



**West Hudson Psychiatric Society**  
of the American Psychiatric Association  
*serving Rockland, Orange, Sullivan & Delaware Counties*



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# eSynapse: June 21, 2010

## Editor's Comments

James Flax, MD, MPH, DFAPA

This is our 7<sup>th</sup> issue of eSynapse. In the May issue there were 2 responses to our President's invitation to comment on the Vermont's Psychiatric Societies' proposal regarding Universal Health Care – both against. I guess no one felt strongly enough to write an affirmative reply. You could still do so, for publication in the next issue of eSynapse sometime in fall 2010. Continuing the debate is an editorial by Dr. Leah McCormack, President of MSSNY from the MSSNY eNews that Jane Kelman, MD asked to be reprinted here and a letter to Dr. McCormack written by Rick Brand that he asked us to reprint. Surely one of our member's must have some comments in response.

Our President, Dom Ferro comments on the state of your district branch. The minutes of our recent Executive Council meeting are below, summarizing some of what your district branch is involved in. I've reprinted the published paper on which Dr. Nigel Bark based his talk at our June 18<sup>th</sup> meeting for those who missed the lively meeting or those who want to read further. Not included in his article is the enlightening review of the history and epidemiology of schizophrenia. There is a wise and thought provoking article by Dr. Abdullah, referencing the history of medicine and questioning our own practices in 2010.

There are a number of announcements from the APA, highlighting the many activities your national organization is involved in on your behalf that you may not otherwise know about. One is the announcement that the APA no longer is endorsing PRMS as our malpractice carrier. The rumor I heard in late May was that the new carrier, American Professional Agency, was not yet organizationally prepared to handle an onslaught of new clients. Since the due date for enrolling in coverage was imminent I sent my money to PRMS and plan to monitor what happens over the next year to make my decision about which company to use for malpractice insurance as of 7/1/2011.

Finally, I attended the June 9<sup>th</sup> meeting of the Mid-Hudson Psychiatric Society in Fishkill where we handed out the previous issue of eSynapse and our Information Brochure, "Choosing A Psychiatrist". I had a lively interchange, comparing notes on how we each conduct our business. They promise to invite us to their **NINE** meetings a year and I hope to attend. I hope some other WHPS members will also. In turn, members of the Mid-Hudson Psychiatric Society have been invited to our meetings and I hope some of them join us at our **TWO** yearly meetings and/or our monthly executive council meetings.

***IS ANYONE LISTENING TO THIS PLEA?  
PLEASE SEND ME ANY NEWS, ADS, COMMENTS, ARTICLES. I  
WANT THIS PUBLICATION TO BE AN ACTIVE SOURCE OF  
INFORMATION FOR THE MEMBERS.***

My goal in publishing is to increase communication between and among all of our members. I can only do this with your participation. I want a psychiatrist from every organization, clinic and institution in the counties of Rockland, Orange, Sullivan and Delaware to send me an article, of any length, describing any events, news, changes, presentations or opinion. That means that YOU can contribute by designating someone at your place of employment, or volunteering yourself, to send me something about where you work, how you practice, opinions about anything of relevance to psychiatrists, etc.

There are a myriad of opportunities for you to become involved in your community through your district branch. The advantages are numerous in addition to the pleasure of giving back. There is the true pleasure of working with your colleagues in psychiatry and/or in other mental health fields. There is the opportunity to be creative in developing a program around your interests. There is the joy of learning something new.

**If you are curious about what happens at the executive council meetings, PLEASE JOIN US.** Our next meeting is Friday, September 17<sup>th</sup>, 2010 at noon @ il Fresco Restaurant in Orangeburg. Contact Dr. Ferro if you are planning to come ([drferro@optonline.net](mailto:drferro@optonline.net)).

If you speak to your colleagues who are not members of the APA, remind them to become members. If members, tell them you've received your eSynapse and ask if they received theirs. If not, tell them to email me at [DrFlax@aol.com](mailto:DrFlax@aol.com) with their email address so I can add them to the list.

While some have indicated it is too costly to join the APA, I want to remind them of the many benefits of membership (<http://www.psych.org/Resources/Membership.aspx>). Membership in your district branch is one of the least costly in the nation and we hope to keep it that way. The benefits are numerous.

### **President's Column**

#### **Dominic Ferro, MD**

When I reported to you at our Fall Meeting, I spoke about improving our corporate governance. We do now have an electronic version of our Constitution and By-Laws. We are in the process of updating them as we repair our incorporation status. We are in meetings with an attorney and we expect to complete that process in the coming months.

Regarding our Treasury, this year we prepared a budget to set targets for how we allocate resources. The budget has provided us with a clearer picture of our income and expenses. In the fall, we approved an increase in our very low dues. I am pleased to say that so far we have lived within or below our budget this year. We have drawn on our internal

resources for our speaker at this meeting. Nigel Bark, M.D. has generously agreed to keep costs down by speaking for his supper. Thanks to some greater advertising revenue in our eSynapse, I am pleased to say that the Board will be reconsidering the dues increase. Hopefully, we will continue to be the very active DB that we have been and continue to do so with the lowest dues in the nation.

Speaking of eSynapse, our thanks go to Jim Flax, who has kept the newsletter going. The eSynapse has been published after each of our Executive Council meetings, making for much better communication between our Council and our membership. The electronic newsletter is inexpensive and can be published frequently. The potential for improved communication is still being realized. Jim also continues to manage our DB referral line, fielding several calls per month. This is another service to both our members and our community.

Speaking of Nigel, he has ably represented us at the APA Assembly. He has kept us abreast of what has been a tumultuous year for the Assembly, and information has been available to everyone within days in the newsletter. We are indebted to Nigel, not only for our talk tonight, but also for his work as our representative.

Lois Kroplick has resumed the co-Presidency of the Mental Health Coalition. The Coalition remains a vibrant organization, a model for advocacy. The Coalition ran another successful public forum in October, and the planning for next fall's public forum on Post Traumatic Stress Disorder is well under way. The Coalition is expressing gratitude to NAMI-FAMILYA by conducting a fund raiser for them. They have brought their energy to putting together recipes representing the diversity of our community into a cookbook, the proceeds of which will go to NAMI. The Mental Health Walk and the benefit fashion show are two other functions that have raised awareness in our community. The Mental Health Coalition continues to educate the young people of our community through numerous high school and college programs.

Mary Mavromatis has been exploring bringing our public depression screening to an event such as the Nyack street fair. This is an opportunity to educate our community and raise awareness of our presence as leaders in mental health care.

