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A Lawyer's Guide to Diminishing Capacity and Effective Use of Medical Experts in Contemporaneous and Retrospective Evaluations

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I. INTRODUCTION

With the rapid aging of the population and the resulting increase in life expectancy, mental disorders such as dementia, delirium, depression, and psychoses, or the combination of these conditions, are becoming more and more prevalent. Not surprisingly, conservatorship disputes and will, trust, and contract contests are also becoming more prevalent. As a result, trust and estate lawyers must increasingly rely on experts in both the contemporaneous evaluation of clients to determine their capacity to contract, to make a will, or to manage their affairs, or in retrospective analysis of a person's mental condition, typically as a result of litigation.

There is ample literature on the legal requirements and the factors that may persuade the fact finder to reach a conclusion that a proposed conservatee is incapacitated or that a decedent lacked testamentary or contractual capacity or was susceptible to undue influence. The authors have collaborated on this article for the purpose of assisting trust and estate lawyers to: (1) attain a greater understanding of the diagnosis of mental disorders; (2) demystify medical records; (3) improve the trial lawyer's ability to prepare for depositions of both percipient and expert witnesses; (4) work more productively with an expert witness; and (5) utilize experts at trial more effectively, including understanding the appropriate role of experts. We begin with a summary of the legal criteria for competence to manage one's affairs or resist undue influence, testamentary capacity and testamentary undue influence, and contractual capacity and undue influence, because those criteria dictate the evidence that must be gathered, analyzed and presented at trial. Section III explains in a manner that is intended to be accessible by attorneys and useful to their practice the clinical features and diagnosis of common mental disorders and syndromes known to affect capacity and vulnerability to undue influence. Section IV discusses the proper role of experts, how to use them to shape discovery, and how to present the medical evidence at trial.

II. LEGAL PRINCIPLES

State law establishes criteria for several different types of decisional capacity, including the capacity to execute a will or trust ("testamentary capacity"),[1] to enter into a contract ("contractual capacity"),[2] and to give informed consent for a medical intervention.[3] These laws all concern the individual's mental state at the precise moment that a particular decision is executed, typically via signature on a document.[4] A different form of capacity is spelled out in statutes defining persons eligible to have a conservator or guardian of the person or estate.[5] These statutes focus on the individual's ability to carry out goal-oriented actions (self-care and management of finances) over time. For example, an individual who "is unable to provide properly for his or her personal needs for physical health, food, clothing, or shelter" may have a conservator or guardian of the person appointed.[6] "A conservator or guardian of the estate may be appointed for a person who is substantially unable to manage his or her own financial resources or resist fraud or undue influence."[7]

The conservatorship and guardianship statutes imply (but do not explicitly state) that these functional abilities are in part dependent upon sustained decisional capacity, such as the decision to go to the doctor, to pay the mortgage, and so forth. The distinction between decisional and functional capacity is not

[1] *See, e.g.*, Cal. Prob. Code Ann. § 6100.5; Fla. Stat. § 732.501.

[2] Cal. Civ. Code Ann. § 38.

[3] Cal. Prob. Code Ann.§ 813; Fla. Stat. § 765.204.

[4] *See, e.g.*, Estate of Mann, 229 Cal. Rptr. 225, 230 (Cal. App. 1986); York v. Smith, 385 So. 2d 1110 (Fla. App. 1980).

[5] Cal. Prob. Code Ann. § 1800 et seq.; Fla. Stat. §§ 393.12, 744.331.

[6] Cal. Prob. Code Ann. § 1801(a).

[7] Cal. Prob. Code Ann. § 1801(b); N.Y. Mental Hygiene Law § 81.02 (McKinney's 2007).

made in states (at least 18, as of this writing) that define persons eligible for appointment of a conservator or guardian via a version of the Uniform Probate Code, which focuses on decisional capacity. For example, Mont. Code Ann. § 72-5-101 provides:

> "Incapacitated person" means any person who is impaired by reason of mental illness, mental deficiency, physical illness or disability, chronic use of drugs, chronic intoxication, or other cause (except minority) to the extent that he lacks sufficient understanding or capacity to make or communicate responsible decisions concerning his person or which cause has so impaired the person's judgment that he is incapable of realizing and making a rational decision with respect to his need for treatment.

We discuss the assessment of decisional and functional capacity in separate sections below. Implied in both sections is the general principle that both decisional and functional capacity are *threshold* concepts. Stated otherwise, an individual is either impaired enough to lack capacity or he or she is not, and there is no middle ground. This is in contrast to the broader concept of *susceptibility to undue influence* (discussed in detail below), which is a *dimensional* concept. In other words, there are degrees of susceptibility. It follows that a cognitively impaired individual may be more vulnerable to undue influence than he or she would be without the impairment, even if the impairment is not severe enough to reach the threshold of decisional incapacity. Each of the mental conditions discussed below, if severe enough, can rob an individual of decisional or functional capacity, but even at much milder levels of severity, such conditions can increase a person's susceptibility to undue influence.

A. Decisional Capacity

Mental health experts are called upon to evaluate decisional capacity in two contexts. The first involves a living individual who is about to or who has recently executed a decision related to a will, trust, gift, contract, or medical procedure. For all but medical decisions, the expert is typically asked by an attorney to evaluate the decisional capacity of the attorney's client. For evaluation of medical decision-making capacity, the request typically comes from another physician. Medical decisions will not be discussed further in this article, but the same principles apply as to the other decisions that are discussed. The second context develops when a past decision made by a now-deceased individual is at issue (or, less commonly, by an individual whose contemporaneous lack of capacity is not in dispute), and litigation challenging that decision on the basis of lack of capacity or undue influence, as discussed below, is anticipated or underway. In both contexts the expert must be familiar with the relevant statutory criteria for capacity and must conduct the retrospective or contemporaneous evaluation accordingly. Statutes defining capacity typically enumerate specific information that the competent person must have *the ability* to know, recall, or understand, but none require that the individual has *actual* knowledge, recollection, or understanding. This principle has been articulated as follows: "it is the generally recognized rule that testamentary capacity requires only that the testator have capacity to know and understand the nature and extent of his bounty, as distinguished from the requirement that he have actual knowledge thereof."[8]

Cal. Prob. Code Ann. § 6100.5 follows this same principle. Section 6100.5 states, in relevant part, "(a) An individual is not mentally competent to make a will if at the time of making the will either of the following is true: (1) The individual does not have sufficient mental capacity to be able to (A) understand the nature of the testamentary act, (B) understand and recollect the nature and situation of the individual's property, or (C) remember and understand the individual's relations to living descendants, spouse, and parents, and those whose interests are affected by the will." The distinction between the *ability* to "understand and recollect" and *actually* understanding and recollecting is extremely important in retrospective evaluations of capacity and in the occasional contemporaneous evaluations of capacity, as discussed below.

1. Contemporaneous Evaluation of Decisional Capacity

Three key principles guide the contemporaneous evaluation of decisional capacity. First, the vast majority of cases of incapacity entail impairment in one or more *cognitive functions,* which include attention and concentration, immediate, recent and remote memory, language comprehension and expression, ability to calculate, capacity for abstract thinking, reasoning and planning, general fund of knowledge, and nonverbal skills such as figure copying. These functions are impaired, to varying degrees, by the dementing illnesses, such as Alzheimer's disease and by delirium. More rarely, a mental illness such as schizophrenia or major depression, which does not primarily affect cognition, can also lead to lack of capacity. These and other common conditions that can affect capacity are discussed below.

[8] Estate of Jenks, 189 N.W.2d 695, 697 (Mn. 1971).

