Person Under Investigation: Detecting Malingering and a Diagnostics of Suspicion in Fin-de-Siècle Britain

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Abstract: In 1889, The British Medical Journal published a piece titled, “Detective Medicine,” which describes feats of medical detection performed by physicians attending malingering prisoners. Though simulating illness had a long history, the medicalization of malingering at the fin de siècle led to a proliferation of such case histories and cheerful records of pathological feigners thwarted.

An 1897 watercolor by H.S. Robert shows two physicians — one lean and mustachioed, another plump and bald, scrutinizing a chamber pot. It reads: “Deux princes de la science furent chargés à leur tour de se rendre exactement compte ... de ... l'état de l'illustre malade ...” and “The Panama Canal: to determine whether he was fit to be extradited, two eminent physicians examine the stools of Dr Cornelius Herz, who had fled France to escape the results of his mismanagement of the canal’s financing.” The Compagnie Universelle du Canal Interoceánique (French Panama Canal Company) collapsed in 1889, and a few years later a judicial inquiry unearthed bribery, extortion, and government complicity. Among its chief figures was Paris-trained physician and businessman Cornélius Herz (1845-1898), who liaised between the company and fraudulent government officials. Hounded by detectives, Herz fled to England and fought France’s persistent attempts at extradition by claiming that his advanced diabetes was life-limiting. Sequestered in the seaside town of Bournemouth, he soon transitioned from being the poster child for corruption to one for malingering, as jaundiced and antisemitic portrayals in the European press turned his medico-legal struggles into a cause célèbre. Robert’s eleven-watercolor series, titled “Un diabétique,” embraces various aspects of Herz’s alleged medical con-artistry, including: “An English doctor takes Dr Herz’s pulse to see if he is seriously ill” and “Dr Cornélius Herz escapes extradition on the ground that he has a terminal illness, and lives happily in Bournemouth for fifteen years,” augmented by the caption “Ils ne lui donnèrent que quelques heures à vivre et ... il y a 15 ans de cela ... on n’en parle plus. Mystère !!! ...” These glib

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Centering the detection of malingering in Britain from the late nineteenth- to early twentieth-centuries, this paper argues that malingering not only secured distinctly clinical attachments in the fin de siècle, but that those operated in conjunction with its ongoing social and cultural connotations.

The Herz case exemplifies this, sitting at the crossroads of medico-legal and forensic issues, and suturing the private and public spheres.

The case of Cornélius Herz is an illuminating episode in fin-de-siècle approaches to malingering, one which highlights the period’s fascination with the meta-diagnosis of the condition, for to expose a malingerer was not only to diagnose along the continuum of illness and health, but to refine individual symptoms and signs into an understanding of how they cohered, organically or artificially. Malingering reverberates through the classical and historical lore: from Odysseus to King David and Hamlet, and military recruits to the working poor, the act of feigning illness to avoid obligations, disrupt boundaries, and unsettle social structures has persisted in the cultural and political realm. But a transformation occurred in Western Europe and Britain in the nineteenth century, when malingering came under the purview of the physician, a bio-political power we see evidenced in the procession of eminent doctors who visited Herz. This “medicalization of malingering,” to use Simon Wessely’s phrase, had broad effects upon the cognitive and professional roles of medical practitioners and the diagnostic episteme itself, an effect that I argue has had downstream impact on clinical relationships and health and social policies surrounding diagnosis even today. Detecting malingering entered a new forensic and investigative space, and became a way of ordering the social through the clinical.

Centering the detection of malingering in Britain from the late nineteenth- to early twentieth-centuries, this paper argues that malingering not only secured distinctly clinical attachments in the fin de siècle, but that those operated in conjunction with its ongoing social and cultural connotations. The Herz case exemplifies this, sitting at the crossroads of medico-legal and forensic issues, and suturing the private and public spheres. Though feigning illness had a long history, this period witnessed a proliferation in the clinical literature: of sensational case histories and cheerful records of pathological feigners thwarted. Malingering also assumed significance as a node for thinking about diagnosis writ large. Drawing from popular media, fiction, and clinical reports, this paper traces two key prototypes. It shows how the detection of malingering became part of a methodology ascribed to a particular sort of physician: the “malingering detective,” a role bound up with diagnostic proficiency and practitioner skill, existing debates on generalists versus specialists, and the physician investigator model on the rise since the early part of the century. Malingering was a whetstone. It sharpened competency. Consequently, it bolstered professional authority. At the same time, it generated a secondary phenomenon: as a clinical appraisal, it also informed clinical humility. Diagnosing malingering proved one’s mettle or exposed one’s deficiencies, and shaped constructions of the ideal physician: a clinical, investigative, and ethical being. To identify it was not only to hone diagnostic technique, but to pit one’s knowledge of the more “subtle signs of disease” against an ingenuous adversary, against whom one might readily fail.

Yet it was not all down to investigator skill. If disease was traditionally cast as the criminal, in cases of malingering the patient — especially those viewed as prone to degeneracy such as the incarcerated, working class, neurasthenic, and foreign — was definitively
culpable, a “person under investigation.” As such, malingering implanted itself among the “new social diseases” of the end of the century, including contagious and public health threats, neuroses, and childhood ailments, problems which put medical expertise front and center at the intersection of health and policy. Out of these interactions emerged a diagnostics of suspicion: distinguishing “legitimate” from “feigned” illness informed not only the identification of so-called fakers, but also the very act of diagnosis even as it pertained to non-factitious disorders. In doing so, it generated debates about practitioner roles and clinical ethics, and produced unease about where clinicians sat in an emergent medico-legal framework. In these fin-de-siècle formations of diagnosis, malingering was central to physicians’ place in a new regime aligning diagnosis with detection and aiming it not merely toward therapeutic discovery, but suspicious surveillance.

