Capacity and Undue Influence: Assessing, Challenging, and Defending

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Scope of Guide

This Action Guide provides a step-by-step method for applying DPCDA and other relevant statutes when assessing capacity and undue influence issues in the office setting and when litigating these issues in court. The authors present the basics of the law governing protected health information under HIPAA and CMIA and how the rules might affect practitioners dealing with the issue of capacity and undue influence. The authors set out the different tests for capacity and undue influence in the context of wills, trusts, marriage, contracts, medical decisions, financial management decisions, and conservatorships. The authors also address the issues of capacity to drive, gifts to disqualified persons, mediation as an alternative to litigation, and litigation issues of standing, burden of proof, presumptions, and rules of evidence specific to each of these contexts. A neuropsychologist expert witness and a psychiatrist medical-legal consultant contribute their professional perspectives.

Abbreviations

Trust & Prob Litig	California Trust and Probate Litigation (Cal CEB 1999)
CMIA	Confidentiality of Medical Information Act
DPCDA	Due Process in Competence Determinations Act
HIPAA	Health Insurance Portability and Accountability Act of 1996
House & Ross, Guide to the California Rules of Professional Conduct	House & Ross, Guide to the California Rules of Professional Conduct for Estate Planning, Trust and Probate Counsel (State Bar of California 2008 ed)

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Using This Action Guide

STEP 1. SUMMARY AND OVERVIEW

PURPOSE OF THIS ACTION GUIDE

For an attorney facing the issue of a new or existing client's incapacity or of undue influence on the client, whether in an office setting or in the context of litigation, this Action Guide provides a step-by-step method on how to proceed.

IN EVERY SITUATION

a. Determine who is actually the client. See steps 2-4, below.

b. Avoid breach of duty to clients. See step 5, below.

WHEN THE ISSUE IS CAPACITY

a. Start by understanding the Due Process in Competence Determinations Act (DPCDA) (Prob C §§810-813, 1801, 1881, 3201, 3204, 3208) and how it works. See step 10, below.

b. Consider other relevant statutes and applicable case law and their relationship to DPCDA. See step 10, below.

c. Apply DPCDA and other relevant statutes and case law analysis in every context in which the client's capacity to do a particular act or make a particular decision is in question, including the following situations:

(1) When drafting documents (*e.g.,* testamentary instruments or trusts, contracts or conveyances, or documents appointing agents) for a client.

(2) When a client's capacity to have executed a document in the past is being litigated.

(3) When assessing or litigating the client's ability to:

(a) Make medical decisions. See step 22, below.

(b) Authorize the release of personal medical information (so-called protected health information). See step 23, below.

(c) Qualify for long-term care insurance.

(d) Nominate a conservator, or manage his or her own personal and financial affairs. See steps 18 and 20, below.

(4) When assessing the client's capacity to marry or enter into a registered domestic partnership. See step 14, below.

(5) When assessing the client's capacity to drive. See step 24, below.

Communication Capacities and Functional Capacities

The capacity determinations discussed in this Action Guide can be divided into two broad categories:

a. *Communication capacities.* Most capacity determinations involve consideration of how and what a person is able to communicate "verbally or by any other means" (Prob C §812) to the one making the determination. Examples include:

(1) Is a patient able to express what he or she needs? Is he or she able to understand or appreciate the risks, benefits, and alternatives to various medical procedures?

(2) Is a client able to express dispositive wishes to attorney as well as understand and appreciate the consequences, risks, and benefits of various estate planning recommendations?

b. *Functional capacities.* Two capacity determinations discussed in this Action Guide involve consideration of how a person is able to function regardless of how the person communicates:

(1) The determination of a person's capacity to manage personal and financial affairs made by the court in a conservatorship proceeding is based on functional tests set forth in the conservatorship statutes:

(a) If personal and financial affairs cannot be managed even with the help of coping mechanisms, such as appointing proxies, a conservatorship will be imposed regardless of what a person can say or what deficits are present.

(b) The statutory language is somewhat subjective. A strictly functional analysis may not be sufficient, and the court may be interested in mental function deficits in a close or contested case, or when a bad actor is taking advantage of someone who seems to consent, or undue influence is a major issue in some other way.

(2) The ability to drive safely is determined by the Department of Motor Vehicles, based on tests administered there. However, while the functional ability to drive safely is the only issue, the functional tests are not always the end of the analysis:

(a) Revocation decisions can be appealed, and evidence of mental function deficits may be relevant in the process.

(b) A person whose license is revoked may engage in civil litigation to recover it, and a professional assessment of deficits that affect driving may be useful in court. See step 24, below.

Creating Testamentary Documents

a. In the office setting, determine whether the client has the capacity to execute testamentary documents. See steps 11 and 19, below.

b. In a litigation setting, also ask:

(1) Who has standing?

(2) What presumptions apply?

(3) Who has the burden of proof?

(4) What are the relevant rules of evidence?

Cross-Reference: See steps 11-13, below.

Marriage and Registered Domestic Partnership

In assessing a person's capacity to marry or enter into a registered domestic partnership:

a. Apply the presumptions in favor of capacity contained in Prob C §§810(a) and 1900.

b. Identify applicable mental function deficits and determine whether there is a correlation between the deficit and the act or decision.

Cross-Reference: See step 14, below, and Appendix D.

Contracting, Conveying, or Making Agency Appointments

a. In the office setting, determine whether the client has the capacity to do the act in question, *i.e.,* to contract, convey, or make agency appointments.

b. In the litigation setting, also ask:

(1) What presumptions apply?

(2) What privileges might apply?

(3) What are the remedies?

Cross-Reference: See steps 15-17, below.

Nomination of a Conservator and Appointment of the Nominee

See step 18, below.

Creating a Trust

See step 19, below.

Managing Personal and Financial Affairs

See steps 20-21, below. In the litigation setting, also ask:

a. What presumptions apply?

b. What is the standard of proof?

c. What is the standard for imposition of a conservatorship?

Making a Medical Decision

See step 22, below.

Authorizing Release of Protected Health Information

See step 23, below. See steps 6-9, below, for an introduction to the federal and state medical privacy laws.

Driving

See step 24, below.

WHEN THE ISSUE IS UNDUE INFLUENCE

If a client is or might be susceptible to undue influence, the attorney should:

a. In the office setting, try to protect the client by taking the steps indicated for the particular type of act or decision involved.

b. In the litigation setting, refer to the steps that address applicable statutes, presumptions, burdens of proof and rules of evidence, standing, and the remedy, if undue influence is found.

Testamentary Acts

When there is a question of undue influence affecting testamentary documents, ask (see steps 25-27, below):

a. What is the definition of undue influence regarding a testamentary act?

b. What steps can be taken to protect the client?

c. In the litigation setting, also ask:

(1) Who has the burden of proof?

(2) What kind of evidence is relevant?

(3) What are the indicia of undue influence?

(4) What is the remedy?

Contracts, Conveyances, Marriage or Registered Domestic Partnership, and Agency Appointments

When there is a question of undue influence affecting contracting, conveyancing, marriage or registered domestic partnership, or appointing agents, ask (see steps 28-30, below):

a. What is the statutory standard for determining undue influence?

b. What steps can be taken to protect the client?

c. In the litigation setting:

(1) Who has the burden of proof?

(2) What are the indicia of undue influence?

(3) What is the remedy?

TRANSFERS TO DISQUALIFIED PERSONS

See step 31, below.

CONSIDER MEDIATION

See step 32, below.

NEUROPSYCHOLOGIST'S PARTICIPATION

a. Know when to consult a neuropsychologist, when to obtain a client evaluation, and when and how to use a neuropsychologist as an expert witness in litigation. See step 33, below.

b. Understand the neuropsychologist's framework and perspective, *e.g.,* in assessing a person's (see step 34, below):

(1) Capacity to do testamentary acts;

(2) Capacity to consent to or refuse to consent to medical treatment;

(3) Ability to resist undue influence;

(4) Capacity to qualify for long-term care insurance;

(5) Least restrictive environment for placement as a potential conservatee; and

(6) Capacity to execute trusts or enter into contracts.

PHYSICIAN'S PERSPECTIVE

Understand medical issues that may affect capacity and susceptibility to undue influence in older adults.

a. Adverse effects of medical conditions. See step 35, below.

b. Adverse effects of medications. See step 36, below.

Determining Who Is the Client

STEP 2. DETERMINE WHO IS THE CLIENT

PERSON WHO CONTACTS ATTORNEY MAY NOT BE CLIENT

Often, the person whose incapacity or susceptibility to undue influence is in question is not the person who contacts the attorney.

Example: In *Boranian v Clark* (2004) 123 CA4th 1012, 20 CR3d 405, the attorney drafted a terminally ill client's will based on instructions from the client's companion, who benefited at the expense of the client's children. The children then sued the attorney for malpractice for failure to determine his client's intent or capacity. Although the court of appeal reversed the malpractice judgment because the attorney had no duty of care to the children to ascertain the client's capacity (see step 5, below) and because the children's remedy was to contest the will, a drafting attorney should do more to ensure that the estate planning documents carry out the client's wishes.

ONCE DECIDED, MEET ONLY WITH CLIENT

a. Before you decide what action you will take on the client's behalf, decide who will be your client and whom you will not represent.

b. After this decision is made, meet privately with the client when all crucial decisions will be made. Keep in mind the following:

(1) Even if the client claims to be "more comfortable" with an adult child present, insist on meeting privately with the client, even if only to confirm the client's wishes outside the child's presence;

(2) Explain to the client that the purpose of the private meeting is to make it more likely that the client's wishes will be carried out;

(3) It is absolutely critical to determine whether there is any undue influence by meeting with the client alone for a significant period and, if still uncertain, several more times; and

(4) If the client requires outside assistance, the first clue as to incapacity or undue influence has been presented, and the resulting analysis must occur with a clear focus on the client alone.

NOTE

There may be unusual circumstances in which the attorney allows a family member to be present, *e.g.,* the client is developmentally disabled or otherwise difficult to understand and only a family member understands the client's speech.

EXPLAIN THAT DUTY IS ONLY TO CLIENT

Make it clear to the client and others who may be involved that the attorney's duties, including the duty of confidentiality, are owed only to the client.

USE UNRELATED INTERPRETER

If an interpreter will be required, an unrelated interpreter should be hired, or the attorney should consider declining representation and referring the person to an attorney who speaks the person's first language.

STEP 3. AVOID PROBLEM OF JOINT REPRESENTATION

POTENTIAL PROBLEM

The problem of assessing incapacity and undue influence becomes more difficult when an attorney represents more than one client in related legal matters.

Example 1: Representing spouses, especially when the couple has both separate and community property or children from other marriages.

Example 2: Representing both parents and adult children, particularly if the circumstances warrant a program of gifting.

Example 3: Representing the proposed conservatee as well as the person petitioning to be appointed conservator.

Example 4: Representing the older spouse or partner and the younger spouse or partner, whether in a marital or other committed relationship.

Example 5: Representing spouses when there is a great disparity in the value of their separate property, or partners in other committed relationships when there is a great disparity in wealth.

WHEN JOINT REPRESENTATION IS NOT PERMISSIBLE

An attorney cannot:

a. Represent clients whose interests actually or potentially conflict, without each client's informed written consent (Cal Rules of Prof Cond 3-310(C)); or

b. Accept employment adverse to a client or former client without the client's or former client's informed written consent when the attorney has obtained confidential information from the client (Cal Rules of Prof Cond 3-310(E)).

WHEN JOINT REPRESENTATION IS PERMISSIBLE

An attorney may represent clients jointly, *e.g.,* husband and wife, parents and children, and unmarried couples, in estate planning, property acquisitions, or business transactions.

a. Joint representation is premised on there being no actual conflict of interest, although the potential for conflict always exists. See House & Ross, Guide to the California Rules of Professional Conduct for Estate Planning, Trust and Probate Counsel 19 (State Bar of California 2008 ed), referred to throughout this Action Guide as House & Ross, Guide to the California Rules of Professional Conduct.

b. Assuming that no actual conflict of interest exists, joint representation often results "in a more coordinated result at a lower cost than if each party were individually represented by a different lawyer." House & Ross, Guide to the California Rules of Professional Conduct 19.

NOTE

Even when there is no actual conflict initially, joint representation in an elderly parent-child situation poses potential problems.

Example: Parent and child met with attorney to prepare mother's trust, which left estate in equal shares to two children and named child who accompanied mother to all meetings as trustee. Attorney never met with mother alone. Trustee looted the trust. Other child sued attorney for failure to determine whether mother was incapacitated or under undue influence. Attorney's malpractice carrier settled the case.

LETTER OF JOINT REPRESENTATION

The Letter of Joint Representation should:

a. Give examples in which the potential for conflict may become an actual conflict of interest;

b. Specify that the attorney cannot withhold from one client any confidences communicated by the other with respect to the subject of the representation; and

c. Specify that the attorney will share with each client all significant developments relating to the representation.

Sample Form: For a sample letter of joint representation, see Appendix A.

NOTE

An attorney representing clients jointly must be satisfied that each client has the capacity to enter into an attorney-client relationship and to waive the potential for conflicts of interest. Further, an attorney should be sensitive to the issue of whether one joint client's influence on another joint client is, or becomes, "undue" influence.

STEP 4. AVOID UNINTENDED ATTORNEY-CLIENT RELATIONSHIP

RELATIONSHIP ESTABLISHED

An attorney-client relationship may be established, with its attendant duties and potential liabilities, even if the parties do not agree on a fee or have not entered into a written contract, if the client consults an attorney for legal advice and obtains such advice. *Miller v Metzinger* (1979) 91 CA3d 31, 39, 154 CR 22.

CLARIFY WHO IS AND WHO IS NOT REPRESENTED

At the outset, make it clear, both orally and in writing, whom you represent and, just as important, whom you do not represent.

Example: An attorney who represents an adult child in preparing a trust for an elderly parent in which the adult child is named the trustee is likely to be the unintended surety for the child's conduct. It is likely that a court will determine that the elderly parent reasonably believed that the attorney was representing him or her unless the elderly parent had independent representation or consented in writing to a letter of nonrepresentation.

Sample Form: For sample letter of nonrepresentation, see Appendix B.

Avoiding Breach of Duty to Clients

STEP 5. CONSIDER DUTIES OWED TO CLIENT

CONSIDER DUTIES

An attorney should consider the following duties owed to the client:

Undivided Loyalty

The duty of undivided loyalty to the client. *Flatt v Superior Court* (1994) 9 C4th 275, 36 CR2d 537.

Perform Services Competently

The duty to perform legal services competently. Cal Rules of Prof Cond 3-110(A). Failure to do so is malpractice. See *Day v Rosenthal* (1985) 170 CA3d 1125, 1147, 217 CR 89.

Confidentiality

The duty in general to maintain the client's confidences and preserve the client's secrets. Bus & P C §6068(e)(1). The only exception to this duty allows the attorney to reveal confidential information "to prevent a criminal act that the attorney reasonably believes is likely to result in death … or substantial bodily harm." Bus & P C §6068(e)(2).

Keep Client Informed

The duty to keep a client reasonably informed about significant developments relating to the representation. Cal Rules of Prof Cond 3-500(E).

DUTY TO IMPAIRED CLIENT

California has no rule specifically addressing the obligation of an attorney who represents a mentally impaired client. House & Ross, Guide to the California Rules of Professional Conduct 150.

NOTE

A majority of states and other jurisdictions require an attorney to maintain a normal client-lawyer relationship with the client when the client's ability to make adequately considered decisions in connection with the representation is impaired. House & Ross, Guide to the California Rules of Professional Conduct 152.

Revision of California Rules of Professional Conduct

The Commission for the Revision of the Rules of Professional Conduct is currently considering whether to modify California's current rules governing the attorney's duties toward a mentally impaired client. House & Ross, Guide to the California Rules of Professional Conduct 156.

Wills and other testamentary devices

ATTORNEY'S DUTY WHEN CLIENT'S CAPACITY IS UNCERTAIN

It is difficult for an attorney to discharge both the duty of undivided loyalty and the duty to act competently when a client's testamentary capacity is questionable, because:

a. An attorney should not prepare a will or other dispositive instrument for a client who the attorney believes lacks the requisite capacity (American College of Trust and Estates Counsel (ACTEC), Commentary on ABA Model Rules of Prof Cond 1.14, cited

in House & Ross, Guide to the California Rules of Professional Conduct 157); but

b. The attorney "may properly assist clients whose testamentary capacity appears to be borderline." House & Ross, Guide to the California Rules of Professional Conduct 157.

No Duty to Beneficiaries

An attorney who prepares a testamentary instrument for a client owes no duty to beneficiaries of an earlier testamentary instrument to ascertain and document the client's testamentary capacity.

a. *Moore v Anderson Zeigler Disharoon Gallagher & Gray* (2003) 109 CA4th 1287, 1298, 135 CR2d 888 (attorney who executed new will and amended revocable trusts for terminally ill and extremely weak client owed no duty to beneficiaries who received less under settlement of ensuing trust litigation than they would have received under estate plan before it was amended), citing this Action Guide. The *Moore* court:

(1) Reasoned that imposing such a duty to beneficiaries would compromise the attorney's duty of loyalty to the client;

(2) Distinguished earlier cases in which an attorney was held liable to nonclient beneficiaries when the nonclient was the intended beneficiary of the attorney's services and, therefore, there was "no potential for conflict between the duty the attorney owes the client and the duty the attorney owes the intended beneficiaries"; and

(3) Concluded that to extend the attorney's duty to nonclient beneficiaries when the issue is the client's capacity "would place an intolerable burden upon attorneys" and "would unjustifiably deny many persons the opportunity to make or amend their wills." 109 CA4th at 1299.

b. *Boranian v Clark* (2004) 123 CA4th 1012, 20 CR3d 405 (attorney who drafted will for dying testator who was taking morphine and subject to hallucinations did not owe duty of care to individuals who were to receive testator's estate under prior will).

Document Your File

When the client's testamentary capacity is doubtful, it is good practice for the attorney to document in the file the attorney's observations and why the attorney prepared or refused to prepare the testamentary instrument.

POSSIBLE SOLUTIONS

Depending on the circumstances, possible solutions include:

a. Using other methods to accomplish the client's objectives, such as a petition for substituted judgment in a conservatorship proceeding under Prob C §§2580-2586.

b. Deferring discussion or execution of documents until a later time when client capacity may be present.

c. Striving to find a client competent, even if the client's capacity is questionable, if the proposed transaction is one that is beneficial to the client, *e.g.*:

(1) Substituting a revocable inter vivos trust for a will as an estate planning device, when the trust contains the same dispositive provisions as those in the will, in order to save probate costs; or

(2) Agreeing that a competent spouse's separate property is community property in order to obtain a double step-up in basis.

Conservatorship

WHAT CONSTITUTES VIOLATION OF DUTY TO CLIENT

The attorney who has represented a client violates the attorney's ethical duties to the client if, without the client's consent, the attorney represents another who petitions to be appointed conservator over the client's objections. California State Bar Formal Opinion No. 1989-112, discussed in House & Ross, Guide to the California Rules of Professional Conduct 150-151. The attorney may not accept:

a. Representation in a matter in which a client's interest actually or potentially conflicts with the proposed client's, without the informed written consent of both the current client and the proposed client. Cal Rules of Prof Cond 3-310(C).

b. Employment adverse to a former or current client, without the client's informed written consent, if, in representing the client, the attorney has obtained confidential information material to the employment. Cal Rules of Prof Cond 3-310(E).

NOTE

The attorney generally should not represent anyone trying to conserve the client. The written consent of a client who is a proposed conservatee is not likely to protect the attorney from violating her or his duties under the Rules of Professional Conduct. Even if the client does not object at the start of the process, the attorney may inadvertently use confidential information in representing the petitioner.

Further Research: For further discussion, see California Conservatorship Practice §1.4 (Cal CEB 2005).

POSSIBLE SOLUTIONS

Depending on the circumstances, possible solutions include:

a. Advising a client with capacity about methods of avoiding imposition of a conservatorship, including (House & Ross, Guide to the California Rules of Professional Conduct 150):

(1) Durable powers of attorney for asset management (both immediate and springing);

(2) Advanced health care directives;

(3) Revocable trusts;

(4) Community property; and

(5) Joint tenancy.

b. Advising the client about voluntarily accepting the assistance of relatives and friends—although it is important for the attorney to consider potential undue influence by certain relatives and friends.

c. Advising the client about appointing a representative payee for benefits from the Veterans Administration and Social Security. See California Conservatorship Practice §1.16 (Cal CEB 2005).

NOTE

In other jurisdictions, an attorney may seek the appointment of a conservator or guardian for a client, but only when the attorney "reasonably believes that the client cannot adequately act in the client's own interest." ABA Model Rules of Prof Cond 1.14(b); see also ABA Formal Opinion 96-404 (Aug. 2, 1996)—both cited in House & Ross, Guide to the California Rules of Professional Conduct 150. This approach is not recommended.

Introducing Medical Privacy Laws and Evidentiary Privileges

STEP 6. KNOW THE BASIC HIPAA AND CMIA REQUIREMENTS AND THE APPLICABLE EVIDENTIARY PRIVILEGES

THREE SETS OF RULES AFFECT ABILITY TO OBTAIN AND USE MEDICAL INFORMATION

The attorney seeking medical information for the purpose of determining a person's capacity or susceptibility to undue influence, or both, whether by subpoena in a contested proceeding or by request, must understand three separate but interrelated sets of rules that affect the attorney's ability to obtain and use medical information:

a. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) (Pub L 104-191, 110 Stat 1936) (particularly the HIPAA privacy provisions found in 42 USC §1320d-2 and 45 CFR pts 160, 164), which is a regulatory scheme directed at the health care industry that requires the Secretary of Health and Human Services to adopt national standards to protect the security and privacy of certain health information;

b. California's Confidentiality of Medical Information Act (CMIA) (CC §§56-56.37), which provides for a private cause of action for violations as well as criminal and administrative sanctions (CC §§56.35, 56.36); and

c. Evidentiary privileges under Evid C §§990-1007 (physician-patient privilege) and Evid C §§1010-1027 (psychotherapist-patient privilege).

HIPAA, CMIA, AND THE ISSUE OF PREEMPTION

a. The HIPAA regulations preempt state law unless the state law provides broader privacy protection. 45 CFR §160.203.

b. CMIA in some ways goes beyond the HIPAA regulations, and to the extent that CMIA is stricter than the HIPAA regulations, CMIA is not preempted by them. 45 CFR §160.203.

WHO IS RESPONSIBLE FOR THE PRIVACY OF HEALTH CARE RECORDS

Under HIPAA

The HIPAA regulations apply to "covered entities," defined as health plans, health care clearinghouses, and health care providers that transmit health information in electronic form. 45 CFR §§160.102, 160.103.

Under CMIA

CMIA applies to:

a. Health care providers, including doctors, dentists, pharmacists, emergency medical service providers, chiropractors, medical clinics, health dispensaries, or health facilities, but not insurance institutions (CC §56.05(j));

b. Medical information businesses (CC §56.06);

c. Employers who receive medical information (CC §56.20); and

d. A recipient of medical information (CC §56.13).

INFORMATION THAT IS PROTECTED

Individually Identifiable Health Information Under HIPAA

a. Health care providers may not use or disclose "protected health information" except as HIPAA permits. 45 CFR §164.502(a).

b. "Protected health information" is broadly defined as "individually identifiable health information," which is further defined as

a subset of health information that (45 CFR §160.103):

(1) Is created or received by a health care provider, health plan, employer, or health care clearinghouse;

(2) Relates to:

(a) The past, present, or future physical or mental health or condition of an individual;

(b) The provision of health care to an individual; or

(c) The past, present, or future payment for the provision of health care to an individual; and

(3) Identifies the individual or can reasonably be used to identify the individual.

c. Protected health information can be transmitted in any form or medium, such as electronic, written, or oral. 42 USC §1320d; 45 CFR §160.103.

Medical Information Under CMIA

a. CMIA also defines "medical information" broadly to include information in possession of or derived from a health care provider containing any element of personal identifying information. CC §56.05(g).

DISCLOSURE OF PSYCHOTHERAPY INFORMATION

Under HIPAA

Under HIPAA, a health care provider must obtain an authorization to use or disclose psychotherapy notes, with certain exceptions. The relevant exceptions allow disclosures to:

a. A government authority authorized by law to receive such reports, such as a protective services agency, about a patient who is a victim of abuse, neglect, or domestic violence (45 CFR §164.512(j)(1)(i)); and

b. A person or persons whom the health care provider in good faith believes is reasonably able to prevent or lessen a serious and imminent threat to the health or safety of a person or the public (45 CFR §164.512(j)(1)(i)).

Under CMIA

CMIA's protection for the privacy of psychotherapy information is broader in some respects than that afforded under HIPAA and, therefore, in those respects is not preempted by HIPAA. 45 CFR §160.203.

a. Under CMIA, psychotherapy information may not be disclosed to a court investigator in a conservatorship proceeding unless the person requesting the information provides a written request, with a copy to the patient, that includes (CC §§56.10(c)(12), 56.104):

(1) The specific information being requested and its specific intended use;

(2) The length of time during which the information will be kept before being destroyed or disposed of;

(3) A statement that the information will not be used for any other purpose; and

(4) A statement that the requester will destroy the information and all copies in the requester's possession or will return the information within the time specified in (2).

b. CMIA does not contain the exception provided in 45 CFR §164.512(j)(1)(i) (see above), except for information about the "general nature" of the patient's condition or the patient's "general condition." CC §56.16; see step 7, below.

c. A psychotherapist may use or disclose medical information if a patient who has capacity to make health care decisions is present or available, and if the psychotherapist:

(1) Obtains the patient's permission; or

(2) Provides the patient with an opportunity to object and he or she does not do so.

EXTENT OF DISCLOSURE

Under HIPAA

Under HIPAA:

a. "When using or disclosing protected health information or when requesting protected health information from another covered entity, a covered entity must make reasonable efforts to limit protected health information to the minimum necessary to accomplish the intended purposes of the use, disclosure, or request." 45 CFR §§164.502(b)(1), 164.514(d).

NOTE

The minimum-necessary rule does not apply to disclosures pursuant to a written authorization (see below), or to the patient or the patient's representative, including an agent under a health care power of attorney. 45 CFR §164.502(b)(2)(ii).

b. A patient's entire medical record may be disclosed as long as the health care provider has appropriate policies and procedures in place. See Frequently Asked Questions, http://www.hhs.gov/ocr/privacy.

Under CMIA

CMIA permits a general acute care hospital, on receiving an inquiry concerning a specific patient, to disclose, among other matters, the patient's name, a general description of the reason for the treatment, and the patient's general condition. CC §56.16, discussed in step 7, below. CMIA also permits a health care provider to disclose to a family member, other relative, registered domestic partner, a patient's close personal friend, or other persons whom the patient identifies the medical information that is directly relevant to the person's involvement with the patient's care or to payment related to the patient's health care. CC §56.1007(a).

REDISCLOSURE

No Restrictions Under HIPAA

HIPAA apparently does not place any restriction on the ability of a recipient of health information who is not a health care provider to disclose to others the information received.

New Authorization Required Under CMIA

A person who receives information under an authorization may not further disclose that information except under a new authorization. CC §56.13.

NOTE

This restriction under CMIA does not apply to medical information the disclosure of which is compelled by a court order or by a party to a court proceeding by subpoena or other discovery. CC §§56.10(b)(1), (b)(3), 56.13.

SANCTIONS

For Violation of HIPAA: Penalties Imposed Before February 17, 2011

a. Applicable to penalties imposed before February 17, 2011 (42 USC §17939(b)(1)), HIPAA provides penalties up to $25,000 for violating the privacy rules. 42 USC §§1320d-5, 1320d-6.

b. Before that date, the Secretary of Health and Human Services (HHS) will not impose a penalty:

(1) On persons who "did not know, and by exercising reasonable diligence would not have known," that the person was violating HIPAA (42 USC §1320d-5(b)(2)); or

(2) When the failure to comply was due "to reasonable cause and not to willful neglect" and is corrected within a certain time (42 USC §1320d-5(b)(3)).

c. HHS may reduce or waive the penalty to the extent that the penalty is "excessive relative to the compliance failure involved." 42 USC §1320d-5(b)(4).

For Violation of HIPAA: Penalties Imposed On or After February 17, 2011

a. Applicable to penalties imposed on or after February 17, 2011 (42 USC §17939(b)(1)), HIPAA provides penalties on a tier

system for violating the privacy rules. 42 USC §§1320d-5(a), 1320d-6.

(1) If the person "did not know (and by exercising reasonable diligence would not have known)" that the person was violating HIPAA, the penalty is:

(a) At least $100 per violation; and

(b) Not to exceed $25,000 total for all violations of an identical rule during a calendar year.

(2) For violations due to reasonable cause and not to willful neglect, the penalty is increased to:

(a) At least $1000; and

(b) Not to exceed $100,000 annually.

(3) For violations due to willful neglect that are corrected as required, the penalty is:

(a) At least $10,000; and

(b) Not to exceed $250,000 annually.

(4) For violations due to willful neglect that are not corrected, the penalty is:

(a) At least $50,000; and

(b) Not to exceed $1,500,000 annually.

b. HHS may reduce or waive the penalty to the extent that the penalty is "excessive relative to the compliance failure involved." 42 USC §1320d-5(b)(3).

NOTE

The Department of Justice has concluded that only health care providers and certain directors, officers, and employees of these entities may be directly liable under 42 USC §1320d-6. The liability of other persons under 42 USC §1320d-6 will be determined by principles of aiding and abetting liability and of conspiracy liability. Memorandum for Alex M. Azar II, General Counsel, Department of Health and Human Services, by Timothy J. Coleman, Senior Counsel to the Deputy Attorney General (June 1, 2005).

For Violation of CMIA

a. Any person (not just a health care professional) who knowingly and willfully obtains, discloses, or uses medical information in violation of CMIA is subject to damages and penalties. CC §§56.35, 56.36.

b. Unlike the more limited consumer protections of HIPAA, a patient whose medical information has been disclosed in violation of CMIA and who has sustained economic loss or personal injury may recover (CC §56.35):

(1) Compensatory damages;

(2) Punitive damages not to exceed $3000;

(3) Attorney fees not to exceed $1000; and

(4) Litigation costs.

c. A violation is also a misdemeanor, subjecting a violator to a civil penalty of as much as $250,000 if the violation occurs "for the purpose of financial gain." CC §56.36(c)(3)(A).

NOTE

An attorney who knowingly and willfully discloses protected medical information may be subject to an administrative fine or civil penalty of up to $25,000 under CC §56.36(c)(2)(A). The highest penalties could also apply to family members, heirs, and beneficiaries who act in probate cases for financial gain.

STEP 7. KNOW TO WHOM AND UNDER WHAT CIRCUMSTANCES HEALTH CARE PROVIDERS MAY DISCLOSE HEALTH INFORMATION

UNDER HIPAA AND CMIA

Disclosure to the Patient

a. Under HIPAA, a health care provider is permitted to use or disclose protected health information to the patient. 45 CFR §164.502(a)(1)(i).

b. Under CMIA, the health care provider is required to disclose medical information when compelled by the patient or the patient's representative under CC §56.10(b)(7) or when the patient or the legal representative of a minor or incompetent patient submits a valid authorization. CC §56.11(c)(1)-(2).

Patient's Ability to Limit Disclosure

a. Under HIPAA, a patient may request that a health care provider not provide information to persons involved in the patient's health care and to family members, but the health care provider is not required to honor the request. 45 CFR §164.522(a)(1)(i)-(ii).

b. Under CMIA, a patient or patient's conservator who authorizes the release of health information may limit the use of the information. The health care provider must communicate to the recipient of the information any limitation in the authorization. CC §56.14.

Disclosure to the Patient's Agent Under an Advance Health Care Directive

a. Under HIPAA, a health care provider must:

(1) With exceptions not relevant, treat a personal representative as the patient for purposes of the privacy regulations (45 CFR §164.502(g)(1)); and

(2) Treat as a "personal representative" one who "has authority to act on behalf of [the patient] in making decisions related to health care." 45 CFR §164.502(g)(2).

b. CMIA requires the health care provider to disclose medical information to an agent under a power of attorney for health care when necessary for the agent to fulfill his or her duties. CC §56.13; Health & S C §123105; Prob C §§4683, 4690.

Disclosure to the Patient's Conservator

a. Under HIPAA, a conservator of the person who has the power to make health care decisions for the conservatee under Prob C §2355 would be entitled to be treated as the patient under 45 CFR §164.502(g)(1)-(2).

b. CMIA requires the health care provider to disclose medical information when:

(1) Compelled by the patient's guardian or conservator of the person presenting a written request (CC §56.10(b)(7); Health & S C §§123105, 123110(a)); or

(2) The legal representative of an "incompetent" patient submits a valid authorization (CC §56.11(c)(2)).

