Testamentary capacity, the ability to make a will, is a legal issue that physicians are frequently, either directly or indirectly (e.g., records), involved with. Approximately 3% of all wills will be challenged, with about 1% being found invalid. Often, when a will is challenged, the individual’s estate remains in probate for years, incurring expenses and causing hardships and frustrations for families and friends.

In the United States, legal challenges to wills became common during the mid-1800s for three reasons:

1. The first reason was because a larger percentage of the population was beginning to acquire wealth, resulting in more legal challenges over issues of inheritance.
2. The second was because of “new” medical and legal theories regarding insanity and mental illness, which were espoused by individuals such as Isaac Ray, MD, in A Treatise on the Medical Jurisprudence of Insanity (1838).
3. The third was legal ambiguity regarding what constituted a sound mind.

Benjamin Rush, MD, one of the founding figures in American psychiatry and a signer of the Declaration of Independence, wrote, “There are instances in which madmen talk rationally, but write incoherently.” Because of Rush’s influence, this concept of ambiguity became the basis for breaking a will when no clear evidence of insanity was present except for an upset heir.

The frequency with which wills are challenged is expected to increase during the 21st century for a multitude of reasons, some of which are similar to factors that occurred in the 1800s. Before the recent financial troubles, it had been estimated that $41 trillion of wealth would be transferred before 2050 by means of inheritance. Legal and medical systems are again having to fine-tune legal concepts, which are being strained by the fact that individuals are living longer and, therefore, are more likely to experience symptoms of dementia around the time wills are written or the individual dies. Recent figures indicate that 4.5 million persons in the United States have Alzheimer’s disease (just one of many causes of dementia), twice as many as in 1980, and this increasing trend is expected
to continue.\cite{11} Typical family structures have become more complicated since the 1800s (e.g.,
stepchildren, frequency of divorce, family members living in different legal jurisdictions), resulting in
more people laying claims to and challenging inheritances.\cite{4-6}

Unfortunately, most doctors, even those who primarily see patients of advanced years, are not
knowledgeable about key issues surrounding testamentary capacity. A study in 2002 found that only
7\% of general practitioners, psychiatrists, geriatricians, and medical students near completion of their
training could answer basic questions regarding testamentary capacity.\cite{12} A physician’s lack of
knowledge concerning testamentary capacity serves our patients poorly (Table I). We must be
knowledgeable if we are to help our patients when they seek our advice about issues such as making
wills, initiating advance directives, defining health surrogates, and other legal matters related to
healthcare and death. In addition, if there is a legal challenge to a will, our medical records are likely to
become key documents in subsequent legal actions and should address expected key issues and facts.

**Brief History of Testamentary Law**

All societies, whether through religious practice or some form of governmental decree, have a
system to determine inheritance. This article will focus on Roman and English law since they are the
primary basis for many of the current laws in the United States.\cite{1,13}

Early Roman law developed a system whereby a person’s guardianship and control of his or her
property was determined by his or her paternal relatives. In 529-534 AD, Emperor Justinian created the
Corpus Juris Civilis (Body of Civil Law), a unified collection of fundamental works of jurisprudence (legal
philosophy) dating back to the rule of Emperor Hadrian (76-138 AD). The Corpus Juris Civilis (also
known as Roman Law, Code of Justinian) became the basis for Canon Law (the ecclesiastical law of the
Catholic Church).\cite{14} The Corpus Juris Civilis recognized that it was “Soundness of mind, not health of
body, [which was] required of a testator when he makes a will.”\cite{1,13}

By the 1100s, when Rome’s influence over northern Europe was beginning to wane, Anglo-
Saxon law established the inheritance pattern of “primogeniture,” where the eldest son inherited the
family estate and title.\cite{1,13,15} In 1540, Henry VIII passed the Statute of Wills, which allowed competent
landowners to “bequest by will” how their estates would be disposed of instead of them simply passing
by lineage.\cite{1,15} The Statute of Wills and the 1677 Statute of Frauds also established other practices of
will-making that exist today, including that a will must be in writing, a will must be signed by the
testator, and the signing of the will needs to be witnessed by at least two other persons.\cite{1,15,16} The
Statute of Wills also made the ability to create a will a statutory right (governmentally defined, not a
fundamental or natural right), and one that could only be engaged in by an individual who had a
“sound and disposing mind.”\cite{1} These two principles gave the courts permission to comment on the
conveyance of property postmortem and also raised the question of who would determine if a testator
had a “sound and disposing mind.”\cite{1}

