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# California Trusts and Estates Quarterly

## *Inside this Issue...*





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# From the Editor

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With this issue of *California Trusts and Estates Quarterly* we complete a full year of our new publication. Your praise and constructive criticism have been very gratifying. It is nice to know that someone reads what so many people have worked so hard to produce!!!!

While this issue has no single theme, a substantial amount of space is devoted to new and prospective legislation in our field of practice. Please note the following legislative articles:

- In the lead article of this issue of the *Quarterly*, the Informal Administration Committee of the Executive Committee of our Section has prepared an Analysis of the highly controversial Proposal for Informal Administration of Decedents' Estates in California. To help us understand this proposal, the Committee has not only summarized the proposed statute, but they have also included a discussion of the "pros" and "cons" painstakingly discussed during its formulation. Please heed the Committee's solicitation of your comments, both for and against the proposal.

- Jim Birnberg gives us his annual *Summary of 1995 Legislation* of interest to trusts and estates lawyers.

- In *A Brief Introduction to the Due Process in Competence Determinations Act: A Statement of Legislative Intent*, Marc Hankin gives us a reprise of the Due Process in Competence Determinations Act, which has the potential to revolutionize the determination of incapacity in California, not only in conservatorships and Will contests, but in a wide range of civil litigation involving capacity, as well. The DPCDA is the worthy progeny of EADACPA ("Elder Abuse and Dependent Adults Civil Protection Act") of which Marc was the father a number of years ago. Those who lament the absence of "real" science in the courtroom will hail the DPCDA as a major step forward.

- Mike Vollmer gives us a brief summary of the 1995 changes to AB21 in *Mike's Minutiae*.

- Mike also warns the Notaries among us to stock up on moist towelettes to clean our clients' thumbs after they have been fingerprinted under the new statewide statute requiring fingerprinting under certain circumstances (we L.A. Notaries have already had several years of practice). This one is truly worthy of the "Minutiae" label!

In addition to these articles with a legislative focus, this issue also contains several articles of particular interest to the probate litigators, namely:

- Rich Gorini's article on the ramifications of the holding in *Estate of Irwin* insofar as it relates to pretermitted spouses and republication of a pre-marriage Will.

- Noël Lawrence's and Jim Barringer's article on *The Effect of Elder Abuse Law on the Conduct of Estate and Trust Litigation*. This is the first time I have seen anyone pull together all the pieces of the elder abuse statutes into one article and apply them to the common circumstances which arise regularly in our field of practice.

- The *Litigation Reporter*, which gives us summaries of several more probate cases at the trial/settlement level.

- The *Litigation Alert*.

Dominic Campisi will send you to your dictionary to refresh your memory of the definition of "punctilio" when you read (and squirm while reading) his *"The Punctilio of an Honor the Most Sensitive": An Uncomfortable Perch*. In a comprehensive, but entertaining way, he gives us a survey of the ethical issues facing trusts and estates lawyers as seen through the eyes of the courts. You may be surprised at some of what you read!

**Your praise and constructive criticism have been very gratifying. It is nice to know that someone reads what so many people have worked so hard to produce.**

In an effort to encourage our Section Members to become more active in the work we do, the Membership Committee of the Executive Committee has included a brief article on how one can become a member of the Executive Committee and what it means to serve on that Committee. The application process for appointment to the Executive Committee begins on January 1, and a form is published in this issue for those Section Members who are interested.

Finally, we have Alerts from the Estate Planning Committee and the Estate Planning and Tax Committee.

This issue brings to a close my tenure as Editor of the *News/Quarterly*. It has been an exhilarating and rewarding two years, but I am more than ready now to turn over the editorial helm to the capable hands of Jim Ellis. Before I do, however, I cannot stand down without giving my most sincere thanks to Bob Sullivan, for relentlessly pursuing his dream of upgrading our publication; to my very patient authors, who graciously accepted my editorial changes and re-writes; to my secretary, Marge Cain, who expertly processed and proofed more words in the past two years than either one of us cares to remember; and to you, the readers, for your support.

Good luck, Jim. And please don't take it personally if you see me reading your first issue of the *Quarterly* with a red pen in my hand—old habits are hard to break.

This publication may be cited as
[author], [title], 1 Cal. Tr. & Est. Q., Winter 1995, at p. __.

to the Federal Insolvency Statute. The court based its opinion on an analysis of the weight of federal authorities and on what it considered to be the better reasoned analysis in *Nesbitt v. United States* (N.D. Cal. 1978) 445 F.Supp. 824, aff'd. 622 F.2d 433 (9th Cir. 1980), cert. den. 451 U.S. 984 (1981). The *Nesbitt* court conducted a detailed analysis of the applicable statutes and concluded that Congress did not intend an implied exception to the Federal Insolvency Statute.

As a point of interest, the judgment lienholders argued on appeal against the priority of the administrative expenses, however, since they did not file a cross-appeal, the court did not consider their arguments on this issue. The issue was not properly before the court.

### VII. BEQUESTS TO A FORMER SPOUSE'S CHILDREN WERE REVOKED BY OPERATION OF LAW WHEN THE MARRIAGE WAS DISSOLVED.

Decedent's will, which was executed during his marriage, left bequests to his spouse's children if his spouse pre-deceased him. The marriage was later dissolved but the will was not changed. The gifts to the former spouse were clearly revoked by operation of Probate Code §6122, which provides that dissolution or annulment of a marriage revokes any disposition or appointment of property in a will, any provision any will conferring a special power of appointment on the former spouse, and any provision nominating the former spouse as executor, trustee, conservator, or guardian. However, the question before the court was whether the gifts to "my spouse's children" and "my spouse's issue" survived the dissolution or were revoked.

In the trial court, decedent's four former step children argued that Probate Code §6122 revoked the gifts only as to the spouse. The statute is silent as to lineal descendants. Decedent's only son argued that the will is ambiguous in light of the subsequent divorce. The gifts to the spouse's issue or children were in essence a gift to a class and, because of the divorce, there were no members of the class. The trial court held that the ex-spouse's children were clearly those to whom decedent was referring in the bequests and therefore they took under these gifts in the will.

The Court of Appeal in *Estate of Hermon* (Cal.Ct.App. 1st Dist., Nov. 9, 1995) reversed the trial court and determined that the gifts were revoked unless the testator clearly expressed an intent that the gifts survived the dissolution. Here decedent expressed no such intent.

Because the question was one of first impression in California, the court looked to out-of-state cases, which the court did not find particularly helpful. The court then turned to an analysis of the gift as a class gift. Because the former stepchildren were named only in the preamble to the will for identification purposes and the dispositive provisions of the will did not name any individuals, the court concluded that the testator intended the members of the class to be determined by relationship to him. In other words, the court was unwilling to read the dispositive provision as an intent to provide for "my *former* spouse's issue" or "my *former* spouse's children."

Finally, the court noted that the new Uniform Probate Code §2-804 revokes not only testamentary bequests to the former spouse, but also to the former spouse's relatives. However, §2-804 has not been adopted in California.

# A BRIEF INTRODUCTION TO THE DUE PROCESS IN COMPETENCE DETERMINATIONS ACT: A STATEMENT OF LEGISLATIVE INTENT

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## I. INTRODUCTION

On October 12, 1995, Governor Wilson signed Senate Bill 730, which engrafts onto the law of legal mental competence the terminology used by today's science of mind. Entitled *The Due Process in Competence Determinations Act* (SB 730 Mello, Chap. 842 Stats. of 1995), the new law creates a proceeding by which a patient or physician can obtain a determination that the patient's consent to a medical procedure is a competent and informed consent. The Due Process in Competence Determinations Act ("DPCDA" pronounced *dip-see-duh*) prohibits any determination of legal mental incapacity in any context under California State law which does not comply with the new law's terms (except proceedings under the Welfare & Institutions Code). The DPCDA also codifies the case law standards for the capacity to consent to medical treatment and to contract. By connecting those standards to a discrete list of mental functions which alone may form the basis for legal mental incapacity, the DPCDA creates a road map for determinations of contractual and medical consent incapacity and a new theoretical model by which all legal mental capacity or incapacity determinations may be made.[1]

## II. THE DUE PROCESS IN COMPETENCE DETERMINATIONS ACT: MUCH ADO ABOUT NOTHING - OR - ALL THE DIFFERENCE IN THE WORLD

From one perspective, the Due Process in Competence Determinations Act may appear to be much ado about nothing. A lawyer who is a careful, well prepared conservatorship "specialist" might rightfully conclude that nothing different need be done now that the DPCDA has been enacted. This is because the new Act largely codifies existing case law as it should be applied using state of the art forensic psychiatric assessment techniques regarding incapacity. Indeed, for the rare situation where the lawyer appears regularly before a judge who has both a strong academic interest in forensic psychiatric testimony, and a great deal of experience with litigation over legal mental incapacity, nothing will have changed. But for the rest of us, the new law is likely to make all the difference in the world.

