beth Kirschenbaum
Nicholas Joseph Klenow
Joshua Scott Knoll
Tilak Jesudasan Koilvaram
Leigh Simon Krafchek
Robin Rae Kravitz
Anna Kreimerzak
Preeti Krishnan
Guy Michael Kulman
Hiroyuki Kurihara
Alvin Kwong
Nicholas Kypriotakis
Jose Landivar
Adam Carmelo Bergman Lanza
Jonathan Andrew Laplante
Sam Lawand
Michelle Kay Letourneau-Belock
Jesse Phillips Levine
James Yi Li
Limunga Doris Milena Litombe
Matthew James Livingston
Naeema Shahiydah Livingston
Joshua Joseph Loring
Matthew Justin Luchs
Mircea Alexandru Lupu
Joshua Joseph Lustiger
Kurt Lloy Lyn
Tianyu Ma
Sean Patrick Madden
Seymour Magier
Bachar Mahmoud
Hugh Hamilton Manahan
Jose Manalo
Eric Scott Marder
Dylan Rob Marvin
Anthony Matos
Russell Allen Mawn
Ashley Evin May
Jonathan Ira Mayblum
Nicholas Mayer
Andrew Michael Mazzarella
Susan Huang McClure
Lauren Blair McGlothlin
Christine Megan McGrath
Joshua I. McLaurin
Maura Glynn McNamara
Spencer Cullings Meade
Matthew Peter Tobago Merritt
Gerard Anthony Messina
Alexandra Sage Messiter
Luke Woods Meyers
Michelle Meng-si Miao
Kristina Bianca Moehle
Kaitlin Amanda Morrison
Elinor Hart Murarova
Patricia Murguia
Arman Naraghi-pour
Caelah Elizabeth Nelson
Laura Meredith Nelson
Kensing M. Ng
Julianne Thu Nguyen
Mark Oliver Norell
Lyndon Jackson O'Connor
Ololade Olayemi Oladapo
Molly Cassandra Olsen
Christopher Pacelle
Daniela Jeaneth Paez Salgado
Tali Michal Panken
Alex Atticus Parkinson
Zeina Pasquini
Anastasia Mcletchie Pastan
Kushal Naishad Patel
Edward Perkins
Kelsey Ann Pfleger
Eric Andrew Plourde
Maria Lourdes Pomares Mas
Amanda Casal Pompeo
Jennifer E. Poon
Meagan Emily Potter
Patrick Leonard Prin
Jessica Leigh Prince
Jessica R. Pulitzer
Patrick Thomas Quinn
Omar Raddawi
Irina Razumovskaya
Matthew Zachary Reed
Ashley Danielle Reinhardt
Caue Rezende Myanaki
Eileen Vanessa Rhein
Megan Beth Richardson
Maria Del Pilar Rivera Ruiz
Nicolas Guillermo Rodriguez Gaziglia
Ashley Elisabeth Rose
Evan Matthew Rosenberg
Harlan Philip Rosenson
Emily Suzanne Rosenthal
Reuven Roslyn
Thomas Spencer Rosso
Rachelle Leora Tenenbaum Rubin
Cameron Charles Russell
Michael Kristopher Sala
Lauren Jane Salamon
Andrew George Sangster
Daryl L. Saylor
Paige Hamilton Schmidt
Katelyn Helene Seigel
Erica Kristie Senat
Wan Jun Seow
Carolyn Elizabeth Shanahan
Alexander Brandt Shiffman
Yo Watanabe Shiina
Sang Min Shim
Sahar Shirazi
Merav Shor
Diana Mary Sidlowski
Brian Sieben
Mary Rollings Silverman
Michelle Julie Skalrud
George Kimball Smith
Justin James Sommerkamp
Tania Stephanie Soris
Paul Joseph Springer
Geoffrey Keith Stauffer
Nathan Caine Stein
Samuel Winston Stelk
James Tai
Elinor Lynn Tarlow
Beau Vivod Taylor
Emily Victoria Thomas
Yukiko Tomimatsu
Tin-fu Tsai
Jameelah Hanan Tucker
Alita L. Tulsi
Katherine Tyurin
Marc J. Veilleux
Nicole Hallie Velazquez
Sofia Anna Vitiello
Jolene L. Wang
Alexander Jack Warents
Ariana Sahar Watson
Herbert Weisburgh
Matthew Bret Weiss
Cort Welch
Michael Frederick Werno
Matthieu Olivier Wharmby
Hannah Kelly Whiteker
Jonathan Wilcon
Karen Elizabeth Wiswall
Kaileigh Elisabeth Wright
Jingjing Wu
Peter Hunt Wyman
Mona Xianjing Xia
Mengshan Xu
Yifei Yang
Yilin Yang
Alexander Richard Yarm
Janice Xiaoying Ye
Gary L Yeung
Dongyuan Yin
Alex Lester Young
Zichao Zhang
Yi Zhao
Michael Brandon Zytnick

