International Psychogeriatrics (2010), 22:6, 950–956 © International Psychogeriatric Association 2010
doi:10.1017/S1041610210000712

REVIEW

Testamentary capacity and delirium

Benjamin Liptzin,[1] Carmelle Peisah,[2] Kenneth Shulman[3] and Sanford Finkel[4] for the International Psychogeriatric Association Task Force on Testamentary Capacity and Undue Influence

[1] *Department of Psychiatry, Baystate Health, Springfield, MA, U.S.A.*
[2] *Academic Department for Old Age Psychiatry, Prince of Wales Hospital, and University of New South Wales, Sydney, Australia*
[3] *Department of Psychiatry, Sunnybrook Health Sciences Centre, University of Toronto, Ontario, Canada*
[4] *University of Chicago Medical School, Wilmette, IL., U.S.A.*

ABSTRACT

Background: With the aging of the population there will be a substantial transfer of wealth in the next 25 years. The presence of delirium can complicate the evaluation of an older person's testamentary capacity and susceptibility to undue influence but has not been well examined in the existing literature.

Methods: A subcommittee of the IPA Task Force on Testamentary Capacity and Undue Influence undertook to review how to assess prospectively and retrospectively testamentary capacity and susceptibility to undue influence in patients with delirium.

Results: The subcommittee identified questions that should be asked in cases where someone changes their will or estate plan towards the end of their life in the presence of delirium. These questions include: was there consistency in the patient's wishes over time? Were these wishes expressed during a "lucid interval" when the person was less confused? Were the patient's wishes clearly expressed in response to open-ended questions? Is there clear documentation of the patient's mental status at the time of the discussion?

Conclusions: This review with some case examples provides guidance on how to consider the question of testamentary capacity or susceptibility to undue influence in someone undergoing an episode of delirium.

Key words: medical-legal issues, wills

Introduction

Several years ago the International Psychogeriatric Association (IPA) established a Task Force on Testamentary Capacity and Undue Influence. This was in response to the large amount of wealth that is likely to be transferred over the next 25 years and the possibility that mental disorders, including dementia, could interfere with the appropriate distribution of that wealth. This could result in legal conflicts over whether the individual testator had the capacity to make a valid and competent will. In previous papers (Peisah *et al.*, 2009; Shulman *et al.*, 2009) the IPA Task Force has addressed the issues of undue influence and established guidelines for a contemporaneous assessment of testamentary capacity. Spar and Garb (1992) have also addressed the question of assessing competency to make a will. Delirium is a common condition in older persons who are medically ill and which can affect decision-making. In community settings the prevalence of delirium in a geriatric population may be only 1–2% but in inpatient hospital settings the prevalence may be as high as 80% (Liptzin and Jacobson, 2009). Despite the high prevalence in hospitals and the availability of trained health care professionals, delirium is often undetected. Questions about the presence, severity, or timing of delirium can lead to disputed wills and yet has received very little attention in the existing testamentary capacity literature. In this paper, we address the question of testamentary capacity in patients who have or are experiencing an episode of delirium as a way to highlight important questions about the assessment of testamentary capacity and vulnerability to undue influence.

The ability to execute a valid will may vary in different jurisdictions. In common law countries, the criteria for testamentary capacity have been

Correspondence should be addressed to: Benjamin Liptzin, Department of Psychiatry, Baystate Health, 759 Chestnut Street, Springfield, MA 01199, U.S.A. Phone: +1 413-794-4235; Fax: +1 413-794-4234. Email: benjamin.liptzin@bhs.org. Received 30 Jan 2010; revision requested 5 Mar 2010; revised version received 28 Mar 2010; accepted 29 Mar 2010. First published online 1 July 2010.

https://doi.org/10.1017/S1041610210000712 Published online by Cambridge University Press

derived from the well-known Banks v Goodfellow case and include: understanding the nature of a will; understanding the general extent of one's assets; appreciating the claims of those who might expect to benefit from the will; understanding the impact of the distribution described in the will; ensuring that the testator is free of any disorder of mind or delusions that influenced the disposition (Banks v Goodfellow, 1870). Additional criteria for testamentary capacity have been suggested in a recent paper (Shulman *et al.*, 2009).

