that Mr. Loyd actually communicated to Dr. Benton his intention to harm Ms. Rodriguez. The plaintiffs argued, however, that actual communication is not necessary. Relying on a prior case of *Munstermann v. Alegent Health*, 716 N.W.2d 73 (Neb. 2006), the court stated that it had previously considered the extent of a psychiatrist's duty to warn and protect third-party victims. In *Munstermann*, the court had reviewed Nebraska's legislative response following the California case of *Tarasoff v. Regents of University of California*, 551 P.2d 334 (1976), which imposed on mental health professionals a duty to protect. In *Munstermann*, the court ruled that a psychiatrist is liable for failing to warn and protect "when the patient has communicated to the psychiatrist a serious threat of physical violence against himself, herself, or a reasonably identifiable victim or victims" (*Rodriguez*, p 239, citing *Mustermann*, p 82). Because the legislature has not further amended the *Munstermann* rule, the court viewed the rule as having received "legislative acquiescence." According to the court, to negate the requirement that an actual threat be communicated to clinicians, it would undermine the state's statutes that underly the *Munstermann* rule. Here, the only reasonably identified victim of threats communicated by Mr. Loyd was his mother.

For Lasting Hope, the court addressed whether it had a duty to protect based on any custodial special relationship to Mr. Loyd. The district court had found undisputed facts that Mr. Loyd had been discharged from Lasting Hope pursuant to Dr. Benton's discharge plan. The Special Administrators alleged that the district court viewed the relevant time period too narrowly and pointed to an expert opinion that the discharge was premature. Finding that Dr. Benton was the person responsible for Mr. Loyds's treatment and discharge, the court said that the duty to protect claim is solely based on the alleged duty and breach by the psychiatrist. Here, even assuming Mr. Loyd was in custody while he was a patient at Lasting Hope, Ms. Rodriguez's death cannot be attributed to a breach of duty because no threat was communicated about intention to harm her. "We reach this decision not based on a lack of custody but instead because Loyd did not communicate to the defendants that he intended to physically injure Melissa" (*Rodriguez*, p 722).

Concurring Opinion

Justice Papik concurred in the judgment but wrote separately to express reservations regarding the court's original analysis in *Munstermann*. In *Munstermann*, the court reviewed existing state statues that did not specifically name psychiatrists and found that, for policy reasons, the duties and limitations imposed on licensed mental health practitioners and psychologists also applied to psychiatrists. Despite reservations about the applicability of prior law to psychiatrists, Justice Papik concurred in the judgment.

Discussion

In *Rodriguez v. Lasting Hope,* the Nebraska Supreme Court considered a psychiatrist's duty to warn and protect under the state's *Munstermann* rule, which was based on the state's legislative response following *Tarasoff*. The *Rodriguez* case makes clear that, in order for such a duty to arise in Nebraska, the patient must "actually communicate" information to the psychiatrist about harming a third party (*Rodriguez*, p 719). The court noted that the Special Administrators did not dispute the fact that Mr. Loyd had not actually communicated a threat of violence against Ms. Rodriguez, rather the Special Administrators invited the court to "reconsider" whether such actual communication was necessary. What information or manner of disclosure is needed to sufficiently communicate a threat was not decided in this case. A future case could address what constitutes an "actual communication."

State laws on mental health providers' duties to warn or protect vary around the country. Nebraska is not alone in having some limiting language in their laws about the parameters that trigger the duty, such as the requirement of an actual communication to harm an identifiable victim. Recognizing that duties to protect third parties may conflict with clinicians' legal and ethical duties to protect patient confidentiality, limiting the duty to protect to circumstances in which an actual threat of harm is communicated about a reasonably identifiable victim is one way to balance these responsibilities.

