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### *Barefoot on pine needles*

Dorit Dinur

Acrylic on canvas, 1.20 x 1.00 m, 1994

Dorit Dinur was born in Tel Aviv, and lives there today. She studied art at the Massachusetts College of Art in Boston, the Avni School of fine Art in Tel Aviv, and the College of Visual Art in Beer Sheva. Dorit teaches Art at the College of Visual Art in Beer Sheva and is the former Art Director of the school. Her education includes an MSc in Chemistry and Physics, and studies towards a masters degree in History of Art. She is also a Feldenkrais assistant trainer.

Dorit's art includes painting, writing, working with materials, constructing installations, performing, and photography. She has exhibited her art throughout Israel in both solo and group shows. Dorit says about her art and teaching:

"Practicing my art has many advantages for me. It lets me do what I please, it lets me reveal my identity in different ways, to be playful, experimental and daring. It also gives me the opportunity to be expressive, to search for beauty and at the same time to deal also with pain, sorrow, longings and protest. It lets me show what I love the most (colors).

I look at my art as a lifelong adventure.

My art is parallel to my life, changing and revealing the unseen, the under-current, transforming my experience to visual evidence."

The picture shown here is part of the series *Subjective Paintings*.



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# The Istanbul Protocol (Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment): Implementation and Education in Israel

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**ABSTRACT:** All victims of violence encountered in our emergency rooms and clinics need to be recognized and documented as such. Although there has been progress in the implementation of rules concerning (domestic) violence against women, children and the elderly, the management of cases where patients have been subjected to violence while under the custody of legal enforcement agencies, or patients who have been victims of torture, is still not sufficiently standardized. We describe the Istanbul Protocol of the United Nations, an excellent tool that can help physicians and health professionals recognize and treat cases of torture or institutional violence.

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**KEY WORDS:** Istanbul Protocol, torture, refugees, post-traumatic stress disorder (PTSD), violence

In the last few decades, Israel's medical system has undergone a significant change with regard to recognizing victims of (domestic) violence and relating to those cases proactively, especially those in vulnerable or helpless population groups (minors, mentally impaired, institutionalized). Nurses and physicians as well as social workers undergo training to identify and deal correctly with cases of domestic violence and abuse. Many victims do not complain directly of the abuse, due to helplessness, shame or fear, and it is often the role of the examining physician to offer an opening in a private and confidential conversation. Physicians have learned that their professional obligation in these cases extends beyond providing purely medical relief and includes steps to provide for the safety and well-being of the patient. This is why we have laws for the obligatory reporting of suspicion of violence against helpless victims [1]. Despite these developments, there are still groups of vulnerable and helpless individuals where the suspicion of violence is often overlooked

by medical practitioners. We present two scenarios based on real-life events in order to highlight this point.

## CASE 1

A 22 year old male asylum seeker complains of severe flank pain and blood in his urine. Examination reveals white scars on his back. When prompted he says, "I got those while crossing the desert on my way to Israel." He has a scar on his forehead and says, "This is from the electricity." The physician does not enquire further. He suspects a kidney stone, prescribes pain medication and refers him for further tests. The following week he hears that the patient took an overdose of the pain medication he prescribed and is in the intensive care unit [2]. The social worker informs the physician that the patient was held in captivity and tortured in Sinai until his family paid enough ransom for him, but that his brother is still captive [3].

## CASE 2

A 32 year old detainee is brought to the emergency room by prison guards. He complains of severe pain and weakness in both hands and difficulty walking. He cannot walk without support. His extremities are swollen. He has weakness in both hands in ulnar and radial distribution, abrasions on his wrists and ankles, and bruises on his back and abdomen. His creatine phosphokinase is elevated. The physician asks how those came about and the patient starts answering but is interrupted in the middle of a sentence by the guards. The physician insists on hearing the mechanism of injury and the patient replies that he was handcuffed and beaten by his interrogators for 4 days [4].

## DISCUSSION

These two patients are apparent victims of torture. The first patient sought help for an unrelated matter and was not rec-

ognized as a severely traumatized victim. Consequently, he was not offered the more comprehensive help he required. The second patient is a helpless victim of institutional violence and might be in danger of continued abuse.

In the case of domestic violence the medical community has become aware of an obligation to recognize such cases and treat them in a multidisciplinary fashion. However, in the case of institutional violence and torture similar progress has not been made. Physicians are less likely to recognize such patients as victims of violence. The appropriate treatment has not been standardized, or even taught, and consequently the obligation to report is less routinely observed.

Changing this situation requires two distinct elements: a) an understanding on the part of the medical establishment that it is obliged to recognize and treat such victims and ensure as far as possible their future safety from harm; and b) the implementation of medical protocols for treating such victims, including a full and appropriate history taking, physical examination and workup, and the filing of a detailed and clear official report. Another objective is the creation of multidisciplinary teams trained to handle such cases.

