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Paper

George III's Illness and its Impact on Psychiatry

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George III's illness is the most famous and momentous in our history. Up to now it also has been clinically the most perplexing. 'Mad King George' – this is the picture every schoolboy learns and every history book teaches, which pervades every study of his long and eventful reign.

We became interested in the royal malady when our researches into the history of psychiatry showed the impetus that illness gave to the development of the specialty (1). It was all the more surprising to find how little research had been done to discover what was really the matter with him, despite some striking features of the illness. Indeed, in Bacon's language, the King's 'insanity' appears to have been 'more professed, than labored, & yet more labored than advanced' for we found 'much Iteration, but small Addition' (2). We therefore decided to reinvestigate it in the light of modern medical knowledge and were so fortunate as to find four manuscript collections of the notes and records of his own physicians: at Windsor Castle, Lambeth Palace¹, the British Museum and in the hands of descendants. None had previously been consulted in a medical study

and two were not even known to historians. These enabled us to piece together a coherent story and arrive at a different and, it seemed to us, correct diagnosis.

Our task proved difficult and laborious for many reasons. First, there was the great abundance and diversity of published sources which had to be consulted, spread over almost the whole sixty years of the reign spanning the recurrences of the attacks. It was a period teeming with great men and great events and never had there been so many diarists, correspondents and chroniclers, all of whom may have noted pertinent facts not recorded elsewhere. In contrast, the public bulletins were of little value. They were designed to allay alarm rather than to record the nature and progress of the disease. A typical bulletin reads: 'His Majesty has had a restless night, and is this morning much indisposed' (3). Even when his doctors tried to be informative their reports were garbled, like one to Prime Minister Perceval in 1810: 'He is under a great degree of irritation, and the whole frame is so much disturbed as to make us consider Him in some danger' (4). One sympathizes with Lord Grenville who complained: 'The report of the physicians is worded as foolishly as ever' (5).

Georgian Medicine

Another difficulty was that the doctors' observations were made and couched in the theory and language of a bygone age. To understand them one needs a background knowledge of eighteenth century medical theory and practice. Doctors still thought in terms of noxious humors. How they pictured the illness is well described by Lord Grenville in November 1788:

'The cause to which they . . . ascribe it, is the force of a humor which was beginning to show itself in the legs,

¹The Regency Act of 1811 established a Council to advise the Queen on the care of her husband during his incapacity. The chairman was the Archbishop of Canterbury who received the physicians' daily bulletins and detailed reports and answers to quarterly questionnaires. These are all preserved at Lambeth Palace Library

when the King's imprudence [he had failed to change out of wet stockings] drove it from thence into the bowels; and the medicines which they were then obliged to use for the preservation of his life, have repelled it upon the brain . . . The physicians are now endeavouring . . . to bring it down again into the legs . . .' (6).

However quaint this way of medical reasoning may seem today, it records the characteristic progression of the royal malady from the legs to the abdomen and finally the head. It also shows that the King's condition rapidly became so serious that his doctors feared for his life.

Diagnosis of diseases of organs like heart, lungs, liver and so on could make little headway while there was as yet no science of physical signs. Doctors did not listen to the chest, for instance, for they would not have known what to make of what they heard. Little was known of the nervous system other than coma and paralysis due to injury, infection, strokes and fits. They had no stethoscope, no knee-jerk hammer, and even had to guess whether a patient had fever since the clinical thermometer had not yet come into use. Frequently the royal physicians could not even agree on the King's pulse rate. Physical examination was therefore not practised as it would have served little purpose. It seems incredible, with so many doctors about him, but there is no indication that the King was ever examined. They arrived at their diagnosis by what was called 'an estimate of symptoms and appearances'. They listened to the patient's complaints, enquired into his 'animal' or excretory functions and general health, looked at the tongue and felt the pulse.

Even within this limited range of fact-finding the royal physicians were peculiarly handicapped. They were expected to observe protocol however ill or delirious the King might be. If he did not deign to address them first, they could ask no questions. Whole visits were therefore spent in fruitless silence as they reported to the Queen's Council in 1812: 'His Majesty appears to be very quiet this morning, but not having been addressed we know nothing more of His Majesty's condition of mind or body than what is obvious in his external appearances' (7).