The second principle is that the timing of the evaluation of decisional capacity is critical. An expert opinion about someone's decisional capacity is most relevant on the day of the evaluation, which ideally is the same day that the document at issue is executed. The longer the time period between evaluation and execution, the greater the possibility that interval change in mental status can occur and render the results of the capacity evaluation moot. Merely the possibility of a pre- or post-evaluation change in mental status may encourage a potential contestant to reject the conclusions of an untimely competency evaluation.

The third key principle is that any particular performance by the individual being evaluated is only a surrogate for what the expert is really trying to assess: what the individual is able to do. We assume that the most reliable and valid expression of a person's cognitive ability is his or her performance under ideal conditions, free of extraneous factors that could negatively affect cognitive function. Extraneous factors that can compromise cognitive performance include: (1) environmental circumstances, such as poor lighting, distracting noises, and suboptimal acoustics; (2) client factors, such as acute emotional stress, medication side effects, and excessive sleepiness due to pre-evaluation insomnia; and (3) examiner factors, including an examination technique that provokes unnecessary anxiety or otherwise fails to evoke a reasonably representative performance. Accordingly, the examiner should strive to reduce or eliminate these factors to the extent possible. In this regard many elderly individuals with dementia predictably perform better at certain times of the day than others. If this information is available, legal documents should be executed and evaluations of capacity performed at the time of day when the individual is typically at his or her best.

With these principles in mind, the contemporaneous evaluation of decisional capacity typically includes two parts. In the first part, the examiner asks the individual to demonstrate his or her actual knowledge, recollection, or understanding of the specific information prescribed by statute. For example, if testamentary capacity is at issue, the examiner asks the examinee to recite a list of his or her assets, to name and identify his or her relations to living descendants, spouse, parents, and those whose interests are affected by the will, to describe the function of the will or trust at issue, and to explain why the bequest pattern is the way it is. If the testator accurately provides the requisite information and reveals no delusional beliefs that directly affect the will or trust, the conclusion that he or she has testamentary capacity follows. Similarly, if contractual capacity is at issue and the individual demonstrates to the examiner's satisfaction adequate understanding and appreciation of: (1) the rights, duties, and responsibilities created or affected by the decision to enter into the contract; (2) the probable consequences for the individual and, where appropriate, the other persons affected by the contract; (3) the significant risks, benefits, and reasonable alternatives to entering into the contract, then the conclusion that he or she has contractual capacity follows. Because different examiners may have different notions of what is "adequate," it is advisable to write down the individual's verbatim responses to key questions so the court can decide.

The second part of the evaluation comprises administration of a general mental status examination and a battery of standardized tests of cognitive function. The results of these tests provide support for the expert's main conclusions, and may be particularly important in two situations. First, if the individual does *not* demonstrate sufficient *actual* knowledge, recollection, or understanding of the content specified by statute, the expert may still believe that the individual is capable of such knowledge, recollection, or understanding on the basis of his or her performance on standardized tests. Similarly, if the expert concludes that the individual does not have capacity, test scores consistent with this opinion are important. In the authors' experience, some elderly individuals who clearly retain testamentary capacity do not recall major features of their estate plans simply because they choose "not to think about those things." In most cases these individuals need only be convinced to review their estate plans for a few minutes and then are able accurately to respond to questions about their estate plans. Accordingly, we recommend that referring attorneys instruct their clients to review key information relevant to the testamentary documents, gifts, or contracts that are at issue prior to the capacity evaluation.

There is no widely accepted battery of cognitive tests for this application. The physician coauthor employs a Folstein Mini-Mental Status Examination ("MMSE"), supplemented by tests of naming, remote memory, verbal comprehension, and frontal executive function, including word list generation, similarities, proverb interpretation, alternating figure copying, clock drawing, and general information items taken from the Wechsler Adult Intelligence Scale ("WAIS"). Additional tests are added if the client reveals deficits that warrant more detailed assessment. The MMSE is a rough measure of "global" cognitive functioning that is used by a wide variety of mental health professionals. It is a 30-item test that takes about 15 minutes to administer to a cooperative individual who speaks English and has adequate hearing and vision. Published norms take both age and

educational level into account, and allow categorization of scores into "normal for age and education" (generally above 24), "mild impairment" (18-24), "moderate impairment" (10-18), and "severe impairment" (below 10).[9] The co-author has administered this test as part of the evaluation of capacity of hundreds of individuals aged 60-100+, with every type of disorder of cognition and has found that decisional capacity is rarely present in individuals with MMSE scores below 10, sometimes present in those with scores between 10 and 20 (depending upon the specific pattern of deficits and the capacity at issue, as discussed below), and usually present above 20.[10]

2. Special Considerations in Contemporaneous Assessment of Decisional Capacity

As defined by law in most states, testamentary capacity generally requires minimally intact recent and remote memory and is relatively less impacted by deficits in other cognitive functions, such as language comprehension and expression and frontal executive functions. In that regard, testamentary capacity is generally regarded as the "lowest" form of capacity and may be retained until the later stages of dementing illnesses, when impairment in all domains of cognition is severe. The physician co-author evaluated one elderly gentleman who had a Folstein Mini-Mental State score of 10 (consistent with severe impairment) who knew that he owned "a shack in the desert," that his only living relative was a cousin, Lem, and that he wanted "Lem to get the shack when I die." Based on the applicable legal standard, this elderly gentleman had sufficient capacity to make a will.

Statutory terms such as "recollect" and "recall" have several meanings. As discussed in a previous article, some elderly individuals with moderately advanced dementia cannot produce a list of their assets or of their heirs from memory but can correctly recognize their assets and relatives if shown a list that contains correct and incorrect choices.[11] When a testator cannot recall key information on request, the examiner should give the individual the opportunity to demonstrate "recognition memory" for that material by constructing an appropriate list. The list should include the correct items, along with at least an equal number of plausible but incorrect items, and its contents should be included in the report of the evaluation.

The statutory terms "understand" and "appreciate" appear in Cal. Prob. Code Ann. § 812, which is the "default" definition of decisional capacity that applies wherever a more specific statutory definition of capacity does not exist. It is generally assumed to supplement Cal. Civ. Code Ann. §§ 38 and 39(a) and (b), which together define contractual capacity. The ability to understand and appreciate ("to appreciate" is the ability to relate relevant information to one's own personal situation) information generally depends upon the ability to comprehend language, to think abstractly, and to reason via a rational thought process. In some cases these "higher" cognitive abilities are preserved relatively late in the course of dementia, even after memory is severely impaired. In other cases, these abilities are relatively more impaired, especially if the underlying dementing disease is complicated by focal damage to the receptive language area of the brain, such as by stroke, trauma, or tumor. Some demented individuals who may not be able to recall important material are able to comprehend and appreciate detailed aspects of a contract. These individuals retain contractual capacity as long as they are not required to rely upon their unaided memory alone.

3. Retrospective Evaluation of Decisional Capacity—Deciphering Medical Records

It is often possible to determine an individual's decisional capacity at a particular point in time in the past by examining medical records that encompass the time period in question. In the ideal case, the medical record contains a detailed, quantitative assessment of cognitive function on the date at issue. Unfortunately, such records are rare. Almost as useful is the medical record that contains multiple quantitative assessments of cognitive function prior to and after the date in question. Such a record would allow the expert to estimate, by interpolation, the individual's mental ability at any intermediate point in time (with a few assumptions, as discussed below). But records of this type are also rare. Most commonly, medical records contain an assortment of variably detailed descriptions of behavior that, in the hands of an adequately experienced expert, can be translated

[9] M. F. Folstein, S. E. Folstein. P. R. McHugh, *Mini-Mental State: A Practical Method for Grading the Cognitive State of Patients for the Clinician,* 12 J. PSYCH. RES. 189–198 (1975).