Second District

Shahzadi Baez Ahmed
Jason Andrews
Yousef Annab
Jared Byrne Arader
Michael Drew Ashton
Dyon D. Auguste
Nimra Azmi
Andrew Stirling Baker
Michael William Bethoney
David Carl Billingsley
Nickolas Milan Bogdanovich
Oleg Bolehivskyy
Stefania Boscarolli
William McKinney Brown
Michelle Marie Carmon
Xavier Eddie Carr
Christopher Carter
Brett Evan Cattani
Sasha Neema Chegini
Benjamin David Clack
Richard Brendan Corde
Amanda Rose Cottingham
Geoffrey Kingston Crary
Jonathan W. Croft
Andrew D. Dellaripa
Kaitlyn Taylor Devenyns
Helen Downes
Jessica Briana Downes
Alexandra Villamia Drimal
Jessica Drury
Collet Ebadi
Elizabeth Christa Zen Encinas
Miles Davenport Freeman
Aliona Gherasimov
William Jang Giacofci
Samuel Zachary Goldfine

Bruce Liang Gottlieb
Roohi Jitendra Gupte
Taisa Gurshumova
Daniel John Haley
Andry Henriquez
Grisell Hernandez
Luke Herrine
Peter Michael Hertzog
John Andrew Hreno
Norly Samantha Jean-Charles
Kyoung Jung
David A. Karopkin
Omar Husain Kazmi
Maxwell Haviland Kelly
Sabreena Khalid
Urooj Khan
Julia Khokhlova
Dohyung Michael Kook
Nicole Kornblum
Vinay Ram Krishnan
Kristian Curtis Krober
Katelyn Ann Krueger
Chaka Shakira Laguerre
Joanna Corrie Laine
Octavius Lamour
Keith Adam Langlais
Wei-fang Luo
Vara Gartin Lyons
Nawal Katrina Maalouf
William Alan Macrae
Amelia Anne Maddox
Clementine Malvarosa
Jacob Marks
Charles Thomas Mather
Viola R. Mathews
Theodore Odland Mcbride
Michael Ryan McDonald
Rachel Lynn McGhee
Jessica Montes
Tyler Harrison Morris
Shira Moyal
Caroline Margaret Murphy
Scott Morgan Murrish
Dmitriy Nam
Daniel R. Neer
Abimbola Olusegun Onafuwa
Justin Ronald Orr
Ariana Alcasabas Pabalan
Roman Koropeckyj Pazuniak
Stephanie Marie Persson
Justin Pierre-louis
Lauren Frances Daneu Price
Daniella Raveh
Simcha Rechnitz
Ryan Sebastienne Redway
Rafael Reyneri
Lidia Helena Souza Rezende
Christopher William Robinson
Shawn P. Roche
Stephanus Johannes Ronen-van Heerden
Daniella Roseman
Beth L. Rosner
Jacques-andre Roussel
John Francis Ryan
Kevin Michael Ryan
Patrick Joseph Santos
Tobias Dylan Schad
Viviane Kim Scott
Vanessa Selbst
Jill Kassandra Serpa
Christina Marie Sindoni
Perla Solis-Silva
Alessandra Spina
Jeni Lynn St. George
Noah Gates Susskind
Perry Isaac Teicher
Neige Augusta Celeste Thebault
Alina Titievskaya
Priya Madhavi Varaprath
Eszter Agnes Vincze
Cheryl Wang
Elizabeth Lisa Wang
Brandon Montrell Whittaker
Bailey Kathleen Williams
Jonathan William Wood
Percy K. Xu
Maggie C. Yang
Jordan G. Zimolka