Similarly, in the Commonwealth of Massachusetts in the U.S.A. testamentary capacity requires the testator to be "of sound mind" (Massachusetts General Laws Chapter 191 Section 1). A person is presumed to be "of sound mind" unless there are suspicious circumstances (Hull and Hull, 1996) or when a will is legally contested. In a contested case what standards are used to make a determination? "Sound mind" has been interpreted to mean "at the time of executing a will, the testatrix must be free from delusion and understand the purpose of the will, the nature of [his] property, and the persons who could claim it." (O'Rourke v. Hunter, 446 Mass. 814, 826–827 (2006)) The standard for testamentary capacity also "requires [the] ability at the time of execution of the alleged will to comprehend the nature of the act of making a will" (Palmer v. Palmer, 23, Mass.App.Ct. 245, 250 (1986), quoting from Goddard v. Dupree, 322 Mass. 247, 250 (1948).

How do the above standards apply in the case of a patient who has delirium? According to the *Diagnostic and Statistical Manual of Mental Disorders*, 4th edition, text revision (DSM-IV-TR) (American Psychiatric Association, 2000) the diagnostic features of delirium are "a disturbance of consciousness that is accompanied by a change in cognition that cannot be better accounted for by a preexisting or evolving dementia. The disturbance develops over a short period of time, usually hours to days, and tends to fluctuate during the course of the day" (p. 136). In describing the fluctuation, it is noted that "during morning hospital rounds the person may be coherent and cooperative, but at night might insist on pulling out intravenous lines and going home to parents who died years ago" (p. 137). The fluctuation can also be associated with perceptual disturbances which "may include misinterpretations, illusions, or hallucinations . . . The individual may have a delusional conviction of the reality of the hallucinations and exhibit emotional and behavioral responses consistent with their content." Given the possibility of fluctuation, the O'Rourke decision cited above noted: "The critical question is whether the testator was of sound mind at the time the will was executed. It has been held that 'a person . . . may possess testamentary capacity at any given time and lack it at all other times.'" This explicitly acknowledges that if a person was experiencing a lucid interval when he signed his will, then it will be valid, particularly if there is consistency over time (hours, days, weeks, or months) in the person's expressed wishes. Legally, this is similar to the case of a person who is frequently intoxicated and incapacitated as a result of being under the influence of alcohol but who can be competent when sober. What complicates the assessment is that many older patients with delirium (perhaps 50%) also have an underlying dementia. The dementia can be severe enough to impair the patient's testamentary capacity even during lucid intervals (Sprehe and Kerr, 1996).

In some cases wills may be invalidated if they are procured by "undue influence", which is defined as "whatever destroys free agency and constrains the person whose act is under review to do that which is contrary to his own untrammeled desire" (Neill v. Brackett, 234 Mass. 367, 369 1920). During an episode of delirium an individual is especially vulnerable and susceptible to undue influence from caregivers including family members. That issue is sometimes raised when wills are contested, an issue addressed elsewhere (Peisah *et al.*, 2009). The role of the expert is to determine the extent of vulnerability and express their opinion but it is the court's role to determine whether such influence was or was not exerted and to be the final arbiter of the question of "undue" influence (Frolik, 2001).

The clinician may be asked to give an expert opinion regarding testamentary capacity or susceptibility to undue influence in the context of delirium either contemporaneously or retrospectively after the person has died and the will is challenged. With regards to the latter, the issue of "mental soundness" in delirium is similar to cases in which a retrospective opinion is sought from an expert witness as to whether a patient with dementia had testamentary capacity or susceptibility to undue influence at the time a will was executed. It is common in such cases for an individual to be clearly demented at the end of their life and to be clearly cognitively intact earlier in life. The question is what was their cognitive ability at the time a will was executed. The standards noted above are pretty general and are not a high threshold.

The following cases illustrate some of the considerations to take into account in evaluating the testamentary capacity or susceptibility to undue influence of a patient who is experiencing episodes of delirium.

https://doi.org/10.1017/S1041610210000712 Published online by Cambridge University Press

Case example 1

A case example based on Massachusetts Probate Court documents will illustrate how a person's testamentary capacity or susceptibility to undue influence can be evaluated in retrospect and suggest ways for a lawyer to assess and document that capacity contemporaneously.