[10] Decision-making capacity is an active area of research among mental health professionals, and numerous standardized instruments for assessing competency and capacity have been developed for use in specific contexts. Most focus on capacity to consent to medical interventions, while others are being developed for assessment of financial decision making capacity. Review of this research and these instruments is beyond the scope of this article, but Moye & Marson (2007) (on file with the authors) have published an excellent review of research, and Dunn and colleagues (2006) (on file with the authors) provide an excellent overview of available instruments. In general, the authors feel that none of these instruments is preferable to a competent office assessment as described in this article.

[11] J. E. Spar and A. Garb, *Assessing Competency to Make a Will,* AM. J. PSYCH. 149 (1992).

into an estimate of what quantitative assessment on the date in question would have revealed. Experience in the care of patients with a wide range of cognitive impairment, in both inpatient and outpatient settings, is most valuable in this context. Such "first-hand" experience provides the basis for the interpretation of the number and sequence of otherwise vague and ambiguous terms like "confused," "alert," "A&O X4" (alert and oriented times four), "able to make needs known," and other terms of medical and nursing art.

A comprehensive guide to this interpretation is beyond the scope of this article, but a few rules of thumb may be helpful. First, the physician co-author's experience conducting contemporaneous evaluations of competency supports the general rule that severe impairment must be documented before it is possible to conclude, to a reasonable medical probability, that decisional capacity was lost. This follows from the fact that a significant proportion of individuals with mild or moderate impairment retain decisional capacity.

Second, hospital records are generally much more revealing than office records. Hospital records contain multiple daily entries by physicians, nurses, social workers, and other allied professionals. Entries in hospital records are much more detailed than the doctors' notes typically kept in outpatient settings, and the records provide a continuous picture of the individual's functioning, 24 hours per day, over the hospital course. Hospital records of patients with severe cognitive impairment (i.e., a MMSE score of 10 or less) commonly share a few key features. Almost every note mentions the impairment. The impairment often interferes with the delivery of care, and it frequently becomes a focus of treatment in itself. Notes reflect concerns about ability to give informed consent for procedures, requests for consultation by psychiatrists on issues of capacity may be present, and consent forms may be signed by surrogate decision makers. Chart entries document severe deficits, such as "wife at bedside." "Patient does not recognize wife." "Patient thinks he is in a hotel and wants to check out." In cases of moderate or mild impairment, the chart typically contains multiple entries stating, "confused," "disoriented," "Ox2 (oriented times two) only," and "forgetful," but quantitative assessment is not present. Terms like "confused" and "disoriented" clearly document impairment but do not specify the degree of impairment, so it is rarely possible to conclude lack of capacity from records of this type.

Finally, contrary to what appears to be popular belief among attorneys, knowing what medications were administered at the time of execution of a will, trust, or contract does not, by itself, allow any firm conclusions about cognitive function. Individual sensitivity to medication effects is much too variable and is influenced by too many factors to support any reliable conclusions in this regard. In the end, the important fact is what the individual's cognitive status actually was, not what it could have been.

4. Beyond the Medical Record

If medical records are not available, written or other productions by the individual in question can be very useful, particularly in assessing language function. If it can be assumed that the individual created the content spontaneously, without memory aids or assistance, assessment of memory, abstract thinking, and reasoning may also be possible. Similarly, deposition testimony of disinterested witnesses in which the individual's intellectual functioning is described may be probative to the extent that there is adequate detail and consistency.

B. Functional Capacity—Contemporaneous Evaluation of Capacity to Care for One's Self and Manage One's Finances

Office assessment of an individual's capacity for self care and management of finances is often a significantly more difficult task than is assessment of decisional capacity. This is because, except in extreme cases, office evaluation of mental function, including scores on standardized tests of cognitive function, does not predict day-to-day function with acceptable reliability. Extreme cases include, at one end of the spectrum, the individual who demonstrates perfectly normal cognitive function on a broad range of tests, and at the other end, those who demonstrate severe impairment in all spheres. In the former situation the conclusion that a conservatorship is not appropriate is obvious, while in the latter situation the conclusion that a conservatorship is appropriate (if less restrictive alternatives are not available), is equally obvious. But individuals whose cognitive function falls into the "grey" area of mild to moderate impairment are harder to categorize. In these cases, the examiner must supplement the office evaluation with information about the individual's actual level of day-to-day function, ideally from "disinterested" parties such as caregivers, spouses, friends, or close associates.

Several factors contribute to this ambiguity of "mid-range" performances on tests of cognitive function. Personality features are often important. Individuals who have been very independent all their lives may be able to maintain daily function in the face of significant cognitive impairment, while less independent individuals may become quite dysfunctional at a much earlier stage of impairment. The cluster of related cognitive abilities that fall into the category of "frontal executive function" seem to be of particular importance in determining daily function, but are not assessed well by the standardized instruments employed in most office eval-

uations of capacity. These frontal executive deficits are manifested by inability to organize thought, speech, and behavior over time and by apathy, reduced motivation, and impaired judgment. Together these deficits lead to impaired problem-solving ability and reduced ability to carry out many activities of daily living, such as paying bills, depositing checks, balancing a checkbook, taking the right medications at the right time, shopping and cooking, and maintaining personal and household hygiene. The physician co-author has evaluated many individuals who clearly demonstrate retained decisional capacity—the ability to grasp details of a complex contract, accurately recall testamentary information, and arrive at individual decisions that are consistent with their lifelong goals and values via an obviously rational thought process. Yet these same individuals, left to their own devices, allow dividend checks to pile up on the kitchen table and fall into the trash, fail to pay electric, phone and gas bills, resulting in the discontinuation of service, and allow their personal health and hygiene to deteriorate because of deficits in frontal executive functions. Finally, the relative stability of the individual's physical and social environment is also important. The elderly individual who has lived in the same apartment and shopped in the same local stores for decades may be able to live independently for a lot longer than a similarly impaired peer whose environment is fluid and unpredictable.

C. Undue Influence

1. Undue Influence in a Testamentary Context

As established by case law, to be considered undue, influence must contain an element of "coercion destroying the free agency on the part of the testator."[12] According to the Michigan Supreme Court:

> Influences to induce testamentary disposition may be specific and direct without becoming undue as it is not improper to advise, persuade, solicit, importune, entreat, implore, move hopes, fears, or prejudices or to make appeals to vanity, pride, sense of justice, obligations of duty, ties of friendship, affection, or kindred sentiment or gratitude or to pity for distress and destitution, although such will would not have been made but for such influence, so long as the testator's choice is his own and not that of another....[13]

Rather, the testator's mind must be subjugated to that of another, the testator's free agency destroyed, or the testator's volition overpowered by another.[14] Courts will "presume" the existence of undue influence if certain facts are proved, requiring the accused party (the "influencer") to produce evidence to rebut the charges.[15] These facts are: (1) the accused party played an active role in procuring the will; (2) the party occupied a confidential relationship with the testator (such as a close relative or adviser); and (3) the accused profited unduly under the will.[16] If any of these three factors do not exist, the burden of proof remains with the contestant.