In the 1800s, there were two competing views in Anglo-Saxon law on what determined
competence. The first, highlighted in the 1848 English case of Waring v Waring, is known as the
“perfect memory rule.”\cite{13,17} This rule required an individual to be “in a perfect mental state” in order to
execute a will, since determining the degree by which a mental illness hindered one’s ability to write a
will was considered beyond the court’s ability.\cite{13} One was either all sound or all unsound. The second
view of competency evolved from the 1848 Georgia case of Potts v House where the “mere glimmer
rule” was defined. This rule required an individual only “to have the mere glimmer of reason” in order to execute a will and protect the individual’s testamentary rights.

The generally accepted criteria for determining whether an individual was competent to make a will in countries that followed the Anglo-Saxon legal tradition was finally determined in 1870 by Lord Cockburn in the case of Banks v Goodfellow. In his written opinion, Lord Cockburn defined the five basic requirements for determining testamentary capacity. These criteria have become known as “Lord Cockburn’s Rule” and are still the basis for most American and English commonwealth inheritance laws, as well as those in several countries outside of the commonwealth.

Of historical interest, it is known that Lord Cockburn was aware of Isaac Ray’s, A Treatise on the Medical Jurisprudence of Insanity (1838). Lord Cockburn read from it when he defended Daniel McNaghten during a precedent-setting insanity trial in 1843. In addition, one year after the Banks v Goodfellow decision, Isaac Ray testified in the Pennsylvania case of Pidcock v Potter, where in his testimony he reached a conclusion about testamentary capacity similar to that elucidated by Lord Cockburn.

It is also of historic interest to note that Lord Cockburn had no legitimate heirs to leave his title to, although he had one illegitimate heir to whom he was not able to pass his title. It is interesting that both Henry VIII and Lord Cockburn, the two individuals who did the most to shape current legal concepts regarding wills, had concerns regarding heirs.

**Lord Cockburn’s Rules**

The first of Lord Cockburn’s rules requires that a testator understand the nature of the act he or she is engaging in. The individual must know that he or she is writing a will and what a will is (i.e., a legal document that determines how assets are to be distributed). The second rule is that the individual has to appreciate the effect of his or her act (e.g., distribution of wealth). The third is that the individual must know the extent of his or her bounty (e.g., property) in order to be able to appreciate the significance of the decisions he or she is making. The fourth is that an individual “shall be able to comprehend and appreciate the claims to which he ought to give effect” (e.g., those who should be included and excluded) or, as it is commonly phrased in current language, “know their natural heirs.” The final component of Lord Cockburn’s rules is “That no insane delusion shall influence his will.” In the case of Banks v Goodfellow, the individual who wrote the will was suffering from the paranoid delusion that a factious individual was trying to harm him. During the course of the trial, it was determined that the delusion did not influence Mr. Banks’ decision to leave his money to a niece by marriage rather than some remote blood relatives.

<table>
<thead>
<tr>
<th>Summary of Lord Cockburn’s Rule</th>
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<tbody>
<tr>
<td>Testator understands the nature of the act he is engaging in (understands what a will is, understands he is making a will)</td>
</tr>
<tr>
<td>Testator appreciates the effect of his act</td>
</tr>
<tr>
<td>Testator understands the extent of his property</td>
</tr>
<tr>
<td>Testator knows his natural heirs</td>
</tr>
<tr>
<td>No delusion/mental illness is influencing the provisions of the will</td>
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focused on where the trier of fact (e.g., judge or jury) should focus attention to determine whether the testator does, in fact, have “capacity” to execute a will (Table II).

