TESTAMENTARY CAPACITY IN ALZHEIMER'S DISEASE

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Our aging population increasingly falls victim to Alzheimer's disease, a dementing and progressively worsening illness. Medical (clinical) capacity is a physician's opinion regarding an individual's ability to make decisions and to act for himself. Legal capacity is an individual's capacity to understand the nature and effect of what he is doing. An individual can retain legal capacity even if he demonstrates eccentric behavior, holds bizarre beliefs, experiences medical conditions producing confusion and memory deficits, or is physically feeble.

Testamentary capacity is the mental competence to execute a will, requiring that the testator be aware of the nature and extent of his property, know the persons to whom he will give his property, and understand the effects of his acts. The standards for retention of testamentary capacity are extremely permissive, and persons experiencing lucid intervals may be considered competent to execute wills during such periods. The determination of testamentary capacity is a fact-driven inquiry; the physician's opinion is not dispositive. The few courts addressing the issue have consistently held that testators with mild or mild to moderate Alzheimer's disease are competent to execute wills based upon testimony of those who interacted with the testator on the day the will was executed, often contrary to a physician's opinion.

America is an aging society. In the past decade, from 1980 to 1990, the percentage of elderly persons sixty-five years of age or older increased by twenty-two percent.[1] By the year 2011, when the Baby Boomers born during the war years from 1940 through

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1. BUREAU OF THE CENSUS, U.S. DEP'T OF COMMERCE, CURRENT POPULATION REPORTS, SPECIAL STUDIES, SERIES P-23, NO. 178, SIXTY-FIVE PLUS IN AMERICA v (1992).

1946 reach age sixty-five, the elderly will make up fourteen percent of our population.[2]

As individuals age, they suffer an increase in frequency of age-dependent illnesses such as Alzheimer's disease.[3] Alzheimer's disease is the principal disease producing dementia at any age throughout life.[4] Most studies place the prevalence rate of Alzheimer's disease between four and ten percent of the elderly population, and recent studies show that four million or more Americans suffer from Alzheimer's disease.[5] The cost in medical bills, nursing home costs, home care costs, and lost productivity for 1991 were estimated at a staggering $91 billion per year.[6]

Many elderly persons, including some who have already become victims of Alzheimer's disease, declare themselves to be of sound mind, with or without an attorney's guidance, and proceed to execute a last will and testament. This article discusses whether persons in the various stages of Alzheimer's disease possess the mental competence, or in legal terms, the testamentary capacity, to execute a will.

I. Clinical Capacity: The Physician's Opinion of Competence

The terms "competence" and "incompetence" have different meanings in general usage, in medicine, and in the law. In general usage, "competence" means the quality of being adequate, or the possession of sufficient skill, knowledge, or qualification to be adequate.[7] The word can also mean the condition of having sufficient means to

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2. *Id.* at 2-1.

3. Robert Terry & Robert Katzman, *Alzheimer Disease and Cognitive Loss*, *in* PRINCIPLES OF GERIATRIC NEUROLOGY 207, 208 (Robert Katzman & John Rowe eds., 1992).

4. JEFFREY L. CUMMINGS & D. FRANK BENSON, DEMENTIA: A CLINICAL APPROACH 5-8 (2d ed. 1992); Leslie I. Wolfson & Robert Katzman, *The Neurologic Consultation at Age 80*, *in* THE NEUROLOGY OF AGING 221, 235 (Robert Katzman & Robert D. Terry eds., 1983).

5. *See generally* CUMMINGS & BENSON, *supra* note 4, at 46-47; Denis A. Evans et al., *Estimated Prevalence of Alzheimer's Disease in the United States*, 68 MILBANK Q. 267 (1990); Denis A. Evans et al., *Prevalence of Alzheimer's Disease in a Community of Older Persons: Higher than Previously Reported*, 262 JAMA 2551 (1989); B.T. Hyman et al., *Alzheimer's Disease*, 10 ANN. REV. PUB. HEALTH 115 (1980); Terry & Katzman, *supra* note 3, at 208.

6. U.S SENATE SPEC. COMM. ON AGING, PUB. NO. DHHS 91-28001, AGING AMERICA: TRENDS AND PROJECTIONS 116 (1991); Warren F. Gorman, *Benign Aging or Alzheimer Disease?*, 88 J. OKLA. ST. MED. ASS'N 383, 384 (1995) [hereinafter Gorman, *Benign Aging*]; Warren F. Gorman, *Alzheimer Disease: Diagnosis, Progression and Staging* (article forthcoming 1996).

7. THE OXFORD ENGLISH DICTIONARY 603 (2d ed. 1971).

live comfortably or in easy circumstances, as in Tennyson's *Enoch Arden*, "seven happy years of health and competence."[8]

In internal medicine, "competence" usually means the ability of an organ or a structure of the body to perform its function.[9] For example, immunologic competence is lost in AIDS, when the body's immune system breaks down and the individual develops a fatal infection. In general medicine and psychiatry in particular, informed physicians follow the rule that competence is not a medical diagnosis, but instead a legal determination.[10] However, only a small number of physicians are aware of the legal rule that an adult person is presumed to be competent unless declared otherwise by an appropriate court.[11]