Exceptions for Disclosure to Personal Representative

a. Under HIPAA, a covered entity may elect not to treat a person as the personal representative of an individual if (45 CFR §164.502(g)(5)):

(1) The covered entity has a reasonable belief that:

(a) The individual has been or may be subjected to domestic violence, abuse, or neglect by such person; or

(b) Treating such person as the personal representative could endanger the individual; and

(2) The covered entity, in the exercise of professional judgment, decides that it is not in the best interest of the individual to treat the person as the individual's personal representative.

b. CMIA has no comparable exception.

Disclosure to the Personal Representative of a Deceased Patient's Estate

a. Under HIPAA, health care providers must treat an executor, administrator, or other person with authority to act on behalf of a deceased individual or of the individual's estate as a personal representative for purposes of providing health care information. 45 CFR §164.502(g)(4).

b. Under CMIA, the beneficiary or personal representative of a deceased patient may obtain medical information by submitting a valid authorization. CC §56.11(c)(4).

Disclosure to Persons Involved in the Patient's Care

a. Under HIPAA:

(1) When the patient is not present or cannot agree or object because of incapacity or an emergency, and the health care provider, in the exercise of professional judgment and experience, determines or reasonably infers that it is in the patient's best interests, the health care provider may disclose directly relevant health information to the patient's (45 CFR §164.510(b)(3)):

(a) Family member;

(b) Other relative;

(c) Close personal friend; or

(d) Other person whom the patient identifies.

(2) If the patient is present and has capacity to make health care decisions, a health care provider may disclose protected health information to a family member, other relative, close personal friend, or any other person whom the patient identifies, when the information is directly relevant to that person's involvement as long as the health care provider (45 CFR §164.510(b)(1)(i), (b)(2)(i)-(iii)):

(a) Obtains the patient's agreement;

(b) Provides the patient an opportunity to object and he or she does not do so; or

(c) Reasonably infers from the circumstances, based on the exercise of professional judgment, that the patient does not object.

b. CMIA allows disclosure in situations that closely parallel disclosures allowed under HIPAA.

(1) Under CC §56.1007(a), as noted in step 6, above, a health care provider may disclose medical information that is directly relevant to the person's involvement with the patient's care or to payment related to the patient's health care to:

(a) A family member or other relative;

(b) A registered domestic partner;

(c) A patient's close personal friend; or

(d) Other persons whom the patient identifies.

(2) Under CC §56.1007(c), if a patient who has capacity to make health care decisions is present or available, a health care provider may use or disclose medical information if it:

(a) Obtains the patient's permission;

(b) Provides the patient with an opportunity to object and he or she does not do so; or

(c) Reasonably infers from the circumstances, based on the exercise of professional judgment, that the patient does not object.

Disclosure to a Person Reasonably Able to Prevent or Lessen a Serious Threat to Health or Safety

a. Under HIPAA:

(1) The health care provider has broad authority to disclose health information if the provider in good faith believes that the disclosure (45 CFR §164.512(j)(1)):

(a) Is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public; and

(b) Is to a person whom the provider believes in good faith is reasonably able to prevent or lessen a serious and imminent threat to the health and safety of a person or the public, in which case consent, authorization, or opportunity to agree or object is not required.

(2) A health care provider who discloses or uses protected health information under this standard is presumed to have acted in good faith if the disclosure or use was based on (45 CFR §164.512(j)(4)):

(a) Actual knowledge; or

(b) In reliance on a credible representation by a person with apparent knowledge or authority.

b. Under CMIA, the same rules apply as discussed above in the section on "Disclosure to Persons Involved in the Patient's Care."

Disclosure to Anyone Whom the Patient Authorizes in Writing

a. Under HIPAA, health care providers may disclose health information to anyone whom the patient authorizes. 45 CFR §164.502(a)(1)(iv). To be valid, a disclosure authorization must include (45 CFR §164.508(c)(1)):

(1) A specific and meaningful description of the information to be used or disclosed;

(2) The name or other specific identification of the person(s), or class of persons, authorized to make the requested use disclosure;

(3) The name or other specific identification of the person(s), or class of persons, to whom the covered entity may make the requested use or disclosure;

(4) A description of each purpose of the requested use or disclosure;

(5) An expiration date or an expiration event that relates to the individual or the purpose of the use or disclosure; and

(6) Signature of the individual and date.

b. The requirements for a valid authorization under CMIA are that (CC §56.11):

(1) It must be handwritten by signator or in typeface no smaller than 8-point type;

(2) It must be clearly separated from other language on the same page;

(3) The signature serves no other purpose than to execute the authorization;

(4) It must be signed and dated by:

(a) The patient;

(b) The legal representative of the patient, if the patient is a minor or an "incompetent";

(c) The patient's spouse or the person financially responsible for the patient (if medical information is sought for purpose of enrollment); or

(d) The beneficiary or personal representative of a deceased patient;

(5) It must state specific use and limitations of the medical information to be disclosed;

(6) It must state names and functions of the health care provider, health care service plan, pharmaceutical company, or contractor that may disclose the medical information;

(7) It must state names and functions of persons authorized to receive the medical information;

(8) It must state specific uses and limitations on the use of the medical information by the receiver;

(9) It must state an expiration date after which disclosure is no longer authorized; and

(10) It must state the right of the signator to receive a copy of the authorization.

Sample Forms: For forms and clauses under both HIPAA and CMIA, see California Powers of Attorney and Health Care Directives §§8.34-8.38 (Cal CEB 2008).

Disclosure of General Condition to Anyone Who Asks for Patient by Name

a. Under HIPAA:

(1) A health care provider may use protected health information to maintain a directory of patients in its facility that contains the following information (45 CFR §164.510(a)(1)):

(a) Name;

(b) Location in the facility;

(c) "[C]ondition described in general terms that does not communicate specific medical information" about the patient; and

(d) Religious affiliation.

(2) The health care provider may disclose the information in the directory, except for religious affiliation, to anyone who asks for the patient by name.

(3) The patient has the ability to restrict or prohibit disclosure of some or all of this information. 45 CFR §164.510(a)(2).

b. Under CMIA:

(1) Unless the patient has made a specific written request to the contrary, a general acute care provider, on receiving an inquiry, may release the following medical information:

(a) The patient's name, address, age, and sex;

(b) A general description of the reason for treatment;

(c) The general nature of the condition; and

(d) The patient's general condition. CC §56.16.

(2) At least one court has held that a doctor did not violate CMIA by disclosing to the patient's work supervisor that the patient was suffering from stress and probably was not able to then return to work. *Garrett v Young* (2003) 109 CA4th 1393, 1408, 1 CR3d 134. The *Garrett* court:

(a) Construed "general condition of the patient" to be kind of information that "one would expect to be disclosed to concerned friends or relatives inquiring about the condition of a loved one" (109 CA4th at 1408);

(b) Noted that the doctor did not reveal the underlying diagnosis, *i.e.,* that the patient was suffering from anxiety or depression, or both, and possibly needed psychiatric treatment (109 CA4th at 1408); and

(c) Held that the doctor was not liable for disclosing that the patient suffered from a rash and itchiness, even though those disclosures "might be sufficiently specific" to fall outside the ambit of the patient's "general condition," because the rash was visible to the patient's fellow employees and because she herself had talked to the supervisor about those matters (109 CA4th at 1409).

Disclosure for Judicial or Administrative Proceedings Under HIPAA

Under HIPAA, a health care provider may:

a. Disclose protected health information in response to a court or administrative agency order (45 CFR §164.512(e)(1)(i)); and

b. Provide health information without a court or administrative agency order in response to a subpoena, discovery request, or other lawful process:

(1) After receiving satisfactory assurance that the party seeking the information made a reasonable effort to give the patient notice (45 CFR §164.512(e)(1)(ii)(A)) and either the patient did not timely object or the court resolved the objection (45 CFR 164.512(e)(1)(iii)(C)); or

(2) After receiving satisfactory assurance from the party seeking the information that has reasonable efforts have been made by such party to secure a qualified protective order from a court or administrative tribunal that (45 CFR §164.512(e)(1)(ii)(B), (e)(1)(v)):

(a) Prohibits the parties from using or disclosing the information for any other purpose than the litigation or proceeding for which the information was requested; and

(b) Requires the return to the health care provider or destruction of the protected health information, including all copies made, at the end of the litigation or proceeding.

Disclosure for Judicial or Administrative Proceedings Under CMIA

Under CMIA, a health care provider:

a. Must provide medical information if the disclosure is compelled by a court order or by a party to a court proceeding under a subpoena or any other discovery in a court proceeding (CC §56.10(b)(1), (b)(3)); and

b. May provide information relevant to a patient's condition and treatment to a probate court investigator (CC §56.10(c)(12)).

NOTE

The method that California attorneys use in court proceedings to obtain medical records is a subpoena. Under CCP §1985.3(a)(2), (b)(1), (e), the subpoenaing party must serve the patient with a copy of the subpoena and notice of the patient's right to object. The patient then has the right to bring a motion to quash the subpoena. CCP §1985.3(g). An attorney therefore would not have to resort to the use of a qualified protective order in a California probate or civil proceeding.

Disclosure for Purpose of Coordinating Health Care Services and Medical Treatment for a Minor

Under CC §56.103, a health care provider:

a. May provide medical information to a county social worker, a probation officer, or any other person who is legally authorized to have custody or care of a minor for the purposes of coordinating health care services and medical treatment provided to the minor. CC §56.103(a).

b. May provide medical information regarding a minor who has been taken into temporary custody or as to who a petition has been filed with the court, or who has been adjudged to be a dependent child or ward of the juvenile court. CC §56.103(g).

EVIDENTIARY PRIVILEGES PROHIBITING DISCLOSURE

Physician-Patient Privilege

a. Under Evid C §994, unless a holder has waived the privilege under Evid C §912, a patient has a privilege to refuse to disclose, and to prevent another from disclosing, a confidential communication between patient and physician if the privilege is claimed by:

(1) The holder of the privilege;

(2) A person whom the holder of the privilege has authorized to claim the privilege; or

(3) The person who was the physician at the time of the communication, unless no holder of the privilege exists or the patient instructs the physician to permit disclosure.

b. The "holder of the privilege" (Evid C §993) means:

(1) The patient, when the patient has no conservator or guardian;

(2) The patient's conservator or guardian; or

(3) The personal representative of a deceased patient.

c. A disclosure "to a third person to whom disclosure is reasonably necessary for the accomplishment of the purpose for which the physician is consulted" does not waive the privilege. *Rudnick v Superior Court* (1974) 11 C3d 924, 932, 114 CR 603.

d. Applicable exceptions to the physician-patient privilege include:

(1) A "communication relevant to an issue between parties all of whom claim through a deceased patient, regardless of whether the claims are by testate or intestate succession or by inter vivos transaction" (Evid C §1000);

(2) A "communication relevant to an issue concerning the intention of a patient, now deceased, with respect to a deed of conveyance, will, or other writing, executed by the patient, purporting to affect an interest in property" (Evid C §1002);

(3) A "communication relevant to an issue concerning the validity of a deed of conveyance, will, or other writing, executed by a patient, now deceased, purporting to affect an interest in property" (Evid C §1003);

(4) In a "proceeding to commit the patient or otherwise place him or his property, or both, under the control of another because of his alleged mental or physical condition" (Evid C §1004); and

(5) In a "proceeding brought by or on behalf of the patient to establish his competence" (Evid C §1005).

Psychotherapist-Patient Privilege

a. Under Evid C §1014, unless a holder has waived the privilege under Evid C §912, a patient has a privilege to refuse to disclose, and to prevent another from disclosing, a confidential communication between patient and psychotherapist if the privilege is claimed by:

(1) The holder of the privilege;

(2) A person whom the holder of the privilege authorized to claim the privilege; or

(3) The person who was the psychotherapist at the time of the communication, unless no holder of the privilege exists or the patient instructs the psychotherapist to permit disclosure.

b. A "psychotherapist" is a person who is, or is reasonably believed by the patient to be, a:

(1) Psychiatrist;

(2) Psychologist;

(3) Clinical social worker;

(4) Marriage, family, or child counselor;

(5) Person registered as an assistant, intern, trainee, or associate of a licensed or certified psychotherapist, who practices under a psychotherapist's supervision;

(6) Psychiatric nurse; or

(7) Person rendering mental health treatment or counseling services under Fam C §6924. Evid C §1010.

c. The "holder of the privilege" (Evid C §1013) means:

(1) The patient, when the patient has no conservator or guardian;

(2) The patient's conservator or guardian; or

(3) The personal representative of a deceased patient.

d. Some of the exceptions to the psychotherapist-patient privilege are the same as the exceptions to the physician-patient

privilege, and others differ. The exceptions relevant to capacity and undue influence determinations include:

(1) A "communication relevant to an issue between parties all of whom claim through a deceased patient, regardless of whether the claims are by testate or intestate succession or by inter vivos transaction" (Evid C §1019);

(2) A "communication relevant to an issue concerning the intention of a patient, now deceased, with respect to a deed of conveyance, will, or other writing, executed by the patient, purporting to affect an interest in property" (Evid C §1021);

(3) A "communication relevant to an issue concerning the validity of a deed of conveyance, will, or other writing, executed by a patient, now deceased, purporting to affect an interest in property" (Evid C §1022);

(4) When "the psychotherapist has reasonable cause to believe that the patient is in such mental or emotional condition as to be dangerous to himself or to the person or property of another and that disclosure of the communication is necessary to prevent the threatened danger" (Evid C §1024); and

(5) In a "proceeding brought by or on behalf of the patient to establish his competence" (Evid C §1025).

STEP 8. CONSIDER SUGGESTIONS FOR ATTORNEYS ENGAGED IN ESTATE PLANNING AND ADMINISTRATION

USE OF PHYSICIAN OR PSYCHOLOGIST'S CERTIFICATE OF INCAPACITY

In estate planning and administration, documents often contain provisions requiring a physician's certificate of incapacity to trigger certain actions, including:

a. Replacement of an incapacitated trustee or effectiveness of a springing power of attorney; and

b. Determination of an elder's inability to manage his or her own affairs.

NOTE

Under Prob C §15642(b)(7)-(8), a court may remove a trustee who is substantially unable to manage the trust's financial resources, is otherwise unable to execute properly a trustee's duties, or is substantially unable to resist fraud or undue influence.

WHEN DRAFTING ESTATE PLANNING DOCUMENTS, USE AN ALTERNATIVE TRIGGERING PROVISION

In drafting estate planning documents, instead of using a provision in which a physician or psychologist's certificate of incapacity is required to trigger replacement of an incapacitated trustee or effectiveness of a springing financial power of attorney, consider the following alternatives:

a. Substitute family members, a trusted friend, or a committee for a physician or psychologist. If you choose a committee, consider having between two and five members.

b. Substitute a currently effective financial power of attorney for springing power. The agent is not required to exercise the power. Prob C §4230(a). Use precatory language asking agent not to act until the principal is no longer able to substantially manage his or her financial affairs.

c. Give the agent under an advance health care directive the express authority to act immediately, even though the principal is still able to make health care decisions for himself or herself:

(1) Under Prob C §4682, unless otherwise provided in a power of attorney for health care decisions, the agent's authority "becomes effective only on a determination that the principal lacks capacity" to make health care decisions.

(2) Both the statutory form for an advance health care directive (Prob C §4701) and the form published by the California Medical Association permit the principal to give the agent authority to make health care decisions even though the principal is still able to make them. The agent then will be able to obtain medical information that may otherwise be unavailable. 45 CFR §164.502(g)(2); Prob C §4678.

STEPS TO TAKE IF A PERSON CAN NO LONGER MANAGE HIS OR HER OWN AFFAIRS AND INSTRUMENT REQUIRES PHYSICIAN'S CERTIFICATE

If a person is no longer able to substantially manage his or her affairs and the instrument, *e.g.,* a power of attorney or replacement of incapacitated settlor/trustee of a revocable trust, requires a physician's certificate of incapacity:

a. Carefully consider who your client is (see step 2, above), *i.e.*:

(1) The person;

(2) The person's spouse or registered domestic partner; or

(3) The person's child.

b. If the person is your client, discuss the advisability of your client resigning as trustee, appointing a cotrustee, or appointing an attorney-in-fact under a currently effective power of attorney.

c. If the person is not your client, consider the following alternatives:

(1) If your client is the agent, ask him or her to authorize the physician to release medical information,

(2) Have a family member, other relative, close personal friend, or other person identified by the person who is involved with the individual's care or payment related to that care ask the health care provider:

(a) To describe the person's general condition (CC §56.16); and

(b) Whether, in the exercise of professional judgment and experience, he or she determines the disclosure to be in the patient's best interests (45 CFR §164.510(b)(1), (b)(3)) (see step 7, above).

d. If none of the above alternatives is possible, bring a conservatorship proceeding and subpoena the doctor's records.

STEP 9. CONSIDER SUGGESTIONS FOR ATTORNEYS ENGAGED IN LITIGATING THE ISSUE OF CAPACITY

TRY TO OBTAIN THE INFORMATION AS DISCLOSURE OF THE PATIENT'S GENERAL CONDITION

a. If the issue is, *e.g.,* the appointment of a conservator, the triggering of a trustee removal or the effectiveness of a financial durable power of attorney, or rescission of a transaction based on incapacity or undue influence, legal standards apply that may require only disclosure of the patient's "general condition," which, although protected health information, may be disclosed. See *Garrett v Young* (2003) 109 CA4th 1393, 1408, 1 CR3d 134; 45 CFR §164.510(a)(1); CC §§56.11, 56.16. See step 7, above.

b. In other litigation situations, *e.g.,* a trust or will contest of a decedent based on incapacity, or when capacity to make health care decisions is at issue, try to construe the needed information as other than protected health information as defined under HIPAA and CMIA by arguing that, *e.g.*:

(1) A statement that the patient has "capacity to make health care decisions" (see Prob C §813) and agrees or does not object is a conclusion and not protected health information; or

(2) The capacity determination can be construed to be treatment under 45 CFR §§164.502(a)(1)(ii) and 164.506, which allow for disclosure without the patient's consent.

DETERMINE IF INFORMATION CAN BE OBTAINED UNDER ADVANCE HEALTH CARE DIRECTIVE

If the patient has signed an advance health care directive, determine whether:

a. The directive allows the agent to act even if the patient has the ability to make health care decisions; and

b. The agent will agree to ask for the needed information.

DETERMINE WHETHER AN EXCEPTION UNDER HIPAA AND CMIA APPLIES FOR DISCLOSURE

If 45 CFR §164.510(a)(1) and CC §§56.11, 56.16 do not apply, determine whether one or more of the following exceptions permitting disclosure applies (see step 7, above):

a. The patient cannot agree or object because of incapacity or emergency and the physician determines that disclosure to a person involved with the patient's care or payment related to the individual's health care is in the patient's best interests (45 CFR §164.510(b)(3));

b. The information to be disclosed is directly relevant to the person's involvement with the patient's health care and the physician infers from the circumstances that the patient does not object (45 CFR §164.510(b)(2)(iii)); or

c. The physician believes that the disclosure is to a person reasonably able to prevent or lessen a serious and imminent threat to the health or safety of the patient or another (45 CFR §164.512(j)(1)).

NOTE

In a litigation situation, the author suggests that the attorney include in a letter to the physician all three exceptions and an argument that the only information requested is information about the general condition of the patient.

OBTAIN COURT ORDER OR SUBPOENA INFORMATION

If previously mentioned alternatives do not work, depending on the context in which the capacity issue or the issue of undue influence is being litigated, and on whether more is required than disclosure of the person's general condition:

a. Obtain a court or administrative agency order (*e.g.,* Ex Parte Order re Completion of Capacity Declaration—HIPAA (Judicial Council Form GC-334); see step 21, below) granting the power to authorize the release of the needed information, file the order, and proceed with the underlying litigation; or

b. Subpoena the needed health information (45 CFR §164.512(e); CC §56.10). See Disclosure for Judicial or Administrative

Proceedings in step 7, above.

NOTE

In the author's experience, physicians often will sign capacity declarations for patients without a court order or subpoena even if no particular exception applies.

Understanding DPCDA and Its Relationship to Other Statutes When Capacity Is an Issue

STEP 10. KNOW THE REQUIREMENTS FOR ASSESSING INCAPACITY UNDER DPCDA

INTRODUCTION TO DETERMINATION OF CAPACITY

Incapacity is not determined by a diagnosis or a showing of certain traits. Evidence of a deficit in one or more of a person's mental functions must be established for a court to determine that an individual does not have capacity to perform specific acts.

DUE PROCESS IN COMPETENCE DETERMINATIONS ACT (DPCDA)

Capacity to Perform Particular Acts

The Due Process in Competence Determinations Act (DPCDA) (Prob C §§810-813, 1801, 1881, 3201, 3204, 3208) codifies standards for a court to use in determining whether a person has the capacity to perform particular acts in a variety of contexts, including but not limited to the capacities to (Prob C §811(a)):

a. Execute a will;

b. Marry or enter into a registered domestic partnership;

c. Execute a contract;

d. Make a conveyance;

e. Execute a trust; and

f. Make medical decisions.

Capacity to Perform Other Acts Not Specifically Listed

Although not specifically listed in Prob C §811(a), DPCDA also applies to determinations of capacity to:

a. Amend or revoke a will or a trust;

b. Manage personal and financial affairs;

c. Drive;

d. Divorce or end a registered domestic partnership;

e. Apply for long-term care insurance;

f. Nominate a conservator; and

g. Authorize release of "protected health information" under HIPAA and CMIA.

NOTE

Except for its use in the title of DPCDA, the words "competent" and "incompetent" are not used; they are too general to be helpful.

DPCDA APPLIES TO JUDICIAL AND NONJUDICIAL DETERMINATIONS

a. Although Prob C §811(e) limits the statute's applicability to "evidence that is presented to, and the findings that are made by, a court," anything that happens in an attorney's office may be subject to judicial scrutiny at some point. Examples:

(1) Wills can be contested.

(2) Contracts can be rescinded.

(3) Conveyances can be revoked.

(4) Conservatorships can be established.

(5) Individuals who have been denied long-term care insurance based on subjective or incomplete review of relevant documents may sue the insurance company.

(6) Drivers whose driving privileges have been revoked because of incapacity may sue the DMV, their doctors, and other persons who reported their incapacity to the DMV.

b. DPCDA also provides a method of analysis for an attorney's use in the office regarding matters that may never go to court but that present issues of capacity.

BASIC CONCEPTS OF DPCDA

Familiarize yourself with DPCDA by reviewing Prob C §§810, 811(b), (d), 812:

a. Prob C §810(a) establishes a rebuttable presumption of capacity: "For the purposes of this part, there shall exist a rebuttable presumption affecting the burden of proof that all persons have the capacity to make decisions and to be responsible for their acts or decisions."

NOTE

Although the statute says "all persons," it should say "all adult persons," because the presumption does not apply to minors. See, *e.g.,* Prob C §6100(a) (will); CC §1556 (contract).

b. Prob C §810(b) makes clear that having a mental or physical disorder, by itself, does not affect the presumption of capacity: "A person who has a mental or physical disorder may still be capable of contracting, conveying, marrying, making medical decisions, executing wills or trusts, and performing other actions."

c. Prob C §810(c) puts diagnosis in its proper place by requiring that a determination of incapacity be based on "evidence of a deficit in one or more of the person's mental functions rather than on a diagnosis of a person's mental or physical disorder."

d. Prob C §811(b) states that a deficit in mental functions may be considered only if the deficit "significantly impairs the person's ability to understand and appreciate the consequences of his or her actions with regard to the type of act or decision in question."

e. Prob C §811(d) also emphasizes the proper place of diagnosis, stating that "[t]he mere diagnosis of a mental or physical disorder shall not be sufficient in and of itself to support a determination that a person is of unsound mind or lacks the capacity to do a certain act."

f. Prob C §812 states, however, that a person lacks capacity to make a decision unless the person has "the ability to communicate, verbally or by any other means, the decision."

ENHANCING COMMUNICATION BETWEEN ATTORNEY AND CLIENT

Communication plays a key role in the Probate Code provisions governing the determination of capacity. The following suggestions take into account normal changes in processing information that occur with age:

a. Ask the client if he or she can hear you well enough.

b. Sit face to face to give the client the extra advantage of reading your lips and seeing how you articulate the words.

c. Ask if there are any additional things you can do to enhance the client's hearing or ability to see you.

d. Recognize that information is processed more slowly by elderly clients:

(1) Break topics down into "bite-sized" pieces; and

(2) Present topics carefully, highlighting the main points.

e. Ask the client to repeat and review what you've just said. While this might seem condescending, the client (who is probably nervous) will appreciate your attention to this point. Say things like:

(1) "I really want to be sure that I've explained this information clearly and that I'm representing your wishes accurately."

(2) "In order to know if this is so, it would be helpful if you could just tell me, in your own words, what I've just said."

f. If there are many estate planning documents to be prepared and reviewed, schedule shorter appointments in which each document can be reviewed separately. Consider the following benefits:

(1) Research has shown that learning curves are improved when sessions are broken down into shorter but more frequent segments.

(2) It is harder to multitask when older, and it is also harder to process different types of new information that are presented all at once.

(3) The time between appointments provides for consolidation of what has been presented and increases the likelihood of effective absorption of material.

g. Understand that with age, difficulty with retrieving information from memory is normal. If you have doubts about the client's comprehension, provide the client with a summary of the business transacted at the meeting in a follow-up letter. The summary can:

(1) Provide a memory cue as well as a record for the client; and

(2) Be used to schedule the client's next appointment.

h. If your practice consists mostly of elderly clients, consider having significant documents rewritten, using larger print. This will be noticed and appreciated by your clients.

Further Research: For a detailed discussion, see Assessment of Older Adults With Diminished Capacity: A Handbook for Lawyers (2005), published by the American Bar Association Commission on Law and Aging and the American Psychological Association, available on the American Bar Association website at http://www.abanet.org (search for the word "capacity" on the website).

STEP-BY-STEP ANALYSIS UNDER DPCDA

In each case, take the following steps in determining capacity under DPCDA. For a one-page summary of the following steps, see Appendix C.

1. Determine if the Act or Decision Is Governed by DPCDA

Determine if the act or decision in question is one of the following that have civil legal consequences that are or may be governed by DPCDA:

a. Executing or revoking a will;

b. Entering into marriage or registered domestic partnership;

c. Making or revoking a contract;

d. Making a conveyance;

e. Executing, amending, or revoking a trust;

f. Managing personal and financial affairs;

g. Making (or declining to make) a medical decision;

h. Driving;

i. Nominating a conservator;

j. Qualifying for long-term care insurance; or

k. Authorizing release of "protected health information" under HIPAA and CMIA.

NOTE

Not all kinds of a parent's behaviors that children are upset about are within the DPCDA. For example, insisting on wearing wool clothes on a hot day probably does not have legal consequences unless it causes the parent to faint. Going outdoors with little or no clothing on, on an extremely cold day, however, may indicate an inability to manage personal affairs, including clothing, and may lead to a conservatorship petition. See step 20, below.

2. Apply the Presumptions in Favor of Capacity

Apply the rebuttable presumption in favor of capacity contained in DPCDA (Prob C §§810(a)) and/or the presumptions that apply in other contexts of incapacity, such as Prob C §1900 (re marriage and registered domestic partnership).

NOTE

Discuss the presumption in favor of capacity, especially if the client is a child who is sure a parent does not have the capacity to, *e.g.,* marry or revoke a will favoring the client. Remind the client that finding incapacity is essentially an uphill battle.

3. Apply the Communication Standard of Prob C §812, if Appropriate

a. Unless one of the exceptions noted below applies, apply Prob C §812 to determine whether the person has the ability:

(1) To communicate the decision verbally, or by any other means.

(2) To understand and appreciate, to the extent relevant, all of the following:

(a) The rights, duties, and responsibilities created by, or affected by the decision;

(b) The probable consequences for the decisionmaker and, when appropriate, the persons affected by the decisions; and

(c) The significant risks, benefits, and reasonable alternatives involved in the decision.

NOTE

Counsel's ability to facilitate communication is very important here. Being an attentive, patient, and undistracted listener goes without saying. Asking prompting questions such as "Is that what you're not sure about?" and allowing time for the client to resolve any ambiguities may be very helpful.

b. If the person cannot communicate, the analysis goes no further. The person does not have capacity to perform the act in question. If the person can communicate, by whatever means, then consider whether the person understands and appreciates the factors set out in Prob C §812.

c. Neuropsychologists define the key terms of Prob C §812 as follows:

(1) "Communicate" means the client's ability to express him- or herself, whether through spoken language, gesturing, or writing. A problem in this area is referred to as an "expressive language deficit."

(2) "Understand" means the client's ability to comprehend what is said to him or her both through speech and in written documents. A problem in this area is referred to as a "receptive language deficit."

(3) "Appreciate" means to have insight and perspective about how the deficits might affect one's life. Clients who "appreciate" the array of strengths and deficits that both illness and life experience have wrought generally have made compensations in their lives.

Example: A person who appreciates that he or she has a receptive language deficit would hire someone, *e.g.,* to read the mail and pay the bills; a person with an expressive language deficit would rely on a phone message machine, voice mail, and an aide to help answer calls.

d. The Prob C §812 standard for the ability to communicate does not:

(1) By its express language, substitute a set of criteria for what must be communicated for those found in statutes or case law regarding capacity to do testamentary acts or make medical decisions (see steps 11, 22, below).

(2) Apply to a conservatorship determination, which is based on a loss of functional skills. Note, however, that the capacity to nominate a conservator requires the ability to communicate. See step 18, below.

NOTE

The analysis of whether conservatorship may be appropriate in a given case starts with reviewing a person's functional difficulties. The court applies a functional test even when communication skills are intact. Prob C §1801. See step 21, below.

(3) Apply to a determination of the capacity to drive, which is based on a strictly functional test. See Health & S C §103900; step 24, below. In an appeal or litigation following revocation of a drivers license, however, performance on deficit assessment tools may be helpful.

NOTE

Functional skills may be maintained, in some circumstances, by alternative arrangements for getting things done, other than by doing them entirely oneself. Compensation strategies may include having someone write out monthly checks, which the person then signs, adding a trusted joint tenant to a checking account to pay regular bills, or hiring an investment adviser to make recommendations about managing a portfolio. Because the potential exists for abuse by the agent/helper, another trusted person should provide some oversight on a regular basis.

4. Review Other Applicable Statutes and Related Case Authority

a. In addition to DPCDA, the attorney must consider various other statutes that codify the standards for determining a person's capacity to do or make a particular kind of act or decision, including standards regarding what must be communicated and the cases that clarify and amplify those statutes. See, *e.g.,* Prob C §§813, 1801, 1810, 6100.5(a); Health & S C §103900.

b. An extensive body of case law deals with testamentary capacity and with marriage. Although some of the cases are of little general help because their terminology is vague, they should not be overlooked if they can be helpful to the case at hand.

5. Identify Mental Function Deficits

Can a particular mental function deficit be shown to limit a person's ability in certain activities? Identify any mental function deficits that are apparent from the client's communication with you, or in some other way (such as repeatedly forgetting an appointment), including deficits in (see Prob C §811(a)):

a. Alertness and attention, including:

(1) Level of arousal or consciousness;

(2) Orientation to time, place, person, and situation; and

(3) Ability to attend and concentrate;

b. Information processing, including:

(1) Short- and long-term memory, including immediate recall;

(2) Ability to understand or communicate with others, whether verbally or otherwise;

(3) Recognition of familiar objects and persons;

(4) Ability to understand and appreciate quantities;

(5) Ability to reason abstractly and to plan, organize, and carry out actions in one's own rational self-interest; and

(6) Ability to reason logically;

c. Thought processes, as demonstrated by:

(1) Severely disorganized thinking;

(2) Hallucinations;

(3) Delusions; or

(4) Uncontrollable, repetitive, or intrusive thoughts; or

d. Ability to modulate mood and affect, as demonstrated by a pervasive and persistent or recurrent state of euphoria, anger, anxiety, fear, panic, depression, hopelessness, despair, helplessness, apathy, or indifference that is inappropriate in degree to the person's circumstances.

NOTE

Mental function deficits can become obvious during an extended conversation. Look for such things as a client's relying on a child or spouse to "fill in the blanks" or provide information on dates, size of estate, or where money is sheltered; repeating information; or forgetting purpose of meeting with attorney.

6. Determine Whether There Is a Correlation Between Deficit and Capacity Required for Particular Act or Decision

a. Even if a mental function deficit is present, there must be evidence of a correlation between the deficit(s) and the capacity required for the specific act or decision in question. See Prob C §811(a).

b. In the context of a court proceeding, which may result from any transaction, act, or decision:

(1) A deficit under Prob C §811(a) may be considered only if the deficit, by itself or in combination with one or more other mental function deficits, significantly impairs the person's ability to understand and appreciate the consequences of his or her actions with regard to the type of act or decision in question (Prob C §811(b));

(2) In determining whether a person suffers from a deficit in mental function so substantial that the person lacks the capacity to do a certain act, the court may consider the frequency, severity, and duration of periods of impairment (Prob C §811(c)); and

(3) Deficits in alertness and attention or in the ability to understand or communicate with others under Prob C §811(a) may indicate that the person lacks the ability to communicate the decision and understand and appreciate the rights, duties, and responsibilities created or affected by the decision and the risks, benefits, and reasonable alternatives involved in the decision, as required by Prob C §812.