As people live longer, the prevalence of dementia in the population increases. It becomes progressively more important for health care providers to be able to ascertain whether a patient is competent to make a decision. For example, if a physician suspects that a patient is too demented to give legally valid consent to a recommended medical procedure and close family members violently disagree about the advisability of the procedure, the physician might refrain from treating the patient for a condition that does

not *seem* to require urgent care. The physician may fear that if the treatment is administered and something goes awry, and the patient was *not* competent to consent to the treatment, the patient's family may get a conservator or guardian *ad litem* appointed, and the conservator or guardian *ad litem* may sue the physician for battery, *i.e.*, for an unconsented touching.[2]

The same issues confront persons transacting financial business with an individual who behaves strangely. For example, title companies sometimes need to know if an individual who is refinancing his or her home, or selling it at a *strange* price, is competent to sign a refinance contract or to make a gift. If [1] the transferor was not competent to make the deal, [2] the title company was on notice that the transferor might be incompetent, [3] the demented transferor was the victim of financial abuse, and [4] the abuser skipped town with the ill gotten gains after selling the property to an innocent third party, the title or escrow company might have to pay the victim's conservator for the victim's foreseeable losses. A lawyer who negligently misrepresents that his incompetent client understood a deal may be liable to third parties when the deal unwinds.[3]

The DPCDA was designed to help laymen, physicians, judges and lawyers understand and address these problems. The DPCDA enacts new Probate Code §§810-814, setting out tests for determinations of competence. Under a technical corrections bill which is likely to be introduced soon, those provisions of the DPCDA will form a new Part 17,[4] entitled "Legal Mental Capacity." New §812 will be reenacted as §811, creating fundamental rules for all competence determinations, and new §811 will be reenacted as §812, codifying the basic standards for legal mental capacity. Although the tests in the DPCDA are not as objective as those which check the alkalinity of water in a swimming pool, the tests in the DPCDA are far more meaningful and verifiable than those that were previously readily available in the law. This legislation was jointly developed by and was co-sponsored by Estate Planning Trust and Probate Section of the California State Bar and the California Medical Association. The campaign to get the legislation enacted was inspired in part by the results of a survey of the American College of Probate Judges conducted by Prof. James E. Spar, M.D., Commissioner (Ret.) Ann E. Stodden and the author, the results of which were published in an article entitled *Assessing Mental Capacity and Susceptibility to Undue Influence*.[5] The Bill received strong support from the California Judges Association, Adult Protective Services workers, law enforcement officers, mental health professionals and others. The DPCDA was drafted principally by the author of this article, and in alphabetical order, by Don Green, Alice Mead, Senator Henry Mello's aide, Paul Minicucci, and James Spar, M.D.[6]

## III. PROBATE CODE §813: CODIFICATION OF THE STANDARDS FOR THE CAPACITY TO CONSENT TO MEDICAL TREATMENT

The DPCDA gives health care providers clear legal standards to ascertain a patient's capacity to give informed consent to medical treatment. These newly codified standards were previously buried in case law. While the legislation indicates that the standards are intended for use in a judicial context, rather than at the bedside, the new law may provide instructive guidelines for the physician as well. The standards are a mixture of *operational capabilities*, such as the ability to "respond knowingly and intelligently to queries about that medical treatment," and a *data set*. The term *data set* is used here to refer to the information which health care providers must convey to a patient so that the patient's consent to a particular treatment will be a legally valid *informed* consent, *e.g.*, the nature and seriousness of the illness, disorder or defect that the person has, and the nature of the medical treatment that is being recommended by the person's health care providers.

The DPCDA makes these standards available to laymen and the medical and legal communities by reducing the standards to a few lines in new California Probate Code §813. New §813 says that a person has the capacity to give informed consent to a proposed medical treatment, and to *refuse* consent, if the person is able to:

1. Respond knowingly and intelligently to queries about that medical treatment,
2. Participate in that treatment decision by means of a rational thought process, and
3. Understand all of the following items of minimum basic medical treatment information with respect to that treatment:

    a. The nature and seriousness of the illness, disorder or defect that the person has,
    b. The nature of the medical treatment that is being recommended by the person's health care providers,
    c. The probable degree and duration of any benefits and risks of any medical intervention that is being recommended by the person's health care providers, and the consequences of lack of treatment, and
    d. The nature, risks and benefits of any reasonable alternatives.

Section 813 is a codified implementation of the general notion that any decision or consent must be based on knowledge of the relevant facts. No decision can be made competently in the absence of relevant information, and many statutes codify the duty of physicians to transmit to patients data sets applicable to various particular treatments. *See, e.g.* Welf. & Inst. Code §5326.2 (concerning electro-convulsive therapy). Section 813 includes a data set that applies to *all* medical treatments.

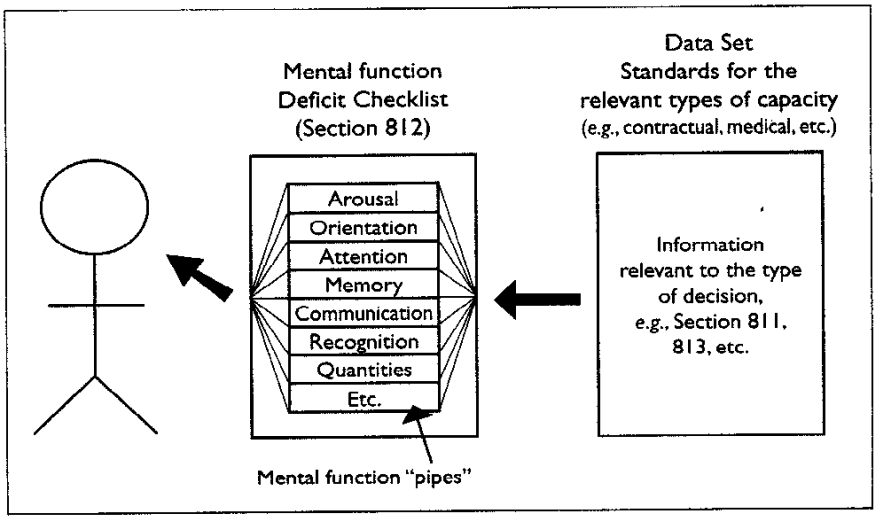
## IV. PROBATE CODE §812: THE FINITE MENTAL FUNCTION DEFICIT LIST —MODERNIZING THE *LINGUA FRANCA* OF *ALL* CAPACITY DETERMINATIONS

The law has long told us that there must be more than a mere transmission of information to the patient. The recipient must be able to understand that information and express a decision based on the information. A decision must be intelligent, or at least the product of as much intelligence as may be demanded of the proverbial uneducated Joe and Sally Sixpack.[7] After all, no amount of information is any good unless it is provided to a principal who is capable of understanding it. A recitation of medical information to the sleeping patient who periodically mutters "Yes" will not transform the unconscious mutterings into an informed, knowing and intelligent consent. Similarly, it would be unfair to saddle an Alzheimer's disease victim with the responsibility for the outcome of a risky treatment if the patient did not have the mental wherewithal to comprehend the relevant medical information and to make an *intelligent* decision based on it.

How can doctors, laymen, judges and lawyers determine if the patient is able to understand the minimum medical information that our society would expect a reasonable person to understand... assuming that a physician were actually to explain everything to the patient? The answer is surprisingly simple.

The DPCDA enacted into law a list of mental functions which may be viewed as *pipes* through which the medical information travels from the physician's mouth and preprinted forms into the patient's mind to be processed there and through which the response flows back from the patient. If a patient is suffering from advanced multiple infarct dementia, several of those *pipes* will be seriously damaged, or metaphorically speaking "clogged." In that case, the relevant medical information cannot meaningfully get through the applicable pipes (such as [a] memory, or [b] ability to reason logically, or [c] ability to understand or communicate with others). Because the minimum data set cannot get into the patient's mind and be processed reasonably, the patient *lacks* the legal mental capacity to consent to the medical treatment.

On the other hand, the DPCDA protects the civil liberties of the mentally impaired by stating that no mental function impairment may *even be considered* in determining legal mental capacity unless the impairment is so severe that "the deficit, by itself or in combination with one or more other mental function deficits, *significantly* impairs the person's ability to *understand and appreciate the consequences* of his or her actions with regard to the type of act or decision in question." Thus, a decision about prostate cancer surgery, which entails balancing a risk of sexual impotence against a risk of death, requires a higher level of mental function integrity than a decision about whether to stitch up a gaping wound in the patient's arm. A patient with a serious deficit in memory and the ability to reason logically using abstract concepts may still be able to understand that he or she is bleeding, and that closing up the wound is beneficial. The same patient might be too impaired to understand the percentage probabilities of risk and benefit necessary to give an intelligent informed consent to prostate surgery.




The above model can be applied to testimentary capacity, too. Probate code § 6100.5 contains *both* testamentary capacity's limited *data* set and its *mental function* requirements.

