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Trauma in Court: Medico-Legal Dialectics in the Late Nineteenth-Century German Discourse on Nervous Injuries

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This paper discusses a dialectic whereby the law not only influenced medical thinking in late nineteenth-century Germany, but also underwent medicalization of its own initiative. At the end of the 1880s, social legislation was crucial in initiating the German discourse on traumatic nervous disorders. By employing doctors as medical experts in court, the law also created a new experiential realm for doctors, altering their behavior toward patients and shifting their focus from therapy to investigation. However, in the wake of their experiences in court, doctors developed a dual etiology of traumatic symptoms, which included the law itself as a pathogenic element with the power to aggravate symptoms. Two medical views of law can be distinguished: some doctors claimed that it was the desire to receive the pensions offered under social legislation that induced workers to perpetuate and exaggerate their symptoms; others argued that since pension claims embroiled claimants in intimidating legal proceedings, the pathogenic effect of social legislation stemmed from fear rather than greed.

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INTRODUCTION

The purpose of this paper is to shed light on the interaction of law and medicine in the wake of the 1889 decision of the German Imperial Insurance Office (*Reichs-Versicherungsamt*) to allow traumatized workers to bring pension claims if their symptoms from the trauma disabled them and thereby reduced their earning ability.[1] Recognized among such disabling symptoms were: tremors; dizziness; palpitations; insomnia; nightmares; startle responses; hypersensitivity; numbness; partial paralysis; headaches; partial mutism; deafness; and so-called tunnel vision, which limits the visual field.

On the one hand, the spread of these symptoms among workers who had been involved in workplace accidents led to a flood of traumatized patients from the working class, who were examined by certifying physicians (*Vertrauensärzte*) appointed by the Imperial Insurance Office. The task of these physicians was to assess the causes of the patients' symptoms, as well as the scope and projected duration of their disabilities. As has been widely noted in the literature, by creating a need and forum for the medical examination of workers, legislative measures led to hundreds of publications on traumatized workers, many of which were revised versions of expert opinions submitted to the arbitration courts or the Imperial Insurance Office. Yet, on the other hand, though social legislation brought working-class

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1 Any research on this topic is conducted in the shadow of Esther Fischer-Homberger's pioneering Die traumatische Neurose: Von somatischen zum sozialen Leiden (1975), and Greg A. Eghigian's excellent Making Security Social: Disability, Insurance and the Birth of the Social Entitlement State in Germany (2000) [hereinafter Eghigian, Making Security Social]; both these works influenced the argument of this article more than footnotes can indicate. *See also* Greg A. Eghigian, *Die Bürokratie und das Entstehen von Krankheit. Die Politik und die "Rentenneurosen" 1890-1926, in* Stadt und Gesundheit: Zum Wandel von "Volksgesundheit" und Kommunaler Gesundheitspolitik im 19. und frühen 20. Jahrhundert. Vol. 3 Nassauer Gespräche der Freiherr-von-Stein Gesellschaft. Stuttgart, Franz Steiner 203-24 (J. Reulecke & A. Gräfin zu Castell Rüdenhausen eds., 1991) [hereinafter Eghigian, *Die Bürokratie*]; Greg A. Eghigian, *The German Welfare State as a Discourse on Trauma, in* Traumatic Pasts: History, Psychiatry and Trauma in Modern Age, 1870-1930, at 92-112 (Mark S. Micale & Paul Lerner eds., 2001) [hereinafter Eghigian, *The German Welfare State*]; Gerd Göckenjan, Kurieren und Staat machen: Gesundheit und Medizin in der bürgerlichen Welt 341-406 (1985); Anson Rabinbach, The Human Motor: Energy, Fatigue, and the Origins of Modernity (1990); Heinz-Peter Schmiedebach, *Post-traumatic Neurosis in Nineteenth-Century Germany: A Disease in Political, Juridical and Professional Context*, 10 Hist. Psychiatry 27 (1999).

patients into the consulting rooms of prominent physicians acting as court experts, by most estimates published at the time, compensation claims for nervous disorders in the wake of workplace accidents did not exceed two percent of all accident pension claims filed.[2] A survey conducted in 1900 of four years of pension claims following accidents within one industrial syndicate reached the conclusion that less than one percent of the claims filed against the accident insurance company demanded pensions for neurotic disorders.[3] Nevertheless the medico-legal debate over neurotic claimants preoccupied the social insurance apparatus and German neurologists for five decades — of which this paper will cover the first three, leading up to the outbreak of the First World War.