NOTE

If the correlation between the deficit and the capacity required is not obvious, consider a consultation with a professional in this area, *e.g.*, a geriatric neuropsychologist who may provide insight about particular deficits and what abilities they affect. For example, can a severely depressed person make his or her own medical decisions? Is a person unable to understand and appreciate the consequences of his or her decision to drive, given his or her mental functional impairments as identified above?

7. Determine Whether Undue Influence Occurred

Even if the person is found to have capacity, there may be undue influence. Many people will pass a capacity test but are unable to resist undue influence. See steps 28-30, below, for consideration of the issues of undue influence.

Assessing and Litigating the Issue of Testamentary Capacity

STEP 11. KNOW THE STATUTORY STANDARD FOR DETERMINING TESTAMENTARY CAPACITY

REVIEW SPECIFIC STATUTES ON TESTAMENTARY CAPACITY

Review the following specific statutes and related case law:

Prob C §6100

Every adult of sound mind may make a will. Prob C §6100(a).

Prob C §6100.5

An individual is not mentally competent to make a will if at the time the will is made either of the following is true (Prob C §6100.5(a)):

a. The individual's mental capacity is not sufficient to be able to:

(1) Understand the nature of the testamentary act;

(2) Understand and recollect the nature and situation of the individual's property; or

(3) Remember and understand the individual's relationships to living descendants, spouse, parents, and others whose interests are affected by the will; or

b. The individual suffers from a mental disorder with various symptoms, including delusions or hallucinations, that cause the individual to devise property in a way that he or she would not have done except for the delusions or hallucinations.

Prob C §1871(c)

A person under a conservatorship may still have the capacity to make a will. See Prob C §1871(c).

NOTE

Key words ("mentally competent," "mental capacity," "understand," "delusions," "hallucinations") from DPCDA appear in the language of Prob C §6100.5(a). Until enactment of DPCDA, there was no agreement about what these terms meant and no standard set of terms for practitioners to use in considering these questions in the office, or by litigators and judges in pleadings, evidence, argument, and decisions. DPCDA clarified the meaning of most of these terms.

COMMUNICATION STANDARD

The communication standard for testamentary capacity is found in the statute (Prob C §6100.5) and case law. See Prob C §812.

STANDARD FOR CAPACITY TO AMEND OR REVOKE A WILL

The standard for capacity to amend or revoke a will or the dispositive provisions of a trust appears to be the same as the standard for making a will. See Prob C §6124, under which it is presumed that a testator destroyed a will with the intent to revoke it if:

a. The will was last in the testator's possession;

b. The testator was competent until death; and

c. Neither the will nor a duplicate original of the will can be found after the testator's death.

NOTE

In *Lauermann v Superior Court* (2005) 127 CA4th 1327, 26 CR3d 258, the court held that a photocopy of a will is not a duplicate original under Prob C §6124. Unfortunately, the court did not define the term "competent" in finding that the presumption of revocation applied to the testator.

APPLY DPCDA

a. Remember that DPCDA includes a rebuttable presumption in favor of capacity. Prob C §810(a).

b. Determine whether there is a mental function deficit as listed in Prob C §811.

c. Determine whether there is a correlation between the deficit and the capacity to make a will, as defined in the underlying statutes.

NOTE

In applying DPCDA and Prob C §6100.5, ask the client open-ended questions, not questions that elicit simple "yes" or "no" answers.

STEP 12. DETERMINE WHETHER CLIENT HAS TESTAMENTARY CAPACITY

ATTORNEY'S ROLE

In each case, the attorney must assess the client's capacity to take the action or make the decision in question and also take steps to protect the client from later challenges to the client's capacity. Part of the attorney's role might be, for example, examining the pros and cons of videotaping the execution of testamentary documents, or referring the client to a neurophysiologist.

EXAMPLE 1

Counsel has prepared a will for client in accordance with client's instructions. Client had communicated clearly throughout the process and met the standards in Prob C §§6100(a), 6100.5(a), as far as counsel could tell. On the day set for execution of the will, counsel gathers the witnesses and hands client the pen. Taking the pen, client looks out the window and says, "What are those cows doing on that roof over there?" What should counsel do, assuming that no cows are actually on the roof?

NOTE

The following analysis may also be used in determining capacity to amend or revoke a will or the testamentary provisions of a trust, which are themselves testamentary acts.

1. DPCDA: Is There a Mental Function Deficit?

Under Prob C §811(a)(3)(B), the deficits that affect thought processes include hallucinations. Cows on the roof seem to be a hallucination.

2. DPCDA: Is There a Correlation Between Mental Function Deficit and Capacity Required to Sign a Will?

Executing a will reflects a series of decisions that have been made and reviewed before and on the day the signing is to occur. Consider the following questions in determining whether there is a correlation between the deficit and capacity to sign the will (Prob C §811(a)):

a. Is the client concerned that the cows must be taken into consideration in the matter at hand, such as by changing the will to leave money to the cows?

b. Is the client unable to concentrate on signing the will because of the cows?

c. Does the client think the cows are the client's children?

d. Perhaps the client periodically sees cows on rooftops but otherwise seems to function normally. If so, there may be no correlation between the deficit and the act, but counsel must make sure, and may want to reschedule the will signing and consult with a neuropsychologist in the meantime.

Apply Criteria of Prob C §6100.5(a)(2)

The client in the example suffers from a hallucination, which is specifically mentioned in Prob C §6100.5(a)(2). Applying the facts to the statute, consider whether the hallucination results in the client's "devising property in a way which, except for the … hallucinations, the individual would not have chosen."

NOTE

The analysis under DPCDA and the requirements of Prob C §6100.5(b) are often somewhat repetitious.

EXAMPLE 2

Client, for whom counsel has prepared one or more wills in the past, now states that he wishes to change his testamentary plan in order to disinherit one child. In discussing this change, it appears to counsel that client meets the capacity standards of Prob C §6100.5. During the conversation, however, client's attention occasionally wanders, and his ability to concentrate seems diminished. Not, presumably, being a health care provider, how should counsel evaluate the situation?

Apply DPCDA: Is There a Mental Function Deficit Correlated With Capacity to Sign a Will and Is There Significant Impairment?

Try to determine if there is a mental function deficit and a correlation between the deficit and the capacity required to sign a will.

a. Prob C §811(a) lists the following mental functions related to alertness and attention:

(1) Level of arousal or consciousness (Prob C §811(a)(1)(A)); and

(2) Ability to attend to and concentrate (Prob C §811(a)(1)(C)).

b. Gather further information by asking, *e.g.*:

(1) Did client have trouble sleeping the night before the appointment?

(2) Is client taking any medications?

(3) Is client worried about disinheriting the child, so that he is distracted?

c. If it is still unclear whether the client has a mental function deficit that significantly impairs the client's ability to understand and appreciate the consequences of signing a will (Prob C §811(b)), counsel should:

(1) Consider scheduling a follow-up appointment at a time when client may be more rested or feeling better; or

(2) Suggest consulting a physician about treatment that might relieve the condition; and

(3) Consider a neuropsychological evaluation to assess the correlation of the deficit with the capacity required to sign a will and the significance of impairment.

CONSIDER INTERVIEWING TREATING PHYSICIAN OR IN-HOME CARE PROVIDERS

Counsel should consider speaking to the client's treating physician or in-home care providers for information on mental deficits. These sources, however, may be unwilling to provide information without first obtaining the client's permission or a court order. If the client's capacity to authorize release of medical information is questionable, follow the analysis in step 23, below.

NOTE

This action may be particularly helpful if the client has had a medical incident, such as a stroke, that has resulted in physical disabilities, such as aphasia, that puts into question the client's capacity under Prob C §812 because of difficulty in communicating.

GENERALLY DO NOT VIDEOTAPE

As a rule, it is not advisable to videotape the conference in which the client executes the instrument because:

a. There is a risk that the videotape may be persuasive evidence in favor of a contestant;

b. The mere fact of videotaping may raise the issue of whether the attorney felt that the client's capacity was in question; and

c. The attorney cannot selectively edit the videotape to present the client at the client's best or delete portions showing the client at less than his or her best.

NOTE

Videotape editing subjects the attorney to discipline (see Cal Rules of Prof Cond 5-220) and constitutes a crime (Pen C §135). See also *Cedars-Sinai Med. Ctr. v Superior Court* (1998) 18 C4th 1, 12, 74 CR2d 248. While generally inadvisable, in an appropriate case, videotape evidence of the client explaining why he or she chose the dispositive provisions of the will can be compelling and may deter a contest.

CAREFULLY CONSIDER THE POTENTIAL CONSEQUENCES OF REFERRING CLIENT FOR MENTAL ASSESSMENT EXAM

The same considerations that apply to videotaping the execution of the document apply to mental assessment examinations. However, if counsel doubts capacity after the DPCDA analysis because the correlation and significant impairment standards are met, that should be sufficient reason not to proceed.

NOTE

For a neuropsychologist's perspective and approach to assessing testamentary capacity, see step 34, below.

STEP 13. KNOW HOW TO LITIGATE THE ISSUE OF TESTAMENTARY CAPACITY

LITIGATION ISSUES

An attorney preparing to litigate the issue of testamentary capacity should be familiar with the statutes and case law that govern the following:

a. Standing to contest.

b. Presumptions.

c. Burden of proof.

d. Privileges.

Standing to Contest

a. "Any interested person" has the right to contest either before probate of the will or, if the person is other than a party to a will contest and other than a person who had actual notice of a contest in time to have joined in the contest, after the probate. Prob C §§1043, 8004, 8270. See California Trust and Probate Litigation §17.6 (Cal CEB 1999), referred to throughout this Action Guide as Trust & Prob Litig.

b. Interested persons include the following (see Prob C §48(a)):

(1) An heir, if he or she would take by intestacy if the will is rejected (*Estate of Field* (1951) 38 C2d 151, 238 P2d 578).

(2) A beneficiary under an earlier will whose interest may be impaired or defeated by a codicil or a later will (*Estate of Plaut* (1945) 27 C2d 424, 164 P2d 765).

(3) The representative of a decedent who had grounds to contest (see Prob C §48(a)(3)).

(4) A judgment creditor who has perfected a judgment lien at the time the property would devolve to the heir if the will is set aside. *Estate of Harootenian* (1951) 38 C2d 242, 238 P2d 992.

c. A person who was a minor or who was incompetent and had no guardian or conservator at the time a will was admitted to probate may petition the court to revoke the probate of the will at any time before entry of an order for final distribution. Prob C §8270(b).

d. In a trust contest, beneficiaries of a trust or a prior trust have standing to petition the court under Prob C §17200.

NOTE

Before initiating any action to set aside a testamentary document, the attorney should review all estate planning documents, including the will and trust, to determine whether such an action might be considered a violation of a no-contest provision. See Trust & Prob Litig, chap 5.

Presumptions

A testator is presumed sane and competent (*i.e.,* to be of "sound mind" as required in Prob C §6100(a)) at the time the will was executed. *Estate of Fritschi* (1963) 60 C2d 367, 33 CR 264.

NOTE

A judicial determination of incapacity in the context of a conservatorship proceeding is not sufficient to support a finding of lack of testamentary capacity. See Prob C §1871(c); *Estate of Nelson* (1964) 227 CA2d 42, 38 CR 459. However, it may raise an inference of lack of testamentary capacity if the finding of substantial inability to manage personal and financial affairs is close in time to the testamentary act. See *Estate of Wochos* (1972) 23 CA3d 47, 99 CR 782; *Estate of Fossa* (1962) 210 CA2d 464, 26 CR 687.

Burden of Proof

a. When a will is contested, proponents of the will have the burden of proving due execution. Prob C §8252(a). See Prob C §§6110-6113 for requirements for execution of wills. See also Trust & Prob Litig §§17.26-17.27. Proof of the testator's and

witnesses' signatures creates a presumption that the will was duly executed. *Estate of Pitcairn* (1936) 6 C2d 730, 59 P2d 90.

b. The contestant has the burden of proving that the testator lacked testamentary capacity at the time the will was executed. Prob C §8252(a). Proof must be by a preponderance of the evidence. *Estate of Fritschi* (1963) 60 C2d 367, 33 CR 264.

Privileges

a. In a will or trust contest, there is no attorney-client privilege (Evid C §§959-960) regarding:

(1) The intention or competence of the client who engaged the attorney who prepared the instrument; or

(2) The execution or attestation of a document of which the lawyer is an attesting witness.

b. If the client is deceased, there is no attorney-client privilege either as to (Evid C §§960-961):

(1) The client's intention in signing; or

(2) The validity of a deed of conveyance, will, or other document affecting an interest in property.

NOTE

Because the attorney-client privilege may not exist, the client's capacity should be documented in the attorney's file.

c. There is no doctor-patient privilege or psychotherapist-patient privilege for a communication relevant to an issue between parties, all of whom claim through a deceased patient. Evid C §§1000, 1019. Therefore, in a will contest, usually neither privilege will prevent discovery of the testator's medical or treatment records.

NOTE

Because of HIPAA, health care providers may be reluctant to comply with a request for medical records without a court order. The authors have found that attorneys are able to obtain subpoenas requiring health care providers to release records regarding a deceased patient.

EVIDENCE OF TESTAMENTARY CAPACITY OR INCAPACITY

The attorney must be prepared to present proof of testamentary capacity or incapacity sufficient to satisfy the evidentiary requirements of DPCDA and other relevant statutes.

Rules of Evidence

The attorney should be familiar with the rules of evidence.

Meeting DPCDA and Other Statutory Requirements

The attorney should be prepared to present evidence about each of the following issues:

a. The communication standard (Prob C §812).

b. The underlying statutory requirements (see Prob C §6100.5).

c. Whether there are mental function deficits and, if so, whether there is a correlation between the deficits and the capacity required for testamentary acts (Prob C §811(a)).

d. Whether the deficits significantly impair the testator's ability to understand and appreciate the consequences of the act in question (Prob C §811(b)).

TYPES OF EVIDENCE

The following types of evidence are most often introduced when testamentary capacity is at issue:

a. Medical testimony.

b. Testimony of percipient witnesses.

c. Documentary evidence.

Medical Testimony

Medical testimony may include the following:

a. *Testimony of treating physician.* The testimony of a treating physician or other health care worker about the patient's condition

may carry more weight than that of an expert who bases an opinion on a review of records or an examination made significantly after the time a document was executed. Health care workers are not qualified to testify as to legal capacity but may provide important facts upon which the trier of fact will make the determination.

NOTE

Although often used as an expert, the treating physician may not have the background and qualifications necessary to refute the testimony of a true expert or may not be allowed to testify as an expert. See California Trial Objections, chap 22 (Cal CEB Annual).

b. *Expert medical or psychological opinion*. It may be most effective to use an expert who relies on the information provided by the treating physician, who can then interpret it based on his or her expertise in the field as to how the medical, psychological, or emotional condition, manifested by the mental function deficits, relates to the act or decision in question. Remember that diagnosis is not particularly helpful.

c. *History of mental disorder*. Evidence of a mental disorder may be admissible if it is a long-standing condition that is of such permanence that it would have existed at the time the testamentary instrument was signed. *Estate of Baker* (1917) 176 C 430, 168 P 881. However, the contestant has the burden of proving that the mental disorder had a direct bearing on the act of executing the instrument. See *Walton v Bank of Cal.* (1963) 218 CA2d 527, 32 CR 856.

d. *History of dementia*. The contestant has the burden of proving by a preponderance of the evidence that the testator suffered from dementia and that it directly resulted in the testator's incapacity to execute the document. See *Estate of Schwartz* (1945) 67 CA2d 512, 155 P2d 76.

e. *History of alcohol or drug abuse*. As with the evidence of a mental disorder, such abuse does not prove lack of capacity unless there is proof that it directly affected the testator's capacity at the time of execution. *Estate of Arnold* (1940) 16 C2d 573, 107 P2d 25; *Estate of Warner* (1959) 166 CA2d 677, 333 P2d 848.

f. *Evidence of eccentricities, idiosyncrasies, and forgetfulness*. Evidence of eccentricities, idiosyncrasies, and forgetfulness will not support a finding of incapacity to execute a testamentary instrument unless such conduct bears directly on and influences the testamentary act. *Estate of Mann* (1986) 184 CA3d 593, 603, 229 CR 225; *Estate of Woehr* (1958) 166 CA2d 4, 17, 332 P2d 818.

Cross-Reference: See step 33, below, for discussion of when to refer a client and when to retain a neuropsychologist, and step 34, below, for a neuropsychologist's perspective and approach to the issue of capacity. See also steps 35-36, below, for a physician's perspective on medical conditions and medications that may affect capacity and susceptibility to undue influence in older adults.

NOTE

Remember that disclosure under a court order, properly issued subpoena, or proper discovery request is exempted under CMIA and HIPAA. See CC §§56.10(b)(1), 56.10(b)(3); 45 CFR §164.512(e); see also steps 7 and 8, above.

Testimony of Percipient Witnesses

Percipient witnesses as to the testator's condition at relevant times may include the following:

a. The drafter of the instrument in question.

NOTE

The drafter should be able to testify that in his or her opinion, the creator of the testamentary document had the required capacity to execute it. The drafter's credibility as a witness is crucial to the ability to uphold or set aside the document. See, *e.g.*, *Moore v Anderson Zeigler Disharoon Gallagher & Gray* (2003) 109 CA4th 1287, 135 CR2d 888.

b. Subscribing witnesses. See, *e.g.*, *Estate of Rabinowitz* (2003) 114 CA4th 635, 7 CR3d 722 (revocable trust established by attorney-in-fact was valid even though durable power of attorney was signed by witness after decedent's death and witness did not see document at time decedent acknowledged its existence).

c. In-home care or service providers, *e.g.*, hospice workers, meals-on-wheels delivery persons, and visiting nurses, particularly if they have recorded dates of visits or services.

d. A notary public. See, *e.g.*, *Estate of Saueressig* (2006) 38 C4th 1045, 44 CR3d 672 (notarized will may be admitted to probate but only if second witness signs will before testator's death in addition to notary as subscribing witness).

e. Bank personnel, investment advisers, and accountants.

f. Disinterested family members.

g. Neighbors and friends.

NOTE

Preparation of percipient witnesses is crucial, including thorough familiarity with documents that will be introduced and preparation for cross-examination questions.

Documentary Evidence

Relevant documentary evidence may include the following:

a. Prior estate planning documents.

b. Correspondence sent by the testator to:

(1) The present beneficiaries; and

(2) To those who may have been included in a prior testamentary instrument but are excluded or whose gifts are reduced in the later document.

c. Financial records, including check registers and canceled checks, that may or may not be evidence of the individual's ability to handle his or her financial affairs.

d. Medical records, including records for at least 1 year prior to the date the testamentary instrument was executed (under certain circumstances, several years' records prior to that date may be relevant).

e. A court investigator's report, if a petition for conservatorship was initiated.

NOTE

Consider subpoenaing notes and papers of the drafting attorney.

ADMISSIBILITY OF EVIDENCE

The following types of evidence are admissible on the issue of testamentary capacity:

a. A decedent's prior statements on whether he or she has or has not made a will, or has or has not revoked the will, or statements that identify the will, may be admissible unless the statement was made under circumstances that indicate its lack of trustworthiness. Evid C §§1260-1261.

b. A decedent's prior statements may be admissible as evidence of, *e.g.,* his or her state of mind, or emotion, unless the statement was made under circumstances that indicate its lack of trustworthiness. Evid C §1251.

NOTE

The parties often stipulate to the admissibility of the court investigator's report when a conservatorship is involved. However, if a party objects based on the hearsay statements in the report, the court will likely rule that those statements are inadmissible unless the court investigator testifies as to the report.

Assessing the Capacity to Marry or Enter Into Registered Domestic Partnership

STEP 14. DETERMINE WHETHER THE PERSON HAS THE LEGAL CAPACITY TO MARRY OR ENTER INTO REGISTERED DOMESTIC PARTNERSHIP

DPCDA APPLIES

a. DPCDA, by its express terms, applies to the capacity to marry or enter into a registered domestic partnership. Prob C §811(a); Fam C §297.5.

b. In addition, marriage or registered domestic partnership clearly has civil legal consequences governed by DPCDA because it is a personal relationship arising out of a civil contract to which consent of the parties capable of making that contract is necessary. See Fam C §§297, 300, 301.

NOTE

A conservatee who has been adjudged to lack the capacity to make a contract (CC §40; Prob C §1872) can nevertheless enter into a valid marriage or registered domestic partnership because of the highly personal nature of the marriage contract, and because the right to marry or enter into a registered domestic partnership is highly protected. Prob C §1900.

APPLY THE PRESUMPTIONS IN FAVOR OF CAPACITY

a. Apply the rebuttable presumption in favor of capacity to make decisions. Prob C §810(a).

b. Apply the additional presumption in favor of capacity to marry or enter into a registered domestic partnership, even for a conservatee. Prob C §1900.

c. Consider that only people of "sound mind" may marry. Fam C §2210. The statute does not define "sound mind." See, *e.g.*, *Goldman v Goldman* (1959) 169 CA2d 103, 336 P2d 952 (no substantial evidence of lack of capacity when psychiatrist testified that wife later diagnosed with schizoaffective psychosis was "not mentally healthy" at time of marriage).

d. Unmarried persons age 18 or older who are not in a registered domestic partnership, and not otherwise disqualified, are capable of consenting to marriage or registered domestic partnership with a person of the opposite sex or same sex. Fam C §§297, 301.

NOTE

Having a mental or physical deficit or diagnosis does not affect the presumption, but the court may determine whether a conservatee has the capacity to enter into a valid marriage or registered domestic partnership. Prob C §1901. In appropriate circumstances, an attorney should consider suggesting that the conservatorship petition include a restriction on marriage or entering into a registered domestic partnership.

APPLY OTHER DPCDA PROVISIONS

Identify applicable mental function deficits listed in Prob C §811(a) (see step 10, above) and determine whether the deficit is correlated with the act or decision and significantly impairs the person's ability to understand and appreciate its consequences. Prob C §811(b).

CONSIDER OBTAINING EXPERT'S OPINION

If the correlation between the deficit and the act or decision or the significance of the impairment is not obvious, consider obtaining an expert's opinion. The evaluation of cognitive capacity to assess one's own best interests and understand short- and long-term consequences of entering into marriage or registered domestic partnership is crucial. See Appendix D for a case study that includes an assessment by a neuropsychologist of the capacity to marry.

NOTE

Even if the person is found to have capacity, check for undue influence. Was the marriage or registered domestic partnership entered into freely, with deliberation over a period of time? Again, an evaluation may be helpful.

Assessing and Litigating the Issue of Capacity to Contract, Convey, or Make Agency Appointments

STEP 15. KNOW THE STATUTORY STANDARD FOR DETERMINING CAPACITY TO CONTRACT, CONVEY, OR MAKE AGENCY APPOINTMENTS

NOTE

Marriage or registered domestic partnership, which arises out of a civil contract, is a special type of contract. See step 14, above, for a separate discussion of this type of contract.

APPLY PRESUMPTIONS

In determining capacity to contract, apply presumptions:

a. Apply the rebuttable presumption in favor of capacity. Prob C §810(a). See step 10, above, regarding presumptions.

b. A patient is presumed to have the capacity to designate or disqualify a surrogate. Prob C §4657.

APPLY PROB C §812 AND SPECIFIC STATUTES ON CONTRACTUAL CAPACITY

Apply DPCDA test and determine if the client can communicate, understand, and appreciate all the elements set forth in Prob C §812. Review other relevant statutes, including the following:

CC §1556

"All persons are capable of contracting, except minors, persons of unsound mind, and persons deprived of civil rights." CC §1556.

CC §38

A person entirely without understanding has no power to make a contract of any kind. CC §38.

CC §39

A conveyance or contract made by a person of unsound mind, but not entirely without understanding, made before the person's incapacity has been judicially determined, is subject to rescission. CC §39(a). The term "conveyance" includes gifts. See, *e.g.*, *Stafford v Groff* (1950) 99 CA2d 67, 221 P2d 246.

NOTE

These statutes are not very helpful unless one knows what constitutes an "unsound mind" and what "entirely without understanding" means. Civil Code §39(b) offers some help by providing that there is a rebuttable presumption affecting the burden of proof that a person is of unsound mind if he or she is substantially unable to manage his or her own financial resources or resist fraud or undue influence.

CC §40

a. After a person's incapacity has been judicially determined in a general or Lanterman-Petris-Short (LPS) (Welf & I C §§5350-5372) conservatorship, that person can make no conveyance or other contract, nor delegate any power or waive any right, until his or her restoration to capacity:

(1) The establishment of a general or LPS conservatorship is a judicial determination of the incapacity of the conservatee for these purposes. CC §40(a). See also Prob C §1872.

(2) If a general or LPS conservatorship has been established, incapacity has also been established for purposes of CC §40. CC §40(b).

b. A conservatee still may have the right to enter into transactions to the extent reasonable to provide the necessaries of life to the conservatee and to the conservatee's spouse and minor children (Prob C §1871(d)) as well as other transactions authorized by the court (Prob C §1873).

c. If a limited conservatorship has been established, determine the conservator's authority to limit the conservatee's ability to contract. Prob C §1872.

Prob C §4120

A person having the capacity to contract may execute a power of attorney granting authority to an attorney-in-fact. Prob C §§4120, 4671(a). See also Prob C §4022.

Prob C §4658

With respect to designation of an agent or surrogate under a written advance health care directive, unless otherwise specified, a determination that a patient lacks or has recovered capacity to make health care decisions, or that another condition exists that affects an individual health care instruction or the authority of an agent or surrogate, shall be made by the primary physician. Prob C §4658.

NOTE

Due to the chilling effect of HIPAA and the ensuing awareness of CMIA, a primary physician may be unwilling to make such a capacity determination without a court order. When a petition has been filed for the appointment of a conservator, the petitioner may file an Ex Parte Application for Order Authorizing Completion of Capacity Declaration—HIPAA (Judicial Council Form GC-333) and Ex Parte Order Re Completion of Capacity Declaration—HIPAA (Judicial Council Form GC-334). If no petition has been filed, try to find an exception under HIPAA. See steps 7 and 9, above.

REVIEW CASE LAW

There is a wealth of case law under the statutes noted above, decided before DPCDA was enacted, that may provide useful examples of specific factual situations in which the issue has been litigated, and that amplify the statutory standard. Under prior case law, *e.g.,* incapacity was determined by courts asking:

a. Whether the party was mentally competent to deal with the subject at hand with a full understanding of his or her rights, and whether the party understood the nature, purpose, and effect of the transaction. See *Hellman Commercial Trust & Sav. Bank v Alden* (1929) 206 C 592, 603, 275 P 974; *Burgess v Security-First Nat'l Bank* (1941) 44 CA2d 808, 816, 113 P2d 298. See also Prob C §§810(c), 812.

b. Whether there was a total lack of comprehension, considering that:

(1) One may be incompetent to some extent and yet have sufficient mentality to comprehend the nature and effect of a particular transaction, and therefore to execute a valid contract. *Hellman Commercial Trust & Sav. Bank v Alden, supra*; *Burgess v Security-First Nat'l Bank, supra*.

(2) Even if a person suffers from senile or manic-depressive psychosis, he or she still may have sufficient understanding of the nature, purposes, and effect of the transaction in question to execute a contract or conveyance. See, *e.g., Smalley v Baker* (1968) 262 CA2d 824, 69 CR 521; *Holman v Stockton Sav. & Loan Bank* (1942) 49 CA2d 500, 122 P2d 120.

APPLY OTHER DPCDA TESTS

a. Determine whether there is a mental function deficit as listed in Prob C §811(a).

b. Determine whether there is a correlation between the deficit(s) and the contract, conveyance, or agency appointment in question. Prob C §811(a).

c. Determine whether the deficit significantly impairs the person's ability to understand and appreciate the consequences of his or her actions with regard to the contract, conveyance, or agency appointment in question. Prob C §811(b).

STEP 16. ASSESS CAPACITY TO EXECUTE CONTRACTS, CONVEYANCES, AND AGENCY APPOINTMENTS

ASSESS CAPACITY

The need to assess capacity to execute contracts, conveyances, and agency appointments arises in many different kinds of fact situations. Following is an analysis based on an example involving a conveyance.

Example: Although the client has three children, he asks counsel to prepare a deed conveying his property to a neighbor he has known for only a short time. Because his children may reasonably be expected to question this act eventually, and because this is not a "natural" disposition of his estate, the attorney must be sure that the client has the capacity to execute the conveyance.

Apply DPCDA Presumptions

Apply the rebuttable presumption in favor of capacity. Prob C §810(a). See step 10, above.

Apply DPCDA Test for Ability to Communicate, Understand, and Appreciate

In ascertaining whether the client can communicate, understand, and appreciate the rights, duties, and responsibilities involved in the transfer (Prob C §812), answers to the following questions may be helpful:

a. Does the client understand the consequences for himself, the neighbor, and his children, including the following facts:

(1) His children will not receive the property at his death; and

(2) He will be living in a house that he no longer owns.

b. Does the client appreciate the risks, benefits, and reasonable alternatives, including that:

(1) He may be evicted;

(2) He may now have to pay rent, which the new owner can periodically increase;

(3) He may have to pay gift taxes, as well as comply with the applicable tax reporting regulations;

(4) As an alternative to a conveyance, he could make the neighbor a joint tenant, thus retaining an ownership interest; and

(5) As another alternative, he could retain a life estate.

Apply Other Relevant Statutory Standards

Determine whether the person is substantially unable to manage his or her own financial resources, as proved by more than isolated incidents of negligence or improvidence. Note the connection between CC §39(b) and Prob C §1801(b). Applying this test, the following questions are among those that should be considered regarding this client:

a. Is he paying his bills?

b. Is he keeping track of his investments?

c. Has he recently begun spending a lot of money on sweepstakes and contests?

d. Has the house insurance lapsed?

Did the Person Understand His Rights and the Nature, Purpose, and Effect of His Acts?

Review cases decided under CC §§38-40, in which the courts applied the test of whether the person understands the rights and nature, purpose, and effect of his or her acts, a test whose language is substantially the same as that of DPCDA. See, *e.g.*, *Smalley v Baker* (1968) 262 CA2d 824, 832, 69 CR 521.

Apply Other DPCDA Tests

a. Determine whether there is a mental function deficit, *e.g.,* does the client:

(1) Exhibit inability to reason using abstract concepts (Prob C §811(a)(2)(E)); or

(2) Display severely disorganized thinking (Prob C §811(a)(3)(A))?

b. Determine whether there is a correlation between the deficit and the capacity to contract, convey, or appoint agents.

Cross-Reference: See step 33, below, for a discussion of when to refer a client to a neuropsychologist for assessment and when to retain a neuropsychologist as an expert witness, and step 34, below, for a neuropsychologist's perspective and approach to the issue of capacity. See also steps 35-36, below, for a physician's perspective on medical conditions and medications that may affect capacity and susceptibility to undue influence in older adults.

STEP 17. KNOW HOW TO LITIGATE THE ISSUE OF CAPACITY TO CONTRACT, CONVEY, OR APPOINT AGENTS

LITIGATION ISSUES

The attorney preparing to litigate the issue of capacity to contract, convey, or appoint agents should be familiar with the statutes and case law that govern the issues of presumptions, privileges, and remedies, as well as the rules of evidence.

Presumptions and Burden of Proof

The following are rebuttable presumptions regarding the capacity to contract or convey:

a. Rebuttable presumption affecting the burden of proof that all persons have the capacity to make decisions and be responsible for their acts or decisions. Prob C §810(a).

b. Rebuttable presumption affecting the burden of proof that a person is of unsound mind for purposes of CC §39 (regarding contracts subject to rescission) if the person is substantially unable to manage his or her own financial resources or resist fraud or undue influence (CC §39(b)):

(1) Substantial inability may not be proved solely by isolated incidents of negligence or improvidence (CC §39(b)).

(2) The language of CC §39(b) is identical to the statutory language of the standard for establishing a conservatorship. Prob C §1801(b).

c. Rebuttable presumption that a patient has the capacity to designate or disqualify a surrogate to make health care decisions. Prob C §4657. The burden of proof is on the person seeking to establish that the patient lacks such capacity. See Comment to Prob C §4657.

Attorney-Client Privilege

If the client is deceased, there is no attorney-client privilege regarding the client's intention in signing or regarding the validity of a deed of conveyance, will, or other document affecting an interest in property. Evid C §§960-961.

Remedy If Incapacity

a. The contracts of a person wholly without understanding or whose insanity has been judicially determined are *void* and need not be rescinded. CC §38.

b. The contracts of a person of unsound mind but not wholly without understanding are *voidable* and are binding unless rescinded. CC §39.

NOTE

Civil Code §39 is intended to protect the incompetent, and it cannot be invoked by the other party to the contract. 1 Witkin, Summary of California Law, *Contracts* §50 (10th ed 2005), citing *San Francisco Credit Clearing House v MacDonald* (1912) 18 CA 212, 215, 122 P 964.

