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Précis Paper

Assessing Testamentary Capacity from a Medical Perspective

A discussion of the use of medical experts in assessing testamentary capacity.

Discussion Includes

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Assessing Testamentary Capacity from a Medical Perspective

In this edition of BenchTV, Dr Jane Lonie (Consultant Clinical Neuropsychologist) and Anthony Cheshire SC (Barrister – Eight Wentworth Chambers, Sydney) discuss the criteria that must be met in assessing testamentary capacity, with particular focus upon the use of medical experts and how they may assist legal practitioners in assessing testamentary capacity.

Testamentary capacity

1. The test for testamentary capacity comes from the 1870 case of *Banks v Goodfellow* (1870) LR 5 QB 549. Testamentary capacity can be described as the capacity to understand the extent of property available, the claims that may be made upon the property, and ensuring that there is not a disorder on the mind and no mental delusion.

2. There is a legal criteria laid out by the *Banks v Goodfellow* case, and the task of the medical expert is to ascertain what cognitive abilities are required for the testator to meet that criteria. It must be asked whether there is a condition that the testator is suffering that may compromise any relevant area of cognitive function, and to assess those relevant areas.

3. Medical experts must be aware of the relevant legal criteria that they have been asked to assess. The first task is to determine whether there is any condition, or any evidence of cognitive compromise which could threaten the client's ability to fulfil that criteria.

4. The mapping process in assessing capacity requires there to be a consideration of the complexity of the estate and the decisions that need to be made around the distribution of the estate. There is interplay between the complexity of the decision in the individual testator's case, and the level of cognitive ability that is required to carry out that decision making process.

5. There are situations where testators wish to make a will, or make changes to a will that gives rise to some cognitive impairment requiring assessment of testamentary capacity. Alternatively, there are cases of retrospective analysis.

6. In circumstances of retrospective analysis, a medical expert is reliant upon the quality of the medical evidence available, which is not always as detailed as one would like it to be. There are many patients that go through the hospital system and are never properly assessed from a cognitive perspective.

7. A medical expert will have the medical notes and the detailed knowledge of how different medical conditions manifest in a cognitive sense. This gives one a good starting point as to

where one might expect them to have been at the time of making the will, cognitively speaking.

8. There are cases, particularly retrospective cases, where the medical evidence that is available does not necessarily allow the medical expert to make a retrospective diagnosis with any degree of certainty. In such a case, the expert is not able to rely on that knowledge.

9. Conditions such as dementia give rise to different levels and types of cognitive impairment at different stages of the condition. The emphasis on medical diagnosis is really just a guide as to what should be considered in terms of determining whether that testator is likely to have met the *Banks v Goodfellow* standard – the diagnosis itself is not the crucial part in determining capacity.

10. Legal practitioners should ensure that medical experts provide very comprehensive, scientifically based reasoning from which they have reached their conclusion. It is that scientific basis and the specialist knowledge that the expert is able to offer the judiciary that is more important than the expert's overall opinion.

11. It is necessary to have a good understanding of the family that is involved – the family structure, the complexity of the estate, any other business or family matters that might have possible implications and so on. If possible, some sort of history of relationships within the family is useful, and some indication of the value of the estate and the various components of the estate.

12. It can be difficult to assess the accuracy of information a testator is providing you when a testator does not want other family members involved. However, there are good means of verifying the information that the testator provides to the legal practitioner, for example a medical expert may ask for the medical records of the testator. The medical professional should always obtain authority to access such information.

13. Assessments of testamentary capacity can typically range from 3-4 hours so it is a very detailed assessment.

<u>Good day/bad day argument</u>

14. The idea that you can ward off claims on grounds that a will was made, altered or changed during a lucid interval is flawed, particularly in the context of dementia. A lucid interval refers to changes in levels of a client's attention and their levels of arousal.

15. What does not change in a client with dementia, whether or not they are having a moment of mental clarity or they are confused, are the underlying cognitive impairments in memory and executive functioning.

16. Some days an individual's levels of arousal and attention may be better than others, and the individual may appear to be mentally alert. However, you will still have the same levels of underling executive and memory impairment. The difficulty is that if an individual has impairments that are there permanently and constantly, they may not always be manifest.