The reason for this asymmetry between the weight of the financial burden imposed by such claims and the extent and intensity of the medico-legal debate triggered by them is connected to the social anxieties this issue evoked and four characteristics of chronic neurotic disorders that exacerbate such anxieties. First, in the absence of somatic injuries, it was difficult to establish whether long-lasting symptoms were caused by trauma, were the result of simulation, or were the effect of a factitious disorder. Second, the persistent symptoms for which workers demanded pensions often had a belated onset; that is, they did not appear immediately after the accident that was supposed to have caused them. Third, if the symptoms were the consequence of a minor accident, the chronic effects of trauma may have seemed disproportionate to the event that caused them. Fourth, the majority of people who underwent even the most dreadful of experiences did not subsequently develop chronic mental disorders. Thus it was unclear what differentiated the minority that did develop symptoms as a consequence of a traumatic accident from the majority that did not. Evidently, the intangibility, delay, disproportionality, and selectiveness of traumatic disorders, as well as the fact that such conditions could bestow substantial benefits upon workers when they used them for pension claims, generated suspicion. Since diagnoses and etiologies of traumatic disorders were necessarily underdetermined by the ostensibly neutral or objective facts of medical practice, much room was left for social anxieties, preconceptions, and identifications in the considerations of physicians, which, as we shall see, often impacted heavily on the position of physicians in the debate on traumatic disorders.[4]

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2 Eghigian, Making Security Social, *supra* note 1, at 234; Schmiedebach, *supra* note 1, at 42.

3 *Aerzteverein Hamburg*, 6 Aerztliche Sachverstaendigen-Zeitung 507 (1900).

4 José Brunner, *Identifications, Suspicions, and the History of Traumatic Disorders*, 10 Harv. Rev. Psychiatry 179 (2002).

There were, by and large, two anxieties that guided the medical discourse of the period. On the one hand, there were those doctors who feared that industrialization, the energies released by the machines of modernity, the conditions of the modern workplace, and the procedures and practices of social legislation had a detrimental effect on the nervous condition of workers. On the other hand, there were doctors who were concerned that wily workers could exploit the welfare state and that those whose constitution was weak or will was overcome by greed and desire could escape their duty and give in to an aversion to work and a pull to idleness. Those who regarded the greed, desire, or weakness of will of workers to be the main danger to Wilhelmine Germany bore strong suspicions against working-class claimants and dismissed colleagues who diagnosed them as ill as being naïve and gullible. Those who considered claimants to be victims of their social and legal environments directed suspicion away from the workers to their medical colleagues by casting aspersions on the objectivity and expertise of those who failed to discover the pathology of those who filed claims for pensions for neurotic disorders.

The social anxieties and prejudices of doctors played an important role in the legal discourse on traumatic disorders, because they acted as expert arbiters in the claims brought by neurotic workers. In contrast to Britain and the U.S., where workplace accidents were dealt with within the domain of tort law, in Germany they were moved from the realm of the private law of torts to the public law of insurance, which imposed a regime of strict liability and collectivized responsibility, replacing compensation payments with pensions and thus abolishing legal conflicts over questions of prudence, fault, negligence, and liability for damages.[5] This form of social legislation accepted that, at least as a statistical event, accidents are foreseeable and not some unforeseen event that happens by fault of some individual. Instead of an exception, accidents came to be seen as a regular, normal part of industrial life, a damage inflicted by industrialization, for which workers had to be compensated, even if only at a minimal rate. As François Ewald has elaborated, this change in approach reflected a new conception of the relationship between the state and its citizens, under which the state not only took upon itself to protect the lives of its citizens and grant them rights

5 François Ewald, *The Return of Descartes's Malicious Demon: An Outline of a Philosophy of Precaution, in* Embracing Risk: The Changing Culture of Insurance and Responsibility 273, 275-76 (Tom Baker & Jonathan Simon eds., 2002).

