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MEDICATION AS A THREAT TO TESTAMENTARY CAPACITY

DAVID J. SHARPE*

I

MENTAL CAPACITY AND MEDICATION: A LATENT LEGAL PROBLEM

The propensity of people to put off making their wills is a trait well-known to lawyers. A few days in the hospital often act as a powerful stimulus to testamentary activity, however, and it is chiefly with the medication which people receive in hospitals that this discussion is concerned.

Few people outside the medical profession appreciate the extent of mental impairment caused by certain medications prescribed for physical illnesses,¹ and therefore mental capacity in relation to medication is called a latent legal problem. In addition to the well-known effects of narcotic drugs upon the mind of man, medical research is currently disclosing that many of the wonder-drugs possess mental side-effects, ranging from sleepiness to psychoses; and it is to be expected that attorneys for caveators will soon discover and employ the results of these medical findings in attacking wills executed by testators under the influence of mind-affecting drugs.

This discussion seeks to alert attorneys to the drugs most likely to cause mental impairment, to acquaint them with the results of lawsuits in which testamentary capacity has been litigated against a background of drug-induced impairment, and to suggest some problems and precautions to be considered in drawing a will under these circumstances.

II

MENTAL SIDE-EFFECTS OF THERAPEUTIC DRUGS

Certain substances used in treating physical illness produce psychological changes in patients which are called "mental side-effects": that is, the primary effect of the medication is something other than impairing the patient's thought processes. For example, morphine primarily deadens the pain of a heart attack, but at the same time it secondarily impairs the patient's ability to think. Neither the medical nor the legal

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¹ Physicians are aware of the problem, however. See letter at 156 JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION 1546 (1954), asking the editor whether giving a cancer patient 2 grains of codeine daily would affect his capacity to make a will. The editor answered No.

profession can overlook mental side-effects, which are none the less real for being ancillary.

Precisely because the concern of this discussion is with side-effects, a large number of mental impairments will not be taken up at all. Long-standing mental derangements, whether caused by malfunction of the brain, by toxic conditions in the body, by damage to brain tissue and blood vessels, or by congenital deficiencies, are not considered.² None of these are mental side-effects so much as they are primarily results of a condition of the brain itself. Furthermore, as a practical matter, these mental conditions are less likely to escape the attention of attorneys than are the mental side-effects of medication.

*Therapeutic Drugs*³

The layman in medical matters often uses the term "drugs" to refer to the narcotics used by addicts, but the term used here, "therapeutic drugs," is broader in meaning and more specific in application. It refers to all substances used in the treatment of disease, including narcotics when used medicinally, and comprehending a vast array of other healing substances employed by the medical sciences. It excludes drugs such as heroin, marijuana, and mescaline, which are not ordinarily administered for therapeutic purposes.

Pain and Pain Relief

Much of the medical literature dealing with the mental side-effects of therapeutic drugs, and almost all of the case law dealing with the impact of mental side-effects upon testamentary capacity, arises out of the pain-killing drugs, known technically as "analgesics."

Pain is a mental reaction. Pain relief can be achieved through three general approaches: local relief by means of anesthetics like procaine and ethyl chloride, which deaden nerves in the affected parts so that pain signals are not transmitted; intermediate anesthetic techniques like spinal anesthesia, which block off nerve impulses en route to the brain; and central pain relief—that is, suppressing the pain-registering function of the brain itself. It is with the pain-killers which act centrally upon the brain that this discussion is concerned.

Centrally-acting pain-relievers have three principal effects upon the responses of persons suffering pain: (1) they raise the threshold of pain perception—the primary effect; and as side-effects, (2) they remove

² For a brief survey of the effects of all types of illnesses upon testamentary capacity, see Note, *Disease as Evidence of Lack of Testamentary Capacity or Undue Influence*, 2 CURRENT MEDICINE FOR ATTORNEYS 15 (1955).

³ The bulk of the general description of drugs and their actions in the pages which follow can be found in any textbook on pharmacology. Extensive use has been made in this discussion of GOODMAN AND GILMAN, *THE PHARMACOLOGICAL BASIS OF THERAPEUTICS* (2d ed. 1955). It is cited only where especially apt or directly quoted.

the usual responses to pain—anxiety, fear, panic, withdrawal, flight; and (3) they induce sleep, which itself raises the pain threshold about 50%.⁴

Morphine and Similar Drugs

The most important centrally-acting pain-relievers are the narcotics derived from opium, together with synthetic narcotics which resemble them: morphine, codeine, Dilaudid, Demerol, methadone, and many others.⁵

Drugs of the morphine family may be administered orally, hypodermically, or rectally. Intravenous injection is the most rapid route, producing peak analgesia within 20 minutes. Subcutaneous injections are slower, requiring as much as an hour or more with morphine and Dilaudid.⁶ The usual dosage varies with different drugs and compounds, but a 15 milligram ($\frac{1}{4}$ grain) injection of morphine sulphate is normally all the morphine given at one time. The usual interval between doses is three to four hours, but for severe pain the interval is shortened.

The mental side-effects of narcotics, unfortunately for anyone wishing to suspend them temporarily without unduly tormenting the patient, appear to outlast the analgesic effect:

“The pain threshold-raising action was not closely related in time to these psychological changes, the latter effects outlasting the threshold-raising action by many hours.”⁷

Several other medical terms applicable to many drugs are introduced here in connection with the morphine family. With persons who have developed “tolerance” to the effects of a drug from administration over a period of two weeks or so, a larger dose or a more potent drug is required to control a given intensity of pain. Partly because of tolerance, a physician always prescribes the least potent analgesic capable of relieving pain, saving the narcotics for the most severe pain. When

⁴ Wolff, Hardy, Goodell, *Studies on Pain*, 19 JOURNAL OF CLINICAL INVESTIGATION 659 (1940).