Dr. S was a 74-year-old physician who was well known in her specialty. She never married and had no siblings. She developed a close and longstanding professional and personal relationship with one of her Fellows, Dr. Jones, starting in 1971. She also became a godmother to Dr. Jones' three sons and kept a photograph of them on her desk at home. When they were children she read to them, played with them, babysat them, took them on trips to New York to see Broadway shows, bought them gifts, discussed what schools they should attend, and traveled on multiple vacations with them and their parents. She gave two of the Jones' sons a significant gift of money when they graduated from college. She also made them beneficiaries under wills she wrote or amended in 2001, 2002, and 2004 as well as a will she executed on 12 May 2005, nine days before her death from metastatic cancer.

In that 2005 will she drastically reduced the portion of her estate going to two former patients (Joan and Betty Smith) whom she had befriended from the time she treated them as young girls in 1975. She saw them regularly for treatment and subsequently had them work for her or colleagues as research assistants. She also purchased a condominium for one of them and also provided a credit card. From 1986 to 2000 she vacationed with the two sisters, traveled widely with them and took them to approximately twenty operas and concerts. She commissioned an oil painting of the Smith sisters that hung in her home. In 2001 she designated one of the sisters as her agent under a Durable Power of Attorney. Clearly she was close to both Smith sisters and to the Jones family noted above and had provided for all of them in her wills.

In 2003 she was diagnosed with breast cancer. Over the subsequent 18 months she had a downhill course as the cancer metastasized despite aggressive treatment. For almost two months in 2005 she was in a rehab hospital following a major surgical procedure to decompress spine metastases pressing on her spinal cord. Her course was also complicated by severe adhesions requiring major abdominal surgery. During that stay she was noted to have episodes of confusion and hallucinations, most likely due to the use of opiates to help her deal with pain. In addition she was anemic and had mild kidney failure. She was transferred to a long-term care facility and died 17 days later. On day nine of that stay she executed documents to change her will and other estate planning documents including the beneficiary designation form on certain retirement accounts which changed the beneficiaries from the Smith sisters who had been her patients to the Jones' sons who were her godchildren.

Legal summary

The Smith sisters subsequently sued, alleging that Dr. S was subject to undue influence from the parents of the Jones brothers, and also that she lacked testamentary capacity to execute the new documents. On the claim of undue influence, the judge as a matter of law dismissed the claim. He found that the Jones' parents were attentive to Dr. S but did not restrict her visitors or participate directly in giving instructions to her attorney who Dr. S had chosen three years earlier. In fact, they had no contact with the attorney until after the estate planning documents were signed. They were not present when the will was signed in the presence of the attorney and two independent witnesses. The judge further found that there was no evidence that the Jones parents overcame Dr. S's intentions since she had been close to the sons for many years so that her decision was not "an unnatural disposition". It was also acknowledged that the Smith sisters had not visited Dr. S for two months, which she found quite disappointing, and was part of her reasoning for reducing their share of her estate. If the will had been revised because she was delusional and believed that she was the mother of the Jones' sons, or if the changes benefited the attorney who drew it up, or a nursing home staff nurse who refused to give Dr. S her pain medication unless she made her a beneficiary of her will, then a claim of undue influence might have made sense.

The claim of a lack of testamentary capacity was allowed to go forward to trial and the case has not yet been adjudicated. How does one evaluate testamentary capacity in the presence of a clear history of fluctuations in mental status? It is essential to review all the evidence documented in Dr. S's medical record and in the depositions of various witnesses.

Legal analysis of the case

A key witness was the attorney, Mr. B, who drew up the revised documents. Mr. B had known Dr. S for over 15 years and had taken her on as an estate planning client in 2002. He had practiced law for over 20 years and as a specialist in estate planning had supervised the execution of thousands of estate planning documents. On 9 May 2005 Dr. S was said to be "not confused" in the nursing home notes. Dr. S signed a codicil to her will and

https://doi.org/10.1017/S1041610210000712 Published online by Cambridge University Press