It was a different story when it came to his mental symptoms. No modern aids were necessary to assess whether the King was excited or composed, rational or deluded. The royal physicians had the same opportunity of forming a picture of their patient's mental state as any modern psychiatrist. They needed only to listen and observe. So it came about that at source, as it were, as soon as mental symptoms appeared they

overshadowed the physical complaints which receded into the background less in fact than in emphasis. Not only were they self-revealing but by their portent they were the most dreaded by government and country alike since it was the monarch's mental state which determined whether he was fit to rule.

The highpoint of this great drama of human, psychiatric and national history came in 1788 when the 50-year-old King for the first time lost his reason. In the consternation which followed, the mental derangement naturally moved into the centre of the public stage in what became an intricate complex of medical and political controversy in which confusion extended far beyond the mind of the patient and so gave the illness its lasting stigma. The physical symptoms, in contrast, hurt no one but the King: they did not enter the social or political arena and so came to be regarded as unimportant or incidental. A later generation of psychiatrists went even further and assumed that they were manufactured by the Court to hide an embarrassing state of affairs. The mental symptoms gained added prominence historically because everyone who came in contact with the King could and did form his own impression of them and did not fail to record it. The seal was set on this historic bias when, early in December 1788, 'Persons who have made this Branch of Medicine their particular Study' – as psychiatrists were referred to in Parliament – were called in, took up residence in the palace and charge of the sickroom. Thus it came about that the King's physical sufferings were minimized and later disregarded, while his mental derangement was magnified as if it had been the whole illness. And so the bias of history created the false image of 'Mad King George' and shut the door to the real diagnosis. Yet, adding together all periods of derangement up to his 73rd year of life, they amount to less than six months!

The Royal Malady

All accounts state that the King had five attacks of insanity, the first in 1765 as a young man of 26, but we found no contemporary evidence that his mind was disturbed at that time (8); the illness was entirely physical. Only after his death some 55 years later, with the hindsight of later attacks, was it surmised that this three-month period of intermittent ill-health must also have been accompanied by derangement and what started belatedly as rumour and speculation entered history books and, by repetition, came to be generally accepted as fact.

There were therefore only four attacks in which mental symptoms appeared. All followed

the same pattern, none lasted longer than a few months, except the last illness where special circumstances prevailed as will be seen later. All left him wasted and weak so that it took him months to recover health and strength.

It is a truism to state that an established derangement of mind may offer little clue to its origin, whereas knowledge of its mode of onset often does. For this reason it is revealing to trace in some detail how the first illness in which derangement appeared – that of 1788–9 – developed. Historically it is the most important and politically the most exciting and hence also the best documented. It gives a picture of all attacks and shows unequivocally that mental symptoms appeared in the train of widespread and severe bodily disorder.

In June 1788 the King had spasms of severe abdominal pain. His physician, Sir George Baker, diagnosed 'biliary concretions in the gall duct' and sent him to Cheltenham to drink the waters. In September he complained of facial pain which prevented sleep but he remained otherwise well till 17 October when he urgently summoned Sir George:

'The King', he wrote, 'has had this night a spasmodic biliary attack though much slighter than in the month of June. He therefore wishes to see Sir George Baker as soon as convenient, and desires he will bring one of the Opium pills in case the pain should not have entirely subsided before Sir George can arrive; He has as yet taken nothing but a pint of warm water from thinking there was an inclination to vomit' (9).

Sir George recorded in his diary:

'I found His Majesty sitting up in his bed, his body being bent forward. He complained of very acute pain in the pit of the stomach shooting to the back & sides, and making respiration difficult & uneasy . . . His Majesty informed me . . . that of late He had been much tormented in the night by a cramp in the muscles of his legs, and that He suffered much from the rheumatism, which affected all his limbs, & made Him lame' (10).

Sir George noted 'Some yellowness in the eyes, & urine bilious', that is dark brown. Three days later pain in the pit of the stomach returned and he also complained of 'great fatigue'. On 22 October his bowels were costive, his spirits low and his pulse fast. That day he received his physician 'in a very unusual manner' of which Sir George

'had not the least expectation . . . The look of his eyes, the tone of his voice, every gesture and his whole deportment represented a person in a most furious passion of anger . . . "One medicine had been too

powerful, another had only teased him without effect. The importation of senna ought to be prohibited, and he would give orders that in future it shall never be given to any of the royal family". With a frequent repetition of this and similar language he detained me three hours. His pulse was much quickened . . . I wrote a note to Mr Pitt immediately on my return to London, and informed him that I had just left the King in an agitation of spirits nearly bordering on delirium' (9).