Courts have also identified several "indicia" of testamentary undue influence, the existence of which will help establish the contestant's case. Awareness of these indicia is important for the psychiatric consultant. They are: (1) unnatural provisions in the will; (2) will provisions inconsistent with prior or subsequent expressions of the testator's intentions; (3) a relationship between the testator and the beneficiary that created an opportunity to control the testamentary act; (4) a mental or physical condition of the testator that facilitates the subversion of the testator's free will; (5) the beneficiary's active participation in procuring the will; (6) an undue profit to the beneficiary under the will; and (7) a confidential relationship between the testator and the beneficiary.[17] These indicia are applicable in most states, even in those states that do not recognize presumptive evidence of undue influence. The mental illnesses discussed in this article are referred to in (4), while (3) captures the other major factor, besides mental illness, that the authors have most often encountered in situations where undue influence was either alleged or feared, which is dependency. For purposes of this discussion, dependency exists when one individual is responsible for the provision of day-to-day care for another. Dementia almost always leads to dependency, and caregivers of demented individuals are commonly accused of exerting undue influence in both contractual (i.e., involving transfers) and testamentary contexts.

In the authors' model of susceptibility to undue influence, mental illness, particularly dementia, is the most powerful factor that increases an individual's susceptibility to undue influence, and the resulting susceptibility is "general." In other words, the individual is equally vulnerable to undue influence exerted by just about anyone. On the other hand, dependency leads to "specific" vulnerability—

[12] Estate of Mann, 229 Cal. Rptr. at 231; In re Camac, 751 N.Y.S.2d 435 (App. Div. 2002).

[13] In re Langlois' Estate, 106 N.W.2d 132, 134 (Mich. 1960).

[14] *Id. See also* Estate of Baker, 182 Cal. Rptr. 550, 556 (Cal. App. 1982); Estate of Gecht, 331 P.2d 1019, 1027 (Cal. App. 1958).

[15] Estate of Sarabia, 270 Cal. Rptr. 560, 563 (Cal App. 1990); In re Neenan, 35 A.3d 475 (N.Y. 2006).

[16] Estate of Sarabia, 270 Cal. Rptr. at 563.

[17] *Id.*

vulnerability to undue influence exerted by the person upon whom the individual is dependent. In practice, most cases involve the combination of both types of vulnerability.

2. Susceptibility to Undue Influence in a Conservatorship, Guardianship, or Contractual Context

State law is generally consistent in defining undue influence. Cal. Civ. Code Ann. § 1575 states,

> "Undue influence consists: 1. In the use, by one in whom a confidence is reposed by another, or who holds a real or apparent authority over him, of such confidence or authority for the purpose of obtaining an unfair advantage over him; 2. In taking an unfair advantage of another's weakness of mind; or, 3. In taking a grossly oppressive and unfair advantage of another's necessities or distress."

Here, the term "weakness of mind" presumably refers to mental illness, but may also include personality features, such as passivity, dependency, and gullibility, that do not rise to the level of illness. "Real or apparent authority" likely includes those in a position of caregiving when the recipient of the care is mentally or physically dependent upon that care.

This definition of undue influence seems somewhat broader than testamentary undue influence in that it does not require any element of "coercion, compulsion, or restraint" and therefore may encompass influence resulting from "gratitude or affection." While "undue benefit" does not appear in the definition, "unfair advantage" may be interpreted to have a similar meaning. Since the appointment of a conservator or guardian of the estate results in the loss of legal capacity to contract, susceptibility to this version of undue influence would seem to be at issue in determining whether a person is "substantially unable to manage his or her own finances or resist fraud or undue influence," as spelled out in Cal. Prob. Code Ann. § 1801(b).

For purposes of this article, vulnerability to both versions of undue influence is assumed to be affected equally by mental illness and dependency.

III. MENTAL DISORDERS THAT CAN ERODE COMPETENCY AND INCREASE VULNERABILITY TO UNDUE INFLUENCE

A. Normal Aging

Cognitive changes with normal aging include reduced speed of information processing, deficits in "working memory," and sensory and perceptual changes. Slowing of information processing can affect attention, memory, and decision making and reduce performance even on tasks that have no obvious speed requirements. Working memory refers to short-term retention and manipulation of information held in conscious memory, a type of "on-line" cognitive processing. Consciously recalling a telephone number long enough to write it down and mentally calculating the sale price of an item that is reduced by 15% both depend upon working memory. These kinds of information tend to fade from working memory within about two seconds, so keeping details "alive" for a longer time requires active rehearsal or continuing refocusing of attention. Normal aging is associated with a decline in working memory skills, especially when active manipulation of information is required (e.g., repeating numbers backward as opposed to forward). Reductions in working memory, in turn, place limits on other complex cognitive skills, including reasoning and other executive processes, and learning and recall of new information. Declines in visual and auditory acuity are also common accompaniments of aging and are correlated with reduced cognitive performance in old age.[18]

The combined effects of "normal" central nervous system slowing, reduced working memory, and sensory and perceptual change may negatively affect the older individual's ability to properly consider and weigh the factors involved in testamentary or contractual decisions, but are rarely in the authors' experience disabling enough to result in lack of decisional capacity. On the other hand, these aging changes commonly do affect older individuals' ability to provide self care and manage finances, especially in the presence of significant physical limitations, and may in themselves increase vulnerability to undue influence.

B. Mood Disorders

1. Depression

A substantial proportion of elderly individuals with depression exhibit concurrent cognitive impairment, particularly in visuospatial ability, psychomotor speed, and executive functioning. Depression with functionally significant cognitive impairment, sometimes known as *depressive pseudodementia* or the *dementia syndrome of depression* (DSD), is distinguished from the milder, clinically silent cognitive impairment associated with depression that may only

[18] J. E. SPAR AND A. LA RUE, CLINICAL MANUAL OF GERIATRIC PSYCHIATRY 23-24. (2006).

be detected by comprehensive neuropsychological testing. The cognitive impairment of DSD is rarely severe enough to result in loss of decisional capacity, but may be accompanied by enough apathy and loss of motivation to result in greatly impaired day-to-day function, and consideration of conservatorship may be appropriate, at least until the depression remits. A more subtle manifestation of depression may be temporary abandonment of one's lifelong goals and values, leading to decisions that are "inauthentic", if not downright incompetent. This is of particular concern in medical contexts, where treatment refusal may reflect the wish for self-harm, or in testamentary or contractual contexts where decisions may reflect pervasive negativism and nihilism that is, at least in principle, reversible. From a clinical perspective, when an individual who is known to be seriously depressed starts giving away previously cherished possessions, concern about suicidal intent is appropriate. But it is not clear whether this type of "impaired" decision making is fully captured by the legal concept of incapacity.

2. Hypomania and Mania

These terms refer to states of pathologically elevated mood that occur in various forms of bipolar mood disorder ("manic depression" is the severest form) and as a result of abuse of psychostimulant medications such as amphetamine and cocaine. These syndromes are typically not associated with cognitive impairment per se, and therefore pose a similar challenge to traditional legal notions of "lack of capacity" as do the depressive decisions discussed above. In hypomania and mania the issue is impairment of judgment and impulse control, not lack of the ability to know and understand key information. Pathological mood elevation leads to decisions that severely overestimate the odds of success and underestimate both the odds and the consequences of failure. Unfortunately, these decisions often overlap with "garden variety" bad decisions, and this overlap tends to obscure the contribution of mental illness and make it difficult for attorneys and judges to apply appropriate legal standards. Often, the only way to discern the pathological nature of such decisions is by comparison with the individual's long standing values and goals, particularly if the decisions at issue are made after clear hypomania or mania has supervened.

