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BY

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ON FEIGNED DISEASES.

In the experience of most general practitioners, malingering, or the feigning of disease, is happily of such rare occurrence that but very little attention is devoted to a study of the subject. Cases, however, crop up now and then even in the most select of practices, and many, I have no doubt, on account of their comparative infrequency, remain undetected. The medical attendant, unsuspicious of any motive to deceive, is naturally puzzled with the anomalous symptoms presented by such a case; he tries all sorts of remedies, becomes eventually chagrined because the cure is protracted, and attributes to the failure of his art the unsuccessful issue of a disease which in this instance did not exist. One is so loath to believe that the sick-bed should be made the arena of deception, that rather than yield to suspicions even though they be well founded, we sometimes fall back upon the complexity of disease, the uncertainty of diagnosis, and end by giving the scheming patient a good deal more than the benefit of the doubt. Hence it is that club patients occasionally make capital out of their clubs, that paupers mulct the parish unduly in the way of relief and extras, and that persons, after receiving handsome damages for a railway accident, often recover with a rapidity which is truly astonishing. Every medical man therefore is, to a certain extent, the custodian of public justice and morality, and in so far as he fails to detect such fraudulent attempts which come under his notice, so far does he fail in discharging efficiently the trust reposed in him.

Perhaps amongst no class of individuals, not even amongst soldiers, is malingering practised with such skill and persistency as amongst convicts; and this is not to be wondered at when we consider the low *morale* of the class generally. "Be civil and take it easy," is the motto of the habitual criminal during his imprisonment, which means simply that a man has a perfect right to his opinions, provided always he keeps them to himself, and that his duty is to do as little as he possibly can in the way of work without running the risk of being reported, or, if the work becomes too severe, to "shirk" it by any expedient which he can adopt.

Formerly, when pardons were granted on medical grounds, the temptation to malinger was considerably greater than it is now, though even now the arduous work and scanty diet of a hard-labour prison render the convict's life distasteful enough. If, therefore, he is put to work which he does not like, he considers it quite fair to sham any illness in order to be recommended to lighter work, to gain admission into hospital, or if possible to become invalided and sent to an invalid prison. Sometimes, again, he feigns insanity, that he may have a chance of being removed to a criminal lunatic asylum, or be enrolled amongst the imbecile prisoners.

Naturally, the code of criminal ethics is so very liberal and elastic, that scheming and duplicity are not only deemed quite legitimate, but the convict who excels in such qualities deserves well of his fellows, provided always he treats them honourably, or, in other words, does not play the part of spy or informer. Hence it seldom happens that the surgeon receives any information relating to a case of malingering from other prisoners; and if he does, the chances are that any such statement would turn out to be a falsehood. Under these circumstances, he has to depend on his own acumen, with whatever aid he can obtain from infirmary warders in the way of observation.

It may be inferred from these remarks that very little reliance can be placed on what are called the subjective symptoms in cases of doubtful illness amongst convicts. Indeed, so much is this the case, that the prison-surgeon, after no lengthened experience, becomes very sceptical concerning such symptoms unless they are confirmed by objective signs of disease. I confess it is not a pleasant feeling to be constantly influenced by this sceptical turn of mind, for it is apt, unless carefully kept in check, to lead one into mistakes; nevertheless, it is the most effectual safeguard against being imposed upon, and I cannot help thinking that a little of it would tend to lessen the number of glaring discrepancies which are too often observable in the medical evidence given before a civil court in cases of railway accidents. Although I have personally had no experience of such accidents, I feel quite sure that if subjective symptoms were as closely scrutinized as they are in prison, the damages which railway companies are made to pay would be materially lessened. No doubt, a hysterical woman, or a hypochondriacal, nervous man, would be very liable to suffer after a railway accident from symptoms characteristic of what has been called "railway spine," even if no actual injury beyond a good shaking has been received; yet though these symptoms are only imaginary, they are very distressing to the patient, and do not in the least impugn his good faith. Hence, in all cases of railway or other accidents claiming damages, it would greatly assist in forming a correct diagnosis to adopt the system which one is induced to pursue in prison—namely, to inquire minutely into the

previous history and character of the patient, and to discover, if possible, the existence of any motives for deceiving. It would be well also if the parties sued for damages had the power of refusing compensation to doubtful cases, unless they submitted to be put under observation in an hospital or elsewhere.

Without attempting to follow any formal classification of feigned diseases, I shall now proceed to point out in detail some of the more common phases of malingering, illustrating by cases derived from prison experience and other sources. And first with regard to feigned injuries and diseases of the spinal cord. Cases of this description are of great importance medico-legally, because they are of such frequent occurrence after railway accidents. The form of disease, or rather symptom of disease, most usually simulated is paraplegia, and though the mode of detection and management must necessarily vary according to circumstances, it may be of some interest if I describe briefly a typical case of the kind occurring in prison practice, and how it is dealt with:—If, for example, a prisoner receives a fall on the works, and has to be carried into the hospital on a stretcher, complaining of great pain in the back and inability to move his legs, but with no loss of sensation and without any signs of local injury, his statements are carefully noted, though left open to question. It is possible he may have received a spinal injury, and as it is always best to err on the safe side, the patient is put under observation, and treated as if the case were genuine. Meantime inquiry is made into the criminal history of the patient, which is fully detailed in his caption-paper, as to his conduct, as to whether he has been previously convicted; whether he has been frequently reported for idleness, or whether he has ever been charged with malingering on any former occasion. The evidence of the officer in charge of his party is also obtained, who furnishes the particulars of the accident. Next morning the night-officer reports as to how the patient slept, and whether or not he observed any movement of the legs. If now it be found that the urine and fæces are passed without any difficulty, that the pulse is normal, that the temperature of the legs is not lowered, and sensation is still intact; if it be found, also, that the fall was not of such a height as would be likely to produce serious injury to the spine, and that the prisoner is just the sort of person to make the most of such an accident,—the case looks very much like one of malingering. As a confirmatory diagnostic test, a pin or the point of a lancet may suddenly be thrust into the leg, when the limb in all probability will be flexed with an amount of violence and to an extent which cannot wholly be explained on the theory of reflex action. A dose of the galvanic, or of an electro-magnetic, battery will complete the cure, and the prisoner is discharged and reported.

Simple though the diagnosis of such a typical case may appear to be, it is necessary to take all these precautions, and to guard against hasty conclusions, because a mistake at the outset may

readily be made; and to my mind there is nothing so painful, on after reflection, as to discover that one has unjustly suspected a poor fellow who has really been injured. The following is an instance of such a mistake. One morning I was called hurriedly to see a prisoner who had fallen from a scaffolding. The scaffolding was only between six and seven feet from the ground, and the prisoner had fallen backwards on his shoulders. He was complaining lustily of pain in his back; but as the extent of the fall appeared so trivial, and as my faith in prisoners' statements was considerably shaken by that time, I concluded that he was making the most of it, and rather harshly told him so. He was carried to the hospital, and placed in a separate cell for observation. On examination, no external sign of injury could be detected, but the patient complained of great pain in the lower dorsal region, of numbness, and a pricking sensation in the legs, and of being unable to move. In the evening he had retention of urine, and the catheter had to be used. The ultimate history of the case was one of ordinary paraplegia from injury to the spinal cord. Complete loss of sensation set in; in a few days the urine became ammoniacal, and the retention was gradually replaced by incontinence. At first enemata had to be used, but afterwards the fæces passed involuntarily; the temperature of the legs became lowered; there was gradual wasting, succeeded by extensive sloughing, and the patient died twelve weeks after the injury was received. Post-mortem examination showed that the portion of the cord corresponding to the ninth, tenth, and eleventh dorsal vertebræ was disorganized and converted into pus, and that the body of the tenth vertebra appeared to project slightly backwards. No doubt, there had been effusion of blood into or round the cord, in consequence of slight dislocation and fracture.

Even in severe spinal injuries it is quite possible that there may exist complete loss of power without appreciable loss of sensation, according as the afferent or efferent tract is affected. Only a short time ago I saw a case of this kind, not connected with the prison. A workman had fallen backwards from off a timber cart, alighting, as it was stated, on the back of his head. He was insensible for about ten minutes, and when conveyed to the surgery where I saw him, it was found that he had a slight contused wound on the occiput; but he was unable to move his legs or arms, and could only grasp one's hand with the feeblest pressure. He could move his head from side to side, and had no loss of sensation. The breathing was not noticeably diaphragmatic, nor could there be discovered any external signs of fracture or dislocation of any of the cervical or upper dorsal vertebræ. Had he been a convict, I believe I would have regarded the case with some suspicion; as it was, the surgeon who attended him very properly had him removed to hospital. I have since learned that he died in a week afterwards, the paraplegia remaining, but without any marked loss of sensation. No post-mortem examination was made.

I mention these cases to show how inadvisable it is to form a rash opinion, even in cases which, at first sight, may not appear very serious. Of course, a few hours' observation, or a second examination, would settle the diagnosis in the great majority of severe spinal injuries; but every fresh case has peculiarities of its own, and if these peculiarities present themselves to us in the light of anomalies, we are apt to become puzzled, and, perhaps, over-suspicious. It has also to be borne in mind, that delineations of symptoms in text-books, however full and accurate, cannot include the varied features of every case.

But in most instances of feigned injury to the spinal cord, the paraplegia, which is generally the only prominent symptom, is a sort of after-thought; it sets in gradually, and, as a rule, is limited to the legs. A person, for example, has sustained a fall or received an injury of some kind, and, on examination, abrasions or contusions may be found in the dorsal or lumbar region. The patient complains of great pain in the back and of stiffness. He may also have numbness and "tingling" in the legs, arising from concussion. He is put to bed and nursed carefully. His appetite is good; there are no febrile symptoms, and no retention of urine. By-and-by the bruises disappear, and when it is thought the patient may get up, he says his legs are nearly paralyzed, and he cannot stand on them though he can move them in bed. Here, then, is a case in which there was undoubted injury to the back and perhaps concussion to the cord, but nothing further; and it takes no small amount of tact and discrimination sometimes to decide positively its real merits. If the patient is a resolute fellow, he will stand any amount of blistering along the spine—will even submit to an application of the actual cautery without giving in; and should he maintain that he has loss of sensation, will not wince at the thrust of a pin or lancet.

As an example of cases of this description, I quote the following from a paper published by Dr Hall, of Sheffield, in *The British Medical Journal*, 21st March 1868, on Railway Accidents:—

"Mr ——, a gentleman in middle life, had the misfortune to be riding in a second-class carriage at the time of a collision on a railway. After the accident he proceeded some distance; and, at the end of his journey, he was seen by the surgeon of the company. He complained of pain over the dorsal and lumbar regions, on which, he said, he had been bruised; and, in addition, of an inability to walk without pain. He returned to his home from London in a first-class carriage, was immediately attended by his family surgeon, and was seen by myself, for the first time, seven days after the accident.

"I found him in bed, laid on his back. He told me 'he was suffering very great pain along the whole course of the spine, and that he had not power to move his legs, or even to turn in bed.' The temperature of the whole body was normal. He had perfect command over the bladder and rectum; he said that at first he had

'difficulty with his water, but that was improved.' His pulse was 76; but as he spoke of the severe injuries he had sustained by the negligence of the company, and the heavy damages (two or three thousand pounds) that he would make the directors pay, he became very excited, and his pulse rose to 98. On getting him out of bed, he was unable, he said, to walk, or to bear any of the weight of the body on his feet; he supported himself by the table, and insisted on being again carried immediately to his bed. There was no mark on any part of the back. During the whole of my attendance these symptoms remained. He complained of a sensation of pins and needles in both legs; there was no reflex action; no drawing up or starting of the legs; no wasting. As we saw him in bed, he appeared a stout healthy man, but told us again and again, 'that he had no power over his limbs, and that he was unable to walk.' In the absence of all objective symptoms, I ventured to express a very strong opinion that no permanent injury to the spine or spinal cord had been sustained; and in this opinion three other medical gentlemen concurred. Having satisfied myself that not only could he walk without assistance, but that he had actually done so, and that, too, at the time when he assured me that he was altogether incapable of moving his limbs, I discontinued my attendance.