Third District

Mary Elizabeth Burgess
Thomas A. Capezza
Joyce Ingrid Crawford
Jeffrey Carmine Gautsche
Lori J. Mason
Kathleen Maura O'Hare
Kimberly August Prince Walsh
Jeffrey John Pritchard

Fourth District

Lynn Anne Pucciarelli

Fifth District

Aidan Bryden Cleghorn
Maria Mastriano

Seventh District

Brian R. Becker
Holly Lynn Eicher
Aaron Matthew Griffin
Christine Carol Lachnicht
Kenneth Maynard Smith
Deirdresha Sasha Gaye Wint

Eighth District

David John Exterovich
Lindsay Karas Stencel
Michael Robert Tucci

Ninth District

Francois Annabi
Katherine M. Baldwin
Dianna Amy Borow
Julian David Buffa
Joseph A. Capozzoli
Sophia Malyne Sarah Carter
Graham Robert Chapman
Shafi Chowdhury
Andriana Nicole Chryssikos
Alessandra Liana Cortina
Gerard A. Djate
Irena O. Feofanova
Kristin Nicole Gualano
Faizan Tariq Habeeb
John Christopher Henschel
Abigail Kennedy Horrigan
Kristan Lynn Lansbery
Konstantin Yefimovich Lantsman
Michael Thomas Lee Meinert
Tamara Regina Levi-Weiser
Paul Vincent Levine
Janine M. Lewis
Ruey-chiang Lin
Andrew Mark Lippman
Jacklyn Marie Macias
Steven Magi
Vera Quimba Malanyaon
Stefan Mikhail McDaniel
Delphine Francoise Nougayrede
Erin L. O'Dea
Michael O'Keefe
Asha Rajen Pandya
Anu Paulose
Timothy Edward Pavelka
Hector Jose Perez
Michelle Jessica Piantadosi
Derek Michael Robinson
Natasha Rose Sabot
Lee J. Sauerhoff
Michael Joseph Segreto
Francis Phillip Taylor
Matthew Charles Toal
Kimberly Lauren Tracey
Marissa Vitolo
Zachary Ross Waldman
Aida A. Zapata

Tenth District

Binish Anjum
Jenna S. Atwell
Jonah H. Blumenthal
Eilleen Cathryn Buckley
Ariel Buziashvili
Peter James Callaghan
Jennifer Ashley Camillo
Cristina Esperanza Ceron
Inyoung Jenny Choi
Toi Lashawn Clifton
Justin Stephen Curtis
Leor Oved Edo
Michael Bradley Engle
Laura Michele Esposito
Liying Feng
Thomas Joseph Frederico
Donald J. Friedman
Alexana Gaspari
Lauren Gaye Gatto
John Henry Geager
Barney James Giannone
David William Goodge
Katerina Grinko Quezada
Jamie Robert Huntley
Alexander Ip
Ashleigh Georgia Kashimawo
Shiva Prasad Khanal
Susanna Elizabeth Laruccia
Evan Reid Levtow
Anastasiya Lipatov
Krystal Matos
Brittany Rae McCormick
Rebecca Medina
Erica Michele Meyer
Joseph Anthony Myers
Brianna Leigh Nelson
Alison Nicole Noonan
Matthew Todd Rutchik
Daniel Sadeh
Michael David Schultz
Jawad Yusuf Shaikh
Rachel Lea Shkolnik
Lawrence Isidore Singer
Aidan B. Slevin
Andrew Bennett Smith
Brian David Stefanovic
Sheraz Minhaj Syed
Adam James Theo
Gerard Raymond Vanleuvan
Kelsey Nicole Walker
Rachel Kate Warren
Jennifer Marisa Wickers
Emily R. Zerkel