Competence remains a legally rebuttable presumption when a physician is asked for his medical opinion regarding a patient's competence.[12] Such an opinion is requested, for example, when a psychiatrist examines a patient who has been involuntarily admitted, or "committed," to a state mental hospital,[13] when a physician performs an examination for the Veterans Affairs Bureau to determine a veteran's ability to manage his own funds,[14] or when a neurologist or psychiatrist examines a patient with Alzheimer's disease.[15] Much more often, the physician relies on the presumption of competence until proven otherwise when he or his surrogate obtains consent for the patient's medical or surgical treatment, as in hospital admission forms.[16] Because valid consent requires that the consenting patient be competent, it is the physician's duty before engaging in treatment to form an opinion on his consenting patient's competence, but this

8. LORD ALFRED TENNYSON, ENOCH ARDEN 5 (London, Edward Moxon & Co. 1864).

9. CECIL TEXTBOOK OF MEDICINE 1908 (James B. Wyngaarden et al. eds., 19th ed. 1992).

10. WARREN F. GORMAN, LEGAL NEUROLOGY AND MALINGERING 366-71 (1993).

11. P.S. APPLEBAUM & T. GUTHEIL, CLINICAL HANDBOOK OF PSYCHIATRY AND THE LAW 218-19 (1991).

12. *See, e.g.*, Succession of Mack, 535 So. 2d 461, 463 (La. Ct. App. 1988); Edwards v. Edwards, 520 So. 2d 1370, 1372-73 (Miss. 1988); Feiden v. Feiden, 542 N.Y.S.2d 860, 862 (N.Y. App. Div. 1989).

13. APPLEBAUM & GUTHEIL, *supra* note 11.

14. 38 C.F.R. § 3.313 (1996).

15. *E.g.*, *Mack*, 535 So. 2d at 463-64; *Edwards*, 520 So. 2d 1372-73; *Feiden*, 542 N.Y.S.2d at 861-63.

16. APPLEBAUM & GUTHEIL, *supra* note 11.

opinion is rarely recorded.[17] A physician's opinion of a patient's legal competence will be referred to here as "clinical capacity."

Physicians are rarely reminded that they must follow legal standards. Thus, when the American College of Physicians, the senior medical specialists' organization, presented its position paper addressing when cognitively impaired patients, such as Alzheimer's patients, can give informed consent to research on their condition, the College simply followed the Code of Federal Regulations on the subject.[18] These standards state that cognitively impaired subjects are competent if they have the ability to understand the pertinent facts, to choose from the available options, and to communicate their choice.[19]

In another rare reminder, a group of psychiatrists at the Johns Hopkins Medical School presented a brief method for evaluating a patient's clinical capacity to give informed consent for treatment.[20] Their method relied on questioning the patient on his understanding of the standard legal requirements for informed consent: that the consenting person understand the benefits, risks, and alternatives of the proposed treatment (information), that the patient give consent voluntarily (volition), and that the patient be competent (competence).[21] If the patient understands the information component of this three-component standard, then the observers opined that the patient was clinically competent, or to use our term, that he or she possessed clinical capacity.[22]

In short, clinical capacity is the physician's estimate of an individual's ability to retain the power to make decisions for himself and to act for himself.[23] Clinical incapacity, or the loss of this ability, may be caused by neurologic, psychiatric, and other medical conditions, of which many are reversible by treatment. Clinical incapacity fluctuates in severity. Furthermore, it may disappear spontaneously or with treatment, as for example, the incapacity of a Febrile Delirium.[24] Common causes of a persisting, or chronic, loss of clinical capacity are

17. *Id.* at ch.5.

18. 45 C.F.R. § 46.116 (1995); American College of Physicians, *Cognitively Impaired Subjects*, 111 ANNALS INTERNAL MED. 843, 847-48 (1989).

19. AMERICAN COLLEGE OF PHYSICIANS, *supra* note 18, at 847-48.

20. Jeffrey S. Janofsky et al., *The Hopkins Competency Assessment Test*, 43 HOSP. & COMMUNITY PSYCHIATRY 132, 132-36 (1992).

21. *Id.* at 132-34.

22. *Id.*

23. APPLEBAUM & GUTHEIL, *supra* note 11.

24. CECIL TEXTBOOK OF MEDICINE, *supra* note 9, at 12.

polypharmacy, depression, and unrecognized medical or surgical disorders.

Polypharmacy is the medical term for the effect of excessive medication—either too many medications or too much of any one medication—and is seen often in the elderly.[25] Frequently, an elderly patient continues to take a previously prescribed mind-affecting medicine while adding a newly prescribed tranquilizer or pain reliever. This can produce a mild chronic intoxication or even a mental state that manifests characteristics resembling symptoms of Alzheimer's disease.[26] A polypharmacy diagnosis is confirmed by urine screening and blood testing quantification.[27] Although a search for licit or illicit drug content in the body is a recognized part of the examination for Alzheimer's disease,[28] physicians frequently are reluctant to order such tests. Treatment consists primarily of gradual withdrawal of the offending chemical substances, combined with personal supervision and supportive encouragement.[29]

Depression, particularly when severe and accompanied by a hopeless-helpless attitude, can impair the patient's reasoning about his present or his future, and may thus tarnish his potential to make a satisfactory will.[30] Depression also diminishes attention and concentration, thereby producing the clinical appearance resembling structural brain damage, particularly in the elderly.[31] Such characteristics have been described as the pseudodementia of depression.[32]

Undiagnosed disease that affects the mental state, particularly in the elderly, may be a consequence of the patient or the doctor not reporting a complete history. Because elderly persons living in the community have an average of six true medical diagnoses,[33] the elderly patient may not remember, or may not be willing, to add one more complaint to the medical file.

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25. CUMMINGS & BENSON, *supra* note 4, at 249.

26. *Id.* at 250.