The Malingering Detective

The case of Cornélius Herz consumed the Anglo-American imagination. Debates about whether he was malingering were parleyed in the UK Parliament, splashed across newspapers from New York to New Zealand, parodied in cartoon, and scrutinized in medical journals. Himself a highly skilled physician, Herz was believed to be singularly capable of feigning illness, turning his repeated medical evaluations into a “whodunit” that played out on the public stage. His pathography became the object of collective curiosity, and introduced malingering as a site where medical, criminal, and legal structures intersected on an individual and societal level. In her study on the masculine body, Joanna Bourke argues that it was during World War I that doctors began to assume the overt role of detectives, policing the bodies and behavior of shirking servicemen. She cites an army surgeon’s response when asked if he was a doctor: “No…I am a detective,” as well as Dr. Henry Cohen’s “admission that it was ‘tempting to compare the methods of diagnosis with those of crime detection.’” I locate this triad of malingering, detection, and diagnosis earlier in the mid-nineteenth century, especially during the fin de siècle where it becomes more fevered. Arising from this moment is a literary example notable for a malingering detective and an exploration of malingering’s clinical, investigative, and cultural facets.

“Malingering is a subject upon which I have sometimes thought of writing a monograph,” remarks Sherlock Holmes after a successful run at it in “The Adventure of the Dying Detective” (1913, His Last Bow). Published twenty years after “The Final Problem,” where the Baker Street sleuth fakes his own death (“The Final Problem,” 1893), “The Dying Detective” bares the ligaments between clinical diagnosis, criminal detection, and malingering. The narrative is reflexive and promiscuously fascinated with these entanglements: a physician (Arthur Conan Doyle) fictionalizes a physician playing detective (John Watson), diagnosing a malingering detective (Holmes), who malingers in order to entrap a criminal (Culverton Smith). At the story’s outset the reader is invited to inhabit the role of the spectral but baffled Watson, worried physician friend. We are summoned to the bedside of a dying Holmes. The case is plausible. Stigmata are present: “His eyes had the brightness of fever, there was a hectic flush upon either cheek, and dark crusts clung to his lips; the thin hands upon the coverlet twitched incessantly, his voice was croaking and spasmodic.” So alarming is his appearance that his landlady Mrs. Hudson consults Watson (“For three days he has been sinking, and I doubt if he will last the day”). But what Watson sees at a respectable contagious distance is exactly what Holmes wants him to see: a very good piece of method acting. Holmes’ adversary, a British Sumatran planter named Culverton Smith, is equally fooled and — overconfident — confesses his crimes to someone he believes is dying. After duping Smith, Holmes describes his scheme to a shocked Watson: “With vaseline upon one’s forehead, belladonna in one’s eyes, rouge over the cheek-bones, and crusts of beeswax round one’s lips, a very satisfying effect can be produced...A little occasional talk about half-crowns, oysters, or any other extraneous subject produces a pleasing effect of delirium.”

“The Dying Detective” is an unusual Sherlock Holmes adventure. It disrupts the genre formula Conan Doyle burnished, and which his Strand readership had come to expect, opening with the consultation of a doctor, rather than a client approaching the detective. The detective himself, a paragon of stoic vigor, is seemingly debilitated. It is one of the few where the solution turns on a medical diagnosis, even though diagnostic epistemologies are baked into Holmes’ methods via Conan Doyle’s medical training and homage to his professors (i.e. Joseph Bell). At the same time, it represents a malingering apotheosis. Throughout his repertoire, Holmes establishes himself as a master of disguise and trickery, assuming and shedding identities as varied as sailors, clergymen, and elderly women, and ultimately counterfeiting his own death. Police inspector Athelney Jones tells him in The Sign of Four (1890), “you would have made an actor, and a rare one”; the skill is also bidirectional, with Holmes remarking, “the first quality of a criminal investigator [is] that he should see through a disguise” (The Hound of the Baskervilles, 1901). “The Dying
Detective” seems almost inevitable when considering the epidemic of feigning in the rest of the Holmes canon. Just as the investigator prides himself on being able to “see through a disguise,” a fin-de-siècle physician might view the clinical guise of malingering as a test of diagnostic acumen. “The Dying Detective” is rare in its focus upon Watson’s skill as a doctor, not merely as trusty sidekick, loyal friend, or foil for Holmes’ brilliance. Of chief importance are the twin questions of clinical expertise and ethics — here, where the usual roles are reversed and Holmes is incapacitated, is Watson’s field. The bedside is his stage, just as the consulting room is Holmes’ Yet when Watson tries to examine him, an apparently delirious Holmes entreats him to keep his distance due to his ailment, “a coolie disease from Sumatra ... infallibly deadly and horrifically contagious.” Spurred on by a sense of responsibility as both physician and friend, Watson insists: “Do you suppose that such a consideration weighs with me of an instant? It would not affect me in the case of a stranger. Do you imagine it would prevent me from doing my duty to so old a friend?” When threats of contagion fail, and Watson advances undeterred, Holmes turns caustic, undermining his clinical abilities: “If I am to have a doctor whether I will or not, let me at least have someone in whom I have confidence.” Mocking him as a mere generalist — “you are only a general practitioner with very limited experience and mediocre qualifications” — he cites esoteric medical knowledge: “what do you know, pray, of Tapanuli fever? What do you know of black Formosa corruption?” “Shall I demonstrate to you your own ignorance?” he asks brusquely. “There are many problems of disease, many strange pathological possibilities, in the East ... I have learned so much during some recent researches which have a medico-criminal aspect.” Holmes identifies himself as a medico-criminal expert, a specialist in contrast to Watson’s humble generalist. Watson knows domestic and quotidian disease; Holmes researches “foreign” and outlandish afflictions, a clear alignment of the consulting detective and the medical specialist. Despite Holmes’ stinging remarks, Watson offers to seek out tropical disease experts, a convincing example of the character’s subordination of ego to virtue. Later, Holmes tells Watson that he kept him at a distance because of his clinical skills, certain that he would intercept his performance and stymie Culverton Smith’s capture: “Do you imagine that I have no respect for your medical talents? Could I fancy that your astute judgment would pass a dying man who, however weak, had no rise of pulse or temperature?” At the end of this episode, Watson comes through the crucible of malingering as an idealized physician detective: clinically astute (Holmes’ insults notwithstanding), upstanding, and humble. Yet it is Holmes who, as a forensic specialist, intends to write a monograph on the topic.