changed her healthcare proxy from one colleague to another. She also directed Attorney B to prepare a new will and a revised land trust changing the beneficiaries. Attorney B was concerned about Dr. S's ability to execute those documents because of her medical condition and discussed his concerns with two other attorneys on 11 May 2005. On that day Dr. S's attending physician noted intermittent confusion and difficulty focusing. On 12 May 2005 at 9 a.m. Dr. S was described in nursing home notes as "alert, oriented, bright and conversant" and according to the nursing home social worker reportedly recalled a phone number from memory despite taking oxycodone at midnight and 6 a.m. At 11 a.m., Joan Smith had a one-minute phone call which ended because Dr. S's speech was garbled and she was incomprehensible. Prior to leaving his office, Attorney B called Dr. S's former administrative assistant and was told that she had had a cogent discussion with Dr. S the previous day. However, Attorney B acknowledged that he did not know if he would find Dr. S competent to sign the revised estate planning documents on 12 May. When Attorney B arrived at Dr. S's room he asked if Dr. S wanted to proceed and was told yes. Attorney B reviewed the revised provisions of the Land Trust and Dr. S confirmed that she wanted to sign it and did so. Dr. S also read a letter and signed it to confirm that she wanted Attorney B to serve as a trustee of the Land Trust. Attorney B then reviewed the provisions of the new will focusing on the changes from the prior will and Dr. S confirmed the changes.

It is unclear from Attorney B's testimony whether he asked closed questions which Dr. S could simply nod agreement to as a confirmation or asked open-ended questions to probe Dr. S's understanding of what were the documents she was signing and why. Before he had Dr. S sign the will he asked her "Is this your will? Are you about to sign it as your free and voluntary act?" and Dr. S answered yes to both questions and signed the will. Attorney B also asked the two witnesses if Dr. S appeared to be "of sound mind and under no undue influence" and they both agreed and signed the will as witnesses. Attorney B testified that during that meeting Dr. S was "at all times alert and focused. She did occasionally close her eyes and grimace as if in pain, but she never fell asleep, said anything inappropriate, or otherwise gave any indication of incompetence." Attorney B concluded that in his "professional judgment Dr. S was competent to sign the estate planning documents." His opinion would have been strengthened considerably if he had obtained a clinical evaluation by a geriatric expert.

Attorney B went on to say "Because Dr. S was much more focused than I had expected, and because I believed she did not have long to live, I decided to review with her the beneficiary designations of her various retirement plans." Dr. S confirmed the beneficiary designations of several but when she realized that Betty Smith was the beneficiary of another she shook her head and said she no longer wanted her as the beneficiary. When asked who she wanted to name she said the Jones brothers. Attorney B reviewed the beneficiary designation form with Dr. S and had her sign it. He asked Dr. S to have the Jones' parents call him with the Social Security numbers of the Jones brothers. That night, Dr. S called him at home with the Social Security numbers. It turned out that Attorney B already had the numbers because the Jones brothers had been previously named as contingent beneficiaries, and that Dr. S had called with the correct numbers. Attorney B concluded that " Dr. S was competent to sign the new beneficiary designation; she signed it freely and voluntarily; and she understood that by signing the beneficiary designation that Betty Smith would no longer be entitled to the retirement benefits remaining at Dr. S's death." In terms of consistency, Dr. S had months before talked with Attorney B about her concerns that Betty Smith was not a very responsible individual. She was also clear that she was disappointed that Betty had seemingly abandoned her by rarely calling or visiting during the last 18 months of illness, treatment and hospitalizations. This argues against an impulsive decision made simply during the episodes of confusion.

In evaluating Dr. S's capacity to sign the estate planning documents and change of beneficiary form, what other data support Attorney B's conclusions? Even though Dr. S had fluctuating mental status of which Attorney B was aware, she appeared focused and alert during the discussion on 12 May 2005 and answered all questions appropriately. The two witnesses confirmed Attorney B's observations and agreed with his judgment that Dr. S was competent when she signed the documents. The expert witness for the plaintiffs, the Smith sisters, argued that delirium is often under-recognized by health care professionals and could have been missed by Attorney B and the two witnesses in this case. Previous studies of delirium in hospitalized elderly have, in fact, demonstrated that even trained physicians and nurses may miss the diagnosis of delirium if they have only superficial interactions with patients (McCartney and Palmateer, 1985). In a study of delirium in a major academic medical center, when the investigator asked a nurse if the patient was delirious, the answer was "No, she's a lovely lady." When the patient was asked if

https://doi.org/10.1017/S1041610210000712 Published online by Cambridge University Press