27. *Id.* at 346-48.

28. Eric B. Larson et al., *Diagnostic Evaluation of 200 Elderly Outpatients with Suspected Dementia*, 40 J. GERONTOLOGY 536, 536-37 (1985).

29. CECIL TEXTBOOK OF MEDICINE, *supra* note 9, at 28.

30. M.F. Folstein, *Dementia Syndrome of Depression*, *in* ALZHEIMER DISEASE 87-93 (Aging Series Vol. 7) (Robert Katzman ed., 1978).

31. *Id.*; *see also* Gorman, *Benign Aging*, *supra* note 6 (summarizing the pseudodementia of depression).

32. CUMMINGS & BENSON, *supra* note 4, at 295-301.

33. Wolfson & Katzman, *supra* note 4, at 221.

II. Legal Capacity

The determination of legal incapacity frequently arises from a deficit in reasonableness or in self-care. The Uniform Probate Code defines an incapacitated person as one who is so affected mentally as to lack "sufficient understanding or capacity to make or communicate responsible decisions."[34] Some state statutes define the mentally incompetent person as "incapable of caring for himself."[35] Similarly, other state statutes describe the incompetent person as "unable to properly provide for his own personal needs for physical health, food, clothing and shelter."[36] These standards are consistent with the Activities of Daily Living Test, which is widely used by physicians.[37]

Old definitions of legal capacity or competence denoted a competent person as one who was not under the age of majority, had not been convicted of a heinous crime, or had not been adjudicated incompetent due to drunkenness, imprudence, or a lack of integrity or understanding.[38] Another historical approach, picturing the prototypical poor and honest man, maintained that a person was competent if he possessed the mental and moral qualifications of competency, even if he was lacking in means.[39]

Legal competence, as it is presently defined, generally requires a person to have the ability to understand the nature and effect of what he is doing.[40] According to one definition, "[l]egal capacity is the mental ability to make a rational decision, which includes the ability to perceive and to appreciate the relevant facts, and to reach a rational judgment upon such facts."[41] Because the rationality required to be considered competent is a hallmark of reasonableness,[42] competence may be judged under a reasonable person standard. Additionally, memory is an important component of legal capacity.[43]

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34. UNIF. PROB. CODE § 5-103(7) (1993).

35. APPLEBAUM & GUTHEIL, *supra* note 11.

36. *Id.*

37. AMERICAN MEDICAL ASS'N, GUIDES TO THE EVALUATION OF PERMANENT IMPAIRMENT 1 (4th ed. 1993).

38. *See* 15A C.J.S. *Competent* § 3 (1967).

39. *Id.*

40. *See* 12A C.J.S. *Capacity* § 135 (1980).

41. State Dep't of Human Servs. v. Northern, 563 S.W.2d 197, 209 (Tenn. Ct. App. 1978); *see also* 6 WORDS AND PHRASES 82-85 (West 1966 & Supp. 1996).

42. *See* BLACK'S LAW DICTIONARY 1265 (6th ed. 1990).

43. *See* WORDS AND PHRASES, *supra* note 41.

A. Eccentricity, Spirits, and Decrepitude

Competence does not require that a person function within the shoulders of its bell-shaped curve. In any group of people, there are always a few who are distinguished by their disregard for some of the actual facts of life.

However, courts have adjudicated individuals as competent even if they exude severe behavioral or mental abnormalities.[44] Thus, persons have been held to be competent when they are markedly eccentric or are guided by rare or even bizarre beliefs and prejudices, or by supernatural spirits or witchcraft.[45] When courts consider such individuals' competency, it is the expert witness's task to show that the bizarre beliefs are consistent with the person's background.[46]

B. Insane Delusions and the One Fact Rule

Generally a will is rendered invalid if it is the product of an insane delusion.[47] The term "insane delusion" is not a medical term. In fact the word "insane" has been dropped from medical usage for over seventy years, probably because in 1924 the American Psychiatric Association changed the name of its official journal from the American Journal of Insanity to the American Journal of Psychiatry.[48] The Association explained that although the terms "insanity" and "insane" were appropriate to the law, they no longer had any place in psychiatric medicine.[49]

However, the term "delusion," consisting of a false belief which is both persistent and doubly aberrant, as defined above, is medically well established.[50] A recent legal case provides a useful definition of insane delusion: a belief in things which are either impossible, or under the surrounding circumstances, so improbable "that no person of sound mind would give them credence," because it is a belief neither based in fact nor in reason.[51]

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44. *See* Jane B. Baron, *Empathy, Subjectivity, and Testamentary Capacity*, 24 SAN DIEGO L. REV. 1043 (1987).

45. WILLIAM J. BOWE & DOUGLAS H. PACKER, PAGE ON THE LAW OF WILLS §§ 12.37-.38 (1960).

46. *In re* Estate of Raney, 799 P.2d 986, 994, 996 (Kan. 1990).

47. 79 AM. JUR. 2D *Wills* § 87 (1975).

48. *See* AMERICAN PSYCHIATRIC ASS'N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS xxvii (4th ed. 1994).

49. *Id.*

50. *Id.* at 765.

51. *In re* Estate of Raney, 799 P.2d 986, 994, 996 (Kan. 1990).