#### CONVENTIONS ON TORTURE

In the words of the United Nations Convention against Torture, 1984:

Torture means any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person for such purposes as obtaining from him or a third person information or a confession, punishing him for an act he or a third person has committed or is suspected of having committed, or intimidating or coercing him or a third person for any reason based on discrimination of any kind, when such pain or suffering is inflicted by or at the instigation of or with the consent or acquiescence of a public official or other person acting in an official capacity. It does not include pain or suffering arising only from, inherent in or incidental to lawful sanctions. [5]

The World Medical Association Declaration of Tokyo [6] defines torture as

... the deliberate, systematic or wanton infliction of physical or mental suffering by one or more persons acting alone or on the orders of any authority, to force another person to yield information, to make a confession, or for any other reason.

According to the Declaration, physicians are absolutely prohibited to take part in torture or even be present in a place where torture is committed. The physician is furthermore required to report cases of torture that come to his attention to

the “relevant authorities” [6]. The convention was adopted by the Israel Medical Association in December 2007 [7].

The *Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment – Istanbul Protocol* was written in 1999 by more than 75 experts in mental health and medicine (including forensic medicine), human rights and law. The aim of the protocol is to improve the (medical/forensic) documentation of the physical and psychological effects of torture or cruel, degrading or inhuman treatment [8]. It was recently published in translation on the Israel Medical Association website [9].

#### THE ISTANBUL PROTOCOL

The experience of a torture victim is in most cases one of severe traumatization – physical and psychological. The Protocol is meant to equip the treating physician with the tools to correctly assess and address the needs of a person who is or was the victim of torture whether he/she is a patient or a person seeking a professional medico-legal opinion. The Protocol defines the legal and international standards and procedures in relation to torture and describes the ethical principles from which these stem, as well as the implications of a claim of torture in the legal framework. The main body of the protocol relates to the medical and psychological examination of the torture victim and to the actual writing of a medico-legal opinion in those cases.

The informed consent of the client is of utmost importance, as the examinee has to understand to whom and for what purpose he is telling his story. In some settings the complaint of torture will put the victim at risk for reprisal especially if he is still in the custody of the authorities. In a refugee situation, on the other hand, the proof that a person suffered persecution and torture in his country of origin or during his flight can be an important piece of evidence in the application process for asylum.

Consent is also psychologically important. It puts the examinee in control of the situation. The examinee should understand that he can give or withdraw consent at any time or for any part of the examination and that he dictates the conditions and pace of the examination. The purpose of the examination has to be clear and agreed upon: medico-legal opinion, treatment and rehabilitation, or simple documentation of injuries.

Creating an appropriate physical setting for the examination can be challenging. If the examination takes place in a detention center or prison there are problems of privacy and time constraints. In prison, there is always a question of the safety of the examinee. His complaints might make him vulnerable to further harassment or violence from both the prison personnel and from fellow inmates. As such, privacy and confidentiality must be assured. According to international standards as specified in the Declaration of Tokyo, the physician has the duty to examine the patient without

restraints and in privacy – in other words to make sure in the case of examinations of detainees or prisoners that handcuffs and shackles are removed during interviews and physical examinations [7]. Even if the examination takes place in the offices of the physician or an organization, it is important to assure that privacy and an appropriate setting are provided so that re-traumatization does not occur.

There is often a need for translation, which has to be provided by an independent translator who is not connected to either the examinee or the authorities. A word-for-word translation is of utmost importance. In addition, notes regarding the cultural significance and meaning of the victim's words should be added as necessary.

The detailed narrative of the victim and its documentation are crucial. The questions should be formulated in an open manner. The way in which the story is told can in itself be diagnostic for memory gaps and mental health issues. These should be noted as they can be indicative of post-traumatic stress disorder or traumatic brain injury, common sequelae in victims of violence.

Methods of torture vary around the world. The examining physician should be familiar with the local practices and their consequences. The physician should be able to recognize acute and chronic signs of abuse and know how to document them both by description and by photography. For example: signs of beating, kicking and punching can be identified in acute cases, *falanga* (beating the soles of the feet) can leave typical signs on the feet, prolonged handcuffing can cause acute and sometimes chronic nerve damage, and suspension and overstretching can leave injuries of the musculoskeletal system. Electrical injury and cigarette burns leave typical scars. Also, physical or psychological sexual abuse should not be overlooked, as this is frequently part of the torture [10]. All physical signs need to be identified and documented and differentiated from signs of unrelated injuries [11].