Eleventh District

Benjamin Joshua Adelson
Sumaiya Aftab Ahmed
Usman Ahmed
Ogochukwu Anthoninus Akunefo
Cody Alongi
Nathaniel Caleb Ament-Stone
David Benjamin Angel
Violeta Arciniega
Erin Virginia Bergey
Archana Arvind Bhakta
Nitisha Bishnoi
Kelsey Monique Burgess
Gregory S. Choi
Nuzhat Jahan Chowdhury
Alexander Blake Cohen
Donial Dastgir
Stephanie Yvonne Day
Anthony Francis Delury
Rose Ding
Dolgora Dmitrievna Dorzhieva
Christelle Ducray
Ignacio Vladimir Duran
Timothy John Durbin
German Andres Fernandez
Octavian Marian Florescu
Peter Richard Flynn
Michael Anthony Forsette
Christopher Marshall Forstrom
Afrodite Fountas
Sini Fu
Gayatri Galav
Derek Robert Garman
Christen Giannaros
Andrew Kiiru Gichuru
Victor Gorman
Candi Green
Alexander S. Gutierrez
Kehkeshan Hafeez
Albert Hakimi
Eleni Marie Hatzis
Jillian Marie Hernandez
Jimei Louise Hon
Wonhee Hong
Valerie Bukola Igbinoghene
Abraham Jacob Jeger
Shang Jiang
Colin Michael Johnson
Eric Cormier Johnson
Kimberly Samantha Juszczak
Jongchan Daniel Kang
Robert Kellogg
Joshua David Kingsley
Andrew Klaben-finegold
Sonu Lal
Nancy Lam
Illana Devorah Leiser
Stephanie Y. Lin
Constantine Loizides
Nitasha Madan
Lunar Mai
Leo Lanny Mensah
Caitlin Isobel Mullan
Gregory Robert Musso
Michael Papson
Devi Patel
Michael Amilcar Perez
Richard Quatrano
Jessica Louise Richman
Edward John Robinson
Whitney Alexandra Robinson
Natasha Devi Sahadeo
Farrell Schwartz
Wishuporn Shompoo
Christine Shyu
James Francis Simermeyer
Harpreet Singh
Tamara Rachelle Slogosky
William Joseph Smolinski
Syeda Mazida Tasnim
Boyan R. Toshkoff
Carlos Alfredo Valenzuela
Luis Antonio Velez-Hernandez
Brandon Israel Walker
Lauren Dianna Zaccagnino
Guoyang Zhang
Yujian Zhang

Twelfth District

Anthony Alba
Michael J. Antolini
Bernard Benyayezor Armoo
Hayden Nadine Briklin
Noelle Christina Forbes
Ashley Nichole Guarino
Makousse Bintou Ilboudo
Scott Gary McDonald
Devin Edward Millbower
Alexander Ramirez
Jordan Lehner Silver
Kirby Jermaine Smith
Iris Ismelda Ventura

Thirteenth District

Peter Cusick
Charles Ryan Luk
David Machado
Paul S. Metcalf
Michael Joseph O'Beirne
Lisa M. Parisio
Joanna Plonska
Robert James Ramsey
Jill M. Spinelli
Gregory Stone

