The Rhetoric of Malingering and the Management of Risk

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ABSTRACT

This article discusses the professional writing of those medical practitioners who have taken a particular interest in malingering—i.e., the feigning or exaggeration of disease—and the interdependence between these writers' accounts of their strategies for the detection of malingering on the one hand, and the strategies of malingerers themselves on the other. A reading of four medico-legal texts dating back to the mid-nineteenth century and ending with a recent edited collection on this topic posits the causes and consequences of the shifts in this discourse over time. Because malingerers themselves do not typically leave records of how they use medical genres, I also look to the literary archive for an example of how the malingerer is constructed in the social consciousness. The analysis leads to a characterization of these shifts as a move from *detection* in the earliest texts, toward *diagnosis* in the early twentieth

century (as Freudian psychoanalysis gains a foothold), and finally back again toward *detection* as risks of malingering are increasingly actuarialized in twenty-first century contexts of risk management.

Keywords: rhetoric of health and medicine; genre; pentadic analysis (Burke); malingering; risk; Foucault

> *Within medical encounters, embodied rhetorical moves become particularly urgent and consequential, and the roles individuals assume as they negotiate their medical-rhetorical contexts—in addition to the roles of texts and genres within those contexts—provide clues to the construction of biomedical subjects. (Emmons 135)*

> *Where there is medical uncertainty rhetoric moves in to fill the gaps in knowledge. (Segal* Health *39)*

A few years ago, I was rear-ended on my morning commute. The interaction that followed could be characterized as a genre unfolding as it should: the driver of the other car apologized with convincing earnestness and asked me if I was okay. I said I was, and we proceeded to assess the damage to my car and exchange the necessary details in case I decided to pursue my rear-ender for any repairs. As the day wore on, I began to experience some stiffness and pain in my neck but thought little of it. Upon returning home, however, I was advised by friends and family that a trip to the after-hours medical clinic was in order. Effects of even minor whiplash, some had heard, could without warning render you dead from a brain clot! At the clinic, the doctor on call examined me, asked a few questions, and told me that unless symptoms got worse over the next day or so, I had nothing to worry about. He also added that there was nothing in my presenting symptoms to suggest that there would be any basis for a compensation claim.

I left the doctor's office feeling both vaguely assured but also somewhat accused and dismissed. I had learned via the consultation that a neck injury might be the basis for monetary compensation, and that the doctor speculated that this might be on my mind. In the words of genre theorist Carolyn Miller, then, it would seem to illustrate her point that, through genre (in this case a doctor-patient interview), we can "learn . . . what ends we have" (165).Were there expectations about my motive, assigned by the genre?

"Motive" in this case emanated from a system of intersecting discursive regimes—familial, legal, medical, insurance—all seemingly structuring my embodied experience in the doctor-patient interview. Did the doctor suspect I was exaggerating my symptoms in the hope of acquiring some secondary gain, i.e., malingering? And was I, even slightly, exaggerating my symptoms to ensure the doctor would take me seriously, out of a half-conscious fear that I really was at risk of sudden death from a blood clot to the brain?

Using this narrative as what Kenneth Burke in a *Grammar of Motives* describes as a "representative anecdote," this paper takes a rhetorical approach to explore such questions. Burke reminds us that "rhetoric compris[es] both the *use* of persuasive resources, … and the *study* of them …" (560, italics in original). Specifically, I trace malingering historically through an archive of historical texts that confronts malingering for legal, actuarial, or medical reasons. Malingerers themselves do not typically leave records of how they use medical genres. For this reason, I include anecdotal and literary examples of how the malingerer is constructed in the social consciousness, allowing us to see malingering as a strategy of resistance to dominant power structures.

While malingering has received extensive focus in biomedical, psychological, and forensic disciplines (Halligan, Bass and Oakley; Rogers; Malleson), no accounts include a rhetorical approach. Building on groundwork in the rhetoric of health and medicine, most notably that of Judy Segal on migraines and hypochondria, the rhetorical approach taken here allows me to posit a claim about the interdependence between the various strategies for detecting malingering and the strategies of malingerers themselves. I trace the causes and consequences of the shifts in the rhetoric of malingering over time—from *detection* in the earliest texts toward *diagnosis* in the early twentieth century as Freudian psychoanalysis gains a foothold, and finally back again toward *detection* as risks of malingering are increasingly actuarialized in late-twentieth century contexts of risk management such as the insurance industry, which subjects the malingering body to actuarial regimes of probability and risk. In all cases, malingering as a category operates in various matrices of knowledge and power. As we will see below, the malingerer lies on the periphery of institutional encounters between soldiers and their commanding officers, doctors and patients, insurance adjusters and claimants, psychologists and clients, and even teachers and students. It is on these peripheries that social subjects enact truant roles.