To his great relief the next day the King was 'calm, composed, and free from fever', but he remained languid and weak. During the next days he became more excited, sleepless and talked with more than his usual rapidity. Pain and weakness of the limbs continued, his vision became confused and he could no longer see to read. Giddiness and headache followed. Two weeks after the onset, on 1 November, Fanny Burney who lived at Court recorded:

'Our King does not advance in amendment; he grows so weak that he walks like a gouty man . . . and is so hoarse it is painful to hear him . . . The King is very sensible of the great change there is in himself . . . It seems, but Heaven avert it! a threat of a total breaking up of the constitution. This, too, seems his own idea. I was present at his first seeing Lady Effingham on his return to Windsor . . . "My dear Effie", he cried, "you see me, all at once, an old man" . . . He then produced a walking-stick which he had just ordered. "He could not", he said "get on without it; his strength seemed to diminish hourly"' (11).

Here then we have enumerated the physical symptoms of porphyria and on 3 November came the first report of frank delirium, typically at night. Yet the King had been out riding as usual and even wrote to his Prime Minister:

'The King thinks it must give Mr Pitt pleasure to receive a line from him . . . He attempts reading the despatches daily but as yet without success . . . He . . . is not the least now fatigued with riding, though he cannot yet stand long, and is fatigued if he walks' (12).

It was his last official letter for more than three months. In the evening of 5 November Sir George 'found him under an intire alienation of mind, and much more agitated than he had ever been' (10). The next day his pulse rose above 120, his life was considered in danger and Dr Richard Warren was called in. Pitt wrote to the Lord Privy Seal:

'The King's disorder . . . has within a few hours taken so serious a turn that I think myself obliged to lose no time in apprising your Lordship of it . . . from what I learn, there is too much reason to fear . . . a fever . . . has settled on the brain, and . . . may produce immediate danger to His Majesty's life' (13).

Two days later the Prince of Wales wrote to Lord Chancellor Thurlow: 'I am sorry to acquaint you, yt. H. My. is in infinitely a more dangerous state than he has hitherto been, having no recollection whatever' (14). Indeed, the following day 'the ninth of November, being Lord Mayor's day, the belief was universal throughout the metropolis, that his Majesty was no more, and that the awful event had been with-held from publication till the [new] Mayor of London was sworn into his office' (15). Greville, the King's equerry, described 12 November:

'In the morning constant rambling of thought continued, yet still at times recollecting Persons around him by Name . . . At length this . . . caused a Violent perspiration – He called to have the Windows opened, and complained of heat and burning . . . He became more violent . . . [and] his pulse rose to 130 . . . This night I sat up with H.M., during the first part of which the ramblings were great . . . About . . . three o'clock, H.M. had a violent struggle, jerking very strongly with his Arms & Legs, but made no attempt to rise – Three quarters of an hour after this, He became quite recollected . . . asked how many days He had been confined to his bed, looked around at his Attendants with attention, & smiled, & nodded to Them frequently . . . On laying down He promised to compose Himself, & said He would sleep if He could; & indeed it was now particularly desirable He should have some rest, as He had been without sleep for above twenty-nine hours' (16).

The jerkings were of course a convulsion and further evidence of cerebral involvement.

The papers reported that the King was delirious and the London *Morning Chronicle* assured its readers that: 'The case has nothing different in it from what accompanies all fevers that have raged with equal violence . . . there is [therefore] good reason to believe that the King's complaint, however severe, will prove merely temporary' (17). But the end of November was reached without sustained improvement and it became obvious that the regular physicians could no longer manage him. He was therefore transferred – lured is perhaps more exact – from Windsor to Kew for easier access from London and to remove him from the public gaze; and the Reverend Dr Francis Willis, owner of a private, high-class madhouse in Lincolnshire and known as 'Doctor Duplicate' because of his double qualification in divinity and medicine, was sent for with his sons by Pitt. Fanny Burney lamented on 1 December:

'Mournful was the opening of the Month . . . the length of the Malady so uncertain, the steps . . . now requisite so shocking; for new advice, and such as suited only disorders that physicians in general relinquish, was

now proposed . . . Dr Willis, a physician . . . of peculiar skill and practice in intellectual maladies, had been sent for express . . . a measure which seemed to fix the nature of the King's illness in the face of the world' (11).

And so it did, and what is more George III himself was fully aware of what it meant. On 5 December, when Willis was introduced, Greville wrote in his diary:

'The Appearance of Dr Willis seemed to Engage much of His Majesty's Attention throughout this day – he was at no time Violent but often seemed distressed . . . He told one of the pages, that as Dr Willis was now come He could never more shew his face again in this Country that He would leave it for ever, & retire to Hanover' (16).