The court's opinion concluded that if the individual's belief had any basis in fact or in reason, he was not suffering from an insane delusion.[52] Therefore, his testamentary capacity was preserved and his will was valid.[53] Because any fact can participate in the basis of a belief,[54] we call this the "One Fact Rule," which may overcome an allegation of testamentary incapacity due to an insane delusion.[55] Yet, even when the court fails to find a single fact supporting such a belief, the court may find the person to have had testamentary capacity.[56]

C. Test for Testamentary Capacity and Standards for Retention

The purpose of a will is to carry out the desires, or will, of the individual testator after his death: "[T]he courts guard jealously the rights of all rational people, including the aged, the infirm, the forgetful and the queer, to make wills sufficient to withstand the attacks of those left out and those dissatisfied with the expressed desires of the departed."[57]

The Uniform Probate Code test for the sound mind that is a basic requisite of testamentary capacity contains five major provisions. The testator must: (1) know those persons, such as relatives, who are the natural objects of his bounty and understand the nature of their legal claims, and their moral claims, to his bounty; (2) know the nature and extent of his property; (3) comprehend the disposition that his will is making; (4) appreciate the relation of these three elements to each other; and (5) form an orderly plan for this disposition of his property.[58]

In short, a testator is competent if he has the mental capacity to understand the nature of his act, to understand and remember the nature and situation of his property, and to understand his relations to

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52. *Id.*

53. *Id.* at 996-97.

54. *Id.* at 993, 996.

55. A psychiatrist who had treated the decedent one year before the date of the will and had also interviewed the decedent's ex-wife, sister, children, and social worker concluded that "decedent's belief that his ex-wife and children were siding against him was at least partially based in fact." Thus, the court found that the decedent did not have a legally real delusion. *Id.* at 946.

56. 79 AM. JUR. 2D *Wills* § 87 (1975).

57. Burke v. Burke, 801 S.W.2d 691, 693 (Ky. Ct. App. 1990) (quoting Tye v. Tye, 229 S.W.2d 973, 975 (Ky. 1950)).

58. LEWIS D. SOLOMON, TRUSTS AND ESTATES: A BASIC COURSE 92 (1981).

those persons who have claims to his bounty.[59] A person is presumed to achieve testamentary capacity when he attains adult age, and retains this capacity throughout his life, unless an appropriate court declares him incompetent.[60] Jurisdictions are split regarding the burden of proof required to overcome this presumption. Some courts require one challenging testamentary capacity to present a preponderance of the evidence while others require clear and convincing evidence.[61]

Standards for the retention of testamentary capacity throughout adult life and old age are extremely permissive. Advanced age, senility, poor health, and confusion are not always incapacitating.[62] For example, after a stroke which caused very severe memory problems, a testatrix was held competent to make her will.[63] In another case, a person was considered to be in possession of sufficient competence to execute a valid will even after a stroke which rendered her unable even to dictate the provisions of a will.[64] Although a testator may suffer from severe drowsiness or from an ailment producing a state of stupor characterized by deep unresponsiveness,[65] that testator may have sufficient understanding to make a will.[66] A person may make a valid will when he is "feeble in mind and decrepit in body,"[67] not competent to conduct his business affairs,[68] and even under guardianship.[69] Thus it comes as no surprise that "less mental capacity is required to make a will than any other legal document."[70]

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59. *E.g.*, *Raney*, 799 P.2d at 991 (citations omitted); Edwards v. Edwards, 520 So. 2d 1370, 1372 (Miss. 1988) (citations omitted); Hanson v. Williams, 398 P.2d 616, 619 (Mont. 1965) (citations omitted).

60. *See* UNIF. PROB. CODE § 2-501 cmt. (1993).

61. *E.g.*, Succession of Christensen, 649 So. 2d 23, 27 (La. Ct. App. 1994) (citations omitted); *Hanson*, 398 P.2d at 619 (citations omitted); *In re* Estate of Hastings, 387 A.2d 865, 868 (Pa. 1978) (citations omitted).

62. Ryel v. Parsons, 871 P.2d 437, 439 (Okla. Ct. App. 1993) (quoting *In re* Estate of Bracken, 475 P.2d 377, 380 (Okla. 1970)).

63. Caldwell v. LeRoy, 309 N.W.2d 261, 266-67 (Minn. 1981).

64. *In re* Dougan's Estate, 53 P.2d 511 (Or. 1936).

65. BOWE & PACKER, *supra* note 45, § 1243.

66. Logsdon v. Logsdon, 104 N.E.2d 622 (Ill. 1952).

67. *In re* Estate of Raney, 799 P.2d 986, 992 (Kan. 1990).

68. *Id.*; *In re* Estate of Hastings, 387 A.2d 865, 868 (Pa. 1978).

69. *Raney*, 799 P.2d at 992; Ryel v. Parsons, 871 P.2d 437, 438 (Okla. Ct. App. 1994).

70. *In re* Will of Goldberg, 582 N.Y.S.2d 617, 620 (N.Y. Surrogate's Ct. 1992).