⁵ This is the first encounter with the problem of trade names for drugs. Every drug has a scientific name which describes its chemical composition, a name not in common use. Most drugs are also given medical short titles, which may or may not come to be the most common name for the drug, because every pharmaceutical manufacturer also trade names his version of the preparation, and his trade name may be the one that sticks. In this discussion, trade names will be capitalized and used if they are more meaningful to the layman than the medical name. Thus, dihydromorphinone is referred to above as Dilaudid and meperidine as Demerol, but methadone is a medical name in fairly common use—though the attorney may encounter its trade name, Dolophine. Another profession's jargon is never easy for the layman.

⁶ Seevers and Pfeiffer, *Study of Analgesia, Subjective Depression, and Euphoria Produced by Morphine, Heroine, Dilaudid and Codeine in the Normal Human Subject*, 56 JOURNAL OF PHARMACOLOGY AND EXPERIMENTAL THERAPEUTICS 166 (1936).

⁷ Hardy, Wolff, Goodell, *Pain Sensations and Reactions* 344 (1952).

pain is expected to continue and increase, as with incurable cancer, the physician will first prescribe aspirin, then codeine, and finally morphine. As tolerance develops, the patient must be given increasing doses of morphine to control his pain; but tolerance to pain relief is accompanied by tolerance to mental side-effects, a fact demonstrated by the ever-increasing quantities of narcotics required by addicts in order to produce the desired level of mental effect.⁸

When pain is especially severe, as in coronary thrombosis, physicians sometimes administer two or three times the normal number of doses of morphine in order to obtain pain relief. Such a quantity of morphine in a normal individual would probably produce unconsciousness and possibly death from respiratory failure; but a man with a heart attack appears to be alert and wide awake, because his acute pain has given him a high "level of reflect excitability."⁹

"The more severe the pain, the larger is the dose of opiate required and the greater the amount of drug that can be tolerated. . . . This is in keeping with the general principle that the degree of stupefaction caused by a given amount of a depressant drug is directly proportional to the level of reflex excitability of the nervous system."¹⁰

Hence, a large quantity of drugs administered is not in itself conclusive proof of mental impairment. The primary consideration is the observed mental condition of the patient.

Various organs, notably the kidneys and liver, perform detoxifying operations upon drugs. When these organs are not operating properly, it becomes difficult to predict the reaction to a drug with mental side-effects. For example, if there is a stoppage of kidney function, morphine is often administered to relieve the discomfort of a patient's last illness; but a dose of morphine which normally would have no mental effects may be delayed in detoxication and excretion to such an extent that its effects persist, cumulating to some extent with repeated dosage. This persistence tends to limit the improvement to be expected in the usual ups and downs of patients suffering from degenerative diseases of the kidneys and liver in particular.

Anxiety and Euphoria

Still by way of definition, against the background of the morphine family, the terms "anxiety" and "euphoria" are presented as the core of the latent medico-legal problem of therapeutic drugs' side-effects upon mental capacity.

⁸ Tolerance to mental side-effects was acknowledged in *Miller v. Oestrich*, 157 Pa. 264, 27 Atl. 742 (1893).

⁹ GOODMAN AND GILMAN, *op. cit. supra* note 3, at 248.

¹⁰ *Ibid.*

"Anxiety" is a word whose commonplace connotations agree tolerably well with the medical meaning. Anxiety is mental pain, a psychological condition. Anxiety often exists by itself, without any physical cause; but anxiety also accompanies physical pain. Just as the primary effect of centrally-acting pain-relievers is the suppression of physical pain, a significant psychological side-effect of the same drugs is the reduction of anxiety. The parallel in effects goes further. A patient given morphine for abdominal pain also forgets the pain of a boil on his arm; and likewise, when the anxiety over pain is suppressed, anxiety over other cares diminishes at the same time.¹¹

"Euphoria" is approximately the opposite of anxiety, in the sense that euphoria represents a general feeling of well-being. It has been known for centuries that opium produces a feeling of well-being in its habitual users. Moderate amounts of morphine (up to 15 mg.) are said to produce euphoria, drowsiness, loss of anxiety and inhibitions, ". . . and increased ease of discriminating and making decisions. There is inability to concentrate, difficulty in mentation, apathy. . . ."¹² This statement is typical of the description of the mental side-effects of morphine found in most textbooks; but current research casts doubt upon the wisdom of applying the generalization indiscriminately to normal persons as well as addicts. For example, the addict experiences euphoria from a 15 mg. dose of morphine, but a normal person feels discomfort, ranging from an all-over unwell feeling to nausea and vomiting.

"The impressive reputation of the opiates as dangerous euphorians in normal persons seems largely based on the writings and experiences of celebrated literary figures such as De Quincey, Coleridge, Baudelaire, and Cocteau and on the unqualified transfer of the results of studies on drug addicts . . . to non-addicts. The fact that many agents are capable of producing euphoria in addicts emphasizes the importance of the addict rather than the drug."¹³

Thus a person under the influence of morphine for a heart attack might be expected to react with discomfort to its side-effects; but a person in terminal stages of cancer who had been given morphine steadily for a matter of weeks would certainly be dependent upon it physically and would probably be addicted to it and react with the addict's response.

¹¹ Hardy, Wolff, Goodell, *Pain Sensations and Reactions* 326 *et seq.* (1952).

¹² GOODMAN AND GILMAN, *THE PHARMACOLOGICAL BASIS OF THERAPEUTICS* 191 (1941). Notice that the quotation is from the first edition; the second edition in 1955 is far less dogmatic.

¹³ von Felsinger, Lasagna, Beecher, *Drug-Induced Mood Changes in Man*, 2. *Personality and Reactions to Drugs*, 157 *JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION* 1113, 1117 (1955).

The second observation is that the healthy individual's response to drugs varies with his pre-drug state of mind.