Membership remains an important issue. We are holding our own in terms of retaining members, but we need more involvement in the leadership. We have welcomed some new members to our Executive Council, but we need more. We might be able to do without more of your money, but without your time and energy, we will not survive. Please join our board. Please give us the names of colleagues who might join.

Finally, our Professional Education Committee, headed by Jane Kelman, continues to bring us together twice per year for interesting presentations. Nigel's talk was fascinating, on a topic that would not be covered by a drug company supported meeting. She has done a great job for us, and getting her husband, Dr. Rick Brand, also a member, to play a little guitar in the background is an added bonus. We are fortunate to have Jane guiding our educational meeting, and we appreciate that she is already considering speakers for our fall meeting.

It has been a good year for DB, and as Dr. Flax drummed during his presidency, it is important that we “keep it going.” Please get in touch, volunteer some time, be an active part of our West Hudson Psychiatric Society.

## **CORRESPONDENCE**

Jane Kelman, MD

Please read Leah McCormack's statement in full. I think it should be published in Synapse. Everything she is talking about was out there before it was passed, but nobody wanted to know or believe it.

### **Leah McCormack, MD, President, MSSNY, published in MSSNYeNews, 6/11/2010**

#### **The Present and Future of Medicine in 2010**

The profession of medicine is at a critical juncture. The Patient Protection and Affordable Health Care Act signed into law by President Obama is about to make massive changes in the practice of medicine, and it is not clear what those changes will be.

Despite its 2700 pages, the law apparently is being crafted as it goes along and we may not be happy with the results. Let me say from the outset that I know the health system needs reform. But I do not believe it needs to be completely demolished and reconstructed, and I certainly do not believe the government will do a better job of caring for the health of the citizenry than physicians.

Since the Healthcare Act is now the law and since we believe in the rule of law, we must either follow the law or we must repeal it or try to amend it. It is very troubling to learn that the basic premises of the law are flawed.

We, the people, and the Congress were told that the law would "bend the cost curve downward" and that we would be able to pay less and get more health care. The cost of the legislation has been underestimated. The cost of the doctor fix has been omitted, Medicare cuts have been counted twice, and the number of people who will probably move from job-based coverage into the subsidized insurance exchanges are underestimated.

The Dartmouth Study, which was extolled as showing that Americans pay more money for worse care than in other countries, has now been debunked. It turns out that the study evaluated only cost, not quality of care.

The director of the Congressional Budget Office, Dr. Douglas Elmendorf, has advised that the cost curve will continue to rise, and that the legislation will increase the federal budgetary commitment to health care. Those with health insurance will have less money to spend on other needs; it will be harder for the uninsured to buy insurance, and government spending on Medicare and Medicaid will break federal and state budgets.

We are being told that new payment and delivery systems will improve care and decrease costs. The move is away from fee-for-service to bundled payments, global budgets and accountable care organizations.

These will start out as demonstration programs with voluntary physician participation, but the law gives the Secretary of HHS the authority to expand the scope and duration of these new models, including the authority to expand them nationwide. The Independent Payment Advisory Board has broad powers with no administrative or judicial review of its decisions.

Doctors are justifiably fearful of the new law since the full force of the government may be brought against those who do not comply. I read in the AMA Health System Reform Insight Bulletin of June 3<sup>rd</sup>, that the new law contains integrity provisions that are retroactive to Jan. 1, 2010. It was chilling to read, "It is essential that your practice take immediate steps to comply with them, including consulting with legal counsel (as appropriate), since failure to implement these provisions can result in denial of payment, civil or criminal liability, and/or exclusion from federal health programs."

Even more troubling were the changes to the intent standard such that it is no longer necessary to prove that an individual had actual knowledge of the statute and intended to violate it in order for liability to be established.

I have spoken out against the new law because I do not believe it will improve care for our patients and because I believe it will further erode our profession. Also, I do not think the cost is sustainable and do believe it will be an unbearable burden on future generations.

I know that there are many physicians who believe that the government can make positive changes in the health care system and I respect their right to their opinion. In a democracy, dissent is healthy.

Those of us who dissent have been accused of being backward thinking, much like the buggy whip manufacturer who refused to retool even after the development of the automobile. We have been dismissed as dinosaurs who are doomed to extinction because we do not want to acquiesce to the coming changes.

Worse yet, those who dissent are accused of not having a social conscience and of not caring about patients or the plight of the uninsured. Physicians are so generous. They render untold amounts of charity care. The current system today is only being sustained because of the altruism of physicians.

It amazes me that physicians are viewed as villains who need to be shackled and controlled by rules and regulations. Physicians are not respected by many of our government officials, hospital administrators and insurance companies.

Everything I read from the government and in the press paints us as greedy, willing to perform any test or surgery, whether necessary or not, just to make

money. I care about my patients as I know you do also and I have always tried to do the right thing for them.

I am opposed to the new law because I do not believe it is patient-centered, and I think that health care will be run by bean-counters and petty bureaucrats. Cost, not quality, will be the main consideration, and rationing will rule the day.

President Obama's nominee to head the Centers for Medicare and Medicaid Services, Dr. Donald Berwick, is a strong proponent of the British National Health Service, and is open to the idea of rationing. I can choose not to practice medicine, but I do not have much choice about being a patient and I do not want to be a patient in the health care system this law will create.

Just as managed care soon became managed cost, accountable care will become accountant care. And to whom is accountable care accountable? Health care should be accountable to the patient. Decisions should be made by the patient in consultation with their physician. Government and other third parties should not be in the exam room, interfering in the doctor patient relationship.

I think that there is only a small window of time for physicians to act to preserve the profession. The long years of rigorous training, with standards of quality and ethics set by the profession, and the ability to set one's own fees, are hallmarks of a profession. The gradual change from physician/professional to doctor/employee that started with managed care will be completed in the new health care system.

The system will indoctrinate medical students to give more consideration to the system than to the patient. Less costly, less trained non-physician providers will use cook-book formulas to treat patients. So much effort will be expended on compliance and electronic records that innovation and contemplation of patient problems will suffer.

At least for now, physicians are still necessary. Some of us may decide for ourselves that we do not wish to practice in this new environment. I hope we do not discover too late the kind of doctors and the kind of care that the new system will produce.

What can we do? We need to educate our patients, friends, families, colleagues and legislators. We need to write letters to the editors of our local papers and to our elected officials. We need to elect legislators that will make the needed changes to the health reform act. We need to demand that there be no interference in the doctor-patient relationship.