The documentation of physical signs has to be as accurate as possible. Sometimes auxiliary examinations can help, but painful or invasive examinations should be avoided unless absolutely necessary [12]. It must be remembered that perpetrators of torture often deliberately strive to avoid leaving any physical signs of their actions and in many cases use techniques that do not leave physical signs, such as sleep deprivation, humiliation, exposure to noise, degrading conditions of imprisonment, threats directed towards the victim or those close to him, forcing the victim to witness the torture of others, sensory deprivation including hooding, and solitary confinement [8,13].

In addition to physical consequences, torture frequently has prolonged psychological effects. Prolonged stress that is both severe and unpredictable can cause post-traumatic stress disorder and depressive reactions, with memory and concentration problems, irritability, sleep disturbances and

flashbacks. These symptoms may affect the daily functioning of the victim as well as those around him [14,15].

#### IMPLEMENTATION OF THE ISTANBUL PROTOCOL

The Istanbul Protocol has been taught to physicians, psychologists and law experts in various countries around the world. In Turkey more than 5500 professionals including primary physicians and ER physicians, who are likely to meet torture victims at the obligatory examination after arrest and interrogation and before the transfer to prison, have taken part in a course on the Protocol conducted by the Turkish Medical Association. Physicians have undertaken similar training programs in the United States, Mexico, Cuba, Egypt, Morocco, Lebanon, Uganda, Georgia, Philippines, Sri Lanka, Uzbekistan, Armenia, Azerbaijan and New Zealand [16].

Physicians and psychologists might meet victims of torture in different treatment scenarios, including the ER, outpatient clinics, prisons or detention facilities, and in medical encounters with refugees and asylum seekers. The victim of torture does not always connect his current symptoms with his history of torture and frequently does not want to talk about his experiences to strangers, including physicians. The reasons are manifold – lack of trust in the physician, shame, guilt, fear of re-traumatization through telling, fear of traumatizing the health care provider, and fear of the consequences of telling the story (especially if the victim or his family are still in a vulnerable position). Even patients who are in long-term treatment for various mental and somatic problems, including pain syndromes, and who have a history of torture may not tell their treating physician about this history [17]. A study performed in an American primary care setting found that 6% of non-American born patients reported experience of torture in their past, yet in none of the cases was the primary treating physician aware of this fact [18].

The health care provider cannot see what he or she does not suspect, or does not want to see. The Istanbul Protocol is a tool to assist the physician or psychologist to fulfill the obligation to recognize, document and report the evidence of torture.

#### SIGNIFICANCE AND IMPLEMENTATION IN ISRAEL

Israel is a signatory to the Convention against Torture [5]. Despite this, the Landau Commission (1987) reached the conclusion that “use of a moderate degree of physical pressure, in order to obtain crucial information, is unavoidable under certain circumstances.” The Commission defined measures that are meant to keep the moderate physical pressure in check (advanced directives have to be in place, pressure shall never reach the level of torture, and mandatory supervision). The state compiled a (classified) catalogue of permitted interrogation techniques. In 1993 the guidelines were updated, including an added clarification that it is not permissible to humiliate

ER = emergency room

a person under interrogation, deny him water or food or access to a toilet, or subject him to extreme temperatures [19].

Not infrequently, victims of torture and institutional violence are encountered by medical personnel in the ER, who due to insufficient training and awareness will not adequately record the complaints, document a directed examination of the victim, and report to the relevant authorities [20]. Military physicians might also encounter victims of torture. Their dual loyalty and the situation they find themselves in might make an appropriate examination even more difficult. Knowledge of international ethical and procedural standards are all the more important in these situations [21].

In addition, many arrested persons suffer violence at the hands of the arresting authority. Though it does not amount to torture, it should be documented and reported nevertheless, especially if the victim is still in custody when a timely report may have implications on the patient's safety and well-being [22].

Refugees and asylum seekers constitute another population in Israel that is most likely to have a history of torture, either in their home countries or in the Sinai Desert [3]. A history of torture is hugely significant in these cases, as a person who was tortured in his home country may not be sent back under the principle of non-refoulement [5]. The documentation of the refugee's narrative and the physical and psychological findings – according to the Istanbul Protocol – can be instrumental in substantiating a claim of torture.

The example of other countries like the UK, Turkey, the Philippines and Venezuela can teach us that the education of physicians with regard to their ethical duties and how to manage situations where violence and torture are suspected can make a significant difference [23]. The first course for physicians based on the Istanbul Protocol took place this year in the framework of the Public Committee against Torture in Israel. The chairman of the ethics committee of the Israel Medical Association has announced the Association's intention of instituting courses about the Protocol for Israeli physicians [24].

Under the UN Convention against Torture and the World Medical Association Tokyo Declaration, Israel and the Israel Medical Association have ratified that physicians are under obligation to file a complaint with the appropriate institution if they suspect torture or violence by the arresting authorities. In January 2012, the Ministry of Health announced the establishment of a committee to investigate reports by physicians of injuries inflicted on arrestees during investigation [25]. Although we petitioned the Ministry of Health, they declined to answer any questions regarding the work of this committee, and to the best of our knowledge it has not dealt with a single complaint. Furthermore, the committee has not published any protocol of its work or guidelines for physicians regarding instances that fall under its purview.