Transfer on Death Agreement and Mental Incapacity

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Medical Evidence of Neurocognitive Impairment Does Not Automatically Constitute Grounds for Vacating Summary Judgment for the Execution of a Transfer on Death Agreement

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Key words: transfer on death agreement; mental capacity; contractual incapacity; summary judgment; neurocognitive

In *Merrill Lynch, Pierce, Fenner & Smith, Inc. v. Flanders-Borden*, 11 F.4th 12 (1st Cir. 2021), Katherine Flanders-Borden challenged the execution of a Transfer on Death (TOD) Agreement of her father, Alton Flanders, III, on the basis that he lacked contractual capacity when he signed the TOD Agreement. The district court of Massachusetts rejected Ms. Borden's claim that hospitalization records proved Mr. Flanders' mental incapacity and concluded that Ms. Borden's claims failed to raise a genuine dispute of material fact as it related to Mr. Flanders's contractual capacity. The U.S. Court of Appeals for the First Circuit Court affirmed the district court's ruling.

Facts of the Case

On March 22, 2016, Alton Flanders, III, signed a TOD Agreement. The purpose of a TOD Agreement is to avoid probate of assets and provide an immediate and simple transfer to designated beneficiaries upon death. The execution of the TOD Agreement in this case was managed by Merrill Lynch, Pierce, Fenner & Smith, Inc., and included the following designated beneficiaries: 20 percent to Mr. Flanders' daughter Katherine Flanders-Borden, 20 percent to Mr. Flanders' brother, and 40 percent, 10 percent, and 10 percent, respectively, to three of Mr. Flanders' friends. Ms. Borden claimed that Mr. Flanders lacked mental capacity to enter into the TOD Agreement because he had a neurocognitive disorder. Under Massachusetts law, a "contract is voidable by a person who, due to mental illness or defect, lacked the capacity to contract at the time of entering into the agreement" (*Merrill Lynch*, p 18, citing *Sparrow v. Demonico*, 960 N.E.2d 296 (Mass. 2012), p 301). She argued that the assets distributed should revert to Mr. Flanders' estate, of which she was the sole executor and heir. Merrill Lynch commenced an interpleader action, a suit to determine a defendants' rights to something of value that plaintiff is holding but does not claim.

After the consenting beneficiaries moved for summary judgment, Ms. Borden filed an "emergency motion" containing "newly uncovered evidence." She produced Mr. Flanders' medical records from a two-week hospitalization that occurred four months before he signed the TOD Agreement. The medical records referenced that Mr. Flanders was sufficiently "managing his affairs" until four months prior to signing the Agreement, when he developed "confusion" and "hostility/paranoid ideation" toward his caretakers. His treating doctors described his incapacity as the result of a neurocognitive disorder that was "irreversible" and of "moderate extent." They also believed that his presentation was precipitated by his history of substance use. Prior to his hospital discharge, his doctors noted that he was "alert" and "aware of discharge plans"; however, he had had "residual confusion" and "poor insight and judgment."

The district court granted summary judgment to the consenting beneficiaries, holding that "no reasonable jury" could find that Mr. Flanders had lacked capacity at the time he entered into the TOD Agreement based on the medical records. The district court denied Ms. Borden's motion for reconsideration. Appeal was taken to the First Circuit.

Ruling and Reasoning

The First Circuit cited three main shortcomings in Ms. Borden's argument that the district court erred. The first two involved legal questions unrelated to psychiatry.

The main psychiatric concern was Ms. Borden's assertion that the district court erred in granting summary judgment to the defendants because of her father's mental incapacity. The court reviewed the evidence that had been presented at the lower court. The consenting beneficiaries argued that Ms. Borden did not present evidence to prove that Mr. Flanders lacked capacity such that the TOD Agreement would be void. This notion was supported by affidavits from the consenting beneficiaries and Mr. Flanders' attorneys. The beneficiaries then filed for summary judgment arguing that there was no genuine dispute of material fact.