**Why Wills Are Challenged and the Question of Undue Influence**

In a 2005 review of why wills are challenged, Shulman et al found two common reasons for challenges and two common characteristics of wills that are challenged. The primary reason a will was challenged was due to a dramatic or “radical” change from a previous will or inconsistently expressed wishes of the testator (72%). The second reason was because of alleged undue influence (56%). The characteristics of wills that were challenged included: (1) cases where the decedent had no biological children (52%); and (2) cases where the will was written less than one year prior to the testator’s death (48%).

The most frequent comorbid psychiatric conditions found in cases where wills were challenged included: (1) dementia (40%); (2) alcohol abuse (28%); and (3) other neurological/psychiatric conditions (28%). These medical conditions/states provided a strong basis for challenge and are often related simply to aging or to a concurrent history of psychiatric disorder/substance abuse. (See the section on “The Medical Professional’s Role When Wills Are Challenged” for additional information on illnesses, including dementia, that put persons at high risk for having their testamentary capacity challenged.)

Challenges based on undue influence, historically, were most likely to be successful. Undue influence occurs in relationships where there is a power imbalance or a dependency, and where the power imbalance is used to influence (e.g., coercion, compulsion, deception) the weaker party to secure changes in how assets are distributed to the stronger individual. Although the exact legal definition of undue influence changes from state to state, the above description contains the general notions found in most jurisdictions (see box on this page). Undue influence can be exerted by family members, “friends,” professionals (e.g., lawyers, accountants, physicians, spiritual leaders), and/or caretakers. Undue influence can be difficult to prove. Often, courts will look for evidence of harassment/pressure, threats of abandonment, or intentional lies that result in negative feelings to other heirs. Rarely are overvalued friendships, increased attention, the rendering of services, or insincere or excessive praise or flattery considered enough evidence of undue influence to break a will. When undue influence is perpetrated by a family member, there is often a history of family discord, with the individual responsible for exerting the influence, feeling “entitled” to the estate for services rendered and sacrifices made.
Shulman et al,\textsuperscript{5} writing about Canadian law, modified Lord Cockburn’s rules to include the additional requirement that “the individual’s wishes can be expressed clearly and consistently.” Depending on the legal philosophy of the people applying the law, this interpretation can, at times, be controversial, especially in the United States, where individual and financial autonomy are highly valued.\textsuperscript{1,15,27} Shulman et al saw testamentary consistency as being an important and crucial way to protect aging individuals from being taken advantage of, when they may be more susceptible to undue influence due to environmental factors (e.g., need for a caretaker) and/or medical conditions. They recognized that an individual may change his or her mind, which is why they included the word “clearly” in their criteria. They were especially concerned that individuals with dementia can at times pass the Cockburn criteria even though they do not fully understand the “consequences” of changing their wills due to their dementia especially in complex or conflictual family environments.”\textsuperscript{5}

It is not uncommon for persons who exert undue influence over a testator to try to incorporate professionals such as doctors, lawyers, or accountants into their efforts to control the individual.\textsuperscript{25} Physicians should question whether they are being manipulated by caretakers who are guilty of exerting undue influence when requests for a competency evaluation are initiated. If there is a legal challenge, primary care physicians often will be asked if they witnessed behavior suggestive of undue influence. For this reason, it is important that physicians are familiar with the concept and potential warning signs that an individual is exerting undue influence. Signs of potential elder abuse/undue influence that a physician may observe include refusal to leave the patient alone during the evaluation, a history of the individual being isolated by the caretaker, or the caretaker making repeated demeaning or derogatory