The approach of the physician to a person who appears to have suffered maltreatment should be structured and

conducted according to clear guidelines, and should not be affected by the patient's place of origin, who brought him to treatment, or who might be responsible for the possible abuse. Teaching of the Istanbul Protocol to Israeli physicians would be an important step in that direction.

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**Capsule**

**Intranasal epidermal growth factor treatment rescues neonatal brain injury**

There are no clinically relevant treatments available for improving function in the growing population of very preterm infants (less than 32 weeks gestation) with neonatal brain injury. Diffuse white matter injury (DWMI) is a common finding in these children and results in chronic neurodevelopmental impairments. As shown recently, failure in oligodendrocyte progenitor cell maturation contributes to DWMI. Scafidi and colleagues, who demonstrated previously that the epidermal growth factor receptor (EGFR) has an important role in oligodendrocyte development, now examine whether enhanced EGFR signaling stimulates the endogenous response of EGFR-expressing progenitor cells during a critical period after brain injury and promotes cellular and behavioral recovery in the developing brain. Using an established mouse model of very preterm brain injury, they show that selective overexpression of human EGFR in oligodendrocyte lineage

cells or the administration of intranasal heparin-binding EGF immediately after injury decreases oligodendroglia death, enhances generation of new oligodendrocytes from progenitor cells, and promotes functional recovery. Furthermore, these interventions diminish ultrastructural abnormalities and alleviate behavioral deficits on white-matter-specific paradigms. Inhibition of EGFR signaling with a molecularly targeted agent used for cancer therapy demonstrates that EGFR activation is an important contributor to oligodendrocyte regeneration and functional recovery after DWMI. Thus, our study provides direct evidence that targeting EGFR in oligodendrocyte progenitor cells at a specific time after injury is clinically feasible and potentially applicable to the treatment of premature children with white matter injury.

*Nature* 2014; 506: 230  
Eitan Israeli

**Capsule**

**Estrogen increases hematopoietic stem cell self-renewal in females and during pregnancy**

Sexually dimorphic mammalian tissues, including sexual organs and the brain, contain stem cells that are directly or indirectly regulated by sex hormones. An important question is whether stem cells also exhibit sex differences in physiological function and hormonal regulation in tissues that do not show sex-specific morphological differences. The terminal differentiation and function of some hematopoietic cells are regulated by sex hormones, but hematopoietic stem cell function is thought to be similar in both sexes. Nakada and group show that mouse hematopoietic stem cells exhibit sex differences in cell cycle regulation by estrogen. Hematopoietic stem cells in female mice divide significantly more frequently than in male mice. This difference depends on the ovaries but not the testes. Administration of estradiol, a hormone produced mainly in the ovaries, increased hematopoietic

stem cell division in males and females. Estrogen levels increased during pregnancy, increasing hematopoietic stem cell division, hematopoietic stem cell frequency, cellularity, and erythropoiesis in the spleen. Hematopoietic stem cells expressed high levels of estrogen receptor- $\alpha$  (ER $\alpha$ ). Conditional deletion of ER $\alpha$  from hematopoietic stem cells reduced hematopoietic stem cell division in female, but not male, mice and attenuated the increases in hematopoietic stem cell division, hematopoietic stem cell frequency, and erythropoiesis during pregnancy. Estrogen/ER $\alpha$  signaling promotes hematopoietic stem cell self-renewal, expanding splenic hematopoietic stem cells and erythropoiesis during pregnancy.

*Nature* 2014; 505: 555  
Eitan Israeli

**“If people knew how hard I worked to get my mastery, it wouldn’t seem so wonderful after all”**

Michelangelo (1475-1564), Italian sculptor, painter, architect, and poet. Michelangelo has been considered the greatest artist of all time, with some of his works ranking among the most famous in existence, such as the sculptures *Pietà* and *David*, and the frescoes in the Sistine Chapel

# Testamentary Capacity of the Schizophrenic Patient

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**ABSTRACT:** Testamentary capacity refers to an individual's capability to write his or her own will. Psychiatrists are required occasionally to give expert opinions regarding the testamentary capacity of individuals with a medical history or suspected diagnosis of a mental illness. This may stem from the patient/lawyer/family initiative to explore the current capacity to testate in anticipation of a possible challenge, or may be sought when testamentary capacity of a deceased has been challenged. In this article we examine the medico-legal construct of testamentary capacity of the schizophrenic patient, and discuss the various clinical situations specific to schizophrenic patients, highlighting their impact on the medical opinion regarding testamentary capacity through examining the rulings of Israel's Supreme Court in a specific case where the testamentary capacity of a mentally ill individual who was challenged postmortem, and provide a workable framework for the physician to evaluate the capacity of a schizophrenic patient to write a will.