EVIDENCE

The attorney should be prepared to present to the court evidence on the issue of capacity sufficient to satisfy the requirements of DPCDA and other relevant statutes, including evidence on each of the following issues:

a. The communication standard (Prob C §812);

b. The underlying statutory requirements (see CC §§38-40);

c. Whether mental function deficits exist and, if so, whether there is a correlation between the deficits and the capacity required

for the act in question (Prob C §811(a)); and

d. Whether the deficits significantly impair the person's ability to understand and appreciate the consequences of the act in question (Prob C §811(b)).

Cross-Reference: See step 13, above, regarding types of evidence that may be used to litigate these issues.

Assessing Capacity to Nominate Conservator

STEP 18. KNOW THE STANDARD FOR NOMINATION OF A CONSERVATOR AND APPOINTMENT OF THE NOMINEE

CONSIDER UNDERLYING STATUTE

The statute on nomination and appointment of a conservator has two parts that must be analyzed separately.

a. "If the proposed conservatee has sufficient capacity at the time to form an intelligent preference, the proposed conservatee may nominate a conservator" (Prob C §1810 (first paragraph)):

(1) In the petition for appointment of a conservator; or

(2) In a writing signed either before or after the petition is filed.

b. "The court shall appoint the nominee as conservator unless the court finds that the appointment of the nominee is not in the best interests of the proposed conservatee." Prob C §1810 (second paragraph).

KEY CONCEPTS: "INTELLIGENT PREFERENCE" AND "BEST INTERESTS"

Although Prob C §1810 uses the word "capacity," DPCDA is not particularly helpful in analyzing the statutory standard for nomination and appointment of a conservator. Rather:

a. The key concepts in Prob C §1810 are:

(1) "Intelligent preference" (first paragraph).

(2) "Best interests" (second paragraph).

b. In a hearing to challenge, or uphold, the appointment of the nominee, the court will need evidence as to these key concepts, which will ordinarily be the same evidence as to both.

EXAMPLE OF CONTESTED CONSERVATORSHIP PROCEEDING

It has been determined that a conservatorship is appropriate, and the inquiry moves to who should be appointed as conservator.

Nominee's Position

The conservatee has nominated a daughter who lives with him, and his attorney (or the daughter's attorney, if she has separate counsel) takes the position that the nomination is intelligent and the appointment is in the conservatee's best interests.

Petitioner's Position

Petitioning daughter takes the opposite position. She has nominated a private professional conservator and has alleged that:

a. The nominated daughter is a parasite taking financial advantage of the father;

b. The father's finances are in disarray; and

c. The father's in-home care is inadequate.

Definition of Intelligence

The court will want to know whether, given the facts, the father's nomination was based on the following aspects of "intelligence" (see, *e.g.,* American Heritage Dictionary (2d college ed 1982)):

a. Thought.

b. Reason.

c. Sound judgment.

d. Rationality.

e. Application of what is learned from experience.

f. Use of the power of reasoning and inference.

Same Evidence for Intelligent Preference and Best Interests

The evidence that the preference was or was not "intelligent" in these terms will also go to whether the appointment of the nominee is in the conservatee's "best interests." If, for example, while the nominated daughter was living with him, his bills were not paid and his care was inadequate:

a. His preference was not intelligent.

b. Her appointment will not be in his best interests.

PRIVILEGE

Occasionally, a doctor or other medical professional will refuse to disclose information. The attorney may have to remind the doctor that in conservatorship proceedings, there is no physician-patient privilege. Evid C §1004.

OTHER RELEVANT STATUTORY STANDARDS

Although the proposed conservatee may have the required communication abilities under Prob C §812 to nominate a conservator (see step 10, above), the court must disregard the nomination if it finds that the appointment of the nominee is not in the best interests of the proposed conservatee. Prob C §1810.

NOTE

There may be undue influence, *e.g.,* if the proposed conservatee was induced to sign a nomination that was placed in front of him or her.

Assessing and Litigating the Issue of Capacity to Create or Revoke a Trust

STEP 19. KNOW THE STANDARD FOR DETERMINING CAPACITY TO CREATE OR REVOKE A TRUST

NO SPECIFIC STATUTE IN TRUST LAW

No part of the Trust Law (Prob C §§15000-19403) discusses the capacity required to execute, amend, or revoke a trust.

NOTE

Trusts funded by court order under Prob C §§2580-2586 (substituted judgment), Prob C §§3100-3154 (transaction involving incompetent spouse), and Prob C §§3600-3612 (money paid under judgment for minor or incompetent person) must contain provisions that will result in continued court supervision. Cal Rules of Ct 7.903 (Probate).

TRUST MAY BE BOTH TESTAMENTARY ACT AND CONTRACT

A typical revocable trust, whether in the form of a trust agreement or a declaration of trust, contains testamentary provisions and appoints successor trustees to act in the event of the settlor's incapacity and on the settlor's death.

a. To the extent that a settlor of a trust provides for disposition of assets on the death of the settlor and any life beneficiaries, creation of the trust is a testamentary act. Testamentary capacity analysis therefore applies. See steps 11 and 12, above.

b. If the document is in the form of a trust agreement, the trustee or co-trustee (if the settlor is not the sole trustee) signs it when the settlor does, thereby agreeing to act under the terms of the trust. The instrument, therefore, is contractual in nature, and DPCDA analysis of capacity to contract applies. See steps 15 and 16, above.

c. To the extent that the revocable trust agreement or declaration of trust authorizes a successor trustee to act in the event of the settlor's incapacity, it has the characteristics of a contract. DPCDA analysis of capacity to contract therefore applies. See steps 15 and 16, above.

d. The trust document may contain provisions that govern the determination of capacity to amend or revoke the trust. See, *e.g.*, *Rands v Rands* (2009) 178 CA4th 907, 100 CR3d 632 (determination by two physicians that settlor lacked capacity resulted in settlor not being able to revoke trust under unusual trust provision until court determined that settlor had capacity or two physicians determined that settlor had regained capacity).

CASE LAW: SETTLOR MUST HAVE CAPACITY TO TRANSFER PROPERTY

Under case law:

a. A person who has the capacity to transfer property also has the capacity to create a trust. *Walton v Bank of Cal.* (1963) 218 CA2d 527, 541, 32 CR 856; 13 Witkin, Summary of California Law, *Trusts* §25 (10th ed 2005); Restatement (Third) of Trusts §11 (2003). See also Trust & Prob Litig §6.4.

b. The test for capacity to transfer property is the same as the test for capacity to execute a will. *Tuttle v Bessey* (1955) 137 CA2d 725, 290 P2d 884.

NOTE

Consider whether *Tuttle* is consistent with the command of Prob C §811(a) that a determination of a person's incapacity to make a contract, make a conveyance, execute a will, or execute a trust must be supported by evidence of a correlation between specified mental function deficits and the decision or act in question.

ASSESSING CAPACITY

Take the following steps when analyzing a client's capacity to create a trust:

Apply Presumption in Favor of Capacity

See step 10, above. Prob C §810.

Apply Test for Ability to Communicate, Understand, and Appreciate, and Other Specific Statutes

a. Apply test to determine whether client can communicate, understand, and appreciate all the elements set forth in Prob C §812.

b. See steps 11 and 15, above, regarding other specific statutes governing testamentary and contractual capacity. Prob C §6100; CC §1556.

Apply Other DPCDA Tests

a. Determine whether there is a mental function deficit listed in Prob C §811(a).

b. Determine whether there is a correlation between the deficit and the decision to create or revoke a trust. Prob C §811(a).

c. Determine whether the deficit significantly impairs the client's ability to understand and appreciate the consequences of creating or revoking a trust. Prob C §811(b).

LITIGATING THE ISSUE OF CAPACITY

See steps 13 and 17, above, for litigation issues.

Assessing and Litigating the Issue of Capacity to Manage Personal and Financial Affairs

STEP 20. KNOW STATUTORY STANDARD FOR DETERMINING CAPACITY TO MANAGE PERSONAL AND FINANCIAL AFFAIRS

ISSUE IS ABILITY TO FUNCTION, NOT ABILITY TO COMMUNICATE

The capacity to manage personal and financial affairs is a matter of whether a person can function at an adequate level in running his or her life. Because the test is one of function—*i.e.,* the performance of certain tasks—and not communication, Prob C §812 does not apply.

a. The test of a person's ability to function may be evaluated in light of whether the person has developed techniques for compensating for any deficits in this area. For further discussion of this point, see step 10, above, and step 34, below.

b. It is irrelevant how well someone can articulate, understand, and appreciate a wide range of issues if he or she:

(1) Cannot get the bills paid regularly enough to keep the gas and electricity on;

(2) Is giving money to sweepstakes, contests, or strangers coming to the door; or

(3) Has failed to eat and drink for long enough that hospitalization for dehydration and malnutrition is required.

NOTE

In the neuropsychologist's experience, the court and/or the referring attorney are frequently interested in whether a client understands the consequences to him- or herself of the financial actions that he or she has taken. This is in addition to the administration of tests that allow for functional assessment to determine if the client retains enough skill to continue managing his or her financial affairs. Thus, even though the test is a functional one, and not one of communication, requesting the information contained in Prob C §812 provides the neuropsychologist with an additional source of data relevant to the mental function deficits test of Prob C §811. The Global Deterioration Scale also may be useful by identifying which functional skills are impaired and relating them to a particular level of cognitive impairment. See Appendix K.

APPLY CONSERVATORSHIP STATUTES

Because inability to manage one's own personal or financial affairs may give rise to a conservatorship petition, the applicable standard is found in Prob C §1801.

a. "A conservator of the person may be appointed for a person who is unable to provide properly for his or her personal needs for physical health, food, clothing, or shelter." Prob C §1801(a).

b. "A conservatorship of the estate may be appointed for a person who is substantially unable to manage his or her own financial resources or resist fraud or undue influence." Prob C §1801(b).

Allegation of Diagnosis Not Required

If the facts in a given situation appear to meet the statutory standard of inability to manage one's own personal or financial affairs, and no suitable alternative is apparent, it is appropriate to file a conservatorship petition and to allege facts and attach documentation that address the standard:

a. No allegation of diagnosis is required.

b. Given concerns about HIPAA and CMIA regarding release of protected medical information (see steps 6-9, above), no discussion of diagnosis is either necessary or appropriate.

Use Common-Sense Approach

Although the statutory terms "provide properly" and "substantially unable to manage" are subjective, a common-sense approach will usually work: Has harm to person or estate actually occurred, or is it imminent? For example:

a. Is it healthy to live in a house without running water and therefore without a working sanitation system?

b. Has the person been hospitalized for failure to monitor diabetes and eat properly, or self-administer the required medications?

c. Has electrical and gas service been turned off?

d. Are CDs being cashed in, incurring penalties, in order to send thousands of dollars off to sweepstakes and contests?

Personal and Financial Tasks May Be Substantially Managed With Help

It does not matter whether a person actually manages various tasks him- or herself, or receives help from others, as long as the helpers are not taking advantage of the situation, *e.g.*:

a. Someone who is blind may have assistance in paying bills:

(1) If the bills are paid, finances are "substantially" managed; but

(2) If that assistant is paying her or his own bills with the blind person's money, and the blindness prevents detection:

(a) The system in place is not working to "substantially manage" financial resources; and

(b) Conservatorship may be the only alternative.

b. If a daughter who lives next door administers medications adequately, physical health is being "properly" provided for.

NOTE

The major disadvantage of these kinds of arrangements is that there is probably no supervision or monitoring, whereas the court supervises the activity of a conservator.

Investigate Alternative Management Methods

Alternative methods of management, such as powers of attorney and trusts, may be in place and can work, or can be provided if the person has sufficient capacity to do so. Always investigate that possibility before commencing a conservatorship proceeding.

NOTE

While a neuropsychological assessment may not be necessary in a conservatorship proceeding, an assessment of capacity may be helpful in other circumstances; for example, when the question arises whether the person may be subject to undue influence in revoking a trust. See Appendix M.

CONSIDER IMPACT OF MEDICAL PRIVACY LAW

a. Allegations of diagnosis or other medical information need not be made in the initial petition for a conservatorship; therefore, the medical privacy laws (see steps 6-7, above) should not be an issue.

(1) Prob C §1801 sets forth a functional test.

(2) Allegations regarding function alone are sufficient.

b. If inability of the proposed conservatee to come to court is an issue, or medical powers (including dementia powers) are requested, a Capacity Declaration—Conservatorship (Judicial Council Form GC-335) must be filed.

(1) Despite HIPAA and CMIA provisions (see step 9, above), a letter from the petitioner's attorney to the petitioner's physician, explaining and enclosing the form with a return envelope, is often sufficient.

(2) It is helpful to highlight those places on the form requiring a writing, including the physician's signature and date, for the following reasons:

(a) The form is long and complex.

(b) The Dementia Attachment to Capacity Declaration—Conservatorship (Judicial Council Form GC-335A) is repetitive of earlier sections.

(3) The process can be streamlined by obtaining an Ex Parte Order re Completion of Capacity Declaration—HIPAA (Judicial Council Form GC-334) when the petition is filed and sending it with the request to the physician.

c. If a temporary conservatorship proceeding is being requested, consider the following:

(1) Has the proposed conservatee been personally served, and all others entitled to notice by mail, with the petition and notice of hearing? See Prob C §2250(c).

(2) Is waiver of notice essential to protect the proposed temporary conservatee or his or her estate from substantial harm? Prob C §2250(j).

APPLY DPCDA WHEN APPROPRIATE

Because establishment of a conservatorship is a judicial determination that a person lacks "the legal capacity to perform a specific act"—*i.e.,* to manage personal or financial affairs—DPCDA provides that evidence of one or more mental function deficits must be alleged and, if necessary, proved. Prob C §810(c).

a. The Judicial Council conservatorship forms do not elicit this information, but it is appropriate to allege a mental function deficit at the end of the Confidential Supplemental Information (Probate Conservatorship) Form (Judicial Council Form GC-312).

b. Other than fulfilling the Prob C §810(c) requirement, it is not necessary to allege any mental function deficits in the petition and related forms. If litigation results, see step 21, below.

c. When in doubt about these issues, consult an expert.

NOTE

Incapacity to manage one's financial affairs is not the same thing as poor judgment, eccentricity, selecting people to help you, or not doing so. Judgment involves considering the consequences of one's action or inaction, both for oneself and others. Spending more than truly discretionary income on sweepstakes and contests may be a matter of judgment or, in the absence of prior gambling tendencies, compulsive behavior signifying a frontal lobe deficit and/or dementia. If there is a deficit or dementia, the functional test for conservatorship of the estate is probably met.

STEP 21. HOW TO LITIGATE THE ISSUE OF CAPACITY TO MANAGE PERSONAL AND FINANCIAL AFFAIRS

KNOW SPECIFIC STATUTORY STANDARDS

The statutory standards for imposing a conservatorship of the person or of the estate are (with certain exceptions relating to limited conservatorships of the developmentally disabled):

a. Conservator of the person may be appointed for a person who cannot provide properly for his or her personal needs for physical health, food, clothing, or shelter. Prob C §1801(a).

b. Conservator of the estate may be appointed for a person who is substantially unable to manage his or her own financial resources or resist fraud or undue influence. Substantial inability may not be proved solely by isolated incidents of negligence or improvidence. Prob C §1801(b).

NOTE

Although only one mental function deficit (MFD) need be alleged when filing a conservatorship petition and related documents (see step 20, above) and the presence of MFDs is not relevant if the statute's functional test is met, alleging and proving additional MFDs may be helpful in a trial situation. The words "properly" (Prob C §1801(a)) and "substantially" (Prob C §1801(b)) may be viewed quite differently by individual judges. Sometimes, proving several MFDs, with examples ("she was certain that the host of a television show was broadcasting thoughts specifically meant for her"), will make the judge feel more comfortable about removing a person's control over his or her own life. Further, a judge may prefer a formal assessment by a neuropsychologist setting forth MFDs that are present to relying on lay testimony (which should be legally sufficient). If this is true in a given case, consider using a neuropsychologist at trial for this purpose. The standard of proof is high, and a judge may need plenty of evidence to feel that the standard has been met.

APPLY PRESUMPTIONS IN FAVOR OF CAPACITY

There is a rebuttable presumption affecting the burden of proof that everyone, including the proposed conservatee, has the capacity to make decisions and be responsible for his or her acts or decisions. Prob C §810(a).

KNOW STANDARD OF PROOF

The standard of proof for the appointment of a conservator is clear and convincing evidence. Prob C §1801(e).

EXAMPLES OF EVIDENCE OF INCAPACITY AS TO PERSONAL NEEDS

Following are specific examples of facts that have been properly introduced in court as evidence relevant in determining a person's capacity to properly provide for personal needs, *i.e.,* the person:

a. Received no regular medical or dental care, although treatment for a serious infectious disease was prescribed, but was refused.

b. Refused follow-up services of a physical therapist, social worker, and home health aide following recent hospitalizations.

c. Was incapable of providing adequate nutrition for self and repeatedly unplugged refrigerator and left it unplugged.

d. Did not allow gas company into the house to relight pilot lights, so that gas stove did not work.

e. Attempted to heat a can of soup without opening it, with the result that it exploded in the kitchen; needed help and supervision in preparing and eating food, but would not accept Meals on Wheels.

f. Piled clothes throughout the house and wore the same clothes for days and nights at a time.

g. Lived in a house with no heat because pilot lights had not been relit after gas was turned off for nonpayment.

h. Barricaded the house from the inside with plywood and two-by-fours; in case of a fire, the person might be unable to get out,

and in an emergency, no one could get in.

i. Did not answer the door and seldom answered the phone, testifying to being able to tell who was calling without answering it; changed phone number and forgot new number.

EXAMPLES OF EVIDENCE OF INCAPACITY IN FINANCIAL MATTERS

The following are specific examples of relevant evidence actually presented in court concerning a person's substantial inability to manage his or her own financial resources, *i.e.,* the person:

a. Did not pay utility bills regularly enough to keep utilities from being turned off; this went on for some time, and when a utility was cut off for nonpayment, there was a charge to have it reconnected.

b. Received rent from a tenant, and testified to having uncashed checks going back for several years, most of which were no longer acceptable by any bank.

c. Did not file income tax returns for 10 years; when informed by the IRS of what it thought was owed, paid the tax, including the accrued interest and penalties, but did not cooperate when taken by niece to see a tax preparer.

d. Had a checking account, but did not know, when asked at trial, where the checkbook was.

e. Had other accounts, but did not know how much was in them.

NOTE

If the judge wants to consider the proposed conservatee's mental function deficits (although this should not be necessary), witnesses can testify to them.

CLOSING ARGUMENT

The following summarizes an attorney's closing argument made to the court and demonstrates how to apply the relevant conservatorship statutes and DPCDA to the evidence presented:

a. The ability to manage personal and financial affairs requires understanding the consequences of one's actions or inactions.

b. The person has clearly demonstrated short-term memory loss, which affects the ability to understand and appreciate the consequences of:

(1) Failing to pay utility bills;

(2) Changing telephone number and forgetting new number;

(3) Failing to file tax returns and consequently paying interest and penalties every year (plus, possibly, more taxes than are owed);

(4) Holding rent checks from tenants for years without cashing or depositing them; and

(5) Failing to keep track of liquid assets.

c. The person has demonstrated an inability to plan, organize, and carry out actions in own rational self-interest, including personal and financial self-interest, as shown by the following:

(1) Refusal to accept a medical diagnosis and to accept treatment for the diagnosed condition, although the consequences of that decision are potentially extremely grave (person is 91 and believed to have tertiary syphilis);

(2) Inability to reason logically; does not understand that refusal to allow pilot lights to be lit after the gas was turned back on means that gas furnace would not work;

(3) Disorganized thinking; repeats facts about own early life, which are irrelevant to current situation, even when repeatedly cautioned about doing so by own counsel and court;

(4) Hallucinations; sees strangers in the house when no one is there;

(5) Claims to know who is calling without answering phone; and

(6) Inability to modulate mood and affect, including during trial, disrupting hearing with angry outbursts, crying, and whispering "liar" continually until admonished by court.

Cross-References: For two hypothetical cases involving issues of capacity to manage financial affairs and capacity to contract and convey and an analysis of these cases, see Appendixes E and F.

Assessing and Litigating the Issue of Capacity to Make Medical Decisions

STEP 22. KNOW STATUTORY STANDARD FOR DETERMINING CAPACITY TO MAKE MEDICAL DECISIONS

PRESUMPTIONS

In addition to the Prob C §810(a) rebuttable presumption that every person has the capacity to make decisions and to be responsible for his or her acts or decisions, a patient is presumed to have the capacity to make a health care decision and to give or revoke an advance health care directive. Prob C §4657.

ABILITY TO COMMUNICATE

Assessing and litigating the issue of capacity to make medical decisions begins with an analysis of the person's ability to communicate, as defined in Prob C §813. A person has the capacity to give informed consent to a proposed medical treatment if the person is able to do all the following:

a. Respond knowingly and intelligently to queries about the treatment;

b. Participate in the treatment decision through a rational thought process; and

c. Understand all the following with respect to that treatment:

(1) The nature and seriousness of the illness, disorder, or defect;

(2) The nature of the treatment being recommended by the health care providers;

(3) The probable degree and duration of any benefits and risks of any medical intervention recommended by the health care providers, and the consequences of lack of treatment; and

(4) The nature, risks, and benefits of any reasonable alternatives.

NOTE

The language of Prob C §813, which codifies informed consent, is similar, at least in concept, to that of the communication standard in Prob C §812, which applies in most DPCDA contexts. However, Prob C §812 expressly does not apply in cases involving capacity to make medical decisions; in those cases, only Prob C §813 applies.

APPLY OTHER DPCDA TESTS

If the person is able to do everything required under Prob C §813:

a. Identify any Prob C §811 mental function deficits, considering whether:

(1) The patient is unconscious or otherwise unable to pay attention; or

(2) The patient has uncontrollable, repetitive, or intrusive thoughts that prevent a meaningful discussion of the situation.

b. Determine whether there is a correlation between the deficits and the decision in question, considering whether:

(1) An unconscious or otherwise nonalert person is able to consider the nature and seriousness of his or her illness; or

(2) Someone with repetitive and intrusive thoughts is able to respond knowingly and intelligently to queries about medical treatment.

Cross-Reference: For a hypothetical case and analysis, see Appendix G.

APPLY OTHER RELEVANT STATUTORY PROVISIONS

Unless otherwise specified in a written advance health care directive, a determination that a patient lacks or has recovered capacity to make health care decisions, or that another condition exists that affects an individual health care instruction or the authority of an agent or surrogate, shall be made by the primary physician. Prob C §4658. The physician, in making the Prob C §4658 determination, must apply the Prob C §813 criteria.

EFFECT OF HIPAA AND CMIA

Due to the chilling effect of HIPAA and the ensuing awareness of CMIA, a primary physician may be unwilling to make such a capacity determination without a court order. Try to find an exception under HIPAA. 45 CFR §§164.510(b)(2)(iii), 164.510(b)(3), 164.512(j). See steps 7 and 9, above.

Cross-Reference: See also step 23, below, on capacity to authorize release of protected health information.

Assessing the Capacity to Authorize Release of Protected Health Information

STEP 23. KNOW THE STATUTORY STANDARD FOR ASSESSING CAPACITY TO AUTHORIZE OR REFUSE TO AUTHORIZE RELEASE OF PROTECTED HEALTH INFORMATION

ASSESS CAPACITY

Consider Underlying Statutes

a. Authorizing or refusing to authorize release of protected health information is a decision that has legal consequences that might be reviewed by a court; thus, DPCDA analysis applies. See Prob C §811(e); step 10, above.

b. The underlying statutes and regulations are found in HIPAA and CMIA. See steps 6 and 7, above.

NOTE

Neither HIPAA nor CMIA defines what constitutes "capacity" to authorize release of protected health information.

Know the Definition of Protected Health Information

Individually identifiable health information concerns a patient's past, present, or future physical or mental health or condition. See 45 CFR §160.103 and step 6, above; CC §56.05(f) and step 8, above.

Apply DPCDA Presumption

Apply the rebuttable presumption in favor of capacity. Prob C §810(a). See step 10, above. A diagnosis of a person's mental or physical disorder does not rebut the presumption. See Prob C §§810(b)-(c), 811(d).

Apply Prob C §4657 Presumption

A patient is presumed to have the capacity to (Prob C §4657):

a. Make a health care decision;

b. Give or revoke an advance health care directive; and

c. Designate or disqualify a surrogate.

Apply the Communications Standard of Prob C §812

a. Apply Prob C §812 to determine whether the person can communicate in some way that he or she does or does not authorize the release of personal medical information. See step 10, above.

b. If the person cannot communicate, the analysis goes no further. The person does not have capacity. Remember that the person can communicate by any means, including orally, by gesture, and in writing. Prob C §812.

Identify Mental Function Deficits

Identify any mental function deficit, such as those listed in Prob C §811(a).

Determine Whether There Is a Correlation Between Deficit and Capacity and Whether There Is Significant Impairment

Even if a mental function deficit is present, there must be:

a. Evidence of a correlation between the deficit and the capacity required to authorize release of health information (Prob C

§811(a)); and

b. Significant impairment of the person's ability to understand and appreciate the consequences of the release (Prob C §811(b)).

Obtain an Expert's Opinion

If it is unclear whether the person understands the consequences of releasing his or her protected health information under Prob C §811(b), obtain an expert's opinion.

DETERMINE WHETHER UNDUE INFLUENCE OCCURRED

In each case, consider the possibility that the person was subject to undue influence when he or she signed the authorization, and therefore did not consent to the release of information.

LITIGATE CAPACITY

If the capacity to authorize release of protected health information is contested, there may be an issue of obtaining protected health information. See steps 7 and 9, above.

Assessing the Capacity to Drive

STEP 24. KNOW THE STATUTORY STANDARD FOR ASSESSING CAPACITY TO DRIVE

INTRODUCTION

One of the most difficult concepts for those with some form of "incapacity" to accept is a restriction on their ability to drive. It invades an individual's sense of independence. Vehicle Code §13800 allows the Department of Motor Vehicles (DMV) to investigate the qualifications of any driver when it appears necessary after receiving information about a person's ability to drive.

DPCDA APPLIES TO CONTESTED DETERMINATIONS OF CAPACITY TO DRIVE

a. DPCDA applies to evidence that is presented to, and findings that are made by, a court determining the capacity of a person to do a certain act or make a decision. Prob C §811(e).

b. Persons whose drivers' licenses have been revoked by the DMV based on a finding of incapacity may request a hearing.

c. In addition, older persons are now increasingly challenging the DMV's decisions to revoke their licenses by bringing suits against the DMV, their own physicians, and other persons who have filed reports stating that they lack the capacity to drive. Because court proceedings may be involved, DPCDA applies.

NOTE

The American Medical Association (AMA) has published a Physician's Guide to Assessing and Counseling Older Drivers (July 2003), available on its website at http://www.ama-assn.org. These guidelines suggest that the client should be advised to seek an outside, objective opinion of his or her driving by a certified driving rehabilitation specialist before pursuing a lawsuit. Many hospital-based rehabilitation programs can help the lawyer identify a team of specialists to whom to refer the client, including certified driving rehabilitation specialists, neuropsychologists, and driving school instructors. See step 34, below, for further information and neuropsychologist's view.

d. Because DPCDA applies, the presumption in favor of capacity stated in Prob C §810(a) applies.

NOTE

There is no communication standard for driving. The test is entirely functional. Even if a person can pass a written test, which is a communication exercise (Can the person read and answer questions accurately?), the vision and driving tests are determinative (Can the person see? Can the person handle the car?).

DMV PROCEDURE FOR ASSESSING CAPACITY TO DRIVE

Initiating Investigation and Reexamination

Vehicle Code §§13800 and 13801 permit the DMV to investigate and reexamine a person's ability to safely drive a motor vehicle for a variety of reasons. One reason is that a report has been made to the department that a person has a physical or mental disorder that may affect his or her ability to drive safely. The report can be made by:

a. A physician or surgeon, who *must* report immediately to the local health officer in writing, and the local health officer, who *must* report to the DMV the name of every patient at least 14 years of age or older whom the physician or surgeon has diagnosed as having a disorder characterized by lapses of consciousness, including Alzheimer's disease and related disorders, that are severe enough to be likely to impair a person's ability to operate a motor vehicle. Health & S C §103900(a), (d).

b. The following persons:

(1) A physician or surgeon who believes that a patient cannot drive safely because of a medical condition, and who *may*, but is not required to, report any condition other than one characterized by lapses of consciousness (Health & S C §103900(a)). See

Appendix H (Driver Medical Evaluation (DMV Form DS 326)).

(2) A person, such as a relative or friend, *may* report to the DMV an individual believed to have dementia or other condition who is exhibiting unsafe driving skills; the report may be in the form of a letter to the local Driver Safety Office of the DMV and must be signed, although the reporter may request that his or her name be kept confidential. In addition, the person may complete a DMV form. See Request for Driver Reexamination (DMV Form DS 699).

(3) A peace officer, who *may* request a reexamination of any driver with whom he or she comes in contact, if he or she observes or discovers reasons to believe the person may be unable to drive safely. Veh C §21061.

(4) A driver may request an evaluation himself or herself by submitting a DMV form. See Self Referral For Reevaluation Of Driving Skill (DMV Form DS 699A).

(5) An employer must report to the DMV commercial A or B drivers who fail to qualify for a medical certificate. Veh C §14606(b). See Employer's Report Of Medical Exam Failure/Employer Request For Reexamination Of Driver (DMV Form DS 524) (all forms available on the DMV website at http://www.dmv.ca.gov/forms/forms.htm).

NOTE

HIPAA is not an obstacle to a physician's mandatory or optional report or completion of DMV Form DS 326 because the following exceptions apply: 45 CFR §164.512(e) (disclosures for administrative proceedings); §164.512(f) (law enforcement purposes); §164.512(j) (imminent threat to health and safety). See step 7, above.

DMV Sends Notice to Reported Person

The DMV will send a reported person a notice that he or she has been scheduled for a reexamination and will be sent a DMV Form DS 326 that must be completed by the person's treating physician. If the person does not appear for the scheduled appointment or have the medical form completed, his or her driving privileges will be suspended.

a. DMV Form DS 326 asks for information about relevant medical conditions and levels of functional impairments that may affect safe driving ability in various categories, including information about:

(1) Lapse-of-consciousness disorder and Alzheimer's disease and other dementia or cognitive impairments; and

(2) The severity of the cognitive impairments in a number of specific categories (for Form DS 326, see Appendix H).

b. DPCDA mental function deficits listed in Prob C §811(a) are in many of their particulars similar to deficits identified in Form DS 326. DPCDA requirement of correlation to acts in question, in this case driving, are similarly met by responses to the questions asked in Form DS 326.

Reexamination by Hearing Officer

a. Reexamination, conducted by a driver safety hearing officer, consists of an interview and may include a vision test, a written test, and a driving test.

b. Based on the information in the report and the reexamination, the hearing officer may order either that:

(1) No action be taken; or

(2) There be a restriction, probation, suspension, or revocation of the driving privilege.

c. A person is entitled to written notice of the action and an opportunity to contest the decision at an administrative hearing. Veh C §13950.

NOTE

Many people suffering from incapacitating illnesses lack sufficient awareness to care about whether they have a valid driver's license.

Cross-Reference: For a case study and analysis from a neuropsychologist's perspective, see Appendix I.

Assessing and Litigating the Issue of Undue Influence in Cases Involving Testamentary Instruments

STEP 25. KNOW THE DEFINITION OF UNDUE INFLUENCE ON A TESTATOR

RELEVANT STATUTES AND CASE LAW

The definition of undue influence in different contexts is contained both in statutes and a large body of case law.

Definition of Undue Influence in Contract Cases

Although no specific Probate Code section defines "undue influence" (as used in Prob C §6104) in the context of procuring execution or revocation of a will, CC §1575, which defines undue influence in the context of contract cases, is often applied. See step 28, below.

Subjugation to the Will of Another

"Undue influence consists in the exercise of acts or conduct by which the mind of the testator is subjugated to the will of the person operating on it; some means taken or employed which have the effect of overcoming the free agency of the testator and constraining him to make a disposition of his property contrary to and different from what he would have done had he been permitted to follow his own inclination or judgment." *Estate of Ricks* (1911) 160 C 467, 480, 117 P 539. See also *Rice v Clark* (2002) 28 C4th 89, 96, 120 CR2d 522.

Pressure From Another So Great That Mind Gives Way

"It is not undue unless the pressure has reached a point where the mind of the person subjected to it gives way before it so that the action of such person taken in response to the pressure does not in fact represent his conviction or desire, brought about perhaps by argument and entreaty, but represents in truth but the conviction or desire of another." *Estate of Anderson* (1921) 185 C 700, 707, 198 P 407.