Ms. Borden argued that the medical records raised a genuine question of material fact as to Mr. Flanders' mental state when he executed the TOD Agreement. She asserted that no witness provided evidence that his condition had been successfully treated or cured and that a reasonable jury could

find that he lacked the requisite mental capacity. The lower court had found the medical records submitted by Ms. Borden to be unconvincing. The consenting beneficiaries argued that the medical records were "unauthenticated" and "constituted inadmissible hearsay."

The First Circuit recognized that the medical records showed that Mr. Flanders had experienced confusion but pointed out that the records were dated four months prior to execution of the TOD Agreement. The court also pointed out that Ms. Borden did not offer sufficient evidence that Mr. Flanders' neurocognitive disorder caused a loss in his ability to execute the TOD Agreement. The court reasoned that a "tentative diagnosis" of a moderate level of neurocognitive disorder "does not itself equate with contractual incapacity" (*Merrill Lynch*, p 24).

Ms. Borden further argued that Mr. Flanders had the "lesser level of testamentary capacity, not the higher standard for contractual capacity" (*Merrill Lynch*, p 25). The court reiterated that the burden is on Ms. Borden to demonstrate lack of capacity, not on the consenting beneficiaries to demonstrate that he had the requisite capacity. Ms. Borden also argued that Mr. Brescher (one of Mr. Flanders' estate lawyers) did not have a valid opinion as to Mr. Flanders' capacity. She said that Mr. Brescher's observations should be disregarded because he is not a medical expert, and that his statements regarding Mr. Flanders' capacity were "speculative." The court said that nonmedical experts are competent to testify as to physical appearance and conditions and acts of the person and disregarded her argument. On these bases, the First Circuit affirmed the decision of the lower court and ruled that the district court did not err in granting summary judgment to the consenting beneficiaries. Ms. Borden had not met her burden; she failed to raise a genuine dispute of material fact as to this contractual capacity.

Discussion

This case discusses competences for asset allocation on death, namely testamentary capacity, contractual capacity, and TOD Agreement capacity. Forensic psychiatrists may be asked to opine in retrospective analysis on these competencies.

Testamentary capacity is the ability to make a will. In the United States, legal challenges to wills first emerged during the mid-1800s. Over time, a greater acquisition of wealth has ushered in new legal challenges over inheritance. Forensic psychiatrists may expect to see a greater frequency of challenges to wills when contractual capacity is in question in the future. Longer life expectancy leading to increased risk of neurocognitive disorders around the time of will-making, more fragmented family structures, and an increased accumulation of wealth have led to challenges in inheritances.

Common law has long considered that contractual capacity requires a higher mental ability threshold than testamentary capacity. Contractual capacity requires comprehending the effects of the proposed decision, the consequences involved, and the weight of other possible alternatives. Further, there is a presumption of capacity, not incapacity. In the case of *Merrill Lynch, Pierce, Fenner & Smith, Inc.*, the burden was on Ms. Borden to prove that Mr. Flanders lacked contractual capacity, not on the consenting beneficiaries to show that he had this capacity.

Presently, many states allow for some form of a TOD Agreement. While TOD Agreements have various names such as "beneficiary deeds" or "Residential Real Property Transfer on Death Instrument," the agreements have a similar purpose, namely transfer of property on death without probate. There are jurisdictional differences, however, regarding standards of competency required to execute a TOD Agreement. For example, in Texas, the capacity to execute a TOD Agreement is the same as contractual capacity, whereas in Utah, the standard is testamentary capacity. Ohio does not explicitly identify the form of capacity required to execute a TOD Agreement in statute. In *Merrill Lynch, Pierce, Fenner & Smith, Inc.*, the court distinguished testamentary capacity from contractual capacity.

In conducting retrospective capacity assessments, objective medical evidence near the time of the execution of the document is an important consideration, as are witness statements about the person's thinking and behaviors at that time. Consistent with this case, it is important for evaluators to recognize that evidence of neurocognitive disorder does not, by itself, necessitate a lack of contractual capacity. Given the differences in standards for assessing various competencies, it is important for psychiatrists who are asked to opine on these questions to be familiar with the standards within their jurisdiction.