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**KEY WORDS:** testamentary capacity, schizophrenia, psychosis, postmortem, mental disorders

The concept of will-writing among schizophrenic patients seems to harbor inherent contradictions. Schizophrenia, the 'prototype' of mental illness, usually affects young adults and writing a will is often associated with older age. Schizophrenic patients generally have difficulties maintaining relationships and are less likely to form families – the potential beneficiaries of estates [1]. Also, the employment potential of schizophrenic patients is reduced, limiting their ability to accrue property. When attempting to establish testamentary incapacity of a patient, assets and social environment are central issues. Furthermore, the question of capacity may arise in various contexts during the patient's life cycle, e.g., compulsory hospitalization and need for guardianship [2]. In contrast stands the healthy elderly testator, whose capacity to perform legal actions such as writing a will is rarely questioned – until the writing or execution of a will. As stated in Israel's Legal Capacity and Guardianship Law: "every man proclaims the capacity for rights

and debts," and "every man is capable of any legal action unless this was denied by virtue of legal action" [3]. Nevertheless, though to a lesser extent, mentally ill patients do write wills. Shulman et al. [4] defined 25 retrospective challenges to testamentary capacity, and dementia emerged as the most common (40%), followed by alcohol-related issues (28%), and neurological or psychiatric disorders (28%) [4].

In practice, psychiatrists are occasionally asked to give expert testimony regarding the testamentary capacity of individuals with a medical history or suspected diagnosis of schizophrenia. For example, if an individual with a suspected diagnosis of schizophrenia wishes to write a will, contemporaneous assessment of his/her testamentary capacity when signing the will might be requested [5]. In this case a lawyer, family member or the testator seeks expert testimony regarding the testator's current mental disorder and capacity to testate in anticipation of a possible challenge to the will by potential beneficiaries. Second, after the demise of the testator, his/her testamentary capacity at the time the will was written might be challenged. The psychiatrist might then be asked to provide an expert retrospective or 'postmortem' evaluation based on extrapolations from indirect evidence and interpretations of assessments by other clinicians. Though this situation is more common, it is less revealing than direct examination of a living patient. In these cases, the expert opinion is generally sought by the court or by potential beneficiaries [4]. Psychiatrists find themselves in the juridical arena and are asked to use their clinical expertise and professional experience to evaluate a schizophrenic patient, and their clinical evaluation is often the basis for a legal ruling.

In this article we discuss the impact of various clinical situations specific to schizophrenic patients on the medical opinion with regard to testamentary capacity. We also offer insights into a specific case in which the testamentary capacity of a mentally ill individual was challenged postmortem in the Israeli Supreme Court and provide a workable framework for the physician to evaluate the capacity of a schizophrenic patient to write a will.

## PATIENT WITH AN ACTIVE DISEASE AND PATIENT IN COMPLETE REMISSION

Most patients move along the clinical spectrum of schizophrenia from complete remission and absence of positive symptoms



(delusions, hallucinations) through partial remission to active stages of the illness including psychoses. In the psychotic state there may be various relationships between the active psychotic content and issues concerning the will. Psychotic content related to delusions does not necessarily influence the patient's judgment or capacity to make decisions in other facets of life such as bequeathing possessions, i.e., testamentary capacity. The situation differs when the patient suffers from hallucinations and delusions concerning his capacity and his assets. For example, if the patient has delusions of grandeur she might be convinced that she has assets beyond her actual possessions, has nothing at all, or that all her property was stolen. In this case it is clear that she does not have the capacity to judge the extent of her assets and therefore does not have testamentary capacity.

If psychotic content distorts the patient's conception of reality with regard to his relatives, it may influence his decisions regarding the heirs. For example, paranoid delusions towards a spouse could lead to disinheriting her. We emphasize that a psychotic state alone does not revoke testamentary capacity. In addition, 'bizarre' decisions in the eyes of the observer do not necessarily indicate decisions resulting from illness whatsoever. Psychiatrists must restrict themselves to decisions directly related to psychotic content.

#### IMPACT OF COGNITIVE DISABILITY AND NEGATIVE SYMPTOMS

A psychiatric patient with unidentifiable active positive symptoms might exhibit illness-related components that could influence testamentary capacity. Negative symptoms (e.g., affective flattening, avolition) and cognitive decline are also part of the schizophrenia process. Certain cognitive and intellectual impairments, especially in language, semantic memory and executive function, are observed in schizophrenic patients in the early stages of the illness [6]. Chronic schizophrenic patients with prominent negative symptoms demonstrated poor cognitive functioning on tests sensitive to frontal and parietal lobe functions [7], and studies of young schizophrenic patients revealed stability in scoring on neurocognitive batteries up to 10 years following the first psychotic episode [8,9]. In older schizophrenic patients with suspected cognitive/intellectual impairments, a dementia process might be emerging.