New Probate Code §812 requires:

> A determination that a person is of unsound mind or lacks the capacity to make a decision or do a certain act, including, but not limited to, the incapacity to contract, to make a conveyance, to marry, to make medical decisions, to vote, or to execute wills or trusts, shall be supported by evidence of a deficit in at least one of the following mental functions, subject to subdivision (b):
>
> (1) Alertness and attention, including, but not limited to, the following:
>
> (A) Level of arousal or consciousness.
>
> (B) Orientation to time, place, person, and situation.
>
> (C) Ability to attend and concentrate.
>
> (2) Information processing, including, but not limited to, the following:
>
> (A) Short- and long-term memory, including immediate recall.
>
> (B) Ability to understand or communicate with others, either verbally or otherwise.
>
> (C) Recognition of familiar objects and familiar persons.
>
> (D) Ability to understand and appreciate quantities.
>
> (E) Ability to reason using abstract concepts.
>
> (F) Ability to plan, organize, and carry out actions in one's own rational selfinterest.
>
> (G) Ability to reason logically.
>
> (3) Thought processes. Deficits in these functions may be demonstrated by the presence of the following:
>
> (A) Severely disorganized thinking.
>
> (B) Hallucinations.
>
> (C) Delusions.
>
> (D) Uncontrollable, repetitive, or intrusive thoughts.
>
> (4) Ability to modulate mood and affect. Deficits in this ability may be demonstrated by the presence of a pervasive and persistent or recurrent state of euphoria, anger, anxiety, fear, panic, depression, hopelessness or despair, helplessness, apathy or indifference, which is inappropriate in degree to the individual's circumstances.

### A. Who is Vulnerable to a Finding of Incompetence under Probate Code §812?

The DPCDA says that *no court* may determine that a person lacks legal mental capacity *unless* that determination is based on evidence of an *impairment* in one or more of the mental functions listed in new Probate Code §812. Section 812 does *not* imply that a person will be deemed incompetent to consent to medical treatment if he or she suffers from *any* impairment in memory or any other mental functions. The author frequently forgets persons' names but vigorously asserts that this is not significant evidence of an incapacity to consent to medical treatment, or any other type of legal mental incapacity. Indeed, Probate Code §812(b) virtually bends over backwards to protect civil liberties

by stating the truism that:

> A deficit in the mental functions listed [in subdivision (a)] may be considered only if the deficit, by itself or in combination with one or more other mental function deficits, *significantly impairs* the person's ability to *understand and appreciate the consequences* of his or her actions with regard to the type of act or decision in question. (Emphasis added.)

Nor does Probate Code §812 mean that if a person lacks the capacity to do one thing, such as consent to a particular medical treatment, the person necessarily lacks the capacity to do anything, including the execution of a will. Section 811 confirms this, indicating among other things that the law of testamentary capacity is not affected by the DPCDA. Somewhat simplistically speaking, testamentary capacity, which is codified in Probate Code §6100.5, demands only the ability to know and recall what one owns, who one's relatives are, and to whom the will transmits the assets. In many cases, this does not demand the ability to learn and recall new information or to reason using abstract concepts. Thus, a person may have testamentary capacity even though he or she has severe mental function deficits.

**B. The Subjective Meaning of the Term "Appreciate"**

The author has been unable to find any definition in the law of the term "appreciate." An ABA monograph on capacity defined "appreciate" as follows:

> "Appreciation" differs from factual understanding in requiring that the individual consider the relevance to his or her own situation of the risks and benefits and attach an emotional value to those risks and benefits.[8] Conditions that may affect appreciation include denial, which may prohibit respondent from recognizing the severity of his or her condition; depression, which may cause a respondent not to attach value to life; mania, which may create feelings of invincibility; and pathological perception of dependence on another person, which may distort evaluation of alternatives.[9]

The foregoing definition suggests that a person's ability to "appreciate" can only be determined with reference to the then current social norms and expectations about a person's emotional and cognitive awareness. The author suggests that no person should be deemed unable to appreciate information unless there is clear evidence of such inability which is not explainable otherwise.

**C. Incompetent People's Wishes Should Be Respected Whenever Practical**

Incapacity to consent to medical treatment does *not* require a complete loss of self-determination. Although the vigor with which a patient expresses consent or objection to a treatment is irrelevant to the issue of capacity, the incompetent patient's feelings *may* be considered by the health care agent in deciding whether a treatment is appropriate under the circumstances, or is something the patient would have wanted before losing capacity.

**D. The Mental Function Deficit List as a Two-Edged Sword**

The introduction of a finite mental function deficit list into the law of competence determinations is a two-edged sword. It is a powerful weapon in the hands of an advocate fighting to protect the rights of a *competent* proposed conservatee whose civil liberties have been jeopardized by the filing of a petition alleging that the proposed conservatee lacks the capacity to consent to all medical treatments. The very finite character of the list enables the proposed conservatee's attorney to narrow the scope of controversy to a list of mental or behavioral functions which are, for the most part, subject to fairly objective assessment. On the other hand, a petitioner seeking a finding that the proposed conservatee lacks the capacity to consent to medical treatments can more easily overcome the objections of a resistant conservatee by showing [1] that the conservatee suffers from a significant impairment in one or more of the mental functions in the Probate Code §812 list, and [2] that the impairments are so severe as to prevent the proposed conservatee from being able to give informed intelligent consent to medical treatments with reasonable reliability.

**Somewhat simplistically speaking, testamentary capacity, which is codified in Probate Code §6100.5, demands only the ability to know and recall what one owns, who one's relatives are, and to whom the will transmits the assets. In many cases, this does not demand the ability to learn and recall new information or to reason using abstract concepts. Thus, a person may have testamentary capacity even though he or she has severe mental function deficits.**

*1. A road map for a finding of incapacity*

The list of deficits is a road map for the determination of incapacity. For example, the physician who previously suspected that a patient lacks the capacity to consent to a particular treatment, such as prostate surgery, but could not say exactly why, will now know how to clarify the situation. The physician can ask questions designed to flesh out a deficit in attention, or memory, or language function or logical reasoning, and elicit obviously wrong answers demonstrating that the patient cannot meaningfully understand the medical information; or speaking in more general terms, that the patient cannot meaningfully understand the *data set* relevant to the treatment decision in question. The physician can then seek consent from a health care agent under a durable power of attorney, if a health care agent is available.

*2. The civil libertarian's shield against vague allegations of incapacity*

On the other hand, a physician, relative or a friend may sometimes *incorrectly* believe that a *competent* patient *lacks* the capacity to consent to medical treatment. Now, for the first time, the patient has a clear operational methodology for protecting his or her civil liberties. The patient can demand that the person claiming incapacity *prove* [1] the existence of an impairment in one of the measurable mental functions listed in new Probate Code §812, and [2] that the impairment is so substantial that the patient cannot understand and appreciate[10] critical medical information.

Under the DPCDA, garden variety cases of obvious incapacity will probably continue to be handled as they are today. But the difficult cases, which are sometimes litigated, will be handled more scientifically and *consistently* than they are now. In a memo circulated by the proponents of the DPCDA to legislators, California Medical Association attorney Alice Mead observed, "The [DPCDA] requires judges (and therefore physicians) to base a determination of a person's mental incapacity on evidence of specific functional impairments, rather than conclusory diagnoses. Although it might require a bit more effort on a testifying/examining physician's part, providing such evidence to a court will no doubt greatly increase the quality and accuracy of such adjudications."

**Under the DPCDA, garden variety cases of obvious incapacity will probably continue to be handled as they are today. But the difficult cases, which are sometimes litigated, will be handled more scientifically and consistently than they are now.**

At the request of Protection and Advocacy, a federally mandated patients' rights organization, Section 13 of the DPCDA provides that none of the DPCDA's terms apply to proceedings under the Welfare and Institutions Code. Hence, Probate Code §§811-813 may neither be used as a statutorily mandated road map nor as a shield in such proceedings.

*3. Controversies outside the judicial arena*

This new more objective methodology of identifying the relevant *data set* and looking at the functional integrity of the mental function "*pipes*" may also improve the way controversies over medical consent capacity are handled in an extra-judicial context. Other types of capacity, such as the capacity to contract or marry, also may be analyzed in court and in the community at large by identifying a data set, and by then determining if the pipes are too clogged for the information to pass through and be processed with a minimum amount of functional integrity.

No longer will judicial competence determinations be influenced significantly by competing experts' diagnostic characterizations of the patient as "schizophrenic" or "borderline." And no longer will medical experts be asked by lawyers and judges to give their "medical opinion" about whether the "patient's free will was overborne by the agency of another." This erstwhile amorphous "spirit" approach to capacity will be replaced by evidence of medically recognized phenomena that have a clear reference to verifiable reality.

Physicians will share a *lingua franca* now with judges and lawyers, and are likely to find this new judicial forum far less foreign and byzantine. For lawyers, too, things will be different. To paraphrase the CMA's Alice Mead, "Although [the new approach] might require a bit more effort on a [lawyer's] part, providing such evidence to a court will no doubt greatly increase the quality and accuracy of such adjudications." Personal injury lawyers, whose province is usually physical injury, have learned enough medicine to think and speak in the same medical terms as their expert witnesses. Now, conservatorship and probate litigation lawyers, whose province is legal mental capacity, will become conversant in the language employed by today's science of mind.

### E. The Frequency, Severity and Duration of Periods of Impairment

One of the goals of the DPCDA was to assist the trier of fact in obtaining a more comprehensive and realistic view of the mental functioning of proposed conservatees. On occasion, a proposed conservatee has been able to briefly simulate intact mental functioning in court, and that has been enough to deter courts from the unpleasant task of taking away that proposed conservatee's medical decision making power and granting it to another. The DPCDA *invites* but does not require the court to consider variations in mental functioning. New Probate Code §812(c) provides:

> In determining whether a person suffers from a deficit in mental function so substantial that the person lacks the capacity to do a certain act, the court may take into consideration the frequency, severity, and duration of periods of impairment.