The traits which Conan Doyle lionizes in “The Dying Detective” appear in contemporary clinical literature about malingering. The word itself appears in 268 *Lancet* articles between 1800 and 1900. The first time it appears in a title is 1885. Notably, many of the malingering descriptions take the form of a “strange” or “curious” case, highlighting their kinship to the detective genre. Malingerers are often cast as having criminal intelligence, or in many instances, being criminals themselves, with the doctor diagnostician serving as super sleuth. This is exhibited in an 1889 article “Detective Medicine,” reporting from Her Majesty’s Convict Prisons:

There can be no doubt that the variety and multiplicity of devices resorted to by the more confirmed exponents of this imposing art show a remarkable degree of ingenuity, perverted, it is true, and cases arise where special opportunity of gaining knowledge of the more subtle signs of disease have been found, and fully and intelligently turned to account.

It describes feats of medical detection performed by physicians attending malingering prisoners. By exercising their “diagnostic powers,” they familiarize themselves with the “infinite varieties of physical malingering” and “many forms of assumed insanity.” They develop a comprehensive nosology of disease across a continuum of legitimate and fictitious, gaining knowledge with each encounter and standing up their expertise against the “expert class of malingerers.” Framing these encounters as competing forms of prowess and virtuosity, the *British Medical Journal* indexes clinical authority to rooting out malingering and announces an adversarial relationship between physician and patient, where the patient’s body and mind become loci of suspicion. Physicians caution each other to remain vigilant and on multi-sensory alert, aware that penetrating the disguises of malingering indicates superior skill. Writing on feigned insanity, Henry Wentworth Acland (1815-1900) argues that, “if masters of our art, we ought always to detect an imitation of this disease.” Specialists also staked their expertise upon being able to identify malingering within their exclusive ambit, as when English dermatologist F. Parkes Weber (1863-1962) comments on malingers presenting with esoteric skin conditions, or New Jersey surgeon B.A. Watson discusses central nervous system concussions and lesions. Such differ-
entiation was also viewed as critical to general medical education, wherein the diagnosis of malingering served as a doppelgänger to the diagnosis of legitimate illness, testing the same skills but through inversion. Acland wrote that malingering examples should be presented to advanced medical students, “if a case of supposed feint were offered to him for diagnosis.”

Outwitting such tactics was not initially considered part of a garden-variety medical education, nor part of the ethos of a physician, as when Holmes explains why he couldn’t share his secret with Watson: “among your many talents dissimulation finds no place.”

As the century turned, medico-legal pedagogy reinforced unraveling patient artifice and detecting malingering as tricky, yet necessary challenges. For with malingering one was not merely contending with natural histories of disease, but the evasions of the investigated subject themselves. Whether these feints were the “normal” and understandable behavior of “normal” individuals under extraordinary circumstances (as in the case of prisoners of war), the normal and calculated behavior of allegedly abnormal individuals (the avaricious, criminal, or cowardly), or the abnormal behavior of the assuredly and involuntarily abnormal (the insane or otherwise pathological), was a matter of iterative debate and a cardinal feature of the clinical literature. Coterminous with emergent social theories such as Emile Durkheim’s differentiation of the normal and pathological (in The Rules of Sociological Method, 1895), which postulated that even something that seemed intuitively “abnormal,” such as crime, was indisputably “normal” given its presence and frequency in society across numerous contexts, malingering problematized traditional categories of well and ill, suggesting the contingency of the normal and pathological in a way that Canguilhem would articulate some years later. For the “genuine” was not necessarily normal, nor was the counterfeit necessarily pathological. Irredubibly contextual and phenomenological, the “normal” counterfeiter and the “pathological” genuine sufferer could not be reduced to binary heuristics, but existed along a continuum. Indeed, the upending of these categories of illness and wellness was part of what made malingering so epistemologically and affectively challenging for practitioners, and their dissolution triggered uneasiness about how and where physicians ought to intervene, as well as more existential questions about the rightness of such interventions. 

Malingering narratives went hand in hand with other diagnostic narratives of this period, including those of early detection and systematic clinical approach. Practitioners needed to recognize the tempo and progression of illness and refine their diagnostic method. One could not hope for success without “an analytical mind” and a “carefully arranged system of examination.” In the case of infectious diseases in particular such vigilance would be rewarded, as Robert Farquharson, Rugby School medical officer offered in 1869: “to discriminate between trifling complaints and those of a more serious character is at all times desirable, but especially so when the slightest error of judgment may encourage the spread of contagion.” He argues that it is easy to be a good diagnostician when confronted with florid symptoms, “when the skin, and the throat, and the eyes, and the tongue tell their plain story,” but that detecting sublety “tries the skill of the most accomplished observer,” and therefore the “value of premonitory symptoms stands in danger of being overlooked amid the more brilliant and exciting investigations of modern medicine.” Unlike many other ailments, for which early detection offered little but a longer duration of illness (in a pre-therapeutic era), infectious diseases could actually be warded off through such attentiveness. The process of distinguishing between “trifling” and “serious” complaints suggests a linked program between the detection of malingering and apprehending infectious disease early, expressing that both crime and disease are epidemic, and that the same techniques which might expose malingering could also detect “the first entrance of infection into our system” and “enable us to state with absolute fidelity whether any group of phenomena indicates serious disease or superficial derangement.”

Above all, malingering offered an exercise in clinical humility. Tracts cautioning against overconfidence, bias, and prejudice come up more frequently with malingering than with non-factitious diagnoses. Some writers warned that such diagnostic hubris would abet the malingerer and reflected poorly upon the profession itself. Here, B.A. Watson: “it is unfortunately too frequently the case that a surgeon commences his examination in medico-legal contests after having fully formed an opinion, or at least a bias or prejudice... [a] serious defect frequently observed in the members of our profession, which sometimes has its origin in laziness, although occasionally in an inordinate greed, where the physician has been accustomed all his life to given an opinion to a patient without either an examination or thought ... I have not yet reached the case of the malingerer; but I have thus far merely paid my respects to those who aid and assist the malingerer.” Another admonishes physicians to develop qualitative aptitudes: “opportunity, discretion, and tact.” Doses of clinical humility delivered, many textbooks of medical jurisprudence and forensic medicine highlighted the juridical role of diagnosing malingering, devoting entire sections to its nosologies and the role of
the medical expert in transmitting these diagnoses to the extra-clinical/legal world, for without the medical jurist as a liaison, “avenues of fraud are opened up and capital, lawyers and courts are practically at the mercy of a clever malingerer.” Some viewed the diagnosis of malingering as merely a prelude to the physician’s ethical obligation and an explicitly moral duty: the “task of inducing in such a creature the moral change which shall incline him to return to the ordinary course of the duties and customs of life around him,” for this second, paramount phase test the true character of a physician, the subtle skills that “no science taught in schools” can aid. They associate a great responsibility with identifying a malingerer, or wrongly accusing an innocent person.