"A gentleman of great skill and long experience was now called in, and, through trusting to subjective symptoms only, he was led to conclude that the injury to the spine and spinal cord was severe and probably permanent.

"About three months after the accident, the case was compromised, by a payment by the company of several hundred pounds. It is, doubtless, a consolation to this gentleman and his friends now to know that my prognosis was correct, and that his and their fears proved altogether groundless. Shortly after the case was settled, he was observed walking about in the street. He has almost ever since attended to his business; and no trace of the injury remains."

Occasionally, paralysis is feigned by convicts who have been admitted into hospital, and are being treated for some other ailment. As an instance in point, I give the following case:—Prisoner G. D. was admitted into hospital 25th February for debility. He had lost a good deal of flesh, having been employed at hard labour, and said he felt dizzy when at exercise. His appetite was good, and he was put on liberal diet and tonics. Although he continued to improve in appearance and to gain weight, he himself would never admit that he was any better. On 22d March, the night-officer reported that he had a fit of some kind. Next day there was nothing unusual in his appearance. His appetite had all along been good, and he could give no satisfactory explanation of how the fit came on. He was told that he was making rather too much of it; he took the hint, and has had no more fits since. But a few days afterwards he complained of soreness in the legs, and said he could not walk

properly. When asked to walk, he went tripping along, taking short rapid steps, and without allowing the heels to touch the floor. Although I could not think so, it was quite possible that this might be some strange and insidious form of locomotor ataxy, and I therefore examined into all the features of the case as carefully as I could. I found the temperature of his legs normal; sensation normal; no wasting or flabby state of the muscles; no ocular disturbances; the urine normal. He could stand with his eyes bandaged; and, when asked to walk, tripped along as he had done before, keeping his arms extended to prevent his falling or knocking against anything. He could even shuffle backwards. The officer also told me that he could carry his urinal to the water-closet with both hands, and that, at these times, he walked much better than when exhibiting during the visit. Being satisfied as to the nature of the case, he has been treated to a daily application of an electro-magnetic battery, to which he submits apparently with the greatest resignation. Finding that this did not succeed, I applied Corrigan's cautery along the spine, so as to produce a series of small blisters, and these have been kept open by ung. sabinæ dressing. In spite of all this, he daily maintains that he is "much the same—no better and no worse." He looks well, takes his food well, and sleeps well. I have told him my opinion of his case, and have ordered an ordinary galvanic battery, which, in my experience, is far more suitable for such cases, because more powerful, than the electro-magnetic. I expect that a few doses from the new instrument will produce a rapid cure. If it be asked, how is it possible that a prisoner would submit to all this if there were not something the matter with him? the answer is that, in this case, the prisoner detests work, and is an old malingerer; in the second place, he would like to be invalided; and, thirdly, he is afraid of being reported and flogged when he is discharged from hospital. All these are sufficiently powerful motives, without taking into consideration that spirit of dogged determination common to almost all cases of malingering amongst convicts, which prompts the schemer to persist to the utmost verge of endurance, for the simple reason that, in being obliged to give in, he loses caste amongst his fellows, and is liable to be reminded of his failure oftener than he likes.

But when a prisoner, by feigning paralysis, has succeeded so far as to escape detection, and is at last removed to an invalid prison, the case presents itself in a new aspect. In the first place, the prisoner has been invalided because his disease was believed to be genuine; but beyond the mere statement of the cause of invaliding, no detailed history of the case is forwarded. The surgeon has, therefore, to trust to the patient's own account of the commencement and progress of the disease, and to the conclusions which he himself may arrive at after a physical examination. If he has doubts concerning the exact nature of the case, he is

averse to communicating frankly with the surgeon who has invalided the prisoner, because he could not expect the latter to entertain his opinion at any rate until he has proved it to be correct; and, indeed, we all know that the evidence must be clear and conclusive before any one would admit that he has been caught tripping in this way. Fortunately, however, a great assistance to diagnosis may be obtained from a well directed cross-examination of the patient, especially if the questions be put in a sympathizing tone. He has gained the end for which he has intrigued so long and perseveringly, and consequently he is more or less off his guard; but if from look or remark he gets the least inkling that he is suspected, he forthwith retires into his shell of reticent caution, and no amount of coaxing will get him out of it again. If he can be got out at all, it will only be by having recourse to forcible ejection, and sometimes that is no easy matter. The cross-examination must, therefore, be conducted in the kindliest manner, and so as to give the patient the impression that his credibility is unquestioned. By a process of what may be called inferential interrogation, he will very probably be induced to give a very incongruous and contradictory account of his case, and will usually admit that, thanks to the "skill and kindness of the doctor" who invalided him, "his life has been saved, and he has even improved a good deal lately, but he never expects to get well again." Indeed, his expressions of gratitude to all and sundry would be as gratifying as his quiet resignation, were it not that the one is as hollow as the others are false. It will also be found that distasteful remedies such as blistering or galvanism, if they have been tried at all, did him no good; in fact, they made him worse. Any improvement in his health that has taken place has been entirely owing to the generous diet which the doctor was good enough to give him, and to the medicines which he so skilfully prescribed for him; thereby giving you to understand that if you adopt a different course of treatment your professional reputation is at stake. And so the interview ends. If the case is clear, he may either be assured that you have no doubt he will soon get well again, because you have seen other patients get cured whose condition was much more hopeless than his; or he may be flatly told that he is a malingerer, and the sooner he gives it up the better. If the latter course be adopted, there must not be the slightest room for doubt in the case; and one must also be fully satisfied, from judging the character of the patient, that he will yield readily to prompt and legitimate measures. As a matter of expediency, therefore, it is advisable, in the majority of cases, to humour the patient a little, and to assist him in getting well, deferring the opinion entertained of his ailment until some considerable advance towards cure has been attained. He may even be allowed the aid of crutches for a few days, and the luxury of an easy-chair; but if the indulgence is protracted, one cannot be surprised if he takes such a liking to these articles that he will not readily give them up.

When assistant-surgeon to the Woking Invalid Prison, I saw a good many cases of this description; but with the exception of individual idiosyncrasies of character, they were all very much alike in presenting little or no physical changes indicative of disease beyond the paralytic symptoms. And here, lest I might be charged with reflecting on the professional acumen of my brethren connected with the convict service, I would honestly state that it brings no discredit on them to have been deceived by such cases; nor does it imply a greater power of discrimination on the part of any one, under whose care they came, to have detected them. Medical diagnosis has not yet reached that point of perfection when it can be said that he who makes a mistake is not *well up* in his profession; and I fully believe that our most accomplished physicians would be liable to be duped occasionally if they had convicts for their patients. I have already said that malingerers, when they are invalided, are less on their guard, and are even desirous to be freed from some of the irksomeness attending the sick-bed, that they may enjoy as much of the amenities of the hospital as possible, while taking great care not to lose them altogether. For this reason they are much more open to detection, in the same way that children afford far better opportunities to judge of their characters when on a visit to a friend's house than when at home, especially if they are naughty children. This illustration may appear to be unscientific, but it is none the less apposite.

Sometimes, however, prisoners do not throw off the mask so readily even after they have succeeded in being invalided; and when this is the case it is found that they have in prospect either a remission of part of their sentence or final liberation on medical grounds. Dr Campbell, Medical Officer to the Woking Invalid Prison, who has had extensive experience in the detection of invalided malingerers, gives the following instances of this species of feigning in his annual report for the year 1869. He writes:—"Feigned paralysis of the lower half of the body has often come under my notice, but two remarkable cases occurred this year. The first met with an injury in September 1866 in prison, which was said to have been followed by complete paralysis of the lower half of the body, and continued up to the time of reception in June last. He then appeared perfectly helpless, pretended he could not turn in bed without assistance, and that he could not retain his urine. His behaviour was at the same time very insolent and discontented, constantly reflecting on those he had previously been under, and threatening us here when anything was attempted for his benefit. He was placed under close observation, and the usual remedies for the disease employed in a firm but gentle manner. On the sixth day after reception he got out of bed, and on the tenth, when we went to the ward at the usual hour to galvanize him, we were rather astonished to be told that he had gone down to the exercising yard with the other patients. This quick recovery from paralysis of about three years' duration is

sufficient to show that whatever may have been the immediate effect of the accident, he must at all events have been feigning for some considerable time. Failing in this, he tried to feign epileptic fits, asked to be removed to a cell, and allowed a bed on the floor, which was refused; and on being closely watched, he soon desisted.

"Another, received in apparently the same helpless condition, deceived us for a considerable time; but by steadily persevering with the treatment, he suddenly regained the use of his limbs, and walked to the bed he had so long occupied in a seemingly helpless state."

A case of the same kind was received at this prison last year for transmission to an invalid prison. His paralysis, he said, was the result of an accident, but he had lately got so much better that he could sit out of bed and move about a little with the aid of crutches. When spoken to, he affected a sort of paralysis agitans of the head, otherwise his appearance was very healthy, the legs well nourished, and the sensation and temperature normal. There was no incontinence, nor was the urine unhealthy. He resisted the galvanic treatment for a time, but at last we came to a mutual understanding; he was reported to the Visiting Director, and has since been employed on the public works.

When such cases as these occur amongst female prisoners the diagnosis becomes much more difficult, because they are liable to be confounded with hysterical manifestations or with functional paralysis. The following is a case in which this difficulty arose. A prisoner, about 40 years of age, was received into the Woking female prison with paralysis of one leg. On examination, I could not detect any difference between the two limbs, but the patient said she had no feeling in the one that was paralyzed. In spite of this, however, I concluded that it was a case of shamming, and suddenly thrust the point of a lancet into the leg, expecting of course that the limb would be suddenly flexed. But I was deceived; there was no movement of the limb, and the patient only gave me a reproachful look when she saw a little blood trickling from the puncture. From this I changed my diagnosis, and put it down in my own mind as a case of so-called functional paralysis; and believing that galvanism would really prove beneficial, I used the battery daily with apparently very marked benefit. In a short time the patient could move about without a crutch, and one day during the visit she fell down on her knees in the ward, and showered down her blessings on me, just as only an Irishwoman can, for having saved her from being a life-long cripple. All this, though somewhat stagey, was nevertheless gratifying, for the woman had been a cripple for a long time previous to reception; and though she still dragged the foot when she walked, I was in hopes that in a short time she would be completely cured. In a day or two afterwards, however, she misconducted herself in the ward, and had to be reported; after which she became so noisy and violent that she was removed to a separate cell, and it was considered necessary to put her in a strait-jacket. I was very much astonished

when informed next day that she had struggled out of the jacket, pitched it out of the cell-window, which she had smashed, and finished by dancing Irish jigs with a vigour that soon put her out of breath. When I asked her to account for her conduct, she told me that the "Blessed Virgin" had appeared to her in a vision and cured her. At any rate I received no more of her blessings, but something the reverse, when I explained to her my opinion of her case. She several times afterwards refused to get out of bed, maintaining that her leg was again paralyzed; but, whether rightly or wrongly, I as invariably reported her for malingering. In fact, she was an incorrigible, though I have sometimes thought since that possibly it was not all feigning on her part.

Paralysis of a limb, unless it arises from actual injury to the nervous supply, is of such rare occurrence, that in the absence of any objective symptoms, any case of the kind ought naturally to arouse suspicion. I believe it has often been feigned in the army, but, with the exception of the above somewhat doubtful case, I have met with no other instance amongst prisoners.