We need to insist that the determination of the quality of medical care be made by the profession, not by government or other third-party payors. We must have medical liability reform. Physicians should be able to collectively negotiate. We must have the ability to set our own fees. Patients and physicians must be allowed to privately contract without penalty.

As an individual, it is very difficult to bring about change at the state or federal

level. We must use our medical societies as the agent of change. There is strength in numbers. Please ask a non-member colleague to join the Medical Society. Please make a donation to MSSNYPAC. We need you now— more than ever—to join with us.

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Richard Brand, MD

This is a letter I wrote to Leah McCormack, the president of MSSNY, in response to her column in the last MSSNY enewsletter, in which she excoriated the health bill (after the fact). I included a copy of her article below mine. I would appreciate it if this was included in the next eSynopsis.

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Ms. McCormack, I read your column (below) with great interest and some anger. MSSNY dropped the ball. I knew what Obama's bill would do to health care before it was passed and I went to Washington DC to protest against it. I'm just one doctor, a single voice. You are the president of a statewide physician organization with staff and resources and you speak for many. Did you really believe Obama, Reid and Pelosi could give us more for less? Where have you been? What were you thinking? Is this the kind of leadership we should expect from MSSNY?

You ask what we should do and suggest education, a letter writing campaign. That is as inadequate as MSSNY's failure to fight against this 2700 page travesty before it was rammed through. Nobody is listening to the doctors. Obama has portrayed us as cutting off people's feet for cash instead of treating their diabetes, and of removing kids' tonsils instead of giving them medication. We are Big Medicine, victimizing everyone. That is who we are up against. The president is naively misguided at best and cynically deceptive at worst.

Are you prepared to commit the resources of MSSNY to defeat the Democrat party that gave us this manure sandwich? Are you prepared to suggest that doctors bargain collectively, with or without legislative permission, or leave the system en masse, or refuse third party reimbursement entirely, or anything else decisive in concert with what we know is right, to take back medicine by force if necessary?

That would demonstrate leadership. Or is your post just words? Do you think we should continue to let them push us and our patients around forever? If we fail to act, more will suffer later, as we ration more and deliver less care as we are ordered. We are being slowly nudged into sickness and death. What kind of care does our privileged Congress receive? Do they deserve better than our patients? They think they do.

Perhaps we should follow the model of other unions and demand the right to treat patients the way only we know how and to be paid for our commitment and work, just like teachers, police, nurses and others. Remember, without us, there is no health care.

We cannot defeat this bill without defeating those who gave it to us. A letter writing campaign? Useless, impotent. If you cannot discern and recommend decisive action, you should resign as president of MSSNY. The gloves must come off. This is not an intellectual exercise. It is a war to save the health and lives of our patients and one inexperienced, misguided president is quite enough.

**West Hudson Psychiatric Society**  
**Summary of Executive Council Minutes**  
**Il Fresco Restaurant, Orangeburg, NY**  
**Date: 6/4/2010**

Present: Diane DiGiacomo, Lois Kroplick, Syed Abdullah, Dominic Ferro, Jim Flax, Nigel Bark, Mary Mavromatis, Susan Hoerter, Jane Kelman, Lena Haber

Absent: Richard Brand, Mona Begum, Madhu Ahluwalia, Marc Tarle

1. Distribution of agenda and minutes: minutes of 4/30/10 meeting accepted
2. President's report: Dominic Ferro
3. Public Affairs: Lois Kroplick. The MHC board met yesterday. The forum will be held on 10/20 and there will be a speaker from NKI/NYU. The MHC is also working on a cookbook. 200 recipes have been submitted. The Mental Health Parity walk was very successful, over 300 people attended. NAMI is holding a fashion show on 6/16 at 5:30 at The View.
4. Membership/Mentoring: Dominic Ferro
5. Private Practice: Jim Flax will be attending the Mid-Hudson Psychiatric Society meeting on Wednesday 6/9, other board members are welcome to attend.
6. Assembly: Nigel Bark
7. Professional Education: Jane Kelman. The spring meeting is in two weeks. June 10 is the deadline to register. Jane will remind the usual attendees to register. Currently 17 people registered, maximum is 35. Nigel Bark will be the speaker. The meeting will be held at La Terraza. Let Jane know if you have any thoughts about topics for next fall. Mary suggested the idea of evaluation and management coding, Jim suggested a speaker from NYSPA, Lois suggested the APA president Carol Bernstein and Jane will look into it. Names and phone numbers of people to be contacted to see if they will attend the spring dinner were distributed.  
The next women's meeting is scheduled for 6/11 at 12:15 in Madhu's office.
8. Synapse: Jim Flax encourages everyone to submit articles for Synapse.
9. Depression Screening: Mary Mavromatis spoke with the contact person from Pickwick Bookstore. There are a limited number of spots for non-profit organizations and preference is given for Nyack-based organizations. We will be offered a spot only if there is one available after the Nyack-based organizations sign up. The idea of doing the screening at the Septemberfest instead was discussed. Mary will contact the organizers of the Septemberfest about the date. Mary will check to see if moving our post office box to Nyack would qualify us to be a Nyack-based organization.
10. Information from the District Branch: Diane DiGiacomo will forward this information to Jim for inclusion in Synapse
11. Newsletter: Syed Abdullah: Syed is working on writing articles for Synapse
12. Treasurer: Lena Haber: Lena emailed the lawyer about incorporation and will update Dom when she has more info.

WHPS Board positions are open for next year, tell your friends.

Date of next meeting: September 17, 2010 at Il Fresco

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**Assistant Vice President, Claims**  
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**Donna Vanderpool, JD, MBA**  
**Assistant Vice President,**  
**Risk Management**  
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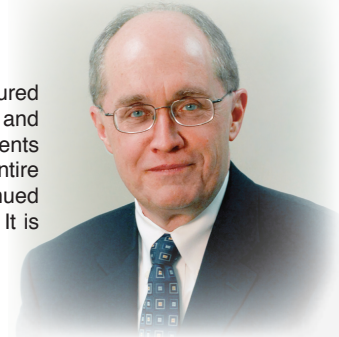
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Yes, that's right - call the president of Professional Risk Management Services, Inc. directly. How many other companies give you direct access to their president? You can also email him at [tracy@prms.com](mailto:tracy@prms.com). Best of all, he will respond to you.

