

Commentary: Contested Wills and Will Contests

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When disinherited heirs challenge a will drafted by a person suspected of having dementia, a legal battle may ensue. The “lucid interval,” a brief return to competence from a state of dementia, has been invoked in years past to establish the validity of contested wills. Shulman *et al.*, having reviewed the medical and legal literature, make a convincing argument that no such period of competence occurs in the course of dementia. A neuropsychiatric autopsy is outlined in this commentary to provide a method of determining the validity of a last will and testament, by applying the clinical method described when witness statements do not provide accurate guidance.

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In “Cognitive Fluctuations and the Lucid Interval in Dementia,” Shulman *et al.* discuss the legal concept of the “lucid interval” as it applies to the ability of persons with dementia to make a valid will. The term lucid interval in this context refers to presumed cognitive fluctuations occurring in a person with dementia and is defined by the authors as, “spontaneous alterations in cognition, attention, and arousal” (Ref. 1, p 989) that result in a return of competent cognition.

The article provides a comprehensive review of the concept of the lucid interval in the context of dementia, the most common medical condition that is the subject of testamentary capacity evaluation. The DSM-5 definition of major neurodegenerative disorder, which replaces the earlier definition of dementia is described.² The length and frequency of the return to competency are reviewed from both legal and medical perspectives, and an illustrative case study is presented. As the case law for wills varies by state and from jurisdiction to jurisdiction, a comprehensive review is beyond the scope of this commentary. Shulman and colleagues conclude that cognitive fluctuations in dementia are especially prevalent in vascular dementia and Lewy body dementia. These fluctuations mainly affect attention and alertness, rather than memory and the higher-level executive func-

tions of the brain. Therefore, the concept of the lucid interval must be reconsidered, as it may not be useful when establishing the validity of a will.

Significance of the Lucid Interval

This question is of great importance because wills may divide families, shift the control of multimillion dollar corporations, and change the course of history. Will challenges are not uncommon, but only 1 percent succeed.³

The Lucid Interval

Shulman *et al.* review the question of cognitive fluctuations in case law from a historical perspective, describing the evolution of the idea as far back as 1870. The lucid interval has been used to undermine challenges to testamentary capacity by purporting to show that it is possible for a person with dementia, thought to be legally incompetent, may return temporarily to normal rational cognition.

If the attorney drafting the will and two witnesses assert that the person signing the will appeared to be capable of acting rationally, who is to dispute that? Generally, wills are contested by those who presume that they should be heirs: sons and daughters, spouses and ex-spouses, cousins, and faithful servants or caretakers. When an existing will is changed by an elderly person on the deathbed to disinherit a spouse and children in favor of an estranged relative or a new love interest, suspicions arise. Questions may also arise when there is the loss of free will because of undue influence, deceit, or outright duress. The el-

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derly with dementia may fall prey to designs of others and be forced to sign documents. When there is the appearance of motive, or at least a peculiar deviation from those who would seem to be the natural heirs, a will may be contested. Sometimes there are holographic codicils or new wills that raise suspicion, especially when the witnesses or attorneys appear to be part of a conspiracy, as when they are relatives or associates of beneficiaries. A person with a weakened intellect may be subject to nefarious influences, resulting in invalid testaments. There is seldom a bright line between valid and invalid changes in beneficiaries. It is in such cases that a probate judge or jury trial must settle the question.

An example is the Pennsylvania case of the Estate of Erminto Masciantonio, Deceased.⁴ The court denied a rehearing in this case in which there was a language barrier, witnesses with an interest in the outcome, and the testimony of a doctor who said the decedent, who was confused, stuporous, and incompetent, did not have a lucid interval. Fact witnesses prevailed over the opinion of the doctor who was not present when the will was signed. The explanation by the court for that decision “treated the testimony of the attending physicians as pure opinion evidence and applied to their testimony the rule that opinion evidence is of little weight as against the direct, factual evidence of the scrivener and subscribing witnesses.”⁴ A dissenting judge opined that the decision was erroneous. The case record contains an illuminating discussion of the dilemma that retrospective analysis of a will can present.

Legal Concerns

Shulman and colleagues carefully discriminate between the legal and medical aspects of the lucid interval. For a will to be legally valid, the onus is on the testator to prove testamentary capacity. It must be shown that the testator knew what he was doing, knew what property he was disposing of, and to whom he was bequeathing it, and, as stated in a 150-year-old English case, that “. . . no disorder of the mind shall poison his affections, pervert his sense of right, or prevent the exercise of his natural faculties—that no insane delusion shall influence his will in disposing of his property and bring about a disposal of it which, if the mind had been sound, would not have been made.”⁵ The authors provide an excellent summary of case law regarding the use of the lucid interval, indicating that it is extremely

dated and is in need of revision to reflect the current state of medical knowledge.