In intimate relation with this part of the subject, there is a class of diseases primarily or ultimately affecting the spinal cord, which, in military or prison practice, are liable to be regarded at the outset as feigned;—I refer to chronic diseases of the cord or its membranes, and to caries of the vertebræ and lumbar abscess. Acute spinal meningitis and acute myelitis are attended by symptoms so well pronounced that, whether their diagnosis be differentiated or not, no doubt could arise as to the existence of serious active disease. But when these affections are chronic, the train of symptoms sets in so insidiously and indistinctly that there is great difficulty in making a correct diagnosis even in cases which are beyond the range of suspicion of being influenced by any motives to deceive. The possibility of the occurrence of such cases has always to be borne in mind by the prison-surgeon, and, consequently, he has to be very cautious in deciding upon the merits of any case presenting symptoms, however ill defined, that could be attributed to the commencement of one or other of these diseases. With regard to caries of the vertebræ or to lumbar abscess, these remarks are doubly applicable, because while the incipient symptoms are as obscure, the diseases themselves are of far more frequent occurrence. I have myself seen two cases, one of caries of the cervical vertebræ, and another of caries of the lumbar vertebræ associated with lumbar abscess, which were at first regarded with a considerable amount of suspicion; and in military reports there is abundant evidence to show, that not only have such cases been sometimes regarded as fictitious, but have even been treated as such.

I think it may safely be laid down as a rule that in all cases of shock or possible injury to the spinal cord, a favourable prognosis may be given so long as the symptoms remain purely subjective, and, indeed, where there exist any motives for exaggeration or

deception, the absence of all objective symptoms ought to arouse suspicion. Paraplegia resulting from accident, unless it be of a hysterical nature, is speedily followed by symptoms of a more or less grave character. If the seat of injury be situated above the fifth cervical vertebra, the whole of the limbs are paralyzed, and dyspnœa and difficulty of deglutition are intense. If the injury is below the second dorsal vertebra, the arms are not affected, but the intercostal muscles are paralyzed and the respiration becomes diaphragmatic, thereby rendering sneezing, coughing, or deep inspiratory and expiratory efforts impossible. But whether the seat of injury be in the cervical, dorsal, or lumbar regions, the healthy functions of the bladder are more or less interfered with, the urine becomes eventually ammoniacal, and the sphincter ani is relaxed. When the injury is severe, the temperature of the paralyzed parts becomes lowered, the muscles waste, the cuticle desquamates, and bed-sores are formed. Sensation may or may not be lost. These are the more important objective symptoms attending disease or injury of the spinal cord, and they cannot be lost sight of when we have to decide as to whether a suspicious case of the kind is feigned or not. The safest and most legitimate means of detection, as I have already indicated, is a free use of the galvanic or electromagnetic battery, along with strict observation. I have twice tried chloroform, but the patients objected so strongly, and became so violent at the outset, that I did not like to run the risk of putting them sufficiently under the influence of the drug, there being a possibility, in their excited state, of some untoward accident arising.

The other feigned diseases of the nervous system which merit special attention are those connected with the brain itself. They may be grouped as follows:—

I. Feigned insanity.
II. Feigned epilepsy.
III. Feigned cephalœa and other cerebral disorders.
IV. Feigned and factitious diseases of the organs of sense.

I. Outside the criminal population I apprehend that insanity is seldom feigned. In prison, however, feigned attempts are of frequent occurrence, and, although usually their detection is not difficult, it is no easy matter to point out such a series of well-marked distinguishing features as will enable one to arrive at a correct diagnosis in every case. Generally speaking, a feigned attack commences without any premonitory symptoms. A prisoner has got himself into trouble, and wishes to evade the consequences; or he has given way to a violent outburst of temper, during which he may have torn up his clothing, and considers it expedient to keep up the excitement in some way. Or, again, he may be undergoing a course of punishment in separate confinement, which he is desirous

of cutting short; and in some instances, though I think they are few, he makes the attempt deliberately, and with a view to his being ultimately removed to a lunatic asylum, or to some other prison for observation. But whatever the motive, the simulation, as I have said, is commenced suddenly, and often extravagantly. The malingerer's notion of insanity is so imperfect and erroneous that he believes any course of conduct, provided it be outrageous or nonsensical enough, will be a very credible representation of a real attack, and ought to be recognised as such, if he only perseveres. But it does not occur to him that, having once assumed his part, he ought to play it out consistently. If he breaks out in a violent, noisy, and destructive display, he very speedily becomes exhausted, and betrays himself by indulging in a sound night's rest. If he tries to ape monomania, he will keep repeating some absurd statement which he hopes will be regarded as a delusion, and will rigidly abstain from entering into any conversation, or of answering any question coherently. Should he feign dementia, he will very likely maintain a sullen attitude for some days if allowed to do so, and at the end of that time, or after a shorter interval, take to burlesquing of some kind to relieve the monotony. Hence it is that every attempt at feigning insanity is incongruous, incomplete, and disconnected. The simulator has never any lucid interval, because he believes that if he were to behave rationally for one moment, he would betray himself. He therefore studiously avoids recognition of those around him, disregards any questions which may be put to him, and will rarely look any one in the face. He is fond of stripping himself naked, is sometimes abhorrently filthy in his conduct, and occasionally refuses to take any food for a time. The varieties of insanity to which his imitations bear most resemblance are acute mania, chronic mania with delusions, and dementia. In many cases, however, different phases of the feigned attempt present resemblances—now to one, now to another of these varieties—and this want of coherency, or natural sequence of the phenomena, is in itself an important aid to diagnosis. Of course, in all cases there is an absence of those purely physical symptoms which, in greater or less degree, usually attend genuine attacks of insanity. If, for example, the attempt at the outset resembles an attack of acute mania, the pulse may be rapid from muscular exertion, and the skin moist; but there will be no evidence of febrile disturbances, nor will the skin be clammy, harsh, or dry. The tongue will not be coated, nor can the ceaseless agitation and restlessness characteristic of acute mania, themselves difficult to imitate, be prolonged for many hours; within twenty-four hours at the utmost, the malingerer will have exhausted his energies, and falls into a sound sleep. The diagnosis of a feigned attack of acute mania is, therefore, an easy matter, and I need not adduce cases to illustrate this part of the subject. Of a more puzzling character are those cases which present some of the features of chronic mania, monomania,

or dementia; and here a few examples, which have recently come under my own notice, may be of interest:—

Case 1.—Several weeks ago, prisoner J. S. was admitted into hospital suffering from loss of flesh and general debility. He had a pale dejected appearance, a hydrocephalic-looking head, and widely dilated pupils. He complained of dizziness when at exercise, great weakness, and slight cough, although there were no physical signs of pulmonary disease. His appetite was very good, and he was put on liberal diet, with tonics. He was not of the habitual criminal class; his conduct when in prison had been exemplary, and his behaviour in hospital in every way creditable. In short, he appeared to be one of those cases on which prison-life tells somewhat severely, and gave one the impression that he might also be suffering from nostalgia or home-sickness. He remained under treatment for three weeks; but though he had gained in weight, his appearance still remained pale, his expression languid and apathetic, and his pupils widely dilated, he himself admitting of no improvement, and indeed maintaining that he was becoming weaker every day. One morning about this time he would not get out of bed, and paid no attention to the warder when expostulated with, but he took his breakfast as usual. When I saw him in the forenoon he refused to answer any question, nor would he put out his tongue when requested. His dreamy, staring eyes looked straight before him, and not even when I told him that if he did not put out his tongue, I must pull it out and have a look at it in spite of him, did he evince the slightest consciousness of what was said to him. His pulse was quiet, his skin cool, and I found that he had passed his urine in the morning. Although he was the last patient in the hospital whom I would have suspected of malingering, I felt convinced he was shamming in this instance, and accordingly applied the strong ammonia to his nostrils. He struggled a little, muttered something about his mother, and all of a sudden got hold of the sponge, saturated with the ammonia, between his teeth, and I believe, if I had not been prompt enough, would have swallowed it. He had then a dose of the electro-magnetic battery, to which he submitted without struggling. As he was in an open ward along with other patients, I was averse to pushing matters to extremes, and ordered a blister to the back of his neck, with a couple of drops of croton-oil to be taken internally. For two days there was no change in his symptoms or behaviour, but during the third night he got out of bed, went whistling through the ward, stopping now and again to stare into a patient's face, and ended by standing on the crown of his head on the top of the night-stool. Next day I ordered him to be restrained in a strait-jacket, and removed to a separate cell, and told him that the sooner he gave it up the better. He took the hint, and on the following day he appeared to be all right again—maintaining, however, that he did not know what was the matter with him. He was reported, and afterwards confessed that he had been "led into it" by other prisoners.

Now, this is a case which, at first sight, might have been mistaken for dementia of a subacute form; or, possibly, the widely-dilated pupils and the seemingly unconscious state might have suggested the existence of serous effusion into the ventricles or beneath the membranes of the brain. But against both of these views were opposed the facts that the bodily functions were performed naturally. He got out of bed to fetch his food, and ate it heartily; there was no retention of urine, nor did he pass either it or his fæces in bed.

Case 2 is worthy of note, chiefly on account of the persistency of the malingerer. I find from the hospital papers that prisoner W. H. was admitted into hospital for observation 8th Nov. 1869. His previous prison history was one of repeated punishment for refusing to work, breaking windows, destroying his clothes, filthy conduct, and the like. On admission he alleged that he would not work because the terms of his sentence precluded labour, and that he was the Duke of Orleans. He was put on low diet, and was ordered to have the back of his head shaved and blistered, which latter operation he resisted so vigorously that it was deemed necessary to restrain him in the strait-jacket. In a few days afterwards he promised to "give it up," upon which he was allowed a more liberal diet, and subsequently discharged. But he disliked work of any description, and was not long out of the punishment cells, again maintaining that he was "Egalité," and varying the monotony of his seclusion with occasional outbreaks. He first came under my notice when I joined this prison in April last year, and I fully concurred in the opinion which had hitherto been entertained of him, that he was a malingerer. He was a sullen, bullet-headed fellow, and when he did speak, which was seldom, he still feigned the old delusions, and invariably refused to go out to work. This went on for some time, until one day he assaulted an officer, for which offence he was sentenced to be flogged by the Visiting Director, and to be kept in separate confinement for six months. During the whole of this period he scarcely ever exchanged a single word with any one. When his sentence expired he resumed the old practice of refusing to labour, and persisted in the old delusions. He repeatedly received bread-and-water punishment, and though sent to do the lightest out-door labour, would do nothing. He was again put under medical observation; but on this occasion his dull intellect had coined a new "delusion." He maintained that "he had been dead and crucified; that he had been made a martyr for the cause of the glorious religion," etc. Any questions as to his sentence, crime, age, name, his former life, and the like, he refused to answer. He slept well, took his food well, and, in spite of the blister at the back of his neck, would have been content to remain in hospital long enough, although he significantly hinted that he was sure no amount of treatment would make him give up his belief. I detained him in hospital for two weeks, and allowed him liberal diet, because after so much punishment he was somewhat below

par. When discharged, he was reported to be sane and responsible for his actions; or, in other words, amenable to prison discipline. The sentence which was awarded him this time allotted him three days bread and water for every refusal to go to work during a period of fifteen days, provided, of course, as in all such cases, he were found to be medically fit. He was put to light labour, and refused to work on two consecutive occasions, after which he began to complain that he was very weak. I assured him that I would not in any way interfere, and, as kindly as I could, expostulated with him on the folly of his conduct. One day shortly afterwards he requested to speak with me, and promised to give up his scheming. Since that time he has behaved well, and been employed at ordinary outdoor labour.