Independent Free Will Subverted

"Undue influence, then, is the legal condemnation of a situation in which extraordinary and abnormal pressure subverts independent free will and diverts it from its natural course in accordance with the dictates of another person." *Estate of Sarabia* (1990) 221 CA3d 599, 605, 270 CR 560.

STEP 26. PROTECT THE CLIENT FROM UNDUE INFLUENCE IN CREATING TESTAMENTARY INSTRUMENTS

ASSESS ACTUAL OR POTENTIAL UNDUE INFLUENCE

The following steps should be taken in assessing whether the client is being or has been subjected to undue influence in creating a testamentary instrument:

Review Documents

Obtain and review the client's previous and existing plans and consider that:

a. One indication of undue influence is that the will provisions are unnatural. *Estate of Yale* (1931) 214 C 115, 122, 4 P2d 153.

b. The client's previous estate planning documents are the equivalent of the "legislative history" of a client's dispositive wishes. A radical change in the dispositive provisions indicates a possibility of undue influence.

Note Any Indicia of Potential Undue Influence

Note the following signs of potential undue influence:

a. Control by one individual;

b. Secrecy regarding the client's financial affairs;

c. Difficulty in obtaining financial information;

d. Difficulty in seeing the client alone; and

e. Chief beneficiaries were active in procuring the instrument. *Estate of Yale, supra*. See also step 30, below, regarding donative transfers to disqualified persons.

Further Research: See California Elder Law Resources, Benefits, and Planning: An Advocate's Guide §2.47 (Cal CEB 2003).

Interview the Client Alone

Interview the client alone:

a. Carefully question the client about his or her reasons for the dispositive provisions.

b. In your file notes, document why the client changed those provisions, the date of the interview, and who was present.

Review Unusual Provisions Before Execution

Mail the estate plan to the client to review before execution; call the client's attention to any unusual provisions in the plan and the client's reasons for them.

Exclude Interested Persons

Exclude interested persons from the conference at which the client executes the documents.

NOTE

Even though the better practice is to exclude interested persons from the conference at which the client executes the documents, the presence of a person who benefits under the estate plan, without more, does not show undue influence. *Estate of Mann* (1986) 184 CA3d 593, 608, 229 CR 225 (will beneficiary "a passive observer").

Consider Additional Precautions

The following additional precautions may be taken if a challenge is possible or likely:

a. If the dispositive document is a will and a contest is likely, consider questioning the client in the presence of the attesting witnesses as to why the client made the dispositive provisions he or she chose.

b. If the dispositive document is a trust and a contest is likely, even though witnesses are not required, consider having the execution witnessed and questioning the client in front of the witnesses.

c. If there are witnesses, have the client explain to them any unusual provisions and, if appropriate, why the document varies from the client's previously expressed intentions. See California Will Drafting §36.14 (3d ed Cal CEB 1992).

d. Consider discussing with the client whether to take depositions or seek responses to written interrogatories to preserve the testimony of witnesses to the document. See CCP §2035.010; Will Drafting §36.15.

VIDEOTAPING

If the client clearly has capacity and the attorney is concerned about a charge of undue influence, a videotaped statement by the client explaining why he or she is creating an unusual dispositive plan can be compelling evidence and deter a challenge.

Example: A widowed testator who disinherits a child in favor of a long-time friend may explain that the child never calls or visits, but the friend often helps with daily errands and visits regularly. The videotape may discourage the child from challenging the estate plan.

NOTE

Videotaping should always be approached with caution, even if capacity is not an issue. See step 12, above.

MENTAL ASSESSMENT EXAM

The same considerations that apply to videotaping the execution of the document apply to referring the client for a mental assessment examination. See step 12, above.

Cross-References: See step 33, below, for discussion of when to refer a client to, and when to retain, a neuropsychologist. See step 34, below, for a neuropsychologist's perspective and approach to assessing susceptibility to undue influence and for a comparison of a mental assessment of capacity with a mental assessment of susceptibility to undue influence.

CLIENT SHOULD PAY ATTORNEY'S BILL

The client, not a beneficiary or someone close to the beneficiary, should pay the attorney fees for legal services. If the client does not pay the bill, undue influence may be suspected.

NOTE

If the attorney undercharges the client, a contestant may argue that a beneficiary secretly compensated the attorney.

STEP 27. KNOW HOW TO LITIGATE THE ISSUE OF UNDUE INFLUENCE REGARDING TESTAMENTARY INSTRUMENTS

BURDEN OF PROOF; SHIFTING THE BURDEN

The contestant has the burden of proving undue influence. Prob C §8252(a) (will contest). The contestant can shift the burden of proof to the proponent of the will if the proponent is a disqualified person (see step 31, below) or the contestant can show (*Estate of Fritschi* (1963) 60 C2d 367, 376, 33 CR 264; *Estate of Sarabia* (1990) 221 CA3d 599, 605, 270 CR 560):

a. The existence of a confidential relationship between the testator or settlor and the person alleged to have exerted undue influence;

b. The person's active participation in procuring the instrument; and

c. Undue profit.

Confidential Relationship

The existence of a confidential relationship is often not difficult to establish and can be proved under the following tests:

a. "Whether a confidential relationship exists is always a question of fact and must depend upon the circumstances of each case. … The relation and the duties involved need not be legal. They may be moral, social, domestic or merely personal. The rule embraces both technical fiduciary relations and those informal relations which exist wherever one man trusts in and relies upon another." *Estate of Bliss* (1962) 199 CA2d 630, 640, 18 CR 821 (patient-nurse relationship).

b. "[A] confidential relationship exists whenever trust and confidence is reposed by one person in the integrity and fidelity of another." *Estate of Rugani* (1952) 108 CA2d 624, 630, 239 P2d 500 (social relationship).

Active Participation in Procuring Instrument

a. Active participation is often inferred from the circumstances.

Example: Active participation can be inferred from evidence that (1) decedent had five children, two of whom were proponents of the will; (2) one of the proponents of the will was present when the will was executed; (3) the proponent gave decedent pen, ink, and paper; (4) decedent wrote the will and immediately gave it to the proponent, who took it to his attorney, whom decedent did not know; and (5) the three disinherited children had no knowledge of the will's existence for several months after decedent's death. *Estate of Garibaldi* (1961) 57 C2d 108, 113, 17 CR 623.

b. The California courts' interpretation of the term "causing to be transcribed" as used in Prob C §21350 for impermissible donative transfers can be instructive in undue influence cases. See *Rice v Clark* (2002) 28 C4th 89, 120 CR2d 522; *Estate of Swetmann* (2000) 85 CA4th 807, 819 n9, 102 CR2d 457. See step 31, below.

Undue Profit

To determine undue profit, the trier of fact must:

a. Assess the relationship, *e.g.,* between decedent or settlor and beneficiary, on one hand, and decedent or settlor and contestant, on the other. See *Estate of Sarabia* (1990) 221 CA3d 599, 605, 270 CR 560 (no undue profit when decedent left his entire estate to his business manager and nothing to his brother).

b. Decide what profit would be due: "These determinations cannot be made in an evidentiary vacuum. The trier of fact derives from the evidence introduced an appreciation of the respective relative standings of the beneficiary and the contestant to the decedent in order that the trier of fact can determine which party would be the more obvious object of the decedent's testamentary disposition." *Estate of Sarabia*, 221 CA3d at 607.

ESTABLISHING UNDUE INFLUENCE WITHOUT BENEFIT OF PRESUMPTION

Even though a contestant has failed to prove one or more of the factors above, the contestant still may prevail if the contestant shows that the evidence as a whole establishes undue influence. See, *e.g.*, *David v Hermann* (2005) 129 CA4th 672, 684, 28 CR3d 622, in which the court affirmed a finding of undue influence even though the contestant had failed to prove active participation in procuring the testamentary instrument.

USE OF CIRCUMSTANTIAL EVIDENCE

Circumstantial evidence may be used to prove undue influence:

a. "That the alleged wrongdoer had power or ability to control the testamentary act may be established by a variety of circumstances—such as control over the decedent's business affairs, dependency of the decedent upon the beneficiary for care and attention, or domination on the part of the beneficiary and subserviency [sic] on the part of the deceased. Unless explained, a transfer of property by the decedent to the alleged wrongdoer has a tendency to establish the charge of undue influence." *Estate of Washington* (1953) 116 CA2d 139, 145, 253 P2d 60.

b. For examples of evidence proving undue influence, see *Estate of Garibaldi* (1961) 57 C2d 108, 367 P2d 39; *Estate of Peters* (1970) 9 CA3d 916, 88 CR 576.

c. Physical and financial isolation also may be used as evidence in an elder abuse action. *Estate of Lowrie* (2004) 118 CA4th 220, 12 CR3d 828. See Elder Abuse Remedies, below.

d. "'Undue influence,' obviously, is not something that can be seen, heard, smelt or felt; its presence can only be established by proof of circumstances from which it may be deduced." *Estate of Ferris* (1960) 185 CA2d 731, 734, 8 CR 553.

DIFFICULTY OF PROVING UNDUE INFLUENCE BY DIRECT EVIDENCE

It is often difficult to prove undue influence by direct evidence, because:

a. Undue influence takes place between the proponent of the will or trust and decedent, and usually occurs behind closed doors. By the time the possibility of undue influence is under investigation, decedent is no longer available to testify about it.

b. Cases are rarely decided on the basis of testimony or other direct evidence of undue influence; rather, evidence of cumulative events must be introduced that, taken together, supports a finding of undue influence. See Trust & Prob Litig §6.22.

INDICIA

The following are indicia of undue influence (*Estate of Lingenfelter* (1952) 38 C2d 571, 585, 241 P2d 990; *Estate of Yale* (1931) 214 C 115, 122, 4 P2d 153; see also *Estate of Gonzalez* (2002) 102 CA4th 1296, 126 CR2d 332):

a. Provisions of the will are unnatural;

b. Dispositions of the will are at variance with decedent's intentions as expressed both before and after its execution;

c. Relationship of chief beneficiaries and decedent gave beneficiaries an opportunity to control the testamentary act;

d. Decedent's mental and physical condition was such as to permit a subversion of his or her free will; and

e. Chief beneficiaries were active in procuring the instrument to be executed.

REMEDY IF UNDUE INFLUENCE PROVED

The execution or revocation of a will or a part of a will is ineffective to the extent that the execution or revocation was procured by undue influence. Prob C §6104.

ELDER ABUSE REMEDIES

In *Estate of Lowrie* (2004) 118 CA4th 220, 12 CR3d 828, decedent amended a revocable trust to benefit one son over other descendants and transferred property to that son during decedent's lifetime. After decedent's death, a granddaughter succeeded in setting aside the trust amendment and the transfers to the son and obtained a judgment awarding her compensatory damages, punitive damages, and attorney fees under the Elder Abuse Act (Welf & I C §§15600-15660). See step 30, below.

Assessing and Litigating the Issue of Undue Influence in Cases Involving Contracts, Conveyances, and Agency Appointments

STEP 28. KNOW THE DEFINITION OF UNDUE INFLUENCE IN STATUTES AND IN CASES INVOLVING CONTRACTS, CONVEYANCES, AND AGENCY APPOINTMENTS

RELEVANT STATUTES

a. Under CC §1575, there are three separate grounds for undue influence:

(1) The use, by one in whom a confidence is reposed by a person, or by one who holds a real or apparent authority over the person, of such confidence or authority for the purpose of obtaining an unfair advantage over the person;

(2) The taking of an unfair advantage of a person's weakness of mind; and

(3) The taking of a grossly oppressive and unfair advantage of a person's necessities or distress.

b. An apparent consent, which is an essential element of a contract, is not real or free if obtained through undue influence. See CC §§1565, 1567.

CASE LAW

a. Confidential relationships used to obtain unfair advantage were found in, *e.g.*, *Main v Merrill Lynch, Pierce, Fenner & Smith, Inc.* (1977) 67 CA3d 19, 31, 136 CR 378, disapproved on other grounds in *Rosenthal v Great W. Fin. Sec. Corp.* (1996) 14 C4th 394, 407, 58 CR2d 875 (stockbroker); *Rehmann v Major* (1970) 5 CA3d 684, 85 CR 399 (attorney).

b. Taking unfair advantage of another's weakness of mind was found in, *e.g.*, *Wells Fargo Bank v Brady* (1953) 116 CA2d 381, 398, 254 CR 71.

c. Undue susceptibility in combination with excessive pressure may result in undue influence sufficient to warrant rescission of a contract or conveyance. *Odorizzi v Bloomfield Sch. Dist.* (1966) 246 CA2d 123, 54 CR 533.

NOTE

A weakness of mind that, even if not long-lasting or wholly incapacitating, consists of lack of full vigor owing to age, physical condition, emotional anguish, or a combination of such factors, may be sufficient to warrant rescission. *Odorizzi v Bloomfield Sch. Dist., supra.*

STEP 29. PROTECT THE CLIENT FROM UNDUE INFLUENCE IN CASES INVOLVING CONTRACTS, CONVEYANCES, AND AGENCY APPOINTMENTS

NOTE

All the points made in step 26, above, with respect to protecting clients against undue influence in the context of a testamentary instrument, apply when the context is a contract, a conveyance, or agency appointment.

CONSIDER TRUSTWORTHY SURROGATE

If the client may be susceptible to undue influence, consider suggesting that the client name a trustworthy surrogate (*e.g.,* trustee, conservator, or agent under power of attorney) to be responsible for managing the client's financial and business affairs.

CONSIDER STEPS TO PROTECT POTENTIALLY SUSCEPTIBLE CLIENT FROM FIDUCIARY

If the client is particularly susceptible (*e.g.,* an elderly widow or widower whose children live far away or who has no children and whose friends are also aged and demented), consider requiring the surrogate to account to certain categories of interested persons (*e.g.,* the client's family members, accountant, financial consultant, or attorney) as well as to the client.

NOTE ANY INDICIA OF POTENTIAL UNDUE INFLUENCE

Indicia of undue influence include:

a. Control by one individual;

b. Secrecy regarding the client's financial affairs;

c. Difficulty in obtaining financial information;

d. Unusual transactions or expenditures;

e. Unusual explanations for transactions;

f. Difficulty in seeing the client alone; and

g. Bizarre behavior.

STEP 30. KNOW HOW TO LITIGATE ISSUE OF UNDUE INFLUENCE IN CASES INVOLVING CONTRACTS, CONVEYANCES, AND AGENCY APPOINTMENTS

BURDEN OF PROOF

a. There is no statute expressly establishing who has the initial burden of proving undue influence in contract cases.

b. In cases involving fiduciaries decided under former CC §2235, now repealed, once a fiduciary relationship is shown, the burden of proof is on the fiduciary to show that the transaction was fair and that the client was fully informed of all facts necessary to enable the client to deal at arm's length. *Bradner v Vasquez* (1954) 43 C2d 147, 152, 272 P2d 11 (case involving trustee).

NOTE

Under CC §1575(2)-(3), it is not necessary to allege or prove a confidential relationship.

INDICIA

Indicia of "overpersuasion" that takes unfair advantage of another's weakness of mind include the following (*Odorizzi v Bloomfield Sch. Dist.* (1966) 246 CA2d 123, 133, 54 CR 533):

a. Discussion of the transaction at an unusual or inappropriate time;

b. Consummation of the transaction at an unusual or inappropriate time;

c. Insistent demand that the business be finished at once;

d. Extreme emphasis on untoward consequences of delay;

e. Use of multiple persuaders by the dominant side against a single servient party;

f. Absence of third party advisers to the servient party; and

g. Statements that there is no time to consult advisers or attorneys.

REMEDY IF UNDUE INFLUENCE PROVED

The remedy for undue influence is rescission of the contract or conveyance, not damages. CC §§1566, 1689(b)(7); *O'Neil v Spillane* (1975) 45 CA3d 147, 158, 119 CR 245.

ELDER ABUSE REMEDIES

If the client is an elder or a dependent adult, consider using the enhanced remedies under the Elder Abuse Act (Welf & I C §§15600-15660). Under the Act:

a. An "elder" is a California resident age 65 or older. Welf & I C §15610.27.

b. A "dependent adult" is any other adult California resident whose physical or mental limitations (including those due to age) restrict his or her ability to (Welf & I C §15610.23(a)):

(1) Carry out normal activities; or

(2) Protect her or his rights.

c. A defendant who commits "financial abuse" on an elder or dependent adult may be liable for (Welf & I C §15657.5(a)-(b)):

(1) Attorney fees and costs, including the reasonable fees of a conservator who litigated the claim; and

(2) Punitive damages; in addition to

(3) Compensatory damages and any other remedies provided by law.

Further Research: See California Elder Law Litigation: An Advocates Guide, chap 6 (Cal CEB 2005).

Determining Whether the Client Is Making a Donative Transfer to a Disqualified Person

STEP 31. KNOW THE RULES REGARDING A DONATIVE TRANSFER TO A DISQUALIFIED PERSON

CONSIDER THE PURPOSES OF THE STATUTES

a. In response to the scandalous behavior of an attorney who reportedly drafted wills and trusts for thousands of elderly clients, naming himself as beneficiary, and had abused his position as trustee or conservator in many cases to benefit himself or his law partners, the legislature limited donative transfers, which include outright gifts and transfers by will or trust, to a "disqualified person." See Prob C §§21350-21356; *Rice v Clark* (2002) 28 C4th 89, 97, 120 CR2d 522.

b. The statutes are intended to protect not only those who entrust their financial affairs to attorneys, but all those who entrust themselves or their property to the administration of others. *Graham v Lenzi* (1995) 37 CA4th 248, 257, 43 CR2d 407.

COMPARISON OF PROHIBITED TRANSFERS TO DISQUALIFIED PERSONS AND TRANSFERS RESULTING FROM UNDUE INFLUENCE

The prohibition of testamentary transfers to disqualified persons is "more absolute in certain respects, but narrower in the persons targeted" than the prohibition of testamentary transfers resulting from undue influence. *Rice v Clark* (2002) 28 C4th 89, 103, 120 CR2d 522.

a. The prohibition of a transfer to a disqualified person is more absolute in that:

(1) All gifts, not only those involving an undue benefit to the transferee, are presumptively invalidated;

(2) The presumption of disqualification is conclusive as to the drafter; and

(3) Others subject to the presumption must prove absence of undue influence by clear and convincing evidence and without relying on their own testimony.

b. The prohibition of a transfer to a disqualified person is narrower in that the prohibition on testamentary transfers resulting from undue influence applies to anyone, while the prohibition under Prob C §21350:

(1) Applies only to drafters and to fiduciaries (and persons close to them) involved in the instrument's transcription; and

(2) Excludes the transferor's relatives.

DETERMINE WHETHER THERE IS A DISQUALIFIED PERSON

Unless they fall within certain exceptions, the following persons are disqualified to accept a donative transfer (Prob C §21350(a)):

a. The person who drafted the donative instrument (see, *e.g.*, *Bank of America v Angel View Crippled Children's Found.* (1999) 72 CA4th 451, 85 CR2d 117).

b. A person who is related by blood or marriage to, or is a cohabitant with, or is an employee of, the person who drafted the instrument.

c. Any partner or shareholder of any law partnership or law corporation in which the drafter has an ownership interest and any employee of any such law partnership or corporation.

d. A person who has a fiduciary relationship with the transferor and who transcribes the instrument or causes it to be transcribed (Prob C §21350(a)(4)).

e. A person who is related by blood or marriage to, or is a cohabitant with, or is an employee of, the person with the fiduciary

relationship.

f. A care custodian of a dependent adult (Prob C §21350(a)(6)).

(1) A care custodian includes any person who provides health or social services to elders or dependent adults (Welf & I C §15610.17).

(a) The term "care custodian" is not limited to paid or professional caregivers who provide health or social services. It includes persons who provide substantial ongoing health services as a result of a preexisting personal friendship named in the donative instrument after they begin to provide health services. *Bernard v Foley* (2006) 39 C4th 794, 797, 47 CR3d 248.

(b) The term "care custodian" also applies to one who does not provide health care but who provides in-home care social services such as cooking, cleaning, shopping, and driving to appointments. *Estate of Odian* (2006) 145 CA4th 152, 167, 51 CR3d 390.

(2) A dependent adult is a person older than age 64 or between the ages of 18 and 64 who resides in California and whose physical or mental limitations restrict his or her ability to carry out normal activities or to protect his or her rights, or who has been admitted as an inpatient to a 24-hour health facility (Prob C §21350(c); Welf & I C §15610.23).

(3) A recipient's status as a care custodian of a dependent adult does not end if the recipient or the donor leaves the care facility (*Estate of Shinkle* (2002) 97 CA4th 990, 1006, 119 CR2d 42 (prohibition applied to former care ombudsman who left skilled nursing facility in which elder no longer resided; court reasoned that allowing prohibition to end if care custodian changed jobs in order to benefit from donative transfer would frustrate purpose of Prob C §21350)).

DETERMINE WHETHER AN EXCEPTION APPLIES

A donative transfer is valid under the following circumstances:

a. The transferor is related by blood or marriage to, is a cohabitant with (see Pen C §13700), or is the registered domestic partner (see Fam C §§297-299.6) of the transferee or the person who drafted the instrument. Prob C §21351(a).

(1) For this purpose, "related by blood or marriage" includes persons within the fifth degree. Prob C §21351(g).

(2) The statutory exemption for spouses applies even if the spouse was formerly the care custodian of the dependent adult donor. *Estate of Pryor* (2009) 177 CA4th 1466, 99 CR3d 895.

b. An independent attorney reviews the donative instrument and:

(1) Counsels the transferor about the nature of his or her intended transfer; and

(2) Signs a certificate to the effect that the transfer is not the product of fraud, menace, duress, or undue influence. Prob C §21351(b); see Prob C §21351(b) for a "Certificate of Independent Review" form.

c. After full disclosure of the relationships of the persons involved, the court makes an order following a petition for substituted judgment under Prob C §2580 in a conservatorship proceeding. Prob C §21351(c).

d. The court determines, on clear and convincing evidence, but not based solely on the testimony of the presumptively disqualified person, that the transfer was not the product of fraud, menace, duress, or undue influence. Prob C §21351(d). This exception applies only to (Prob C §21351(e)):

(1) Any instrument executed by a person who was a nonresident of California at the time;

(2) Any instrument other than one making a transfer to the drafter; or

(3) Any instrument executed on or before July 1, 1993, by a person who was a California resident at the time.

e. The transferee is:

(1) A federal, state, or local public entity;

(2) A charitable, tax-exempt entity under IRC §501(c)(3); or

(3) A tax-exempt organization of United States Armed Forces personnel under IRC §501(c)(19). Prob C §21351(f).

DETERMINE WHETHER THE PERSON TRANSCRIBED OR CAUSED THE DOCUMENT TO BE TRANSCRIBED

Transcribing or causing an instrument to be transcribed is not the same as drafting or causing an instrument to be drafted:

a. Transcribing means to make a copy of the matter. It is "the act that follows the composition of the document and reduces the creation to its final, written form" (*Estate of Swetmann* (2000) 85 CA4th 807, 819, 102 CR2d 457).

b. A person who causes the document to be transcribed is one who "directs the drafted document to be written out in its final form." *Estate of Swetmann*, 85 CA4th at 819. See also *Rice v Clark* (2002) 28 C4th 89, 120 CR2d 522.

NOTE

As explained in *Rice* and *Swetmann*, the person who *caused the instrument to be drafted* (as distinct from the person who caused the instrument to be transcribed or the person who drafted the instrument) was deleted from the list of disqualified persons in Prob C §21350(a).

KNOW THE REMEDY FOR A TRANSFER TO DISQUALIFIED PERSON

a. A transfer to a disqualified person fails as if the disqualified person predeceased the transferor without spouse or issue, but only to the extent that the value of the transfer exceeds the intestate interest of the disqualified person. Prob C §21353.

b. If the court reviewing a transfer under Prob C §21351(d) finds that the transfer was the product of fraud, menace, duress, or undue influence, the disqualified person shall bear all costs of the proceedings, including reasonable attorney fees.

NOTE

Pending legislation recommended by the California Law Revision Commission may make substantial changes to the law regarding disqualified persons. See SB 105 (2009).

Considering Mediation as an Alternative to Litigation

STEP 32. CONSIDER SETTLEMENT THROUGH MEDIATION

WHAT IS MEDIATION?

Mediation is a confidential process in which a trained neutral person serves as a facilitator to assist the parties in reaching a voluntary resolution of their disputes.

a. Information learned through the mediation process cannot be used later in the proceeding if the case does not settle (although it may be possible to obtain that same information through subsequent discovery, which would make it available at trial).

b. A successful mediation results in a binding agreement enforceable under CCP §664.6; however, under certain circumstances the agreement will be contingent on approval of the probate court.

CONSIDER THE POTENTIAL ADVANTAGES OF MEDIATION COMPARED TO ARBITRATION AND TRIAL

Potential advantages of mediation are that it:

a. Is generally less expensive and resolves the dispute faster than either arbitration or trial;

b. Allows the parties to control the process and make the decisions themselves;

c. Allows for more creative solutions for resolving the dispute than a court's decision;

d. Provides a forum for communication among the parties to enable them to maintain family relationships rather than destroy them—including the opportunity for an apology by a party, or at least acknowledgment of a troublesome circumstance that contributed to the dispute; and

e. Preserves confidentialities, because information obtained through the mediation process may not be used in any civil proceeding. Evid C §1119.

KNOW APPLICABLE LOCAL RULES

a. A number of probate courts refer all contested matters to mediation before setting them for trial; it is important to check local rules and be prepared for that eventuality.

b. The Third District Court of Appeal and some other districts are ordering parties in selected trust and estate appeals to mediation before setting the matter for appellate briefing. See, *e.g.,* 3d Dist Local R 1.

CHOOSE THE MEDIATOR CAREFULLY

Consider Different Approaches to Mediation: Evaluative Versus Facilitative

a. A mediator using the evaluative approach is:

(1) More proactive in the discussion;

(2) May express his or her view of the strengths and weaknesses of each party's case; and

(3) May suggest and encourage a particular resolution.

b. A mediator using the facilitative model:

(1) Typically will not express any opinion about a party's case; and

(2) The parties will have more control over the process and the outcome.

Consider the Qualifications of the Potential Mediator

a. Consider the extent of mediation training and the mediator's knowledge of the law. It is advisable to work with a mediator who has a minimum of 40 hours of mediation training.

b. In the area of trust and estate litigation, it can be quite helpful if the mediator has a good understanding of estate planning and administration, as well as income and estate tax concepts and issues. A knowledgeable mediator in this area:

(1) Is likely to be more sensitive to and capable of addressing the emotional dynamics that are frequently present in trust and estate disputes;

(2) May be able to provide helpful suggestions regarding alternatives for settlement; and

(3) Can evaluate the probable effectiveness of proposed agreements, based on knowledge and experience with issues such as what a court would likely approve.

NOTE

The courts generally have a panel of attorneys who serve as mediators, some on a pro bono basis, and others who act pro bono for a set number of hours and thereafter charge for their time.

Consider the Mediator's Fees and How They Will Be Allocated

a. Fees can vary significantly, from pro bono mediators assigned by the court to mediators who charge in the range of $150 to $500 or more per hour.

b. Fees are typically shared equally among the parties, although other arrangements for payment may encourage an otherwise reluctant party to participate.

PREPARE FOR MEDIATION

To prepare for mediation:

a. Be sufficiently knowledgeable about the case to evaluate the strengths and weaknesses and negotiate intelligently. This usually means that a significant amount of, if not all, discovery will have been completed before mediation and that legal and factual issues will have been researched, including the value of disputed assets.

b. Spend sufficient time with your client in advance of the mediation session to ensure the client has an understanding of the process and is prepared to make a binding agreement on the day of the mediation.

c. Be mindful of who needs to attend the mediation session (or at least be available by telephone) to assist the parties in resolving the dispute. It is not uncommon for nonparties in trust and estate disputes (*e.g.,* spouses, children, parents) to play an active role in the litigation and for those people also to be actively involved in coming to the resolution.

d. Prepare organized and concise materials for review by the mediator, including pertinent documentary evidence such as disputed testamentary documents or other pertinent writings.

e. Negotiate in good faith and treat the other side respectfully. A mediator should not tolerate vitriolic comments or bursts of temper by any participant.

f. Arrange your schedule (and have your clients arrange theirs) to devote as many hours as reasonably necessary to resolve the issues; mediation sessions frequently last 8 to 10 hours and, if progress is being made, may be extended.

CONSIDER TIMING OF MEDIATION

Mediation can occur at different points in a proceeding or even before any papers are filed with the court. There is much discussion in the literature about optimal timing for participating in mediation. Consider whether:

a. Each side has enough information to knowledgably assess the strengths and weaknesses of both their own case and the other side's case to reach an agreement;

b. The parties are motivated to avoid both the expense and acrimony that typically occur in trust and estate disputes;

c. The parties have spent enough in attorney fees to be motivated to look to another method for resolving their dispute; and

d. The parties have determined what it will cost both financially and emotionally if they do not resolve the dispute, and instead continue to litigate.

Neuropsychologist's Participation

STEP 33. KNOW WHEN TO REFER CLIENT TO NEUROPSYCHOLOGIST FOR ASSESSMENT AND WHEN TO RETAIN NEUROPSYCHOLOGIST AS EXPERT WITNESS

KNOW WHEN REFERRAL TO OR RETENTION OF NEUROPSYCHOLOGIST AS EXPERT MAY BE HELPFUL

A neuropsychologist may be helpful in capacity or undue influence assessments, whether made in the office or in the courtroom, in the following ways:

a. Helping to determine whether there is a correlation between any mental function deficits and the person's capacity to do the act or make the decision in question and, if the matter is being litigated, testifying on this issue in court.

b. Gathering additional data for the attorney and for use as evidence if there is a court proceeding.

c. Advising the attorney about the witnesses, documents, and other evidence that may be most helpful in presenting the case.

d. Helping the attorney understand the client's circumstances and mental and emotional capabilities.

e. Exposing masking statements; one of the features of Alzheimer's-type dementia is the retention of social skills long after short-term memory and the ability to retain new information has faded, *e.g.*:

(1) Clients are able to engage in superficial social banter even though they cannot remember people's names or what they had for lunch;

(2) Clients in the earliest stages of Alzheimer's disease are able to use these skills, which mask their cognitive losses in thinking, reasoning, and remembering, by deflecting some of the more acceptable questions the attorney might be inclined to ask;

(3) Based on a client's seemingly amusing answers, the attorney may think (erroneously) that the client is very clever, rather than be alerted to the possibility that the client lacks capacity.

f. Gathering specific information regarding a client's ability to function in his or her natural environment that may not be appropriate for the attorney to ascertain, based on just an office visit, regarding the following:

(1) Activities of daily living (ADLs). These include assessing whether the client is independent, needs assistance, or is totally dependent on others for the following:

(a) Bathing.

(b) Dressing.

(c) Eating.

(d) Toileting.

(e) Ambulating.

(2) Instrumental activities of daily living (IADLs). These include the ability to do the following:

(a) Manage one's finances.

(b) Take medications properly.

(c) Shop for groceries.

g. Consistent with the task described in f. above, providing the court with a recommendation regarding the least restrictive

environment in a case in which a conservatorship is necessary. Different levels of need for supervision correspond to different living environments:

(1) If a client only needs supervision for bathing and dressing, help can be provided for the client at home.

(2) However, if a client needs help with managing medications, meal preparation, and ambulation, the functional assessment accumulative score usually corresponds to recommendations for an assisted living environment.

NOTE

Several functional assessment tools can be used to determine how much supervision a client needs, based on an evaluation of his or her cumulative abilities to do both ADLs and IADLs. Use of these tools is often particularly helpful when there is a dispute between family members as to what would be the most appropriate living environment for the client. The Global Deterioration Scale discussed in Appendix K also allows the attorney to gather information about what ADLs and IADLs the individual was capable of at the time an estate planning document was changed and correlate it to a general level of mental functioning.

h. Helping the attorney to reconstruct the probable mental function deficits at the time a decedent changed his or her estate plan.

Cross-Reference: For examples of actual statements made by clients who were found to have significant cognitive losses beyond normal age changes, see Appendix J.

Determining Correlation Between Mental Function Deficits and Capacity

The neuropsychologist's evaluation can be most helpful in determining whether there is a correlation between a mental function deficit and the act or decision in question, and in presenting testimony on this issue in court, *i.e.*:

a. The correlation between the mental function deficit and ability to do an act or make a particular decision may not be obvious, and a neuropsychologist may have more sophisticated tools and skills in determining whether there is a correlation.

b. A trained neuropsychologist's careful assessment of compensations for deficits, *e.g.,* may support the conclusion that, although there are mental function deficits, the person has found ways of compensating that in fact show great resourcefulness.

Persuasive Opinion

The neuropsychologist's personal evaluation of an individual or expert opinion based on a hypothetical arising from the facts of a case may be quite persuasive for:

a. The attorney trying to ascertain whether the person can execute a document in the office setting; or

b. The court when capacity or undue influence is the subject of litigation.