C. Psychotic Disorders—Schizophrenia, Schizoaffective Disorder, Bipolar Disorder, Psychotic Depression

For purposes of this article, the common "psychotic" features of these illnesses include hallucinations, delusions, severe thought disorder, and bizarre behavior, all of which can impair decision making, capacity for self-care, and capacity to manage finances and resist fraud and undue influence. DSM-IV-TR (the standard classification of mental illnesses used by mental health professionals) defines a delusion as follows:

> A false belief based upon incorrect inference about external reality that is firmly sustained despite what almost everyone else believes and despite what constitutes incontrovertible and obvious proof or evidence to the contrary, that is not ordinarily held by other members of the person's culture or subculture. When a false belief involves a value judgment, it is regarded as a delusion only when the judgment is so extreme as to defy credibility."

While it is usually clear when a belief is delusional, some cases are difficult to interpret. If a transfer from John to Joe is based upon Joe agreeing with and encouraging John's clearly false belief that he (John) is a great artist (clearly a value judgment), what evidence will prove that the belief is a delusion, and that the transfer is therefore invalid?

D. Dementia

Each of the dementing illnesses discussed below is progressive and causes increasingly impaired decision making capacity, day-to-day functional capacity, and increasing vulnerability to undue influence. In the early stages, when cognitive impairment is mild, vulnerability to undue influence may increase while decisional and functional capacity is retained. When the level of moderate cognitive impairment is reached, some individuals lose the ability to manage their personal and financial affairs, and some decisional capacities may be lost. Finally, in the later stages, when cognitive impairment is severe, all functional and decisional capacity is lost. In general, the principles of contemporaneous and retrospective assessment of capacity and susceptibility to undue influence discussed above apply when any of these conditions are present. Considerations specific to each of the common dementing diseases are discussed below.

1. Alzheimer's Disease ("AD")

AD is the most common cause of progressive dementia. Including both early onset (age 65 or younger, accounting for about 1% of all AD cases) and late-onset (older than 65) subtypes, AD is the cause of about 50% of all cases of primary dementia. It may combine with other conditions, primarily vascular dementia, in another 10%–20%.[19] Impairment in all cognitive functions occurs eventually in AD, but early

[19] K. Langa, N. Foster, and E. Larson, *Mixed Dementia: Emerging Concepts and Therapeutic Implications*, J. AMER. MED. ASSN. 2901-08 (2004).

manifestations may be limited to impairment in recent memory. In cases uncomplicated by vascular disease, it is reasonable to assume a gradual course of progression, with a decline of two to four points on the MMSE per year throughout most of the course. This allows the expert consultant to estimate an individual's mental status at various time points before and after cognitive assessments are either documented or can be "reconstructed" from available information.

2. Frontotemporal dementia ("FTD")

FTD is a term used to describe a group of disorders that share a common pattern of relatively focal degeneration of the frontal and temporal lobes of the brain. Classic Pick's disease, primary progressive aphasia, and several other histopathologically distinct conditions are the main contributors to this category. Personality changes may precede obvious cognitive deficits by several years, so FTD must be considered when a pattern of behavior that is "out of character" for the individual is observed. Otherwise, capacity issues follow principles as outlined for Alzheimer's disease.

3. Parkinson's Dementia

Some patients with Parkinson's disease develop noticeable cognitive deficits within a year or two of the onset of motor symptoms. Other patients remain free of all but minor executive deficits for five to 10 years, and many never exhibit the level of cognitive deficit that would be detected on mental status exams. When cognitive deficits become severe enough, the resulting dementia is sometimes described as "subcortical" because it comprises a cluster of clinical features that are relatively less common in dementing illnesses with primarily cortical (referring to the cerebral cortex, or "grey matter," of the brain) pathology such as Alzheimer's disease. These "subcortical" features include relative preservation of language function, visuoperceptual skills, and ability to do mathematical calculations, with comparatively severe deficits in frontal executive functions, including attention, verbal fluency, and ability to plan and execute multi-step actions.

4. Lewy Body Dementia

Dementia with Lewy bodies is a progressive, degenerative dementing condition with clinical and pathologic features that overlap with those of Alzheimer's disease and Parkinson's disease.[20] Unlike other dementias, fluctuation in cognitive function are common, and this may be the only dementing illness in which the concept of a "lucid period," i.e., a period of relatively normal cognitive functioning surrounded by periods of significant impairment, is applicable. Unfortunately, there is no definitive diagnostic test for this illness. Forensic considerations are generally as for AD.

5. Vascular Dementia

This condition is caused by the accumulation of small strokes,[21] each of which may damage a small enough bit of brain tissue as to be not noticed by the patient or those around him or her. When enough brain tissue is damaged in this way, cognitive and functional deficits severe enough to warrant a diagnosis of dementia result. The history of the present illness in vascular dementia is classically one of a more abrupt, stepwise course of cognitive impairment than the more gradual onset and decline typical of "pure" Alzheimer's and the other degenerative dementias listed above. When there is evidence of vascular disease of the brain, making vascular dementia a possible diagnosis, it is much less reasonable to assume a gradual progression of cognitive impairment and harder retrospectively to determine when any given level of impairment was reached, unless appropriate testing at the critical time is documented.

6. Dementia Due to Other Medical Conditions

Although many other conditions can cause impairment in cognition and function severe enough to meet criteria for dementia, DSM-IV-TR specifically recognizes HIV infection, head trauma, and Huntington's, Creutzfeldt-Jakob, and Pick's disease (discussed above in the section on Frontotemporal Dementia) as capable of causing dementia via direct damage to brain structures by infection, trauma, or degeneration. Differentiation of each of these conditions from Alzheimer's disease, FTD, dementia with Lewy bodies, vascular dementia, and other dementing conditions depends on identification of the characteristic physical and laboratory abnormalities associated with each disease entity, supported by appropriate historical information.

7. Dementia Due to Substance Abuse

Certain substances with central nervous system activity, such as alcohol, can produce both intoxication, during which cognitive and functional impairment severe enough to otherwise qualify as dementia may be present, and dementia per se, which persists for months or years after the substance use is terminated. Mild dementia of this type is not uncommon in those who drink heavily, and even though cog-

[20] I. McKeith, D. Galsko, and K. Kosaka, et al., *Consensus Guidelines for the Clinical and Pathologic Diagnosis of Dementia with Lewy Bodies (DLB), Report of the Consortium on DLB International Workshop,* 47 NEUROLOGY 1113-24 (1996).

[21] A stroke is most commonly caused by blockage of blood flow to a part of the brain, resulting in the permanent loss of function of neurons and other cells in that part.

nition tends to improve after drinking is discontinued, some deficits may persist for years and may be permanent. On neuropsychological testing, older adults with alcohol-related dementia demonstrate relatively prominent features of subcortical dementia including reduced mental control and executive function impairments, and some may exhibit learning and memory problems similar to those of AD patients at comparable levels of dementia severity. Unfortunately, it is not possible to determine the presence or severity of an individual's cognitive changes at any point in time just by knowing how much they were drinking.

8. Delirium

This is a syndrome of "reduced clarity of awareness of the environment" and "reduced ability to focus, sustain, or shift attention." It is typically seen in the context of acute medical illness or injury or intoxication with or withdrawal from certain psychoactive substances, such as alcohol. Delirium tends to come on suddenly, develop rapidly, and improve as the underlying medical condition improves. The course may be hours to weeks, but some cases persist for months. Delirium tends to have a waxing and waning course, and may cycle several times during the course of a day. Accordingly, decisional capacity may also wax and wane during the course of the day. Unlike the dementing conditions, discussed above, in uncomplicated delirium the "hard wiring" of the brain is not damaged. By way of analogy, a delirious person is like a radio that is intact, but is drifting in and out of tune to a station. For the brief periods that the station is properly tuned in, the radio may function normally. Similarly, a skilled interviewer may be able to capture a delirious individual's attention long enough to elicit a meaningful and competent decision. This is the quintessential condition in which "lucid periods" can occur. It is important to note, however, that dementia is a risk factor for the development of delirium, so the conditions not uncommonly co-exist.