Case 3 may be cited as a doubtful case. Prisoner J. L. was admitted into hospital for observation 29th April 1868. He had been repeatedly under punishment, but always for the same offence, viz., an unfounded complaint about the due weight of his bread. The medical record goes on to state:—"The loaf was weighed in his presence, and yet he was dissatisfied. He has been heard to say also that the doctor drugged his food so as to increase his appetite, and that the bread was purposely robbed of its proper proportions to torture him. He is not only a hard-working man, but in conversation he does not (with that exception about his bread) betray the slightest sign of mental aberration. It is a curious fact that, if his bread is stale, and therefore firm, he never disputes its proper weight; but if it is new, and therefore easily compressed between his fingers, he complains of light weight." He was retained in hospital till 5th August, during which period he repeatedly complained about the bread, and sometimes that his food was poisoned, stating that, though he could not detect any difference in the flavour, he knew it was poisoned from the effect on his stomach. When discharged he was recommended to the shoemakers' shop, because he had been a shoemaker by trade. On 21st Sept. of the same year he was again admitted into hospital for observation, having once more got himself into trouble, and created a disturbance about his bread. He remained in hospital till 1st Jan. 1869, the history of his case differing but little from what had previously been recorded; and, when discharged, I find the following entry:—"No sign of disordered intellect; says he has conquered his difficulty about light weight in his loaf." For more than a year afterwards he appears to have conducted himself tolerably well; but in May 1870, when he first came under my notice, he was a third time admitted into hospital for observation. The following is an extract from his hospital paper on this occasion:—"Patient maintains that frequently his food has been drugged, and in several ways. Although he cannot describe how this is done, he asserts that one way is so disgraceful that he could not mention it. When it is drugged he feels afterwards as if he could eat a bullock, and often becomes

very ill-tempered without really knowing why. Complains also that his food is often of light weight. Is quite rational on all other points." He was kept under observation for two weeks, and, as there was no change in his symptoms, I certified him to be of unsound mind, and recommended his removal to Millbank Prison. As I have heard nothing of him since, the probability is that the same opinion of his case was entertained by the authorities there, and that he was ultimately removed to the Criminal Lunatic Asylum.

With regard to this case I frankly admit that there are certain points which might make it appear probable that the prisoner was an impostor. For example, although he often complained that his food was drugged, he never refused it, and, with the exception of his repeated outbreaks about this matter, his general conduct was satisfactory, nor was anything strange to be observed in his manner. It is true, he was at times moody, and was of a somewhat irritable temperament, but in this respect he did not differ from many prisoners who are considered to be amenable to prison discipline. There was no primary affection, such as acute mania or melancholia, nor did his delusion, if delusion it may be called, vary in its intensity or character during the separate period when he was under observation. Altogether it was a case concerning whose merits one could not decide with certainty, and under the circumstances I considered it to be my duty to give the prisoner the benefit of the doubt, though I must confess that such doubt was very shadowy in my own mind.

Case 4.—On the 17th June this year, prisoner W. S. was found stripped to his shirt in his cell. He had been for some time in separate confinement on penal class diet for repeated breaches of discipline, but he had nearly finished his sentence. When spoken to, he kept his eyes shut, and, after crossing himself, commenced repeating the Lord's Prayer, the Creed, and portions of the Litany. For two days he refused food and drink, and on the third, I fed him roughly with the stomach-pump forenoon and evening. On each of these occasions I also gave him some strong whiffs of the liq. am. fort. During a period of five days he tasted no food of any description but what was pumped into him; and so dogged was his temper at this time, that I verily believe he would have died of self-starvation had he been left to himself. Whenever the liq. am. fort. was used, he promised to give up the feigning, but before the next visit he as invariably recommenced it. His head drooped on his chest, he allowed the saliva to trickle from his mouth, and would neither dress nor undress himself. Judging from his appearance, he might have been taken for a patient suffering from dementia, were it not that the tremulousness of the eyelids showed that he was always on the *qui vive*, endeavouring to peep out between them and see what was going on. After a time I admitted him into hospital, as he was in a somewhat emaciated condition, to try

what kindness and a liberal diet would effect. Both were alike wasted on him, although he promised amendment whenever he had a chloroform or liq. am. fort. stupe applied to the nape of the neck, varied by an occasional dose from a galvanic battery. When he regained his normal weight, I discharged him, and he received a sentence of twenty-eight days' bread-and-water punishment in separate confinement. His feigning now assumed a new phase. He became extremely noisy and violent, would at times plaster himself over with his excrement, and would sometimes endeavour to assault any one who went near him. At last he was sentenced to be flogged. The punishment was administered a few days ago; and though he has not yet quite *given in*, there is every reason to believe that this treatment will result in a permanent cure.

This may fairly be regarded as one of those cases, so frequently to be met with in prison-life, which may be said to drift on that ill-defined border-land which separates sanity from insanity. For a time, the thin varnish which discipline supplies serves to conceal, and even to control, the turbulent nature within, but every now and again the veil is rent, and the prisoner becomes the veritable slave of frantic ungovernable passion, or of dogged determination to have his own perverse way in spite of expostulation or punishment. The inherent—or rather, I should say, the inherited—mental incapacity of the habitual criminal makes him an easy prey to the worst impulses of the human heart. Possessed of little self-restraint or regulative power at any time, it is not to be wondered at that occurrences of the most trivial kind are quite potent enough to upset the unstable equilibrium of his mental and moral life. A cross word from a warder, a slight difference with a fellow-prisoner, or even a disordered state of the system, will often suffice to unhinge the passions and reveal the animal nature in all its naked repulsiveness.

Dr Maudsley, in his chapter on the Insanity of Early Life, writes: —"There is another class of boys who cause great trouble and anxiety to their parents and to all who have to do with them. Afflicted with a positive moral imbecility, they are inherently vicious; they are instinctive liars and thieves, stealing and deceiving with a cunning and a skill which could never be acquired; they display no trace of affection for their parents, or of feeling for others; the only care which they evince is to contrive the means of indulging their passions and vicious propensities. Intellectually, they are certainly defective also, for they usually read no better when they are sixteen years old than a healthy child of six years of age would do; and yet they are very acute in deception and in gratifying the desires of their vicious natures. Passionate, selfish, cruel, and sometimes violent, they are intolerable at home; and if they are sent to school, they are sure to be expelled. When they belong to the lower classes, they find their way to prison many times; indeed, they contribute their quota to the criminal population of the coun-

try; when they belong to the better classes, there is nothing for it but to seek out some firm and judicious person who, for suitable remuneration, will take care of them, keep them out of mischief, and, while checking their vicious propensities, will try to discover and foster any better tendencies which they may have in them. The resemblance of these beings in moral character to the lowest savages, and even to monkeys, is not without interest."

I have quoted this passage because I believe it to be a scientific and accurate description of the psychological state of the great majority of our habitual criminals. They form a distinct class by themselves, and are fitter objects for well-considered reformatory influences than for punishment. Not that I think that punishment, when judiciously administered, is not attended by good and wholesome results, but it ought not to be applied indiscriminately, nor without taking into consideration the condition of mind in consequence of which any violent outbreak or serious breach of discipline has taken place. Such prisoners are subject to a real "mania of acts," and it requires great care and tact on the part of all who have charge of them to treat them fairly and justly. Out of prison the law takes no cognisance of their inherited or acquired predatory disposition and insane temperament; they are regarded as agents wholly responsible, and punished accordingly. When they finish their sentences, they are again let loose on society, and, true to their nature, again return to their old habits. It is like discharging lunatics from an asylum before they are cured; but the public has not yet learned to look at the matter in this light, and so both the public and habitual transgressors against its social institutions have to suffer from a policy which is as thriftless as it is near-sighted and unjust. The habitual criminal, I maintain, ought not to be liberated until the authorities have assured themselves that he is so far reformed as to be safely trusted with his liberty. As it is, however, at the close of every fresh sentence he is allowed full scope to propagate crime in two ways,—by the direct transmission of his criminal taint to his children, should he beget any, and by the force of his example or the pernicious influence of his teaching on the young of both sexes who may come within his reach.

It may be thought that this is somewhat apart from the subject in hand; but in treating of feigned insanity, especially amongst prisoners, these pathological states of the criminal mind cannot be overlooked. While a comparatively large percentage of the habitual criminal class are acknowledged to be insane, imbecile, or epileptic, and are therefore not subjected to the ordinary restrictions of prison discipline, there is a far greater number who are liable to attacks of maniacal excitement, but who cannot on that account be excused from complying with the prison rules and regulations. Female prisoners of a depraved character are notably prone to these attacks, and generally at the menstrual period; indeed, with

some who have come under my notice, an outbreak could be predicted whenever the period commenced. It would be alike without avail and cruel to punish severely all who offend under such circumstances as these; and as the question concerning the degree of responsibility of the delinquent depends on the medical officer, it is his duty to recommend mitigation of punishment whenever he thinks the merits of the case warrant it. At the same time, I am bound to admit that, with male prisoners, I have seen the best results follow a flogging when no amount of other punishment, expostulation, or kindness, could check a course of conduct that appeared outrageous enough for the devil-possessed; and, with incorrigible female prisoners, shaving the head has a wonderfully calmative effect.

Concerning the best means which can be adopted to make the malingerer who feigns insanity give it up, I need say little. Here, as in other feigned diseases, the galvanic battery is of great assistance, or a chloroform stupe applied to the nape of the neck. This latter remedy is speedy and safe in its action; and the intense stinging pain which it produces will, in a few minutes, make the schemer speak, if he is inclined to be taciturn, when harsher means fail. I need hardly say, that sharp measures such as these are never employed as means of diagnosis;—the nature of the case must be clear before they are had recourse to, and then they can be conscientiously administered as legitimate remedies.

It would have been an easy matter to have cited a larger number of cases; but I preferred to bring forward a few that presented more difficulties in the way of diagnosis than those usually to be met with in prison practice. I shall now endeavour to recapitulate briefly some of the more salient points in diagnosis, which, though they may not be of much value when taken singly, may nevertheless be of some service when taken collectively.

1. In feigned insanity, the attack comes on suddenly and without any warning. This is rarely the case in real insanity.
2. There is an absence of all purely physical symptoms.
3. If the feigned attack be violent, the malingerer soon exhausts his energies, and will fall into a sound sleep within twenty-four hours.
4. In the ravings of feigned insanity, there is a marked absence of any variety of ideas.
5. In all feigned cases, the malingerer will either refuse to answer simple questions, or will answer them in a wilfully absurd and incorrect manner.
6. He will seldom look any one in the face.
7. If delusions are feigned, he cannot conform his conduct and bearing to the character of the delusions.
8. As a rule, the feigned attack is over-acted.
9. There are no lucid intervals, the malingerer striving to appear insane on every point.
10. A feigned attack is so incongruous and incomplete, that it

is next to impossible to classify it under any of the known varieties of insanity, whereas all feigned attempts bear a greater or less resemblance to each other.

There are several other points which are common to cases of acute mania, such as stripping naked, filthy conduct, and age (the prisoners who feign insanity being all young); but to these I do not attach much importance.

II. With regard to epilepsy, the difficulty experienced in detecting feigned cases does not consist so much in being able to discriminate between a false and a genuine attack when seen, but in being able to determine whether or not a patient, when brought forward after having had a "fit" which others have witnessed, has really been feigning. If the patient be seen immediately after the "fit," a good deal may be gathered as to its nature by his appearance and behaviour. Should there be no suffusion of the eyes, no puffiness and redness of the eyelids, no torpid and heavy appearance of the countenance, no confusion of thought, and no headache, the "fit" may pretty safely be put down as a feigned one, if the convulsions are described as having been violent or prolonged. It will also be found, as a general rule, that the patient has not injured himself in any way, provided the attack has been feigned in the presence of others. For example, there are no signs of the tongue having been bitten, nor any bruises from a fall. But sometimes a prisoner, who says he is subject to fits, presents himself with very distinct marks on the face or head, and maintains that he received these while in a fit, and when he was locked up in his cell. I have met with several such cases, and it has always turned out that they were malingerers. With one exception, the marks have always consisted of abrasions on one or both temples, and sometimes on the nose, in which the cuticle has been removed by friction, either by a rough towel, or by rubbing the parts against the cell wall, or on the floor. Not long ago, however, I saw a prisoner who presented himself in this way, having a contused wound on the forehead, surrounded by a considerable amount of tumefaction, as if produced by a violent blow. He said he had fallen down in a fit; and though his appearance was by no means epileptic, and he had the reputation of being a malingerer, I could hardly help concluding that the "fit" must have been genuine. But the merits of the case were cleared up shortly afterwards. The prisoner happened to have a "fit" when I was near at hand, and I had sufficient grounds afforded me for altering my previous opinion. There is no doubt that he had intentionally knocked his head against the wall or floor.