The challenges facing the geriatric population in the legal arena are largely the same as those encountered by other age groups, except that the presumption of competence may be replaced by a suspicion of incompetence. It is well known that mild cognitive impairment, and even serious cognitive impairment, may not be obvious to the casual observer. For example, a will often starts with the preface, “Being of sound mind and body . . .,” when neither mind nor body is entirely sound. Physicians are often asked to confirm or refute a person’s competence to make a will, to enter into another sort of contract, to request euthanasia, to adopt a child, to enter a plea, or assist in his defense. These functions may all have different standards for competence, making the task of the expert difficult. It is important for the physician expert to understand the basis of the question, to arrive at the correct answer. The real question is one of cognition and voluntariness. Cognitive impairment, executive dysfunction, or dementia may be present in various degrees; not all persons with dementia are incompetent, depending on the type of competence required. To correctly answer the question, the physician must communicate with the attorney and learn the necessary definitions for the specific case.

Like “insanity,” lucid interval is not a medical term, but a term suited to different circumstances in different situations. As it exists in the fabric of thought, the lucid interval is not amenable to a positive demonstration with certainty by any currently available device or technique. As a historical legal concept, the lucid interval is not based on science, but on the observations of laymen or those schooled in the law. Law and legal opinion rely in large part on precedent, and if the precedent is in error, subsequent iterations and modifications may also deviate from objective reality. The concept of the lucid interval depends on legal interpretations that have no objective test. Moreover, these standards and definitions are highly variable across the United States. In Pennsylvania, a doctor testified that a patient with Alzheimer’s disease could not have a lucid interval, but he conceded that he was unfamiliar with the level of mental competence needed for testamentary capacity. The court discredited the doctor and then ruled that the testator possessed testamentary capac-

ity and that none of the proponents had exercised undue influence over him to obtain the document.⁶

Medical Perspective

After summarizing the history of rulings about the lucid interval, Shulman *et al.* present the medical evidence that, except in the case of delirium where cognitive fluctuations are the rule, the lucid interval is fictitious. If there is an established diagnosis of dementia sufficient to prove a lack of testamentary capacity, the authors would argue that, in such cases, cognitive capacity does not return. Persons under care may have good days and bad days, but Shulman and colleagues have shown that courts should not assume that these fluctuations mean a return of testamentary capacity, when they may simply have been brief changes in alertness or attention.

An expert witness in such cases must begin explanation at a very basic level without assuming any foundation of understanding of brain function. The task of the expert is to teach the jury, for without education, there was a time when a jury would have ruled that the world was flat.

Retrospective Determination of Mental Status

Irrespective of its legal or medical definition, the most serious challenge in the concept of the lucid interval is its retrospective determination. Similar to state of mind in criminal cases, evidence for lucidity is based on historical interpretation of cognitive capacity, often years after a legal document was signed. There is now substantial evidence from epidemiology⁷ and cognitive science⁸ regarding the limited validity of retrospective recall that becomes less reliable as a function of elapsed time.

The Neuropsychiatric Autopsy

A neuropsychiatric autopsy can provide probative information from which one may draw conclusions postmortem about the mental state of the person now deceased. The psychological autopsy, which has long been used to study suicide with the goal of looking for causes and a means to effect prevention, can provide a model for inquiry into previous mental capacity at a particular time point.⁹ Similar to a psychological autopsy, a neuropsychiatric autopsy examines the statements of caregivers, family, and friends, and especially the witnesses who were pres-

ent at the development and signing of the will. Added to the process of making a retrospective determination of competence is a medical aspect, incorporating the medical history, a physical examination, laboratory tests and imaging, and in the best case, follow-up and observation of response to treatment as obtained from the medical record.¹⁰

In the case of an established diagnosis of dementia, there still is the question of the degree of impairment. Not every person with dementia is incompetent; some have a lesser degree of mental impairment. Developmental mental deficiency and impairment may make persons subject to undue influence. Such persons are especially vulnerable to those who have a close relationship or are in a position to use duress or threats.