<table>
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<tr>
<th>General Warning Signs Indicating Undue Influence</th>
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<tr>
<td>1. Elderly person's actions inconsistent with past longstanding values/beliefs.</td>
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<tr>
<td>2. Older person making sudden changes in financial management that enrich one individual.</td>
</tr>
<tr>
<td>3. Elderly person suddenly changes his/her will or disposition of assets, belongings, or property and directs assets toward one individual, who is not a natural “object of their bounty.”</td>
</tr>
<tr>
<td>4. Caretaker dismisses previous professionals and directs older person to new ones (e.g., bankers, stockbrokers, attorneys, physicians, realtors).</td>
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<tr>
<td>5. Elderly person isolated from family, friends, community, and other stable relationships.</td>
</tr>
<tr>
<td>6. Nonfamily caretaker moves into the home or takes control of daily schedule.</td>
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<tr>
<td>7. Older person directs income flow to caretaker (e.g., Social Security benefits, pensions, trust distributions).</td>
</tr>
<tr>
<td>8. Wills, living wills, or trusts altered with new caretaker or friend as beneficiary/executor.</td>
</tr>
<tr>
<td>9. Elderly person develops mistrust of family members, particularly about financial affairs, with this view supported by new friend, acquaintance, or caretaker.</td>
</tr>
<tr>
<td>10. Older person finds new caretaker guaranteeing lifelong care if he/she gives caretaker his/her assets.</td>
</tr>
<tr>
<td>11. Elderly person in relationship characterized by power imbalance between parties, with caretaker assuming restrictive control and dominance.</td>
</tr>
<tr>
<td>12. Caretaker or friend accompanies elderly person to most important transactions, not leaving him/her alone to speak for himself/herself.</td>
</tr>
<tr>
<td>13. Elderly person writes checks for cash, in round numbers or large amounts, or gives cash gifts to caretaker or caretaker’s family.</td>
</tr>
<tr>
<td>14. Older person increasingly helpless, frightened, or despondent, feeling that only the caretaker can prevent his/her further decline.</td>
</tr>
<tr>
<td>15. Elderly person sees acquaintance or caretaker as exalted, with unusual powers or influence.</td>
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Testamentary Capacity: Why Wills Are Challenged

statements toward family or other potential heirs while exposing his or her own virtue\(^\text{25,28}\) (Table III).

The Medical Professional’s Role When Wills Are Challenged

Medical professionals, whether primary care providers or specially retained psychiatrists, are usually brought into will contests to provide information in one of four ways:

1. to define the health of the individual at the time the will was made;
2. to determine if the will was made voluntarily;
3. to determine if an emotional connection existed between the testator and an individual named in the will; and
4. to comment on the testator’s level of functioning at the time the will was made.\(^\text{13}\)

Generally, medical personnel carry the most weight for issues involving illness and its potential effect on mental function. In contradistinction, judges and juries see physicians’ input about emotional connection (e.g., good marriage, affinity of a friend, “she seemed to be like a daughter”) as no more or less creditable than a layman’s views.\(^\text{13}\) The exception to this is when physicians testify to the specific question of undue influence based on personal interview or a detailed review of medical/historical records.

Older persons are at particularly high risk for having their testamentary capacity challenged due to the higher frequency of illnesses they may be experiencing at the time a will is written. For many reasons, illness can affect cognitive abilities, insight, perception, impulse control, susceptibility to influence, and both short- and long-term memory.\(^\text{4,6}\) For example, many medical and psychiatric conditions such as cancer, cardiovascular disease, primary endocrine and neurological disease, stroke, diabetes, organ failure, dementia, or delirium can adversely impact one’s cognition.\(^\text{2,6,29}\) In addition to these illnesses, individuals may also be taking various medications such as muscle relaxants, anticholinergics, sedatives/hypnotics, or narcotics, etc., which could affect their cognition and, thus, their ability to make a will.\(^\text{30}\) When medical practitioners are asked to comment about the health of an individual, the potential side effects of medication, or a particular patient’s level of functioning, they can either testify as fact witnesses (e.g., treating doctor) or as expert witnesses (e.g., did not treat the patient but are recognized by the court as having specialized knowledge—through education, training, and experience—and, thus, are able to assist the trier of fact in reaching a decision).\(^\text{23}\)

Common psychiatric conditions that often become points of contention in will contests include a