NOTE

It is important that counsel have a clearly defined purpose before referring a client to or retaining the services of a neuropsychologist. Referral is not appropriate or necessary in every case, and counsel should not assume that a neuropsychological assessment is always required. See step 12, above.

LIMITATIONS ON USING NEUROPSYCHOLOGIST

A neuropsychologist's opinion, which may be extremely helpful, is not determinative of the legal issues of capacity and undue influence.

a. Capacity and undue influence are legal determinations that are made either by:

(1) An attorney in the office; or

(2) A trier of fact applying the standards and tests of DPCDA and other relevant statutes in the courtroom setting.

b. A neuropsychologist's conclusions are not binding on the court, and the terms and concepts used by the neuropsychologist are not necessarily the same as the legal standards and requirements in the statutes.

STEP 34. NEUROPSYCHOLOGIST'S PERSPECTIVE

ASSESSING CAPACITY TO DO TESTAMENTARY ACT

To determine whether a patient has the ability to understand the nature of the testamentary act, understand and recollect the nature and situation of his or her property, and remember and understand his or her relationship to heirs, the following cognitive skills are examined as part of a neuropsychological assessment:

a. Ability to attend and concentrate;

b. Expressive language skills;

c. Receptive language skills;

d. Short- and long-term memory;

e. Recognition of familiar persons;

f. Ability to understand and appreciate quantities;

g. Mental status; and

h. Judgment.

Ability to Attend and Concentrate

The first step for the neuropsychologist is to assess the patient's ability to attend and concentrate. This cognitive skill is a precursor to the display of all of the other cognitive abilities, without which a person:

a. Cannot easily or clearly express desires or understand written or spoken language;

b. Could possibly have short-term memory problems; and

c. Will have difficulty processing information.

Expressive Language Skills

The neuropsychologist assesses whether the patient can communicate, whether by speaking, writing, drawing, or gesturing.

NOTE

Relying on gestures alone might be considered insufficient evidence of ability to communicate, particularly with regard to dispositive wishes.

Receptive Language Skills

The neuropsychologist assesses the individual's understanding of what is said to him or her, whether in written, oral, or schematic form.

a. The mere fact that a client can respond to a question doesn't mean that the client has understood what the attorney has said.

NOTE

In a case involving a 94-year-old man who was physically frail and suffering from advanced stage Alzheimer's dementia, his lawyer stated in a deposition that he felt his client was competent to change the beneficiaries of his trust from his hospice bed because "he responded." The judge hearing the case ruled that this criterion fell short of a determination that the man was competent to change the beneficiaries. The judge stated that the man's recently arrived son, who would be the beneficiary of the change, had restricted access to the hospice room, so that none of the local relatives (who had been caring for the gentleman for

months) could visit him. In the presence of the attending nursing staff, the son repeatedly told the older gentleman of all the "bad" things that these local relatives had done.

b. The *absence* of the ability to respond, however, does not indicate an inability to communicate or an inability to understand.

(1) Following a stroke, or as a result of a dementia, an individual can develop aphasia:

(a) They may be able to speak, but their speech or the words used are garbled and difficult to understand.

(b) They may also no longer be able to write.

(2) A hearing evaluation may be advisable because an individual who does not seem to understand spoken communications may have an undetected hearing loss. Men are particularly apt to deflect or deny a hearing loss.

(3) An eye examination may be appropriate because certain conditions (*e.g.,* macular degeneration or glaucoma) can compromise an individual's ability to read.

Short- and Long-Term Memory

Analysis of long-term memory, especially with regard to testamentary capacity, always includes:

a. Analyzing the person's knowledge of:

(1) Family members, *e.g.,* their birth dates, number of grandchildren; and

(2) Assets and financial and business affairs.

Example: An elderly patient may state that a Merrill Lynch broker is managing the patient's money when, in fact, a Charles Schwab broker has been managing the assets for many years. The patient's recall of the size of his or her estate may reflect a net worth from 5 years earlier.

b. Considering the following:

(1) There are sex differences with regard to recall of family members and dates. Many men rely on their wives to keep track of family dates such as birthdays and anniversaries, particularly in this era of multiple marriages, which have generated stepchildren and stepgrandchildren. Many men, therefore, even before their testamentary capacity was questioned, may have had this difficulty.

(2) The inability to recall all of one's extended family might not reflect a short-term memory deficit at all, but may reflect a lack of interest in this type of data, in some cases because of confidence that the spouse, usually the wife, was managing this area of family relations quite well.

(3) The lack of memory of financial assets sometimes reflects a long-standing inattention and lack of interest in keeping track of one's assets.

(4) With regard to long-term memory, the person must be able to relate the instruments invested in and who is managing the money.

Using Visual and Motor Skills to Recall Personal Information

The neuropsychologist co-author of this Action Guide has developed a technique for use in estate planning that relies on visual and motor skills to recall personal information relevant to testamentary capacity (for a case illustration of this technique, see Appendix L):

a. The objects that are manipulated are known as "memo clips" and can be bought at most stationery stores. Think of these objects as pieces moved around in a game of chess or Monopoly:

(1) The memo clips have a handcast resin base that can come in different colors.

(2) A cable is inserted vertically into the base, with an alligator clip at the top, to which either pictures or names of family members can be attached (see photographs in case illustration in Appendix L).

b. This technique borrows from methodology well established in developmental psychology:

(1) It bypasses speech and language; and

(2) Instead relies on both visual processing and motor skills in asking an individual for responses to questions.

NOTE

Rather than relying on episodic memory (the memory for personal information), this technique, by using motor skills, actually relies on procedural memory, which is a more primitive memory system. Procedural memory is unaffected in early to middle stage dementias, or amnesic conditions. It is this memory system that one draws on when learning to ride a bicycle or drive a car. It is why individuals with early Alzheimer's-type dementia can, in fact, still play golf and continue to drive a car for awhile. Knowledge is displayed in action, not in words.

c. These objects also allow for the introduction of color as another way to draw the client's attention to different generations within his or her family. Note that:

(1) Children as young as 4 years old recognize how color can be used to create categories of similar items.

(2) Separate colors can represent different groupings.

d. The relationships represented by these objects are grasped without the use of conceptual understanding, which is often lacking in individuals who are in the moderate stage of a dementing illness.

Ability to Understand and Appreciate Quantities

If the patient is managing his or her own affairs and money, it is appropriate to assess arithmetic skills, with particular attention to any reasonable compensations the patient makes, such as use of a calculator.

NOTE

For neuropsychological purposes, having a deficit in this area alone, or even in combination with other deficits, does not automatically signal concerns about capacity. An assessment must be made of whether and how the individual has initiated compensations for these deficits in order to continue to, *e.g.,* carry out financial transactions, manage medications, or go shopping.

Examples: Compensations may include, *e.g.,* use of a calculator if the individual can no longer do mental arithmetic with paper and pencil, and use of notes and records to recall the names of significant heirs.

Mental Status Regarding Delusions and Hallucinations

a. Under Prob C §6100.5(a)(2), to support a claim of incapacity, delusions or hallucinations must result in the individual's devising property in a way that, except for the existence of the delusions or hallucinations, the individual would not have done.

b. The analysis of mental status regarding delusions and hallucinations is accomplished by a thorough clinical interview with both the patient and the family to learn whether the patient has a psychiatric history of hallucinations or delusions, or whether they occurred late in life.

NOTE

Generally, the two types of delusions and hallucinations are quite different in character in that those of late-life onset are often accompanied by cognitive deficits that could, in combination with the psychotic features (*i.e.,* the delusions and hallucinations), compromise capacity.

Mental Status Regarding Coping Style

In assessing mental status, the neuropsychologist is also assessing the patient's coping style, including the use of denial. Denial as a means of coping with changing life circumstances can:

a. Reach psychotic proportions that:

(1) Affect a person's capacity to make testamentary decisions (*e.g.,* "If I don't create a will, then I won't die"); or

(2) Compromise an individual's health and safety (*e.g.,* an individual can assure you that he or she is eating and taking medications, yet the patient is losing weight and relatives tell you that the pill bottles are full and the refrigerator is empty).

b. Be a signal that the neuropsychologist should assess whether the patient's environmental demands exceed his or her

diminished physical and cognitive abilities. The problem may be solved by lowering aspirations and shifting responsibilities to set the "balance" right again without legal intervention.

Example: An 86-year-old woman who had been having short-term memory problems for more than a year had nevertheless been able to shop, cook, and pay her bills. Then, in what appeared to be a sudden change, she began complaining of constant exhaustion, would not get out of bed, and stopped eating and tending to her mail. An evaluation revealed that she still lived in the 5-bedroom house in which she had raised her family and that she was managing a complex financial estate. Her cognitive skills were all within normal limits for her age and educational level, but she was suffering from severe depression. In her own words, "I can't handle this any more." The solution was to hire a housekeeper for 3 hours a day to cook and clean until the house could be sold. The patient moved to her own independent apartment unit in a life-care community. Her children, all busy professionals living in various cities out of the area, hired a trust department to manage her finances.

Ability to Modulate Mood and Affect

Affective states (moods, *e.g.,* depression, anxiety) must be examined to assess whether they are so severe that they interfere with the person's ability to meet the cognitive criteria required for capacity.

NOTE

Severe depression, an emotional disorder, can mimic the cognitive symptoms of true dementia. Only through administration of objective tests and gathering a medical and psychiatric history can these two conditions be sorted out.

Judgment

Assessment of judgment includes determining whether the person:

a. Can plan, organize, and carry out actions that reflect his or her own self-interest.

b. Can understand the consequences of his or her estate planning with respect to how it affects the person and his or her family now and in the future.

c. Has the ability to think logically before acting (an assessment of impulsiveness).

ASSESSING CAPACITY TO MARRY OR ENTER INTO REGISTERED DOMESTIC PARTNERSHIP

For a sample case study in which the neuropsychologist examines the patient's cognitive skills to determine whether the patient has the cognitive capacity to assess his or her own best interests and understand the short- and long-term consequences of entering into marriage or registered domestic partnership, see Appendix D. The case study highlights the fact that capacity must always be determined with regard to a specific act or decision. See also step 14, above.

ASSESSING CAPACITY TO CONSENT OR REFUSE TO CONSENT TO MEDICAL TREATMENT

The following cognitive skills are examined as part of a neuropsychological assessment of capacity to consent to or refuse to consent to medical treatment, *e.g.,* in a dispute about the physician's conclusion under Prob C §813:

a. Ability to attend and concentrate;

b. Expressive language skills;

c. Receptive language skills;

d. Short- and long-term memory;

e. Recognition of familiar persons;

f. Ability to understand and appreciate quantities;

g. Mental status; and

h. Judgment.

See discussion above of assessment of ability to attend and concentrate, expressive language skills, and receptive language skills.

Short- and Long-Term Memory

In addition to doing laboratory-type tests, the neuropsychologist must assess whether the individual can recall:

a. The nature of the medical condition being treated;

b. The seriousness of the condition; and

c. The proposed course of treatment.

Judgment

The neuropsychologist should assess whether the individual can appreciate the consequences of the decision to accept or decline treatment. As part of this assessment, the neuropsychologist should determine whether the individual can:

a. Weigh the nature, risks, and benefits of the treatment alternatives;

b. Prioritize them; and

c. Consider those alternatives logically and rationally.

NOTE

Although the individual may not initially be able to process all of this information, he or she must be able to do so in a reasonably short time if, for example, an operation is needed.

Mental Status

Determining mental status includes assessment of:

a. Presence or absence of significant hallucinations or delusions that would interfere with the patient's ability to reason logically and be consistent in the choice of treatment; and

b. Underlying mood, to determine whether the patient has the ability to rationally refuse a medical treatment or whether such a refusal results from a prolonged severe depression. This issue is particularly important for patients with chronic illnesses, who may have been in pain for a long time and may have suicidal thoughts.

NOTE

An essential criterion for deciding whether a response is competent is whether it is logical and consistent over repeated assessments.

ASSESSING CAPACITY TO QUALIFY FOR LONG-TERM CARE INSURANCE

Neuropsychologists are increasingly called on to provide capacity evaluations related to applications for long-term care insurance:

a. The percentage of the population age 65 and older is expected to increase from 12 percent in 2005 to 20 percent by 2030.

b. As the baby boom generation, consisting of 78 million individuals born in 1946-1960, approaches retirement age in the next few years, the number of individuals applying for long-term care insurance will also rise.

Example of Capacity Evaluation

Recently, the neuropsychologist co-author was referred a case calling into question a 71-year-old man's capacity with regard to obtaining long-term care insurance:

a. The insurance company had acquired physician's notes wherein the physician had recorded that the patient was worried about his short-term memory, stating that the patient was noticing "more difficulty finding words and remembering names."

b. The company denied long-term care insurance based on that entry alone, and quoted the entry in its denial letter.

c. The patient planned to contest the denial of insurance, and sought legal advice as to what would be the best approach to do so.

d. To provide an objective measurement of the area in question, the attorney recommended a capacity evaluation with emphasis on assessment of short-term memory.

Results of Capacity Evaluation

The above-mentioned capacity evaluation produced the following results:

a. The patient had a doctorate in the area of geology.

b. Though semi-retired, the patient was still the chief investigator of several field studies on geothermal plates, funded by the United States government, and had just finished writing a book summarizing his research.

c. The patient was completely independent in caring for himself and managing his own finances. He took no prescription medications.

d. The capacity evaluation thoroughly assessed the patient's immediate, short-, and long-term verbal memory:

(1) All the short-term memory tests revealed within normal range recall of newly learned information after a 30-minute delay.

NOTE

The research literature is specific that early detection of degenerative disorders, such as Alzheimer's disease, is correlated with below normal delayed recall on these memory tests.

(2) The test results confirmed the patient's own subjective observations of his memory ability.

(3) The test results indicated that the patient, in fact, had normal age-related changes associated with the frontal lobe task of encoding new information with efficiency. As noted in the evaluation:

(a) These changes are experienced by all individuals; and

(b) Most people notice them well before their seventh decade of life.

Reversal of Insurance Company Decision

The results of the capacity evaluation were submitted to the insurance company. After a 2-month delay, the company reversed its decision and offered the man more extensive coverage than he originally applied for, at a lower rate.

ASSESSING CAPACITY TO DRIVE

In assessing an individual's capacity to drive, a neuropsychologist should consider the following:

a. Although neuropsychologists are often asked to provide an evaluation of the cognitive, judgment, and motor skills most related to driving, these professionals, unlike physicians, are not protected from liability by the California reporting statutes.

b. When the test data do not provide a definitive profile of an individual who clearly is unsafe to himself or others as a driver, neuropsychologists commonly refer these clients to certified driving rehabilitation specialists for an additional validation of their assessment of the individual's driving skill.

c. Driving rehabilitation specialists usually are trained in the area of occupational therapy, and use off-road tests to screen drivers for problems and consult with a driving school instructor, who will take the client for an on-road test.

ASSESSING ABILITY TO RESIST UNDUE INFLUENCE

In assessing whether a person can resist fraud or undue influence, the factors discussed above under Assessing Capacity to do Testamentary Act should be considered, as well as the factors discussed below.

Other Factors to Consider

In addition to the factors discussed above, consider whether:

a. There is a disparity between the patient's physical condition and the degree to which a relative or friend is exerting financial control or influence;

b. The patient is accustomed to having others handle financial matters or was always predisposed to being dependent;

c. The patient's fear or avoidance is expressed or is sensed by the clinician;

d. The patient has become increasingly isolated from the rest of the family due to the influence of another person; and

e. The person who would benefit places undue emphasis on the consequences of delay if the transaction is not completed immediately, making the patient fearful or anxious.

NOTE

People age in character, and there is the possibility that the individual was always predisposed to being dependent, perhaps not in all areas of life but in the area of financial planning. The tendency to rely on others, in combination with diminishing judgment, may result in reliance on untrustworthy individuals.

Common Undue Influence Factual Scenario

The environment in which undue influence occurs happens in a very measured and premeditated way. In many cases, the influencer plans how he or she will gain control over the individual's (typically an elder) environment. Often, the elder is isolated from input and advice from others whose opinions would differ from those of the influencer. Fear of retribution or neglect and further isolation cowers and intimidates the elder into compliance. Frequently, the influencer is a caretaker who at least initially gains the trust and confidence of the elder. The influencer is attentive and overly solicitous in wanting to meet the elder's every need and desire. At the same time, the influencer starts to isolate the elder, making it harder for relatives and friends whose opinions might be divergent from gaining access to the elder (*e.g.*, influencer may inform others attempting to gain access to the elder that this is an inconvenient time or the elder is sleeping). As the elder becomes more dependent on the caretaker, conditions start to change, either subtly or boldly. For example, if things are not done a certain way, the caretaker will not be as attentive. The most fundamental and manipulative ways of exerting control over the elder include withholding food or verbally abusing the elder. As time goes by, the elder's self-esteem erodes and the elder loses hope that he or she is worth anyone's trouble or time.

Undue Influence During Estate Planning

When an individual makes a significant alteration in an estate planning document, it is very useful to ask the question: Why now? Elders who are being unduly influenced will often make a significant change in some estate planning documents on the day of either admission to or discharge from a hospital. While this action alone does not imply that the elder is being unduly influenced, asking this question will initiate a series of questions designed to determine if the elder is acting out of character. The attorney will need to determine if the elder is alert, able to communicate decisions rationally, and appears to understand and appreciate the risks, benefits, and consequences of the decision he or she has just made concerning his or her estate planning documents.

Individuals With Frontal Lobe Dementia Are Particularly Vulnerable to Fraud and Undue Influence

Individuals with a dementia of the frontal lobe type are particularly vulnerable to being unable to resist fraud (*e.g.,* contest participation solicited through the mail), because of:

a. Particularly poor judgment;

b. Perseverative behavior (*i.e.,* the inability to stop participating once a pattern of responding has been established); and

c. Tendency toward "stimulus bound" responses (*e.g.,* believing, at face value, the contest publicity's claims that they will win).

NOTE

With frontal lobe dementia, memory is not as impaired as in Alzheimer's dementia. If a person with frontal lobe dementia receives a few dollars once from a contest, that can serve to increase the persistence of the behavior.

FRONTAL LOBE ABILITIES, NORMAL AGING, AND MENTAL FUNCTION DEFICITS

While the assessment of many mental function deficits relies on *what* a person can do, the assessment of frontal lobe abilities is determined by *how* a person goes about doing tasks. Because the skills based in the frontal lobes bear direct relation to the tasks essential to estate planning, a good evaluation should include an analysis of frontal lobe integrity.

NOTE

The only way for an attorney to determine if there is a potential problem in this area is to allow for part of the attorney-client interview to be unstructured. The best time for this to happen is in the first few minutes of a meeting, when introductions are completed, and light social conversation ensues.

Frontal Lobe Skills

The following skills, as well as the ability to resist immediate temptations of telemarketers, are based in the frontal lobes:

a. Planning, organizing, and initiating projects and seeing them through to completion;

b. Encoding and retrieval aspects of memory;

c. Problem-solving and reasoning abilities; and

d. Language and attention to achieve a goal.

NOTE

An individual who is considerably above average intellectually when young retains this above average ability as he or she gets older, in relation to others of the same age group. Nevertheless, this person may still show signs of impairment in everyday tasks that require the skills based in the frontal lobes.

DIFFERENCE IN ASSESSING CAPACITY VERSUS SUSCEPTIBILITY TO UNDUE INFLUENCE

From the neuropsychologist's point of view, there is an overlap in evaluating capacity and evaluating susceptibility to undue influence. In assessing susceptibility to undue influence, however, a more extensive clinical interview should be undertaken in which the person's personality characteristics that affect decision-making ability are assessed, particularly characteristics that predispose the person to dependency and to reliance on others' judgment.

Physician's Perspective

STEP 35. ADVERSE EFFECTS OF MEDICAL CONDITIONS

HOW MEDICAL CONDITIONS MAY AFFECT CAPACITY

This section provides a psychiatric physician's perspective on ways in which medical conditions and medications (see also step 36, below) may affect mental status and thereby affect both capacity and susceptibility to undue influence, especially in older adults.

Adverse Effects

Medical conditions may adversely affect capacity and susceptibility to undue influence through effects in the following categories:

a. Physical disability that interferes with communication capacities or functional capacities (*e.g.,* activities of daily living).

b. Emotional and psychological reactions to illness.

c. Cognitive disorders.

d. Mental disorders other than cognitive disorders.

PHYSICAL DISABILITY

Physical disability may interfere with the ability to communicate and other functional capacities. This discussion focuses on the ability to communicate. Functions essential to this ability that may be affected by medical conditions are the following:

a. Vision.

b. Hearing.

c. Speech.

d. Writing and notating.

Ability to Communicate

Various medical conditions may interfere with the ability to communicate. The ability to communicate is central to capacity to make a decision. Prob C §812. Communication has two components:

a. Receptive component in which an individual receives and understands information.

b. Expressive component in which an individual transmits information.

VISION

Importance of Vision

Vision is important with respect to both capacity and susceptibility to undue influence.

a. Vision is the most important source of information about the world.

(1) Ability to recognize people.

(2) Ability to "read" people (*e.g.,* interpret facial expression).

(3) Ability to read lips (especially important for hearing-impaired individual).

(4) Ability to read documents.

b. Impaired vision may affect the ability to notice and respond to changes in environment (*e.g.,* checks are missing, money has been taken out of bank account).

c. Impaired vision can cause feelings of vulnerability and dependency.

d. Impaired vision may contribute to psychiatric symptoms (*e.g.,* anxiety, depression, hallucinations, and suspiciousness or delusions).

Medical Conditions That Impair Vision

Medical conditions that can impair vision include the following:

a. Cataracts.

b. Macular degeneration of the retina (most frequent cause of blindness in the elderly).

c. Glaucoma.

d. Damage to the retina due to diabetes.

Vision Remedies

Impaired vision can be mitigated by the following:

a. Visual enhancement techniques (*e.g.,* adequate lighting, large print, legible type font, beige-colored paper, optimal formatting, magnification or image enlargement).

b. Nonvisual methods (*e.g.,* oral presentation, Braille documents).

HEARING

Importance of Hearing

Hearing is important with respect to both capacity and susceptibility to undue influence.

a. Along with vision, hearing is an important source of information about the world.

b. Impaired hearing may exclude people from much of what is going on around them, leading to:

(1) Social isolation;

(2) Lack of responsiveness to the interpersonal environment; and

(3) Misunderstanding of circumstances.

c. Impaired hearing can cause feelings of vulnerability and dependency and may contribute to psychiatric symptoms.

Medical Conditions That Impair Hearing

Medical conditions that can impair hearing in various ways (*e.g.,* causing deafness, difficulty with speech discrimination, inability to determine inflection or tone of voice) include the following:

a. Blockage of the outer ear canal (*e.g.,* by earwax).

b. Head cold with fluid in the middle ear.

c. Ear infection.

d. Exposure to loud noise (*e.g.,* explosion, loud music).

e. Stroke in the brain stem or brain.

Hearing Remedies

Impaired hearing can be mitigated by the following:

a. Auditory enhancement techniques:

(1) Enunciate clearly (but avoid exaggerated lip movements); speak more loudly and slowly, to the better ear if there is one, and in a lower tone (pitch) of voice.

(2) Use assistive listening devices (*e.g.,* hearing aid, portable electronic amplifier).

(3) Use short words and simple sentences.

b. Improved listening conditions (*e.g.,* create quiet setting, minimize distractions, directly face listener, avoid silhouette effect (standing in front of light source)).

c. Nonauditory methods (*e.g.,* visual presentation, nonverbal cues (gestures, facial expression, body language)).

Further Research: See Mace & Rabins, The 36-Hour Day: A Family Guide to Caring for Persons With Alzheimer Disease, Other Dementias, and Memory Loss in Later Life (4th ed 2006) (authors Nancy L. Mace, M.A., and Peter V. Rabins, M.D., M.P.H.).

speech

Speech and Language

Speech refers to "the mechanics of producing words." Language may be defined as "the meaningful content of speech."

Further Research: For discussion of these definitions, see Weiner & Lipton, The American Psychiatric Publishing Textbook of Alzheimer Disease and Other Dementias (2009) (editors Myron F. Weiner, M.D. and Anne M. Lipton, M.D., Ph.D.).

Importance of Speech

Speech is important with respect to both capacity and susceptibility to undue influence. It is a means of expressing and explaining oneself, seeking information, stating intention, agreeing or disagreeing, accepting or refusing, and participating in problem solving.

How Speech May Be Impaired

Speech may be impaired in the following ways:

a. Articulation (*e.g.,* slurred speech).

b. Phonation (*i.e.,* the production of vocal sounds).

c. Output (*i.e.,* too much or too little).

d. Tone, with possible change in emotional expression and meaning.

e. Fluency.

Medical Conditions That Impair Speech

Medical conditions that can impair speech include the following:

a. Cerebral palsy.

b. Stroke.

c. Myasthenia gravis.

d. Multiple sclerosis.

e. Traumatic brain injury.

f. Parkinson's disease.

g. Dementia.

h. Amyotrophic lateral sclerosis (*i.e.,* Lou Gehrig's disease).

i. Lung disease (*e.g.,* emphysema).

j. Intubation (*i.e.,* insertion of breathing tube) or tracheostomy (*i.e.,* opening in front of neck that connects to airway).

Speech Remedies

Impaired speech can be mitigated by the following:

a. Improved conditions (*e.g.,* create comfortable atmosphere, offer full attention, create rapport, place speaker at ease, have speaker present one idea at a time).

b. Supplemental communication (*e.g.,* make educated guesses about what speaker is saying; confirm content of speech; have speaker use alternative, visual means of communication).

writing and notating

Importance of Writing and Notating

Writing and notating are important with respect to both capacity and susceptibility to undue influence. They may be used as a means of expressing or explaining oneself, seeking information, stating intention, agreeing or disagreeing, accepting or refusing, processing ideas, memorializing decisions, managing finances (*e.g.,* calculating amount to be paid, writing checks)).

How Writing and Notating May Be Impaired

Writing and notating may be impaired in the following ways:

a. Effects of tremors, incoordination, or abnormal involuntary movements.

b. Effects of pain, weakness (including limb paralysis), muscle stiffness, or immobile joints.

Medical Conditions That Impair Writing and Notating

Medical conditions that can impair writing and notating include the following:

a. Stroke.

b. Dementia.

c. Parkinson's disease.

d. Alcoholism.

e. Generalized weakness (*e.g.,* viral syndrome, congestive heart failure).

f. Pain (*e.g.,* rheumatoid arthritis).

g. Joint disease (*e.g.,* osteoarthritis).

Writing and Notating Remedies

Impaired writing and notating can be mitigated by the following:

a. Improved writing conditions (*e.g.,* proper positioning (sitting up rather than lying down), writing with desk as support, adequate lighting).

b. Writing enhancements (*e.g.,* optimal writing implement such as right-sized pen or keyboard, voice-recognition software).

EMOTIONAL AND PSYCHOLOGICAL REACTIONS TO ILLNESS

Emotional and psychological reactions to illness may adversely affect capacity and susceptibility to undue influence.

a. Physical illness may cause mental discomfort, suffering, and turmoil ranging in intensity from mild to severe.

b. Clinically significant reactions generally fall into two broad categories: anxious states and depressive states (or a mixture of the two). Reactions may include the following:

(1) Shock.

(2) Denial of the frightening reality.

(3) Anxiety.

(4) Depressive feelings.

(5) Anger.

Example of Emotional Reaction to Illness

A patient is diagnosed with acute appendicitis in a hospital emergency room. She refuses appendectomy but does not say why. A psychiatrist is called to determine capacity to refuse treatment. The psychiatrist asks her to explain why she is refusing surgery. Looking terrified, she says, "I don't know. I just don't want it!" Without a compelling rationale offered for refusal and sensing emotional distress, the psychiatrist determines that the patient lacks capacity because she is overcome with fear causing her to make a fatal misguided decision that she would not make otherwise. After surgery, looking much improved, the patient is glad to be alive and says to the psychiatrist, "I don't know what I was thinking yesterday. I was just so afraid."

NOTE

All examples in this section (Physician's Perspective) are fictionalized accounts based on the author's knowledge and professional experience that are provided for illustrative purposes only.

Anxious Features

Anxious features may include the following:

a. Tension.

b. Restlessness, nervousness, or distractibility.

c. Apprehension, worry, fear, or dread.

d. Rumination.

Depressive Features

Depressive feature may include the following:

a. Decreased interest, motivation, and pleasure.

b. Indifference, apathy, and reduced reactivity.

c. Irritability and negativity.

d. Social withdrawal.

e. Helplessness and hopelessness; low self-esteem, sense of worthlessness; demoralization, pessimism, and nihilism.

f. Sense of dependency and being a burden; excessive guilt.

g. Difficulty thinking, concentrating, and making decisions.

h. Desire for a hastened death and suicidality.

NOTE

While physical illness may lead to problematic emotional and psychological reactions, it can also lead to psychological change, and this change may lead an individual to make decisions or take actions that to others are questionable or even objectionable (*e.g.,* in a will, leaving certain assets to charity instead of family members) but are not necessarily due to a lack of capacity or susceptibility to undue influence.

COGNITIVE DISORDERS

Cognitive disorders such as dementia and delirium may adversely affect capacity and susceptibility to undue influence.

dementia

Cognitive Deficits and Disturbances in Dementia

According to the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV), dementia is characterized by multiple cognitive deficits that include a memory disturbance and one or more of the following cognitive disturbances:

a. Language disturbance.

b. Apraxia, *i.e.,* impaired ability to perform organized movements (*e.g.,* put on a coat) not due primarily to sensory or motor deficits (*e.g.,* blindness, paralysis).

c. Agnosia, *i.e.,* failure to recognize or identify objects (including people) despite intact sensory function.

d. Disturbance in executive functioning, such as difficulty with the abilities to:

(1) Plan, organize, and sequence activity; and

(2) Think abstractly.

NOTE

Other difficulties in this category include poor judgment and impulsive behavior.

Other Cognitive Difficulties in Dementia

Other cognitive difficulties may occur with dementia, such as disorientation to time, place, person, and situation as well as visual-spatial impairment (*e.g.,* getting lost in familiar surroundings, having difficulty performing manual skills such as mechanical repairs).

NOTE

Visual-spatial impairment may interfere with the ability to care for oneself by making it difficult to find one's way home while driving or even find one's way to the bathroom at home.

Noncognitive Difficulties and Behavioral Disturbances

In addition to the cognitive difficulties that occur with dementia, individuals may have noncognitive difficulties and behavioral disturbances that are associated with incapacity and susceptibility to undue influence. Examples:

a. Unawareness of deficits or illness.

b. Personality change (*e.g.,* passivity, apathy).

c. Anxiety or depression.

d. Catastrophic reactions.

e. Hallucinations or delusions (*i.e.,* fixed false beliefs).

f. Agitation, including verbal or physical aggression.

NOTE

Unawareness of deficits or illness is especially problematic in someone with dementia who insists on driving but is unsafe to do so.

Mental Function Deficits Represented in Dementia

All four domains of mental function deficits specified in Prob C §811(a) are represented in the cognitive and noncognitive difficulties found in dementia:

(1) Alertness and attention.

(2) Information processing.

(3) Thought processes.

(4) Ability to modulate mood and affect.

Examples of Mental Function Deficits in Dementia

Example 1: "Orientation to time, place, person, and situation" is a mental function specified in the alertness and attention domain. Prob C §811(a)(1)(B). In many dementias, orientation to time is the first sphere of orientation to be affected (*e.g.,* not knowing the month and date). As the illness worsens, an individual may end up not knowing what year it is, where she is (*e.g.,* law office), to whom she is talking (*e.g.,* lawyer), and her purpose in being there (*e.g.,* to make a will).

Example 2: "Short- and long-term memory, including immediate recall" is a mental function specified in the information processing domain. Prob C §811(a)(2)(A). Memory impairment is essential to a dementia diagnosis. With respect to capacity, an individual who does not remember owning a home but is being asked to sell it may well lack capacity to make a decision.

Example 3: "Delusions" are specified as a mental function deficit in the thought processes domain. Prob C §811(a)(3)(C). Delusions of theft (*e.g.,* personal property being stolen) and jealousy (*e.g.,* spouse having a romantic affair) are examples of delusions that may be found in Alzheimer's disease. An individual suffering from one of these delusions might make an inappropriate decision based on the delusion.

Example 4: "Depression" is specified as a mental function deficit in the ability to modulate mood and affect domain. Prob C §811(a)(4). Depressive features are fairly common in various dementing illnesses such as Alzheimer's disease, vascular dementia, and dementia due to Parkinson's disease. Depression may adversely affect capacity either to make decisions or to manage personal and financial affairs by a number of pathways, including indifference, a sense of worthlessness, irritability, and excessive guilt.

Common Causes of Dementia

Dementia is a clinical syndrome that may be caused by many different medical conditions. A more complete list of the causes of dementia is provided in Appendix M. Common causes of dementia among seniors include the following:

a. Alzheimer's disease.

b. Vascular disease of the brain.

c. Neurodegenerative disorders such as Lewy body disease and Parkinson's disease.