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# APA Press Releases

**On Behalf Of** Ardell Lockerman **Sent:** Monday, June 21, 2010 4:13 PM  
**To:** [botnet@lists2.psych.org](mailto:botnet@lists2.psych.org) **Cc:** Irvin Muszynski; Nicholas Meyers; Eve Herold; Jaime Valora; Cathy Brown  
**Subject:** Court Decision in Parity Lawsuit

TO: APA Board of Trustees  
FROM: Eugene Cassel, Director of Advocacy  
SUBJ: Court decision in parity lawsuit

I wanted to provide the Board of Trustees some positive breaking news on the mental health parity lawsuit. On June 21, the US District Court for the District of Columbia dismissed the lawsuit filed by the Coalition for Parity, Inc. against the Departments of Labor, Health and Human Services, and the Treasury seeking to prevent application of the interim final rules on the Wellstone-Domenici mental health parity act. In her decision, the judge stated that the Departments were allowed to issue interim final rules (IFR) in order to expedite the rulemaking process given the short timeframe allowed by the law. She ruled that the IFR will stand, but stated that it was also her expectation that the Departments should move swiftly to finalize the rules by responding to 4,000+ comments submitted on the IFR and complete the rulemaking process.

Next Steps: Since the regulations are in effect, and apply generally to plans beginning on or after July 1<sup>st</sup>, we expect that plans will begin to modify their requirements to comply with the interim final rules. We will conduct outreach to our District Branches and to the business community regarding compliance. In addition, we will be communicating with the Departments again to discuss enforcement and issues we have already seen arise, as well as carefully monitoring the field for plans which are not in compliance.

*Ardell Lockerman*  
*Senior Governance Specialist - Board of Trustees*  
*APA, Association Governance Dept.*

*Tel: 703-907-8528, Fax: 703-907-7852*  
*Email: [alockerman@psych.org](mailto:alockerman@psych.org)*

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**From:** [Linda Hughes](#)  
**To:** [dbpres@lists2.psych.org](mailto:dbpres@lists2.psych.org) ; [dbexecs@lists2.psych.org](mailto:dbexecs@lists2.psych.org) ; [Kathleen Gross](#)  
; [Janet Shaw](#)  
**Sent:** Thursday, May 13, 2010 5:03 PM

**Subject: DBExecs: APA endorsed malpractice provider**

DB Presidents/Presidents-elect and DB/SA Executive Staff

I know many of you have had questions from your members regarding the transition of APA's endorsement from PRMS to a new program.

Terri Swetnam, APA's Chief Financial Officer, will respond to each of your members who have contacted the APA with questions about the new program. A message to be shared with the whole membership is currently being developed and I will share that with you when it is released. A representative of American Professional Agency, Inc., will be at the Orientation for Incoming Presidents/Presidents-elect and also will meet with those DB/SA staff who are attending the annual meeting.

Terri's message to those who have contacted the APA follows:

**We are pleased to announce the American Professional Agency Inc, as our new endorsed provider. We are working with them to finalize the details of the program. They will be pleased to coordinate your coverage and discuss your options to transition into the new Program. Your point of contact is the supervisor of their Psychiatry underwriting team, Deirdre Ferrigan. Their toll free number is 800-421-6694.**

**With your permission, I can forward your email to them so that they might be in touch – just let me know!**

**Please do not hesitate to contact me if you have any questions or if there is anything I can do to assist. And, again, I appreciate your patience during this transition period.**

I hope this information is helpful. Don't hesitate to contact Terri or

me if you have questions.

Linda

Linda Hughes  
Director, Office of Ethics and District Branch  
and State Association Relations  
American Psychiatric Association  
1000 Wilson Blvd. #1825  
Arlington, VA 22209  
[lhughes@psych.org](mailto:lhughes@psych.org)  
703-907-8589  
703-907-8677

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**Subject: Psychiatric Online Continuing Medical  
Education (CME)**

**Sent:** Thursday, May 13, 2010 1:44 AM

Dear Psychiatric Society Director:

Your members will find a useful source of continuing medical education at the Annotated List of Online Continuing Medical Education, <http://www.cmelist.com/list.htm>

We now have links to more than 300 Online CME sites offering more than 13,000 CME courses and more than 22,000 hours of CME credit. The list is updated regularly as new online CME sites and courses become available. There is no charge for accessing the list and no registration is required.

Psychiatrists will find the Psychiatry section, <http://www.cmelist.com/psychiatry.htm>, of special interest.

Please contact me with questions or comments.

Bernard M Sklar, M.D., M.S. [bersklar@netcantina.com](mailto:bersklar@netcantina.com)

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**From:** [Allison Moraske](mailto:Allison.Moraske@psych.org)

**To:** [dbexecs@lists2.psych.org](mailto:dbexecs@lists2.psych.org)

**Sent:** Friday, May 14, 2010 8:39 AM

**Subject: DBExecs: PRESS RELEASE: Scott-Sullivan  
Legislation Would Allow for Patients to make More  
Informed Decisions about their Health Care**

**For Information Contact:**

Eve Herold, 703-907-8640

May 13, 2010

[press@psych.org](mailto:press@psych.org)

Release No. 10-38

Jaime Valora, 703-907-8562

[jvalora@psych.org](mailto:jvalora@psych.org)

## **Scott-Sullivan Legislation Would Allow for Patients to make More Informed Decisions about their Health Care**

**ARLINGTON, Va. (May 13, 2010)** – The APA was pleased to see Congress introduce legislation today that works to ensure patients have accurate information about the education, training, and qualifications of the professionals who provide their health care.

The APA and a broad coalition of medical specialty organizations, including the American Medical Association, supported H.R. 5295, the Healthcare Truth and Transparency Act of 2010, which was sponsored by U.S. Reps. John Sullivan *R-Okla.*, and David Scott *D-Ga.*

The legislation clears confusion and promotes an informed patient population by requiring all health care professionals, including physicians, to disclose their qualifications and licensure in all advertisements. The bill will also empower the Federal Trade Commission to combat deceptive or misleading advertisements that misinform patients about a health care professional's level of training.

“Patients living with mental illness can easily be confused about the level of qualifications of health professionals, and are especially vulnerable to fraudulent advertising,” said APA President Alan F. Schatzberg, M.D. “This bill will help Americans better understand the types of care that are provided by different professionals, and allows

them to have more manageable expectations in terms of the care they are going to receive.

In a Rep. Sullivan’s statement, he explained, “H.R. 5295 simply holds all healthcare providers to the same truth-in-advertising standards as every other provider of a good or service in the United States – that is something that will benefit anyone who seeks medical care.”