The question of undue influence on persons who may have mental deficiency was defined and discussed in a ruling in the Superior Court of Pennsylvania in the case of the Estate of Amos A. Angle, Deceased. In that case of a person with Alzheimer's disease, the court ruled there were periods of lucidity, stating:

The relevant inquiry is whether at the time of the execution of the document, the decedent was lucid and competent. A doctor's opinion on medical incompetence is not given particular weight, especially when other disinterested witnesses established that a person with Alzheimer's disease was competent and not suffering from a weakened intellect at the relevant time.⁶

What if the person who may have dementia has not received an official diagnosis? Then, how should one determine if dementia existed at the time of the will? The Mini-Mental State Examination may not test executive ability and may not be probative, because testamentary capacity requires more than an intact memory.¹¹ Beyond a simple test of memory, one must determine whether the testator's judgment is intact in regard to decision-making. Complete neuropsychological testing or psychiatric assessment is almost never available around the time a will is drafted. Video recording of the testator making the will may be executed in an attempt to show competence, but the recording can be edited and the scene is easily staged.¹² In the absence of actual statements of a judgment of dementia or competence, collateral persons may produce affidavits regarding the mental state as they have observed it in family or business settings.

Clinical Evaluation

Asserting a lucid interval should therefore no longer suffice to establish the validity of a suspect will. Comprehensive evaluation of the clinical and corroborative evidence can often provide insight into potential medical conditions that may influence lucidity. The first goal is to discover whether the testator could see and hear well enough to comprehend and transmit the elements of the will.⁴ A person who speaks a foreign language presents a particular problem, but legally certified translators are available to the court. Such cases are not a matter of a lucid interval, but an ongoing problem with communication. If the person is hospitalized or receiving medical or nursing care, the doctor's medical record or notes of nurses, occupational therapists, physical therapists, and other caretakers may be probative. Rarely in the course of routine medical care does a formal statement of incompetence appear. The use of magnetic resonance imaging, positron emission tomography, and the neurological examination to assist in retrospectively determining the ability to make decisions has been affirmed in federal court after a challenge under the *Daubert* standard.¹³ Brain imaging may reveal severe atrophy from Alzheimer's disease or demonstrate hydrocephalus, arteriosclerosis, metastases, or brain tumors. However, brain imaging cannot constitute proof of diagnosis when it is only corroborative. Examining the contemporaneous medical record for laboratory values should also be undertaken. There are many conditions that can lead to either acute or chronic impairment of lucidity.

The Differential Diagnosis

A person with delirium may be competent one minute and incompetent the next, but persons with dementia, although they may have good days and bad days, generally do not regain competence once they have lost it. Delirium is one of the most common disorders in elderly persons that may be reversible. Severe electrolyte imbalance, kidney failure with uremia, or liver failure, with hepatic encephalopathy, may lead to acute or chronic mental impairment. Severe anemia, hyperviscosity from dehydration or multiple myeloma, or hypoxemia from chronic obstructive pulmonary disease may also cause temporary impairment. The question is how to determine if the required conditions existed, or to determine that they did not. If the lucid interval refers to a brief time in the course of the day during which a

person with dementia regains his senses to a degree not seen for the rest of the day, there must be evidence. A doctor's opinion on medical incompetence is not given particular weight when other disinterested witnesses establish that a person with Alzheimer's disease was competent and did not have a weakened intellect at the relevant time, but did at other times in the course of the disease.¹⁴

Prescribed medications such as sedatives, analgesics, and steroids as well as alcohol and substances of abuse have well-documented influences on cognitive capacity. Different types of aphasia present a problem as well. Persons with expressive aphasia may understand quite well but be unable to discuss a set of facts. They may, however, be able to express consent to a document they read or that was read to them. On the other hand, some with aphasia may speak logically, but lack the ability to understand documents.¹⁵ Therefore, a differential diagnosis is critical in evaluating competence at the time of executing a will, and a medical expert must understand the legal criteria for competence.

Recommendations

Shulman *et al.* have provided an excellent review of the concept of the lucid interval that should stimulate discussion regarding the review of current standards for determination of mental capacity in both the legal and medical systems. As in the criminal justice system, there should be far greater integration of the legal definitions with medical evidence to determine culpability and mental and cognitive capacity. In the legal system, there should be far more systematic definitions based on current medical evidence. For example, in legal testamentary decisions of any person with diminished mental and cognitive capacity, any document that has major financial, social, or occupational impact should require another disinterested party and an objective test of the person's ability to make a decision before the document is valid. Medical standards for clinical evaluation should also be developed to incorporate current state of the art systematic diagnostic criteria. Shulman *et al.* should be commended for approaching this important subject.

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