Thus, in determining if a proposed conservatee lacks the capacity to consent to any form of medical treatment[11], the court may consider whether general medical powers should be granted even though a proposed conservatee *sometimes* has the capacity to consent to treatments. If the mental function deficit is [1] sufficiently severe when it manifests itself, and [2] the periods of impairment are either [a] frequent, or [b] of lengthy duration when they do occur, it would seem that new Probate Code §812(c) allows a Court to grant general medical powers even if the proposed conservatee can sometimes muster enough strength to put on a *brief* show of medical consent capacity. It may still be appropriate to take the conservatee's current wishes into account. See paragraph IVC above.

## V. PROBATE CODE §811: CODIFICATION OF THE STANDARD FOR CONTRACTUAL CAPACITY

### A. Is Probate Code §811 a *Minimum* Standard for Capacity of Any Type?

In a three-page description of SB 730 distributed first to members of the Senate Judiciary Committee[12] on April 14, 1995 and then

to the Assembly Judiciary Committee.[13] Senator Mello described new Probate Code §811 as a "statement of the *minimum requirements* for legal capacity of *almost any type*.... Those minimum requirements are entirely culled from and merely codify abundant case law." (emphasis added.) The endnotes accompanying §811 as reprinted below may be cited in briefs interpreting §811 because the endnotes were culled *verbatim* from a footnoted version of SB 730 presented on April 14, 1995 to the Senate Judiciary Committee, explaining why §811 would be good statutory law. All of the cases cited in the footnotes decided controversies turning on issues of contractual capacity. Probate Code §811 provides:

> Except where otherwise provided by law, including, but not limited to, Section 813 and the statutory and decisional law of testamentary capacity as in effect on January 1, 1995, a person lacks the capacity to make a decision unless the person has the ability to communicate verbally, or by any other means,[14] the decision, and to understand and *appreciate*,[15] to the extent relevant, all of the following:
>
> (a) The rights, duties, and responsibilities[16] created by or affected by the decision.
>
> (b) The probable consequences for the decisionmaker and, where appropriate, the persons affected[17] by the decision.
>
> (c) The significant risks, benefits, and reasonable alternatives involved in the decision.[18]

Like Probate Code §813, which determines medical consent capacity, §811's standards include both *operational capabilities* (such as the ability to communicate) and a *data set* (*i.e.*, subdivisions (a), (b) and (c) of §811).

### B. Do the Standards in Probate Code §811 Apply to Every Type of Capacity, Absent a Clear Statutory or Common Law Mandate to the Contrary?

Is Probate Code §811 (soon to be renumbered as §812) merely the codification of the standards for the capacity to contract? Or do the standards in §811 apply to *every* type of capacity, absent a clear statutory or common law mandate to the contrary?

The first six words of §811, "Except where otherwise provided by law," suggest that §811's standards are what Senator Mello's three page analysis of SB 730 said they were: to wit, a "statement of the minimum requirements for legal *capacity of almost any type* ..." (emphasis added.) The six words, "except where otherwise provided by law," appear in many places in the California Codes.

*Mosby v. Superior Court*[19] interpreted those words as indicating that "*express statutory* justification" is required for an exception to the general venue rules of Code of Civil Procedure 395. The *Mosby* approach to statutory interpretation would suggest that Probate Code §811's standards apply *unless* there is an *express statutory* indication to the contrary.

The following italicized words, which were added to the July 6, 1995 version of SB 730, *long after* the publication of Senator Mello's April 14, 1995 three-page statement, provide additional support for the proposition that Probate Code §811 may have been *intended* to create a new minimum standard for capacity in all cases except where the imposition of the new standard would work an absurd[20] result:

> Except where otherwise provided by law, *including, but not limited to, Section 813 and the statutory and decisional law of testamentary capacity...*

Section 811's explicit reference to two exceptions may support a *Mosby* approach, which would acknowledge only explicit statutory exceptions to §811's general rule. One exception to the general rule was a new statute, §813, which defined medical consent capacity, and which the sponsors of SB 730 represented to the Senate and Assembly Judiciary Committees was a codification of existing law. The second exception was, "*the statutory and decisional law of testamentary capacity....* This *explicit* reference to both the statutory *and decisional* law of *testamentary capacity*, juxtaposed next to a reference to Probate Code §813, might be interpreted as suggesting that Probate Code §811's general standards will apply to all types of capacity except where a statute, *including* §811, *explicitly* suggests otherwise. Thus, §811's *explicit* reference to the *statutory* and *decisional* law of testamentary capacity may be an explicit statutory exception to the general capacity standard set out in Section 811, as the *Mosby* approach would require.

The California Supreme Court's reasoning in *Brown v. Superior Court*[21] provides guarded support for the interpretation of Probate Code §811 as a general standard for capacity. The Court held that in order to determine the Legislature's intent, a court looks first to the words of the statute.[22] However, the Supreme Court also observed that legislative purpose will not be sacrificed to a literal construction of legislation where doing so would result in absurd consequences which the Legislature did not intend.[23] Thus, the *Brown* Court held there is no *absolute* rule requiring express statutory justification for an exception to a general rule in a statute containing the words "except where otherwise provided by law."

On the other hand, Senator Mello's April 14, 1995 three page statement said that he understood that Probate Code §811's "minimum requirements are entirely culled from and merely codify abundant case law."[24] Thus, the early three page statement also may be interpreted as suggesting that Probate Code §811 was *not* intended to change the standards applicable to *any* type of capacity.

### C. Is the Standard for the Execution of a Trust the Same as for the Execution of a Will, and Is the Standard Any Different now under the DPCDA?

In the 1926 case of *Pomeroy v. Collins*,[25] the California Supreme Court considered in dictum the issue of whether a different standard of capacity applied to the execution of a deed or a contract or a will, and held that there was no clearly different standard. The law of legal mental capacity has changed much since then, and different standards are now applied to contracts and wills. But the reasoning in *Pomeroy* may be instructive in determining what level of capacity should be required where the settlor and the trustee are different people, and the trustee *agrees to perform* certain duties. In those cases a trust bears some similarity to a contract because there is a duty of performance assumed by agreement in both contexts.

No hard and fast rule may be announced as to whether a different degree of capacity is required to make a deed or contract than is necessary to the execution of a valid will. A contract may be so complex and intricate as to require a keener discernment of intellect and understanding than would be required to execute an ordinary, simple will. And *vice versa*. As a general proposition of law, it is

impossible to say that either requires a greater degree of capacity than the other. Each must be construed with reference to its own particular or peculiar facts. *Id.* at 68-69.

*1. Testamentary Capacity*

Since the time of the *Pomeroy* decision, an especially low standard for capacity has been applied to wills and codified in Probate Code §§6100.5 and 6104. That standard was preserved in new Probate Code §811. The testamentary data set is small (essentially who the testator and the testator's relatives are, what the testator owns, and who will take under the will), and only a peculiarly low operational level of mental function integrity is required. For example, depending on the will, there may be little or no need for the ability to learn new information, to reason using abstract concepts, or to plan, organize and carry out actions requiring several steps, or to understand and appreciate quantities.

In the author's opinion, this low mental function integrity standard has been accepted and preserved because the law wishes to preserve the right of aging mentally failing testators to have *some* control over their world. The low standard may also have been preserved because wills appear to impact only on the disposition of the testator's property *after* the testator's death. When a conservator has been appointed to take control over all of the testator's estate and to preserve the assets, and to make sure above all that the assets are used for the testator's benefit, rather than stolen or squandered, the mentally failing testator generally feels a loss of control over his or her world. Aging probate lawyers and judges often feel that whatever the heirs get is a windfall to them anyway. "Let's let the elder have his way in the will, if it will make him or her happy. The old one has earned that right."

The elder's retention of a general power of appointment over his or her estate, exercisable at death through a will, enables a failing testator to reward those who insinuate themselves into the testator's good graces, and to punish those who neglect the elder. A will, therefore, has often been characterized as a general power of *dis*appointment, or as a filial devotion insurance policy. Unfortunately, it is also an invitation to artful persons to prey on the mentally failing aging population, isolating them and filling their impaired minds with misperceptions of what is happening around them.

*2. Contractual Capacity*

Like testamentary capacity, the standards for *contractual* capacity were originally developed in case law. They are now codified in Probate Code §811. The data set in §811 is obviously larger and more complex than the data set in §6100.5. Moreover, unlike §6100.5, §811's operational capabilities and data set require that virtually all of §812's mental functions operate at a minimally acceptable level.

*3. Trust-making Capacity*

Although a trust bears some resemblance to a will, a trust is like a contract in the sense that a trust usually provides for named successor trustees to agree to step in and manage and control the property after the settlor-initial trustee becomes unable to manage the estate. This aspect of a trust would suggest that *contractual* level of capacity is necessary to establish a trust, since the trustee functions much like an agent of the settlor who established and funded the trust with his or her assets. Since a principal must have *contractual* capacity to appoint an agent under a power of attorney[26], pursuant to Probate Code §4120, an argument could be raised that contractual level of capacity is also required to establish a trust. After all, both the agent and the trustee obtain from the principal the authority to enter into contracts binding the estate. The law of agency is mindful of the danger that, if we allowed a lesser level of capacity for the appointment of an agent, incompetent people would be induced to give away to artful people the power to self-deal, make gifts and otherwise deplete the estate. Why should a lesser standard apply to the appointment of a trustee?