Rep. Scott issued the following statement, “The passage of health insurance reform brings millions of new patients into the healthcare system. This means that thousands of new health care professionals need to be trained annually to address the demand for health services. It only makes sense that the health consumer be empowered to make decisions based on accurate information about their service provider. This legislation gives patients another layer of certainty about who is providing services for them.”

The American Psychiatric Association is a national medical specialty society whose physician members specialize in the diagnosis, treatment, prevention and research of mental illnesses including substance use disorders. Visit the APA at [www.psych.org](http://www.psych.org) and [www.HealthyMinds.org](http://www.HealthyMinds.org).

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### **APA Submits Comments to Ensure Patients Don’t Lose Coverage in the Details of the Parity Regulation**

**ARLINGTON, Va. (May 3, 2010)** – The American Psychiatric Association (APA) submitted Interim Final Rule (IFR) comments today on the mental health parity law to help ensure the law is implemented the way it was intended— to provide equal access to mental health care for individuals with mental illnesses.

“The APA worked for years to pass parity—perhaps the most important piece of legislation for our patients,” said APA President Alan F. Schatzberg, M.D. “We are very pleased with the rule, but we need to work with the various federal government departments to properly implement some of the remaining details so full parity is preserved for our patients. We particularly need to ensure that any loopholes that can be used to deny access to parity are eliminated.”

The APA's comments on the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) were submitted to the Departments of Labor, Health and Human Services and Treasury and recommended the following:

**Six Benefit Classification Scheme:** The IFR requires that plans have six classes of benefits for all services and that insurers must offer mental health/substance use disorder benefits in any classification for which they offer medical/surgical services. APA supports the scheme and believes the classification system is logical. APA also urges the Departments to clarify that these classifications must cover all of the benefits provided by the plan to minimize any risk that insurers will attempt to invent new categories for the purpose of avoiding the intent of the law. To achieve this, the Departments should clearly state that a plan may not exclude a particular service or benefit simply because it does not fall squarely into one of the six classifications proposed because there is no analog on the medical/surgical side.

**Single Deductible:** The IFR requires a single deductible for all health care costs. APA strongly supports the requirement that plans offer a single combined deductible for all health care costs as we believe it follows the intent of MHPAEA and will greatly benefit patients. This protection would most directly benefit those with serious and persistent mental illness, many of whom have co-morbid medical and surgical conditions and would have difficulties meeting two separate deductibles. APA believes that separate deductibles only serve as a barrier to accessing mental health treatment and would undermine the law.

**Non-Quantitative Treatment Limitations (NQTLs):** The IFR proposes restrictions on so-called "NQTLs," such as medical management, formulary design, preauthorization, and step therapy, which are means of limiting or denying a patient access to appropriate and necessary care. Even before the law is implemented, APA members have had insurers in multiple states demand that they sign unprecedented agreements to accept prior authorization and related requirements when no such conditions were demanded of physicians on the medical/surgical side. Thus, APA believes that regulation of NQTLs is a critically important issue under MHPAEA and that the law requires that they be regulated in the same manner as quantitative treatment

limitations, such as frequency of treatment, number of visits, and days of coverage. APA recommends the Departments finalize the requirements imposed on NQTLs in the rule and also clarify that they are subject to the same “predominant” and “substantially all” standards as quantified treatment limitations. APA also urges the Departments to add to the list of NQTLs which are covered under MHPAEA.

**Availability of Plan Information:** MHPAEA includes a requirement that plans must disclose the reason for any denial of reimbursement or payment for services with respect to mental health/substance use disorder benefits, if requested. However, patients have encountered significant delays in receiving the required disclosure when requested and APA therefore requests that the Departments clarify this requirement. Specifically, APA urges the Departments to require that information regarding the plan’s medical necessity criteria be provided to the insured within three days of an adverse care decision.

**Application to Medicaid Managed Care Plans:** APA has significant concerns that the Departments have omitted an essential part of the regulations under MHPAEA, namely the application of these regulations to Medicaid managed care plans. Given the high percentage of Medicaid beneficiaries whose benefits are administered through a managed care program and the high number of Medicaid beneficiaries with mental illness, APA believes the lack of regulation in this area could be confusing at best and also potentially harmful to patients. We urge the Departments to move swiftly to issue regulations for this segment of the population and recommend that these regulations and guidance be consistent with those issued under MHPAEA.

**Preemption and State Laws:** APA agrees with the Departments that MHPAEA should not supersede the application of stronger state laws on parity and urges the Departments to include this guidance in the final rules.

**Cost Exemption:** MHPAEA permits an exception to the mental health parity requirements for plans that experience a cost increase of two percent in the first year of implementation of parity and one percent in subsequent years. APA recommends that the Departments clarify in the final rule that any application for the cost exemption must be retrospective and based on actual costs incurred, as opposed to projected or estimated costs.

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## **President Washington's Last Illness**

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Almost nothing is certain in medicine. Yet the best meaning physicians have continued to search for the certainty to cure the patients under their care. Sometimes well-established procedures in medicine and surgery have proven to be devastating in outcomes. Blood letting was an established method of treatment for a multitude of disorders from the time of Galen, the Greek physician. In America it was popularized anew by no less a person than Dr. Benjamin Rush, the 'father' of American Psychiatry. It became an edict which hardly any one dared to challenge.

In mid-December of 1799, when President George Washington developed a sore throat, he sent for one of his overseers, Mr. Albin Rawlins, to perform a blood letting while the arrival of the doctors was awaited. Mr. Rawlins had extensive experience of the technique having performed it on slaves when they got sick. Martha, the President's wife begged that too much blood should not be taken. But the President signaled to Rawlins to go ahead and urged him to do what he was called to do. After some hesitation, Mr. Rawlins proceeded to draw about a pint of blood, with no visible sign of improvement in the patient's condition.

The first physician to arrive was a lifelong friend of the President, Dr. James Craik. He examined the patient and commended the treatment already administered but thought that enough blood was not taken out. He therefore proceeded to draw some more blood besides producing a blister of Cantharides on the throat. As the general could now swallow a little, he was given Calomel and Tartar emetic to purge him, another one of the 'certain' remedies.