In dealing with these cases, I have generally found it to be most expedient to speak frankly to the prisoner; assuring him, if there be no doubt in my own mind, that I believe his "fit" was feigned, and that I cannot change my opinion until I have an opportunity

of judging for myself by seeing him in a "fit." He is also told that having a fit now and then need not interfere with his work, provided he is not working where he runs the risk of falling from a height. If employed at such work, he is recommended change of labour, suitable enough for an occasional epileptic, but none the less arduous. He will afterwards either take the hint, and give up this species of feigning, or he will afford an early opportunity of being seen in a "fit," when, as I have already said, detection is not difficult, and he gets reported and punished.

The symptoms of a common epileptic seizure are so well-marked and unique, that we can scarcely conceive it possible that they could be well feigned, even by a person sufficiently cognisant of them. The sudden fall; the frequent scream or groan when the attack sets in; the total loss of consciousness; the violent convulsions; the rapid jerks, as if caused by a galvanic battery; the contortions of the facial muscles; the short and hurried breathing; the grinding of the teeth and foaming at the mouth; the spasmodic turned-up action of the eyes; the insensible iris; the pallid, afterwards bloated, congested countenance; the clenched hands; the bitten, bleeding tongue—are, in the majority of cases, more or less so well-pronounced, that their genuineness cannot be mistaken. In the feigned attack, on the other hand, the mind of the impostor can only direct its energies to the display of two or three manifestations simultaneously, and even these give the impression of studied effort; whereas, in a real seizure, the absence of all control is not only prominent, but every symptom seems to be under the influence of a power beyond human effort. Fortunately, however, a differential diagnosis between a real and feigned epileptic seizure need not be confined to symptoms; for, if the case looks suspicious, the application of a sponge saturated with strong ammonia to the nostrils will speedily make clear its character. Sometimes dashing cold water on the patient will make him wince, though in the majority of cases it does not readily bring him to his senses; but if the hand or a towel is pressed over the lips so as to prevent breathing through the mouth, the schemer will at once commence to struggle, and, according to my experience, gives in almost immediately, if the sponge be kept applied.

III. Headache and vertigo are frequently feigned by prisoners, in order to escape work for the day, or to gain admission into hospital. In arriving at a decision in such cases, a great deal may be gathered from the character of the patient, especially if there be no significant physical sign to lay hold of. If the tongue be clean, the pulse quiet, and the countenance devoid of any expression of pain or discomfort, there need be little doubt that the case is feigned, or, at any rate, that the complaint is exaggerated; and an emetic, judiciously administered, will, in all likelihood, produce a permanent cure. Children, it is well known, are very apt to feign headache on the slightest pretexts; but to them a dose of salts and senna, or

of Gregory's powder, is sufficiently distasteful to prevent them from frequently repeating this form of scheming.

I have never seen an instance of feigned hemiplegia, nor can I conceive, though several such instances have been recorded, how any painstaking medical man could be duped by a case of this description. It might be easy to drag one leg, and to allow the arm to hang listless and slightly adducted by the side, but no amount of effort could at the same time produce the flabby and relaxed state of one side of the face, the drawing of the mouth to the other, the inequality of the size of the nostrils on deep inspiration, the characteristic curve of the protruded tongue, and the peculiar twist of the mouth on attempting to blow or whistle. A careful examination would also detect, in the real disease, a slight difference in temperature between the healthy and affected sides, as well as a difference in the firmness of the muscles and general condition of the limbs.

Severe neuralgic affections, whether proceeding from derangement of the cerebral or spinal system, are always attended by an expression of countenance indicative of pain, which cannot easily be feigned; and particular diseases, such as sciatica and tic douloureux, are so clearly defined, that patients suffering from them can describe the symptoms with sufficient precision as to admit of no doubt concerning their genuineness. Pain itself cannot be regarded as an isolated symptom if it be of any severity. The patient ought to be able to localize it, and to describe its character; if he can do neither, he suffers from what is called the "all-overs," and may safely be put down as a *humbug*. I need not say that in all such cases, inquiries are made with regard to appetite, loss of sleep, the state of the tongue, pulse, etc. No concomitant symptoms should be overlooked, and no adverse opinion given unless it is well considered and admits of no question.

IV. Feigned diseases of the organs of sense are confined to affections of the eye and ear. Now that the ophthalmoscope has been introduced into practice, and the study of eye diseases has become so general, such conditions of the organ of vision as myopia and amaurosis cannot well be feigned successfully. A person pretending to be short-sighted will not readily pass an examination with different sets of glasses (plain, convex, and concave) without being detected; while with the aid of the ophthalmoscope, one ought to be able to make out the pathological changes which take place in the really amaurotic eye. In suspected cases of amaurosis, a ready test can also be resorted to by confining the patient in a dark room for a time, and afterwards exposing him to a bright light, such as that of the burning magnesian wire. If he can bear such a light without wincing, and if the iris remains sluggish, and the pupil dilated, there is no doubt that vision is affected.

In my own experience, however, I have found that tampering

with the eyes, so as to induce conjunctivitis, or ulceration of the cornea, is of far more frequent occurrence than feigned myopia or defective vision. Any irritating substance, such as a small particle of lime, white-wash, etc., if introduced beneath the eyelids will, in a short time, produce a highly congested state of the whole conjunctival membrane, and ultimately ulceration of the cornea, if the irritation be kept up. As a rule, both eyes are tampered with, and present an intensely inflamed appearance when first seen, the inflammation being pretty equally diffused over the whole membrane. The patient generally states that the inflammation set in during the night, and attributes it to cold. Treatment, if limited to the usual remedies, does him no good; so that the conjunctivitis, which commenced without any apparent cause, may continue to exist for weeks. In such cases as these, and indeed in all cases of conjunctivitis setting in suddenly and unaccountably, it is advisable to examine minutely with a magnifying lens the surfaces of the eye and of the everted eyelids, when very frequently some foreign substance may be discovered. If removal of the substance be not followed by relief, there need be no doubt that the irritation is kept up in some way, such as by rubbing the eyes, by bathing them with urine, by inserting soap, etc. But the disease may be factitious without our being able to discover the means employed, and hence, in all suspicious cases, the speediest and most effectual treatment is to prevent any further tampering. After having the inflamed eyes carefully douched with cold water, this can be effected either by applying a pad of cotton-wool, and retaining it with strapping and bandage; or, if this be interfered with, by having the patient put in the strait-jacket and tied down in bed.

Little need be said with regard to feigned or factitious diseases of the ear, though both in the army and amongst prisoners cases are not at all uncommon. Feigned deafness comes on suddenly, whereas the real affection takes place very gradually, and is, or has been, accompanied by some tangible symptom of disease. A person not wholly deaf has a gaping and observant cast of countenance, the mouth being kept open to aid the hearing, and the eyes keenly watching the movements of the lips of any one addressing him. He generally talks in a loud, harsh, unmodulated tone of voice. The impostor, on the other hand, has a furtive expression, does not elevate his voice when speaking, and generally overacts his part. In coming to a decision with regard to such cases, it is necessary to inquire minutely into the history of the complaint, and to make a careful examination of the ear itself. A little *finesse* in conducting the conversation, or in taking the patient by surprise, will generally succeed in detecting imposture.

Otorrhœa is sometimes simulated, and sometimes induced. It has been feigned by introducing honey, soap, etc., and excited by the introduction of acrid substances. A free use of the speculum and ear-syringe will suffice to make clear the character of such cases.

In discussing further the different varieties of feigned diseases, it will be convenient to classify them as follows:—

I.	Feigned and factitious	diseases of the	circulatory	system.
II.	,,	,,	respiratory	,,
III.	,,	,,	digestive	,,
IV.	,,	,,	urinary	,,
V.	,,	,,	generative	,,
VI.	,,	,,	locomotive	,,
VII.	,,	,,	integumentary	,,

I. Feigned disorders of the circulatory system are comparatively rare. I have met with a few cases, in which convicts, preparatory to the hospital visit, if treated in separate cells, have accelerated the pulse and produced profuse perspiration by covering their heads over with the bed-clothes and breathing rapidly for some time. If the tongue has been previously coated with whiting from the walls—a practice not at all uncommon—such cases may be mistaken for febricula; but their real nature is easily ascertained by visiting them at an unusual hour.

Palpitation and irregularity of the heart's action have sometimes been induced by taking doses of the veratrum album or white hellebore; and, according to Gavin, so widespread was this practice at one period amongst the Royal Marines, that many were invalided before it was detected. The dose was about ten or twelve grains, and was repeated until symptoms of a somewhat grave nature set in—such as incessant vomiting, frequent tremors, clammy sweats, weak and irregular pulse, followed by violent and interrupted action of the heart. In like manner, the heart's action has been intentionally lowered and seriously disturbed by over-dosing with digitalis, tartar emetic, tobacco, etc.

While a state of syncope is often feigned by hysterical females, mendicants, and others, it is next to impossible to simulate its characteristic symptoms, and hence detection is easy. Indeed, in almost all cases of induced or simulated disorders of the circulatory system, a careful examination with the stethoscope, after the patient has been allowed to remain quiet for some time, will make clear their character; and when drugging is suspected, it is requisite that the patient be kept so far secluded as to prevent him from obtaining any further supply.

II. The symptoms of diseases of the respiratory system most commonly feigned are, pain in the chest, cough, hæmoptysis, dyspnœa, and aphonia. With regard to the first of these, it is important to bear in mind that it often exists independently of any lung affection, and may be of considerable severity. For example, it may be purely muscular—as in the case of persons who are accustomed to work at low benches or desks; or it may be sympathetic,

as in some forms of dyspepsia. In the former case, it is generally well localized; and in the latter, though of a dull, undefined character, it constitutes one of a group of other symptoms, which need leave no doubt as to its genuineness. When it is feigned, on the other hand, it is usually represented to be "all over the front of the chest," and the malingerer will either be unable to describe its character, or will readily acknowledge that it corresponds to any incongruous description that may be suggested to him. If the pain be described as sharp and "catching" on a deep inspiration, and confined to a particular spot—if, too, the manner of the patient accords with his statement—it always ought to be treated as genuine, even though no stethoscopic signs of commencing pleurisy or other lung disease be detected. In subacute attacks of pleurisy, there is no doubt that special auscultatory phenomena are often absent, while the pain may be so severe as to interrupt the respiratory rhythm.

As a rule, feigned pain in the chest is accompanied by feigned cough. This latter, when listened to, gives one the idea of studied effort, and is of a dry, barking, blowing character. As might be expected, it never disturbs the patient's rest—and, indeed, is only troublesome to him when he can make it troublesome to others—it being found that he has no fit of coughing so long as he believes he is not heard. Any expectoration that may be kept for inspection consists chiefly of saliva mixed with a little clean mucus; though I have seen a few instances in which expectorated matter has been freely purloined from the spittoon of a patient in the same ward suffering from phthisis or chronic bronchitis, and represented as the schemer's own. Sometimes, however, the cough is associated with hæmoptysis; and, when this is the case, the contents of the pot or spittoon are of a dark, thin, treacly appearance, and of a somewhat ropy consistence, owing to the admixture of mucus and saliva with the blood. There is an absence of air-vesicles and of the floridness to be observed in acute attacks of hæmoptysis; there is no tendency to coagulation, nor are there any of the spots or streaks of blood in the sputa, so characteristic of genuine slight attacks. The blood in these cases is generally obtained by sucking the gums or biting the tongue, and if the patient is expectorating it when visited, the bleeding part can usually be seen. But more frequently the patient complains that he has a bad cough, and *has been* spitting up blood, in which case it is only necessary to examine the mouth, and afterwards ask him to cough and expectorate, to establish the suspicious character of his complaint. A careful examination with the stethoscope will confirm the diagnosis. If the blood shown in the spittoon be of considerable quantity and coagulated, the probability is that it has been derived from one or both nostrils, when traces of blood will be found on the mucous membrane of the nose, and very often on the tip of the forefinger of the right hand, the nail of which has been used to produce the bleeding. Cases have been recorded of hæmoptysis having been feigned by inserting foreign substances

into the mouth, such as carmine, brick-dust, vermilion, etc., but none such have come under my notice.