The King's personal misfortune was equally a calamity for the state because it deprived the machine of government of its head. So began that historic party struggle, the Regency Crisis, which for months occupied the exclusive attention of Parliament, when the opposition, led by Fox, Burke and Sheridan and identified with the Prince of Wales, tried to seize the opportunity created by the King's incapacity to oust his ministers led by Pitt. Everything depended on whether the mental derangement was due to bodily derangement so that the King could be expected to recover his senses with his health as Pitt hoped and Willis maintained; or whether 'a direct lunacy', that is mental illness proper which would run a chronic course and, even if he had 'lucid intervals', leave his judgment for ever suspect, as would have suited the Whigs and which Dr Warren asserted. To get at the facts, all seven physicians now looking after him were interrogated by parliamentary committees, first in December 1788 and again in January 1789 (18). Baker maintained the illness had begun with fever, but could not link it with persistent mental derangement. Warren, who only came into the case three weeks after its onset, did not believe there had been fever and so implied the King was not delirious but insane. Willis merely boasted that he would speedily achieve a cure. Their answers represented the opposite poles of hope and despair. If Willis proved right, recovery was in sight and a regency might be avoided; if Warren, it was inevitable and possibly permanent. In this way the doctors became unwittingly but historically identified with party and added fuel to the political crisis.

In the meantime Willis took control of the sick room, replaced the pages by keepers, and began a system of government of the King by coercion, intimidation and restraint. Not without reason did he boast to Greville that he broke in patients

like horses in a manège (16). Within one week he had the King confined in a strait-waistcoat for any infringement of discipline. And at night, when the delirium was at its height, Willis fastened him to the bed with his legs tied together. Understandably, the King tried several times to bribe his keepers to allow him to escape and when recovered could not stand the sight of his doctors, least of all the Willises. That violent treatments and enforced inactivity make violent and mischievous patients was only learnt later in the nineteenth century through the work of Samuel Tuke (19) and John Conolly (20) – in George III's time his obstreperous behaviour was taken as the manifestations of furious mania and his fierce dislike of his attendants as delusional.

A period of improvement after Christmas was not maintained and as the illness threatened to turn into a chronic one betokening insanity, the need for a regency was agreed by both parties. But just before the Regency Bill would have passed into law the King's mind began to clear rapidly as if he had been delirious all along. On 12 February 'a progressive state of amendment' was announced and two weeks later 'the entire cessation of the illness'. On 23 February the King wrote his first official letter beginning: 'It is with infinite satisfaction that I renew my correspondence with Mr Pitt' (12). Willis got the credit for the cure when nature thus triumphed over art and spontaneous recovery restored the patient. By March, although thin and feeble, the King left his confinement at Kew and returned to the Castle amid scenes of national rejoicings. He resolved to celebrate his recovery by a public thanksgiving at St Paul's Cathedral on 23 April.

'Many who loved him feared that the excitement of the day might produce a return of his disorder, and therefore endeavoured, though in vain, to divert him from his pious purpose. Among these was the Archbishop of Canterbury. "My Lord" was the King's reply to him, "I have twice read over the evidence of the physicians on my case and if I can stand that, I can stand anything"' (21).

Medals commemorating the occasion were distributed to the crowds lining the processional route through the City of London, bearing on one side the royal image and, on the other: 'Lost to Britannia's hopes, but to her prayers restored'. Willis, not to be outdone, had medals struck bearing his own likeness and name and the message: 'Britons rejoice, your King's restored' – surely the greatest piece of advertising ever achieved by a medical man.

The next two attacks came twelve and fifteen years later. They lasted less than two months each

and in both the King was dangerously ill but incapacitated mentally for only brief periods. The fourth and last illness started in October 1810 and, in February 1811, the Regency was established. For at least twelve months confident hopes of his return were entertained but each time he recovered only to relapse. He was now in his 73rd year and blind and the recurrent onslaughts of the illness had taken their toll leaving him much reduced, physically and mentally. When in January 1812 the last parliamentary enquiry took place, Dr Matthew Baillie deposed: 'I cannot state that His Majesty's recovery is altogether without hope, but I think it . . . extremely improbable . . . His memory seems to be impaired' (22). In his last years he was on the whole tranquil, played the harpsichord, was described as 'good-humoured and cheerful', 'trifling and silly' or 'sullen and lost in mind' and often 'tears and laughter' came in 'quick succession' (23) – so characteristic of senility. So isolated was he from all he had ever known in the world by illness, old age, blindness and finally deafness, that visitors could only make their presence known by tapping him on the arm. Long periods of being 'silent and weak on his legs' were interrupted by the old, painful paroxysms. The last attack took place one month before he died when he spent 58 turbulent hours without sleep or rest and 'gave other remarkable proof of the extraordinary energies of his constitution'. Thereafter he sank and died quietly on 29 January 1820.