MALINGERING AS RHETORICALLY STRUCTURED

Simply put, malingering is the pretension or exaggeration of illness in order to escape duty or work or to acquire some other external benefit. Many distinguish "frank feigning" from the exaggeration of symptoms; still others see malingering as on a continuum "that varies according to the extent of conscious awareness" (Halligan, Bass and Oakley 12). In the *Diagnostic and Statistical Manual of*

Mental Disorders: Fourth Edition (DSM-IV) malingering is listed in the appendix as a term under consideration and needing elucidation. There it is distinguished from "factitious disorders," which are those disorders via which the dissembler supposedly derives no extrinsic benefit, meaning their rewards are either intrinsic (psychological) or nonexistent. In a clinical setting, this would be the difference between feigning or exaggerating symptoms to receive compensation via an insurance claim, or doing so to receive sympathy or reassurance from a physician.

From the sociological viewpoint of Talcott Parsons, illness is not simply a condition, but also a social role, operating in a "motivational economy" (101), placing both the material conditions and the motives of individuals within social and institutional structures. In these terms, malingering is the pursuit of the benefits of "the sick role," for example the exemption from societal obligations, without the presence of actual illness. Because understanding motive seems crucial to understanding malingering, Kenneth Burke's dramatism—or "the attributing of motives" (*On Symbols* 139)—lends itself to a rhetorical understanding of how institutional discourses help formulate the category "malingerer."

Burkean rhetoric and its uptake in rhetorical genre studies provide a framework for understanding the rhetorical embodiment of a medical condition that by definition has no material evidence, but which has material origins and consequences. All of the authors in the array of texts under consideration in this paper are grappling with the same body/mind dichotomy that confronts not just the medical community but also those who would theorize the rhetorical body rhetorical genre studies. Carolyn R. Miller's observation that through genres "we learn … what ends we may

have" (38) suggests that genres are not simply strategies taken up according to consciously perceived social exigencies; they also structure and shape those social exigencies, and the identifications they entail, by defining them according to the discourses provided by the genre. Since Miller's ground-breaking work, others have shown how identity performances are shaped by genres in various settings and not always with ideal consequences (e.g., Fuller and Lee; Emmons; Segal *Health*; Segal "Breast"). Most relevant to this study are the observations from Segal about how genres shape answers to the question "How shall one be ill?" ("Breast" 16). The breast cancer narrative, for example, limits women to certain roles as agents, both feminine and a "fighter" of the disease. It is impossible, it seems, to just *be* ill. We cannot do so without metaphor (here Segal is alluding to Susan Sontag's *Illness as Metaphor*) and without narration, which suggests, of course, that one cannot be ill without rhetoric.

For Kenneth Burke, these ways of looking at language in use constitute an extension of "the range of rhetoric" to include conscious and unconscious identifications that are linked to contexts. (See Bruner for a recent discussion of the "rhetorical unconscious.") "Identification" is not a one-time event as much as a diffuse aspect of being languaged beings. In *A Grammar of Motives* Burke introduces dramatism as his "generating principle" for understanding human motivation, utilizing ratios of five elements associated with drama, namely scene, act, agent, agency, and purpose (xviii).These are not rigid nor necessarily discrete categories for Burke: "What we want," he says, "is not terms that avoid ambiguity, but terms that reveal the strategic spots at which ambiguities necessarily arise" (xx). Various elements in a field can be assigned various motives even in the same situation. Dramatism calls for analyses based on a range of

dramatistic ratios, in particular the scene/act ratio and the scene/agent ratio, which for Burke are "at the very centre of motivational assumptions" (11). A patient, as the term suggests, is often scenic in the doctor-patient encounter (xxii). And the patient-as-body may be the scene not only for the doctor, but also for the disease. In her rhetorical analysis of medical reports of the Tuskegee Syphilis Project, Martha Solomon notes how readers in the medical profession can "regard the subjects as 'scenes' or 'agencies' in [the doctors'] own endeavours" (244). This dehumanization of African American men left them to suffer as unknowing subjects of a study to trace the trajectory of untreated syphilis longitudinally.

Within the rhetoric of malingering, the medical profession—which may have originally held the malinger up as a purposeful agent posing a challenge to the rigors of scientific medicine from the outside—has since encompassed the malingering body as both a scene for diagnosis, and the agency, instrument, or means via which knowledge of the subject is pursued.

Burke notes how scenes do not so much change people's essential character as bring forth appropriate types of people, or "appropriate voices" (19). Extending Burke's claim, we could also argue that particular scenes also bring forth "appropriate bodies." To posit such fluidity between the materiality and the sociality of the body is to acknowledge how the body both *is* and *is not* "text," and illustrates more generally, I think, how a rhetorical approach mediates between empiricism and post-structuralism. It is a paradox prefigured and portended in Burke's "paradox of substance," which is, as he describes it, that a "given subject both is and is not the same as the character with which and by which it is identified" (32). The paradox of substance recognises identity as relational as opposed to

essential, as social subjects gain their identity through consubstantiality with others. The paradox of substance is also the paradox of the body, a Burkean "scene" or stage upon which a variety of knowledge making enterprises are enacted, but also an agent in the motivational economies of other scenes, notably those of detection or diagnosis.