On the other hand, a trust is also like a will in the sense that it usually includes provisions for the disposition of the settlor's property after death. Thus, the arguments favoring the application of a testamentary level of capacity to a trust would seem to apply to a settlor who [1] had testamentary capacity, but [2] lacked contractual capacity, and [3] who dies shortly after executing the instrument, [4] before a named successor trustee can take over as successor trustee, and possibly dissipate the estate. Why should the contractual level of capacity be applied to an instrument whose sole effect was the same as a will?

If the settlor had lived long enough for the successor trustee to attempt to take over the management of the trust and embezzle much of the estate, should not a contractual level of capacity be required for the document's validity? An argument could be raised that contractual level capacity should only be applied to the identity of the trustee, leaving intact the post-death dispositive terms of the trust. But should not contractual level capacity be required to determine the duties of the trustee, and the other managerial terms of the trust? If so, little remains of the trust except its post-death dispositive terms, and query whether any effective transfer in trust was made. Regardless of whether new Probate Code §811 is the general standard that applies in the absence of *explicit* statutory or case law to the contrary, trusts established by persons lacking contractual capacity are of very questionable validity. It is unclear whether §811 adds anything to help answer these questions.

## VI. NEW PROBATE CODE §811 AND THE APPOINTMENT OF A CONSERVATOR

Both Civil Code §40 and Probate Code §1872 state that the appointment of a conservator is an irrebuttable adjudication of the conservatee's lack of capacity to contract or exercise any right over property. Section 812 enjoins that no "determination that a person...lacks the capacity to make a decision or do a certain act" may be made *unless* it is supported by evidence of a deficit in at least one of the Probate Code §812(a) mental functions. Hence, the appointment of a conservator is subject to the new limitations set forth in Probate Code §812. Will these new requirements reduce the number of conservatorships?

The DPCDA's sponsors expect that the new law will result in neither fewer nor more petitions for appointment of conservator. On the one hand, it is believed that fewer meritless petitions will be filed, because it will be obvious to lawyers and laymen that it ill behooves them to request a conservatorship unless there is evidence of deficits in the rather palpable and verifiable mental functions listed in §812(a). On the other hand, some meritorious petitions which might otherwise *not* have been filed, will be filed because

health care professionals, laymen, lawyers and judges will be more readily able to identify mental function deficits which justify the appointment of a conservator.

The DPCDA will have a dramatic impact upon the trial of contested conservatorship hearings. For example, to petition for a conservatorship of the estate, the petitioner must allege that the proposed conservatee is "substantially unable to manage his or her financial resources or resist fraud or undue influence."[27] This inability must be proven by clear and convincing evidence under a common law rule which the DPCDA codified in Probate Code §1801(e). Since the appointment of a conservator is an adjudication of the incapacity to contract, the petitioner must now take pains to allege and prove deficits in §812(a) mental functions, *e.g.*, a memory impairment severe enough to render the proposed conservatee "substantially unable to manage his or her own financial resources."

If the proposed conservatee opposes the petition, his or her lawyer can inquire of the petitioner what category of memory functioning is allegedly impaired, or, at least, when and how does a memory impairment present itself? Is the alleged impairment in immediate memory, recent memory, remote memory? Or is it eidetic memory, or the ability to recall names, or faces, or places, or other specified categories of information? From what evidence did the petitioner or his or her witnesses draw the conclusion that memory was in fact impaired?

The proposed conservatee's advocate can use standardized testing techniques *with the proposed conservatee on the witness stand* to demonstrate in the courtroom that the specific mental function in question is not in fact impaired, or is not as impaired as claimed by the petitioner. For example, in the case of immediate or recent memory, the conservatee's attorney can provide information, both oral and written, to the proposed conservatee on the stand. After going into testimony on other matters for a standardized lapse of time, the examiner may return to the information provided to the proposed conservatee to test her or his short term memory. The attorney can then question the conservatee to demonstrate the proposed conservatee's ability to [1] understand the information and [2] recall the information, and to demonstrate the proposed conservatee's intact [3] language functions which are used to report the information back to the examiner. The questions can call for answers which will demonstrate the proposed conservatee's ability to [4] reason using abstract concepts, *etc.*

Since the DPCDA codified the rule that the appointment of a conservator must be made on the basis of clear and convincing evidence,[28] the sufficiency of the evidence to support a judgment that the conservatee is "substantially unable to manage his or her financial resources or resist fraud or undue influence," may for the first time be subject to meaningful review at the appellate level. The record for review will show whether there was clear and convincing evidence of significant impairment in one or more of the Probate Code §812 mental functions.

On the other hand, the value of the DPCDA as a tool to render more objective determinations of legal mental capacity should not be over-rated. Virtually everyone has some mental function anomaly, which might be termed an impairment or a deficit in a §812 mental function. Hence, a significant amount of discretion comes into play in determining whether an impairment in one or more Probate Code §812 mental functions justifies a finding that a person is "substantially unable to manage his or her financial resources or resist fraud or undue influence."

The very existence and extent of several of the Section 812 mental function impairments is a matter of opinion. For example, the medical jargon terms "judgment" and "insight" appeared in an early version of the DPCDA.[29] In response to valid objections that these words were not sufficiently well-defined, the sponsors replaced the medical concepts "judgement" and "insight" with "the ability to reason logically," "the ability to reason using abstract concepts," and "the ability to plan, organize and carry out actions in one's own rational self-interest." These latter mental functions [1] comprise much of what is needed in order to have the ability to have *insight* into one's own circumstances and feelings, and [2] enable courts to take cognizance of reasoning deficits and *motivational* impairments which prevent a person from doing the things which any sane person would have the judgement to do to protect himself or herself. But the presence of an *inability* to plan, organize and *carry out* actions in one's own rational self-interest can be a very subjective determination involving social expectations. Legal mental capacity, or "competence" as it has been known since time immemorial, will *never* be objective because current changes in social norms will always play a role in the determination.

Another subjective mental function deficit identified by the DPCDA is the "Ability to modulate mood and affect." Section 812(a)(4) provides that one of the mental function defects which can cause a person to lack capacity is an

> [I]nability to modulate mood and affect. Deficits in this ability may be demonstrated by the presence of a pervasive and persistent or recurrent state of euphoria, anger, anxiety, fear, panic, depression, hopelessness or despair, helplessness, apathy or indifference, which is inappropriate in degree to the individual's circumstances.

It may be difficult for a court to determine when an individual's emotional behavior is so "inappropriate in degree to the individual's circumstances" that the deficit in question may be considered a basis for legal mental incapacity. In order for the trier of fact to count that inability in the equation, the court must implicitly find that the mood disorder "by itself or in combination with one or more other mental function deficits, significantly impairs the person's ability to understand and appreciate the consequences of his or her actions with regard to the type of act or decision in question."[30] With rare exceptions the common and the statutory law have long recognized that *severe* emotional states cannot be disregarded in good conscience by the trier of fact.[31] But there will always be some theoretical risk that a trier of fact could assign too much importance to a merely moody personality, and inappropriately appoint a conservator solely on that basis.

## VII. OBTAINING GENERAL MEDICAL POWERS FOR A CONSERVATOR

In order to obtain general medical powers for a conservator under Probate Code §2355, the Court must determine pursuant to Probate Code §§1880 and 1890 that the conservatee lacks the capacity to give informed consent to *any* form of medical treatment. Section 1890 requires a declaration of medical practitioner opining that the conservatee lacks the capacity to give informed consent to any form of medical treatment. New Probate Code §1881 provides both a road map and new hurdles for the physician and lawyer trying to navigate their way toward that longstanding objective.

Section 1881 provides:

(a) A conservatee shall be deemed unable to give informed consent to any form of medical treatment pursuant to Section 1880 if, for all medical treatments, the conservatee is unable to respond knowingly and intelligently to queries about medical treatment or is unable to participate in a treatment decision by means of a rational thought process.

(b) In order for a court to determine that a conservatee is unable to respond knowingly and intelligently to queries about his or her medical treatment or is unable to participate in treatment decisions by means of a rational thought process, a court shall do both of the following:

(1) Determine that, for all medical treatments, the conservatee is unable to understand at least one of the following items of minimum basic medical treatment information:

(A) The nature and seriousness of any illness, disorder, or defect that the conservatee has or may develop.

(B) The nature of any medical treatment that is being or may be recommended by the conservatee's health care providers.

(C) The probable degree and duration of any benefits and risks of any medical intervention that is being or may be recommended by the conservatee's health care providers, and the consequences of lack of treatment.

(D) The nature, risks, and benefits of any reasonable alternatives.

(2) Determine that one or more of the mental functions of the conservatee described in subdivision (a) of Section 812 is impaired and that there is a link between the deficit or deficits and the conservatee's inability to give informed consent.

(c) A deficit in the mental functions listed in subdivision (a) of Section 812 may be considered only if the deficit by itself, or in combination with one or more other mental function deficits, significantly impairs the conservatee's ability to understand the consequences of his or her decisions regarding medical care.