Delirium or Insanity

We are now in a position to appreciate that the King suffered periodically from a widespread and severe disorder of his nervous system, preceded by abdominal symptoms and affecting the peripheral nerves, the autonomic nervous system, the cranial nerves and ultimately the brain itself so that to neuropathy was added encephalopathy. Attacks began with nausea, colic and constipation, followed by painful weakness of his limbs so that he could ride when he could neither walk nor stand; fast pulse, sweating attacks; hoarseness, visual disturbances, difficulty in swallowing; mounting excitement, non-stop rambling, intractable insomnia, irritability, emotional outbursts, uncontrolled behaviour, confusion first at night and soon persisting through the day. On the neurological side he developed dizziness, headache, tremor, stupor and convulsions. At the height of attacks his physicians described his mental state as: 'Delirious all day . . . impressed by false images . . . continually addressed people dead or alive as if they were present . . . engrossed in visionary scenery . . . his conversation like the details of a dream in its extravagant confusion' (24). These are, of course, the hallmarks of a

toxic-confusional state, as were also the rapid fluctuations in his condition and his at times remarkable insight.

We can see too how his doctors were defeated in particular by two aspects of the illness: first, the perplexing physical manifestations by which attacks were ushered in and accompanied. These did not fit any disease with which they were familiar but made them suspect fever because tachycardia, sweating, hoarseness and agitation were prominent. And secondly, the puzzling features of the mental derangement itself which had the characteristics of febrile delirium but lasted too long. Their diagnostic difficulties came out clearly from their interrogation by a parliamentary committee in December 1810. Twenty-two years had passed since the great crisis of 1788 and with the knowledge that the King had recovered from three previous attacks they spoke with a degree of assurance their predecessors lacked. It should be added too that political steam had gone out of the illness and the form of a regency, if one there had to be, had already been laid down, so that the doctors were free to concentrate on the medical issues without fear of political repercussions. Furthermore, the old political opponents, Pitt, Fox and Burke, and the old medical rivals Baker, Warren and Willis, were dead, and medical practice and political advantage no longer hung on whether the King recovered or not, although among the Whigs the old fires blazed briefly.

To the Committee Dr Robert Darling Willis, son of the late Reverend Dr Francis Willis, Dr H R Reynolds who had attended all attacks since 1788, and Sir Henry Halford deposed that the King suffered from a 'derangement' of mind 'partaking of delirium, but never . . . of insanity'; and they added they had never seen a similar case or, in Halford's words, 'The King's case appears to have no exact precedent in the records of insanity'. Dr William Heberden junior, whose famous father had also attended in 1788, said: 'It is not merely the delirium of fever; nor is it any common form of insanity . . . the whole frame has been more or less disordered, both body and mind . . . [due to] a peculiarity of constitution of which I can give no distinct account' (25). Their thoughtful answers were wiser than they could have realized. Not until the turn of our century did advances in medicine and biochemistry allow Sir Archibald Garrod to put forward the concept of 'inborn errors of metabolism' in which inherited enzymatic defects cause disease affecting particularly the nervous system. Of these one well-known but rare type is porphyria. Attacks are always dangerous and often fatal. At their height

patients are described as 'ill, paralysed, delirious, and in agonizing pain' (26), which exactly fits George III. Indeed, his symptoms and their sequence read like a textbook case. The only feature not recorded was hypertension because blood pressure was not measured, but the repeated crises which made his doctors fear 'a paralytic stroke' or 'imminent dissolution' may well have been hypertensive. In keeping with this diagnosis of the royal malady are also: age of onset; that attacks were precipitated by mild upper respiratory tract infections; rapid fluctuations; protracted convalescence; excess of symptoms and hence complaints over signs which make patients appear demanding, irascible, and notoriously difficult to manage. Even today one-third are referred initially for psychiatric care – undiagnosed (27). To prove it the physician would examine the urine for the characteristic dark, purple, 'Coca-Cola' or portwine colour of porphobilin-like chromogens. And in the half-dozen or so instances when the royal physicians noted the colour of his water they described it as 'dark', 'bilious', 'bloody' and even on occasion saw a bluish tinge on the emptied (porcelain) vessel (28).