"... [T]he usual effects of opiates (blunting of reactivity, reduction of urgency to action, interference with associational activity, and lassitude) may constitute a pleasant relief and temporary cessation of tension and struggle for the unbalanced personality. To the balanced personality these same effects may well constitute a useless, confusing, unwanted, and unpleasant interference with normal functioning."¹⁴

These generalizations can only be of value when put to use in a particular situation. It would seem reasonable to assume that if a man's attention can be aroused and focused upon the problems of his estate and maintained as long as need be, then a feeling of mild euphoria is of little legal consequence.

But consider the euphoric testator's appraisal of his only son, who sides with his mother in every dispute, as a proper object of his bounty; and how can the testator resist the urgings of his niece Sally, who has stood by him and comforted him, even if she did marry a Catholic? Who gets the old home place and who gets the General Motors? Decisions which would torment the testator if he were free from the influence of drugs will be far easier to make if the anxiety over their normal consequences can be severed from the decisions themselves, in much the way that A can solve B's problems much more easily than he can solve his own.

Other Pain-Relieving Drugs

None of the non-narcotic pain-relievers produce the mental side-effects of morphine and its relatives; none are as potent, and none seem to arouse habituation, addiction, or tolerance. The salicylates and antipyretics, of which aspirin is the most common representative, have no mental side-effects, even when administered in massive doses for the relief of pain from rheumatic fever and arthritis.¹⁵ Acetanilid and acetophenetidin (Phenacetin) have the same general pain-relieving characteristics as the salicylates. In large doses they have a depressant effect upon mental activity, but no euphoria is generally associated with their use.¹⁶

Barbiturates and Scopolamine

The barbiturates and scopolamine are used as hypnotics, administered for the primary purpose of inducing relaxation and sleep. The bar-

¹⁴ *Id.* at 1118.

¹⁵ Hardy, Wolff, Goodell, *Pain Sensations and Reactions* 354 (1952).

¹⁶ *Id.* at 355, 356.

biturates will relieve pain by putting a patient to sleep, but in non-soporific doses they possess no specific analgesic properties. Scopolamine has no pain-relieving properties, but it does cause amnesia in most patients, and therefore the patient does not remember his pain. Scopolamine and the barbiturates possess some powers of magnifying the effectiveness of narcotic pain-relievers and are frequently administered with them, but in some persons in pain they also produce mental and physical disturbances.¹⁷ As far as the primary mental effect of these drugs is concerned, if the patient is awake and apparently lucid, his capacity to think probably is not significantly impaired, though he will find it harder than usual to concentrate on and retain what he is told.¹⁸

The barbiturates and scopolamine present a threat from another direction, however: that of undue influence upon a testator's decisions. These drugs possess as a side-effect the power to increase the suggestibility of some people.¹⁹ Drug-enhanced suggestibility has received a certain amount of attention from the medical profession. Scopolamine enjoyed wide notoriety in the early 1930's as a "truth serum"²⁰ but has been replaced in experimental research by amytal and pentothal, both of which are barbiturates and both commonly referred to as their salts, sodium amytal and sodium pentothal.²¹ The truth-encouraging properties of the drugs are supposed to result from relaxation of normal anxiety over the consequences of admitting crimes or embarrassing experiences; but psychiatrists admit frankly that they have to be careful not to put their own ideas into the subjects' minds, whence the ideas obligingly reappear as the subjects' own.²²

Other Hypnotics

Chloral hydrate, paraldehyde, and chloretone somewhat resemble the barbiturates in possessing mild hypnotic properties. They are administered to induce sleep. They possess poor analgesic properties, and there appears to be little if any impairment of the patient's mental processes, once he is awakened.²³

¹⁷ GOODMAN AND GILMAN, *op. cit. supra* note 3, at 42, 141, 145.

¹⁸ Hardy, Wolff, Goodell, *Pain Sensations and Reactions* 359 (1952).

¹⁹ GOODMAN AND GILMAN, *op. cit. supra* note 3, at 141.

²⁰ House, *The Use of Scopolamine in Criminology*, 2 AMERICAN JOURNAL OF POLICE SCIENCE 528 (1931); Lorenz, *Criminal Confessions under Narcosis*, 31 WISCONSIN MEDICAL JOURNAL 245 (1932). For an exhaustive survey of this field, see Despres, *Legal Aspects of Drug-Induced Statements*, 14 U. CHI. L. REV. 601 (1947).

²¹ Redlich, Ravitz, Dession, *Narcoanalysis and Truth*, 107 AMERICAN JOURNAL OF PSYCHIATRY 586 (1951).

²² *Ibid.*

²³ GOODMAN AND GILMAN, *op. cit. supra* note 3, at 164.

Benzedrine

Amphetamine, known often by its trade name "Benzedrine," is used chiefly for its stimulating effects upon the mind. In this euphoriant capacity, it is referred to by its manufacturers as a "mood-ameliorant." The mental effects of Benzedrine, ranging from sleeplessness to extreme exhilaration in small doses, have led to its replacement in the familiar inhaler for nasal congestion by a less euphoriant ingredient, Dexedrine;²⁴ but Benzedrine continues to be administered widely by the medical profession. Far from increasing suggestibility, Benzedrine often arouses resistance to outside suggestion, and there is evidence that it can induce paranoia.²⁵

*Tranquilizers*²⁶

Chlorpromazine (Thorazine), reserpine (Serpasil), and meprobamate (Miltown, Equanil), which are chemically unrelated drugs with similar properties, are coming to be called "tranquilizers" or "ataraxics." The extent of therapeutic and experimental use of these drugs defies description, yet none of them have been available in this country for much longer than five years.²⁷

Tranquilizers are widely used to reduce tension, anxiety and fear in mental patients, and in the treatment of high blood pressure, narcotic addiction, psychoneuroses, and psychosomatic illnesses generally. The patient under the influence of tranquilizers is generally conscious, depending upon the drug, the dosage, and his general condition; he may sleep, but he is easily aroused and is free from tension when awake.

Reserpine²⁸ appears to be capable of producing mental disturbance²⁹ as well as reducing tension; but chlorpromazine³⁰ tends to make severely

²⁴ Monroe and Drell, *Oral Use of Stimulants Obtained from Inhalers*, 135 JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION 909 (1947).