Assessing cognitive function

17. The Mini-mental State Exam (MMSE) commonly used to assess capacity, is problematic because it does not assess executive function at all, which is thought of amongst medical experts as the most significant aspect of cognition when it comes to testamentary capacity.

18. When making a will, solicitors are encouraged and expected to ask questions such as 'what assets do you have, how many children do you have, why are you leaving your assets this way?' and so on.

19. It is suggested that a good starting point in assessing testamentary capacity should be open ended questions around the *Banks v Goodfellow* criteria. By using medical experts' knowledge of how the brain breaks down in dementia, and what skills are lost and how those skills are crucial to meeting the *Banks* criteria, it is possible to refine the practice used by solicitors.

20. Asking questions such as why a testator has distributed their estate in a certain way is getting at an aspect of executive functioning and memory function to some degree. There are certain ways that solicitors could formulate open ended questions around *Banks* that would maximize the legal practitioner's ability to recognise anything untoward.

21. There is a lack of knowledge among practitioners as to what cognitive requirements are necessary to meet *Banks*, and how the loss of cognitive function can manifest itself in terms of not being able to meet that criteria.

22. Executive deficits are, by their nature, very hard to pick up. Things such as insight, reasoning and judgment are not the sorts of things that are necessarily going to come up in surface conversation. This is made more difficult by the fact that with many forms of dementia, a client will maintain what is referred to as a good social façade for a long way into their dementia.

23. Cognitive function is the umbrella term for brain function – there are a number of recognised primary domains of cognitive function. Executive functioning is one of those areas. Language function, processing speed and visio-spacial are other examples. There are defined systems or networks within the brain that perform certain cognitive functions.

Irrational or unusual decisions

24. In recent decisions, most of the basis of the arguments around testamentary capacity focus on the last two limbs of *Banks v Goodfellow*, being the issue of whether there is a disorder on the mind or a mental delusion.

25. Most forms of dementia do not typically erode our semantic memory system until a much later stage. In terms of being able to understand who your beneficiaries are, most people retain knowledge of their family and those that are close to them well into the late stages of all forms of dementia.

26. It would be hard to argue that a person lacked capacity on a basis that the decision that they made did appear to be irrational or unusual. If the irrational or unusual decision was made on a backdrop of established cognitive and executive impairment, this would lead one to question whether the issue was one of capacity.

27. A delusion or a thought process that is not based in reality, is not liable to changing as a result of explanation or reasoning on somebody else's part. A delusion is different from a mistake or false belief. Many neurocognitive theories of delusion suggest that the reason those delusions aren't amenable to change as a result of reasoning is because they are occurring on a backdrop of frontal lobe deficits. In such circumstances, the reasoning process and the self-monitoring and checking process is not there for the person to enable them to self-correct their thinking.

Normal ageing processes vs serious cognitive impairment conditions

28. Neuropsychology is very well placed to address the question of distinguishing between ordinary markings of old age and slowing down of capacity versus the lack of testamentary capacity. This question is addressed commonly in assessing the presence of early stages of dementia.

29. Medical professionals in clinical practice are routinely differentiating between what are cognitive changes that occur as part of a normal ageing process and more serious impairments such as dementia.

30. It is fairly easy to see when cognitive changes are within what is generally expected for normal ageing, when compared against average standards that have been developed.

31. The issue of change arises most commonly in a situation where a client or patient presents with a degree of cognitive impairment – that there is some uncertainty about whether that is going to progress. The term for this is 'Mild Neurocognitive Disorder'. Around 30% of those patients over a 3 or 4 year period will convert to dementia.

32. The time period within which you consider a patient's condition will depend upon the instrument you are using to measure cognitive function. It also depends upon the practice effects associated with that instrument, and the reliability of the instrument.

Determining which kind of expert to consult

33. There is a good deal of overlap in the skill sets of the various medical professions that become involved in legal capacity assessments.

34. It would be helpful if the legal practitioner was able to briefly, on a surface level, discuss the situation with a medical expert, or give an outline of a situation highlighting the key areas prior to appointing the medical expert to ensure that they have the particular skill set necessary for whatever the question is.