Contemporary Psychiatry

It is an instructive exercise to follow what doctors have made of George III's illness because it reflects the scientific and medical climate of the time. The historical or biographical method is an integral part of medical practice and especially psychiatry: every time we take a case history we use it. It is only when we come to examine the patient and submit him to laboratory tests in our diagnostic work-up, that we approach science. To apply this method to the development of psychiatry itself may allow us equally to assess its present state and possibly look into the future.

To start with the contemporary scene: the doctors thought in terms laid down by Battie in his 'Treatise on Madness', 1758, that is within living memory (29). Baker in fact proudly told the Parliamentary Committee in 1788 that he had been his pupil at St Luke's Hospital for Lunatics (18). Battie taught 'that Madness with respect to its cause is distinguishable into two species . . . viz. *Original and Consequential* . . . The first is solely owing to an internal disorder of the nervous substance: the second . . . owing to the same . . . being disordered *ab extra*'. This was the beginning of the modern distinction between functional psychoses and organic mental states. The latter were further subdivided – as they are today – into acute delirious states accompanying fevers, subacute conditions or toxic-confusional states called 'derangement', and the chronic or

dementias. Battie's 'Original Madness' was what Warren called a 'direct lunacy'. Baker clearly thought the King suffered from 'Consequential Madness' from his observations of the beginning of the illness but could not say consequent on what. Willis attributed the illness to 'Twenty-seven Years . . . weighty Business, severe Exercise, and too great Abstemiousness, and little Rest' (18). His grandson later explained that what he had meant was '*delirium and derangement cum febre*' (30). John Hunter, surgeon extraordinary to the King, judged 'that at the end . . . it would probably come to some sort of crisis, by which it would appear whether there was strength enough in the constitution to prevail over the disease', and 'that it would be very bad luck indeed if he did not recover', implying that it was a derangement '*ab extra*' (6). In this sense too Dr Anthony Addington argued that it was not mania 'from this Circumstance – that it had not for its Forerunner that Melancholy which usually precedes a tedious Illness of this Sort' (18).

Other medical men voiced their opinion in books. Dr Robert Jones early in 1789 wrote and hastily sent the King a copy of his 'An Inquiry into the Nature, Causes, and Termination of Nervous Fevers . . . with observations . . . [on] the method of restoring His Majesty to health, and of preventing relapses of his disease' – on Brunonian principles of which he was an exponent (31). Dr Andrew Harper in his 'Treatise on the Real Cause and Cure of Insanity' considered 'Insanity . . . a disease *sui generis*' dependent 'upon some specific alteration in the essential operations and movements of the mind, independent . . . of every corporeal . . . irritation within the brain' which caused the delirium of fever from which the King suffered (32). And he chided Willis for confusing the two. Dr William Rowley concluded that the royal malady resembled what he had described as 'a new species of temporary madness' (33), a derangement without fever caused by 'some prevailing irritating acrimony' – the toxins of today – settling upon the brain and differing from 'the true inflammatory phrenitis' by 'being destitute of fever' (34). Dr William Pargeter too argued that 'this case could not have been *maniacal*' since undoubtedly fever had been present at the commencement and by ancient usage insanity was 'delirium without fever' (35). Dr William Black revised his notes gathered from examining the records of some three thousand patients admitted to Bethlem Hospital between 1772 and 1787, which he had originally assembled for his highly original work on medical and vital statistics (36), in order to calculate the prognosis of 'insanity'. This had never been attempted before and Black's public

letter to Pitt and Fox (to show his political impartiality he sent copies to both) marked the beginning of the application of the statistical method to psychiatric problems (37):

'The opinions . . . of Medical individuals, as to the consequence or duration of the malady', he wrote, 'are as far inferior to numerical calculation in ascertaining truth or probability, as the Oracles of old were to the demonstrations of Euclid'. He concluded, 'to use the language of calculators and annuitants [the statisticians of today], that the odds in this malady are as follows: Against cure, within one year, about 3 to 1; against death, in the same period, from 6 to 9 to 1; against relapse when cured from 5 to 1; but after two years continuance of the disease without any lucid intervals, the odds will be multiplied far beyond the duplicate ratio, and will be from 50 to 100 to 1 against cure'.