²⁵ Chapman, *Paranoid Psychoses Associated with Amphetamine Usage*, 111 AMERICAN JOURNAL OF PSYCHIATRY 43 (1954).

²⁶ Martin, *The Therapeutic and Toxic Effects of Tranquilizing Drugs: Medical Aspects*, 17 NORTH CAROLINA MEDICAL JOURNAL 396 (1956).

²⁷ The tranquilizers present the problem of up-to-the-minute medical research in acute form. Hardly a month passes without the introduction of another tranquilizing preparation, each one with its own trade name. The most complete bibliographical sources seem to be the brochures distributed by the manufacturers. For example, a pamphlet published in 1956 by Wallace Laboratories, manufacturers of Miltown, listed 34 articles in medical journals which have to do with Miltown and with various other versions of the same drug. These pamphlets are widely distributed to the medical profession.

²⁸ Noce, Williams, Rapaport, *Reserpine (Serpasil) in the Management of the Mentally Ill and Mentally Retarded. A Preliminary Report*, 153 JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION 821 (1954).

²⁹ Schroeder and Perry, *Psychoses Apparently Produced by Reserpine*, 159 JOURNAL OF THE MEDICAL ASSOCIATION 836 (1955); Muller, Pryor, Gibbons, Orgain, *Depression and Anxiety Occurring during Rauwolfia Therapy*, 159 JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION 839 (1955).

³⁰ Yohe, *Chlorpromazine and Mental Health* (1955); Cohen, *Undesirable Effects and Clinical Toxicity of Chlorpromazine*, 17 JOURNAL OF CLINICAL AND EXPERIMENTAL PSYCHOPATHOLOGY 153 (1956).

disturbed mental patients more accessible to psychotherapy.³¹ Mil-town,³² a milder preparation, appears to have no serious mental side-effects, but it has been on the market for an even shorter time than other members of the group.

Hallucinogens

Mescaline, peyote, and lysergic acid diethylamide (LSD) are three drugs which produce hallucinations and other mental disturbances in normal persons.³³ They are currently being used experimentally but not administered for therapeutic purposes. Reports from behind the Iron Curtain contain rumors that LSD has been used in order to increase suggestibility, so that persons accused of crimes will confess more readily.

Anti-Histamines

Common anti-histamines, such as Pyribenzamine, Dramamine, and Benadryl, have mental effects upon certain individuals, depending upon the dosage, the length of time the drugs have been administered, and the purpose of the administration. Mental side-effects of the different anti-histamines vary widely, but most persons find the befuddling side-effects of anti-histamines unpleasant but not severe in moderate doses.³⁴

Cortisone and Related Drugs

Medical science is currently exploring a real danger to mental stability from the use of certain hormones, notably cortisone and corticotropin (ACTH), which have been used principally in treating arthritis but which are now being tried experimentally in a constantly expanding number of disease conditions—even in the treatment of mental disease.³⁵

The degree of psychotic effect varies with the prior mental state of the patient, his age and general physical condition, the size and duration of dosage, and probably in regard to other yet unidentified factors.³⁶ These side-effects seem to disappear when the drug is discontinued. The psychoses apparently produced by ACTH and cortisone are typically

³¹ Bennett, Ford, Turk, *Clinical Investigation of Chlorpromazine and Reserpine in Private Psychiatric Practice*, 112 AMERICAN JOURNAL OF PSYCHIATRY 782 (1956).

³² Selling, *Clinical Study of a New Tranquilizing Drug*, 157 JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION 1594 (1955); Borrus, *Study of Effect of Miltown . . . on Psychiatric States*, 157 JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION 1596 (1955).

³³ Rinkel, Hyde, Solomon, *Hallucinogens: Tools in Experimental Psychiatry*, 16 DISEASES OF THE NERVOUS SYSTEM 229 (1955); Hoch, *Experimentally Produced Psychoses*, 107 AMERICAN JOURNAL OF PSYCHIATRY 607 (1951).

³⁴ GOODMAN AND GILMAN, *op. cit. supra* note 3, at 658, 662.

³⁵ Lindeman and Clarke, *Modification in Ego Structure and Personality Reactions under the Influence of the Effects of Drugs*, 108 AMERICAN JOURNAL OF PSYCHIATRY 561 (1952).

³⁶ Quarton, Clark, Cobb, Bauer, *Mental Disturbances Associated with ACTH and Cortisone: A Review of Explanatory Hypotheses*, 34 MEDICINE 13 (1955).

schizoid rather than being of the toxic variety, "disorientation and confusion."³⁷

Idiosyncrasy

The medical term used to describe wide variations in the response of individuals to drugs is "idiosyncrasy."³⁸ For example, a person who responds with continued vomiting to the administration of morphine demonstrates an idiosyncrasy—an unusually severe manifestation of a common side-effect; or at the other extreme, a patient might exhibit no mental reaction whatever to a substantial dosage of morphine.

Idiosyncrasy is mentioned here rather than earlier in order to stress the importance of individual reactions to drugs. What has gone before has been pharmacological, describing typical or average reactions to drugs; but what follows is in the medical sense clinical—the observed reaction of a particular patient. In determining typical reactions, the textbook writer necessarily disregards extremes on both sides, but drugs are notoriously capable of producing atypical reactions in individuals. Medically and legally, the only clearly indicated procedure in examining a patient for testamentary capacity is the most painstaking investigation of the patient himself, in the light of whatever forewarning this medical background can provide.

III

MENTAL SIDE-EFFECTS AND TESTAMENTARY CAPACITY

Although each jurisdiction has its own definition of testamentary capacity, the definitions do not differ widely from one another analytically; and since there are no clearly distinguishable majority and minority views, it is convenient to turn to the text-writers for foundation definitions.