Cognitive screening instruments such as the Mini Mental State Examination and the clock-drawing test used by clinicians demonstrated deficits in elderly patients with severe mental illness, but the cutoff point was determined mainly for elderly dementia patients [10-12]. The presence of such deficits does not necessarily indicate an impairment of testamentary capacity.

#### LEGAL GUARDIANSHIP AND INCOMPETENCE

When a guardian has been appointed we must differentiate between a patient who was declared legally incompetent, in which case under Israeli law he lacks testamentary capacity [3], and a patient for whom a guardian was appointed though

he/she was not declared legally incompetent. For the latter, the patient's legal rights are not revoked and testamentary capacity must be evaluated.

Appointment of a guardian is a warning light, as the court assumed that the patient lacked the capacity to manage his affairs – personal/physical affairs, medical care and/or affairs related to his property (purchase of basic needs, financial management). However, this does not imply absence of testamentary capacity. For example, a patient might lack the capacity to manage his daily affairs but can still have a general desire to leave all his assets (even if he does not know exactly what they are) to his children. What happens if the beneficiary of part or all of the estate is the guardian? The guardian is often a family member who cares for the patient, and it might be assumed that the patient would want to bequeath part or all of his/her estate to the guardian/relative. Because the guardian is supposed to devote his time and energy to the patient's needs and not for his own benefit, a guardian/relative might be considered a conflict of interest [13]; thus the court should be informed if the guardian is a potential heir.

#### UNDUE INFLUENCE AND SIGNIFICANT OTHERS

The Israeli Inheritance Law states that: "a will that was formed under rape, threats, *undue influence*, etc., conning or scamming holds no validity" [14]. The question of undue influence is complex, even when the testator does not have schizophrenia. Israel's Supreme Court ruled on a problematic case involving undue influence when an elderly man with no living relatives and no mental illness chose to leave all his assets to a woman who nursed him prior to his death and who he had met only 4 months before he wrote his will. The Attorney General appealed the will and argued that the elderly man wrote his will while subjected to undue influence of his caregiver, creating a flaw in the will that should therefore not be executed. The appeal was denied by the District Court and subsequently by the Supreme Court, and the deceased's will was honored:

Each and every one of us is subject to the influence of those who surround us ... Our acts are the consequence of our personality as well as these and other constraints that life puts before us. ... All these influences are components of the 'true' desires of man and do not harm intent. ... An elderly man, sick, weak and forgotten – should we deny his true and independent will to leave all his possessions to the woman who cared for him in the last months of his life? (even if only for that reason?), why should we assume that it is obvious that the woman used undue influence on the deceased and declare the will invalid?.. There is no doubt that his disturbed mental and physical conditions contributed to his decision to leave all his assets to the woman, but why should we characterize this as undue influence in order to disqualify the will? [15]

When the testator suffers from schizophrenia it is more difficult to distinguish “fair” from “undue” influence owing to the complex network of relationships created within the patient-family-disease triad. The term “high expressed emotion” expresses the influence of communication patterns in some families on the illness process of the patient and is an example of this complexity [16]. Patients might depend on their families for long periods due to extensive functional impairment stemming from the chronic illness. It is then difficult to define whether the family’s influence on the patient is “fair” or “undue influence.” Clearly, mental illness, and its medical, social and economical consequences make the patient vulnerable to those who seek to take advantage of him/her within and outside the family.

#### **MENTAL ILLNESS AND THE CONSTRUCT ‘TESTAMENTARY CAPACITY’ – THE CASE OF BANKS VS. GOODFELLOW**

A mentally ill individual, tried in an English Court, led to the examination of the legal term “testamentary capacity” and formalization of a legal test (Cockburn’s laws) for the evaluation and validation of wills according to the Anglo-Saxon legal tradition [17]. The case *Banks vs. Goodfellow* was brought to court in 1870 [18]. Mr. Banks changed his will in 1863 and left all his property to a niece through marriage who was a remote blood relative. Mr. Banks was hospitalized for several months in 1840 and was declared insane. Following discharge he continued to suffer from paranoid delusions. Under the influence of these delusions, he believed that a deceased person’s spirit was trying to hurt him. It was determined that the very existence of this delusion did not affect his decision to bequeath his property to his niece. From the legal test in the trial, clinical criteria for the evaluation of testamentary capacity were derived. Understanding, knowledge and lack of influence are the three main factors to be examined by the expert. Does the ‘creator of the will’ (the testator) understand what a will is; is he aware of the nature of his assets and their quantity? Does he know who might claim to inherit from him, and does he understand the consequences of the division of the assets in a specific manner? Is he under the influence of a delusion that directly affects the division of his assets? Does he have the capacity to express his desires in a clear, explicit and orderly manner? [19]. It was decided that Mr. Banks was fit to write a will and his will was fully respected.