Astonishingly a group of drugs which dominates the psychiatric scene in our time also owed its name to George III: it was as a remedy for him that Dr Edward Suttleff recommended his 'herbaceous tranquillizer' (38). The royal malady also inspired the first therapeutic trial of a new method 'for the relief of persons afflicted with insanity'. Although a secret at the time, it consisted in cold douching of the head with the patient sitting in a warm bath. Its advocates were Messrs Delahoyde & Lucett and it was sponsored by two royal Dukes – Kent and Sussex (39). We cannot here describe how the illness and its medical, social and political ramifications filled the newspapers and periodicals. Nor can we trace how the thread of the royal malady runs through much of the large output of psychiatric literature and writings on nervous diseases which followed.

The Poor and Mad

The royal malady naturally also directed public attention to the plight of the poor and mad. One leading spirit in this philanthropic concern was the Honourable George Rose, one of King George's closest personal friends. It was he who managed to persuade Parliament to set up the famous 'Committee on Madhouses' which sat from 1815 to 1817 and he chaired it. The wealth of psychiatric data and experience, especially of institutional care, which it brought to light and published, paved the way to what became known as the asylum era of psychiatry which lasted well into this century. From it derived much of what we know or think we know of psychiatry to this day, including the classification of so-called mental illnesses, to which we still adhere. But by isolating the patient whose illness caused social disruption or incapacity, it created artificially two orders of disease, each with its own specialist – the physical and the mental – and so unhappily set psychiatry apart from medicine and divorced

psychiatrists from physicians in space and spirit. The greatest overall service – if one may so express it – the royal malady rendered psychiatry was that it dragged the ‘the mad business’ out of obscurity and ill-repute into the limelight of respectability.

Nineteenth and Twentieth Century Studies

The first psychiatrist who studied the illness from the asylum background was Dr Isaac Ray in 1855 in his presidential address to the Association of Medical Superintendents of American Institutions for the Insane (now the American Psychiatric Association). He approached it from the experience the newly gained asylums offered for close and long-term observation of the mentally ill. He therefore contented himself with giving a consecutive account of all attacks culled from the printed sources then available. He believed that a mere recital of outward ‘mental’ symptoms would suffice to make the type of illness clear and considered its nature, that is the differential diagnosis, only when he came to the royal physicians’ dilemma of whether the King was delirious or insane. He wrote: ‘The attacks . . . [were] manifested by hurry, restlessness, caprices, indiscretions, violence, and delusions. In one word . . . all the characters of ordinary acute mania’. By this Ray meant any acute psychosis or breakdown, a diagnosis no more satisfying today than to diagnose ‘fever’. But he added a significant caveat which unfortunately was not heeded:

‘Few men would have seemed less likely to be visited by insanity. His general health had always been good; his powers were impaired by none of those indulgences almost inseparable from the kingly station; he was remarkably abstemious at the table; and took much exercise in the open air. Insanity had never appeared in his family, and he was quite free from those eccentricities and peculiarities which indicate an unbalanced mind’ (40).

For Dr Arnold Chaplin some sixty-five years later: ‘The symptoms of the malady presented no unusual features. It was a case of delusional insanity attended with exacerbations of mania and followed by periods of melancholia’ (41).

By the time the next psychiatrist referred to the illness the psychiatric climate had changed considerably. At the turn of the century Kraepelin had built up a classification in which prevailing symptomatology was correlated with clinical course. He formulated two main groups of mental disorder: those which came in attacks and were marked by excitement or depression – the mood disorders or manic-depressive psychoses; and chronic disorders characterized by disturbances of thought and fragmentation of personality which he called dementia præcox and which

Bleuler (1911) renamed schizophrenia. This tidying up of accumulated asylum experience was in its time an advance and psychiatry entered its Kraepelinian era. But today its limitations should be realized.

Kraepelin’s classificatory system – one must stress – was built on prescientific medicine and the rudimentary neurology of three-quarters of a century ago: before the advent of laboratory investigations, before the days of lumbar puncture or Wassermann reaction, of X-rays and EEGs, before knowledge of deficiency diseases or metabolic disturbances, before the first case of encephalitis had been reported or the spirochæte seen in the brain, even before the significance of the extensor plantar response as an indicator of cerebral disease was appreciated. For these reasons the old labels like manic-depressive psychosis must nowadays hide more than they reveal; they cannot be regarded as equivalent to a modern diagnosis based on scientific knowledge of ætiology or pathogenesis.