Once malingering has been ascertained, there are consequences, and while diagnosis infers treatment, detection infers punishment. In *Discipline and Punish*, Foucault elucidates how seventeenth- and eighteenth- century tactics of social control involved public spectacles such as torture and execution, which were eventually replaced by institutional vigilance via the modern prison system and by self-monitoring via an internalized panopticon. This shift heralded an extensive knowledge-making venture in which "knowledge of the offence, knowledge of the offender, knowledge of the law … made it possible to ground a judgement in truth" (19). The soul of the criminal became the object of a discourse, and the desired outcome of punishment became not revenge but prevention, treatment and cure, thus heralding a shift from the "vengeance of the sovereign" to the "defence of society" (90). Done under the guise of "humanizing" the treatment of criminals, it had the effect of generalizing judiciary power. Using the penal system as an example, Foucault is able to argue that knowledge itself is a product of power relations, as self and institutional surveillance merge in an all-encompassing continuum of knowledge making and subjection.

In light of Foucault's work, it is on the boundary between the body and the social where motives of institutions and those of individuals come together in institutionalised medico-psychiatric and forensic genres.[1] It is in these genres that malingering is "rhetorically

constructed," which does not deny the presence of the body or its disease (Segal *Health* 39, drawing from Hacking). Rhetorical genre theory also enables me to suggest that between varying degrees of minimization and exaggeration of symptoms there really can be no neutral assessment of one's own condition, a dilemma that continues to haunt medical genres in clinical and other professional settings today.

DETECTION AND THE "VENGEANCE OF THE SOVEREIGN"

If to feign illness requires medical rhetoric, so too does its detection. In his 1834 *On Feigned and Factitious Diseases*, Hector Gavin created a diagnostic tool in the form of a listing of all the complicated ways in which "the honourable physician" could be made the dupe of an "artful impostor" (vii). With its goal of categorizing those soldiers and sailors who were shirking military and other life-threatening duties, it is one of the earliest examples of addressing malingering as an object of scholarly attention.[2] Gavin was responding to the concerns of his day about the incidence of malingering and exaggeration by soldiers in a context of Britain's increased involvement in wars and growing actuarial concerns about the increase in military pensions resulting from doctors being too easily duped and too free with medical certificates.

Gavin acknowledges "the difficulty of distinguishing the feigned from the real" in medical diagnosis (iii) and recounts various detection strategies to catch out the culprit . These strategies often included taking advantage of the element of surprise: "There are circumstances in which it is necessary to visit the patient at intervals,

and unexpectedly, and to have him watched by persons whom he does not suspect" (40). Surveillance would be necessary only because of costs incurred. The malingerer is seeking benefits; the military is seeking to project unity and conserve resources (both financial and embodied), positioning the institution of the military and the allied pension system as motivating scenes upon which these acts gain meaning. In his discussion of "the paradox of substance," Burke ascertains four directional "nuances" to the term motivation (motion, movement, emotion, and moment). Moments "are directional in that, being led up to and away from, they summarize the foregoing and seminally contain the subsequent" (*On Symbols* 245). The physician alerted to the possibility of malingering, as one could imagine, was very much shaped by previous discourse. As Segal notes of patients with migraines, "the headache patient . . . is helplessly exposed before he or she has said anything at all" (49). Over the twenthieth-century, the biomedical subjectivity of migraineurs shifted in terms of gender, first as a man who was described as ambitious, over-achieving and in accord with other positive male stereotypes, and then to the negatively valanced (needy, uncompromising, overly fussy) female sufferer (Segal 49).

It was initially also a male prerogative to malinger, and men made up the bulk of case studies by far in Gavin. Women did, however, figure as he increased his purview to general practice, saying

> one or other mode of feigning is often resorted to in civil life, especially among indulged females, in order to obtain compliance with their wishes, or to excite interest, or for the pleasure of deceiving; and, in such cases, the practitioner may lower himself in the estimation of the person attempting to impose upon him, by not detecting the cheat. (16)

To be successfully duped by a woman was especially degrading, and

female patients were subject to particular scrutiny. In John Collie's *Fraud in Medico-Legal Practice*, first published in 1913, there is a chapter on "Malingering in Skin Affections" in which he describes cases of the mysterious wounds and scars presented on the bodies of young women. Once these wounds were determined as self-inflicted, they fell into the category of "dermatitis artefacta," and became of little medical or for that matter psychological consequence, unless it fit "with the class of case in which pecuniary advantage is likely to be gained" (361). It turns out there had been a rash of such cases after one maidservant had been paid five pounds as "compensation for dermatitis, alleged to be caused by irritant soap and alkalies" (361). Other than catching the culprits, Collie's interest did not venture beyond comments about "hysterical girls who injure themselves to attract attention" (352), ignoring other potential explanations of why young girls would repeatedly present such self-mutilations.[3] That which first presents itself as an amorphous embodied symptom becomes intransigent once signification happens in a particular gendered discourse, moral regime, or scene of arbitration.