(d) In determining whether a conservatee's mental functioning is so severely impaired that the conservatee lacks the capacity to give informed consent to any form of medical treatment, the court may take into consideration the frequency, severity, and duration of periods of impairment.

(e) In the interest of minimizing unnecessary expense to the parties to a proceeding, paragraph (2) of subdivision (b) shall not apply to a petition pursuant to Section 1880 wherein the conservatee, after notice by the court of his or her right to object which, at least, shall include an interview by a court investigator pursuant to Section 1826 prior to the time at which the petition is filed, does not object to the proposed finding of incapacity, or waives any objections."

### A. The Medical Declaration Required by Probate Code §1890

First, the seemingly lengthy findings required by Probate Code §1881 *do not apply* to a conservatee if [1] the conservatee does not object to the grant of general medical powers to the conservator, *and* [2] the Probate Court Investigator has interviewed the conservatee prior to the hearing. In most cases, a Probate Court Investigator will have met with the conservatee before the hearing anyway. The requirement that a Probate Court Investigator meet with the conservatee before the hearing was included in SB 730 at the request of Protection and Advocacy, a federally mandated patients' rights organization, and seems reasonable and appropriate.[32]

### B. New Tool: Proposed Declaration of Medical Practitioner re: Medical Consent Capacity

A medical declaration has long been required by Probate Code §1890 for the award of general medical powers under Probate Code §2355, but has frequently been a source of annoyance for physicians who did not know what information judges and lawyers want. To facilitate the furnishing of the medical information required by new §1891, the Estate Planning Trust and Probate Law Section has prepared a "Medical Consent Capacity Declaration" which the Section proposes the various County Courts permit lawyers to use until a new Judicial Council form is adopted.

The proposed "Medical Consent Capacity Declaration" form is set forth at the end of this article. The new form was produced as a joint effort of the Section and various medical practitioners, including Professor James Spar, M.D. of UCLA's Neuropsychiatric Institute.[33] The Medical Consent Capacity Declaration's format is derived in significant part from a Mental Function Deficit Checklist that was developed by James Spar, M.D., Stephen Read, M.D., and the author, and was employed by the author and other conservatorship practitioners over a two-year period. The author found that, *virtually without any exception*, doctors were *willing to complete* the form, and the doctors tended to be *forthcoming with additional* information on their own, after they had completed the form. In an attempt to simulate a pilot project to assist in the development of this form, the author's Mental Function Deficit checklist was distributed to other practitioners who similarly experienced good results with the use of that form. Hence, the much improved "Medical Consent Capacity Declaration" (produced by the Estate Planning, Trust and Probate Law Section's Incapacity Committee) set forth at the end of this article is likely to be accepted by physicians and used without complaints. The California Medical Association is in the process of reviewing the form, and informal comments from persons associated with the CMA have uniformly been supportive.

### C. What is "Any Form of Medical Treatment"?

The author always experiences certain pangs of conscience whenever he asks a court to determine that the conservatee lacks the capacity to give informed consent to *any form of medical treatment*. Probate Code §4609 in the Power of Attorney Law (Division 4.5 of the Probate Code) defines health care as "any care, treatment, service, or procedure to maintain, diagnose, or treat an individual's physical or mental condition." This definition would appear to include nutrition and hydration. Thus, a very literal interpretation of the words "any form of medical treatment" as used in Probate Code §§1890 and 2355, would suggest that the order granting general medical powers to a conservator may not be issued unless the conservatee lacks the capacity to consent to a drink of a glass of water when he or she is thirsty. But so literal an interpretation of those words leads to an obviously absurd result since most

conservatees should be deemed to have the capacity to give or refuse consent to a drink of a glass of water. A more reasonable interpretation of the words "any form of medical treatment" would treat those words as referring to medical treatment which is not so obviously necessary that anyone in his right mind would consent to them. Instead, suggests Dr. James Spar, those words should be deemed to refer to medical treatments with respect to which either a physician or a layman would expect that the patient would have a right to be informed and to make a decision about treatment options and alternatives. Treatments that are complex or involve risk would appear to be the target of the words in question.

## VIII. NEW CIVIL CODE §39(B)

### A. *Unsound Mind* - A Vague and Unpredictable Standard

Under the law before the DPCDA, Civil Code §39 said that if someone is "of unsound mind" when making a transfer of property (or entering into a deal), a court may use the law of equity to determine if rescission is fair under the circumstances. That text is preserved as subdivision (a) in new Civil Code §39.

Unfortunately the term "unsound mind" is undefined and vague, leading to unpredictable and inconsistent court rulings. The sponsors and the California Judges Association believed that it would be helpful to clarify what "unsound mind" means. The DPCDA added Civil Code §39(b), which provides that a rebuttable presumption of incapacity to contract arises if a person is "substantially unable to manage his or her affairs or to resist fraud or undue influence." New subdivision (b) of Civil Code §39 incorporates *verbatim* the language of Probate Code §1801(b), which is the test for the appointment of a conservator of the estate.

Old Civil Code §39 [now subdivision (a)] and new subdivision (b) indicate what standard must be proven by a plaintiff (*e.g.*, a conservator, executor, etc.) acting on behalf of an incompetent, when the plaintiff asks a Court to set aside a transaction into which the incompetent entered when he or she was of "unsound mind" and *before* a conservator was appointed. The previous statutory law's only guidance for a determination whether the alleged incompetent was in fact *incompetent* for the purposes of the transaction in question when it occurred turned on the definition of "unsound mind," which is archaic and amorphous language. Now, the specific list of mental deficits set forth in Probate Code §812 should be the reference point for such a determination.

Although there are many cases in which Judges have set aside transfers made by persons for whom a conservator was appointed shortly after a disputed transfer, victimizers who seek to retain the assets transferred to them by incompetents often alleged that the victim was not of "unsound mind" (using the old *unexplained* language of Civil Code §39) the day before the conservator was appointed. Those abusers formerly could go on to allege that "unsound mind" (Civil Code §39) and "substantially unable" (Probate Code §1801(b)) were two different and unrelated concepts, and that the alleged incompetent was not of unsound mind when the transaction occurred.

### B. New Civil Code §39(b) Resolves a Split of Opinion

At the appellate level, there has been a split of opinion on the issue of whether there should be a *presumption* that a person who was uniformly *in*competent for eleven months was not suddenly "lucid" for a moment when she or he executed a document.[34] But at the ground level, experienced Probate Judges, Probate Commissioners and most probate lawyers have long tended to subscribe to the view that if a person is *so mentally impaired that* a conservator *could be* appointed for that person (at a particular time), it follows logically that (a) the person also lacks the capacity to manage his or her own financial resources at that time, and (b) the person is of "unsound mind" within the meaning of Civil Code §§39 and 40 so that he or she lacks the capacity to contract or make gifts. New Civil Code §39(b) will resolve the split in authority. Under circumstances in which the victim suffers from a disease (*e.g.* Alzheimer's) which causes the victim to exhibit particular mental function deficits that are characteristic of the disease and are not subject to sudden onset nor sudden remission, it will ease the proof of a plaintiff against a financial abuser who argues there was a "moment of lucidity" when the victim gave away his assets to the abuser.

### C. Impact on the Law of Commerce

One might wonder whether this new subdivision will adversely affect the general law of commerce. Must every business-person inquire whether the person with whom the business-person is striking a deal is legally competent to make the contract? The answer is no. The proposal to add Civil Code §39(b) was before the legislature for two years, and it received no opposition or expressions of concern from any business groups about this change. This is probably because reputable businesses are careful not to deal with persons who have *obvious* mental or emotional deficits, so they would have no reason to be concerned. Also, the clarity and consistency which will result from this subdivision will benefit everyone. Business interests generally dislike laws which are vague and lead to uncertain results.

### D. How to Use New Civil Code §39(b)

Conservators, executors and successor trustees will use proposed Civil Code §39(b) to shift the *burden of proof on the issue of* ***incompetence*** to the victimizer. Initially, the conservator, the executor and the successor trustee will have to meet their burden of proving that the alleged incompetent was in fact, "substantially unable to manage his or her financial resources or to resist fraud or undue influence," as provided in new Civil Code §39(b). This standard is also set forth in Probate Code §1801(b) [the section which defines when a conservator may be appointed, triggering the application of Civil Code §40 which now says that the appointment of a conservator is an irrebuttable adjudication of incapacity to contract].

The conservator, or executor or successor trustee will have to meet the burden of proving that the alleged incompetent was impaired (as described above) *at the time* when the transfer to the victimizer occurred. Once the burden of proof *on the issue of incompetence* has shifted, if the victimizer contends that the victim was competent to make the gift (*e.g.*, because of a "moment of lucidity"), the *victimizer* will bear the *burden* of proving the victim's *competence* to make the gift or do the deal.

On the other hand, under the new law, as under the old, *even if incompetence is proven*, the *plaintiff-conservator has the burden* to show that *rescission* would be *fair*, since rescission is an equitable remedy. If a business person enters into a fair deal with an incompetent, and the business person did not know that the incompetent

was in fact incompetent, it is unlikely that a judge would set the deal aside under the new or the previous law. But a court of equity looks at the relative cleanliness of both parties' hands. Thus, a victimizer who recklessly disregards obvious signs of severe mental impairments should fare less well when the court decides what result would be equitable.