Atkinson lists five elements of testamentary capacity in his treatise.³⁹ The testator must understand and carry in his mind in a general way:

- (1) The nature and extent of his property,
- (2) The persons who are the natural objects of his bounty, and
- (3) The disposition which he is making of his property.

He must also be capable of:

- (4) Appreciating those elements in relation to each other, and
- (5) Forming an orderly desire as to the disposition of his property.⁴⁰

³⁷ Clark, Quarton, Cobb, Bauer, *Further Observations on Mental Disturbances Associated with Cortisone and ACTH Therapy*, 249 NEW ENGLAND JOURNAL OF MEDICINE 178 (1953).

³⁸ GOODMAN AND GILMAN, *op. cit. supra* note 3, at 12.

³⁹ ATKINSON, WILLS § 51 (2d ed. 1953).

⁴⁰ *Ibid.*

Atkinson also points out two corollaries: first, a testator ". . . need not possess superior or even average mentality"; second, ". . . one may have testamentary capacity though he is under guardianship or lacks the ability to make a contract or transact other business."⁴¹

Undue influence was also alleged in over half of the cases in which testamentary capacity was attacked because of drug induced mental impairment, and therefore its inclusion at this point seems justified.⁴² Undue influence is an important part of the logic of attacking a will. The caveators assert that the testator did not have the mental capacity to make a will; and yet the propounders have put forward a writing for probate. If the testator could not have made a will, then someone else must have implanted the wishes represented as the testator's; and the substitution of someone else's wishes is considered to be a form of undue influence. When the testator's will-power is weakened, it is likely to be overridden; when it disappears, it is likely to be replaced. It would thus be unrealistic to consider testamentary capacity apart from undue influence, especially in the light of the ability of some drugs to weaken the power to resist unwanted suggestions.

The legal standard of mental capacity required to make a will is far from severe. "The standard of testamentary capacity has been properly fixed at a very low point in the scale of intelligence. . . ."⁴³ The courts have gone far to uphold wills in spite of illness and drug effects which give rise to serious doubt, especially where there was collateral evidence that the testator was really expressing his own wishes—for example, where the will under attack resembled prior wills,⁴⁴ or where there was evidence of sensible business activity at the same period during which the will was made,⁴⁵ or where there was good eyewitness testimony in favor of capacity either by persons well acquainted with the testator or by attending medical experts.⁴⁶

The cases, decided as they are on their individual facts, do not lend themselves to deep legal analysis. Several cases cited not one other case to the factual point at issue,⁴⁷ and in general there is no thread of leading cases which may be pursued in studying the development of law in this field.

⁴¹ *Ibid.* In North Carolina and several other states, however, guardianship raises a presumption against testamentary capacity. See *Sutton v. Sutton*, 222 N. C. 274, 22 S. E. 2d 553 (1942) and cases cited. See also Note, *Effect of Competency Adjudication in Subsequent Will Contest*, 2 SYRACUSE L. REV. 329 (1951).

⁴² See Green, *Fraud, Undue Influence, and Mental Incompetency; A Study in Related Concepts*, 43 COLUM. L. REV. 176 (1943).

⁴³ *Executors of Moore v. Blauvelt*, 15 N. J. Eq. 367, 384 (1862).

⁴⁴ *Miller v. Oestrich*, 157 Pa. 264, 27 Atl. 742 (1893).

⁴⁵ *Cude v. Culberson*, 30 Tenn. App. 628, 209 S. W. 2d 506 (1947).

⁴⁶ *In re King's Will*, 251 Wis. 269, 29 N. W. 2d 69 (1947); *Blake v. Rourke*, 74 Iowa 519, 38 N. W. 392 (1888).

⁴⁷ *E.g.*, *Dieffenbach v. Grece*, 56 N. J. Eq. 365, 39 Atl. 536 (1898).

Indeed, the law has shown little development since 1855.⁴⁸ A testator on his deathbed from typhoid, "stimulated" as the doctor thought by doses of laudanum and brandy,⁴⁹ was roused with difficulty from his stupor by the attorney, who tested his capacity by asking how long he had been sick. The testator answered correctly, "Four weeks Friday." The opinion of the Supreme Court of Georgia is as pertinent today as it was a hundred years ago:

"Though very ill—though in a sinking and dying condition, yet, it appears to us that what time his attention was aroused and given to the purpose of making his will, his mind acted definitely, and with discriminating judgment."⁵⁰

Every reported contest must be read with an eye to the size of the estate being contested. Where money is the object, counsel will spare a large estate no expense in giving the court all the evidence available on both sides of the issue of testamentary capacity. Conversely, small estates produce skimpy evidence, and the medical evidence noted in appellate opinions is likely to have been inadequately presented to and poorly understood by the court of first instance.

The Presumption in Favor of Testamentary Capacity

"In a will contest case, where due execution and attestation are established, a presumption of testamentary capacity arises, and the burden of proving unsoundness of mind of the testator is upon the contestant."⁵¹

What sort of evidence must the contestants introduce in order to rebut this presumption?

Where a testator has been under medical administration of drugs for a comparatively short time, and where there is no claim of mental derangement of a continuous nature, successful contestants must show that at the time the will was executed, the testator had not sufficient mental capacity to make it:

"... [I]n the instant case the mental incapacity is claimed to be due to temporary causes, *i.e.*, paroxysms of pain and the administration of opiates. The burden being on the contestant to show mental incapacity . . . , it is incumbent upon him to show

⁴⁸ Hall v. Hall, 18 Ga. 40 (1855).

⁴⁹ Laudanum is an alcoholic solution of opium, and both alcohol and opium are depressants, not stimulants.

⁵⁰ Hall v. Hall, 18 Ga. 40, 46 (1855).