Conan Doyle was evidently preoccupied with contemporary debates on malingering as well, importing them not only into his fictional practice, but his clinical prose. Like Watson, a veteran of the Anglo-Afghan war, Conan Doyle’s military experiences were formative. In 1900, he published on an outbreak of enteric fever during the Boer War, and singled malingering out as something he saw uncommonly among military recruits. Indeed, the piece devotes substantial effort to rescuing the reputation of soldiers, often maligned as “skulkers and shirkers.” He writes, “of the courage and patience of soldiers in hospital it is impossible to speak too highly ... I have not had more than two or three cases in my wards which bore a suspicion of malingering, and my colleagues say the same.” Catherine Wynne believes Doyle’s South African experiences to have been determinative, shaping the ways in which Dr. Watson — post Boer War — becomes a more “primary investigative” figure in texts such as The Hound of the Baskervilles and “The Adventure of the Dying Detective.” What is clear is that malingering becomes a way for Conan Doyle to refract contemporary debates around physician authority and virtuosity, diagnostic acumen, vigilance, and surveillance, and draw a clear line from the Baker Street consultation and the medical practices of Harley Street to the specialized medicine practiced by a growing cadre of domestic and colonial physicians. Indeed, “The Dying Detective” pays homage to several such medics when Watson offers to consult them: tropical specialists Dr. Ainstree (an adaptation of William Francis Ainsworth (1807–96), surgeon, cholera specialist, traveler, editor, and one of the founders of the Royal Geographical Society) and Penrose Fisher, likely a portmanteau of a few doctors who trained at Edinburgh with Conan Doyle; even the police officer, Inspector Morton, may have been named for Charles J. Morton, an 1886 Edinburgh medical graduate.

Packing so many doctor investigators into a story about a malingering detective raises the question: what did it mean to be at the receiving end of such scrutiny? What did this generation of malingering detectives mean for patients?

Person Under Investigation

“The Adventure of the Dying Detective” is unorthodox precisely because the detective himself becomes the patient and subject of medical and criminal investigation. As with Cornelius Herz, the expert becomes an object of study. The transformation of patient to person under investigation is a kind of cosmological shift not accounted for in Jowson’s famous ontology of the sick-man, nor in his reappearance at the center of patient-centered medicine toward the end of the twentieth century. David Armstrong has located the “rise of surveillance medicine” in the early twentieth century based on the reconnaissance of normal populations and an extra-corporeal spatialization of diagnosis, reconfiguring the relationship between symptom, sign, and illness into a series of health factors, an “infinite chain of risks.” Armstrong carves a sharp boundary between the nineteenth-century diagnostics of hospital medicine, with its lesion-centric pathological approach, and surveillance medicine’s monitoring of healthy populations to “identify the precursors of future illness” and distribution of lifestyle factors. He sees this as medicine’s entrance into the social sphere: no longer content to confine itself to the individual patient in a hospital bed, “medical surveillance would have to leave the hospital and penetrate into the wider population.” But I posit that these ideas root themselves in the nineteenth century, and that rather than the total dissolution of a somaticist and localization structure giving way to chains of risk, diagnostic entities such as malingering took on especial relevance at the century’s pivot, reflecting more fluid models integrating discourses of localization, risk and vulnerability, the individual and public, clinical and social. Nineteenth-century precursors like the diagnostics of suspicion as exercised in the work of malingering detectives prototype surveillance ways of thinking. For malingering existed in a liminal space between lesion and symptom, between organic pathology and presentation, and therefore taxed physicians in a very specific way. These continuities suggest that fin-de-siècle formations of diagnosis were negotiating illness semiology, pathological anatomy, and physiology while also veering toward the detection of the “normal,” i.e. the healthy individual feigning illness, a behavior pathologized in association with specific traits, alleged predispositions and susceptibilities, and in many instances a perceived lack of moral and physical fitness.
Holmes’ malingering is aided by the fact that he is mimicking not only a tropical ailment unknown to most European medical practitioner, but an entirely fictitious one. This creates an epistemic rift between himself and Watson. Not only is Holmes is acting, and Watson in earnest, but Holmes’ behavior draws him closer to the marginalized classes and criminals he is devoted to ferreting out. It also associates him with many others, who in the mainstream view, were guilty of such pathological acts. Taxonomies stratifying risk for malingering cropped up around the turn of the century. This surveillance medicine tracked those who made a “career of imposture” versus the unwitting feigners or the mentally ill, and generated probabilities of guilt depending on individual and social factors. The “Detective Medicine” report argues that feigners are found more frequently amongst the “criminal classes,” while in 1890 J.T. Eskridge classes malingers as “the tramp, criminal, and mercenary.” Unlike many of his colleagues, Eskridge believed that it was less important to generate a differential diagnosis of malingering than it was to classify the malingerer: the “tramp class” try to “dead-beat” their way ... to gain sustenance in hospitals, or to eke out a miserable existence by imposing upon the charitably inclined.” The criminal malingger “hope to escape their deserved punishment,” while the mercenary “feign injury for the hope of gaining remuneration.”42 Such wariness only increased in the setting of the Workmen’s Compensation Act (1898) and the growth of such workers’ compensation schemes in industrializing nations, so that by the early 20th century clinicians across domains maintained a similar administrative roster of offenders: duplicitous workers, “soldiers, prisoners, schoolboys, conscripts ... ‘hospital birds,’ hysterical young women, club patients, persons injured or supposed to be injured in railway accidents, and persons who have been accused of some crime,” according to neurosurgeon Byron Bramwell (1847-1931), or as F. Parkes Weber attested, “young women with abnormal psychical states,” and prisoners of war attempting to achieve repatriation.43