9. Effects of Electroconvulsive Therapy ("ECT") on Cognition

In the hours immediately following a treatment episode, patients are typically groggy and may display cognitive impairment indistinguishable from mild delirium. This state usually clears up in a few hours. Over the course of treatment, which may entail two to four weeks of three treatments per week (treatments are usually administered on alternating days, not including weekends), a mild dementia may develop, depending upon electrode placement and other factors. This dementia reaches its peak after the last treatment, starts to resolve immediately, and is no longer noticeable, in the great majority of cases, within a few weeks of the end of treatment. During this period, new learning is impaired, and deficits in remote memory, especially for events immediately prior to and during the course of treatment, may be present. Impairment is rarely severe enough to result in loss of decisional capacity, but does increase vulnerability to undue influence.

10. Effects of Psychopharmacology on Cognition

Most psychopharmacologic agents do not significantly impair cognition when administered in normal doses. Mild deficits in attention and concentration may be produced by medications with "central anticholinergic effects" (that is, effects on specific neurons in the brain), while tranquilizers and sedatives, including alcohol and benzodiazapines (such as Valium, Xanax and Ativan), may produce intoxication, with impaired judgment and impulse control, if taken in excessive dosages. As mentioned above, short of near-lethal dosages, it is generally not possible to predict what, if any, effects on cognition a particular medication will produce.

IV. USING EXPERTS IN DISCOVERY AND TRIAL

In this part of the article, the authors assume that litigation is anticipated or underway and focus on the role of experts concerning decisional or functional capacity and susceptibility to undue influence. In general, experts should be used to teach and persuade the judge or jury that the party's theory is more reasonable and should be adopted by the trier of fact. All experts possess greater knowledge of their field of study than anyone else in the courtroom, but effective experts are those who can communicate their expertise in a way that is understandable and believable by a lay person. Below, the authors discuss strategies for selecting an expert to testify on issues of capacity and undue influence, using the expert to plan discovery, and deposing and examining the expert at trial.

A. Using the Expert Before Trial

1. Selecting an Expert Witness

The authors strongly recommend involving the expert early. The best practice is to consult with the expert before the first pleading is ever filed,[22]

[22] If for no other reason (and there are plenty of other reasons), the lawyer will want to make certain that the lawyer is able to retain the right expert without interference from the lawyer's adversary. If the adversary provides confidential information to an expert, the expert will be precluded based upon a conflict of interest from serving as an expert for your client. It is unethical to contact possible expert witnesses for the purpose of creating conflicts for an adversary. Unfortunately, there are lawyers who engage in such tactics and early action to retain your expert is always the best practice.

particularly if the attorney is contemplating a contest based upon lack of capacity or undue influence. Instituting an action without first consulting an expert to evaluate whether there is a good faith basis for believing that such a case can be alleged and proven would be, at best, a gamble of unknown risk. It may not be possible because of HIPAA regulations to obtain information that allows the expert to render a definitive opinion, but the attorney should determine with the expert whether there is sufficient information on the basis of the client's observations and those of third parties to make a good faith allegation of incapacity or undue influence.

When the issues in the case involve the mental status of an individual, a psychiatrist or neurologist certified by the American Board of Psychiatry and Neurology is highly recommended. In general, psychiatrists are better qualified to opine on an individual's mental status, but neurologists who specialize in neurobehavioral medicine are usually well-versed in this area as well. Depending on the age of the individual whose mental status is in question, it may be advisable to retain a physician who has additional subspecialty training in geriatric psychiatry or neurology. The expert physician should have substantial clinical experience treating patients with the specific disorders or diseases at issue in your case, and depending on the type of mental illness, the attorney may seek additional, more specialized expertise. For example, Parkinson's disease has clinical features that can be misunderstood, and it may be critical to employ a physician who has particular expertise in Parkinson's and its effects on cognition.

It is also advisable to select an expert with experience as an expert witness. The experience of testifying in a deposition and at trial is different than the experience of treating patients or lecturing to an audience of medical students or professionals. As a corollary point, it is also a mistake to assume that the expert with the longest resume will necessarily be the best witness. . Credentials may be impressive but are not necessarily persuasive.

2. Making Effective Use of Experts Before Trial

Experts can be extremely useful in guiding the attorney's discovery plan. A review of medical records is a given. With those records, the expert can help the lawyer focus on other documents which may be of use. For instance, there may be laboratory results that are not included in a particular medical record that may be useful in ruling out alternatives to a diagnosis of dementia, or that might militate against such a diagnosis. As an example, was there an electroencephalogram that suggests delirium in addition to, or even instead of dementia? Beyond medical records, the expert can help the attorney explore other avenues of document discovery. If, for example, the expert suspects frontotemporal dementia, documentary evidence of the patient's "out of character" conduct could support that diagnosis. Perhaps there is anecdotal evidence of problems at the place of employment. In that case, employment records might reveal unusual conduct. What might not have seemed a terribly fruitful path could in fact support a medical diagnosis.

An expert can help guide the attorney in asking fact witnesses questions that may be useful in formulating or supporting the expert's opinion. For example, it can be difficult for the expert to differentiate between DSD and early dementia of the Alzheimer's or vascular type. The distinction may be critical because the cognitive impairment associated with DSD can be reversed or improved by treating the underlying depressive illness. There are facts which may be useful to the expert in making the distinction. For instance, persons with DSD may show apathetic behavior in their daily life, frequently complain about their loss of cognition, and display improved cognition during temporary periods of improved mood. These features are typically not associated with dementia of the Alzheimer's or vascular type and may be revealed by testimony of friends and neighbors.

3. Preparing Experts for Deposition

Of great concern to the expert is that the retaining attorney will neglect to mention certain facts that the expert learns for the first time on cross examination in deposition, or even worse, at trial. When the expert must concede that those facts would affect his or her opinion, the expert's concern turns into the attorney's nightmare. The best prevention of such a scenario is to provide the expert with as much of the documentary evidence and deposition testimony as is practicable, preferably in a reasonably organized fashion, to meet with the expert, to brainstorm about what the expert may find useful or not, and to allow the expert to make decisions about what the expert needs to look at more closely. Most experienced experts will ask early on for disclosure of the evidence the attorney thinks is most damaging to the case in an effort to be prepared for cross examination.

Full disclosure is important for another reason. Once the expert is designated as a testifying witness, all communications between the retaining attorney and the expert become discoverable. The opposing attorney will demand the production of all communications, including all documents and records that the attorney provided to the expert. The expert will be cross examined as to whether the expert was provided only information or documents that would tend to support the expert's opinion but was not given

information that might refute the expert's opinion. Even if the missing information would not change the expert's opinion, the otherwise avoidable damage has been done. To avoid the appearance that the retaining attorney selected the documents and records, including deposition transcripts of fact witnesses, which tended to support the conclusion that the retaining attorney desired, the authors suggest providing to the expert as full and unexpurgated a file as practicable. It is ultimately far more persuasive for the expert to testify that the opinion provided is based upon relevant documents and transcripts, including those which might refute the opinion.