⁵¹ *In re Holmes' Estate*, 270 P. 2d 320, 322 (Okla. 1954) [arteriosclerosis, uremia; morphine]. Beginning at this point, a brief note giving the disease of the testator and the drug administered will follow the citation, in brackets.

that the temporary causes are operating at the time the will is made.⁵²

The courts have set rather short time intervals which are at least open to question: "Testator's suffering required the administration of an opiate at times, but none was administered the day he executed the will."⁵³ The implication that an opiate-free morning or afternoon assures testamentary capacity is not free from doubt, if it is assumed that testator was not competent in the preceding period:

"The testimony shows that in the morning and fore part of the day [testator] was usually free from pain, and the effect of the drug administered in the evening and night having passed away, he was in better condition than at any other time during the twenty-four hours."⁵⁴ [The will was executed in the morning.]

This decision is questionable, in view of medical statements that the psychological effects of morphine outlast the analgesic action by many hours.⁵⁵

Another case makes the same assumption, this time in regard to barbiturates:

"Though drugs were administered to the testator intermittently to produce sleep and rest, the record is without contradiction that no drugs of any kind were administered during the entire afternoon of March 12, 1945, the date the will was executed."⁵⁶

The cases mentioned thus far were instances where witnesses could be found to testify that before or after the will was drawn, the testator lacked mental capacity. In protracted illness, it may be said that a testator is at one time capable of executing a will, eventually becomes consistently incapable, and in the meantime may swing back and forth between these extremes.

One case deals neatly with a situation where the testator was clearly capable at one point and rapidly became incapable, passing in a few hours through a single questionable period, during which the will was executed, into coma. This 67-year old farmer, who caught his arm in

⁵² *In re Cochrane's Estate*, 211 Mich. 370, 375, 178 N. W. 673, 674 (1920) [cancer; morphine].

⁵³ *In re Estate of Burwitz*, 272 Mich. 16, 17, 261 N. W. 121, 122 (1935) [cancer; "opiate"]; see also *In re Glockner's Will*, 17 N. Y. St. Rep. 798, 2 N. Y. Supp. 97 (Surr. Ct. 1888) [cancer; opium].

⁵⁴ *Epling v. Hutton*, 121 Ill. 555, 559, 13 N.E. 242, 244 (1887) [vascular occlusions in the leg; morphine].

⁵⁵ Wolff, Hardy, Goodell, *Studies in Pain*, 19 JOURNAL OF CLINICAL INVESTIGATION 659, 664 (1940).

⁵⁶ *In re Llewellyn's Estate*, 83 Cal. App. 2d 534, 565, 189 P. 2d 822, 840 (1948) [cirrhosis of liver, ulcer in rectum, gallstones; seconal, nembutal, phenobarbital].

a hay baler and died the following day, received a total of 10 mg. of morphine sulphate and 100 mg. of Demerol; his will was executed three hours after the accident and following the heavy dosage of Demerol, a drug which resembles morphine. The raised level of reflex excitability caused by great pain should be considered in evaluating the probable effect of the drugs. The court said:

"In view of the fact that all of the witnesses at the execution of the will and prior thereto testified to testator's competency, together with the fact that he was suffering from irreversible shock, and getting progressively worse due to his injury, there is no logical relation between the fact that he was later in a stupor or unconscious, and the issue of mental capacity at the time of the making of the will."⁵⁷

It has long been held that illness does not in itself prevent a testator from having testamentary capacity. The statement of a Louisiana notary in witnessing a will, paraphrasing a familiar saying, makes the point clearly:

"Personally came and appeared Dreux Angers, a single man of lawful age, residing in the Parish of Terrebonne, State of Louisiana, *ill in body, but of sound and disposing mind, as he appeared to the said named five witnesses and me, Notary. . .*"⁵⁸

By the same token, the fact that a testator has been given narcotic drugs is not conclusive evidence that he is so much under their influence as to be incapable of making a will.

"If . . . a physician prescribes a sedative or some medicine to ease pain or reduce nervousness, the fact that such a drug has been administered is not, of itself, proof or even weighty evidence of testamentary incapacity."⁵⁹

"The ministration of narcotics was but one of the evidentiary facts of the whole case. . ."⁶⁰

"Main reliance is had on the fact that within forty-six hours of the time the proposed will was executed testator had fourteen administrations of opiates for rest and to deaden his constant pain, two of which were within three hours of the time the will

⁵⁷ *In re Walters' Estate*, 77 Ariz. 122, 126, 267 P. 2d 896, 899 (1954) [accident; morphine, Demerol]. Remanded with direction to admit to probate.

⁵⁸ *Succession of Angers*, 205 La. 190, 194, 17 So. 2d 247, 248 (1944) [cancer of prostate; amytal, phenobarbital, codeine, morphine]. Quotation by and emphasis supplied by the court.

⁵⁹ *In re Kinssies' Estate*, 35 Wash. 2d 723, 734, 214 P. 2d 693, 699 (1950) [heart attack; pantopon].

⁶⁰ *In re Mikelson's Estate*, 41 Wash. 2d 97, 99, 247 P. 2d 540, 541 (1952) [heart attack; morphine]; see also *Nunn v. Williams*, 254 S. W. 2d 698 (Ky. 1953) [abdominal cancer; Demerol].

was executed. The record in the hospital shows they were the usual and average dosages of drugs, such as demerol and pantopon, at three to four hour intervals during testator's waking hours. The testimony of the witnesses who had an opportunity to observe him is that at the time the will was prepared and executed he was in sound mind, alert, knew what he wanted, and had full testamentary capacity. While it is conceded that opiates have some effect on the alertness and judgment of persons to whom they are administered, this effect varies widely in individuals, particularly in relation to the amount of drugs to which they are accustomed. The evidence clearly sustains the trial court on the question of mental capacity."⁶¹

Pain, drugs, advanced age, blindness, and kindred physical impairments may be used as evidence tending to show lack of testamentary capacity, but the courts recognize that the choice is between the will, which probably contains at least some of the testator's wishes, and the distribution prescribed by the law of intestate succession, which by the very fact of the contest will bestow some of his property to persons he considered positively undeserving. Faced with this choice, the courts understandably find for the will unless the evidence strongly points toward incapacity or undue influence.