D. The Lucid Interval

The lucid interval, which has been likened to an interval of sunshine during a storm,[71] is an interval of apparent health between attacks or periods of a disease.[72] The lucid interval is defined as a "period of rest or calm in the midst of tumult or confusion."[73] The venerable Blackstone made a further contribution: "If a lunatic hath lucid intervals of understanding," he wrote in 1769, "he shall answer for what he does in those intervals."[74] The lucid interval has long been recognized in American jurisprudence. In the young American republic, Dr. Isaac Ray, the forensic psychiatrist, reported in 1839 on a key English case: "It was decided by the court . . . that she had a lucid interval while making the will."[75]

The lucid interval is a period during which an insane person enjoys the restoration of his faculties, sufficient to enable him to judge his act.[76] It is a period in which the individual is not "wholly incompetent."[77] The testamentary lucid interval must encompass the time during which the testator executed his will.[78] Proof of such lucidity can consist of observations of the testator by lay witnesses as well as examination by professional witnesses.[79] A subscribing witness may testify as an expert witness on testamentary capacity.[80] And in one interesting variation, when an insane person wrote his will in his natural manner and its provisions were "sensible and judicious," the will itself was held to prove testamentary capacity.[81]

III. Alzheimer's but Competent

In the early or mild stages of Alzheimer's disease, quantified by simple tests based on the Activities of Daily Living criteria, an Alzheimer's patient is capable of living independently and of tending

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71. OXFORD ENGLISH DICTIONARY, *supra* note 7, at 80.
72. *Id.*
73. *Id.*
74. *Id.*
75. *Id.*
76. Kastner v. Husband, 372 P.2d 520, 522 (Or. 1962) (quoting 44 C.J.S. *Insane Persons* § 2).
77. Feiden v. Feiden, 542 N.Y.S.2d 860, 862 (N.Y. App. Div. 1989).
78. *See* Edwards v. Edwards, 520 So. 2d 1370, 1373 (Miss. 1988); *In re* Cook's Estate, 372 P.2d 520, 521-23 (Or. 1962).
79. *See, e.g.*, Succession of Mack, 535 So. 2d 461, 464; *Edwards*, 520 So. 2d at 1373; *Cook's Estate*, 372 P.2d at 522-23.
80. *Edwards*, 520 So. 2d at 1373.
81. Succession of Cahn, 522 So. 2d 1160, 1162 (La. Ct. App. 1988).

his individual needs.[82] But in the later stages, usually described as moderate or severe, such a patient manifestly becomes medically incapacitated.[83]

In a case of Alzheimer's disease, the medical expert may marshall scientifically compelling evidence to demonstrate that a patient is severely impaired and mentally disabled. He may demonstrate, based on history, examination, laboratory studies, evaluation based on Activities of Daily Living criteria, repeated neuropsychological testing, genetic studies, and other procedures, that the patient shows specific and severe abnormalities of this progressively dementing disease.[84] He may conclude medically that the patient's judgment was too impaired to make a valid will.[85] But the medical expert should be disabused of any notion that this medical diagnosis will always prevail when the court determines whether a testator possessed testamentary capacity when he executed a will. Medical diagnostic information is relevant and admissible, but on the legal matter of competence to make a will, the doctor's diagnosis proposes, while the court disposes.[86]

Few appellate courts have expressly addressed the testamentary capacity of diagnosed Alzheimer's patients.[87] Those courts which have addressed this issue have consistently held that a testator in a mild or mild to moderate stage of Alzheimer's disease does have testamentary capacity if, at the time the person executed the will, he clearly understood the nature of his acts, notwithstanding testimony of physicians to the contrary.[88] In short, the courts have consistently held that such testators were what we may call "Alzheimer's but competent."

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82. Gorman, *Benign Aging*, *supra* note 6, at 384.

83. *Id.* at 391.

84. *Id.* at 390-91.

85. *See, e.g., Cahn*, 522 So. 2d at 1160.

86. *E.g.*, Succession of Christensen, 649 So. 2d 23 (La. Ct. App. 1994); Succession of Mack, 535 So. 2d 461 (La. Ct. App. 1989); *Cahn*, 522 So. 2d at 1160; Edwards v. Edwards, 520 So. 2d 1370 (Miss. 1988); Ryel v. Parsons, 871 P.2d 437 (Okla. Ct. App. 1993).

87. In other cases, the testator was determined to have suffered from Alzheimer's after the will was executed, or the court did not determine conclusively that the testator suffered from Alzheimer's disease. *See, e.g., In re* Davidson, 839 S.W.2d 214 (Ark. 1992); Succession of Russo, 596 So. 2d 365 (La. Ct. App. 1992); Nelson v. Nelson, 891 S.W.2d 181 (Mo. Ct. App. 1995); *In re* Estate of Lien, 892 P.2d 530 (Mont. 1995); Whiting v. Vines, 810 P.2d 126 (Wyo. 1991).

88. *Christensen*, 649 So. 2d at 23; *Mack*, 535 So. 2d at 461; *Cahn*, 522 So. 2d at 1160; *Edwards*, 520 So. 2d at 1370; *Ryel*, 871 P.2d at 437.

A. *Estate of Edwards*

Jimmie Edwards was sixty-nine years old when he died of cancer in late December 1983. During the previous year, on September 30, 1982, he had executed a will.[89] On the day he made his will, Edwards drove to his son Jerry's home, asking Jerry to accompany him, saying he was going to make a new will. Jerry suggested a lawyer whom Edwards rejected. Instead, Edwards drove to the office of a lawyer who was an old friend. After the attorney drew up the new will, Edwards and Jerry drove to the local bank where they obtained two witnesses.[90]

At trial, Jerry testified that at the time his father executed the will, the elder Edwards' state of mind was "fine."[91] The lawyer testified that Edwards "talked like he knew what he was doing and what he wanted."[92] One witness testified that Edwards's appearance and behavior were not remarkable. The other witness, a bank vice president who knew Edwards's drinking history and had talked with him for over fifteen minutes, testified that he found Edwards to be "sane and sober."[93]

Edwards's doctors testified that their previous examinations indicated that Edwards's mental capacity would have been significantly impaired at the time he made his will. Approximately eighteen months before Edwards executed the will, one physician made the diagnosis of organic brain syndrome, due to permanent brain damage which affected Edwards's ability to make judgments. Another physician who had examined Edwards twelve months before the will was executed testified that the patient's judgment would have been poor. Three months before Edwards executed the will, a third physician had diagnosed Alzheimer's disease, which he testified produces "chronic mental problems."[94]