## IX. PROCEDURE TO OBTAIN A FINDING THAT A PERSON *IS* COMPETENT

Until recently, there was no way that a patient could ask a court for a determination that he or she is, in fact, competent to give informed consent to a medical treatment, and there was no way that a health care provider could be assured that the patient's consent was validly given by a competent patient, and that the consent would later be deemed to be an *informed* consent. The DPCDA corrects this deficit by amending Probate Code §3201, which now allows a patient or a physician to seek a court order determining that the patient is, in fact, competent to give informed consent to a procedure, and that the consent in question was in fact an *informed* consent. This will avoid lawsuits after the treatment is administered in which a patient's conservator or executor claims that the patient lacked the capacity to consent, or that the consent was not an informed consent.

## X. NEW PART 17 ENTITLED "LEGAL MENTAL CAPACITY"

As indicated above, a Technical Corrections Act is being proposed by the Estate Planning, Trust and Probate Law Section of the California State Bar to correct certain technical areas in the DPCDA. Probate Code §812, which contains the mental function deficit checklist, applicable to all types of capacity, will be repealed and reenacted as Probate Code §811. Probate Code §811, which defines the standards for the capacity to contract, and possibly provides the general standards for *all* capacity determinations absent clear statutory indications to the contrary, will be repealed and will be reenacted as Probate Code §812. Thus, the mental function deficit checklist which applies to all types of capacity "data sets," will come first as §811. Following §811 will come the various data sets for the various types of capacity in §812 (for, e.g., the capacity to contract and do other things) and §813 will continue to contain the standards or data set for the capacity to give informed consent to medical treatment.

The standards for other specific types of capacity (e.g, to vote, to hire counsel, to marry) will be defined in subsequent legislation and assigned section numbers following Probate Code §813. The work of defining in modern terms the parameters of the various types of capacity which the law recognizes has just begun.

## XI. CONCLUSION

It has been accurately observed that the DPCDA is the logical progeny of the Elder Abuse and Dependent Adult Civil Protection Act (EADACPA).[35] The defense of every abuser of mentally incapacitated elders or dependent adults, in a lawsuit or prosecution for abuse, is that the victim consented to the conduct which the complaining party claims was abusive. "And even if [the victim] *was* incompetent, how was I supposed to *know* that? The expert lawyers and psychiatrists disagreed, and even the judge had a hard time deciding legal incompetence!" If knowledge and evil intent cannot be proven, EADACPA's important deterrent remedies of attorneys fees and survival of pain and suffering are not available, and criminal liability is non-existent.

But due to the enactment of the DPCDA and the aging of our baby boom population, the elements of legal mental incapacity gradually will become known to the general populace. As the DPCDA's terms and structural models filter into the general consciousness of the expert and lay populations, the automatic defense that "I did not think he was incompetent to make the gift" will seem progressively less likely to succeed.

The DPCDA's more scientific, component based concept of incapacity will not immediately become understood by the general population. But soon in legal and medical circles, disputes over capacity will take much less time to resolve. With the methodology for competence determinations being clearer, the process will be speedier. Mentally impaired individuals, who are ill equipped to handle the emotional stress and legal fees and costs which legal proceedings entail, generally will have their cases resolved more quickly and inexpensively. Conflicts about levels of capacity, and even levels of culpability, will gradually be addressed in a more constructive manner. The process of modernizing this area of the law and social consciousness has only just begun.

### Endnotes

1. The author dedicates this article to his uncle, Irving Small, a role model whose gift of guidance can never be repaid, to the author's father, whose humanity, suffering and love of education serve as a constant source of inspiration, and to the author's father-in-law, Jay B. Cohn, M.D., who provided the author with the initial technical bases for turning the dream of the Due Process in Competence Determinations Act into a scientifically sound reality.
2. *See, Villasenor v. Gutman* H008486 (July 27, 1992)(unpublished). It is noteworthy that there are very few lawsuits claiming battery in the absence of family dissension.
3. *Home Budget Loan v. Jacoby & Myers*, 207 Cal.App.3d 1277, 255. Cal.Rptr. 483 (1989).
4. Subdivision (e) of §812 in SB 730 refers to "*this* part." In other words, §§812-813 were intended to be the first provisions of a new Part entitled "Legal Mental Capacity." The original version of SB 730 explicitly indicated that these sections (i.e., 810-813) were being enacted as a new Part 17, and the omission in SB 730 of any reference to a new Part 17 in the Chaptered Bill was a typographical error or technical oversight. A Technical Corrections Bill currently being proposed by the Estate Planning Trust and Probate Law Section of the California State Bar Association as an urgency bill for the 1996 legislative section would create a new Part 17, and repeal new Probate Codes §§811 and 812. The repealed §811 would be reenacted as §812, and the repealed §812 would be reenacted as §811. Section 814 would be repealed and §813 would be amended to include the provisions of the repealed §814.
5. Behavioral Sciences and the Law, Vol. 13, 391-403 (1995). Copies of the then unpublished survey results were furnished to the author, Senator Mello, and the sponsors both before and during the legislative process.
6. Stephen Read, M.D., who did a significant amount of drafting, Roland Jacobs, M.D., and Lisa Rubenstein, M.D., also played a significant role in the development of the Bill, and in persuading the California Medical Association to co-sponsor it. In alphabetical order, James Birnberg, Robert Foster, Andrew Garb, Antonia Graphos, Susan House, Jonnie Johnson-Parker, Marshall Oldman, Matthew S. Rae, Bruce Ross, Thomas Stikker, and Michael V. Vollmer played significant roles in the development of the Bill and in gaining its passage. Special thanks is due to [1] Commissioner Ann E. Stodden (Ret.) whose support was critical to persuading

the Executive Committee of the Section to sponsor the Bill, and whose presence and cogent arguments persuaded ambivalent legislators to support it, and to [2] Amy Stewart and Timothy Shannon, without whose support the Bill would certainly not have been enacted. Special thanks is also due to the members of the Los Angeles County and City Fiduciary Abuse Specialist Team, and in particular, to Norma Nordstrm and John Coyle, for their suggestions which resulted in refinements to the mental function list.

7. *Villasenor, supra.*, fn. 2.

8. Citing to Appelbaum and Roth. *Competency to Consent to Research*, 39 Arch Gen Psychiatry 954-955 (1982).

9. Anderer, Stephen J., et al., *Determining Competency in Guardianship Proceedings*, 32 [ABA Public Service Monograph Series No. 1. (1990)]. The quoted discussion of appreciation from the ABA monograph was sent to Senator Mello and to both the proponents and opponents of SB730 during the negotiations over the requirements for medical consent. Mello's staff indicated to all concerned parties that this text represented the concept which the author believed fit the term "appreciate." James Preis, of Los Angeles County Mental Health Advocacy Services, objected to the inclusion of the term "appreciate" in Sections 813 and 1881. Mr. Preis indicated that a text authored by Professor Applebaum suggested that a patient's mere refusal to acknowledge that the patient was mentally ill or that a patient needed psychotropic medication might be evidence of an inability to "appreciate." For this, among other reasons, Mr. Preis and Protection and Advocacy objected to the inclusion of the term "appreciate," and for lack of time to work out a compromise definition, the term "appreciate" was deleted from Sections 813 and 1881.

10. Probate Code §812(b).

11. *See* Probate Code §§1880, 1890 and 2355 concerning a request by the conservator for general medical decision making authority.

12. Senator Mello's three-page statement was distributed on April 17, 1995 and April 18, 1995 to most of the members of the Senate Judiciary Committee and to the Committee's analyst, Ms. Mikki Sorensen. The three-page statement was accompanied by [1] a footnoted version of SB 730, citing to various cases and treatises in support of the new provisions of SB 730, and [2] a copy of*Mental Incapacity to Marry*, Hankin and Read, Est. Planning Trust & Probate News, Vol. 24 No. 4 (Winter 1994), an article which the sponsors said showed how capacity determinations would be made under SB 730.

13. Senator Mello distributed to the members of the Senate Judiciary Committee, and in particular to the both the Senate and Assembly Judiciary Committees' analysts, a three page analysis of SB 730.

14. The reference in Section 811 to the ability to *communicate* a decision is drawn in part from the Uniform Health Care Decisions Act. Obviously, communication may be verbal or non-verbal, and by any means.

15. The ability to "*appreciate*" the significance or solemnity of a decision has long been an element of capacity. *See, e.g., Vitale v. Vitale*, 147 Cal. App. 2d 665, 305 P.2d 690 (1957), invalidating a marriage by an incompetent person and observing: "The plaintiff [incompetent] called four doctors who qualified as experts and testified in substance that their examination indicated that the patient was suffering from dementia praecox, that his condition was such that their opinion was that at the time of his marriage it would have been impossible for him to have *appreciated* the solemnity of the marriage vows, as his judgment would have been too impaired for him to *understand the nature, obligations, and responsibilities of marriage*." (Emphasis added.) *Id.* at 670/693. For an analysis and demonstration of the application of the principles of this Act to competence determinations, *see, Mental Incapacity to Marry*, Hankin and Read, Vol. 24 No. 4, California State Bar Association's Estate Planning Trust and Probate News (now being published under the name "The California Trusts & Estates Quarterly") Winter 1994.