35. As our knowledge progresses in terms of how the brain affects the ability to fulfil the *Banks* criteria, particularly in instances of dementia, in a way things become more complex as we understand more about what is going wrong and at what point in time, and how that manifests.

36. Social cognition is a form of thinking that allows an individual to interpret social ques, empathize with others, or to feel along the lines of what somebody else may be feeling. This is a relatively new area of neuroscience, but it is known that in many forms of dementia this social cognition is affected. As our understanding of cognitive loss in dementia becomes more sophisticated, the task of assessing capacity becomes more complex.

37. Along with executive impairment often comes a loss of insight on the part of the client. This can be a very difficult situation, particularly if you do not have a way of verifying the information the client is giving you.

38. It is known that the changes that ultimately give rise to dementia occur, or start to occur, in the brain and accumulate for more than 20 years prior to the point at which a GP or specialist

will diagnose the illness. However, for a legal practitioner it is important to be aware that the absence of a diagnosis does not equate to the absence of cognitive impairment.

Key takeaways

39. Practitioners, particularly those that specialise in wills and estates, should be aware that 1 in 10 clients over the age of 65, and 3 in 10 over the age of 85 have dementia. This means you are likely to encounter clients with some degree of cognitive impairment. As part of that cognitive impairment, the individual may lack insight or awareness into the fact that they are impaired.

40. It is good practice to ensure that whether or not the client comes in with somebody, for example a family member or friend, that they are interviewed on their own. This is important as it enables the practitioner to determine what the client can tell you by themselves.

41. It is also advised to pay attention to who is making the arrangements for the consultation – who is driving the process? This is important because it is a common issue seen by solicitors that family members may be driving the elderly and frail to make new wills or change their existing will.

42. This situation can present a difficulty for the practitioner in that they will have to deal with the family dynamics and may need to raise questions which may be seen as intrusive. This issue can be aided by firstly building rapport with the client, and ensuring to explain why such information is required, so that they understand the fact that ultimately it is in their best interests to reveal the necessary information.

43. Legal practitioners should pay close attention in the early stages of the process to the skill set that is required to address the client's situation. In terms of getting the best quality of assessment and report, it is important to try and match the particular skill set needed by your client with the expert.

44. Many GP's are reluctant to provide opinions as to elderly people's fitness to execute legal documents such as wills. They do not want to involve themselves in a legal arena as they are often not aware of the relevant legal criteria. Even if they were, there is an assumption that many medical practitioners have training and knowledge in cognitive functioning and brain function, and how to assess that – but that is commonly not the case.

45. As a legal practitioner, if there is doubt as to the client's capacity, it is necessary to investigate the issue properly, and satisfy the doubt affirmatively one way or another.

46. In regards to an opinion from a medical expert, the Courts require reasoning for that opinion. If it cannot be explained why any element of the *Banks v Goodfellow* criteria cannot be met, then in many ways the opinion cannot really be evaluated.

47. For this reason, it is recommended that practitioner's, both legal and medical, should keep very detailed notes, not just of their findings and the questions they have asked, but also notes as to their inquiries, the reasons why they are making such inquiries and what their thought processes are.

BIOGRAPHY

Dr Jane Lonie

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Dr. Lonie completed an undergraduate psychology Honours degree and a Clinical Neuropsychology Masters degree at Macquarie University in 1999. In 2010, she completed a PhD with the University of Edinburgh's Department of Psychiatry, investigating neurocognitive markers of early and pre-clinical Alzheimer's disease. Dr. Lonie's medico-legal experience extends to assessment, report writing and court appearances for the purposes of provision of expert opinion regarding capacity.

Anthony Cheshire SC

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Anthony Cheshire SC graduated in law from the University of Oxford. He was called to the Bar in London in 1992. He was then called to the New South Wales Bar in 2004 and appointed silk in 2015. Anthony maintains a wide ranging trial and appellate practice across the civil and equity jurisdictions; and appears in many inquiries, including most recently as counsel assisting the Inquiry into the New South Wales Branch of the Returned and Services League. Anthony also provides advocacy training and lectures extensively.

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