4. Taking Expert Witness Depositions

The attorney co-author segments the expert deposition into three phases. The first phase is the discovery phase. The second phase focuses on pinning down the expert and seeking to define the limits of the expert's opinion. The third phase is devoted to obtaining admissions and testing your own expert's theories.

In the first phase, the attorney should ask only open-ended questions to gather as much information about the expert's opinions, the bases for those opinions, the assumptions made by the expert in reaching those opinions, and the analysis or work performed by the expert in reaching her conclusions. Open-ended questions always begin with "who, what, when, where, why, and how." They are open-ended in that the questions elicit a narrative response, as opposed to questions such as "did you" or "isn't it true that," which tend to elicit "yes" or "no" responses. The attorney should also ask the expert what she was asked to do by the retaining attorney. Experts generally like to teach, and it is the attorney's opportunity in this first phase to learn as much as possible.

Once the attorney has exhausted the expert's ability or willingness to provide information through open-ended questions, it is advisable to suggest topics that the expert may have considered. This is more of a bridge from the first to second phase rather than a new and different phase. This may begin the process of theory testing, but is really intended to gather more information that may not have been elicited from simple, open-ended questions. The attorney leaves a great deal to chance if unprepared to suggest topics or issues that the expert may have an opinion about or may have considered. When there are issues of capacity, it can be helpful to use Cal. Prob. Code Ann. § 811 as a guideline in asking questions, which can be helpful eliciting the bulk of the experts opinions about the decedent's mental status.

In the second phase of the deposition, the lawyer should corral the expert. The lawyer should focus on making sure that the expert is pinned down to the opinions and the basis for the opinions that the expert intends to express at trial. This is generally done by asking leading questions derived from the answers that the expert has already provided and making certain the expert has nothing more to add. Leading questions call for a yes or no response. The lawyer essentially testifies and seeks the witness's confirmation.

It is generally advisable to begin with the discovery phase because once the attorney begins to lead a witness, the witness may become irritated or frustrated that the attorney seems to be putting words in the witness's mouth. Seeking cooperation after irritating a witness may be unproductive. The witness may not feel as generous and may become argumentative with the attorney.

After pinning the witness down, it is time to build a fence around the witness. The attorney should seek to define the outer boundaries of the expert's opinion. The following is an oversimplified series of questions to demonstrate the process. In this example, the attorney seeks to limit the expert's ability to infer the decedent's level of cognitive function at a moment in time between documented quantitative assessments of cognition.

Q. The decedent scored 19 on a Folstein Mini-Mental State Examination in February, 2000, correct?
A. Correct.
Q. He scored only 10 on another MMSE administered in October, 2004, correct?
A. Correct.
Q. You believe that the decedent had Alzheimer's disease?
A. Yes.
Q. Alzheimer's disease typically progresses gradually over months and years, correct?
A. Correct.
Q. So you have concluded that, in August, 2004, the decedent would have scored about 10 had a MMSE been administered at that time?
A. Yes.
Q. And you believe that a score of 10 is consistent with lack of testamentary capacity, correct?
A. Yes.
Q. Did you note that an MRI of the decedent's brain done in March, 2000 showed no evidence of significant cerebrovascular disease?
A. Yes
Q. And did you note that a repeat MRI done in October, 2004 showed extensive deep white matter lacunae consistent with significant cerebrovascular disease?
A. Yes
Q. Some of the cerebrovascular damage could

have occurred after August, 2004, right?

A. Yes

Q. Then you cannot rule out the possibility, can you, that the decedent would have scored significantly higher on a MMSE in August, 2004, and then declined suddenly thereafter because of an intervening cerebrovascular event?

A. No, I suppose I cannot.

The third phase of the deposition is the time to obtain admissions that may be useful to the case and to test your own expert's theories to determine how the opposing expert will respond. The attorney will continue to ask leading questions in this phase. In the following series of questions, the attorney tests his or her expert's theory that electroconvulsive therapy (ECT) did not produce significant post-treatment cognitive impairment:

Q. You would characterize yourself as an expert in ECT treatment of depression in elderly patients? You are studied in the literature on the effects, both positive and negative, of ECT treatment in such patients?

Q. One major indication for ECT is in patients where there is limited effectiveness of psychopharmacological therapy, correct?

Q. ECT remains the single most effective treatment for major depression with or without psychosis in elderly patients, true?

Q. You would agree that in typical elderly patients who have had an inadequate response to other forms of treatment, ECT results in a decline of 50% or more in pretreatment depression ratings in 80%-90% of patients, even in the "old-old" (i.e., older than 75)?

Q. Isn't it the case that side effects are usually limited to transient memory impairment?

Q. And ECT is about equally effective in psychotic and non psychotic depression?

Q. Use of unilateral, non dominant electrode placement minimizes memory impairment?

Q. The typical range of treatment is 6 to 20 sessions to reach full remission?

Q. Even so, typically the effects are limited to mild disorientation to time and mild to moderate anterograde and retrograde memory loss?

Q. But all of the symptoms of disorientation and memory loss usually clear rapidly and are clinically undetectable a week or so after the last treatment, correct?

Q. Even in atypical situations, such effects usually persist for only about 3 or 4 weeks?

Q. The only lasting effect on memory is for events occurring during the course of treatment?

Q. You would agree that given the low risk of any significant memory loss and the high degree of success in achieving remission of the depressive symptoms, ECT is a highly commendable therapeutic course of treatment for the great majority of patients with major depression after psychopharmacological treatment failure?

Obtaining the opposing expert's agreement with this series of questions will lend credibility to the attorney's expert's testimony that the ECT treatments did not result in significant post-treatment cognitive impairment. An expert who disagrees may be shown to be uninformed or biased.

B. On the Witness Stand

1. Direct Examination

Direct examination of the expert on capacity or susceptibility to undue influence should always follow the same basic outline. First, a brief introduction: "what is your profession;" and "where are you employed?" Second, the "teaser:" "are you prepared today to express an opinion about the decedent's capacity to execute her will?" The expert should be advised that this is just a teaser, and not yet the time to state the opinion. Third, is the expert's qualifications. Fourth, is the time for the opinion. Fifth, the bases for the expert's opinion should be stated. Finally, cross examination should be anticipated and the opinion should be reaffirmed.

Direct examination of an expert follows the same rules as direct examination of a percipient witness. The attorney examining his or her expert is prohibited from leading the witness.[23] Not only is it improper and objectionable to lead, it lacks persuasive force. On direct, especially with an expert, the attorney wants the focus on the witness. It is not persuasive for the attorney to testify with the expert by merely confirming the attorney's statements.

To qualify as an expert, the witness must have special knowledge, skill, experience, training, or education relating to the subject of her testimony.[24] Whether the witness qualifies as an expert on a particular subject is a preliminary fact for the trial judge.[25] However, in some states, such as in California, it is not necessary to "tender" the witness (i.e., ask the judge to qualify the witness as an expert).

[23] Cal. Evid. Code Ann. § 767.

[24] Cal. Evid. Code Ann. § 720(a).

[25] Cal. Evid. Code Ann. § 405.

The qualifications portion of the expert's testimony should be carefully considered. Many lawyers simply want to push the button and let the expert take over by rattling off streams of impressive sounding credentials. Other attorneys simply offer into evidence the expert's multi-page curriculum vitae. The first approach is boring and a lost opportunity, and the second approach is simply a lost opportunity. Presentation of the expert's qualifications is an opportunity to show how the expert's qualifications are relevant to the theory of the case. Specific areas of education, training, research, writing, or experience can be highlighted and the expert can be asked to explain how, for example, a particular article is related to the opinion that the expert will be discussing later in testimony.