she knew where she was she answered "I thought this was the Ritz Carlton but the food isn't as good as I remembered it being." This suggests that if health care professionals can miss obvious delirium then certainly lay individuals who have only brief interactions with such patients may miss the presence of delirium. The plaintiff's expert witness also pointed to the phone conversation Joan Smith had with Dr. S just three hours before she met with Attorney B in which Dr. S's speech was garbled and she was incomprehensible. However, whatever caused that brief conversation to convince Joan Smith that Dr. S was confused appeared to have cleared up by the time of the meeting with Attorney B according to him and the two witnesses present. Their description of Dr. S's condition during that meeting is strongly suggestive of capacity despite the previous episodes of confusion and any abnormal lab test results, brain imaging findings, or cognitive exams done previously. Abnormal lab values or long lists of medications a patient is taking could explain why someone is delirious but does not prove that they are so and therefore lack capacity. Furthermore, in this case Dr. S remembered to get the Social Security numbers of the Jones brothers and called Attorney B at home that evening to provide the correct numbers, suggesting a sustained focus on her wishes and the cognitive capacity to take steps to follow through on those wishes.

Case example 2

Miss R was an 82-year-old single woman and shop owner who was neither married nor had any children. Her nearest relatives were her cousin, whom she appointed as her Power of Attorney in 1992, and her niece, who owned and ran a shop nearby and regularly stopped by to visit her. She occasionally mentioned to others that her niece would take over the business one day, and when a colleague offered to buy her stock and fixtures she declined, stating that her niece would need it when she took over. In 1992 when she was clearly cognitively intact she also made a will in which she appointed her cousin and niece as co-executors and bequeathed her shop (her major asset) to her niece with the lesser residue to her cousin.

In 2003 she was first noted to be withdrawn, disheveled and neglectful of her housekeeping and self care. In early 2004, she was described as having " a little memory loss", although no formal testing of cognitive impairment was performed. On 13 November 2004 she had an accident and smashed the car she was driving. Although sustaining no injury, after the accident she was noted by neighbors to be particularly vague, unkempt, disoriented and confused. Investigations by her GP revealed her to be mildly anemic and dehydrated with a sodium level of 124 (normal range 136–148 mmol/l). On 16 November she scored 21/30 on a Mini-mental State Examination with deficits in attention, orientation (she did not know the year or the date), calculation, construction and recall. A brain CT scan on 21 November 2004 showed cerebral atrophy and chronic ischemic changes. The district nurse noted that from the time she first met her on 14 November 2004 through to late December, on most occasions when she visited her, she was unkempt with soiled clothing and required constant supervision and reminding with regard to both basic (e.g. hygiene and self care) and instrumental activities (e.g. food preparation) of daily living. On 20 December 2004 she was approved for permanent residential care because of her long-standing cognitive difficulties which made her unable to care for herself.

On 21 November 2004 she made a new will in which she appointed her cousin as sole executor and bequeathed her entire estate to her cousin. This was a significant change from her previous will and invites probing and an explanation for this change. When giving instructions to the solicitor who executed her will she stated that she had little to do with her niece, whom she "*used to think was a businesswoman and shopowner but now I think she'd probably sell the shop in any event*". There was no evidence that the niece had ever expressed any desire to sell the shop. The solicitor who took instructions stated that she appeared to understand what she was doing, although there was no documentation of how the solicitor ascertained this, specifically, no evidence of open-ended questioning. The solicitor did not seem aware that the patient had an altered mental status after her car accident. Nowhere did he document the patient's mental state nor explore in detail her reasons for changing the will. He did not seek any opinion from a health care professional regarding her testamentary capacity.

In a retrospective review of the case, the expert considered that the history of decline predating the car accident followed by the more obvious disturbance in mental state was suggestive of a dementia (probably vascular or mixed dementia on the basis of the CT scan). The recent change in mental status suggested that her baseline dementia was complicated by a delirium most likely related to hyponatremia. The issue was whether this "disorder of mind" precluded testamentary capacity. As is typical in such cases, the testator had an idea of the nature of a will and an understanding of the general extent of her estate (it was not particularly complex in that it only involved a single asset, her shop), although it was unclear whether she could

https://doi.org/10.1017/S1041610210000712 Published online by Cambridge University Press