Gavin also drew from available stereotypes in characterizing those with both real and malingered conditions. The French, for example, were more likely than the British to suffer from nostalgia, due to their "gaiety of heart . . ., which unfits him to bear disasters" (176). But nostalgia is hard to feign, apparently:

> The nostalgic has no appetite, and often obstinately refuses to take food, he wastes into a marasmus, which leads him to the tomb, while the simulator preserves his appearance of health and stoutness; he has no inclination for prolonged fasting, and however obstinate in remaining in bed, and affecting to be morose, sorrowful, absent, or taciturn, he always returns to the demand of "something to eat." (177)

And the British, of course, were praised for being less likely than others to feign disease in general: "The Irish are the most numerous and expert at counterfeiting disease. The Lowland Scotchman comes next to the Irishman, and what he wants in address, he makes up in obstinacy"(23). This is not to say the labouring class in Britain escaped criticism: Collie commented at length on the propensity of the British working man who would lose his "honest desire to work, hav[ing] become gradually mentally and morally debased" from having taken some time off work due to illness (3).

Gavin lists historical examples of the times when what was first artfully feigned eventually became seriously real. In the case of Pope Julius III, so the story goes, the eventual reality of a malingered condition led to his unfortunate death via gout (iii). Gavin also acknowledges the distressing possibility of physicians "unjustly punishing the innocent" with a false charge of malingering (iii). The disposition of doctors here is paramount. Not only do they need to be experts in knowing the etiology of all conditions that are susceptible to malingering, they must also reign in any enthusiasm for the chase. Any "degree of éclat attending the detection of a fraud" (42) is "likely to lead the practitioner astray" such that "the innocence of the party has been compromised by the vanity of the inquisitor" (43). After listing a few examples whereby those falsely charged with malingering have gone on to suffer or even die, care is then taken to protect the morale of the medical professional who might get disheartened by reading of too many such accounts: "I could illustrate the statements which have just been made by reference to many cases, but for the honour of medicine it were more advisable they should be forgotten, except for the lessons of caution which they contain, and which should be ever remembered" (43-4).

The honour of medicine was also protected, as it is today, by physicians limiting themselves to judging the presenting symptoms, and not concerning themselves with "judgments about intentional deception", leaving the latter up to the judiciary (Malle 83). But Gavin did have some things to say about appropriate punishments, exemplifying what Foucault calls "the transparency of the sign to that which it signifies" (104). Punishments, in other words, were devised to fit the crime, and to signal that crime succinctly to others. For example, if a soldier or sailor were to demonstrate his cowardice through malingering, then he would be made to perform that cowardice in public. The Greek stratagem for dealing with those who avoided going to war, for example, involved placing them "for three days on the scaffold, in women's habiliments" (Gavin v).

This impulse to use shame continued into the nineteenth century. Sailors in the British Army who were caught out as malingerers, Gavin advised, were to be lined up outside the captain's cabin, "there to be admonished by him, . . . as the captain's addressing them in a language calculated to operate on their minds as British sailors" (42). Here, the "vengeance of the sovereign" has taken on what Foucault calls "the gentle way in punishment," with a new impetus to reduce crime "with ridicule and shame," rather than public torture, execution, or branding (Bacarria, qtd. in Foucault 107).

Bodily symptoms that are suspected to be surreptitiously self-inflicted or exaggerated complicate the doctor-patient relationship by countering a medical ethos based on "assumptions of honesty and self-disclosure" (Rogers 1). Tensions ensue when doctors cannot make confident predictions on the intentionality of their patients, and, as Malle recently points out, it is intentionality that makes malingering "more blameworthy" than related disorders such as

hypochondria (81). In Bassett-Jones and Llewellyn's day, it was "the duty of the medical man to protect the State from *imposition*" (40, emphasis in original), even though "[t]o abdicate the title of doctor, to assume that of detective, is to contravene the absolute rule that every examination ought to be impartial" (Sand, qtd. in Bassett-Jones and Llewellyn 85).[4]

As well as occasionally being duped by malingerers, the medical profession also has a history of being complicit in their formation. Doctors treating soldiers during the U.S. Civil War would, for various reasons, "conspir[e] with the malingerer", aiding and abetting his deception (Lande 151). Some would do so out of sympathy; but also, it was in the interests of overworked doctors and nurses to keep recovering soldiers—referred to as "hospital birds"—for as long as possible in return for their efforts helping with day-to-day operations; hospitals were so understaffed and entreaties for more staffing so often went unheard (Lande 147). Similarly, by 1917, Bassett Jones and Llewellyn warned of this "temptation to the medical man," saying that "the refusal of a certificate to a member of standing among his fellows may mean the eventual loss of [the business of other members of his club], a substantial loss of income" (42).[5]

Mostly confining itself to the detection of malingerers in military contexts, Gavin's is one of the earliest examples of a systematic account of all the diseases for which there are records of simulation. Morality figured strongly as a basis for detection. For example, for Gavin, the truly insane demonstrated no moral attachments to family, whereas the malingerer "openly shows his ordinary fondness for his immediate relations" (142). Similarly, Bassett-Jones and & Llewellyn write it is "in the moral and ethical sphere that the

ultimate origins of malingering are to be sought" (11). The emerging discipline of psychology re-encompasses the immoral malingerer by positing the essentially moral disposition as a psychologically healthy one.