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<tr>
<th>Components of a General Mental Status Exam</th>
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<tr>
<td>Appearance (e.g., how dressed, degree of cleanliness, appearing confused or not)</td>
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<tr>
<td>Presence or absence of abnormal movements</td>
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<tr>
<td>Orientation (e.g., person, place, time)</td>
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<tr>
<td>Speech (e.g., rate, rhythm, volume, tone, clarity)</td>
</tr>
<tr>
<td>Speech content (e.g., goal-directed, tangential, presence or absence of word-finding difficulties)</td>
</tr>
<tr>
<td>Mood (both reported and assessed by examiner)</td>
</tr>
<tr>
<td>Affect (e.g., mood-congruent, elevated, constricted, blunted)</td>
</tr>
<tr>
<td>Suicidal ideation/homicidal ideation/passive death wish</td>
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<tr>
<td>Evidence of hallucinations (e.g., auditory, visual, tactile)</td>
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<tr>
<td>Evidence of delusions (e.g., false, fixed idiosyncratic beliefs)</td>
</tr>
<tr>
<td>Anxiety (e.g., presence or absence)</td>
</tr>
<tr>
<td>Mini-Mental State Examination score (if possible)</td>
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</tbody>
</table>
history of alcoholism or other drug abuse, affective disorders (e.g., mania), delirium, dementia, or psychotic disorders (e.g., schizophrenia). Alcohol can lead to short-term reasons for not being able to write a will, such as being in a state of acute intoxication when the will was written or experiencing delirium tremors or an alcoholic blackout. Long-term memory impairment and the inability to encode new memory, as occurs with Korsakoff’s syndrome and other alcohol-related dementias, can also invalidate a will. Delirium can be a particularly difficult question to address due to the waxing and waning nature of its presentation. It is possible for an individual to have capacity at one point in time (e.g., lucid interval) and not have the capacity a short time later. Because of this fluctuating sensorium, it is beneficial for physicians to include a mental status exam in their records, especially around times when individuals are giving consent (e.g., consent for a procedure or testamentary capacity) (Table IV).

The level of functioning of patients with dementia at the time the will is executed is the critical question that must be addressed, because such patients may have symptoms related to dementia but still have the ability to meet the five criteria (Cockburn’s rules) necessary to execute the will (Table V).

Depressive and psychotic symptoms also fluctuate over time; therefore, it is critical to assess their severity, if any are present, at the time the will is executed. Videotaping the mental status and physical examinations preserves a record of the patient’s state at the time the examination occurred. It provides powerful data to the trier of fact and can be difficult to rebut by the opposing side if contrary to their position.

**Conducting a Testamentary Capacity Assessment**

Although any physician can conduct a capacity assessment, testamentary capacity exams (e.g., pre- or postmortem) are generally conducted by psychiatrists due to most will contests involving questions regarding mental state at the time the will was written. In a general sense, the evaluator will look at the three core cognitive domains of competency:

1. comprehension and encoding of information;
2. information processing; and
3. communication of decisions made during an evaluation.

Besides the general competency scheme, the examiner will likely ask questions specifically designed to assess the Cockburn rules and any specific jurisdictional statutes relevant to where the examination is taking place. It is important for the examiner to have and review as much information as possible (e.g., medical records, financial records) prior to the evaluation, to ensure that the testator meets the Cockburn criteria, as well as any other potential state requirements (Table VI).
Primary care physicians may want to recommend a testamentary evaluation to their patients when they are in a state of poor health, have what is considered to be large and complex financial holdings, are members of families with known strife, or intend to leave funds in an unexpected manner (e.g., to a niece instead of their own children) (Table VII).

In Anglo-American law, it is assumed that one has capacity unless the issue is challenged; therefore, it is not required for an individual to have an official assessment before signing a will. If an assessment is to be done, it is important to have it as close in time to the actual signing of the will as possible (e.g., same day). The authors are aware of one attorney who prophylactically obtains videotaped testamentary capacity evaluations by the mental healthcare professionals of his clients who are at risk of potentially having their will challenged (Table VIII).

