Dear Dr. Jeff:

A patient of mine died a few months ago. I was notified by her lawyer that her will may be disputed and that he expects me to testify regarding her mental status and her competence to write a will. Do I have to testify? Will her medical records be revealed in court? How will my diagnosis in her chart of “probable MCI” (mild cognitive impairment) affect all this? Do you have any suggestions?

Dr. Jeff responds:

Interactions between the world of medicine and the legal system always seem problematic. Our categorizations and ways of thinking rarely translate easily into theirs. At the same time, physicians worry that their words will be misinterpreted, or even twisted, potentially injuring patients, families, or the testifying practitioner. Unless you are experienced offering testimony, this whole process may seem like a looming ordeal and an unreimbursed drain on your time and energy.

If you had an established relationship with your deceased patient, ensuring that her wishes are carried out may be the final service you can provide for her. Many practitioners who care for the elderly are outraged that advanced age alone is often treated as a demonstration of incapacity regardless of actual performance. The thought that grasping relatives might try to slander your patient’s name as a route to acquiring money or assets that he or she never wanted them to have is genuinely infuriating. The possibility that mentally frail seniors might unintentionally fail to provide adequately for family members — of whom they are truly fond — or even forget the names of children not seen recently is real.

Unfortunately, care providers can unduly influence some forgetful or confused individuals near the end of life, exploiting them for personal gain. On the other hand, it is not unreasonable to wish to reward a second spouse or a devoted caregiver for kindness near the end of life. “What have you done for me lately?” is different from memory loss. It is not totally unreasonable for the court system to see the validity of wills drawn up when an individual has advanced illness, is receiving multiple medications, and is highly dependent on others for her care.

Paper Trails

Health care professionals are familiar with many of the problems associated with advance directives for health care. A will is simply a financial advance directive, instructing others what to do with property when the deceased individual is unable to direct the distribution of their assets personally. And, as with medical advance directives, changing circumstances and vague language can make interpretation difficult. Advance directives such as DNR or POLST orders are typically reviewed periodically, sometimes quarterly or annually, whereas wills are typically drawn up at a particular point in time with no schedule for review and confirmation. They may be abruptly altered without necessarily revisiting an impulsive decision based on transitory anger or affection.

The Last Say

A durable power of attorney for health care (a health care proxy or agent, depending on the language of particular states) has the power to interpret advance directives in accordance with their best understanding of the patient’s wishes under current circumstances. But the executor of a will, who is similarly charged to carry out instructions, can do so only if all the parties to the will agree. Disappointed parties can use the courts to enforce their interpretation of the dead person’s wishes or to overturn documented bequests. In many states, it is extremely difficult to disinherit close relatives, particularly children. Wills that are not drawn up with sufficient precision and necessary language are likely to be challenged. These challenges are typically based on or reinforced by claims that the deceased person had insufficient mental faculties and understanding to create a valid will. Such claims will, in turn, draw in the medical practitioner. Families often struggle over relatively minor amounts of money or possessions. At times, legal costs may equal or exceed the actual value of the items being disputed. Which child actually inherits grandma’s china is not simply a question of possession of aged crockery; it is often perceived as a measure of who was favored or even who was most loved. Some of my cousins fought for years over a single used car that had belonged to their father. At issue was not the value of the car, which could have been sold and evenly divided, but rather, that on different occasions he had verbally promised it to each child “because he really wanted them to have it.” Only one daughter received it in the will — along with more grief than the car’s value.

When called upon to declare a medical opinion, the professional is not expected to pronounce on whether the patient met legal definitions for testamentary capacity, that is, the capacity to execute a legally valid will. This standard for capacity is, of course, interpreted by the court. It is generally a lower standard than expected for complex medical decisions, since complex risk and benefit analyses are not required, nor is the individual drawing up the will required to review or to choose among alternatives. The simple act of signing a will implies that the individual knows that they can’t take it with them. Generally, they are expected to know what they are giving away and to whom.

These are not questions typically asked in a mental status examination — most patients would be startled and likely suspicious if a doctor asked them to list their financial assets. Ability to draw a clock face or remember three objects in 5 minutes does not define testamentary capacity. BIMS or MMSE or SLUMS tests, even if done close to the time the will was executed, do not by themselves determine capacity for this or for other purposes. Certainly a medical determination that a patient’s cognitive function was below expected levels for age, but not sufficiently low to impair life functions (the definition of mild cognitive impairment), would not imply a lack of capacity in this functional sphere. Being at increased risk for the development of dementia, even if based on determinations of poor memory and poor judgment, does not automatically lead to a determination of incapacity.

Conversely, a good score on testing does not guarantee capacity, since many patients have wide swings in cognitive capacity during the day. Some patients are quite alert and sharp in the morning but sundown as the day progresses, becoming more confused or even agitated and delusional. The exact functional level at the time the will was drawn up and signed might be significant. Also, given the high level of depression among elderly patients, a patient who was emotionally stable at one visit might be despondent and angry a week later when the attorney is present. Medication changes and acute infections are among many factors that can affect cognitive performance as well.

Protecting the Resident

A geropsychiatrist colleague, Michael Goldstein, MD, has proposed that when a will is executed under circumstances that might be suspect (in a nursing home, for a person with diagnosed mental illness or dementia, in the face of very advanced age or vulnerability, and so on), that special safeguards be instituted. They would include videotaping the proceedings and employing a trained mental health professional asking specific relevant questions to document cognitive functioning and emotional status at the time the will is signed. This might, of course, involve considerable expense for the videographer, plus doctor’s fees. Still, if the estate is relatively large, the costs might be much less than an extended court case.

The Health Insurance Portability and Accountability Act determines who has access to a patient’s private medical information. After death, these decisions typically transfer to the executor of the estate. When a will is in dispute, this might be in dispute as well. Even if faced with a subpoena for medical records, you should be cautious regarding their release. I would suggest confirming the release with attorneys for the facility, if that is where the patient was examined, or even with the judge if you have any doubts.

In theory, your testimony can be forced through a subpoena. However, courts are generally respectful of physician time, and both sides are likely to accept a deposition done at a convenient time and in the location where relevant medical records are present, as well as provide compensation as an expert, rather than a fact witness. If you have no useful information to provide, particularly when a patient had only been seen once or twice or your memory and documentation of mental status is scanty or absent, you may be excused. Attorneys often subpoena office records for patients only seen in the nursing home under the mistaken belief that LTC doctors might maintain separate files. A simple call stating that no such records exist may result in the cancellation of the subpoena. Judges are reluctant to authorize a fishing expedition through a medical chart which might violate the privacy of the dead. An annoyed or angry physician is not likely to be a helpful witness for whoever has forced their attendance or wasted their time.

We care for the old and frail. Death is not a stranger in the nursing home. And when our patients still have assets at the time of death, struggles over inheritance are not rare. Issues regarding wills and inheritance simply come with the territory; it might behoove long-term care practitioners to familiarize themselves with the landscape.

Dr. Nichols is president of the New York Medical Directors Association and a member of the Caring for the Ages Editorial Advisory Board. Read this and other columns at www.caringfortheages.com under “Columns.”