Thus diagnosis would help ameliorate the medical establishment's discomfort with detection (and punishment), and replace it with objective biomedical observation. Doctors could turn their attention away from the detection and exposure of the immoral malingerer, to focus instead on the (intellectually interesting) psychological foundations for such behaviours, constituting a shift from acting as moral and ethical arbiters of behaviour to a more diligently scientific approach.[6] In Foucauldian terms, then, we see a shift from the judgement of a sovereign power to a concern with "the defence of society" through the medicalization of social deviance. "In the old system," says Foucault, "the body of the condemned man became the King's property, on which the sovereign left his mark and brought down the effects of his power. Now he will be rather the property of society, the object of a collective and useful appropriation" (109).

DIAGNOSIS AND THE "DEFENSE OF SOCIETY"

In their history of the precedents for Munchausen Syndrome by Proxy (MSBP), David Allison and Mark Roberts argue that the impulse for books such as Gavin's was not medico-scientific or etiological, but rather "a practical matter, one governed by financial concerns, social control, the coherence of medical models, and questions of legal and professional responsibility and status" (80). In other words, the whole diagnostic drive can be seen not just as the

exercise of medical power, a discursive process of scientification in the face of uncertainty over the vagaries of human behaviour and motivation, but one that was driven by "cost-conscious industrial productivity, the efficient use and effective punishment in the military services, and the restoration of proper morality and behaviour within the social order" (79).

As mentioned above, the developing disciplines in the area of psychology would provide a new focus on both the diagnosis of malingering, and on treatment (Allison and Roberts xxvi). Debates about "war neuroses" that waged up to, during, and as a result of World War One exemplify the tensions between a mostly conservative medical profession and the emerging welfare state, heralding a time when, according to Wessely, "malingering moved from the political to the medical sphere" as a mental health issue (31).

According to an overview by Rogers, there are three models through which malingering has been understood in the area of mental health: pathogenically, as the result of an underlying mental disorder; criminologically, based in DSM understandings of anti-social behaviour; and adaptationally, based on predicted utility in contexts (8). Rogers critiques the first two approaches on empirical grounds, and because of the underlying assumptions of "madness" or "badness" of each paradigm respectively. Empirical work leads him to favour the adaptational model, whose attention to context allows for a range of presentations from outright deception to the sort of impression management that we could argue approaches normal interpersonal self-fashioning. As a forensic psychologist, Rogers (and the other authors in his edited collection) sought the standardization of criteria for the purposes of developing and testing multi-scale inventories and other statistical measures, useful, for

example, in determining defendants' fitness to stand trial, in sentencing hearings, or in insurance claims.

Definitions are important in these forensic settings, especially between malingering, for which there are supposed external incentives such as money or rest, and factitious disorders for which there are not. Allison and Roberts dispute that this distinction can be maintained at all, or that they are merely "a pretext for physicians … to exercise punitive power over those people who happen to deceive them" (Allison and Roberts, 68, drawing on Satz). Similarly, psychiatrist Alan Cunnien, makes the point that whereas the DSM makes a distinction between malingering as understandable in terms of the extrinsic goals of the individual and "factitious disorders" where goals are intra-psychic, "clinical experience demonstrates that various levels of intention can coexist" (qtd. in Rogers 24), and that "the mere presence of external gains cannot negate in every case the primacy of psychological motives" (25).

Keeping these categories under control is no easy task. From a rhetorical perspective, Stuart Kirk and Herb Kutchins point out that such ongoing processes of negotiation and revision are the hallmark of the DSM, "keep[ing] critics off balance [struggling] to criticize a constantly moving target" (15). We also know from rhetoric that naming a category is accompanied by a loss of information. Kenneth Burke tells us that vocabularies are by nature a selection of reality, and therefore a deflection of reality too, which renders definitions of medical conditions so amenable to rhetorical study.

Segal, for example, sees hypochondria as "a rhetorical disease if ever there was one" ("Breast" 18). Both hypochondriac and malingerer need to persuade the doctor that they are ill, but the hypochondriac

has already persuaded themselves—or they have been persuaded by others, in the form of "external elements" such as advertisements (Segal *Health* 74). Both the hypochondriac and the malingerer seek the benefits of the sick role—the hypochondriac for the purposes of treatment, and the other for material benefits. Both create a situation for doctors that requires, in the words of Halligan, Bass & Oakley, "the seemingly impossible task of inferring the level of conscious awareness, the degree of consciously mediated intention, and the motivations that accompany the symptoms presented by their patients!" (9). Although seemingly defeated by the task here, the general trend of current research still seems to be to proceed with the goal of thoroughly teasing out and distinguishing psycho-medical causes for malingering (which to varying degrees absolve moral responsibility) from those rooted in conscious deception and free will (which do not). As Segal writes about hypochondria—"Rhetoric reframes the problem. Discursive elements of hypochondria are rhetorical, and bodily actions are rhetorical as well" *(Health* 76)—so we can say about malingering.

To sum up thus far, most of the early attention given to malingering came from its explanatory potential in regard to shirking military duty; framed as a sin of going against God's will, it betrays a focus on morality. Malingering was therefore a crime, whereby would-be malingerers risked prosecution and punishment. It then becomes a diagnosis, a psychiatric condition needing treatment. We could say that concerns over the detection and diagnosis of factitious disorders and malingering range, as Allison and Roberts put it, from being "politically inspired" to being economically so (xxiii). Detection worked for underwriting a nationalistic and patriotic military concerned with actuarial costs; diagnosis emerged at the point when therapeutic approaches were claiming efficacy in "getting soldiers

back to the front" and maintaining a diligent and uncomplaining workforce.