The next physician to arrive was Dr. Gustavus Richard Brown, the two doctors, after a brief consultation, agreed that the patient needed more bleeding and proceeded to do so. The condition of the patient showed no improvement, but this did not deter the two as they were following the established method of treatment, certain about its validity. Dr. Craik bled the patient some more. The third doctor was Dr. Elisha Cullen Dick of Alexandria. Dr. Dick, who at 37 years age, was the youngest of the three, diagnosed that Washington was suffering from "a violent inflammation of the membranes of the throat, which if not arrested immediately would result in death." He suggested the opening of the trachea below the inflammation so the patient could breathe. The two senior physicians

consulted and decided against the procedure. Dr. Dick pleaded that he would take all the blame upon himself for any untoward outcome of tracheotomy, still the other two did not agree.

Dr. Dick then advised that no more blood be taken. He said he did not deny the therapeutic benefits of bleeding but felt that it should be applied to the elderly only sparingly. "Mr. Washington needs all his strength - bleeding will diminish it." This plea was disregarded by Craik and Brown. Washington was bled again - this time the blood ran very slowly and appeared very thick. The patient became weaker, and as the afternoon wore on, the pain and the difficulty in breathing worsened. Summoning all his strength he whispered, "I am just going. Have me decently buried, and do not let my body be put in the vault in less than three days after I am dead." That night, around midnight George Washington breathed his last. He perhaps died of inflammation of the epiglottis, and shock from loss of blood, and dehydration. A total of over five pints of blood was removed from him; besides, the purgative action of Calomel had further depleted his body fluid and electrolytes.

Later, after he had time to reflect on the events of the day, Dr. Craik wrote to Dr. Brown they should have listened to the young Dr. Dick. "Had we taken no more blood from him, our good friend might have been alive now. But we were governed by the best light we had; we thought we were right, and so we are justified."

The point of the above narrative is that the medical science at that time had reached a consensus that bleeding was a panacea to be applied in a wide variety of conditions. If the patient did not respond, more of the same was to be done. Martha, a lay person, and the young Dr. Dick were the two dissenting voices which were over-ruled by the senior doctors who were certain, and rightly so, that what they were doing was in accordance with the practice of the day.

Early in the 20th century we were confident in the knowledge that rational thinking would solve many of our ills. Science would provide an abundance of food and energy. Peace and prosperity were within reach. Certainty was the Zeitgeist of this early modern period. Then we went on to have two world wars, and many lesser ones!

Today, 100 hundred years later, we face environmental deterioration, emerging infections and doubts about the earth's ability to sustain us. This transition from certainty to uncertainty has been a rude awakening. David Peat, a physicist, independent researcher, consultant and recluse, in his book: From Certainty to Uncertainty traces the works of Kelvin, Bohr, Einstein, Russell and others and how their Newtonian ideas had to yield to uncertainty with the birth of quantum theory and Heisenberg's uncertainty principle.

Although Peat's expositions may not seem to have any compelling relevance to

clinical medicine, his dialectic is worth paying attention to. Practice parameters, schedules, and regulations imposed by HMOs limit our thinking to narrower channels. The pressure of Pharmaceutical firms' 'breakthroughs', presented to us by their chosen and paid advocates from academia, further shackle our perspectives. Examples of ambiguity and uncertainty are many in the health care field. We are now forced to question our dearly held convictions about hormone therapy, benefits of mammography and screening the asymptomatic patients. There is a creeping venality in academic medicine and research that is ridden with conflict of interest. We often find that rule-based medicine is stifling and we are forced to inculcate a few healthy doubts about our mission, which is potentially energizing and may promote inquisitiveness and innovation.

## **Did schizophrenia change the course of English history? The mental illness of Henry VI<sup>\*1</sup>**

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### **Abstract**

Henry VI, King of England, at age 19 founded Eton College and King's College, Cambridge. At 31 he had a sudden, dramatic mental illness in which he was mute and unresponsive. Before, he had been paranoid, grandiose, and indecisive. After, he was apathetic with deterioration of ability, drive, interest and self-care, and hallucinations and religious delusions. This illness, which is consistent with a diagnosis of schizophrenia, robbed Henry of his personality, his crown, his wife, his only son, and his life. It led to three decades of brutal fighting for the crown (the 'Wars of the Roses') that resulted in a new dynasty with a dramatic impact on the country: the Tudors, Henry VIII, and Elizabeth I and their descendants. Henry's story illustrates how schizophrenia can devastate individuals and families and change the course of history and yet it raises questions about how achievement and illness are related.

### **Introduction**

Henry the Sixth lived from 1421 to 1471. He was King of England from 1422, when his father Henry the fifth died, until 1461 and again briefly in 1471. He founded King's College, Cambridge and Eton School. During his reign, England

lost all its French Territories, except Calais and there was the first people's rebellion in 70 years. Henry had an episode of mental illness with extreme withdrawal at the age of 31 that lasted a year and a half. After this, rival factions fought over the throne intermittently for 30 years (the Wars of the Roses) with dramatic consequences. Henry has generally been blamed for all these things being considered a weak, inadequate, and unduly pious king.

Although Clarke, a historian of mental disorder in earlier Britain, concluded that Henry VI had schizoid personality and schizophrenia [1] neither historians nor psychiatrists took much notice. Henry's two modern biographers appear to neither accept it nor consider it important. One discusses the diagnosis in a brief footnote ('depressive stupor') [2] the other in a few lines ('may be katatonic schizophrenia but fruitless to speculate') [3]. They struggle, considering Henry's early creativity and liveliness, to explain his personality as weak, inadequate, and misguided. One historian of the 'Wars of the Roses' [4] does recognise that the view of Henry as 'foolish and incompetent... willfully a failure... judges him in the light of the last eight years of his life'. None of them recognise the possibility of a diagnosis contributing to understanding what happened to Henry and to the country at that time.

This paper aims to demonstrate that schizophrenia explains Henry VI's illness, his personality, and the consequences; that he did not have a pre-existing schizoid personality; and that this is helpful for historians and psychiatry. This is unashamedly a fifteenth century 'case' being presented to a twenty-first century readership with as many contemporary descriptions as possible. Readers can decide if they agree that Henry had schizophrenia, following Berrios' admonition that 'the clinical historian should seek to determine which past 'symptoms' were... the product of a cultural quirk... and which described biological signals' [5].

Some historians and social scientists claim that this exercise is neither possible nor legitimate. They see mental illness and its symptoms as purely relative or cultural constructs. Berrios states that this is erroneous: that there is a biological source engendering a dislocation of behaviour with culture-related variations and interpretations [6]. Schizophrenia has a recent, 'western' name but there is good evidence that the concept of schizophrenia is recognisable in very different cultures and times [7]: for example, in the Yoruba [8], Eskimo [8], and Xhosa [9]; and throughout recorded history [10, 11, 12 and 13]. Some experts even see schizophrenia as an essential part of being human: arising with art and religion as the brain increased in size with the help of phospholipids according to Horrobin [14] or related to the development of language according to Crow [15].