Serenay Taysin
Josephine Weiss

Out-of-State

Joseph Elias Abboud
Anthony Salvatore Abiuso
Cevdet Nuri Acar
Adam Jacob Adler
Andres Afanador
Al Waleed Yahya Al Kiyumi
Samantha Tilipman Alexander
Rodrigo Alejandro Alvarado
Stephanie Tiboah Amoako
Judy Pei Xia Ang
David Michael Angeloff
Danielle Angotta
Justin Lewis Ankerman
Mari Aoyagi
Amulya Appalaraju
Brian Arbetter
Justin Vincent Arborn
Melodie K. Arian
Rebecca Michelle Arian
Christopher Michael Armstrong
Bjorn Rudolf Arp
Vincent Justin Arpey
Jeffrey Ira Auerbach
Marian Awad
Ama Gyamfuaa Awua-kyerematen
Soraya Rose Bagheri
Sang Woo Bang
David Ellis Barclay
Jose Guillermo Baron
Kevin Hugh Bell
Adriana Elena Bello Roosen
Caleb Andrew Benadum
Michael Stephen Bennett
Samuel Simon Berrebbi
Veronica Berruz
Patrick Michael Birney
Claire Michael Blakey
Aimee Blenner
Bethany Anne Blood
Gianni Boffelli
Luz Danielle Ortega Bolong
David Bondanza
Bobbi Borsellino
Amaury Alfredo Boscio Colon
Sasha Jung Ae Boshart
Sixtine Bousquet
Allison Shirlene Brehm
Hunter John Briegel
Fatima Guadalupe Brizuela
Zachary James Brumbaugh
Fernando Burman Nicolau
Dakotah Michael Burns
Thomas John Burns
Maria Florencia Cadagan
Maximilian De Cuyper Cadmus
Ana Maria Calero
Azzurra Camillieri
Conor Thomas Campbell
Alissa Christine Cantrell
John Thomas Capetta
Patrick Michael Carey
Elizabeth Louise Carter
Nicholas Angelo Caselli
Zita Eleanor Casserly
Kyle Hudson Cassidy
Samantha Rose Catanese
Wan Cha
Lih Yik Chang
Tung Chang
Tarasi Chantladze
Ruipu Chen
Xueyao Chen
Zhao Chen
Zhuo Chen
Zhe Cheng
Zixuan Cheng
Rita Chertorivski
Vivien Wei Mun Chia
Michelle Hui Shan Chiang
Ian Thomas Childs
Yuen Pui Chiu
Hansang Cho
Karen M. Cho
Anna Rose Christenson
Ha Young Chung
Michael Dominick Cilento
Jessica Kate Cochrane
Sarah Louise Cockrum
Michael Frederick Cockson
Bradford M. Cohen
Paul Jay Cohen
Lauren Elizabeth Connell
Laura Kateri Conroy
Alexander Mikhail Cooke
Christian Edwin Corkery
Nahila Agostina Cortes
Cristina Luisa Costa De Almeida
Brett Rosenbloom Cotler
Lisa Marie Coutu
Barry Scott Crane
Ralph Bruce Crelin
Alice Royce Bancroft Cullina
Christina Marie Culver
Johnlee Scelba Curtis
Deborah Anne Cussen
Kate Schuler D'agostino
Nia Ariel Davis
Robert Linley Dawson
Mignon De Wilde
Taylor Anne Dean
Pelin Demirdere Eski
Lee Joseph Fitzgerald Deppermann
Justin Andrew Dews
Matthew Dias
Lisa Ann Difilippo
Simranjeet Kaur Dolla
Michael David Downs
Zhouyuan Duan
Heather Marie Eichenbaum
Benigna Chibuanuli Ejimba
Smahane El Yacoubi
Sherif Alaaeldin Elatafy
Rhani Abd Elrahman
Carolin Andrea Emmert
Michelle Alayne Emmons
Brandi Kalena Shaddick Endres
Katherine Anne Cole Erickson
Shreya Fadia
Yurima Francia Falcon
Dennis Fan
Zhongyi Fan
Jun Fang
Thomas Robert Fanizzi
Travis Michael Farr
Layne Alison Feldman
Silvia Pereira Fernandes
Jordan Robert Firestein
Simon Lewis Fischer
Gregory W. Fortsch
Andrea Michelle Fraleigh
Colin Francis
Juliette Marie Fraudeau
Valentina Frignati
Rao Fu
Ryan Kevin Gallagher
Lauren Ann Galvani
Annabelle Gantelmi D'ille
Qian Gao
Yan Gao
Zachary Richard Geneseo
Michael Fayez Georgi
Emily Layla Ghadimi
Matteo Giangaspero