Other Causes of Dementia

Other causes of dementia include:

a. Traumatic brain injury (*e.g.,* from a fall).

b. Infections of the brain.

c. Brain tumors.

d. Radiation therapy for brain tumors.

e. Multiple sclerosis.

f. Systemic lupus erythematosus.

Medical Conditions Not Reversible

In a large majority of cases, dementia is not reversible. The following medical conditions cause irreversible dementia:

a. Alzheimer's disease.

b. Frontotemporal dementias.

c. Parkinson's disease.

Reversible Conditions

Potentially, some dementias are at least partially reversible, depending on the amount of permanent brain damage done by the underlying medical condition. These include dementia due to the following:

a. Depression.

b. Alcoholism.

c. Hypothyroidism.

d. Vitamin B12 deficiency.

Medications That May Cause Dementia

Medications that may cause dementia or a dementia-like syndrome include the following:

a. Heart and blood pressure medications, *e.g.,* propranolol (Inderal).

b. Cancer chemotherapy medications, *e.g.,* methotrexate.

c. Tricyclic antidepressants, *e.g.,* amitriptyline (Elavil).

d. Anticonvulsants, *e.g.,* phenytoin (Dilantin).

NOTE

Dementia or a dementia-like syndrome caused by medication may be reversed or partially reversed if the medication is discontinued.

Medications Used for Cognitive Deficits of Dementia

Medications used in the treatment of dementia include:

a. Donepezil (Aricept).

b. Rivastigmine (Exelon).

c. Galantamine (Razadyne).

d. Memantine (Namenda).

Responses to Medications

For the medications listed above, depending on the particular medication, the type of dementia, and the stage of illness, examples

of responses to be hoped for include the following:

a. Slight, temporary improvement in cognition and function.

b. Improvement in noncognitive difficulties and behavioral disturbances.

c. Delay in cognitive and functional deterioration.

d. Reduced caregiver distress.

e. Delayed institutionalization.

delirium

Disturbance in Consciousness, With Cognitive or Perceptual Disturbance

Delirium is a second type of cognitive disorder that may adversely affect capacity and susceptibility to undue influence, especially in the elderly. According to the DSM-IV, delirium is characterized by the following:

a. Disturbance in consciousness (*i.e.,* reduced clarity of awareness of the environment) with reduced ability to focus, sustain, or shift attention.

b. Change in cognition or the development of a perceptual disturbance that is not better accounted for by a preexisting dementia. Examples:

(1) Memory deficit.

(2) Disorientation.

(3) Language disturbance.

(4) Hallucinations.

c. The disturbance develops over a short period of time (usually hours to days) and tends to fluctuate during the course of the day.

d. There is evidence that the disturbance is caused by a general medical condition.

Examples of Mental Function Deficits in Delirium

In addition to the features mentioned above, mental function deficits that may be found in delirium include:

a. Abnormal speech (*e.g.,* too slow, too fast).

b. Abnormal thinking (*e.g.,* disorganized, difficulty processing information).

c. Underactivity or overactivity.

d. Inappropriate behavior.

e. Emotional instability and other emotional disturbances (*e.g.,* anxiety, fear, anger).

f. Apparent personality change (*e.g.,* irritability, apathy).

g. Delusions.

Risk Factors for Delirium

Risk factors for delirium include:

a. Advanced age.

b. Preexisting dementia.

c. Vision or hearing impairment.

d. Sleep deprivation.

Causes of Delirium

Precipitants and causes of delirium include the following (a more complete list is provided in Appendix N):

a. Infections (*e.g.,* urinary tract infection, pneumonia).

b. Dehydration.

c. Heart, liver, or kidney failure.

d. Blood sodium level too low or too high.

e. Blood sugar level too low or too high.

f. Major surgery.

NOTE

In the author's experience, the mental function deficits of delirium are often reversible once the underlying medical condition causing it is corrected; however, it may take weeks from the time the medical condition is corrected for full improvement to occur. If there is an underlying irreversible dementia upon which the delirium has been superimposed, the features of the dementia will still be present after the delirium resolves.

Medications That May Cause Delirium

Medications are a common cause of delirium. All the classes of medication listed in the dementia section above may cause delirium. Other medications that may cause delirium include:

a. Over-the-counter cold and sleep preparations. Examples:

(1) Diphenhydramine (*e.g.,* Benadryl, an ingredient in Tylenol PM, Advil PM); and

(2) Chlorpheniramine (*e.g.,* Chlor-Trimeton).

b. Nonsteroidal anti-inflammatory drugs used for inflammation, pain, and fever, *e.g.,* ibuprofen (Advil, Motrin).

c. Lithium carbonate used for bipolar disorder.

d. H2 receptor blockers for peptic ulcer disease, *e.g.,* cimetidine (Tagamet).

Example of Delirium Caused by Tricyclic Antidepressant

A man in his 70s is prescribed amitriptyline (Elavil) for pain and insomnia. After a week on the medication, he becomes lethargic and has difficulty paying attention. He stays on the medication and his condition worsens such that he has the following features: staring vacantly into space, muttering to himself, agitation, and reaching out into thin air, apparently trying to grab something that only he can see. The medication is stopped and over the course of days the confusional state clears.

Other Cognitive Disorders

In addition to dementia and delirium, medical conditions or medications may cause cognitive deficits of one kind or another (*e.g.,* memory or language impairment) that are clinically significant but do not reach the diagnostic threshold for either dementia or delirium.

OTHER MENTAL DISORDERS

In addition to the cognitive disorders described above, medical conditions can also cause other mental disorders (*e.g.,* mood disorder, psychotic disorder, anxiety disorder, personality change) that may affect capacity or susceptibility to undue influence.

Mood Disorders

Mood disorders (*e.g.,* depression or a depressive-like state) may be caused by the following conditions:

a. Parkinson's disease.

b. Stroke.

c. Hypothyroidism.

d. Anemia.

e. Cancer (*e.g.,* pancreatic cancer).

Psychotic Disorders

Psychotic disorders (*e.g.,* hallucinations or delusions) may be caused by the following conditions:

a. Visual impairment.

b. Auditory impairment.

c. Epilepsy.

d. Nutritional deficiency.

Anxiety Disorders

Anxiety disorders may be caused by the following conditions:

a. Heart arrhythmia (*i.e.,* irregular heart beat).

b. Chronic obstructive lung disease (*e.g.,* emphysema).

c. Asthma.

d. Congestive heart failure.

e. Vertigo.

f. Hyperthyroidism.

Personality Change

Personality change (*e.g.,* apathy, irritability, suspiciousness, emotional volatility, excessive seriousness) may be caused by the following conditions:

a. Seizure disorder.

b. Traumatic brain injury.

c. Brain tumor.

d. Stroke.

e. Multiple sclerosis.

f. Hypo- or hyperthyroidism.

STEP 36. ADVERSE EFFECTS OF MEDICATIONS

HOW MEDICATIONS MAY AFFECT CAPACITY

Various prescription and over-the-counter medications may adversely affect capacity and susceptibility to undue influence.

Therapeutic and Adverse Effects

Medications may have therapeutic effects, adverse effects, neither, or both.

a. If there is an effect on capacity from a therapeutic effect of a medication, it is likely to be positive.

b. If there is an effect on capacity from an adverse effect of a medication, it is likely to be negative.

In some instances, a medication may have both a therapeutic effect that enhances capacity and an adverse effect that detracts from capacity.

Example of Positive and Negative Effects on Capacity

A man with terminal cancer is asked by a family member to change his will. He is in pain and short of breath, both of which cause emotional distress. Morphine sulfate is administered by the hospice nurse for both symptoms.

a. When the medication is at its highest level in his system, due to a side effect there is clouding of consciousness, which detracts from capacity.

b. Later, when the amount of medication in his system has decreased, he no longer has clouding of consciousness, and due to a therapeutic effect of the medication he is in less pain and can breathe more easily. Due to these therapeutic effects, he becomes less anxious mentally and is therefore better able to think clearly, which enhances capacity.

Involvement of Other Substances

In addition to prescription and over-the-counter medications, the involvement of other substances (*e.g.,* vitamins, minerals, botanicals, and natural remedies; alcohol; tobacco; caffeine; illicit substances) should be considered.

Medications That Adversely Affect Capacity

Medications that may adversely affect capacity include:

a. Narcotic pain relievers.

b. Nonsteroidal anti-inflammatory drugs.

c. Heart and blood pressure medications.

d. Antibiotics.

e. Antihistamines.

f. Sleeping pills.

g. Cancer chemotherapies.

h. Antiparkinsonian drugs.

i. Anticonvulsants.

j. Psychiatric medications.

NOTE

If someone is taking a medication and there is a physical or mental difficulty that did not exist before the medication was started, the possibility that the medication is contributing to or causing the difficulty should be considered, even if the difficulty is not a known or common adverse effect of the medication.

Mental Function Deficits Caused by Medication

Medications may adversely affect all the domains of mental function specified in Prob C §811(a). This may occur due to:

a. Side effects of drugs that have the brain as their primary site of therapeutic action (*e.g.,* antidepressants); or

b. Side effects of drugs that do not have the brain as their primary site of therapeutic action (*e.g.,* heart medication) but nevertheless affect the brain.

Brain-Related Medication Side Effects

Individuals in all age groups may experience brain-related medication side effects. In general, however, older adults are more susceptible to these side effects, including problems with cognition, mood, personality, psychosis, and anxiety level.

Causes of Increased Susceptibility

There are a number of causes for this increase in susceptibility to side effects in older adults. Examples:

a. Age-related increase in the sensitivity of the brain (and other parts of the body).

b. Age-related changes (*e.g.,* decreased liver size) in the way the body processes medication (*i.e.,* absorption, distribution, metabolism, elimination), leading to higher blood levels of a drug.

c. Illness-related changes (*e.g.,* liver disease) in the way the body processes medication, leading to higher blood levels of a drug.

d. Excessive use of medication due either to cognitive impairment or a confusing drug regimen.

e. Age-related increase in the number of medical conditions, leading to an increase in the total number of medications being taken.

Effect of Increase in Total Number of Medications

An increase in the total number of medications taken could lead to increased susceptibility to side effects as follows:

a. On a statistical basis, the more medications, the greater the odds of a side effect occurring.

b. The higher the number of medications, the greater the odds of two drugs having the same side effect, with additive adverse effect (*i.e.,* being more symptomatic from the combination of drugs than from either drug alone).

c. Greater risk of a drug-drug interaction in which one drug interferes with the body's processing (*e.g.,* metabolism) of a second drug, leading to a higher-than-expected blood level of the second drug and thereby more risk of a side effect.

Examples of Interference in Processing of Medication

Examples of one drug interfering with the body's processing of a second drug, leading to a side effect from a higher level of the second drug, include:

a. The antidepressant fluoxetine (Prozac) interfering with the metabolism of the pain reliever amitriptyline (Elavil), leading to delirium from a toxic blood level of amitriptyline.

b. The antibiotic erythromycin interfering with the metabolism of the sedative eszopiclone (Lunesta), leading to clouding of consciousness from an increased blood level of eszopiclone.

c. The anti-inflammatory drug ibuprofen (Motrin) interfering with the excretion of the mood stabilizer lithium carbonate, leading to a confusional state from a toxic blood level of lithium.

NOTE

A small dose of medication may cause a significant side effect in anyone, but this is particularly true for older adults, especially those with dementia. Moreover, for many medications older adults may not need as high a dose as younger adults to achieve the desired therapeutic effect. Consequently, a "start low, go slow" approach to dosing medication is often advisable in the older age group.

INTOXICATION

Intoxication is a clinical syndrome that may adversely affect capacity and susceptibility to undue influence. At the extreme, intoxication may manifest as delirium.

Definition of Intoxication

According to the DSM-IV, intoxication is defined as follows:

a. The development of a reversible substance-specific syndrome due to recent ingestion of (or exposure to) a substance.

b. Clinically significant maladaptive behavioral or psychological changes that:

(1) Are due to the effect of the substance on the central nervous system; and

(2) Develop during or shortly after the use of the substance.

c. Symptoms are not due to a general medical condition and are not better accounted for by another mental disorder.

Impairments and Maladaptive Behavior That Could Adversely Affect Capacity

Examples of impairment and maladaptive behavior caused by intoxication that could adversely affect capacity and susceptibility to undue influence include the following:

a. Decreased level of consciousness (*e.g.,* lethargy, drowsiness).

b. Personality changes (*e.g.,* irritability, inappropriate agreeableness).

c. Mood changes (*e.g.,* instability of mood, sadness).

d. Cognitive impairment, including impaired judgment.

e. Behavioral changes (*e.g.,* hostility, aggression).

f. Impaired social or occupational functioning.

Medications That May Cause Intoxication

The following classes of medication may cause intoxication:

a. Opiate pain relievers, *e.g.,* hydrocodone (Vicodin), morphine.

b. Benzodiazepine antianxiety medication, *e.g.,* diazepam (Valium), clonazepam (Klonopin), lorazepam (Ativan), alprazolam (Xanax).

c. Sleeping medication, *e.g.,* zolpidem (Ambien), eszopiclone (Lunesta), temazepam (Restoril).

d. Barbiturates, *e.g.,* butalbital, an ingredient of Fiorinal.

Example of Intoxication by Overmedication

Example: An elderly woman with dementia is living at home and being taken care of by a hired caregiver. The woman had psychosis, agitation, and insomnia, so her doctor prescribed the sedating antipsychotic medication quetiapine (Seroquel), which she is supposed to take once a day at bedtime. When the caregiver gives the medication as prescribed, the woman does better overall and is alert, communicative, and reasonably functional.

a. The caregiver discovers that if she surreptitiously gives the woman doses of quetiapine during the day, the woman becomes lethargic, uncommunicative, dysfunctional and easily manipulated.

b. The caregiver routinely overmedicates the woman and uses these occasions to defraud her by getting her to sign checks made out to the caregiver.

c. When the woman's adult children are going to visit, they always give at least a few days' notice.

d. Counting on this forewarning and anticipating that the adverse effects will dissipate, the caregiver switches back to giving the medication as prescribed only after she hears from the children that they will be visiting.

WITHDRAWAL

The symptoms and signs of withdrawal may adversely affect capacity and susceptibility to undue influence and may vary somewhat with the type of medication involved. At the extreme, withdrawal from certain medications (*e.g.,* benzodiazepines) may manifest as delirium.

Symptoms of Withdrawal

According to the DSM-IV, a withdrawal state is defined by the following features:

a. The development of a substance-specific syndrome due to the cessation of (or reduction in) substance use that has been heavy and prolonged.

b. The substance-specific syndrome causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

c. These symptoms are not due to a general medical condition and are not better accounted for by another mental disorder.

NOTE

A withdrawal state may develop after either an abrupt discontinuation of a drug or a dosage reduction that is too large.

Withdrawal From Opiate Pain Relievers

For opiate pain relievers, symptoms of withdrawal include:

a. Anxiety.

b. Irritability.

c. Restlessness.

d. Psychic distress.

e. Insomnia.

f. Various physical symptoms and signs (*e.g.,* headache, sweating, runny nose, gooseflesh, abdominal cramps, nausea, vomiting).

Withdrawal From Antianxiety Medication

For benzodiazepine antianxiety medication, certain sleep-promoting medications, and barbiturates, symptoms of withdrawal include:

a. Anxiety.

b. Agitation.

c. Insomnia.

d. Visual, auditory, or tactile hallucinations (*i.e.,* perceiving something in the absence of a sensory stimulus) or illusions (*i.e.,* misperceiving an actual sensory stimulus).

e. Various physical symptoms and signs (*e.g.,* hand tremors, sweating, nausea, vomiting, seizures).

Antidepressant Discontinuation Syndrome

While not usually thought of as a withdrawal syndrome, an antidepressant discontinuation syndrome has been described and drugs such as paroxetine (Paxil) and venlafaxine (Effexor) have been implicated. Features of this syndrome include:

a. Anxiety.

b. Irritability.

c. Malaise.

d. Dizziness.

e. Nausea.

f. Insomnia.

OTHER MENTAL DISORDERS CAUSED BY MEDICATION

The following mental disorders other than cognitive disorders may be caused by medication.

Mood Disorders

Medications may cause mood disturbances such as depression or mania. Examples:

a. Corticosteroids used for a wide range of medical conditions, *e.g.,* prednisone, dexamethasone.

b. Cancer chemotherapy medications, *e.g.,* interferon, tamoxifen.

c. Heart and blood pressure medications, *e.g.,* propranolol (Inderal).

d. Metoclopramide (Reglan), a gastrointestinal stimulant.

e. Varenicline (Chantix), a cigarette smoking cessation medication.

Example of Medication That Causes Depression

Example: A man in his 60s has been treated with propranolol, a beta-blocker blood pressure medication. In a suicide attempt with a small-caliber revolver, he has shot himself in the back of the head. The bullet has lodged in his skull and has not caused any direct injury to his brain.

a. He says he tried to kill himself because his wife is divorcing him. He had been working with a divorce attorney and they had discussed how the couple's assets might be divided. Disgusted by the prospect of dividing the assets and depressed about the whole situation, the man decided to "let her have it all."

b. In the hospital after the suicide attempt, a physician obtains a history of a depression developing after the propranolol was started. The medication is stopped and the drug-induced component of the depression slowly resolves. The man decides to work with his attorney and go through the legal process to determine how the assets from the marriage will be divided.

Psychotic Disorders

Medications that may cause psychotic features such as hallucinations and delusions include:

a. Antiparkinsonian drugs, *e.g.,* carbidopa-levodopa (Sinemet).

b. Corticosteroids.

c. Psychostimulants, *e.g.,* dextroamphetamine (Dexedrine).

d. Heart and blood pressure medications, *e.g.,* digoxin (Lanoxin).

Anxiety Disorders

Medications may cause anxious features such as anxiety, worry, nervousness, fearfulness, and distractibility. Examples:

a. Antidepressants, *e.g.,* fluoxetine (Prozac), duloxetine (Cymbalta), buproprion (Wellbutrin).

b. Antipsychotics, *e.g.,* olanzapine (Zyprexa), risperidone (Risperdal).

c. Medications for respiratory conditions, *e.g.,* albuterol (Proventil), theophylline.

d. Thyroid hormone supplements.

e. Decongestants, *e.g.,* pseudoephedrine (*e.g.,* Sudafed).

APPENDIX A
Sample Letter of Joint Representation

_ _[*Date*]_ _

Mr. Elderly Parent

1234 Capacity Lane

Pleasantville, CA 90000

Re: Fee Agreement and Conflicts Letter

Dear Elderly Parent:

This letter (a) sets forth the terms under which I will assist you in your estate planning and (b) warns you of the potential conflict in my multiparty representation of you and your son Adam in connection with your respective estate plans.

1. Fee Agreement.

_ _[*insert fee agreement information*]_ _.

2. Conflicts of Interest.

Because I am advising you on your estate plan and because I represent your son Adam in connection with his estate plan, under the rules of the State Bar of California and under California law, I am required to inform you about certain potential conflicts of interest that exist between a parent and a child when both seek legal advice from the same attorney on their respective estate plans.

I must necessarily obtain confidential information from both of you. However, because I represent both of you, I cannot keep that information confidential from either of you. You and Adam are both entitled to all the knowledge I have about your respective estate plans.

For example, if I represent both of you, and if you decided to disinherit Adam and leave all your property to charity, I would be obligated to make that fact known to Adam because, as you know, he anticipates inheriting property from you and that expectation has informed his own estate planning decisions.

A parent and an adult child may have conflicting interests when an attorney prepares an estate plan that concerns their respective property.

If, as you request, I act as attorney for both of you, I cannot be an advocate for either of you to the exclusion of the other. As the lawyer for both of you, I cannot take sides in any dispute between you.

For example, at our conference, we discussed whether you wanted to give Adam a power of appointment over certain assets in your trust so that he could change the eventual disposition of those assets after your death. We also discussed how broad that power should be, *i.e.*:

Should the power of appointment be limited to your descendants only? Should it include Adam's wife? Should it include charities? Should it be the broadest possible power consistent with the assets subject to the power's not being included in Adam's estate for estate tax purposes? Although you indicated that you wanted Adam to have the broadest possible power consistent with the assets subject to the power not being included in his estate for estate tax purposes, and although Adam was agreeable to your wishes, he and you may disagree in the future about such matters. As lawyer for both of you, I cannot assert one position over the other.

Although we hope that it will not happen, if conflicts do arise between you of such nature that it is impossible in my judgment to perform my obligations to each of you in accordance with this letter, it would become necessary for me to withdraw as your joint attorney and to advise one or both of you to obtain independent counsel.

Under the cases decided in the California courts, it is necessary for you to be fully informed in writing by me about conflicts of interest. It is only after I have informed you as to the facts of such conflicts that you can decide whether you want me to represent

both of you in your estate planning. You are each, of course, welcome to have your own counsel for any part or all of the matters in which I am dealing. Either of you may also forbid me from being involved in any way on behalf of the other.

If the terms of our fee agreement and my representation of you and Adam, despite the potential for conflicts of interest, are agreeable to you, please sign the enclosed copy of this letter and return it in the enclosed stamped, self-addressed envelope.

Very truly yours,

Date: _ _ _ _ _ _ __[*Signature*]__
_ _[*Typed name of attorney*]_ _

Enclosures

I have read the foregoing material and understand that there are many potential conflicts of interest between my son and me in the matters about which we are consulting you. If, and to the extent that, I wish to have separate counsel or want you not to be involved at all, I shall notify you. I consent to having you represent both me and my son in the estate planning that you are doing. I understand that, when you are representing both of us on the same matter, as between my son and me, there are no confidential communications, because you represent both of us.

I have read, understand, and agree to the fee arrangement described above.

Date: _ _ _ _ _ _ __[*Signature*]__
_ _[*Typed name of elderly parent*]_ _

I have read the foregoing material and understand that there are many potential conflicts of interest between my father and me in the matters on which we are consulting you. If, and to the extent that, I wish to have separate counsel or want you not to be involved at all, I shall notify you. I consent to having you represent both my father and me in the estate planning that you are doing. I understand that, when you are representing both of us on the same matter, as between my father and me, there are no confidential communications, because you represent both of us.

Date: _ _ _ _ _ _ __[*Signature*]__
_ _[*Typed name of son*]_ _

APPENDIX B
Sample Nonengagement Letter

_ _[*Date*]_ _

Ms. Jane Doe

1234 Capacity Lane

Pleasantville, CA 90000

Dear Ms. Doe:

I enjoyed speaking with you on _ _[*date*]_ _, and I regret that we will not be able to represent you in connection with _ _[*describe matter discussed*]_ _. We will not be representing you with respect to that matter because _ _[*describe reason*]_ _.

As we also discussed, it is possible that one or more statutes of limitations may _ _[*be about to expire/expire on* _ _[*date*]_ _]_ _. If such statutes expire, you may lose the right to pursue your claims. Therefore, you should immediately take steps to contact another attorney for purposes of preserving whatever rights you may have.

_ _[*I am returning with this letter all the papers you left with me.*]_ _

I appreciate your consideration of our firm and I regret that we will not be representing you. If you have any questions, please do not hesitate to contact me.

Very truly yours,

Date: _ _ _ _ _ _ __[*Signature*]__
_ _[*Typed name of attorney*]_ _

APPENDIX C
Quick Reference for Assessing Capacity Using DPCDA—A Summary

Step 1: Is the act or decision one of the following or another type of act or decision governed by DPCDA:

(1) Making a testamentary disposition, including creating or revoking a trust. Prob C §6100.5(a).

(2) Making a contract, including marriage and registered domestic partnership (although there is no separate statutory standard for determining capacity to marry). CC §§39-40; Fam C §§297, 301; Prob C §1872.

(3) Making a conveyance. CC §39-40; Prob C §1872.

(4) Making a medical decision. Prob C §813.

(5) Managing personal and financial affairs. Prob C §1801.

(6) Driving. See Health & S C §103900.

(7) Nominating a conservator. Prob C §1810.

(8) Authorizing release of "protected health information" under HIPAA or CMIA (Health Insurance Portability and Accountability Act of 1996 (HIPAA) (Pub L 104-191, 110 Stat 1936); 45 CFR §§160.101-160.570, 164.102-164.552; Confidentiality of Medical Information Act (CC §§56-56.37)).

If governed by DPCDA, review the underlying statutory requirements for that act or decision. For marriage, see case law.

Step 2: Apply the rebuttable presumption in favor of capacity (*e.g.,* Prob C §§810(a), 1900 (re marriage and registered domestic partnership)).

Remember that having a mental or physical deficit or diagnosis does not affect the presumption. Rather, a judicial determination of incapacity is based on evidence of one or more mental function deficits listed in Prob C §811(a).

Step 3: Apply the communication standard, if there is one.

Focus on what must be communicated under the underlying statutes. Except for the functional tests in management of personal and financial affairs and driving, a particular communication is required. See Prob C §812 for basic DPCDA communication standard. The statutes outline the communication standards except for marriage and registered domestic partnership. Review also case law that may apply. If the standard is satisfied, proceed. If the person cannot or will not communicate what must be communicated in step 1 (1)-(4) and (7)-(8), stop. You cannot establish capacity.

Step 4: Identify mental function deficits and determine whether there is a correlation with the act or decision and whether there is significant impairment.

(1) Identify mental function deficits listed in Prob C §811(a).

(2) Is the deficit correlated with the act or decision? Prob C §811(a).

(3) Is there the required *significant impairment* of ability to understand and appreciate the consequences of one's actions with regard to the type of act or decision in question? Prob C §811(b).

Step 5: Obtain expert opinion if correlation is not obvious.

If the correlation is not obvious, consider obtaining an expert's opinion on whether the mental function deficit correlates with the act or decision. The opinion of an expert should not be necessary at any other stage. *NOTE:* Some attorneys ask experts to assess the correlation even when the statute requires only a functional test.

Step 6: Determine whether undue influence occurred.

If the person is found to have capacity, check for undue influence. See steps 25 and 28.

APPENDIX D
Neuropsychologist's Perspective—Case Study Assessing Capacity to Manage Own Affairs, Undue Influence, and Capacity to Marry

The Facts

An 82-year-old man had initially been referred for a neuropsychological evaluation in a conservatorship proceeding for the purpose of assessing his vulnerability to undue influence and his capacity to manage his financial and personal affairs. He did not have any children, but his neighbors and cousins were concerned that a 47-year-old female caretaker, initially hired to care for his frail wife, now deceased, was subjecting him to undue influence and slowly spending down his estate.

The caretaker had taken away valuable artifacts and had repeatedly interfered with his medical care. She had urged him to stop taking certain necessary heart medication, and after a serious fall that left him unconscious, she waited for a full day to bring him to the emergency room. At her suggestion, he hired a financial advisor she recommended. When asked about the size of his estate, he said that he did not know what he had any more. He was adamant that it was in his nature to be generous, and he claimed that he knew full well what he was doing. He stressed that he loved his caretaker and resented any outside interference.

The Results of Interview and Testing

The results of the interview and testing indicated that due to significant frontal brain damage, he was not able to size up the totality of his situation and discern how he was being subjected to undue influence and forced to act in ways that were not in his best interests, either medically or financially. Due to the nature of this type of brain impairment, he could not anticipate that he might need more extensive—and expensive—medical care and supervision. At the rate he was spending, it was not likely that he would be able to afford to pay for his own care.

The First Court Order

The court granted a conservatorship of both person and estate, and limited the number of hours of contact between the man and the caretaker.

Subsequent Evaluation by Neuropsychologist

Eight months after the appointment of the conservator, the neuropsychologist was asked to evaluate whether the same man, now 83 years old, had the capacity to marry. He had, indeed, in the intervening months, married the caretaker. They were living in their own homes but she had created a separate bedroom for him in her home in case he ever wanted to spend the night. The neuropsychologist was specifically asked to determine whether the client had the capacity to assess his own best interests and understand the short- and long-term consequences of entering into a marriage contract. A second question was whether the marriage was a product of the client's own free choice and not the result of undue influence.

Neuropsychologist's Conclusions After Second Evaluation

After two separate appointments during which both tests and interviews were conducted, the neuropsychologist concluded that the man had adequate cognitive capacity to understand the nature of the marriage contract and the duties and responsibilities imposed on him. His attention and concentration had improved significantly since the initial evaluation 8 months earlier. He knew whom he had married. He understood what was said to him and was able to freely express his wishes. The man continued to have some limitations as to the capacity to assess his own best interests due to continued frontal lobe damage and a preexisting personality structure (he tended to place the needs of others before considering his own). However, he was capable of understanding the short- and long-term consequences of his decision to marry. He fully intended to meet his fiduciary responsibilities to his new wife, and already had had a meeting with his lawyers for such purpose. He planned to limit what he would provide for his new wife and allow for some of the remainder of his property to go to his relatives.

His decision to marry was made freely, after deliberation over a long period of time. It was not an impulsive gesture. However, influence from the caretaker, now his wife, was not totally absent. It was, in fact, her idea to get married. This alone, however, did not indicate undue influence. The client did love her, wanted to look after her and, in his own words, do "the best I can do."

The Second Court Order

The court allowed the marriage to continue but retained the conservatorship of person and estate with the predesignated court-appointed conservator.

APPENDIX E
Hypothetical I: Is There Lack of Capacity to Manage Financial Affairs and to Contract and Convey, and to Warrant Conservatorship?

The Facts

Granddaughter (GD) makes an appointment to discuss a possible conservatorship of Grandmother (GM). At the appointed time, she arrives with GM and sister of GM (Sister). Attorney meets with them all together for the initial consultation. GD, with assistance of Sister and minimal input from GM, presents the following facts:

GM is susceptible to telemarketers and has recently refinanced her house, greatly to her disadvantage, and tied up all her cash ($123,000, which was with Charles Schwab) in an annuity that automatically makes the mortgage payments. The same telemarketer may have sold her both products. The refinance added years to the mortgage, lowered the monthly payment, and cost several thousand dollars. There would be a prepayment penalty of $7000 if she paid the mortgage off, not to mention penalties for cashing in the annuity. Her other income is $863 from Social Security, which is directly deposited into her checking account. GD is on the checking account and pays GM's bills because GM was not paying them. Because available cash is limited, GD recently paid for insurance, taxes, and repairs out of her own resources.

GM owns a two-unit house and lives upstairs, and GD lives downstairs. GD receives IHSS payments for caring for her own disabled son and a disabled cousin, both of whom receive SSI. Her 7-year-old daughter also lives there. She moved from Los Angeles to Oakland last August based on an agreement with GM providing that GD would take care of GM (who has Parkinson's, high blood pressure, fluid retention, and dementia, and recently had an angiogram) in order to keep GM out of a nursing home, and in return GM would give the house to GD on GM's death. GM executed a Durable Power of Attorney for Health Care 1 year ago naming Sister as her agent; page two is missing at this meeting, so it is unknown whom she named as alternate agent, if anyone.

According to both GD and Sister, GM's three children pay no attention to her. "Mother's Day might as well be Ground Hog Day to them," as Sister puts it. GM does not want her children to get her house when she dies, GD and Sister say, but in fact has done nothing to effect her promise to GD. She has no will or trust, has not executed any grant or joint tenancy deed. According to Sister, GM's seven sisters all know that she wants GD to get the house, not her children. As for what the children will do if they receive the house, according to Sister, "Her body won't be flat in the coffin before there's a For Sale sign on it."

When asked questions about the house and her intention in regard to it, GM starts talking about the condition of the house, saying that she doesn't want it sold when she dies, and other remarks that are not responsive to the questions, although they do relate to the subject of the house.

The Issues

The attorney is faced with three questions:

1. Does GM meet the statutory standard for conservatorship?

2. Does GM have the capacity to make a decision, and commit an act, fulfilling her promise to GD?

3. Is there any indication that GM is subject to undue influence?

Analysis of the First Issue

Step 1: Is this an incapacity that has legal consequences? Yes. The inability to manage one's financial affairs and resist fraud and undue influence has legal consequences, including possible establishment of a conservatorship by a court, and therefore DPCDA applies. Continue.

Step 2: Apply the presumptions. Presume capacity to, *e.g.,* manage finances, and disregard diagnoses. The presumption can be rebutted.

Step 3: Must we examine a statutory communication standard? No, because conservatorship involves only a *functional* test. What is the functional standard? See Prob C §1801 regarding management of financial affairs. Does GM have a problem with this test? Apparently.

Step 4: What are the mental function deficits? More contact with GM, alone, might be necessary, but she does not appear to have the ability to attend and concentrate, and if the allegations about the refinance and annuity are correct, she lacks the ability to reason using abstract concepts.

Step 5: Do those mental function deficits relate to the inability to manage finances and resist fraud or undue influence? Apparently so, given GM's current dilemma, and probably generally.

Step 6: Is an expert opinion needed? No; Attorney could file for conservatorship with these facts and probably prevail; children might file objections and otherwise prolong the process, although one is in prison and one is illiterate. Documentation of the mortgage and the annuity should be attached to the papers.