Immediately following the evaluation (camera still recording), the attorney again reviews the will with his clients audibly, has them explain the rationale for their decision-making, and then obtains their signatures. This helps to prevent or diminish the argument that the individuals had a significant change in their mental abilities between the examination and the execution of the will. Although not a foolproof way to prevent an individual’s testamentary capacity from being challenged, videotaping the interview and signing may be a way to reduce the likelihood that a challenge will occur and be successful. A videotaped interview ensures that the reasons given for why the will was written and distributed in a certain manner are available to future judges and juries to hear for themselves, and hopefully provides a clear sense of the individual’s functioning at the time the will was executed.

There have been cases in which an individual initially was found to have testamentary capacity, only to later have the will found invalid because the examiner conducting the examination did not know the extent of the patient’s assets or who his or her

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### Recommended Documentation/ Collateral Information for a Testamentary Evaluation

- Legal documents (e.g., past wills)
- Access to complete financial records
- Knowledge of who the beneficiaries are, family members, potential close friends
- Complete medical records
- Neuropsychiatric testing (e.g., Mini-Mental State Examination, Hamilton Depression Scale, Neurobehavioral Cognitive Status Examination)
- Additional interviews (e.g., spouse, friends)

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### Situations in Which a Primary Care Physician May Suggest That a Patient Have a Testamentary Capacity Evaluation Before Making or Updating a Will

- Patient is suffering from an acute medical illness or recovering from an illness.
- Patient has had recent medication changes or is taking medications that can affect judgment (e.g., narcotics, benzodiazepines).
- There is concern over cognitive function, whether as a “normal part of aging” or as a dementing process.
- There is a past history of severe malnutrition, substance or alcohol abuse, and impaired ability to encode new memory (e.g., Korsakoff’s syndrome).
- Patient has large and complex financial holdings.
- Patient has recently had episodes in which others have questioned business decisions or has recently had poor business outcomes.
- Patient’s family is known to have conflict (e.g., disowned children).
- Patient’s family is complex in terms of structure (e.g., multiple marriages, stepchildren).
- Patient has made statements in the past indicating how property will be distributed, which no longer reflect his/her wishes or personal philosophy (e.g., made promise to “look after” ex-spouse but no longer feels obligated due to ex-spouse remarrying).
- Patient plans to leave property in unexpected or nontraditional manner (e.g., leave to a niece instead of his/her own children, leave for the upkeep of pets and not give to his/her children).
potential heirs were. Without this information, how can an examiner make an “informed opinion” about the individual’s testamentary capacity?\textsuperscript{8,29} Although one does not need to know the exact value of assets, such as a house or stock whose value can change, what is expected is that both the evaluator and the evaluatee know that the house exists and what the approximate value is.\textsuperscript{8,33}

Although assessing an individual’s testamentary capacity while he or she is alive is a good way to diminish the likelihood of a challenge, most examinations of an individual’s testamentary capacity occur after the testator has died.\textsuperscript{5} In these circumstances, the examiner usually does a postmortem review of the patient’s records to try to determine the state of mind of the individual at the time the will was written, not at the time of his or her death (Table IX).

### Table IX

**Materials That Are Reviewed in a Postmortem Assessment of Testamentary Capacity**

1. Interviews with persons around individual at the time the will was made
2. Medical records
3. Past wills
4. Discovery depositions generated during the will challenge
5. Other documents prepared around the time of the will (e.g., business agreements, prenuptial agreements)

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Postmortem evaluations are, in general, more difficult since they often take place years after the will was written, when less information is available (e.g., the individual who wrote the will is dead, collaborating witness may have died or moved), and the information is distorted (e.g., individuals’ memories are influenced by their recollection of the testator’s mental state at the time of the testator’s death, not at the time the will was written).\textsuperscript{29}

### Summary

It is important for physicians, especially those who treat geriatric patients, to have a basic understanding of the legal terms and principles involved in making a will. In particular, physicians need to understand Lord Cockburn’s rules for testamentary capacity and their basis in modern law. By understanding the key concepts of one’s capacity to make a will, physicians will be better equipped to counsel their patients on such matters, create higher-quality medical records with a focus on detailed mental status documentation as clinically appropriate, and appreciate how patients’ illnesses such as delirium or dementia may affect their ability to write a will.
References

18. Potts v House, 6 GA 324, 50 A.D. 329 (1848).