Citing to Appelbaum and Roth, *Competency to Consent to Research*, 39 Arch Gen Psychiatry 951, 953 (1982), ABA Public Service Monograph Series No. 1, *Determining Competency in Guardianship Proceedings* (Anderer, Coleman, Lichtenstein and Parry) stated, "'Appreciation' differs from factual understanding in requiring that the individual consider the relevance to his or her own situation of the risks and benefits and attach an emotional value to those risks and benefits. Conditions that may affect appreciation include . . . depression, which may cause a respondent not to attach value to life..."

16. The reference to "*duties and responsibilities*" was drawn from various cases including *Dunphy v. Dunphy*, 161 Cal. 380, 383 (1911) where the Court observed that the "capacity requisite to a valid marriage is defined...[as a] capacity to understand the nature of the [marriage] contract, and the duties and responsibilities which it creates." *See also*, 82 ALR2d 1020 *et seq.*

17. The test for testamentary capacity effectively requires that the testator understand that there will be a testamentary impact on certain persons affected by the decision. The California Supreme Court held in *Estate of Smith*, 200 Cal. 152, 158 (1926): "A testator is of sound and disposing mind and memory if, at the time of making his will, he has sufficient mental capacity to be able to understand the nature of *the act he is doing* [*i.e.*, that he is giving property to one person and not giving it to another (MBH)], and to understand and recollect the nature and situation of his property and to remember, and understand his relations to, the persons who have claims upon his bounty and *whose interests are affected by the provisions of the instrument*. (*Estate of Sexton*, 199 Cal. 759 [251 P. 778]; *Estate of De Laveaga*, 165 Cal. 607 [133 P. 307]; *Estate of Huston*, 163 Cal. 166 [124 P. 852].)"

18. Welfare and Institutions Code §5326.2

19. 43 Cal.App.3d 219, 117 Cal.Rptr. 588 (1974).

20. *Brown v. Superior Court*, 37 Cal. 3d 477, 485; 208 Cal.Rptr. 724 (1984).

21. 37 Cal.3d 477, 208 Cal.Rptr. 724 (1984).

22. *Brown v. Superior Court*, 37 Cal. 3d 477, 485; 208 Cal.Rptr. 724 (1984).

23. *Brown v. Superior Court, supra*, at 485.

24. *See* the text accompanying Footnote . above.

25. 198 Cal. 46, 68 (1926).

26. Probate Code §4120.

27. Probate Code §1801(b).

28. Probate Code §1801(e).

29. 1994 Senate Bill 1679.

30. Probate Code §812(b).

31. The *Smalley vs. Baker*, 262 Cal.App.2d 824, 69 Cal.Rptr. 521 (1958), aberration, holding that only cognitive disorders are relevant to capacity, would appear to now be legislatively overruled. *Smalley* explicitly rejected mood disorders as being relevant to legal mental capacity determinations, regardless of the severity of the mood disorder. By holding that only cognitive disorders are relevant, *Smalley* also suggested the absurd result that reality testing disorders such as hallucinations and delusions, which generally are not classified by modern mental science under the rubric of cognitive impairments, have no bearing on capacity.

32. A last minute typographical error in subdivision (e) seems to require that the Probate Court Investigator's interview take place even *before the petition is filed*. But since that is obviously impossible, and since the error will be corrected in the Technical Corrections Act being proposed by the Estate Planning Trust and Probate Law Section, no one should be concerned with it.

33. Roland Jacobs,M.D., Dan Osterweil, M.D., and Stephen Read, M.D., also provided valuable suggestions and criticisms.

34. *O'Brien v. Dudenhoeffer*, 16 Cal.App. 4th 327, 19 Cal.Rptr. 2d 826 (1993).

35. Welf. & Inst. Code §§15600(h) and (j), and §§15657 et seq. (SB 730,. Mello and Davis , Chap. 774, Statutes of 1991).

| ATTORNEY OR PARTY WITHOUT ATTORNEY (Name and Address): TELEPHONE NO.: | FOR COURT USE ONLY |
|---|---|
| SUPERIOR COURT OF CALIFORNIA, COUNTY OF<br>STREET ADDRESS:<br>MAILING ADDRESS:<br>CITY AND ZIP CODE:<br>BRANCH NAME: | |
| CONSERVATORSHIP OF THE ☐ PERSON ☐ ESTATE OF (NAME):<br>(Proposed) Conservatee | |
| **MEDICAL CONSENT CAPACITY DECLARATION** | CASE NUMBER: |

1. My name is: _____.
2. My office address and telephone number are: _____
_____.
3. I am (mark one):
   - ☐ A licensed psychologist acting within the scope of my licensure or a physician licensed in the State of California.
   - ☐ An accredited practitioner of a religion whose tenets and practices call for reliance on prayer alone for healing, which religion is adhered to by the proposed conservatee. The proposed conservatee is under my treatment.
4. I last examined _____ ("patient") on (date:) _____.
   - ☐ The patient is under my continuing treatment.
5. **Evaluation of the patient's mental function.** Note to the medical practitioner: This form is ***not*** a rating scale. It is intended to assist you in recording your *impressions* of the patient's mental abilities. Where appropriate, please feel free to refer to scores on standardized rating instruments.
**Instructions:** Circle the appropriate designation below: ***a*** = No apparent impairment; ***b*** = moderate impairment; ***c*** = major impairment; ***d*** = so impaired as incapable of being assessed; ***e*** = I have no opinion

[A] **Alertness and Attention**

1. **Levels of arousal.** (Lethargic, responds only to vigorous and persistent stimulation, stupor.)
   a b c d e
2. **Orientation.** Encircle each *type of orientation* which is impaired:
   a b c d e Person
   a b c d e Time [day, date, month, season, year].
   a b c d e Place [address, town, state].
   a b c d e Situation [why am I here?].
3. **Ability to attend and concentrate.** (Give detailed answers from memory, mental ability required to thread a needle.)
   a b c d e

[B]. **Information processing.** Ability to:

1. **Remember,** *i.e.*, short and long term memory, immediate recall. (Deficits reflected by: forgets question before answering, cannot recall names, relatives, past presidents, events of past 24 hours.)
   a b c d e
2. **Understand and communicate either verbally or otherwise.** (Deficits reflected by: Inability to comprehend questions, follow instructions, use words correctly or name objects; nonsense words.)
   a b c d e

3. **Recognize familiar objects and persons.** (Deficits reflected by: inability to recognize familiar faces, objects, etc.)
a b c d e

4. **Understand and appreciate quantities.** (Perform simple calculations.)
a b c d e

5. **Reason using abstract concepts.** (Grasp abstract aspects of his/her situation; interpret idiomatic expressions or proverbs.)
a b c d e

6. **Plan, organize and carry out actions (assuming physical ability) in one's own rational self interest.** (Break complex tasks down into simple steps and carry them out.)
a b c d e

7. **Reason logically.**
a b c d e

[C]. **Thought disorders.**

1. **Severely disorganized thinking.** (Rambling thoughts, nonsensical, incoherent or non-linear thinking.)
a b c d e

2. **Hallucinations.** (Auditory, visual, olfactory.)
a b c d e

3. **Delusions.** (Demonstrably false belief maintained without or against reason or evidence.)
a b c d e

4. **Uncontrollable or intrusive thoughts.** (Unwanted compulsive thoughts, compulsive behavior.)
a b c d e

[D]. **Ability to modulate mood and affect.** Pervasive and persistent or recurrent emotional state which appears inappropriate in degree to the patient's circumstances.
**Instructions: Rate the *degree* of impairment of each *inappropriate* mood state (*if any*) as follows: *a* = mildly inappropriate; *b* = moderately inappropriate; *c* = severely inappropriate.**

| | | | | | |
|---|---|---|---|---|---|
| Anger | a b c | Euphoria | a b c | Helplessness | a b c |
| Anxiety | a b c | Depression | a b c | Apathy | a b c |
| Fear | a b c | Hopelessness | a b c | Indifference | a b c |
| Panic | a b c | Despair | a b c | | |

6. ☐(Optional) With respect to one or more of the deficit(s) mentioned above, there is a substantial variation in the frequency, severity, and duration of periods of impairment.

7. ☐ (Optional) Further information regarding the patient's ability to give informed medical consent (*e.g.*, diagnosis, symptomatology and other impressions):

_____

_____

_____

☐Number of Additional Pages Attached:_____

8. Based on the deficits described above, it is my opinion that the patient lacks the capacity to give informed consent to any form of medical treatment because *either* the patient is unable (1) to respond knowingly and intelligently regarding medical treatment *or* (2) to participate in a treatment decision by means of a rational thought process, *or both*. The deficit(s) in the mental functions above significantly impair(s) the (proposed) conservatee's ability to understand and appreciate the consequences of medical decisions. The opinion expressed in this paragraph is limited to medical consent capacity.

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct and that this

Declaration was executed on _____ (date).

_____
Signature of Declarant

**FORM SB355**

Prepared by the Estate Planning, Trust & Probate Section, State Bar of California;
Send comments & suggestions for improvement of this form to: Incapacity Committee, c/o Susan Orloff,
555 Franklin Street, San Francisco, CA 94102