When dyspnœa is feigned, the malingerer calls it an attack of asthma; and I have seen several instances in which the attitude of an asthmatic patient and his laboured breathing have been very well imitated. It is effected by a voluntary constriction or temporary closure of the glottis. The breathing has a wheezing, stridulous sound (somewhat resembling that of laryngismus stridulus), which is also heard more or less distinctly along with the respiratory murmur when the ear is applied to the chest. In real asthma, on the other hand, there is an absence, or marked diminution, of breath-sound on auscultation; while the evident distress pictured on the countenance of the patient cannot well be simulated.

Aphonia is very rarely feigned in prison, because nothing is to be gained by it. A suspected case could be detected by putting the patient partially under the influence of chloroform, and a speedy cure effected by mopping out the larynx with a solution of nitrate of silver, or by having recourse to the galvanic battery. I have only seen two cases amongst convicts; but I did not consider any interference necessary, on the grounds that the quieter a prisoner is, so much the better for himself and all who have got anything to do with him. When aphonia occurs amongst females, it is often of a hysterical nature, but yields readily to galvanic or electric treatment.

In discriminating between real and feigned chest symptoms, it is always advisable to satisfy oneself by auscultation and percussion concerning the state of the lungs, otherwise mistakes might occasionally be made. When feigned hæmoptysis is suspected, the patient should be made to expectorate first, to find out whether the blood proceeds from the mouth, and afterwards to cough and expectorate. Doubtful cases should be treated as genuine, or put under observation; but when the case is clear, the malingerer may either be told so, and dismissed as a humbug, or some distasteful, yet legitimate, course of treatment may be pursued. For example, if pain and cough are feigned, a warm turpentine stupe and an emetic will in all likelihood produce a rapid cure, while low diet is found to be very efficacious in checking hæmoptysis. When children make too much of a cough or cold, as they often do, a mustard poultice is a suitable remedy.

III. Disorders of the digestive system may be either feigned or induced. Vomiting, diarrhœa, dyspepsia, stomachic pain, distention of the abdomen, prolapsus ani, hæmorrhoids or bleeding from the rectum, have all been more or less successfully feigned or purposely excited; and it must be owned, that some cases of this class are attended with more than ordinary difficulty in the way of detection and management. With regard to vomiting, this difficulty becomes at times very considerable; for while, on the one hand, it

is easily simulated, and, by a little practice, can be excited without effort, on the other hand, it may be the only prominent symptom of a disordered state of health, and may resist treatment for some time. It is generally admitted, for example, that it does not always depend upon gastric irritation—that, in fact, it is often associated with a depressed state of the system or nervous irritability, and may be unaccompanied by other signs of derangement affecting the pulse, tongue, the appearance of the patient, or the matter vomited. Moreover, if the persistency sometimes evinced in this variety of malingering is apt to allay suspicions, the protracted nature of genuine cases resisting for weeks and weeks every species of treatment is, in like manner, calculated to arouse them. I have seen a few instances of such extreme emaciation brought about by constantly vomiting the greater portion of the food, that one might readily have inferred that the malingerers were suffering from serious disease. I have also had one case under my care which, for some time, I could not help regarding with suspicion, but which afterwards turned out to be one of thickening and stricture of the pylorus, a form of disease occasionally met with amongst hard drinkers.

Vomiting is sometimes excited by tickling the fauces; but amongst convicts this practice can only be had recourse to on rare occasions, because it is sure to be detected. It is usually effected by pressure on the gastric region, or by voluntary contraction of the recti muscles, and is sometimes aided by swallowing air, thereby producing over-distention of the stomach. In the army it has been induced by emetics, by swallowing tobacco-juice, urine, and bullocks' blood (so as to feign hæmatemesis); and rare cases have been recorded of its having been associated with the swallowing of excrement and other abominations. When no foreign substances have been taken, the vomited matter, if ejected shortly after a meal, as is generally the case, consists of the food in an undigested state. It is free from the ropy mucus so often seen in chronic diseases of the stomach, and it is unmixed with blood, giving it the grumous or coffee-ground appearance of the *ejecta* in cases of ulcer or malignant disease. It will also be found that the patient is always very careful to have something in his pot ready for inspection at the hospital visit, and that he seldom or never admits of any improvement or amelioration of his symptoms. Speaking from my own experience, I would say that microscopic examination fails to detect any *sarcinæ ventriculi* in the vomited matter; but this is of minor importance, and need not be insisted on. There is another point, however, of some diagnostic value, and it is this: that if stimulants be given in the intervals between meals by way of experiment, the patient not only retains them on his stomach, although he rejects liquid food of every other description, but states that they do him far more good than anything else. Furthermore, the vomiting is more apt to occur after the meal preceding the visit than at other times.

The treatment which I have found to be most successful in recent

cases, and when the patient is in tolerably fair condition, is at once to put him on low diet; assuring him at the same time that so soon as the vomiting ceases he will get more food, but if it continues, that it will be lessened, and that he must be fed *per rectum*. When the patient is received in an emaciated condition, care should be taken that liquid food, such as milk and beef-tea, should be given in small quantities and at short inervals, and that the patient should constantly keep the recumbent position. This latter is an important point, because I feel convinced, from cases which have come under my own observation, that voluntary vomiting cannot be readily accomplished unless the patient can suddenly bend and jerk the upper part of the body over the edge of the bed at the moment when the diaphragm is depressed, and the recti muscles contracted, to aid in the act. In persistent cases nutrient enemata should be administered with the œsophageal tube, and the tube retained in the rectum for some considerable time after its introduction, to prevent the return of the enema. It will be seen from these remarks that the course of treatment recommended differs but little from what would be pursued in obstinate vomiting arising from actual disease, such as ulcer of the stomach; and, on this account, it cannot be stigmatized as harsh or unjustifiable, even when employed in doubtful cases.

Concerning diarrhœa of a feigned or factitious nature, brief notice will suffice, although such cases are of almost daily occurrence in prison practice. It is so easy for a prisoner to say that he is suffering from this complaint, and so difficult to tell whether he is or not, without putting him under observation, that I have no doubt many receive treatment amongst the casual sick who are really scheming. This, however, is a matter of small moment, and cannot well be prevented. It is only when the prisoner throws up work on account of his suffering from diarrhœa, or when he keeps complaining for two or three consecutive occasions, that steps should be taken to test the validity of his statements. Of course, if he looks ill, his case is treated as a *bona fide* one, and he need not be subjected to such close scrutiny. But if he presents no other symptoms of deranged health beyond the diarrhœa which, as he alleges, incapacitates him for work, or of which he is constantly complaining, he should at once be put under strict observation, which consists in his being obliged to use a close-stool, in the presence of a warder, when he requires it, and not allowed to go to the water-closet. This close observation is necessary, because a malingerer will have no hesitation in breaking up his fæces and mixing them with his urine so as to imitate a liquid stool, if he be not watched; indeed, several such cases have come under my own personal knowledge. Should it now turn out that there is no diarrhœa, the prisoner is reported, and gets punished; if, however, it be found that he is suffering from diarrhœa, the question arises as to whether it has been induced, or whether it be of such severity as to neces-

sitate his admission into hospital. The former suspicion often crosses the mind of the prison surgeon, because he is well aware that pills made of ordinary soap are at times freely partaken of to excite diarrhœa; but as it is impossible, even in suspicious cases, to assure oneself that such pills have been swallowed, it is advisable to treat the complaint as genuine, if it be of any severity—that is, by spoon or liquid diet, given cold, and in small quantities at a time. If the diarrhœa be factitious it soon ceases, because the malingerer speedily tires of this diet; and, on the other hand, if it be real, such diet is best suited to promote the patient's recovery. In like manner, an emetic is found to be very efficacious and suitable in some cases, inasmuch as it constitutes a valuable remedy in the treatment of the real disease. For ordinary cases, whether they be genuine or not, occurring amongst the casual sick, I have found the following plan of treatment work very satisfactorily:—If the tongue be coated, I order a dose of a mixture consisting of ol. ricini, vin. op., mucilag., and aq. menth. pip.; when it is clean, and no pain complained of, a dose of an acid astringent mixture is given; while if pain be complained of, though the tongue be clean, a dose of carminative mixture containing chalk is administered. In order to be able to prescribe with advantage, and to prevent scheming in hospital, the stools of diarrhœa patients should always be kept for inspection.

Feigned dyspepsia, and feigned stomachic pain, may be considered conjointly, because the latter is generally the only symptom, subjective or objective, upon which the malingerer grounds his complaint as to his suffering from the former. And here the exercise of careful discrimination is specially necessary, inasmuch as dyspeptic disorders constitute the great bulk of minor ailments to be met with in general practice, and, moreover, in many cases beyond the range of suspicion, we have to rely almost exclusively on the sensations of the patient. In differentiating, therefore, between cases, we can only approach to a sound conclusion by what is called a process of exclusion. If we find the tongue clean, the pulse normal, the bowels regular, and the general appearance of the patient healthy, there is strong presumptive evidence that the dyspepsia and pain complained of are feigned, or, at all events, exaggerated, and the patient may either be informed that his ailment is of too trifling a nature to require treatment, or he may be treated with a black draught, which will do no harm if it does not do much good. There is another mixture found to be very serviceable in cases of questionable or exaggerated illness of a dyspeptic nature, which goes by the appropriate name of "choke-em-off" amongst prisoners, and, by way of variation, is dubbed in therapeutical phraseology, *mistura amara*, or *haustus spasmodicus*. It is compounded of sp. am. fœtid., assafœt., tinct. valerian, and infus. chirettæ; and, to judge by the facial expression of the patient after swallowing a dose, it maintains the high reputation which drugs

in general possess as regards their nauseous properties. In persistent cases of simulated dyspepsia, an emetic is found to be very advantageous. Sometimes, as a proof of the genuineness of the dyspepsia complained of, the patient maintains that his bowels have not been moved for days or even weeks, and that the aperient medicine prescribed for him on repeated occasions has had no effect, although he has gone to the water-closet and strained to his utmost. In the absence of any signs of fæcal accumulation in the abdomen, it is advisable to put such cases under observation, when, as a rule, it will be found that the bowels are moved within twenty-four hours without the aid of medicine, thereby clearly establishing their feigned nature.

I need not say that when the pain complained of is severe, a physical examination of the patient is necessary in addition to inquiries concerning the character of the pain, its seat, its relation to time, whether constant, periodical, or occasional, whether after or before meals, etc. When colic is feigned, the malingerer generally betrays himself by complaining loudly on palpation or pressure. The treatment which I pursue in such cases is to administer an emetic, or order turpentine stupes to be kept applied until the patient admits that the pain is removed.