By inhabiting the role of a malingerer suffering from a mysterious tropical disease, Holmes occupies a pathologized identity, one associated with dock workers, global migrants, and colonial subjects. Mrs. Hudson tells Watson that Holmes had been in Southwark, “working at a case down at Rotherhithe, in an alley near the river, and he has brought this illness back with him,” while Holmes himself calls it a “coo-lie disease from Sumatra.”44 Pablo Mukherjee views Holmes’ malingering as confirmation of the “pathological proximity” between the detective responsible for “the defense of the imperial status quo” with the global laboring class — not only working class English but indigenous laborers everywhere. The allegations of laziness and the racialization of malingering amongst “coolies” (especially in the colonial context) is an “almost reflexive taxonomic move,” harbored in the imperial archive of “official reports, plantation diaries, medical treatises, parliamentary debates, or private correspondences.” Reading “The Dying Detective” through Freudian and Kristevan poetics, Mukherjee argues that Holmes’ physical deterioration (albeit self-imposed) joins him with the abject bodies victimized by Culverton Smith’s horrific medical experiments (collapsing Holmes’ final illness with that of these indigenous subjects, Smith brutally says: “Yes, the coolies used to do some squealing towards the end”). In order to uphold British imperial stability and to contain threats, Holmes must himself become subversive and peripheral.45

Despite being insulated by wealth, education, professional status, and Euro-American caché, Cornélius Herz did not fare much better as a person under investigation, his Jewish heritage making him a ready target in a structurally racist society. A full century later some historians still associate his name with malingering, and his English tenure as a ploy “sheltered under the cloak of invalidism.”46 Accounts of his financial speculations and corruption, dosed with antisemitism, bled into his medical assessment, and it is hard to separate where one begins and the other ends. In the Robert carictures as well as French political cartoons depicting then Prime Minister Georges Clemenceau as his puppet (or “L’ex copain de Cornélius Herz”), Herz is shown as a “a stereotyped Jewish figure” with a large nose and swarthy features, juggling money bags and tweaking marionette strings.47 Edouard Drumont’s Le Libre Parole is exemplary even among the generally skewed French press for its antisemitism, leveraging the Panama Scandal (Cornélius Herz and Baron Jacques Reichan) and l’affaire Dreyfus of 1894-1906 (Alfred Dreyfus), both featuring prominent Jewish protagonists, toward a surge of French nationalism and religious intolerance.48 As the medico-legal literature suggested qua malingers, Herz’s criminal intelligence, Jewishness, and foreignness, were thought to enhance his expert counterfeiting. Per Eskridge’s taxonomy, he would exist somewhere between the criminal and the mercenary.

Herz’s reception in England, while still skeptical, was tempered. British physicians, in particular, were more supportive than was their wont. The same qualities undergirding French characterizations of his “pathological proximity” to criminality became their authenticating arguments. They defended Herz as a colleague, an Anglophile (who had spent time in both

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England and America), and a cosmopolitan global citizen. His status as a French exile fueled more fervent advocacy, as when The British Medical Journal avowed “the French press have never ceased to ridicule the reality of the illness, have published the most fanciful accounts of the patient’s outdoor doings, and generally the most indecent misrepresentations and charges against the patient and his physicians.”  These accusations of malingering were viewed as an attack on the professional guild itself, for they were dually directed against a fellow practitioner and the acumen of his examining physicians. The media coverage of Herz was also deemed an ethical violation: The Lancet remarked that the intersection of the private, clinical sphere and the politically exigent showed how “the first principle of social ethics may be overborne,” and that this treatment was not only immoral, but dangerous:

The unfortunate object of this legal persecution has been for the past two years confined to his bed by a mortal illness, which has been gradually advancing towards its inevitable termination; and yet during the whole time he has been kept under police surveillance and has been practically condemned unheard. Surely no course could be better calculated to hasten the end of a sufferer from advanced cardiac disease complicated with diabetes.90

Similarly, angina specialist Lauder Brunton (1844-1916) wrote after examining Herz that “unless the strain which is at present weighing upon him is diminished, and his worry and anxiety lessened, the cardiac disease will progress and lead to an utter and irredeemable ruin of his health, or even to death itself.” These characterizations of Herz as a desperately unwell man, condemned “unheard” through ill will and unable to defend himself, a victim of “legal persecution” under a panoptic regime of surveillance, mark him as both person under investigation and martyr to malingering rhetoric. Unlike the anonymous malingerers distributed across contemporary clinical literature, he is regarded with sympathy. I would argue that this operates in tandem with the ideal of the “malingering detective” we have seen elaborated in both medical and cultural sources — a clinically astute, skeptical, and virtuous being. The conjunction of testimonies from well-regarded specialists, iterative clinical examinations, congratulatory rhetoric on the superiority of English good will and ethics, all operate to reconfigure and uplift this professional ideal in response to Herz’s malingering case. As such, the British medical establishment largely viewed the accusations leveled against Herz as violating these principles. When Herz died, The Lancet published a brief but compassionate obituary, remarkable for its eagerness to vindicate British physicians while subtly denouncing colleagues across the Channel: “his death was due to angina pectoris and in its mode of onset sufficiently justified the opinion of the well-known English physicians who refused to take the responsibility of saying that he was in a fit state to appear at the Extradition Court.”92

Many also critiqued the ways in which Herz’s body and suffering were put on display; the cynical disbelief of his symptoms and scrutiny of every physical sign presented on the European stage. As one writer noted, “we have always regretted that it should have been ever deemed necessary to parade before the public the particular details of the malady of Dr. Herz.”93 Legal proceedings in Paris provoked further outcry across the Channel, as repeated attempts at extradition countervailed what was considered impeccable English medical guidance. In response to this, Malcolm MacDonald McHardy (1852-1913), along with a number of other practitioners who examined Herz, sent “authenticated” clinical impressions to the Cour d’Appel in Paris and the Home Office in London and replicated them in the pages of The Lancet, pointing to the “cruel hardship of the situation,” and the “falsehood and indecency of the comments in the lay press of France [which] are as disgraceful as incredible.”94

Despite these calls for privacy and decency, however, even sympathetic British accounts of Herz’s ailments were cast in an explicitly investigative light. In their enthusiasm to refute the malingering allegations, respected medical journals offered competing “authentic statements” upon the “case of Dr. Corne-lius Herz.” Thomas Barlow described his visit with Thomas Buzzard: “It is fair to state that Dr Herz bore our investigation of one and a quarter hour’s duration extremely well. We were told by those present that he was at his best and that at previous investigations he had acquitted himself with great success, but that he had suffered much afterwards.”95 Lauder Brunton conducted and publicized a meticulous physical exam, including cardiac auscultation, splenic palpation, and urinoscopic analysis.96 These bedside case histories were arduous and detailed, and evidently taxing for the patient. Because they were iterative, the slightest changes or improvements were noted and tabulated, affixing tiny shifts in constitutional symptom (appetite, weight, fatigue) or sign (auscultation, palpation) to the legal apparatus awaiting Herz.