After qualifying the witness, the lawyer should ask for the expert's opinions. If the expert has more than one major opinion (e.g., capacity and susceptibility to undue influence), the expert should be asked to state each opinion first before exploring one in depth. After introducing the opinions, the attorney should ask the expert to explain the expert's process for reaching each opinion. A sample question might be: "what is the basis for your opinion that the decedent lacked testamentary capacity at the time she executed her will?" The bases may include subsidiary opinions. For example, the decedent may have suffered from dementia, the dementia was of the Lewy bodies type, the dementia was early onset, the time at which the decedent executed her will was a lucid period. The bases will also include the evidence relied upon by the expert to reach each of the subsidiary conclusions, and thus, the expert's major opinion. The witness should also be asked what the witness did in order to analyze the evidence and reach the stated conclusions.

Once the expert has laid a persuasive foundation for the opinions reached, the attorney should anticipate the subjects of cross examination and deal with them as objectively as possible on direct. Expert opinions are just that, opinions. The opinions are based on facts, but they are not facts themselves. The manner of selecting relevant facts and disregarding others is one potential area of cross examination. Experts also must make assumptions, and there are certain things that are simply unknowable. For example, without a biopsy or an autopsy of the brain after death, no expert can say with certainty that a person did in fact have Alzheimer's. While there may be enough evidence to render an opinion even to a reasonable degree of medical certainty, since it is not provable as a matter of fact, the opinion is susceptible to challenge. Assumptions must be made and it should be explained why the assumptions made by a party's expert are reasonable and should be accepted by the trier of fact.

2. Cross Examination

Cross examination is about control. The attorney must control the expert from simply repeating, or worse, explaining even more persuasively the bases for the opinions provided. The attorney controls a witness on cross examination by the form of the question and not by whining to the judge. Unless the attorney simply does not care what the answer to the question will be (because the witness is going to hang himself or herself regardless of the answer), questions should be leading. Unlike direct examination, the focus should not be on the witness, but on the attorney. The witness is nothing more than a trained monkey (a trained, talking monkey that is), confirming or denying the attorney statements. Many witnesses, especially experts, will not play along. While it may be appropriate as an absolute last resort to involve the judge, it is the attorney's responsibility to control the witness, and in most instances it is the attorney's fault that the witness has taken off running when all the attorney wanted was a yes or no answer.

In order to prevent the witness from running away with control, it is not enough to phrase the question in the form of a leading question. Every question should contain only one fact. The following question breaks the rule: "isn't it true that the decedent's mental exams demonstrated moderate to severe impairment?" The expert may answer "no" and may even run off with a lengthy answer that involves explaining the correctness of the expert's opinions. By asking the question, the attorney took a shortcut, and in doing so, handed control back to the witness. It is far more effective to ask a series of one-fact questions in order to exert control over the witness. For example: "the decedent scored a 14 on an MMSE in 2000?" "She scored 11 in 2001?" "She scored 10 in 2002?" "She scored 8 in 2003?" It is much more difficult for the witness to run away with the testimony, and by asking a series of simple, direct, concrete questions, the attorney makes the point in a far more persuasive way than asking just one broad question.

The attorney should avoid questions with words that are ambiguous or judgmental because such questions tend to invite argument with the witness. For example, it would be inadvisable to ask the expert the following question: "Isn't it true that it is unreasonable to conclude from subcortical features that the dementia is likely to be Alzheimer's type?" By contrast, the attorney may be able to obtain a useful admission and let his or her expert opine that a conclusion of Alzheimer's is unreasonable: "Isn't it true that subcortical features are less common in dementing illnesses with cortical pathology like Alzheimer's?" Even though "less common" is an ambiguous term, it is not anathema to an expert, as opposed to a more

judgmental phrasing: "Isn't it true that Alzheimer's rarely involves subcortical features?" Unless there is empirical evidence that supports it, the word "rarely" is likely to result in an argument over its meaning. Words like "frequently" are also vague and will result in quibbling.

Cross examination should be sequenced with constructive cross preceding destructive cross. Constructive cross examination seeks to obtain admissions from the expert that fit into the attorney's theory of the case. The expert may be forced to concede that a MMSE score of 10 or less constitutes severe cognitive impairment and may support a conclusion of lack of testamentary capacity, even if the expert believes that the decedent would have satisfied the low threshold requirements for capacity. The attorney is seeking some degree of cooperation, and as mentioned earlier with respect to depositions, it is always easier to obtain cooperation before going on the attack.

Destructive cross examination challenges the expert. There are certain basic strategies for challenging an expert witness on cross examination. The attorney can undermine the expert's credibility by impeaching the expert with prior inconsistent statements. These statements may be from the expert's deposition, a declaration filed with a pleading in the case, an article or book written by the expert, or a statement made to another witness. Although prior inconsistent statements may be hearsay, they are admissible for the purpose of impeaching the witness.[26] An attorney should never impeach for the sake of impeaching, however. Impeaching a witness on something insignificant or easily explainable should be avoided. Impeachment should be a hammer and used only for bludgeoning. Otherwise, it is the attorney who loses credibility.[27]

The expert may also be challenged on cross examination on the basis of faulty, unreliable, or erroneous facts or assumptions as demonstrated by the following scenario. The expert relied on notations in medical records indicating that the client had recently engaged in violent, uncontrollable behavior (the decedent struck a small child), had paranoid delusions and grandiosity (the children were working for the CIA and tried to get his money to support a plot to rob Fort Knox), had been in a serious car accident, and had no idea where he was, where he lived, or how to help himself, and was unable to recall people or recent events. The expert admits that the information recorded by the nurse was supplied by the children. The expert admits the expert has no idea whether any of the facts related in the documents are true or false. The attorney offers into evidence documents and witness testimony to establish that there was no incident of the decedent striking any child, that there was never a car accident, that the evening of the supposed car accident and disappearance of the decedent, she had dinner with her children at a local restaurant, that the children had obtained a declaration from a physician declaring the decedent incompetent based upon the same false evidence and took over the decedent's trust. Through no fault of the expert, the expert's reliance on the medical record in question is unreasonable and the opinion undermined.

While it is often exceedingly difficult to damage the expert's credibility on cross examination, these techniques can be used to limit or reduce the effectiveness of the expert's testimony.

V. CONCLUSION

Trust and estate attorneys, whether they are planners or litigators, confront issues of competence, capacity, and susceptibility to undue influence routinely, particularly in light of the aging of our population. The authors hope that this article will provide those attorneys with a greater awareness of the clinical features and diagnosis of common mental disorders and illnesses, and a greater appreciation for the use of experts in assisting attorneys with the contemporaneous evaluation of clients and retrospective analysis of the mental condition of persons whose decisions may be in question. The expert is simply an integral part of the team in representing clients successfully and in achieving our clients' goals.

[26] Cal. Evid. Code Ann. § 1235.

[27] Impeachment by omission is less common because it is generally ineffective. But when the expert testifies at trial to information that the expert failed to provide when asked about at deposition, impeachment by omission may make sense. For example, assume the expert failed to make mention of anything in the medical record that would indicate psychosis or that the expert believed that the decedent was demented based in part on an underlying psychosis. The expert's later claim at trial that notations in the records indicating that the decedent believed his children were out to get his money were evidence of paranoid delusions (and therefore psychosis) seems suspicious. It may appear that someone suggested this idea to the expert, and perhaps the expert is reaching to help the client more than simply by providing the expert's own fair assessment of the records.