*The Presumption on the Other Foot*⁶²

There are a few cases demonstrating a presumption contrary to the basic presumption that a testator had testamentary capacity. ". . . [W]hen settled and general unsoundness of mind is proved, a presumption arises in favor of its continued existence."⁶³ In a more recent case, the court framed the principle thus:

"In determining testamentary capacity, the mental condition of the testator at the very time of executing the will is the only point of inquiry; but . . . evidence of the testator's condition at a time other than the date of the execution of the will may shift the burden of proof and require the production of affirmative proof of his condition at the very time the will was executed."⁶⁴

Transferring and applying this principle to therapeutically administered drugs should present no serious problem. In one case, the testator was virtually unconscious from disease and large quantities of

⁶¹ Will of King, 251 Wis. 269, 274, 29 N. W. 2d 69, 71 (1947) [heart condition; Demerol and pantopon].

⁶² See also n. 41, *supra*.

⁶³ Kirsher v. Kirsher, 120 Iowa 337, 341, 94 N. W. 846, 847 (1903) [stroke, senility; no drug stated].

⁶⁴ American Trust & Banking Co. v. Williams, 32 Tenn. App. 592, 603, 225 S. W. 2d 79, 84 (1948) [cirrhosis of liver; no drug stated].

narcotics; the court strongly implied that undue influence was present.⁶⁵ In another case, beneficiaries under the proposed will failed to obtain proper execution at one time and tried again a week later. Meanwhile, the testator's rascally brother, a doctor who had once been institutionalized for drug addiction, kept the testator under the influence of heavy overdoses of morphine. Undue influence was the principal issue; there was testimony that the testator was almost unconscious when the will was executed. Said the court, "He was then and had been for some days heavily dosed with morphine and other like drugs. . . Certainly at that time the testator did not have the mental capacity to make a will."⁶⁶

The fact that a testator was ill and had been given mind-affecting drugs can be introduced as evidence to indicate his mental condition at the time the will was executed. Hence, the presumption of continuing incapacity would appear to be a valuable line of attack upon the wills of testators in terminal illnesses, when it is discovered by contestants that there had been a course of administration of drugs extending for some days. The attack, if successful, would force proponents of the will to show that it was executed during a period analogous to a lucid interval in contests based upon alleged insanity.

Strong-Willed Testators and Undue Influence

The courts are willing to find that a particular testator had the capacity to make a will in spite of the mental side-effects of the drugs administered. ". . . [U]nless the theory that [mental unsoundness] ought to exist, or might exist, be followed by proof that it actually did exist at the important moment, the theoretical proof is of no practical value in the contention."⁶⁷

It has been recognized that morphine given over a period of time might "... weaken . . . power of resistance to importunity of others. . . ."⁶⁸—the fear of undue influence appearing once more as the companion of mental incapacity. However, one court used the fact that a testatrix was dressed and able to walk to a table to sign the will as evidence that she was in no way under a drug's influence, and presumably that therefore she was under no undue influence from other persons.⁶⁹ Another court said,

⁶⁵ *In re Skrtic's Estate*, 379 Pa. 95, 108 A. 2d 750 (1954) [cancer; narcotics]; see also *Garrison v. Blanton*, 48 Tex. 299 (1877) [no disease stated; morphine]. Probate denied in both cases.

⁶⁶ *In re Estate of Lande*, 183 Minn. 419, 422, 236 N. W. 705, 706 (1931) [cancer; morphine].

⁶⁷ *Miller v. Oestrich*, 157 Pa. 264, 273, 27 Atl. 742, 745 (1893) [rheumatism; morphine].

⁶⁸ *Dieffenbach v. Grece*, 56 N. J. Eq. 365, 370, 39 Atl. 536, 538 (1898) [cancer; morphine].

⁶⁹ *In re Glockner's Will*, 17 N. Y. St. Rep. 798, 2 N. Y. Supp. 97 (Surr. Ct. 1888) [cancer; opium].

"... [I]nstead of being passive in the face of suggestions concerning his affairs the testator vigorously resisted any interference, and time and time again he declared and avowed his intention to dispose of his property as he himself saw fit."⁷⁰

Cases like these provide the foundation for efforts to prevent contests, when the attorney can show that whatever the generalities of the situation, his witnesses are prepared to testify that *this* testator *when* he executed his will met the legal standard of testamentary capacity and was not under the improper influence of anyone.

Preventive Techniques

Having now posed the threat to testamentary capacity from therapeutic drugs, it behooves the discussion to provide some advice for meeting the threat.

In the typical situation, there is considerable doubt that the patient will recover from his illness, and there is no certain prospect that a moment better than the present will arise for the execution of his will. Perhaps the attending physician can temporarily modify his treatment in order to improve the patient's mental capacity. If so, this will justify a brief postponement in executing the will, but not one of more than a day or so. Even if the prognosis is fairly favorable, it is preferable to have a rudimentary will now, just in case, and plan to do a better job when the patient recovers.

The need for contemporaneous precautions is magnified when there is some likelihood that any will executed at this time will be contested later on. It is true that as a matter of practice, every will ought to be drawn with a view toward making it strong against attack; but with the hazard of impaired mental capacity in the picture, special precautions are called for, especially when the will disposes of the testator's property in a manner likely to provoke a contest.

Looking ahead to defending a will against caveators, the attorney will need witnesses—preferably experts in medicine and in the observation of mental condition. The best time to get these witnesses is at the time the will is executed; and the best place to record their presence is at the foot of the will, as attesting witnesses. Not only does this add weight to the usual layman's attestation that the testator was of sound mind and memory, but it also serves to commit the putative caveators' best available witnesses—the attending physicians and nurses—to the defense of the will.⁷¹ Properly informed of the standard of mental capacity required to make a valid will, and convinced as scientifically-oriented per-

⁷⁰ *In re Llewellyn's Estate*, 83 Cal. App. 2d 534, 564, 189 P. 2d 822, 840 (1948) [cirrhosis of liver, ulcer in rectum, gallstones; seconal, nembutal, phenobarbital].