"DISCIPLINING UNCERTAINTY": DETECTION REVISITED

I now return to the trajectory that emerges in discourses *responding* to malingering, which displays a shift toward modes of governance characteristic of late modern society, and consists of a return towards detection, this time within the insurance industry and forensic psychiatry, as doctors are finding themselves testifying as expert witnesses in compensation lawsuits, or in cases determining fitness to stand trial. In this paradigm, doctors can once again end up engaging in deceptions of their own, supposedly in order to catch malingers out. In the early twentieth century Bassett-Jones and Llewellyn extrapolated on many such strategies, from "method[s] of surprise" (84) to "lay[ing] espionage" (92). Similarly, Gregory Lande talks of Civil War doctors' "clever diagnostic manoeuvres and aggressive almost sadistic, conventions" (133). Today, an entire sub-field of forensic psychology lists "malingering" as its first concern of practice on Wikipedia, and numerous experts now weigh in on insurance fraud. One industry magazine lists strategies for detecting malingerers from psychometric testing, to simple physical tests to determine if claimants complaining of mobility problems are "putting forth [their] best effort": "Can the patient put on his overcoat unaided, while reporting an inability to raise his arms above shoulder height?" (Young and Doyle 35). Richard Ericson, Dean Barry and Aaron Doyle describe the training that insurance adjusters get as aimed at converting them to a "routine distrust" (318); meantime, the public discourse on insurance fraud is aimed at

converting members of the public at large "into agents of fraud prevention who will refrain from exaggeration themselves and serve as informants on other fraudsters" (318).

Interestingly, it was with knowledge of the frequency and success with which soldiers were malingering that Gavin originally devised a scheme to actuarialize the losses associated with malingering during and after World War One, stating as his aim to write "a correct history of the modes of fraudulently simulating disease" (v), as well as a "formulation of such a classification" for the purposes of assessing pension claims (v-vi). He wanted to come up with pension rates based on such frequencies, or as he put it whether or not "the disease on account of which [soldiers] are discharged was or was not capable of simulation" (vi). Recognising the injustice inherent in his proposed system—that "such a rule might (and probably would) be attended with individual injustice"—he nonetheless declared that "its practical advantages would counterbalance such a minor grievance" (vi). Thus, those who legitimately suffered from a condition that might otherwise be easily malingered would receive less compensation as a result. Here we see an early instance of the ways insurers today pass off the costs of fraud onto the consumer, not evenly, but according to various forms of what we call today risk assessment, or, as Nikolas Rose puts it, "disciplin[ing] uncertainty" (214).

In the assessment of mental patients' real risks to themselves and others if released into the community, Rose notes how strategies become more "managerial" the higher the risk, from the "voluntary and self managed" efforts involving therapy in low risk cases through to the highest risk cases wherein "the professional vocation of therapy is replaced by that of administration" (217). It becomes

increasingly harder, says Rose, for the state "to articulate its reciprocal obligations," i.e., protecting individuals from the "actual and symbolic violence" they face as a result of being subjected to these institutional power arrangements (217).

Rose's account shows how risk classifications enter and become stabilized in organisations such as psychiatric wards and the criminal justice system. The risks of malingering and fraud are similarly institutionalised in the insurance industry. In fact, one could argue that Gavin's strategy for passing on the costs of diseases that are at a higher risk of being malingered to those suffering from the condition finds its parallel in an idea afoot in the insurance industry to reward those who agree beforehand to comply with surveillance in the event of a claim with lower insurance premiums. Organisations are subjecting workplaces to "medical surveillance" to increase workplace safely, but also to decrease the costs of insurance (Amacher). Ericson, Doyle and Barry describe the situation as follows:

> Categories that discriminate actuarially can establish differences in cost related to risk. …. Market forces therefore drive all companies in the direction of finer risk rating. This results in more money being spent on surveillance for knowledge of risks, which escalates administrative costs and therefore premiums, leading to further unpooling. (51)

The authors draw on Foucault here, noting that while his focus was on the state and its regimes of discourse and power, "the same techniques are part of private institutions" (30). In Burkean terms, "risk" is now an objectively determined signifier in actuarial contexts, deflecting attention away from the potentially ailing body, with real risks of suffering, sickness, or work place injury, whether in the military, the workforce, or the school. This larger context for

the institutional management of malingering-as-risk can be characterised by "a decline of innocence as every member of the population is suspected to the degree that they might contribute to risk" (*Insurance as Governance* 56). The need for diagnosis and detection is thereby disembodied and diffused, replaced with systems of disaggregated risk based on characteristics of populations. Within this system, denials or affirmations are made for insurance claims and/or workplace accommodations in ways that suggest a clear demarcation is possible. The momentum for detection has been subsumed in managerial systems of risk assessment, where "malingerer" need only be an implicit category.[7]

What is missing from the account thus far are the perspectives of the malingerers themselves. These could come only through those very rare first-hand accounts of how members of subordinate groups resist their domination, or via literary representations. Such accounts could bring forth more humanistic understandings than can be garnered via the otherwise pathological accounts in medico-legal texts. Below, I illustrate how, alongside these dominant discourses in the history of malingering, a counter-discourse is emerging that is, if not counterhegemonic, at least carnivalesque.