Schizophrenia is a specific way all humans react to particular combinations of genes and environmental and psychological stressors.

Concepts of mental illness do change over time and one name may be given to different concepts at different times [10 and 16]. Theories of causation and biases of observers certainly affect descriptions of symptoms but when people in the Middle Ages had to diagnose mental conditions for legal and financial reasons they used methods and reasoning remarkably similar to ours with ascription of causes (head injury, alcohol, poison, and psychological trauma) fairly free of superstition or religion [17 and 18]. The contemporary descriptions of Henry VI were no doubt coloured by their authors' support or opposition to his claim to the throne or to sainthood but there is no reason to believe they were totally made up. They can be used with caution as descriptions of Henry's behaviour.

### **Family and personal history**

This is essential to understand personality and mental illness. On Henry's father's side were strong, ruthless characters with no known psychosis but possible dementia in old age. Henry's mother died at the age of 36 having 'lost her wits' in her terminal illness. Her father, Charles VI of France, had 44 episodes over 30 years of psychosis, mania, and depression [1, 19 and 20]. Charles' wife, Henry's grandmother was 'timelessly dissolute'. Henry's maternal great grandmother, was perhaps psychotic.

Henry's parents, Henry V of England and Catherine, were married in France in 1420 when there was a very severe winter and famine but they left for London in February 1421 for Catherine's coronation, before she became pregnant. As soon as she was pregnant, Henry V returned to France to continue his conquests. Their son, Henry VI, was born on December 1421 at Windsor Castle.

Catherine returned to France around May 1422, leaving her baby at Windsor. Henry V died of dysentery in August 1422 never having seen his son. Dame Alice, an expert in 'courtesy and nurture', was one of the many nurses and attendants appointed to care for the infant King. When he was six he had knights and masters appointed to care for him, with boys 'fostered' to live with him. He had a close friend, Gilles of Brittany, who lived with him until he was 13. Despite these formal arrangements for his upbringing at court, his mother remained close.

At the age of two, he made his first official attendance at Parliament. At seven, he had an elaborate and long coronation in London, repeated in France at 10. At 11 he presided over parliamentary debates and was officially rebuked as too precocious. At 13, he was described as 'robust and handsome' with 'great

understanding', chatting confidently with ambassadors but he was told he was not as capable as he thought he was. At 14 he was participating in national decisions and at 16, he was, in practice, king and criticised for unwise pardons. Henry's mother Catherine had remarried, to Owen Tudor, in about 1429. When she died in 1437 her husband was put in prison due to official disapproval of the marriage. However, Henry had his stepfather released from prison and made provisions for him and his sons. In 1439, he overruled his powerful uncle, Duke Humphrey, to seek peace with France. In 1440, aged 18, he founded Eton College and in 1441, he founded King's College, Cambridge. He was very active in the design and management of both. In 1442, he petitioned the pope for canonisation of King Alfred.

At this time he had a household of 1200. He enjoyed its elaborate ceremonies and personally wrote its much praised procedure manual! He enjoyed falconry and renovated a hunting lodge.

In 1445, aged 23, he chose Margaret of Anjou (aged 15) to be his wife and they spent a lot of time together in the next few years. In 1448, Margaret, following her husband's example, founded Queens' College, Cambridge.

### **Signs of trouble**

In his 20s, Henry was becoming indecisive and less involved in government. For example, in 1448, after the Pope had approved his recommendation for Bishop of London he changed his mind and recommended someone else. His indecisiveness was one of the many contributory causes of the loss of French territories by 1453 and to the people's rebellion in 1450.

In the early 1440s, Henry vindictively and cruelly punished critics and his aunt, the wife of Duke Humphrey. In 1447, he thought Duke Humphrey was going to kill him and had him arrested. He made very grandiose plans for the expansion of King's College in 1446 and of Eton Chapel in 1449 to make them bigger than all other cathedrals or colleges. By 1449, critics were calling him witless.

### **Major illness**

In 1453, age 31, Henry '...fell by a sudden and accidental fright into such a weak state of health that for a whole year and a half he had neither natural sense nor reason capable of carrying on the government and neither physician nor medicine could cure that infirmity' (Giles Chronicle, [21]). He '...suddenly was smitten with a frenzy and his wit and reason withdrawn' [Bele's Chronicle [2]]. After six months, his three-month-old son was presented to him for a blessing several times but '...the King gave no manner answer...all their labour was in vain, for they departed thence without any answer or countenance, saying only that once he looked on the prince and cast his eyes again, without any more'

[Paston letter [21]].

After nine months, a deputation from parliament spent time with him before and after he dined and again after '...he was led between two men into the chamber where he lieth...'. They expressed '...the great desire for his health, and the great diligence of the Lords in this Parliament'. Despite all their 'entreaties, prayers, desire, lamentable cheer, exhortation, moving, and stirring by all wiles and means they could think of...they could have no answer, word nor sign; and therefore with sorrowful heart come there way...' [Rolls of Parliament [2, 21 and 22]].

After 17 months, '...the Queen came to him, and brought my Lord Prince with her. And then he asked what the Prince's name was, and the Queen told him Edward; and then he held up his hands and thanked God thereof. And he said he never knew till that time, nor wist not what was said to him, nor wist not where he had been whilst he had been sick, till now.' [Paston letter [21]]. Others reported 'he spoke...as well as ever he did; and when they came out they wept for joy.' [Paston letter [21]].

There was a six-month recurrence a year later.

### **After the major illness...**

...he talked appropriately, was not considered ill, and was physically healthy but he was never again active as King. The following are contemporary descriptions: '...the king was simple and led by covetous counsyle...the queen with such as were of her affynte revolved the reaume as her lyked.' [English Chronicle 1459 [2]].

'...but of his symplehead he could litle within his brest conceyve, the good from eivill he could uneth Percyve.' (Hardynge 1459) [2].

'...his mother's stupid offspring, not his father's, a son greatly degenerated from his father, a mild spoken pious king but half witted in affairs of state.' (Abbott Wheathamstead 1461) [2].

'This puppet king—Henry was more timorous than a woman, utterly devoid of wit or spirit, who left everything in his wife's hand.' (Pope Pius 1461) [2].