#### **INSIGHTS ON TESTAMENTARY CAPACITY: THE SUPREME COURT IN ISRAEL**

Israel’s Supreme Court ruled on a case concerning testamentary capacity of an individual with mental illness (case of 1212/91) [20]. The testator, Mr. M, had a diagnosis of schizophrenia, paranoid type, was childless and had a history of psychiatric hospitalizations. He died and left three wills. In all three wills he

left his apartment to his employer of many years. In the first will he left the rest of his possessions to his sister and her children, but in the second will he chose to leave the rest of the property to a foundation that supports enlisted soldiers. The third will, which did not differ from the content of the second will, was submitted to the court due to a technical error. Owing to the deceased’s psychiatric history, following his lawyer’s advice he had been examined by a psychiatrist the day before he wrote the second will. The psychiatrist confirmed that Mr. M was fit and capable to write a will. Twelve days later he was admitted to a psychiatric hospital, where he remained hospitalized for 2 years. The third will was written a month after the second will, while he was hospitalized in the daycare facility of the hospital. After Mr. M’s death his sister contested the will. She argued that her brother had been mentally ill and thus “was incapable of discerning the nature of the will.” The district court examined the case according to the Israeli Inheritance Law [3].

The law refers (in article 26) to the capacity to make a will and states that “a will made by a minor or by a person declared ‘legally incompetent’ or that was written when the testator could not discern the nature of a will is invalid.” There is no specific reference in the law to mental illness. Two expert opinions were submitted to the court. The opinion on behalf of the plaintiff claimed that the testator was delusional and believed that his sister was trying to poison him and this belief influenced his will. This expert opinion was prepared post-mortem by a psychiatrist who had never examined the patient but had reviewed the patient’s medical records. The opposing opinion was prepared by a psychiatrist who examined the patient the day before he wrote his second will. The case was further complicated when it became apparent that after writing the first will the deceased had deposited some jewelry and money with his sister and her son, and only the jewelry had been returned to him after the intervention of his lawyer. The money was never returned and the nephew admitted that he had spent it. The District Court favored the plaintiff’s claim but differentiated between the nephew and the patient’s sister, claiming that he was disinherited for “normative motives,” while regarding the sister and the rest of her children eligible for the deceased’s property. The District Court determined that in that context there was a “misconception” resulting from mental illness that had to be corrected by the court to the situation that the court had perceived would have happened in the absence of a mental illness. The district court explained that a will made under the influence of a delusion is a will based on a misconception [21] and should therefore be rectified before it is executed. However, the District Court maintained that the deceased “knew to discern the nature of a will.”

An appeal was made to the Supreme Court. The Supreme Court did not accept the opinion of the District Court and maintained that the will of the deceased was valid and should be implemented verbatim. The Court relied on the interpreta-

tion of section 26 of the Inheritance Law that excludes three persons who cannot testate: a minor, a person declared legally incompetent, or a testator who composed a will when he/she could not discern the nature of a will [12]. The question whether the case of a mentally ill person whose concerns for heritage were dictated by “mental tricks” is addressed. The Supreme Court interpreted that the ability to discern the nature of a will is not only general knowledge of what a will is, nor private knowledge of the implications of one’s will for himself and those around him. In addition, the wishes of the testator must represent his “free” and “true” will, i.e., a will free of “morbid mental pressures.”

The Court maintained that there is testamentary capacity only when all of these components are present. In cases of an appeal, the court must be convinced it was not the “free will” of the testator that dictated his last words, that “his understanding was forcefully thrown by delusions,” that there is a clear causal relationship between these delusions, and that distorted realities influenced his/her will. In any other case, appeals on a will are an impingement on the basic dignity and basic right of the person to divide his property according to his will in life as well as in death:

In the end of all ends, the deceased did not harm anyone – he did not bequeath anything but his assets – apparently there is no reason not to respect his wishes concerning the distribution of his assets after his death. If the deceased had divided his property while alive, we would have encountered great difficulty, perhaps even an undue difficulty to undo his dispositions. And after his death, can we permit ourselves not to acknowledge the will? ..... Ignoring the will of the deceased bears a great deal of paternalism and is perhaps even an insult to human dignity.

Every man has a fundamental right to his own truth and his own reality even if it is not perceived as” normative “or as the opinion of a “reasonable person.”