In connexion with this part of the subject, I may briefly allude to that species of feigning which simulates loss of appetite, or partial or total abstinence from food for a time. A prisoner will readily enough maintain that he does not take his food, when all the while he is taking the whole of it; but there are two checks which prevent his gaining anything by this mode of scheming,—for, in the first place, the rules of the prison not only forbid him to give away his food to a fellow-prisoner, but enjoin him to return any food which he cannot take to his warder; and, in the second place, every warder has instructions to bring to the notice of the medical officer any prisoner who is in the habit of returning portions of his food. The cases, therefore, which present any degree of difficulty in the way of management are those in which food is habitually and intentionally returned, the patient giving loss of appetite as a reason. Such cases should be admitted into hospital for observation, and the ordinary full hospital diet allowed at first; it will then be found that while part of the bread and potatoes are returned, the meat and soup are taken. The patient is also very careful to state the quantity returned, and will rather overstate than understate it. If there are no symptoms to indicate why his appetite should be deranged, he is next put on low diet and ordered a *placebo* mixture—a plan of treatment which is usually attended with the happiest results, for in a day or two he will gently insinuate that he thinks he could take a little more food, as the medicine has decidedly done him good. Obviously it would be bad policy to grant his request, because, if granted, his *ailment* would in all likelihood become chronic; he is, therefore, gravely informed

that, in order to prevent a *relapse*, it is necessary he should be kept on this diet for a few days longer, and that he should continue the medicine. So soon as his request for increased diet becomes importunate, he is told that since he has regained his appetite, he is now quite well, and is accordingly discharged from hospital *cured*. This feigned loss of appetite is likewise often resorted to by patients who have been admitted into hospital for some genuine ailment, and who are very anxious to prolong their stay, as the majority of prison patients undoubtedly are. To those who are constantly saying that although they take their food they have to *force* it down, little attention need be paid.

In complete abstinence from food, or refusal to take it, recourse should be had to the stomach-pump. I have seen several very obstinate cases of the kind in prison, generally associated with feigned insanity; but a little rough feeding with the stomach-pump has always resulted, after a longer or shorter interval, in the prisoner's taking his food without compulsion. If the introduction of the œsophageal tube be resisted, as it commonly is, I use the screw gag, inserting it between the upper and lower molars of one side; and should the food be voluntarily ejected afterwards, both gag and tube are retained *in situ* for some time.

Cases of this description, occurring in general practice, and amongst hysterical females, are usually feigned, the patient obtaining food surreptitiously. Even in such cases, although the treatment might appear harsh, my own opinion is, that the stomach-pump should be used when more lenient measures fail; at all events it may safely be said, that had some such active steps been taken in the case of the Welsh fasting girl, or even had she been left to herself, there is no doubt that her life would have been saved, and a public disgrace to the profession avoided.

The next point of any importance connected with feigned diseases of the digestive system which comes to be considered, is distention of the abdomen. This can be readily simulated by arching forward the lower dorsal and lumbar portion of the spinal column, by keeping the lungs well inflated, and thus depressing the diaphragm, while, at the same time, the shoulders are thrown well backwards. Under these conditions the girth of the waist is increased, and the surface of the abdomen becomes tense and protuberant. Although I have met with a few such cases among convicts, this mode of scheming is seldom resorted to, because it is easily detected on a first examination. The patient should be divested of his shirt, and laid on his back on a hard mattress, or, better still, on the floor. The overarched state of the spine will then become apparent, and if steady pressure be made with the hand on the abdomen, while the patient is directed to count as long as he can without taking an inspiration, the distention will gradually subside. Should he not comply with the instructions, and, instead of making a prolonged expiration, keep taking "short

breaths," the nature of the case becomes clear, and no further trouble need be wasted on it. I have met with only one case of abdominal distention produced by other means, and from the markedly tympanitic sound emitted on percussion, I had every reason to believe that the distention, which was very considerable, had been brought about by swallowing air; at any rate, it soon disappeared under a course of tartar emetic and sulphate of magnesia.

Whether prolapsus ani can be artifically produced or not, I have little doubt, judging from cases which have come under my own observation, that when it does exist, a malingerer can, at any time, exaggerate it to such an extent as to unfit him for work. Not long ago, a prisoner, who had been admitted into the hospital for debility and loss of flesh, began to complain shortly after his admission that his "seat" came down, and that he was losing a great deal of blood every time he went to stool. On examination, a large portion of the rectum was found to be protuding, and there was some blood in the night-stool; there were also traces of blood about the points of his fingers, which the patient accounted for by saying, that he had been trying to force back the "gut." As I had once seen a somewhat similar case before, in which the prisoner had been detected using a small pointed piece of wood to wound the rectum, and so produce bleeding, I strongly suspected that in this case the finger-nails had been employed for the same purpose, and my suspicions were strengthened, because the same condition of things was repeated at each visit. I used a strong solution of nitrate of silver, made the patient keep the recumbent position, and gave him a rectum plug to wear; but, day after day, he complained that he was no better. It so happened, however, that there were some patients in the hospital at the same time who were about to be removed to an invalid prison, and I have no doubt he was aware of this, and hoped that by persevering long enough he might be sent along with them. Whether this was the case or not, he expressed himself as being much better the day after their removal (there was no blood in the stool and no prolapsus), and he wished to be allowed to get up and go to work again. He was discharged from hospital shortly afterwards, and although he has been employed at the ordinary hard labour of the prison ever since, he has not presented himself a second time as a complainant. A few other cases of the same kind have come under my notice, but the daily application of a caustic solution with a probang pushed well up the rectum, along with the recumbent position and confinement in a separate infirmary cell, has always succeeded in ameliorating the prolapsus to such an extent that the patients have soon become fit to resume work and have given no further trouble.

When bleeding from the rectum is complained of, the patient's linen and drawers should be examined, because in genuine cases blood-sains can almost always be detected, and the absence of

them, therefore, makes the case look very suspicious. But sometimes a malingerer will show a quantity of blood which he asserts has been passed in this way, when it is found that it has been derived from the nostrils. The following is an instance of this form of scheming:—One morning I was roused out of bed to visit a prisoner, whose cell-floor was said to be covered with blood. I found him groaning in bed, and there was certainly a considerable quantity of blood on the cell-floor, in his pot, and on the sheets of the bed. He said that he had passed the blood from his bowels, and that he was in great pain; but as he was an old malingerer, I was very doubtful about the truth of his statements. Accordingly, I pushed my finger up his rectum, and, on withdrawing it, could discover no signs of bleeding from that quarter; but on examining his nostrils I found abundant evidence as to how the bleeding had been produced.

Internal hæmorrhoids are often pleaded as a disqualification for being put to the more severe kinds of prison labour. As they sometimes do not exist at all, and, when they do exist, are often made the most of, an examination with the anal speculum is essential to a correct diagnosis in each particular case.

IV. Feigned and factitious diseases of the urinary system chiefly affect the following pathological conditions, viz., incontinence, retention, diabetes insipidus, and hæmaturia. When a prisoner complains that his urine is constantly dribbling away from him, it is a matter of importance that he should be examined at once, because it very often happens that he has not reckoned upon such examination, and his linen, therefore, will be found dry. But sometimes, having prepared for this contingency, he presents himself with his linen properly soaked, and it then becomes a question whether or not this is owing to incontinence. If he be malingering, there will be an absence of the disagreeable urinous odour which is always more or less perceptible in the real affection, and the penis and neighbouring parts will not present the characteristic moist and chafed appearance. To clear up any doubts, the mattress on which he has slept should be examined. Persistent cases should be admitted into hospital for observation, and a catheter passed at an hour when a visit is least expected. If a considerable quantity of urine be drawn off, and if it issue in a tolerably strong jet, there need be little doubt as to the feigned nature of the case, because when incontinence is due to a paralyzed condition of the bladder and consequent over-distention, the urine, unless in recent cases arising from accident, is ammoniacal, and, moreover, it is always associated with some serious form of disease, as paraplegia, apoplexy, fever, etc. As another diagnostic test, a good dose of opium might be administered at bed-time, and the sheets examined towards morning before the patient awakes. In all feigned cases, and when the bed is "wetted" every night, I know of no more

efficacious treatment than to have the patient aroused every hour or so, and made to get up and urinate. With the exception of some rather aged prisoners, and of a few cases of serious disease, I cannot call to mind any *genuine* case of incontinence occurring amongst prisoners, and I therefore feel warranted in saying that, amongst adults, the real disease is extremely rare.

Retention of urine (using the term as quite distinct from suppression) is invariably connected with an over-distended bladder, a condition which can readily be diagnosed by palpation and percussion, while, by passing a full-sized catheter, the existence or non-existence of stricture and the amount of urine can be established. The detection of feigned cases, therefore, is not difficult, and need not require any further remark beyond this, that they are more common amongst female than amongst male prisoners.

Of more frequent occurrence than either of the above modes of scheming is that of feigned diabetes insipidus. As this may be simulated by adding water to the urine, or by drinking large quantities of water and thereby increasing the flow, it is necessary that all such cases be put under strict observation. The quantity of liquid allowed should be clearly stated, and precautions taken that the patient obtain no more than this allowance. It is also advisable that all vessels be removed from the cell, and that the patient, when he wishes to pass water, should be able to intimate his desire to an attendant, in whose presence it should be voided and then removed. Both the quantity and specific gravity can thus be accurately ascertained, and, within twenty-four or forty-eight hours at the utmost, the nature of the case clearly established.

With regard to hæmaturia and other abnormal appearances of the urine, it is likewise requisite that the patient be made to urinate in one's presence, and, in the event of his refusing or asserting that he cannot do so, to pass a catheter. Malingerers will sometimes mix blood, milk, dirty water, etc., with their urine to alter its appearance; but by adopting the above measures, imposture becomes impossible. Indeed, on all occasions when an examination of the urine is intended, it is necessary, at least in prison practice, that it should be voided in the presence of some responsible person, and immediately removed, otherwise its appearance and analysis may become alike very puzzling. Cases have been recorded in which blood and other substances have been introduced into the bladder, but they are of such rare occurrence that the mere mention of them will suffice.

V. So far as my own experience goes, feigning in connexion with the generative system has been confined to females. The distention of the abdomen already described is sometimes simulated by female prisoners to imitate disease of the "womb;" and though the same means of diagnosis will generally succeed in detecting imposture, it is necessary to bear in mind that, in this class of

patients, abdominal distention may actually exist independently of any enlargement of the uterus or other organic disease, as, for example, in cases of so-called spurious pregnancy and hysterical tympanitis. Cases of feigned prolapsus uteri, leucorrhœa, and menorrhagia have occasionally come under my notice, but a digital examination, along with the evidence of a female attendant as to whether or not the linen was stained, rendered detection easy. I may add that women who have had children, and in whom the uterus and its appendages are relaxed, can readily simulate partial prolapsus by "bearing down" when an examination is made, but the requisite straining cannot be attempted without becoming apparent.

VI. Feigned and factitious diseases of the locomotive system include such deformities and affections as curvature of the spine, wry neck, stiff joints and contracted limbs, elevated shoulder, lameness, anasarca, rheumatism, the effects of injuries, and mutilation. Although my opportunities have not been extensive enough to enable me to discuss all these different conditions from personal observation, I may briefly allude to some general principles applicable to most of them, which have been laid down by the best authorities as aids in diagnosis. For example, in a case of suspicious deformity, whether arising from spinal curvature, gibbosity or elevated shoulder, or from a stiff joint and contracted limb, it is recommended to inquire, first, as to how and when the deformity originated, and afterwards to have the patient stripped, either wholly or to the extent requisite for a full and complete physical examination. If the case be one of lateral curvature of the spine (the kind generally feigned), the extent of the curvature and general condition of the spine should be noted, as should also the marked elevation of the haunch on the concave side, the singleness and situation of the curvature (dorso-lumbar), and the absence of gibbosity on the convex side—all these being points which are more or less diagnostic of this variety of scheming. As a test, the patient should be examined when lying on his belly, the loins fixed with a tight bandage, and the arms extended above the head, or he might be made to suspend himself by the hands from a beam or rope. Gibbosity could be detected in the same way. Stiff joints, on the other hand (several feigned cases of which I have myself seen), should be carefully compared with the corresponding healthy joints of the opposite limbs, it being found that, besides a connected history as to how the stiffness arose, there are always abnormalities more or less discernible in the size and conformation of a joint which has become stiff as a result of accident or disease. A feigned stiff knee-joint can be readily detected by fastening the patient in a sitting posture on a table, with the joint projecting over the edge. In this position the power of the extensor muscles of the thigh will soon become exhausted in keeping the leg straight, and consequently it drops. By suspend-

ing a weight, such as a bucket, from the ankle, and afterwards pouring a little water into it, the period of resistance will be considerably shortened; but in adopting this plan of treatment it is necessary that the patient be fastened to the table, else he will slip off, bucket and all, as once happened to myself, so soon as he finds the bucket becoming uncomfortably full. This plan of suspending weights to limbs, whether the arm or leg, has often succeeded in the hands of army surgeons in detecting imposture; but I think the same ends could be gained, and perhaps as satisfactorily in some cases, by fixing suitable splints capable of being extended by means of a screw. Opium or chloroform may also be employed to great advantage.