appreciate and discriminate between the claims of her potential beneficiaries. The deviation from a long-standing testamentary intent and her change in demeanor towards her niece, coincident with her probable delirium superimposed on her dementia suggested that her appraisal of her beneficiaries was "poisoned" by her disorder of mind. In contrast to the previous case, there was no consistency in her wishes regarding her estate and her niece over time. Furthermore, her perception that she had little to do with the niece was inconsistent with the evidence that her niece had regularly stopped by to see her, and was probably attributable to her memory deficits. She was probably unable to make a "balanced judgment" regarding her niece, and unable to weigh and discriminate between the claims she ought to consider. There was no evidence that she executed her will during a time of lucidity. Given the presence of a new onset of delirium it would have been prudent to wait for several weeks or until it was clear whether or not the patient had returned to her baseline mild dementia. It is not uncommon for the testator's appraisal of family members to be tainted by dementia (Peisah *et al.*, 2006), and in this case, that appraisal was made worse by the superimposed delirium.

Discussion

The cases demonstrate that testamentary capacity, like all capacities, is task specific and is not determined simply by the presence of a mental disorder or cognitive impairment. Diagnosis alone is not enough to draw conclusions about testamentary capacity or susceptibility to undue influence. A standardized screening instrument for delirium, such as the Confusion Assessment Method of Inouye *et al.* (1990), can be helpful in documenting whether delirium is present but it does not answer the key questions about capacity. The effect of delirium on testamentary capacity or susceptibility to undue influence will depend largely on the severity, comorbidity (e.g. dementia) and fluctuation of the delirium, and, the complexity of the will-making task, hence the critical importance of considering both the testator's mental status and their ability to meet the task- specific aspects of testamentary capacity.

The Subcommittee identified questions that should be asked in cases where someone changes their will or estate plan towards the end of their life in the presence of delirium. These questions include:

- Was there consistency in the patient's wishes over time?, This applies both to consistency within the delirious episode, where consistency in disposition should be demonstrated ideally over more than one assessment during the course of the delirium, and to consistency with wishes articulated before the onset of delirium. In regards to the latter, a significant change from previous dispositions in the presence of delirium is highly suspicious of incapacity and the testator's rationale for the change needs to be explored carefully.
- Were these wishes expressed during a "lucid interval" when the person was less confused? This may be relative to the complexity of the will such that a person may still be impaired but be sufficiently intact to make a simple will that shows consistency over time. Since delirium may involve a patchy pattern of deficits that fluctuate over time it is important to document lucidity in relation to the task at hand.
- Were the patient's wishes clearly expressed in response to open-ended questions?
- Is there clear documentation of the patient's mental status at the time of the discussion?

Assessing the task-specific aspects of testamentary capacity involves asking the person through open-ended questions if they know why the meeting is taking place; do they know the people who are present and why they are there; do they know what the documents are that they are signing; do they know the nature and extent of their property; do they know their relationship to the persons who will benefit; do they understand the consequences of what they are signing; do they have a rationale for deviating from any pattern of disposition identified in previous wills or wishes regarding testamentary intent; and are they signing the documents as their free and voluntary act? (Shulman *et al.*, 2007; 2009).

A previous paper (Shulman *et al.*, 2009) has addressed the issue of contemporaneous assessment of testamentary capacity. In addition to taking notes of the conversation involving changes in wills or other estate planning documents, the attorney might arrange to videotape the conversation so that if there is a dispute, the judge or jury can see the evidence for themselves based on in-depth probing of the testator's mental state and understanding of the documents being signed and the rationale for any changes. The videotaped interview can provide useful documentation regarding capacity if conducted in an open-ended fashion by a skilled clinician, while a video based on passive acquiescence (or "yes/no" responses) to closed questioning offers very little useful evidence as to the testator's understanding and may actually raise questions about capacity. That is particularly important in a case with a great deal of money at stake and one which is likely to be contested. In such cases it is also important to avoid any actual or perceived conflicts of interest or influence.

https://doi.org/10.1017/S1041610210000712 Published online by Cambridge University Press

For example, it would have been suspicious in the above cases if Attorney B or the two witnesses had been the new beneficiaries of the revised documents or if any of them had a relationship with the Jones family. Similarly, if Miss R's cousin had taken her to her own solicitor and been present in the room when Miss R gave instructions, this might have raised questions about undue influence, to which she was vulnerable given her frailty, dependency and cognitive impairment. (However, it must be noted that testamentary capacity must be present in order to establish undue influence.)