When Brouardel and Dieulafoy visited Herz, a few months after Brouardel’s initial exam with Char-
cot, they noted that their subject was significantly improved, notably “dans la plénitude de ses facultés intellectuelles. Il n’est plus l’homme anémié el amaigri du mois de juin; il n’est plus l’homme tombant d’innovation et de faiblesses,” and that as a result he could be extradited.57 For the French press, this was further evidence of a “faux Cornelius Herz,” “montré aux médecins experts lors de leur mission, le vrai, le seul, jouant au croquet, voyageant en France.” When the British raised an outcry, the French responded on medical grounds: “Il semblait que l’on n’avait ja mais vu un malade atteint de diabète, d’albuminurie ou d’affection du cœur, avoir une rémission dans la marche de sa maladie.”58 Perhaps their British counterparts were simply unfamiliar with the natural histories of diabetes and cardiac disease, and not so skilled at detecting malingers, after all.

A Diagnostics of Suspicion
When Paul Ricoeur characterized a “hermeneutics of suspicion” distinguished by skeptical reading, circumventing obvious meanings in favor of occult or unflattering truths, he triggered a half-century debate in literary and historical criticism.59 For isn’t this self-evident? Are we not always panning for meaning amidst the dross? The same can be said for diagnosis; housed in its very etymology is the praxis of sifting truth from appearances. In her landmark study of medical narratology, Kathryn Montgomery identifies a “diagnostic circle” akin to Heidegger’s hermeneutic circle, an iterative process of interpretation where multiple narratives intersect, scaffolding clinical thought and relationships and centering the physician as reader and interpreter.60 Diagnostician and critic share this fascination for the concealed — unearthing profound meanings and mapping relationships between surface and depth — a genealogy of suspicious reading. Diagnosis is also socially constructed, and as Charles Rosenberg famously described, it “structures practice, confers social approval on particular sickness roles, and legitimates bureaucratic relations.”61 In this regard, it informs a number of policy frameworks. What then is the meaning of a diagnostics of suspicion, and what ramifications might this have for contemporary social policy?

Dwelling upon the late nineteenth and early twentieth centuries, this paper has made the case that during this period, malingering transforms into an entity around which the medico-legal establishment constructed an entire clinical, epistemological, and ethical structure. It fixes the fictional and historical case studies of Sherlock Holmes and Cornélius Herz in the broader context of malingering. Framing malingering as an act of detection, its diagnosis becomes part of a methodology ascribed to a certain sort of physician — the “malingering detective” — a figure characterized by clinical acuity, ethical rigor, and a broad forensic sphere of influence bridging the clinic and the courtroom. As such, it is even attached to diagnostic and billing codes, as when the Centers for Disease Control updated ICD-10 taxonomies to reflect the category of COVID-19 “PUI.”62 This interaction between diagnosis in the clinic, classificatory schemes, public health policy, and business and legal apparatus mirror the networks of malingering in the fin de siècle.
For the late Victorians, the person under investigation was often pathologized, racialized, and distanced from the investigator due to alleged predispositions and susceptibilities. Simultaneously, the practitioner developed a sense of social and ethical responsibility beyond the clinical, to address a condition thought to present risk to the population and medico-legal system at large. The interplay between these figures contributed, in turn, to a diagnostics of suspicion. In contemporary medicine, on the individual and population health scale, such dynamics operate in subtle, but pervasive ways. Though malingering was expunged from the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-V) but remains a “V” code (a numeric code used for visits to a health care professional for purposes other than for illness), its afterlives continue and have ramifications for almost all forms of diagnosis. Doctors are coached to be skeptical of patients or to distrust their reports — before the advent of patient-centred medicine in the last few decades of the twentieth century, this was overt and endemic in published clinical literature, even as late as a 1979 Journal of the American Medical Association piece which counsels physicians to model themselves on the “detective prototype” in order to “detect deception on the part of a patient.”

References
1. "Two princes of science are charged in turn with providing an exact account...of...the state of the illustrious invalid," H.S. Robert, "The Panama Canal: To Determine Whether He was Fit to be Extradited, Two Eminent Physicians Examine the Steels of Dr Cornelius Herz, Who had Fleed France to Escape the Results of his Mismanagement of the Canal's Financing," watercolour drawing, (ca. 1897), Wellcome Collection, available at <https://wellcomecollection.org/worksrexe3mfu> (last visited August 4, 2021).
2. H.S. Robert, "The Panama Canal: Dr Cornelius Herz, Having Fleed to Bournemouth to Escape the Results of His Mismanagement of the Canal's Financing, Simulates Illness to Avoid Extradition to France," watercolour drawing (ca. 1897), wellcome Collection, available at <https://wellcomecollection.org/works/srfg4zxx> (last visited August 4, 2021), “They gave him only a few hours to live...that was 15 years ago...We don't talk about it anymore. A puzzle!”
6. Odysseus may have been the first malingering. Performing madness to avoid serving in the Trojan War, he fills an empty field with salt instead of seed; but he is ensnared by his countryman Palamedes, who tricks him into revealing the deception. He does not forget Palamedes’ trick and is revered upon him at Troy, when he forges a letter suggesting that he has betrayed Greece, invoking the wrath of Agamemnon, who has Palamedes stoned as a traitor. As related by Apollodorus and Hyginus, this tale of Odysseus’ malingering and Palamedes’ death becomes part of the classical and historical lore, but is also a cautionary tale of the consequences for those who divulge the deception. For more on the historical and biocentric afterlives of Odysseus’ malingering, see P. Kheirkhah, “Malingering: A Historical Perspective,” in Neurological Malingering (Boca Raton, FL: CRC Press, 2018): at 1-6; A. Núñez, et al., “Pseudodementia, Malingering and Revenge in Ancient Greece: Odysseus and Palamedes,” Neurosciences and History 4, no. 2 (2016): 47-50; H. M. Hackford, “Malingering: Representations of Feigned Disease in American History, 1800–1920,” PhD. dissertation, American University (2004); L.D. Hankoff, “The Hero as Madman,” Journal of the History of the Behavioral Sciences 11, no. 4 (1975): 312-333.
7. There is a continuous thread through the late nineteenth-century to early twenty-first-century diagnostic literature, concentrated around particular entities: occupational injury, disability and social security assessments, military medicine, traumatic brain injury, neuropsychiatric disorders, pain,
forensic trauma, post-traumatic stress disorder, and illness
decception (malingering/factitious disorder/Munchausen’s
Syndrome) itself. Yet little has been written specifically about
the epistemologies of malingering detection and diagnos-
tic reasoning more generally, physician professionalization/
identity formation, and medico-disciplinary power. The late
twentieth-century and early twenty-first century clinical data-
bases reflect the empirical impulse, with a growing number of
validated instruments and quantification tools: see G. Young,
“Toward a Gold Standard in Malingering and Related Deter-
minations,” in Malingering, Feigning, and Response Bias
in Psychiatric/Psychological Injury (Dordrecht: Springer,
of Malingering: Validation of the Structured Interview of
Reported Symptoms,” Psychological Assessment: A Journal