Amongst convicts, œdema or the swelling of a limb, rheumatism, the results of injuries and self-mutilation, are more liable to be feigned, exaggerated, or produced than the varieties of scheming noticed above. I have seen a few cases of feigned, stiff, and contracted fingers, but there was not much management required in curing them. Swelling of a limb is produced by ligature; indeed, so commonly is this practice resorted to in prison, that all swollen limbs should be examined for the traces of ligature. Injuries likewise are aggravated in the same way, and the cure protracted, as in a case of fracture of the lower third of the radius not long ago under treatment in this prison. It was observed one day, after firm union had taken place, and when only a bandage was necessary for support, that the hand was very much swollen. This at first sight was attributed to over-tightness of the bandage; but, on discovering that the swelling also extended above where the bandage was applied, a further examination was made, and a ligature was found tightly tied round the arm a little above the elbow-joint. Another form of factitious swelling is the puffiness of the dorsal surfaces of the hands or feet, or of the lower part of the forearm on the radial side, which is often produced by thumping for a time on one or other of these parts with the closed fist. The parts themselves, when presented for examination, are swollen, red, and slightly bruised-looking, but without abrasion of the cuticle, and, when once seen, the character of such swellings is readily recognised afterwards. The malingerer generally attributes them to a blow or sprain of some kind which he says he has received on the works. The plan I adopt in dealing with such cases is to tell the prisoner frankly how the swelling has been produced, and to dismiss him with the caution that if the same trick is tried again he will be reported.

Rheumatism, and more especially that particular form of it called lumbago, is also made a frequent pretext for avoiding labour; but here, as in cases of dyspepsia, it is not always easy to discriminate between the feigned and the genuine disease, inasmuch as chronic rheumatism may present no objective symptoms. Persistent cases, therefore, should always be admitted for observation; and if it be found that the patient sleeps soundly on sheets, a dose of the galvanic

battery and a little low diet will in all likelihood produce a speedy cure. When lumbago is complained of, it is best to humour the patient at the outset by examining the pulse, tongue, loins, etc., then to ask him whether he has observed any puffiness about his ankles lately, and end by requesting him to pull down his stockings to show them. As a rule, he will be taken off his guard by the interest displayed in his case, and will bend his back with an amount of alacrity which one really suffering from lumbago would envy, and, in fact, dare not attempt. But sometimes a fellow with his wits about him is not so easily caught, and then the wisest and most effectual course is to treat the case as genuine, and administer hot turpentine stupes.

When a convict receives a sprain or fracture of any kind, he is very apt to make the most of it by protracting the cure; and should he receive a contused wound, he will sometimes render nugatory all other surgical aid by "doctoring" it himself. After amputation, he will even interfere with the stump, so as to induce necrosis, and thereby sometimes necessitate re-amputation a little higher up. After injuries of the former description, he should be discharged to light labour on trial, so soon as a reasonable time has elapsed to effect a cure and all swelling has disappeared. Should there be no subsequent duskiness of the part nor return of swelling, he may safely be kept at his work, no matter how earnest his protestations may be that he is unfit to leave the hospital. In cases of wounds or amputation, the dressings should be so applied that they cannot be interfered with without discovery.

Self-mutilation is another feature of malingering, not at all rare in hard-labour prisons. Some time ago, a convict divided both tendines Achillis at Portland to disqualify himself for work; and the medical officer of Chatham Prison writes, in his annual report for 1869, that "bruising of the hands between the buffers of railway carriages has been a very common mode of producing bad accidents, and thus gaining admission to the infirmary. Of the fracture, one death is recorded, which occurred from a prisoner purposely putting his foot under the wheels of a railway engine in motion; his leg was dragged under the wheel, and amputation was performed; but he died some days afterwards from tetanus." A few cases belonging to this category, but not in any way serious, have occurred at this prison during the present year. All such cases are of course treated for the injury, and are justly punished when they are fit.

VII. Under the heading of the integumentary system, remain to be considered factitious abrasions, ulcers, and abscesses. At one period soldiers were much addicted to producing tolerably fair imitations of such skin diseases as tinea decalvans, urticaria, erysipelas, and impetigo, by the use of various irritants and blistering substances; but now that the study of these diseases has become so much more general, I imagine that this variety of scheming has

become very rare. In prison, I have only seen one case of feigned skin disease, which was, however, limited to the forehead and both cheeks. The cuticle had evidently been rubbed off with a rough towel, and the bleeding, ichorous surface had been well soaped to keep up the irritation. Being satisfied as to the nature of the case, I had the parts carefully washed and dried, and afterwards brushed over with collodion, thereby preventing the patient from tampering without my knowledge. In three days the thin crusts had all cleared away, and the healthy skin appeared beneath. As I have already said, such abrasions as these are sometimes met with in cases of feigned epilepsy, and are produced in order to give the impression that the patient must have fallen during one of his "fits." But more frequently they are made on the shin, and attributed to an accident, the patient in this instance stating that he shows the abrasion thus early lest he should be suspected of tampering with it in the event of its *festering*—a result, by the way, which is not at all unlikely if he be not cautioned at the time; for, generally speaking, the convict who assumes this air of injured innocence is the very fellow who *does* tamper when he thinks he can do so with impunity. In the vast majority of cases of ulcer that occur in prison, I believe the ulceration is commenced in the first place by producing an abrasion, and afterwards keeping up the irritation by applying soap, lime, whiting, etc. This variety of malingering goes by the name of "faking," and is often resorted to in wounds of all descriptions to prevent them from healing. The factitious ulcer is almost invariably found on the leg, or, less frequently, on the forearm. Its edges are generally circular and well defined, without being callous; its surface healthy-looking when cleaned; while the surrounding skin is natural in appearance, except where ulceration has formerly existed. In short, its distinguishing characteristic is an entire absence of a *raison d'être*, so to speak; its existence being altogether inexplicable, except on the ground of artificial production. Sometimes with the aid of a magnifying glass minute particles of whiting, glass, etc., can be detected, but usually examination can only decide that both ulcer and dressings are dirtier than they ought to be. The most effectual plan of treatment is to dress the ulcer in such a way that it cannot be tampered with without discovery, and this mode of dressing should, as far as possible, be adopted with regard to all wounds. Various methods have been proposed, such as sealing the bandages after they have been applied, or painting lines on them, or by enclosing the limb in a wooden box, as first carried out by the late Mr Hutchison. All these have proved more or less serviceable in the detection or prevention of interference, but the plan which I have found to be most efficacious, in a curative as well as preventive sense, is an adaptation of the antiseptic system of treatment, varying it according to circumstances. The first desideratum is to have the wound or ulcer thoroughly cleaned, washed with a carbolic acid lotion, and dried; then, if it be small and superficial, a coating of

styptic colloid or collodion will suffice; if it be larger, say about the size of a florin, the part of the limb affected is strapped, and a coating of styptic colloid applied over the strapping; if it be larger still, a layer of carbolized cotton-wool is applied directly over the ulcer; this is brushed over with styptic colloid, and, over all, a bandage is applied which is also coated with the colloid. In some cases gutta-percha tissue may be advantageously employed in addition. In this way the dressings cannot be disturbed by the patient without detection, and they should not be removed until a reasonable time has elapsed for healing to have taken place. If there should be any tendency to the oozing of pus through the dressing, as will happen in large ulcers, it should be washed with a strong solution of carbolic acid, and a fresh layer of cotton-wool and another bandage be applied over the first dressing. Without going further into detail, I would strongly advocate Professor Lister's plan of dressing in all wounds of whatever description, not only for its intrinsic merits, but because it is a safeguard against tampering in suspicious cases. In simple abrasions, or small ulcers of the leg which are undoubtedly artificial, a very successful plan of treatment is to insist on the limbs being kept exposed day and night outside the bed-clothes, in which case no dressing need be applied.

Factitious abscesses are likewise of common occurrence amongst convicts. They are produced by inserting a small pointed piece of wood or pin, covered with dirt, which is allowed to remain long enough to excite inflammation. The malingerer does not present himself until suppuration has set in, and the surrounding parts are highly inflamed. I have seen several cases of this description, and have found that the puncture is always discernible although it may have closed up. The pus, when the abscess is opened, has a dark sloughy appearance, and sometimes contains some fragments of foreign substance, which clearly establishes the character of the case. As an instance of this kind of malingering, I quote the following from the annual report for 1869 of the medical officer of Portland Prison:—"A man under punishment complained of a sore in his foot. On inspection I found a small punctured wound on the side of the sole. On asking him how he came by it, he replied that a piece of wood ran into his foot while walking to the closet. Knowing that he must have worn a shoe at the time, and that, therefore, if his story were true, there must be a mark of the splint having passed through it, I examined it, and found no trace of this having been the case; and, though consequently disbelieving him, I gave him, as usual, the benefit of the doubt, and ordered him poultices, bed, etc. His foot became much worse, and highly inflamed; he began to be alarmed (which feeling I did my best to increase), and at last confessed that he had run a piece of stick into his foot. The wound was, therefore, laid open, and I extracted two pieces of wood, each about an inch in length. He appeared very penitent, and promised never to repeat the offence. He was placed

on hospital diet, his health having at this time suffered very considerably, and, the wound having healed slowly, he was discharged and began his punishment again. Three days after it reopened, and was nearly as bad as ever; and though he strenuously denied having tampered with it, on a strict watch being kept over him the officer in charge discovered, very neatly hidden in his cell, two inch pieces of pointed stick and one of stone, with string attached to them, that they might be placed and replaced at will within the wound."

So great is the detestation of many prisoners for work that it is only by having recourse to sharp repressive measures that the more frequent occurrence of cases of this description can be prevented, and hence it becomes the duty of the prison surgeon to report, without the least hesitation, any clearly-established instance of malingering, so that the culprit may be duly punished. Factitious ulcers and abscesses are, I believe, more generally resorted to in public works' prisons than any other form of scheming, chiefly because they disqualify for work for the time being, and because the convict knows that unless the evidence against him is beyond doubt, he will be treated as an ordinary patient, and escape punishment altogether.

There is another aspect of feigning occasionally exemplified in prison life, but which merits only passing notice—I refer to feigned attempts at suicide. Hanging is the mode usually selected, and the feigned attempt is characterized by being made at some opportune moment when the proceeding is sure to be interrupted. Sometimes a prisoner threatens to commit suicide in order to be put under observation, but I have always found that he may be safely left to his own resources without the least risk of his putting his threat into execution.

In bringing this sketch of feigned diseases to a conclusion, I am afraid that its practical utility may be somewhat curtailed owing to the special stand-point from which alone I could treat the subject clinically, and as a matter of personal observation and experience. But though the class of patients may vary, the same differential data are as generally applicable in the detection of feigned diseases as are physical signs and symptoms in the diagnosis of real disease; and hence it is chiefly in the *management* of feigned cases that the circumstances of the patient take effect. It is true the prison surgeon possesses facilities for enforcing strict observation, and the carrying out of his instructions, that are not at the disposal of those engaged in general practice, but he is none the less bound to obey those dictates of humanity which secure to the suspected schemer the "benefit of the doubt," and to the undoubted schemer protection from any kind of medical treatment bordering on the cruel or barbarous.

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