Ian Paul Goldstein
Agnieszka Elzbieta Goliszewska
Madeline Michelle Gomez
Elizabeth Ann Gonzalez
Jorge Arturo Gonzalez
Randy Lee Gori
Robert J. Gorrie
Chloe Louise Isabell Gouache
Kurt P. Goudy
Valeria Granata
Laurel Frankston Grass
Erin Nicole Gray
Kristoffer Agner Gredsted
Lash Lenard Green
Steven Douglas Green
Lueka Suzanne Groga Bada
Ran Gu
Fredrik Sven Birger Gunnard
Stephanie Nicole Gwillim
Timothy Curtis Haas
Gerard Jay Habas
Christopher William Hale
Marcelo Halpern
Pablo Eugenio Hamilton-Silva
Iris Hammerschmid
Jingwen Han
Jiawei He
Sarah Ahmed Heba
Heather Grace Hensley
Netanel Hershtik
Daniel Eric Herz-roiphe
Helen Holcomb
Michael Thomas Hollister
Christopher Benton Hopkins
Mark Ronald Arthur Horn
Chauyin Rebecca Hsu
Muyun Hu
Siyu Hu
Weiying Huang
Xiaofu Huang
Yi Huang
Yueyue Huang
Christopher W. Hughes
Mikella Marie Hurley
Claudio Eduardo Iannitelli
Mamoru Ikeda
Kaori Itoh
Michael Richard Jackson
Annella Marella James
Jessica Floyd Jensen
Joshua Rene Jeyaraj
Yanting Ji
Niao Jiang
Jin Jin
Joseph Brian Johns
Karla Monique Johnson
George Francisco Jorges
Henna Jung
Jonathan Zeev Kahana
Eun Joo Kang
Jun Kashio
Gulen Begum Kayum
Stephen Deverall Kelly
Jamie Olivia Kendall
Megan Chauffe Kiefer
Youyoung Kim
Rudolph Graham Klapper
Shana Adele Knizhnik
Yuma Kotake
Saso Kraner
John Francis Kroto
Sharanyaa Kruti Vasan
David Michael Kubiliun
Andrew Ernest Lahey
Elena Lapina
Elizabeth Marie Lautenbach
Byoungjoo Lee
Christopher Jesu Lee
Grace Yeeun Lee
Jae Hoon Lee
Ji Hae Lee
Kyungjae Lee
Minjae Lee
Robert Han Gang Lee
Sang Yub Lee
Su Yeon Lee
Tina Yura Lee
Thomas Michael Lent
Saskia Laura Leopold
Chunbei Li
Jia Li
Kantong Li
Shanshan Li
Xuxu Li
Yan Li
Dandan Lin
James Chih Kai Lin
Po Yen Lin
Xi Lin
Clinton Thomas Lipscomb
Aaron Michael Littman
Qinghe Liu
Yaqin Liu
Tania Loghmani
Anaid Arlet Lopez Uribe
Yuhao Lu
Nijia Luo
Pujun Lv
Gabrielle Margaret Lyons
Bahareh Mahdavi
Irene Mainar Borao
Sara Maktouf
Gabriel Maldoff
Charles Alan Malloy
Yuelei Mao
Alyson R. Marcucio
Leticia Mariz Schweizer
Ana Carolina Markowskyj
Jonathan L. Marks
Bernard Mary Marshall
Tiffany Lynn Martinez
Charlette Lachez Matts-Brown
Beverley Mbu
Joseph P. McDonald
Kyle Sellers McGuire
Jack Eli Meek
Charles Michel Merveilleux Du Vignaux
Shahrukh Mian
Meghan Grace Michael
Mike Phillip Michel
Benjamin Cale Cameron Miller
Christopher Michael Miller
Jason Falk Miller
Olivia Zimmerman Miller
Heather Colleen Milligan
Brian Manuel Miranda
Andrew Perry Moore
Louis Morelli
Ryoji Moroi
Reza Mostafavi
Ryan Francis Murphy
Brittany Marie Murray
Alexander Frederic Murugasu
Moshe Bennie Nachum
Christopher Takeshi Napier
Lauren Kimberly Neal
Kevin Michael Neylan
Khanh Ngoc Nguyen
Ryan Scott Nichols
Taro Nishide
Hideyuki Nishimura
Robert J. Norcia
Kaitlyn O'Shaughnessy
Osarugue Courage Obayuwana
Michael Peter Olel Okayo
Kelechi Emem Okengwu
Peter Jordan Oliveri
Tomasz Pacholec
Daniela Paez Cala
Jeongyeol Park
Jiyoung Park
Sungbin Park
Tatiane Park
Nuria Pastor Martorell
Dhara Janak Patel
Sonal Pankaj Patel
Yiheng Peng
Kali Peterson
Robert Gabriel Pethick
Vu Pham
Daniel Pierre
Chelsea Alexandra