Step 7: Other issues must be considered, including how to pay the costs of the conservatorship when there is no cash available. The court might void the mortgage and/or the annuity, but that's not entirely clear and the process would be expensive. Someone, possibly sisters, would probably have to provide a retainer.

Analysis of the Second Issue

Step 1: Does fulfilling the promise have legal consequences? Yes. A will or trust is a testamentary act. A deed is a conveyance, but also, if it disinherits the conveyor's children, a testamentary act. These children are going to be furious, so whatever the attorney does, judicial review is quite likely. Proceed very carefully.

Step 2: Apply the presumption. GM is presumed to have the capacity to make a will or trust or execute a deed, and her diagnoses are not relevant.

Note, however, that filing for conservatorship involves allegations that she lacks capacity to manage her finances and resist fraud or undue influence, so this determination should be made now, not later, in order to avoid claiming simultaneously that GM is too incapacitated to manage her finances but not too incapacitated to execute a will, trust, or deed. The two capacities are not identical, but are related.

Step 3: Must she be able to communicate? Yes. See Prob C §812 regarding the conveyance, and Prob C §6100.5(a) regarding the will or trust.

To whom is she to communicate about all this? Attorney has established an attorney/client relationship with GD, who made the appointment and presented a request to attorney for help. This attorney cannot be involved in any act or decision that will benefit GD because of a conflict of interest, which children will certainly point out in possible litigation. So Attorney must send GM to someone else for this part.

Step 4: Same mental function deficits as above; do they relate to conveying and testamentary acts? Probably, but the other attorney would have to determine that in a private conference with her. GM may be quite clear in that situation about what she wants to do, but recall that she must recite the names of her spouse(s) and children, say what a will is, what her assets are, what she wants to do, and be clear about who is to get what. Attorney has grave doubts, but the setting was not ideal for this purpose, and no private conference with her occurred.

Step 5: Is outside help needed? Yes; get another attorney involved because of the conflict of interest.

Analysis of the Third Issue

Step 1: Have the plans of GM outlined in her previous testamentary documents been altered? There are no previous documents aside from the power of attorney for health care. Therefore, any real and personal property would pass through intestate succession (to GM's children).

(1) Are the new provisions unnatural? They would pass over GM's children, so any provisions made directly to GD are unnatural.

(2) Do the new provisions represent a radical change? Yes, GM's children would get nothing.

Step 2: Are there any indications of potential undue influence?

(1) Does GD have seeming control? Yes, GD made the appointment and brought GM and Sister. GD lives at the house and provides care to GM.

(2) Is there secrecy regarding the new provisions? This is uncertain and should be clarified. It appears that GD and Sister are attempting to keep GM's children uninformed.

(3) Is there difficulty obtaining financial information? This is uncertain and should be clarified.

(4) Is there difficulty meeting with GM alone? This is uncertain. The attorney did not try.

(5) Was new chief beneficiary active in procuring the new testamentary instrument? Yes, GD made the appointment, and GD and Sister did most of the talking.

Step 3: Has GM been interviewed alone? No.

Step 4: Review unusual provisions before execution. The attorney might consider it prudent to call in an expert to evaluate GM's capacity.

Step 5: Exclude interested person from execution conference.

APPENDIX F
Hypothetical II: Is There Lack of Capacity to Manage Financial Affairs, Including Managing a Trust, to Contract, and Convey?

The Facts

You are a bank trust officer, a private professional fiduciary, and your bank is named as successor trustee in a trust established by Husband and Wife some time ago. The trust provides that Husband and Wife are the original trustees, and on the death or incapacity of either, the other is to serve as sole successor trustee. On the death, resignation, or incapacity of the surviving spouse, your bank is to be the next successor trustee. Incapacity is to be established by the written statements of two physicians stating that the surviving spouse trustee is not able to continue to serve as trustee due to some physical or mental incapacity. (This is a common provision, but in fact doctors are probably not qualified to provide such an opinion.)

Husband died a few years ago, and Wife asked you, because you will eventually take over as successor trustee, to advise her in her duties as trustee, as a way of acquainting you with the assets and providing guidance to her. You agreed to do so, since you are a friend of the family, but there is nothing in writing. You receive copies of statements from all financial institutions on a regular basis and she sometimes calls you for advice.

Recently, you have become concerned about Wife's management of the trust. The statements raise questions that, when you call her, she seems unable to answer to your satisfaction. You are beginning to feel that perhaps you should take over as trustee, but she shows no signs of resigning, although you have suggested to her that she might be ready to give up control.

The Issue

Does Wife have capacity to act as trustee? Your corporate counsel refers you to a local Elder Law attorney. The Elder Law attorney takes you through the following analysis.

Analysis

Step 1: Does DPCDA apply, *i.e.,* do her acts and decisions have legal consequences? If she mismanages the trust, her estate plan may be thwarted, and the remaindermen may be disadvantaged.

(1) Is she making or changing a testamentary plan? Probably not; that's already been done. She may be thwarting it somehow without actually changing it.

(2) Is she contracting or conveying? She may be contracting, depending on how the assets are held and managed, *e.g.,* she may be giving instructions to Merrill Lynch.

(3) Is she making medical decisions? No.

(4) Is she managing personal or financial affairs? Yes. Is conservatorship an appropriate response? There has to be a vacancy in order for you to take over as the successor trustee, so she must resign or you must get her removed by obtaining the doctors' statements called for in the trust, or conserving her. Are family members who would be affected by her continued mismanagement able to get her to resign? Be aware of confidentiality issues, however.

(5) Be aware that the main legal consequence may be to you. You may incur liability if you continue to advise her but she continues to disregard your advice. The remaindermen may have an action against you for doing so. You should tell her that you cannot continue to advise her, because she is not following your advice, and you will not remain involved except as successor trustee; in fact, you should have had a written agreement about all this. Discuss with your corporate counsel if you have further obligations to blow the whistle to the remaindermen.

Step 2: Apply the presumptions about capacity. Any diagnosis is not relevant, but there is no indication of a diagnosis in this case.

Step 3: What kind of communication is required? Apply the functional test provided in the conservatorship statute (Prob C §1801), although it is not clear that conservatorship is the answer here. Management of financial affairs is the problem, however, and the communication provisions in the other statutes may not be helpful.

Step 4: What are the mental function deficits and are they connected to the act or decision in question? You have probably perceived, *e.g.,* memory loss, inability to reason using abstract concepts, in your discussion with her. Do they relate to management of financial affairs? Apparently.

Step 5: Is outside help needed? Probably not.

APPENDIX G
Hypothetical III: Does the Person Have Capacity to Make Medical Decisions?

Facts

My client is a diabetic and recently had surgery to amputate his leg below the knee. Now the vascular surgeon claims that the amputation should have been *above* the knee, and my client refuses to consent to it. He tells me that he doesn't wish to go through any more surgery and he understands that he may die if he does not have the recommended procedure.

His daughter has an advance health care directive (ACHD), and the surgeon is pressuring her to consent to the surgery. The hospital social worker is calling me every day to take care of the problem.

The Issue

Does the patient have capacity to make his own medical decisions?

The Analysis

Step 1: Is this an act or decision governed by DPCDA? Yes; it is a medical decision.

Step 2: Apply the DPCDA presumptions. It is presumed that the patient has capacity to refuse treatment. The diagnosis of diabetes is a physical deficit that does not affect the presumption.

Step 3: Is communication required? Yes; the patient must be able to communicate all the elements of Prob C §813 to the doctor, who will then decide if the patient has the capacity to give or withhold informed consent for medical treatment.

Step 4: Are there mental function deficits? We don't have enough information, but even assuming that the patient has at least emotional responses to the loss of his leg and the information that another surgery is needed, and assuming that he has some disorientation due to pain medication from the previous surgery, is not always oriented to time and person, and doesn't always recognize relatives who are visiting him, those mental function deficits are not obviously related to the act or decision in question.

Step 5: Do I need outside help? I already know the surgeon's opinion; I need another doctor to reach a different conclusion. I will have a conversation with my client to determine if he is able to do all of the things required under Prob C §813. I will inform the surgeon of that conclusion and the statutory basis for it. If that is insufficient, I will ask another doctor to make the determination, in my presence. I will inform the surgeon that the agent under the AHCD cannot act unless there is a determination that the patient cannot give or withhold informed consent, and I do not believe that to be the case.

Step 6. If I believe that the patient cannot meet the Prob C §813 test, I will support the daughter in making a decision in keeping with her father's wishes, as made known to me and, I hope, to her.

APPENDIX H
DMV Form DS 326—Driver Medical Evaluation

A Public Service Agency

DRIVER MEDICAL EVALUATION

(Medical information is CONFIDENTIAL under Section 1808.5 CVC)

INSTRUCTIONS TO THE DRIVER: Please take this form to the doctor most familiar with your health history and current medical condition. **Before** giving this form to your doctor, complete name/address, complete and sign the **HEALTH HISTORY** and the **MEDICAL INFORMATION AUTHORIZATION** sections on this page.

INSTRUCTIONS TO THE DOCTOR: Please complete the section, **DOCTOR'S MEDICAL EVALUATION**, on pages 2 through 5. The Department of Motor Vehicles' records indicate your patient may have a condition that could affect the safe operation of a motor vehicle. In this case, the department is concerned about the following condition:

PHYSICIAN *RETURN FORM TO:*
DEPARTMENT OF MOTOR VEHICLES
Licensing Operations Division
Driver Safety Branch
P. O. Box 934345 MS J-234
Sacramento, CA 95818

RETURN BY:

NAME (LAST, FIRST, MIDDLE)	DRIVER LICENSE NO.	BIRTH DATE	FIELD FILE

STREET ADDRESS	CITY	ZIP	PATIENT'S DAYTIME OR HOME PHONE NO.

PATIENT MUST COMPLETE HEALTH HISTORY BELOW. *(Please explain any "YES" answers)*

YES	NO		YES	NO	
		Head, neck, spinal injury, disorders or illnesses			Kidney disease, stones, blood in urine, or dialysis
		Seizure, convulsions, or epilepsy			Muscular disease
		Dizziness, fainting, or frequent headaches			Any permanent impairment
		Eye problem (except corrective lenses)			Nervous or psychiatric disorder
		Cardiovascular (heart or blood vessel) disease			Regular or frequent alcohol use
		Heart attack, stroke, or paralysis			Problems with the use of alcohol or drugs
		Lung disease (include tuberculosis, asthma or emphysema)			Other disorders or diseases
		Nervous stomach, ulcer, or digestive problems			Any major illness, injury, or operations in last 5 years
		Diabetes or high blood sugar			Currently taking medications

EXPLANATION: *(Include onset date, diagnosis, medication, doctor's name and address and any current condition or limitation. Attach additional sheet, if needed).*

I certify (or declare) under penalty of perjury under the laws of the State of California that the foregoing is true and correct. I further certify that all information concerning my health is true and correct.

DATE	DRIVER'S SIGNATURE

DRIVER'S ADVISORY STATEMENT

Medical information is required under the authority of Divisions 6 and 7 of the California Vehicle Code. Failure to provide the information is cause for refusal to issue a license or to withdraw the driving privilege.

All records of the Department of Motor Vehicles, relating to the physical or mental condition of any person, are confidential and not open to public inspection (California Vehicle Code Section 1808.5). Information used in determining driving qualifications is available to you and/or your representative with your signed authorization.

The department has sole responsibility for any decision regarding your driving qualifications and licensure. The department will also consider non-medical factors in reaching a decision.

MEDICAL INFORMATION AUTHORIZATION (Valid for three years)

DOCTOR, HOSPITAL, OR MEDICAL FACILITY (NAME AND ADDRESS)

DATE	MEDICAL RECORD/PATIENT FILE NO.

I hereby authorize my doctor or hospital to answer any questions from the Department of Motor Vehicles, or its employees, relating to my physical or mental condition, and/or drug and/or alcohol use, and to release any related information or records to the Department of Motor Vehicles or its employees. Any expense involved is to be charged to me and not to the Department of Motor Vehicles.

I hereby authorize the Department of Motor Vehicles to receive any information relating to my physical or mental condition, and/or drug and/or alcohol use or abuse, and to use the same in determining whether I have the ability to operate a motor vehicle safely.

NOTE: You may wish to make a copy of the completed Driver Medical Evaluation for your records.

SIGNED	DATE
X	
WITNESS	DATE

APPENDIX I
Neuropsychologist's Analysis and Case Study of Issue of Capacity to Drive

Introduction

Driving is a privilege, not a right, granted only after the applicant has initially passed both a written and a road test. Chronological age, however, can greatly compromise skills that are fundamental to driving safely. Vision and the ability to scan the environment in a rapid fashion and integrate new information are central components of safe driving. Speed of response and a certain degree of mobility in both upper and lower extremities are also necessary.

Physicians are required to report to the traffic safety division of the DMV patients who have lapses of consciousness, Alzheimer's disease, or other dementias, and are asked to fill out a checklist judging the severity of the patient's memory loss, judgment, attention, language skills, visual spatial skills, impulsivity, problem-solving deficits, and loss of awareness of disability. See Health & S C §103900; DMV Form 326 (see Appendix H). However, losing the privilege to drive, especially in later life, represents a dramatic change in terms of losing independence and poses a challenge to the individual's sense of well-being. As a result, although physicians are given protection from civil or criminal liability, they are often reluctant, even when required by law, to report those elderly individuals who meet the specific medical or cognitive criteria specified in the statute. In addition, a physician's training often does not cover the assessment of these latter cognitive skills. A neuropsychologist is asked to provide this data, which is then used by the physician to complete the reporting form.

Due to the tremendous impact that the loss of a license can have, an increasing number of older people are challenging the DMV's decisions. They are bringing lawsuits not only against the Driver Safety Branch, but also against the physicians who have reported them. Most of these people deny the problems that are being observed by family and their physicians. An individual who has Alzheimer's disease is almost always unaware of the range and extent of his or her cognitive deficits. It is important, therefore, that physicians be familiar with §103900, which explicitly states which medical conditions must be reported, and states the scope and limits of the confidential relationship between physician and patient under this particular set of circumstances.

The case study given below highlights such a situation.

A Case Study

Facts

In 1997, a 75-year-old woman failed two attempts at her written driving test, but passed on the third try. Shortly after the renewal of her license, she was evaluated at a local memory clinic and found to have serious cognitive deficits that reflected poor short-term memory and difficulty with attention, particularly when she had to divide it between competing stimuli.

When another neuropsychological evaluation was requested by the woman's husband, she was already 79 years of age. At the time for renewal of her license, she had failed the written test and was denied the privilege of renewing her license. The denial led the patient's husband to seek out an attorney to dispute the DMV decision. The attorney, however, suggested that a full neuropsychological evaluation be undertaken, for the purpose of clarifying what cognitive abilities the patient retained and what relationship they would bring to bear on the strength of a possible challenge to the DMV's decision.

The patient herself did not consider any of her "reported" cognitive impairments as affecting her ability to drive. She stated that she had never had an accident and felt that she would continue to be a good driver. She and her husband, however, had recently relocated from another part of the state to the Bay Area to be nearer their children. She had no concern that attention to new details of the road, and familiarizing herself with different traffic patterns and pedestrian activity, would pose any problem to her whatsoever.

Test Results

The test results revealed that the patient had little difficulty expressing herself or understanding directions. Yet, they indicated the presence of a frontal lobe-type dementia. In practical terms, this meant that she could not divide her attention between two competing stimuli. This certainly would pose a risk in a driving situation, given how many competing stimuli there are demanding focus (such as attention to traffic lights, other vehicles, and pedestrians). She lacked cognitive flexibility and could not think at a conceptual level that would allow for quick rearrangement of information should that be necessary in a driving situation. Furthermore, she could not sequence information or set priorities as to what stimuli to pay attention to first, second, or third. This latter deficit would be a significant liability in a driving situation, particularly in a crowded urban area where there are so many variables beyond the control of the driver herself.

She also had difficulty on a test assessing the ability to integrate spatial with motor information. This is a fundamental cognitive skill underlying driving. Her reaction time was below average, as measured against norms for individuals in her age group. She also evidenced a deficit with directional orientation, confusing right with left repeatedly. Her verbal short-term memory was more intact than her visual short-term memory. For driving capacity, however, it is the latter that is more important. Furthermore, given that she had just moved to a new area, she would need to rely on visual memory to help orient herself in this unfamiliar environment.

Conclusion

It was the evaluator's opinion that there were enough cognitive and motor deficits to warrant the DMV's decision. The examiner felt that the patient was at a high risk for injury, both to herself and others, should she challenge the DMV's decision through legal representation.

APPENDIX J
Sample Questions and Answers Showing Masking Statements by Clients With Dementia

The following examples of statements were made by clients who were found to have significant cognitive losses beyond normal age changes. In each case, the individual, in fact, was diagnosed with a dementing condition severe enough to call into question his or her capacity to function independently after a neuropsychological evaluation was completed.

These examples have been provided by Vivian Clayton, Ph.D.

Question (asked of a 98-year-old man, in assessing retention of long-term memory): "Where does the sun rise?"

Answer: "In the sky."

Question: "But what part of the sky?"

Answer: "Honey, at my age, that I see it rise at all, is what counts."

Question (asked of a bruised client who had repeatedly fallen without informing the family): "Where did you fall?"

Answer: "I fell on the hard wood floor."

Question: "Who painted the Sistine Chapel?"

Answer: "Outside or inside?"

Follow-up to Question: "Inside."

Answer: "I don't know but he did a good job."

Question: "Who wrote Hamlet?"

Answer by one patient: "An old timer."

Answer by another patient: "You tell me—then we'll both know."

Question (asked of a client whose diagnosis was frontal lobe-type dementia, a diagnosis that implies difficulties with organizing and sequencing of things and renders the individual functionally more vulnerable to undue influence): "What state are we in?"

Answer: "The state of confusion."

Question: After reading several paragraphs, the client is asked what he or she remembers.

Answer by one patient: "Not much, she (the woman in the story) didn't impress me."

Answer by another patient: "I don't know—every time I look at you, I forget: Why is that?"

Question: After being presented with a series of pictures showing people interacting, the client is asked: "What is going on between the three people in this picture?"

Answer: "Mind if I correct you? — It's 'what is going on among the three people.'"

Note: Despite his proper use of grammar, the client was not able to figure out what was happening in the picture even though underlying each scene was a particular theme that was discernible given intact cognitive functioning.

Question (asked of an 80-year-old client whose mail had accumulated in piles all around the house, whose phone and gas had been turned off innumerable times, who could no longer sign checks, having lost the ability to write, and whose daughter had been paying bills out of a joint checking account for years): "Why is your daughter paying all of your bills?"

Answer: "Because I asked her to do it."

NOTE: This client denied the severity of her memory loss and said she was forgetful just like "everyone" of her age.

APPENDIX K
Global Deterioration Scale for Assessment of Primary Degenerative Dementia and Functional Assessment Staging Tool (FAST)

The Global Deterioration Scale is used in psychiatry for the assessment of primary degenerative dementia and delineation of its stages and clinical characteristics from (1) no cognitive decline or (2) very mild cognitive decline through (3) mild cognitive decline, (4) moderate cognitive decline, and (5) moderately severe cognitive decline to (6) severe cognitive decline and (7) very severe cognitive decline. B. Reisberg, M.D., S.H. Ferris, M.J. de Leon, and T. Crook developed the Global Deterioration Scale published in the American Journal of Psychiatry (139 Am J Psychiatry 1136 (1982)). These authors have used the Global Deterioration Scale successfully and have validated it against behavioral, neuroanatomic, and neurophysiologic measures in patients with primary degenerative dementia. To view the published version of the Global Deterioration Scale (for a modest fee), see http://ajp.psychiatryonline.org/cgi/content/short/139/9/1136.

The Global Deterioration Scale is supplemented by the Functional Assessment Staging Tool (FAST) developed by Dr. Reisberg. The FAST assigns a score based on the highest consecutive level of disability, with specified disabilities for each level of decline in order of severity, including physical and mental disabilities affecting daily living activities such as dressing, bathing, and toileting and more extreme disabilities associated with (6) severe cognitive decline and (7) very severe cognitive decline. See http://geridoc.net/assessmenttools.html.

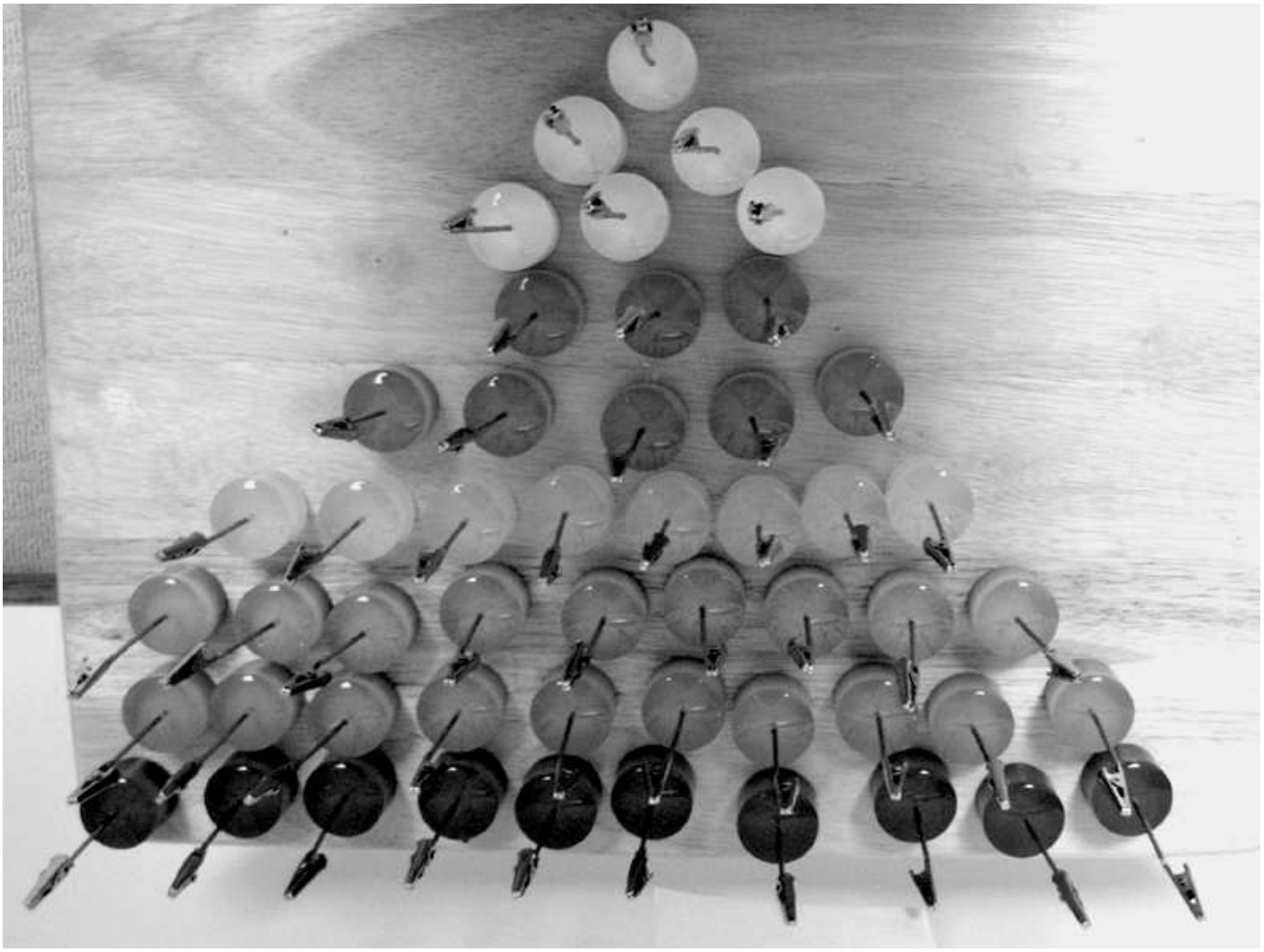
APPENDIX L
Neuropsychologist's Case Illustration of Technique Using Visual and Motor Skills to Recall Personal Information

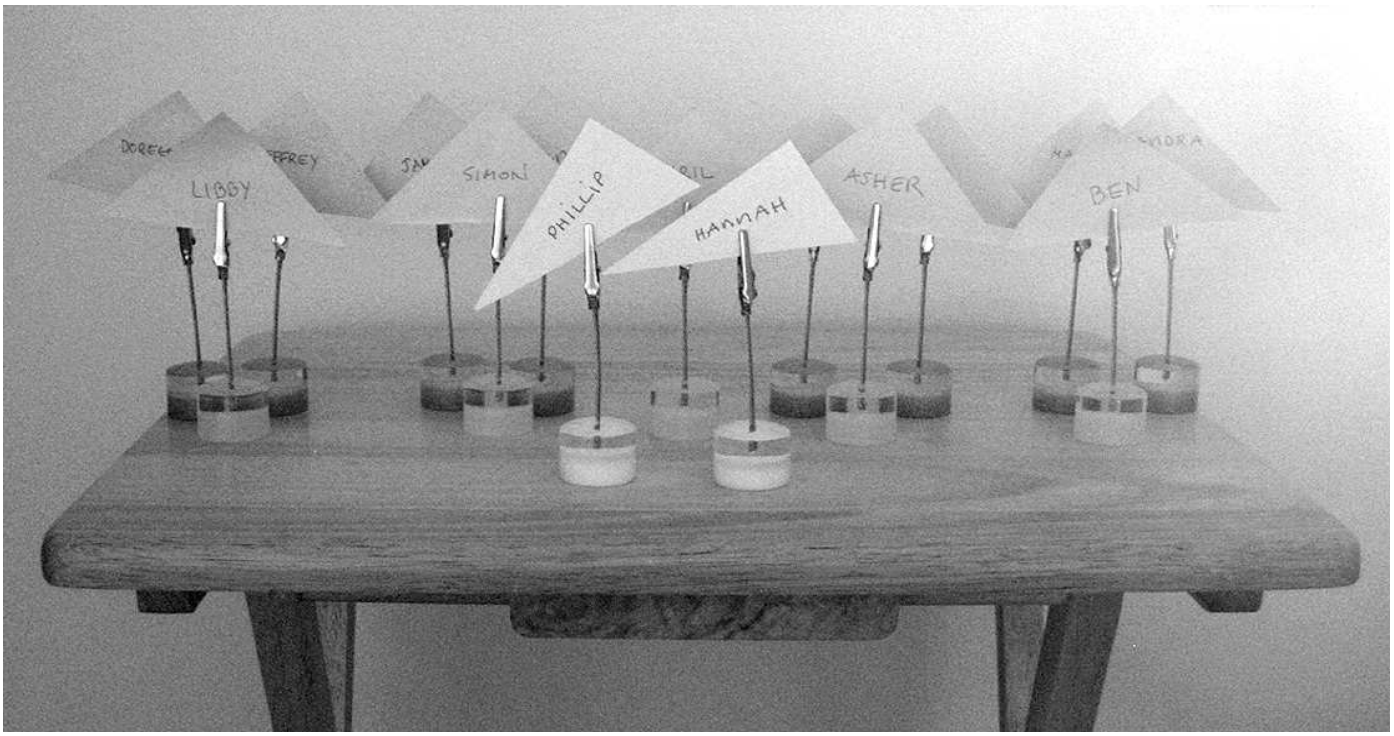
The Facts

Recently, the author was asked to evaluate a 96-year-old woman whose long-standing and progressive dementia brought into question whether she had the capacity to amend her trust. In reviewing the estate planning documents, her lawyer discovered that the wording in her trust was such that it left interpretation as to who would inherit her estate. The potential beneficiaries could include not only her five living children, but her 18 grandchildren as well. The lawyer knew, from early discussions with the client, that she intended her estate to be passed on only to her adult children. However, disputes within the family prompted concern that after the death of the elderly woman, there could be a challenge to her trust, based on the lack of clarity on this particular issue. The client herself now had significant word-finding problems, and often did not seem to understand questions asked of her that required problem-solving or conceptual understanding.

Neuropsychologist's Technique

A pyramid was created with these memo clips. The client was at the apex, her name attached to the alligator clip at top, in a color matching the resin base (white). Then, behind her clip, the names of the five children were displayed, each with his or her own memo clip, all in the same color, but different from the client's (yellow). Finally, behind each adult child's name, were grouped his or her children. Each grandchild had his or her own memo clip. The members of this third generation were all coded in green. See photographs below.





Client Responses

The client was directly asked to identify each level in the pyramid. She was able to do so without hesitation. "These are my children (pointing to the yellow based clips)"; "These are my grandchildren (pointing to the green based clips)." The client was then asked, "When you die, how do you want your estate distributed?" She responded immediately, and with emphasis, "Just the children." She was asked to point out who were her children.

She pointed to each of the yellow based memo clips. She was then asked, "Do you want your grandchildren to receive anything?" She replied, "The children will take care of the grandchildren."

Additional Tests

Just to increase the examiner's certainty of her responses, this client was then shown a two-dimensional pyramid, with each generation again coded in a different color. The colors, however, were different from those used in the three-dimensional memo clips. Again, the client immediately grasped the separation of generations created by the different colors. The question was asked again: "When you die, how do you want your estate distributed?" The client ran her hand along the line in the pyramid on which her children's names were written. See diagram below.

Diagram of Two-Dimensional Pyramid													
						T							
					S1		**S2**						
				C1		**C2**		**C3**					
			N1		**N2**		**N3**		**N4**				
		G1		**G2**		**G3**		**G4**		**G5**			
	GN1		**GN2**		**GN3**		**GN4**		**GN5**		**GN6**		
GG1		**GG2**		**GG3**		**GG4**		**GG5**		**GG6**		**GG7**	

T = testator; S = sibling; C = child; N = niece or nephew; GC = grandchild; GN = grandniece or grandnephew; GG = great-grandchild

APPENDIX M
Partial List of Causes of Dementia

Degenerative Dementias. Alzheimer's disease; frontotemporal dementias (*e.g.,* Pick's disease); Lewy body disease; Parkinson's disease; multiple system atrophy; Huntington's disease.

Head Injury. Subdural hematoma (*i.e.,* collection of blood between skull and brain, causing pressure on brain); brain damage due to trauma (*e.g.,* motor vehicle accident).

Infection. Syphilis; Lyme disease; HIV/AIDS; tuberculosis; prion disease (*e.g.,* Creutzfeldt-Jakob disease); fungal, bacterial, and viral infections.

Cancer. Primary brain tumor; metastatic brain tumor (*e.g.,* from lung cancer); remote effect of cancer elsewhere in the body on the brain.

Disorders Associated With Heart, Lungs, Blood, and Blood Vessels. Heart failure; single or multiple strokes; insufficient oxygenation of the blood; anemia.

Metabolic and Hormonal. Liver dysfunction; kidney dysfunction; hormone imbalance (*e.g.,* hypothyroidism); electrolyte imbalance (*e.g.,* low sodium).

Nutritional. Vitamin B12 deficiency; folate deficiency; niacin deficiency.

Toxic. Alcohol; metals (*e.g.,* lead); gases (*e.g.,* carbon monoxide); solvents (*e.g.,* industrial chemicals, refrigerants, cleaning agents).

Psychiatric. Depression; schizophrenia.

Medications. Heart and blood pressure medication (*e.g.,* propranolol); cancer chemotherapy medications (*e.g.,* methotrexate); tricyclic antidepressants (*e.g.,* amitriptyline); anticonvulsants (*e.g.,* phenytoin).

Other. Hydrocephalus (*e.g.,* normal pressure hydrocephalus); Wilson's disease; multiple sclerosis; brain irradiation; systemic lupus ecythematosus.

APPENDIX N
Partial List of Risk Factors, Precipitants, and Causes of Delirium

Medical Condition. Acute, severe illness; multiple coexisting conditions; terminal illness; pain; fever or hypothermia (*i.e.,* body temperature too low); infection (*e.g.,* urinary tract infection, pneumonia); dehydration; overhydration; heart, liver, or kidney failure; electrolyte imbalance (*e.g.,* sodium level too high or too low); blood sugar abnormality (*e.g.,* too high or too low); major surgery; central nervous system disturbance (*e.g.,* seizure, head trauma).

Preexisting Status and Condition. Advanced age; malnutrition; sleep deprivation; cognitive impairment; dementia; vision or hearing impairment; immobility; impaired functional status.

Environmental. Novel environment; extreme sensory under- or overstimulation; social isolation; admission to intensive care unit; use of physical restraints; emotional stress.

Medications. Over-the-counter cold and sleep preparations (*e.g.,* diphenhydramine, chlorpheniramine); nonsteroidal anti-inflammatory drugs used for inflammation, pain and fever, (*e.g.,* ibuprofen); tricyclic antidepressants (*e.g.,* amitriptyline); lithium carbonate used for bipolar disorder; H2 receptor blockers for peptic ulcer disease (*e.g.,* cimetidine).

Substance Abuse. Alcohol; benzodiazepine antianxiety medication; opiate pain medication; sleeping pills.

Withdrawal Syndrome. Alcohol; opiate pain relievers; benzodiazepine antianxiety medication; certain sleep promoting medications; barbiturates.

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