In 1931 the American psychiatrist Smith Ely Jelliffe diagnosed George III as suffering from ‘a manic-depressive psychosis . . . with the manic element paramount’ (42). But no patient recovering from an attack of ‘mania’ or hypomania with its heightened sense of well-being and exaltation could have felt like George III did, for instance, after his 1801 attack. To his friend the Bishop of Worcester he wrote:

‘After a most tedious and severe illness from which, by the interposition of Divine Providence, I have most wonderfully escaped the jaws of death, I find myself enabled to write to you . . . my health is daily improving though I cannot boast of the same strength and spirits I enjoyed before’ (21).

The diagnosis of manic-depressive psychosis was taken up by another American psychiatrist, Dr Manfred Guttmacher, in 1941. By then it had also become fashionable to analyse historic figures and Guttmacher claimed the whole illness could be understood in dynamic terms. It followed that he had to presuppose that George III had a neurotic and unstable personality, otherwise he would not have had breakdowns. Guttmacher wrote:

‘From my analysis of the events preceding George III’s attacks of insanity, and of the illnesses themselves . . . it appears that frustration was the major force behind his disorders . . . Self-blame, indecision, and frustration destroyed the sanity of George III . . . He took the job of kingship too seriously . . . A vulnerable individual, this unstable man . . . could not tolerate his own timorous uncertainty . . . [and] broke under the strain’ (43).

Pursuing the psychological line, Guttmacher found no place for the physical symptoms and simply dismissed them as partly fictitious and invented by the Court, partly as imagined by the patient himself and so further evidence of his neurotic make-up.

Can Guttmacher's judgment of the King's personality really be sustained? The King's eventful life was so troubled by national affairs, not to mention his large and unruly family, that if this construction were correct, it is perhaps more surprising that he was ever sane. How could he have survived his greatest disaster, the loss of the American colonies, without a suspicion of breakdown? And how can the image of George III conjectured by modern psychiatry be reconciled with that of his people for whom he was Britain's most devoted and best informed King, musician, book collector, patron of the arts and sciences, country lover and family man?

Psychopathology and the Historian

Nevertheless, Guttmacher's thesis was adopted by historians and biographers as if it were the last word in medical diagnosis, if for no other reason than that his was the first study of the illness for a hundred years. And so it came to be universally and uncritically accepted, with the most unfortunate results for poor George III's character. For instance, Mr Watson in the standard Oxford history of the reign says: 'He lacked the pliability and easy virtue of less highly strung people. When his obstinacy encountered an immovable obstacle, all his resources were at an end and the black humor claimed him . . . Madness was but this mood in an extreme form' (44). Another biographer declared that he lived 'in a state of chronic though varying disequilibrium, with recurrent crises of extreme disorder, and ending in permanent lunacy' (45). Dr Plumb of Cambridge divined that the illness of 1765, when as has been stated, he was not mentally disturbed, was 'a total flight from reality' which he attributed to the unbearable sexual strain of marriage to a plain wife (46) – by whom incidentally he had fifteen children. No wonder that Sir Lewis Namier spoke of the 'much maligned monarch' (47).

To such absurdities may historic figures be reduced when the mutterings of a delirious mind temporarily disordered by an intoxicated brain are mistaken for the expressions of psychological complexes. The royal malady was not insanity, not mania, not manic-depressive psychosis. The psychiatric symptoms were but one manifestation of a physical disease, the bodily symptoms and signs of which were overshadowed by the

mental because of the imperfect state of medical knowledge and the unique position of the patient.

No conclusion can therefore be drawn about George III's personality in health from the fact that he became deranged; nor about his psychological situation from the occasions when he became deranged; and least of all from what his delirious mind was occupied with.

Conclusions

While historians and biographers will have to take a fresh look at George III, we as doctors may ponder on the state of psychiatry today in the light of his illness. Should we not ask ourselves to what extent there exists a separate group of disorders of the mind and whether we are not dealing with physical diseases which show early, marked mental symptoms? One may suspect that if psychiatric patients were submitted to modern methods of investigation like other patients, labels like manic-depressive psychosis and schizophrenia would soon dwindle if not disappear. Like the old and, in its time, equally hallowed diagnosis of fever, they would then be seen as symptoms of a disease process instead of being taken for the disease itself. One could take the analogy even further and remember that when causes of fever were discovered, the old methods of suppressing it by purging, vomiting and bleeding and other blunderbuss methods of shock, also went out. May we not hope for a similar development in psychiatry? This may well be the real lesson of the illness of King George III.

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