Secondary literature reveals a tension between sociological
and biomedical analyses of malingering. For example, in their
introduction to Malingering as Illness Deception (Oxford,
2003): 3–31, Peter Halligan, Christopher Bass, and David Oak-
ley contest the prominent role that medicine and the biomed-
ical model continue to play in “shaping and defining current
discussions of illness deception,” as this facilitates a merging of
the “language of medicine” and the “language of morality.” They
reframe illness deception as a “volitional act” that can be con-
ceptualized within a sociological framework, rather than a deter-
ministic disease model, therefore foregrounding the body’s
capacity for free will. Though their intervention attempts to free
“illness deception” from its diagnostic and clinical moor-
ings and physicians from their roles as gatekeepers, embed-
ding malingering further in sociological and social responsi-
bility frameworks still yokes the detection of malingering to morality.

Though there is a small body of ethics scholarship
addressing the clinician’s duties in cases of suspected malin-
gering (via a bioethics/informed consent framework, cf. P. J.
Candills, “Ethics, Malingering, and a Lie-Detector at the Bed-
ing (or Withholding) a Diagnosis of Malingering,” Neuropsychol-
yy of Malingering Casebook (New York: Psychology Press,
2008): 535-547, the necessary critique frequently comes from
the humanities and social sciences, including C. E. Rosenberg,
“The Tyranny of Diagnosis: Specific Entities and Individual
Experience,” The Milbank Quarterly 60, no. 2 (2002): 237-
260 and C. Hartanto, “Lauren Slater, Malingering, Masquerade,
and the Disciplinary Control of Diagnos-
Hacking’s discussion in Mad Travelers (Cambridge: Harvard,
1998) on the politics of assigning diagnoses (distinguishing
between hysteria and epilepsy in Charcot’s time). Clearly the
health humanities has something to say about this intersection of
medical jurisprudence, diagnosis, power, and critique.

8. S. Wessely, “Malingering: Historical Perspectives,” in Malin-
gering and Illness Deception (New York: Oxford University

9. The historiography and health humanities scholarship on
medical jurisprudence and forensic or legal medicine (an
inversion and distinction that is itself worth exploring) is
too vast to encompass in a single footnote or even this entire
paper, but I am including some key sources which have informed my thinking for this article as well as a forthcoming
book on diagnosis and detection. Most recently, work on
forensic cultures (epistemologies, institutions, and technolo-
gies in conjunction with techniques and methods) featured in
a special issue of Studies in History and Philosophy of Sci-
ence (2013) and Global Forensic Cultures, ed. I. Burney and
C. Hamlin (Johns Hopkins, 2019) have influenced my view of
the diagnostic space as a forensic space, and textured the
motif of “doctor as detective” into the cross-cutting figure of
investigating professional, bridging clinic, courtroom, and cul-
ture. On the spatialization of diagnosis, see also G. Mooney,
“Diagnostic Spaces: Workhouse, Hospital, and Home in Mid-
Victorian London,” Social Science History 33, no. 3 (2009):
357-390, and D. Armstrong, “Public Health Spaces and the

Foundation scholarship on legal medicine and views of
the juridical/disciplinary apparatus, especially saturing the
private and public spheres, include Legal Medicine in History, ed.
M. Clark and C. Crawford (London: Cambridge, 1994), J.
Goldstein’s Convoy of Classify: The French Psychiatric
Profession in The Nineteenth Century (Chicago: University of
Chicago Press, 1987), and “Framing Discipline with Law:
Problems and Promises of the Liberal State,” AHR, 1993, and
T. Golan’s Laws of Men and Laws of Nature: The History of
Scientific Expert Testimony in England and America (Cam-
bridge: Harvard, 2007), among others. I have also drawn from
Simon Cole’s Suspect Identities: A History of Fingerprinting
and Criminal Identification (Cambridge: Harvard, 2001) par-
ticularly in the “Person Under Investigation” section which
engages “criminal identity” more explicitly, ranging from the
postcolonial to the metropole. I am grateful to Mitra Sharafi
and Samuel Scharff for generative conversations on forensic
medicine, and their own work, including Sharafi’s article,
“The Imperial Serologist and Punitive Self-Harm: Blood-
stains and Legal Pluralism in British India,” in Global Foren-
sic Cultures: Making Fact and Justice in the Modern Era,
cited above, and Scharff’s dissertation, “The Mask of Expert-
tise: Hervey Cleckley, Psychiatry, and Law in 20th Century
America,” (Dissertation: Johns Hopkins University, 2011).