The court held that the testimony of the subscribing witnesses who had seen the testator when he executed the will was entitled to greater weight than that of the other witnesses, particularly the physicians who had not seen the testator that day. Further, the court discounted one physician's testimony that Edwards lacked testamentary

89. *Edwards*, 520 So. 2d at 1371.
90. *Id.*
91. *Id.* at 1372.
92. *Id.* at 1371.
93. *Id.* at 1373.
94. *Id.* at 1372-73.

capacity because the court was unsure that the physician understood the legal term. Based on the testator's behavior on the date of his will, as reported by those who saw him that day, the court held that Edwards then possessed testamentary capacity to execute the will.[95]

B. *Succession of Mack*

Mrs. Elvira Mack was eighty-six when she died on September 4, 1986. She had made her will on November 14, 1983.[96] A physician who had treated Mack from 1973 until her death thirteen years later had diagnosed her with Alzheimer's disease, noting that its course was both slow and gradual. By March of 1979, the physician testified, she was confused about her medication and appointments. However, he noted that her cognitive ability did not fail until 1984. In fact, in 1983 when she had executed her will, the physician was still willing to treat her alone and to converse with her on a person-to-person basis. It was not until April 1985 that he asked for a family member to accompany her to his office so someone could assist with her medications. An autopsy subsequently confirmed his diagnosis of Alzheimer's disease.[97]

An attorney who was also a notary public had known Mack for many years and had drawn both her 1975 and 1983 wills. When he executed her 1983 will, he asked her questions about her understanding of its provisions. He testified that she appeared to have the mental capacity to make a valid will.[98] The court, recognizing that a notary's testimony has "special credence" in the determination of testamentary capacity, found that the testimony of the notary public who had seen the testator on the day she executed the will was more persuasive than that of her physician. Consequently, the court held the testator to be competent when she executed her will.[99]

C. *Succession of Cahn*

Stella Cahn was a childless widow who died at age eighty-one in February 1986. She had made a will almost two years earlier, leaving all her property to a woman whom she had described as her "foster daughter." In previous wills, she had left her home to her two nieces,

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95. *See id.* at 1373.
96. Succession of Mack, 535 So. 2d 461, 462 (La. Ct. App. 1989).
97. *Id.* at 463-64.
98. *Id.* at 464.
99. *Id.*

naming her "foster daughter" as residual legatee and executrix. This "foster daughter," not further identified as to relationship, had lived with the testatrix and her family since she was seven years old.[100]

In October 1983, seven months before making her will, Cahn was examined by a well-credentialed psychiatrist, who made the diagnosis of Alzheimer's disease. At trial, the psychiatrist testified that Cahn's judgment therefore had been impaired and that she needed help in making decisions. On the other hand, her internist who was her treating doctor from 1980 until her death in 1986, painted a different picture. Only three weeks before Cahn executed her new will, the internist testified, "she was able to converse reasonably well with me. Sometimes she would get things a little backwards. She had memory troubles . . . but she always seemed to have a general grasp of the situation . . . . [S]he would get things wrong a little bit, but it wasn't really inappropriate."[101] Neither physician gave a specific opinion whether she had the capacity to make a valid will.[102]

In addition, several neighbors and the witnesses to her will, including a friend of over forty years, testified that Cahn carried on conversations. A niece who visited the decedent in 1984 described one conversation. "[W]e talked about me. We talked about her. I mean, we talked about a lot of things."[103] Another witness described Cahn as "totally lucid" on the day she made the will.[104]

Furthermore, the holographic nature of the will supported finding that Cahn possessed testamentary capacity. The will, written, dated, and signed "off the top of her head," was clear and legible, and compared favorably to her previous holographic wills. The court deemed her last will to be "sensible and judicious."[105] Based on the nonmedical evidence, the court held that the testatrix was not fully incapable of making her will and was not totally incapable of experiencing lucid intervals.[106]

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100. Succession of Cahn, 522 So. 2d 1160, 1162 (La. Ct. App. 1988).
101. *Id.* at 1161.
102. *See id.* at 1160-61.
103. *Id.* at 1162.
104. *Id.* at 1161.
105. *Id.* at 1162.
106. *See id.* at 1162-63.

D. *Ryel v. Parsons*

Ruth Long was diagnosed as having Alzheimer's disease in January 1988. One month later, a guardian was appointed for her. She made her will on July 25, 1988, and died in 1992.[107]

Her attending physician testified that due to her Alzheimer's disease, Long could not have known what she was doing when she executed her will. But the district judge, required under state law to officiate in the execution of her will, had asked her questions, some of which were complex. Her answers indicated that she was oriented as to time, place, and person. She identified witnesses who were not relatives and identified her daughter and granddaughter as those who would receive her property.[108]

The court noted that although it is admissible, medical testimony is only one facet of the capacity determination.[109] Consequently, because the district judge's questions on the day the will was executed required understanding and thinking, the appellate court found that at the time Long executed her will, she possessed testamentary capacity because she "knew what she was doing, and that she wanted to do it."[110]

E. *Succession of Christensen*

Polly Christensen, an elderly widow with three daughters, made a will on November 15, 1990, leaving all her assets to one daughter. The other two daughters contested this will, claiming lack of testamentary capacity.[111]