THE "HIDDEN TRANSCRIPT"

While wartime scenarios generated early definitions and diagnoses for malingering, accounts of malingerers themselves were almost non-existent. Letters and narratives written by conscripts might be a place to turn, but these are complicated by low levels of literacy, and both institutional and self-censorship (Doherty). As for fiction, Corporal Klinger from the long-running TV series *M.A.S.H.* is

probably the most well-known figure from pop culture who fits the category of malingerer. Klinger is determined to get out of the military via a Section VIII discharge, which determines unsuitability on the basis of, for example, "habits or traits [included acting out behavioral disorders, alcoholism, and sexual perversions as homosexuality] which serve to render his retention in the service undesirable" (Bernucci n.p.). Klinger dresses as a woman, although never identifying as a transsexual or a homosexual.

Because of the nature of World War One in particular, during which a lot of the current bases for the definition, diagnosis, and detection of malingering got their start, and where unranked soldiers were in many cases subjected to terrifying coercion, one can imagine and look for other examples. While frontline soldiers were working-class conscripts, their officers and generals came from the ruling and privileged classes of England, which enabled them to stand back from the front. World War One accounts of commanding officers forcing their men at gunpoint to go "over the top" illustrate this dynamic. Morale was often at a very low ebb, as many questioned their rulers' decisions to continue the war in the face of heavy losses and dubious outcomes.

The U.S. Civil War was also rampant with social inequalities; many soldiers were fighting by virtue of a system of draft substitution, whereby those who could afford it would pay another man to take their place in the war (Lande 132). First-hand accounts of resistance are hard to find, although some of the case studies reveal evidence of families conspiring with doctors to get a soldier home safely, or soldiers agreeing to shoot off each other's hands or fingers to be sent home from active duty. In 1913, Collie first published his *Fraud in Medico-Legal Practice,* which refers at length to the "science" that can

detect whether a hand or finger has been shot off at point blank range. But it is very hard to detect without a witness when a desperate soldier can simply raise his hand out of the trenches and into the firing line, or when they conspire to oblige each other with a well-aimed shot (252-4).

James C Scott coins the term "hidden transcript" to describe a structured feature of discourse that manifests wherever dominant groups exert inordinate power over their subordinates. It is counterpoised with the "public transcript" of subordinate groups, which enables members to assemble in public a surface attitude of compliance and respect. The hidden transcript "consists of those offstage speeches, gestures, and practices that confirm, contradict, or inflect the public transcript" (4-5). Scott is careful to differentiate his focus from Foucault's, which takes as its object "impersonal, 'scientific' disciplining forms of the modern state," saying he is "concerned with structures of *personal* domination" (62, italics in original). His examples include hospitalized slaves in Trinidad, and he recounts how, upon their emancipation, "[t]he hospitals were emptied; the sick were cured, the lame healed, the blind were restored to sight, and the insane to their senses" (46). Such is "the miraculous result of the sanatory effects of freedom" (46).

In order to know for sure if there is a hidden transcript, we would "need to peek backstage" (Scott 4), something that is not easy to do. Scott offers numerous literary accounts of how the hidden transcript finds expression, and in that spirit, I turn to Roch Carrier's *La Guerre, Yes Sir*!, which opens with the character Joseph chopping off his own hand with an axe to avoid conscription into the war Canadians were at the time fighting in Europe. Joseph's practical resistance comes with it a carnivalesque mad glee; after his bloody

hand falls to the ground, he "burst into a great laugh. . . . he hadn't had so much fun since the beginning of the war" (5). Readers may be simultaneously amused and horrified at this scene.

That we can know a hidden transcript only through its effects undergirds Scott's definitional statement that it is not just the discourse, but it is also the practical gains: "*It would be more accurate, in short, to think of the hidden transcript as a condition of practical resistance rather than a substitute for it*" (191, italics in original). For Joseph, the practical resistance is to chop off his hand, and the practical reward is self-preservation. In the words of one of his countryman, who decides to hide and wait the war out, "I'm not going to lose a single hair in their goddam war. . . . The big guys have decided to make their war. Let them do it alone, without us" (8). This fictional account of a hidden transcript illustrates both personal and desperate sacrifices, but also the humour with which resistance can be enacted and recounted.