Finally, on co-production of scientific and social discourses,
an assumption which undergirds much of this work:
S. Jasanoff, States of Knowledge: The Co-Production of Science

10. A paradigmatic model that weaves throughout clinical litera-
ure as a relatively unexamined assumption, see N. Y. Hoff-
man, “The Doctor and the Detective Story,” JAMA 224, no. 1
have in Common with Sherlock Holmes: Discussion Paper,”
33-36. Being a diagnostician is central to the physician’s
contemporary role, and detective methods are often used to
promulgate and consolidate diagnostic reasoning. This is so
obvious that it appeared even in 21st century Medical
Grand Rounds at the National Institutes of Health: diagnost-
ician Faith Thayer Fitzgerald charged her clinical audience
to read Sherlock Holmes because his fictional methods are
archetypal of the diagnostic/forensic process: Fitzgerald, Clinical
Console and Classify: The French Psychiatric
Center Grand Rounds, “Mysterious Cases,” National Institutes
of Health, 2002). Though the canonical doctor-detective motif
is familiar to most humanists (vis-a-vis Sherlock Holmes and
Joseph Bell, diagnosis and semiology, see also C. Ginzburg,
“Clues: Roots of a Scientific Paradigm,” Theory and Society 7,
no. 3 (1979): 273–88; C. Ginzburg, Morelli, Freud, and Sher-
lock Holmes: Clues and Scientific Method,” History Workshop
The Sign of Three: Dupin, Holmes, Peirce (Bloomington: Indi-
a University Press, 1988), it has wider ramifications and points up
a more fundamental forensic shift in clinical episte-
ology and professional identity formation.

11. An excellent analysis of clinical authority as it specifically per-
tains to medical jurisprudence and railway injury trials in the
late nineteenth century in K. M. Odden, “Able and Intelligent
Medical Men Meeting Together: The Victorian Railway Crash,
Medical Jurisprudence, and the Rise of Medical Authority,”

12. This construction was also explicitly gendered (masculine).
For more on how the medical profession invoked visions of
masculinity, heroism, and self-sacrifice, often through martial
metaphors or explicitly military formulations, see M. Brown,
“Like a Devoted Army”: Medicine, Heroic Masculinity, and the
Military Paradigm in Victorian Britain,” Journal of Brit-
ish Studies 49, no. 3 (2010): 592–622; M. J. D. Roberts,
“The Politics of Professionalism: MP, Medical Men, and the

The Journal of Law, Medicine & Ethics, 49 (2021): 343-356. © 2021 The Author(s)

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13. Almost thirty years ago, D. Armstrong argued that the “new social diseases” emerged in the early 20th century, generating novel targets for health care intervention and shifting from the lesion-based pathological medicine of the hospital to the extra-corporeal risk factors of surveillance medicine. But as I will demonstrate throughout this paper, I believe these shifts to have started much earlier and to be more fluid and contingent in the dynamic late nineteenth century. (See D. Armstrong, *The Rise of Surveillance Medicine,* *Sociology of Health and Illness* 17 (1995): 393-404).


24. The psychopathology of malingerers sits in a broader literature of psychological development, criminality, and contemporary concerns about the porous boundaries between normal and pathological (see discussion of Canguilhem and Durkheim below). Arouse this period, heightened medical surveillance starts surveying not only the avowedly pathological — the monomaniac, neurotic, unstable, and criminal — but healthy populations (see Armstrong on surveillance medicine). The malingerer points up the precarity of the normal, and continuous with other susceptibilities and pressure points — becomes a subject of exaggerated medical vigilance.


31. See Watson, supra note 26.

Eighteenth and nineteenth-century entanglements between hygiene, epidemic surveillance, and criminal detection (i.e. medical police, public health and sanitation regimes, and contact tracing) are beyond the scope of this paper, but notable is the introduction of malingering into this dyad — where the methodology of hypervigilance associated with curtailing early contagion (cf. Farquharson, before it spreads rapidly through the population) is applied to exposing feigners. See also P. E. Carroll, “Medical Police and the History of Public Health,” Medical History 46, no. 4 (2002): 461–494; C. Hsien-Yu, “Colonial Medical Police and Postcolonial Medical Surveillance Systems in Taiwan, 1895-1950s,” Osiris 13 (1998): 326–338; A. Bashford, ed. Medicine at the Border (London: Palgrave Macmillan, 2006).

33. See Watson, supra note 31.


38. Post-Conan Doyle, the trope of the detective as suspect or criminal recurs as a formal feature of the genre, i.e. in twentieth-century successors such as Agatha Christie (The Murder of Roger Ackroyd, 1926); Rudolph Fisher (The Conjure Man Dies, 1932), and Dorothy Sayers (Clouds of Witness, 1926) among others. Additionally, in Curtain, The Conjure Man Dies, and Clouds of Witness, feigning illness, debility, or death are central plot structures.


41. For more on contemporary connections between Armstrong’s “surveillance medicine” and personalized medicine, self-monitoring, and the paradigms of a health system that treats patients and enjoins patients to view themselves as composites of risk profiles, see S. Samerski, “Individuals on Alert: Digital Epidemiology and the Individualization of Surveillance,” Life Sciences, Society and Policy 14, no. 13 (2018); See Armstrong, supra note 40, at 398.

42. J.T. Eskridge, Some Points in the Diagnosis of Certain Simulated Mental and Nervous Diseases (New York, 1890): at 2-3.


44. Other similar is the Thames in the 1800s, a shorthand for shipyards, docks, and the port, telegraphing Holmes’ proximity to Rotherhithe is south of the Thames, a shorthand for ship facilities. See Weber, supra note 26.


51. See supra note 49.


53. See supra note 51.

54. See supra note 50.

55. T. Barlow, “Notes and Correspondence Relating to the Medical Examination of Dr Cornelius Herz, at Bournemouth,” Wellcome Collection PP/BAR/F/4 (April 1896).

56. See supra note 53.

57. See Brouardel, Etat de Sante de Cornelius Herz; “…that he is in full possession of his intellectual faculties. He is no longer the anemic and emaciated man from June; he is no longer the man collapsing from weakness and starvation,” at 3.

58. See La Chronique Medecale, “[the fake Cornelius Herz,] shown to the medical experts during their mission, while the real one, the only one, plays croquet, and travels in France;” “It would appear that they [the English physicians] had never seen a patient with diabetes, albuminuria, or cardiac afflictions experience a remission in the trajectory of his illness,” at 480.