In February 1989, a neurologist had diagnosed Christensen as having mild to moderate Alzheimer's disease. On two follow-up examinations, including one after the execution of the will, the neurologist found continued worsening of the disease. At trial, the neurologist testified that Christensen "would not have been able to understand the ramifications of executing a testament on November 15, 1990."[112]

Christensen's lawyer, with whom her late husband had practiced, first attempted to discourage her from leaving all her property

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107. Ryel v. Parsons, 871 P.2d 437, 437-38 (Okla. Ct. App. 1993).
108. *Id.* at 438-39.
109. *See id.* at 438.
110. *Id.* at 440.
111. Succession of Christensen, 649 So. 2d 23, 24 (La. Ct. App. 1994).
112. *Id.*

to only one daughter. The lawyer gave her two wills from which to choose. One would leave her estate equally to her three daughters while the other would leave it solely to the one daughter. The lawyer then left the room. Christensen wrote a very brief holographic will, giving all her property to the selected daughter.[113]

At trial, her lawyer testified that although Christensen's mind "wandered off" occasionally, she had the "mental capacity to understand what she was doing and [to understand] the length and [breadth] of her estate."[114] Two of Christensen's sitters at home testified that as recently as March 1990, six months before executing the will, she could not "remember anything and could not do much for herself."[115] But other sitters and the beneficiary daughter testified that Christensen was aware of what was going on and always knew the people around her. In addition, the pastor of her church testified that Christensen recognized him, was able to "tell [him] exactly what she felt or what she wanted," and was able to carry on involved conversations.[116]

This appellate court, noting that "testamentary capacity is solely a question of fact to be determined by the trial court," held that Christensen was capable of understanding her testamentary act and that she appreciated the effects of this act when the will was executed, despite the diagnosis of mild to moderate Alzheimer's disease.[117]

IV. The Role of the Medical Expert

As the above cases demonstrate, to prove that a testator has Alzheimer's disease in the mild stage requires a specially qualified physician to take a series of established diagnostic steps. The medical expert must be skilled in neuropsychiatric medicine and therefore is usually a neurologist. Most board-certified neurologists have the following qualifications: he must be familiar with the diagnostic inclusion criteria and exclusion criteria for Alzheimer's disease, such as those in Table 1, and the diagnostic techniques such as those of the American Neurological Association's practice parameters for diagno-

113. *Id.* at 24-25.
114. *Id.* at 25-26.
115. *Id.* at 24, 26.
116. *Id.*
117. *Id.* at 27.

sis and evaluation of dementia.[118] He must be generally familiar with the Self Care and the Social Activities of Daily Living criteria (Table 2). Additionally, he must be generally familiar with the grading of severity, or staging, of a disease. Subsequently, he will be able to grade the patient's Alzheimer disease in a stage such as "mild," "moderate," or "severe."

When the testator's competency is at question, the attorney must instruct the medical expert to answer two basic questions. First, the attorney must ask the medical expert to determine if, at the time the testator executed his will, the testator was capable of living independently and with relatively little assistance. For this determination, "capable" is the key word rather than the testator's actual performance. Second, the attorney must ask the medical expert to determine if, at the time the testator executed his will, the testator was in a stage of Alzheimer's disease that was no more severe than a mild to moderate stage.

A qualified physician, usually a neurologist or a psychiatrist, makes the diagnosis of mild Alzheimer's disease in three steps. First, the physician makes the diagnosis of dementia, often following the criteria set forth in Table 4. At that time, he learns the patient's Activities of Daily Living (Table 3) which indicates the degree of independence that the patient enjoys. In the second step, he grades the severity or stage of the patient's dementia (Table 5). The physician diagnostically ascertains that the patient's dementia consists of dementia of the Alzheimer's type, or Alzheimer's disease, following the established inclusion criteria and exclusion criteria (Table 1). Third, the physician uses his clinical judgment, or any of the various established protocols which evaluate memory, orientation, judgment, personal care, and other criteria for staging the severity of this disease as mild, moderate, or severe.[119] Neither in customary clinical judgment, nor in these and similar protocols, are there sharp, objective, and reproducible lines which separate mild Alzheimer's disease from moderate Alzheimer's disease. The physician may then propose his diagnosis, including staging of severity, to a court. The court then considers all the facts and makes its determination.

118. John C. Morris, M.D., *The Clinical Dementia Rating (CDR): Current Versions & Scoring Rules*, 43 NEUROLOGY 2412, 2412-13 (1993).

119. *Id.*

V. Conclusion

Although Alzheimer's disease is a progressive dementing illness, persons in the mild or mild to moderate stages of this disease can retain their testamentary capacity, or the ability to make a valid will. Thus, the attorney and medical expert must be well informed of the diagnostic steps and stages of Alzheimer's disease to assist the court in making its determination of competency.

TABLE 1
Clinical Diagnosis of Alzheimer's Disease

A. Inclusion Criteria - presence of all of 1, 2, and 3 must be proved:
   1. Duration over 6 months
   2. Gradual, "insidious" onset
   3. Continued deterioration, in a person who is alert, of:
      a. memory, plus at least 3 of the following functions:
      b. orientation
      c. judgment and problem solving
      d. community activities
      e. home and hobby activities
      f. personal, or self care

B. Exclusion Criteria - absence of all of 1, 2, and 3 must be proved:
   1. Other neurological disorders
   2. Severe psychiatric disorders, particularly depressive and substance disorders
   3. Reversible dementias

Source: John C. Morris, M.D., *The Clinical Dementia Rating (CDR): Current Versions & Scoring Rules*, 43 NEUROLOGY 2412, 2412-13 (1993).