CONCLUSION

Roch Carrier's Joseph expresses delight at his gruesome self-mutilation, bringing to mind Spivak's "fearful pleasure of a truant world" (lxxii). A rhetoric of malingering would allow for such pleasure, beyond what transpires in the doctor-patient interview, and in the conscious and intentional duping of medical professionals. In a modern world where uncertainty is tamed "by gridding the free and liberal space of community with surveillance, calculation, communication, and control" (Rose 228), malingering can be seen at least in part as a response to such gridding. As Foucault explains, during the Ancien Régime the less privileged in society looked for

ways to defy or avoid restrictions placed upon them. At that time, a person's run in with the law was a random misfortune, a matter of engaging in some activity at the wrong place at the wrong time. We don't live in that world anymore. But regardless of the sophistication of rhetorical and technological strategies for detecting malingering and other "moral hazards," such strategies can only "structure, shape, and manage moral hazards rather than eliminate them" (Ericson, Barry, and Doyle 549).

As for Burke, his "ambiguity of substance" can give the material body its due, while his contention that processes of identification can "operate without conscious direction" (559) supports a view of malingering as in part motivated substructurally by institutional genres and discourses. Rhetoric's imperative is to see the social world as both materially and discursively situated. In his own discussion of malingering, Burke speculates that people can persuade themselves that they are ill so that they can "claim the attention and privileges of the ill (their feigned illness itself becoming, at one remove, genuine)" (560). Malingering draws on the same discursive resources available to those who are really ill. All sides, it seems—patients, doctors, insurance adjusters—can be implicated in a range of conspirational and institutionalised *pas de deux*. Those involved in malingering's performance, and those involved in its detection and diagnosis, can all draw upon, and even *study*, "persuasive resources," and are, thereby, *de facto* rhetoricians.

If both the ill and the feigning draw on the same rhetorical resources and genres to have their needs met as (pseudo) medical subjects, then they also face the same uncertainties. Similarly, in ambiguous cases, doctors' genres or routines of behaviour could be indistinguishable, whether they are responding to a patient's presenting symptoms or

their own suspicions, essentially acting according to two different scenes simultaneously. Catherine Schryer points to the distinction between patients' subjective symptoms and doctors' objective signs as an essential division in medical discourse, one she notes finds its way into the genre of insurance companies' claim rejection letters; in medicine, and therefore in rejection letters based on medical evidence, "signs have more ontological reality than symptoms" (67).Whether the illness is feigned or real the play of signs goes on.

Rhetorically, the medical profession strives to eliminate any ambiguity of substance that interferes with the scientific momentum motivating medicine. But despite its medicalization and criminalization, malingering can be artful and pleasure-ridden, and, from Gavin's era to insurance adjusters of today, so can its detection. This broad account of a shifting rhetoric of malingering can point to opportunities and sites for the "further empirical refinement" posited by Bazerman (2008) in his overview of methods and questions for writing studies (302). One could also speculate, for example, that the rhetorical construction of malingering was shifting as more and more raced, classed and gendered individuals wanted access to medical care, insurance and other social benefits over the course of the century, perhaps just as the discourses of psychosomatics and hysterics may have increased as women sought representation in the public sphere.

Apart from my own anecdote, this discussion has focussed only on secondary genres, but I have tried to show another side to those patients, soldiers, and workers who have otherwise only been made visible via the suspicious accounts of institutional actors. Chavez argues that rhetorical scholarship itself often "surveils and disciplines bodies" (246), and betrays, perhaps, a problem of ableism: "with rare

exception, only when actual bodies are *not* white, cisgender, able-bodies, heterosexual and male do they come into view as sites of inquiry" (246, italics in original). Future research would wisely pay attention.

A rhetoric of malingering is not designed to catch out malingerers by understanding their persuasive strategies; the detection and diagnosis of malingering is not a solution to a problem as much as a justification for a course of action. And that course of action usually includes more structures of surveillance and risk management, occasionally accompanied by more fearful pleasures.

NOTES

1. See Sharon Crowley ("Afterword") for an overview of the fluidity between mind and body, inside and outside, normal body and not normal body. The distinction between the insides and outsides of bodies is even difficult to maintain physiologically. About all the ways in which discourses would attempt to demarcate such boundaries, Crowley says they "are never disinterested" (363).
2. The difficulties Gavin posed for physicians in the nineteenth Century have remained, creating copious amounts of recent professional discourse on the topic. For example, in their introduction to *Malingering and Illness Deception*, the editors describe a similar problem for doctors in terms of a conflict between their duties toward the patient and to society as a whole, "a confusing problem which in the legal profession has been solved by separating the advocate from the judge" (Halligan et al., citing Berney

5).

3. Today, of course, such symptomatology would catapult the case into a completely different realm of possibilities, seeing "cutting" behaviour as some form of acting out, potentially in response to abuse or deprivation.
4. Burke warns against such blanket assertions of impartiality; speaking of the pursuit of science during times of war he writes: "The liberal ideal of autonomy is denied [scientists], except insofar as they can contrive to conceal from themselves the true implications of their role" (*Rhetoric* 35).
5. Collusion today might more likely take the form of GPs signing sickness certificates, or manipulating codes so that patients will qualify for insurance reimbursements (See Wynia for a complete account; see Malleson for an account of whiplash).
6. Collie makes mention of how "malingering" was a term to be avoided in a legal settings: "nothing I find pleases the plaintiff's counsel better than to get a medical witness to use the word 'malingerer,' for he knows he can then appeal to prejudice" (63).
7. I would like to thank one of the reviewers for taking me down this line of thinking.

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