With careful questioning and documentation it may be possible to demonstrate testamentary capacity at the time the documents are signed even in a patient whose delirium causes periods of significant confusion at other times. Clearly, a patient such as Miss R who is too confused to have such a discussion does not have the capacity to sign such papers and should not be asked to do so.

The issue of delirium is not uncommon in will challenges. It is usually relevant when instructions are taken in the hospital setting, particularly when someone decides, or is prompted, to write a will on their "death bed" or when they are extremely unwell. In that situation the patient may be regressed, more dependent on caregivers, anxious and in an unfamiliar environment which adds to their vulnerability. Ironically this is the very time that people want to – or are prompted to – "get their affairs in order", but being sick per se might interfere with this process. Doctors and nurses are often called in at this time to witness a will or attest to someone's testamentary capacity. Such medical experts as well as the patient's attorney should carefully evaluate the patient's capacity to make such decisions based on open-ended questioning of the patient's intent, the rationale for it and its consistency with previously executed documents or expressed opinions.

Conflict of interest

None.

Description of authors' roles

Dr. Liptzin provided the first case and wrote the first draft of the paper. Dr. Peisah contributed the second case and helped revise the paper. Drs. Finkel and Shulman substantially edited and revised the paper.

References

American Psychiatric Association (2000). *Diagnostic and Statistical Manual of Mental Disorders*, 4th edition, text revision. Washington, DC: American Psychiatric Association.

Banks v. Goodfellow (1870). *LR5 QB*, 549.

Frolik, L. A. (2001). The strange interplay of testamentary capacity and the doctrine of undue influence: are we protecting older testators or overriding individual preferences? *International Journal of Law and Psychiatry*, 24, 253–266.

Hull, R. and Hull, I. (1996). Suspicious circumstances in relation to testamentary capacity and undue influence. In Law Society of Upper Canada, *Estates: Planning, Administration, and Litigation* (pp. 77–87), Special Lectures. Toronto: Carswell.

Inouye, S. K., van Dyck, C. H., Alessi, C. A., Balkin, S., Siegal, A. P. and Horwitz, R. I. (1990). Clarifying confusion: the confusion assessment method: a new method for detection of delirium. *Annals of Internal Medicine*, 113, 941–948.

Liptzin, B. and Jacobson, S. (2009). Delirium. In B. J. Sadock, V. A. Sadock and P. Ruiz (eds.), *Comprehensive Textbook of Psychiatry*, 9th edn (pp. 4066–4073). Philadelphia: Lippincott Williams & Wilkins.

McCartney, J. R. and Palmateer, I. M. (1985). Assessment of cognitive deficit in geriatric patients. *Journal of the American Geriatrics Society*, 33, 467–471.

Peisah, C., Brodaty, H. and Quadrio, C. (2006). Family conflict in dementia: prodigal sons and black sheep. *International Journal of Geriatric Psychiatry*, 21, 485–492.

Peisah, C. *et al.* for the International Psychogeriatric Association Task Force on Wills and Undue Influence (2009). The wills of older people: risk factors for undue influence. *International Psychogeriatrics*, 21, 7–15.

Shulman, K. I., Cohen, C. A., Kirsh, F. C., Hull, I. M. and Champine, P. R. (2007). Assessment of testamentary capacity and vulnerability to undue influence. *American Journal of Psychiatry*, 164, 722–727.

Shulman, K. I., Peisah, C., Jacoby, R., Heinik, J. and Finkel, S. for the International, Psychogeriatric Association Task Force on Testamentary Capacity and Undue Influence (2009). Contemporaneous assessment of testamentary capacity. *International Psychogeriatrics*, 21, 433–439.

Spar, J. E. and Garb, A. S. (1992). Assessing competency to make a will. *American Journal of Psychiatry*, 149, 169–174.

Sprehe, D. J. and Kerr, A. L. (1996). Use of legal terms in will contests: implications for psychiatrists. *Bulletin of the American Academy of Psychiatry and the Law*, 24, 255–265.

https://doi.org/10.1017/S1041610210000712 Published online by Cambridge University Press