TABLE 2
Activities of Daily Living

Self Care		
Can the patient, alone, safely:		
	Feeding	Prepare food for own meals
		Eat self prepared food
	Dressing	Remove all own clothing
		Find own clean clothing
		Dress self
	Bathing	Bathe self
		Dry self
	Toilet	Find toilet
		Use toilet satisfactorily
	Continence	Without catheter in place, not wet self with urine
		Without special devices, not soil self with feces
	Transfer	By self:
		Get out of bed
		Get into wheelchair
		Get out of wheelchair
Social		
	Purchase food	
	Purchase household supplies	
	Handle simple finances	
	Arrange for public or private transportation	
	Arrange for nursing and medical care	

Sources: S. Katz, *Studies of Illness in the Aged*, 185 JAMA 914, 915 (1963); Warren F. Gorman, *Mental Acuity of the Normal Elderly*, 88 J. OKLA. ST. MED. ASS'N 119, 120 (1995); Warren F. Gorman, *Benign Aging or Alzheimer Disease?*, 88 J. OKLA. ST. MED. ASS'N 383, 383 (1995).

TABLE 3
Dementia

Inclusion Criteria

Over the past six months, *significant*

1. Interference with work or activities of others
2. Impairment of short term and long term memory

   Plus one or more of the following:

   a. Personality Change
   b. Impairment of Judgment
   c. Impairments of language, or recognition of objects, or manual skills, or other signs of "higher cortical function"
   d. Impairment of abstract thinking

Exclusion Criteria

1. Delirium (in which the level of consciousness is diminished)
2. Severe mental disorder, such as Major Depression, which produces apparent cognitive deficits

Source: AMERICAN PSYCHIATRIC ASS'N DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS 107 (3d ed. rev. 1987).

TABLE 4
Grading Severity of Dementia

Mild:	Although work or social activities are significantly impaired, the individual retains adequate personal hygiene, adequately intact judgment and is capable of independent living.
Moderate:	Independent living may be hazardous; some supervision may be necessary.
Severe:	Unable to maintain personal hygiene; continual supervision is required.

Source: AMERICAN PSYCHIATRIC ASS'N: DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS 107 (3d ed. rev. 1987).

TABLE 5
Functional Assessment Staging Test

STAGE	CHARACTERISTICS	CLINICAL DIAGNOSIS
1	No objective or subjective funtional decrement	Normal Adult
2	Subjective deficit in recalling names or other word finding and/or subjective deficit in recalling location of objects and/or subjectively decreased ability to recall appointments. No objectively manifest functional deficits.	Normal aged Adult
3	*Deficits noted in demanding occupational and social settings* (e.g., the individual may begin to forget important appointments for the first time; work productivity may decline); problems may be noted in traveling to unfamiliar locations (e.g., may get lost traveling by automobile and/or public transportation to a "new" location or spot).	Compatible with incipient Alzheimer's Disease (AD)
4	*Deficits in performance of complex tasks of daily life* (e.g., paying bills and/or balancing checkbook; decreased capacity in planning and/or preparing an elaborate meal; decreased capacity in marketing, such as in the correct purchase of grocery items).	Mild AD

TABLE 5 (contined)

STAGE	CHARACTERISTICS	CLINICAL DIAGNOSIS
5	*Deficient performance in choosing proper attire, and assistance is required for independent community functioning.* The spouse or other caregiver frequently must help the individual choose the appropriate clothing for the occasion and/or season (e.g., the individual will wear incongruous clothing). Over the course of this stage some patients may also begin to forget to bathe regularly (unless reminded) and automobile driving capability becomes compromised (e.g., carelessness in driving an automobile and violations of driving rules).	Moderate AD
6a	*Requires actual physical assistance in putting on clothing properly.* The caregiver must provide increasing assistance with the actual mechanics of helping the individual clothe himself properly (e.g., putting on clothing in proper sequence, tying shoelaces, putting shoes on proper feet, buttoning and/or zipping clothing, putting on blouse, shirt, pants, skirt, etc., correctly).	Moderately Severe AD
6b	*Requires assistance to bathe properly.* The patient's ability to adjust bathwater temperature diminishes; the patient may have difficulty entering and leaving the bath; there may be problems with washing properly and completely drying oneself.	Moderately Severe AD
6c	*Requires assistance with mechanics of toileting.* Patients at this stage may forget to flush the toilet and may begin to wipe themselves improperly or less fastidiously when toileting.	Moderately Severe AD
6d	*Urinary incontinence.* This occurs in the absence of infection or other genitourinary tract pathology; the patient has episodes of urinary incontinence. Frequency of toileting may mitigate the occurrence of incontinence somewhat.	Moderately Severe AD

TABLE 5 (contined)

STAGE	CHARACTERISTICS	CLINICAL DIAGNOSIS
6e	*Fecal incontinence.* In the absence of gastrointestinal pathology, the patient has episodes of fecal incontinence. Frequency of toileting may mitigate the occurrence of incontinence somewhat.	Moderately Severe AD
7a	*Speech limited to about six words in the course of an average day.* During the course of an average day the patient's speech is restricted to single words (e.g., "Yes," "No," "Please") or short phrases (e.g., "please don't hurt me," "get away," "get out of here," "I like you").	Severe AD

Source: S.G. Sclan, *Functional Assessment Staging Test (FAST) in Alzheimer's Disease*, 4 INT'L PSYCHOGERIATRICS 55 (1992).