'Henry was a dolt and a fool who is ruled instead of ruling. The royal power is in the hands of his wife and those who defile the King's chamber.' (Warwick quoted by Pope Pius 1461) [2].

During the second battle of St. Albans (aged 38, 1460) he was left on the side '...under a tree a mile away where he laughed and sang.' [3].

He saw 'our Lord Jesus...in human form in the sacrament of the alter in the hands of the priest...and...the Blessed Mary both corporal and spiritual.' [23].

When he was a fugitive (aged 44) after Edward IV claimed the throne '... an

audible voice sounded in his ears for some seventeen days...' describing what would happen to him... 'all of which he was informed by revelation from the Blessed Virgin Mary'. His chaplains 'were incredulous and believed it not but thought all to be vain wanderings until the event assured them of the truth' [23]. '...many...who were once of his household say that he was wont to almost at every moment to raise his eyes heavenward like a denizen of heaven or one rapt, being for the most time not conscious of himself or of those about him, as if he were a man in a trance or on the verge of heaven, having his conversation in heaven according to that word of the apostle 'our conversation is in heaven' [23]. Henry was a fugitive in northern England for several years but he was looked after in safe houses and monasteries. After his capture in 1465, he was held in the Tower of London where he was well treated with up to 22 personal attendants, including five members of the royal household, but he did nothing. When he was led out in 1470 he was 'not so worshipfully arrayed nor so cleanly kept as befitted such a prince', (Warkworth Chronicle) [2] and he passively renounced his son as his successor.

### **Apotheosis**

Henry's tomb became a place of pilgrimage and miracles. Henry VII and Henry VIII, who completed King's College Chapel in 1515, sought his canonisation. This was discussed in the London Times in 1972 and thought eminently viable [3]! In 1912, an autopsy was done during reconstruction at the Chapel at Windsor. The body was described as that of a '...fairly strong man, aged between 45 and 55...at least 5 ft 9 in. in height...' ...'to one of the pieces of the skull there was still attached some of the hair,...apparently matted with blood.' [24]!

### **Interpretation of symptoms**

Table 1 lists the symptoms of schizophrenia [according to DSM IV [25]] that I conclude Henry had. He had definite paranoid and grandiose behaviour but it is not clear that he had definite delusions. He appears to have had religious visual hallucinations (with delusional interpretation) but these carry little weight because they could equally be considered culturally appropriate examples of piety. Some auditory hallucinations, religiously interpreted by Henry, were considered 'vain wanderings' by his chaplains. The description of his almost constant 'conversation in heaven' is given a religious interpretation by his hagiographer, but is much more like the behaviour of a person with schizophrenia, internally preoccupied and hallucinating, than that of an extremely pious person.

Table 1. Henry VI's symptoms of DSM-IV Schizophrenia

In his initial illness symptoms of catatonia are described: mutism, extreme

negativism, no interaction, and perhaps immobility [25 and 26]. Catatonia may be more common in depressive illness than schizophrenia but apart from these symptoms there is no other evidence of depression. Catatonia also occurs in acute medical, metabolic, and neuropsychiatric conditions but there is no evidence for these [27]. Therefore the catatonia, with his other symptoms, supports the diagnosis of schizophrenia. Yet it was not so much this illness that had the momentous political consequences but his 'recovery' with the deficits of chronic schizophrenia [4].

It is these deficits, the negative symptoms, and course of illness that confirm the schizophrenia. After the major episode he was left passive, apathetic, with the loss of drive and interest he clearly had before and with incongruity of affect. He also deteriorated in function. He was no longer active as king and when deposed it was his wife, not he, who fought for the throne. And there is no evidence of physical deterioration or illness or neurological disorder.

His early years with friends, interests, pleasures, and social abilities preclude a diagnosis of schizoid personality disorder. The change in personality in his 20s with paranoia, grandiosity, vindictiveness, and indecisiveness or ambivalence is not uncommon in someone developing schizophrenia.

### **Consequences of Henry's schizophrenia**

Henry lost his ability to rule and he lost the crown of England in the civil war. He lost his personality and interests. His wife became embittered and died in exile in poverty. He lost his only child, killed in battle. And he lost his own life by murder. The Duke of York was appointed 'Protector' during Henry's major illness. He voluntarily relinquished this on Henry's 'recovery' but tried to reclaim it when Henry VI proved incapable of rule. The result was civil war, the Wars of the Roses, between the supporters of Henry and supporters of the Duke of York. The Duke of York was killed in battle but his son Edward IV seized the throne. Henry VI's heir (Prince Edward) was killed in battle. On Edward IV's death, his brother Richard III claimed the throne and is thought to have killed Edward IV's heirs ('the Princes in the Tower'). Henry (Tudor) VII defeated and killed Richard III in battle. Henry VII's descendants notably Henry VIII and Elizabeth I became kings and queens (see Fig. 2).

Without Henry VI's schizophrenia and the consequent lack of ability to rule, the Duke of York would not have claimed the throne and Henry VII would have been even less likely to have. There would have been no Henry VIII or Elizabeth I. Would that have precluded the English Reformation and colonial exploration?

### **Henry VI's legacy**

Eton College, considered by some the best school in Britain, educates future kings still. King's College, Cambridge, flourishes academically and its Chapel, conceived by Henry, remains magnificent and beautiful after five centuries, its music broadcast around the world. Queens' College, also flourishing, is a sign of his wife's love and admiration.

### **Conclusion**

The changes in the life of Henry VI are characteristic of schizophrenia: from precocious youth with friends and interests, ambitiously founding and designing Eton and King's Colleges, marriage and love, to increasing grandiosity, paranoia, ambivalence, and vindictiveness in his later 20s, leading to a sudden severe mental illness with withdrawal and mutism, followed by deterioration in function, apathy, and loss of interest. Henry's story demonstrates that schizophrenia is a devastating disease, occurring in all ages and classes, able to destroy personality, family, and life, and able to change the course of history. His story also reminds us of the humanity of the person with schizophrenia. He was a creator, a husband who inspired and enabled his wife to found Queens' College, and a father, albeit inadequate or absent as the schizophrenia was by then taking its toll. Finally his story demonstrates that it is possible and legitimate, and useful to history and to psychiatry, to search the past for evidence of current illnesses.

### **Acknowledgements**

Fuller Torrey's 1980 book *Schizophrenia and Civilization* (7) was the inspiration for my interest and it led me to Basil Clarke's 1975 *Mental Disorder in Earlier Britain* (1) which is the foundation from which this article was developed.

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