Plushanski
Laura Possessky
Robert Seaver Powel
Supriya Prasad
Sandeep Avinash Prasanna
Brian Neil Quarles
Dylan Joseph Quinn
Suhey Ramirez
Louisa Mandy Ramsammy
Kristen Grace Rasnic
Sara A. Ravich
Genevieve Grace Redd
Karthik Pottipati Reddy
Courtney Ann Reed Keren
Jeffrey M. Reisner
Aleza Simone Remis
Alicia Reyes-hernandez
Amanda Louise Reynolds
Solomon Rho
Alice Audrey Riviere
Sarah Alice Roache
Milena Rose Yvonne Robotham
Gabriela Maria Rodriguez
Lori Ellen Romano
Casen Baker Ross
Benjamin Lee Rouder
Alexandros Roussos
Jennifer Irene Douglas Rovelli
Judith Gabriele Rubin
David John Rundle
Emmanuel Benson Kwame Saah
Naoto Nelson Saika
Yuki Sakurada
Cagla Salmensuu
Aderayo Oluwaseun Sanusi
Nivedita Shrivalli Sathiakumar
Alexander Nelson Schachtel
Michael Bradley Scher
Eric Anthony Schmidt
Courtney Elyse Schneider
Dominik Schoeneberger
Baxter Thomas Schooley
Joseph James Schuster
Adam Block Schwartz
Yannick Frederic Schweizer
Andrew W. Scott
Jennifer Elizabeth Scro
Sergio I. Scuteri
Nadia Sofia Segura Narvaez
Anushka Sehmi
Jessica Eun Seo
Vidhi Sharma
Nidhi Shetye
Hui Shi
Kevin Lloyd Shildneck
Jee Won Shin
Jonathan Mackenzie Short
Cameron Kinsley Sim
Samantha Simms
Nandini Singh
Michael Alexander Skazick
Mark J. Skinner
Mariam Smairat
Elliott Aaron Smith
Aaron Philip Snellenbarger
Daniel Long Sockwell
Sara Soleymani
Chiyin Song
Lijie Song
Yiping Song
Natalie Sookhoo
Maya Kiera Steite Masri
Lunga Su
Jei Suh
Jennifer Marie Sullivan
Al-amyn Shiraz Sumar
Xinru Sun
Ryan Anthony Sykora
Minli Tang
Tsai-ping Tang
Yuan Tao
Alexey Valerievich Tarasov
Jeremy Richard Teaberry
Elise Tek
Ellen Starling Tenenbaum
Stanton J. Terranova
Adrija Thakur
Andre Thiollier
Sophia Tong
Adela Troconis
Erika Danielle Trujillo
Alda Falicia Tsang
Atsushi Tsujii
Mayuko Tsujimoto
Caitlin Bennett Tully
Elizabeth Barnwell Kelly Turley
Victoria Usova
John Meade Van Deventer
Kamala Marian Vasagam
Matthew Edward Vigeant
Laarni Victoria Quidoles Vinas
Amir Moshe Vitale
Nguyen Cam T Vo Thoi Lai
Alyssa Ailleo Wade
Lawrence Francis Walker
Christine Walz
Airun Wang
Lei Wang
Lillian Li-chien Wang
Sen Wang
Wei Wang
Yuzhong Wang
Robert Allan Watson
Dongjing Wei
Jill J. Weinberg
Pierre Bruce Whyte
Mckenzie Ann Wilson
Ian Zev Winograd
Kaitlin McHugh Wojnar
Jessica Wu
Junkun Wu
Qiongjie Wu
Yiwen Wu
Ye Xia
Feiyue Xu
Miao Xu
Mingyang Xu
Siyi Xu
Rony Yaacoub
Runa Yamamoto
Jing Yan
Jerry Yang
Jingping Yang
Xiaoting Yang
Zhi Yang
Yao Yao
Kengo Yaoi
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