According to the Supreme Court, distorted perception of reality by a testator who does not suffer from delusions caused by a mentally ill mind does not impair testamentary capacity. There is no place to change one’s distorted desires to the desires of a reasonable person under the same circumstances. Otherwise, we coerce into a frame of “normality,” as we perceive it, those who live their lives deviating from this frame. The unusual person has his own desires and his own truths in accord with his reality. He lives his life in his own bubble that is burst after his death, under the pretensions of the desire to follow his “true” inner world. This is not more than an attempt to reconstruct what never occurred in his world. If there was a justification for bursting the ‘bubble’, then it was already present prior to his death.

The Supreme Court sided with the opinion of the defendant’s expert mainly (but not exclusively) because of that psychiatrist’s acquaintance with the deceased and the fact that he personally examined the deceased close to the time of the writing of the will.

## DISCUSSION

We presented the various aspects of the assessment of testamentary capacity in schizophrenic patients and distinguished between the clinical definition of fitness (capacity) and its legal definition (competency). While the court seeks competency, it relies on the clinical psychiatrist to formulate a decision for a legal question. In evaluations of capacity, the psychiatrist is asked a fundamental question regarding the autonomy of the patient. It seems there is a legal as well as a clinical premise that mental illness can indeed impede this autonomy; the degree of impediment varies and relies on different characteristics that require evaluation on a case-by-case basis. In the case of testamentary capacity, the patient’s autonomy is examined in a goal-oriented context – the ability to create a will. However, despite this limited context, a broader evaluation is necessary when examining schizophrenic patients.

The evaluation of testamentary capacity presents the psychiatrist with challenges that are far beyond her usual clinical experience. Jacoby and Steer [22] offer some general guidelines. Prior to performing the clinical evaluation, the psychiatrist must receive from the patient’s attorney confirmed information concerning the assets of the patient and must verify that the patient indeed agreed and legally authorized (via his attorney) that he is aware that the psychiatric evaluation is required for legal matters and will be revealed to non-medical authorities. Reasonable time for assessment must be allowed, and cognitive testing of the patient should be included in order to assess the existence or absence of a demented state. Afterwards, the degree of the patient’s understanding must be evaluated based on the points proposed by the Banks vs. Goodfellow ruling. It is important to verify whether earlier wills were written and to understand any changes in the current will. This examination may reveal deficits in judgment, memory and the existence of delusions. The examination may be embarrassing and felt by the patient to be intrusive, so it is important to explain to the patient the reasons for the detailed questioning. It is necessary to record the findings of the examination in detail and to quote the patient verbatim because the psychiatrist might be required to testify in the event that the will is contested. It is necessary to be thorough in the examination of the testator and to understand his/her decision concerning his/her heirs, in order to expose the motives and to be convinced that they do not result from illness.

Hence, when there is a psychotic condition or impairment, in addition to evaluating the mental and medical state of the

patient, for which they are trained, clinicians must also evaluate the familial, social and economic situation of the patient and emphasize how these are affected by the patient's illness and how they subsequently affect his testamentary capacity; issues that doctors generally do not deal with. We are expected not only to rely on the diagnosis but to try to precisely evaluate the extent of the illness symptoms and their influence on the specific patient's testamentary capacity. Thus the clinician must seek all available information concerning the expression of the patient's illness, including a review of the content of his past delusions and the degree to which they were executed by the patient. Evaluations by various professional authorities over the years should also be included. Thus we can respect the desires of individuals with mental illness in their quest to integrate into society, even after their deaths.

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### Capsule

#### Daily stressors, stress vulnerability, immune and HPA axis

Both stressors and stress vulnerability factors together with immune and hypothalamus-pituitary-adrenal (HPA) axis activity components have been suggested to contribute to disease fluctuations of chronic inflammatory diseases, such as rheumatoid arthritis (RA). Evers et al. investigate whether daily stressors and worrying as stress vulnerability factor as well as immune and HPA axis activity markers predict short-term disease activity and symptom fluctuations in patients with RA. In a prospective design, daily stressors, worrying, HPA axis (cortisol) and immune system markers (interleukin-1 $\beta$ , IL-6, IL-8, interferon-gamma, tumor necrosis factor-alpha), clinical and self-reported disease activity (disease activity score in 28 joints, RA disease activity index), and physical

symptoms of pain and fatigue were monitored monthly during 6 months in 80 RA patients. Multilevel modeling indicated that daily stressors predicted increased fatigue in the next month and that worrying predicted increased self-reported disease activity, swollen joint count and pain in the next month. In addition, specific cytokines of IL-1 $\beta$  and IFN $\gamma$  predicted increased fatigue 1 month later. Overall, relationships remained relatively unchanged after controlling for medication use, disease duration and demographic variables. No evidence was found for immune and HPA axis activity markers as mediators of the stress-disease relationship.

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“A free society is a place where it's safe to be unpopular”

Adlai Stevenson (1900-1965), U.S. governor and ambassador