⁷¹ See ATKINSON, WILLS § 74 (2d ed. 1953).

sons that the testator possessed the required capacity, physicians and nurses will make credible witnesses who will be unlikely to change their minds under cross-examination.

Psychiatric Assistance

If the attorney has some doubt as to whether his client has sufficient mental capacity to make a will, one obvious solution to the problem is to call for a psychiatric examination.⁷² There are two practical obstacles to overcome: finding the time and a psychiatrist to make the examination, and persuading the testator to submit to the examination, which he may consider neither pleasant nor flattering. Nevertheless, it seems that an affirmative finding by a reputable psychiatrist, based upon observation contemporary with execution of the will, would be worth far more than the same psychiatrist's answer to the best imaginable hypothetical question, months later in court. Before he calls in a psychiatrist, the attorney has to weigh two risks: the so-called double-edged sword argument, which asserts that calling in the psychiatrist in itself invites attention to doubt in the attorney's mind;⁷³ and the likelihood that the psychiatrist might find against testamentary capacity, even when carefully informed of the standard of mental capacity involved.

In support of psychiatric examination before the will is drawn, there is a case which clearly supports the careful preventive medico-legal work of a foresighted attorney: *In re Bottger's Estate*,⁷⁴ which is apposite in every detail save one, that it deals not with the mental side-effects of drugs but with a patient whose mental processes were impaired by arteriosclerosis.

Mrs. Bottger was 93 years old. Her attorney had sound reason to believe that guardianship proceedings would soon be initiated when he drew the will, and so at his behest, she submitted to two mental examinations, six weeks apart. Mrs. Bottger left ten dollars to each of the contestants, who were five of her seven surviving children, and the residue to her son Harry. Contestants petitioned to have the will declared void and secured a decree revoking probate.

The Supreme Court of Washington in its opinion described in detail the steps taken by the examining physicians, Dr. Austin J. O'Leary and Dr. Marjorie Heitman, who, "... having satisfied themselves as to her competency, signed her will as witnesses,"⁷⁵ and later testified to the

⁷² See Note, *Psychiatric Assistance in the Determination of Testamentary Capacity*, 66 HARV. L. REV. 1116 (1953).

⁷³ See ATKINSON, WILLS §§ 51, 74 (2d ed. 1953).

⁷⁴ 14 Wash. 2d 676, 129 P. 2d 518 (1942) [arteriosclerosis; no medication specified]. For a comparable but somewhat weaker case, see *Bollinger v. Arkansas Valley Trust Co.*, 202 Ark. 525, 151 S. W. 2d 675 (1941).

⁷⁵ *Id.* at 695, 129 P. 2d at 526. The *American Medical Directory* 1903 (17th ed. 1942) lists Dr. O'Leary as a physician who limited his practice to psychiatry and neuro-surgery; Dr. Heitman had training in obstetrics and gynecology.

same effect. Said the court:

"The testimony of Dr. O'Leary and Dr. Heitman is entitled to great weight, since they were, at the same time, attending physicians and subscribing witnesses. . .

"In this connection, respondents contend that the fact that physicians were called to examine the testatrix indicates that the parties concerned were suspicious of her testamentary capacity. However, we think this was a wise course to pursue, in view of the age of the testatrix, the nature of the will, and the fact that there was reason to believe that guardianship proceedings would be instituted in the near future, and possibly a will contest later."⁷⁶

The supreme court reversed the court below and directed that the will contest proceedings be dismissed.

IV

CONCLUSION

Three matters of practice remain to conclude the discussion.

First, as a matter of medical practice, can the physician temporarily modify the course of medication with a view to improving a patient's mental capacity? It is the province neither of the attorney nor of this discussion to tell the physician how to perform his tasks, but there seems to be no harm in asking, bearing in mind that the particular answer is always up to the attending physician. In asking, the attorney ought to spell out to the physician the low standard of mental capacity required, so that the physician can see how a slight improvement may represent the difference between a will and no will.

Second, there is a distinct legal possibility that the attorney can match the will to the testator's capacity to make it. Suppose that an attorney has time to prepare a detailed, complex will appropriate to his client's circumstances, but he is not certain that the client has the mental capacity to understand the manner in which the will embodies his wishes.

Assuming in this situation that a simple will is preferable to intestacy, it is suggested that the attorney prepare a simple will which briefly states the testator's wishes—a synopsis or sketch. Since the capacity to make a will is measured by the courts against a particular will at a particular time, there seems to be no reason to suppose that a court would reject a simple will for the sole reason that the testator appeared to have been incapable of executing a complex will.

Finally, does an attorney, as an officer of the court, have a duty to refrain from drawing a will when he has some doubt that the testator has

⁷⁶ *Id.* at 696, 129 P. 2d at 526.

sufficient mental capacity to execute it? If the doubt is no more than a doubt, it is suggested that the attorney take the position that he is an advocate whose duty is the care of his client's interests, not the pre-judging of possible disputes arising after his client's death. If the attorney should refuse to draw his client's will, the chances are that some other attorney can be found to draw it, leaving the client with what in all probability will be a poorer instrument, more vulnerable to attack and less useful if probated.

If he does draw the will, the attorney should refrain from signing it as an attesting witness, because if the will should be contested, he probably should not appear in its favor and 'also represent the pro-pounders in court.⁷⁷ In balance, it would seem that when the client's interests stand to gain so much by having the regular attorney draw the will, the regular attorney ought to construe every doubt in favor of doing his best and leave the outcome to the future. In this way, the attorney can make his contribution to the client's peace of mind, to take its place with the ministrations of the medical profession.

⁷⁷ American Bar Association, *Canons of Professional Ethics* § 19 (1955 ed.). If an attorney is an attesting witness, he can be called by the caveators; he does not have the benefit of the attorney-client privilege; and his testimony is admissible. 8 WIGMORE, EVIDENCE § 2315 (3d ed. 1940).