and freedoms, but also to compel employers to insure workers for injuries that they might suffer at work, including mental injury.[6]

At the same time, the 1884 Accident Insurance Law precluded any proper legal dispute over causation, which would have referred to questions such as who caused the accident directly or indirectly, whether it was reasonable, foreseeable, and so on. The only questions that remained to be settled related to medical rather than legal causation. At issue were etiology and prognosis rather than negligence and liability. Especially in cases of nervous disorders without organic substructure, without a visibly injured limb or other somatic disability, the question of whether a pension claimant was suffering from an accidentally caused disorder, from a prior existing illness, or was merely malingering could be determined only by a medical practitioner. Similarly, the nature of the claimant's illness, extent of his or her disability, and its duration had to be assessed by a doctor. Thus, legal causation gave way to medical causation: law became medicalized in the process of juridifying medicine.

Law was also medicalized in another fashion: in the wake of increasing pension claims, Wilhelmine doctors came to consider the 1889 decision to extend the 1884 Accident Insurance Law to traumatic disorders as a causal, constitutive component in the etiology of the very chronic traumatic disorders on which it sought to adjudicate pension payments; that is to say, they maintained that a decision of the Imperial Insurance Office had created the disabilities for which it offered compensation, by encouraging workers to transform what originally were but acute, temporary symptoms into features of chronic disorders. Thus, etiologies of traumatic disorders may be understood not only as constitutive of a medical discourse concerned with symptoms and their somatic and psychic origins, as well as their effects on the patient, but also as the foundation of a critical discussion of the consequences that the increasing juridification of the lifeworld in the welfare state had on the minds of its citizens and, above all, on the minds of the working-class, whose members were the main beneficiaries of Bismarck's pioneering social legislation in the late nineteenth century.

To be sure, the notion of juridification is not one that German doctors could have used at the time in their discourse. It originates in the work of the contemporary German philosopher Jürgen Habermas, who uses it to denote the ascendancy of written law in modernity in general and in the welfare state in particular. Habermas distinguishes two functions of the law: As a regulative force, law orders and modifies processes and actions of various

6 François Ewald, L'Etat providence (1986).

kinds, such as property transactions, which already took place before the law got involved in them. The law has a constitutive force, however, when it generates new forms of behavior and conduct or spawns new institutions and social roles, such as the social insurance claimant. According to Habermas, in the welfare state, law plays an increasingly constitutive role, creating new spheres of social action and/or substantially transforming old ones.[7]

By granting injured workers a new social role, namely, that of the pension claimant, the juridification of the workplace and its accidents also created a new and important role for doctors within the realm of the law: examiner, expert witness, and insurance assessor. Their role as experts, consultants, and referees in the setting of arbitration and legal disputes imposed a task on doctors that was foreign to their medical function but often prevailed over the latter. They met working-class patients as pension claimants, examining them in an atmosphere of distrust, where their opinions inevitably either furthered the interests of the patients or worked against them. There could be no trust between physician and patient, only mutual suspicion. Workers sought to convince the medical men that they were suffering, incapable of working, and hence deserving of compensation — while the doctors had to establish the veracity of the symptoms. Thus physicians primarily played an investigative role in the legal process, which, though it made use of medical knowledge, had not much to do with medical practice. Since the aims of the doctors were defined by legal proceedings, their purpose was not to cure an illness or alleviate suffering, but to uncover malingerers or those whose symptoms were not the result of pretense but of a weakness of will.[8]

Juridification raises questions about about medicine's legal use and, perhaps, about the legal use of extraneous disciplines in general. The courts consult medical experts in order to be informed of a truth discovered by scientific method, so that legal procedures can rely on externally established and independently validated knowledge. As this paper shows, however, when medicine is placed in the service of the law, the techniques by which it gains and establishes its knowledge may be reconstituted in a quasi-legal form. Ironically, the juridification of medicine may deeply compromise the legal uses of the latter, since the validity of its knowledge is taken to be guaranteed by the autonomy of the medical practitioner and the independence of the medical method from legal procedures.

This paper seeks to transcend the claim that law and medicine in Wilhelmine Germany were engaged in a dialogue with each other, if

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7 2 Jürgen Habermas, Theorie des kommunikativen Handelns 536-39 (1988).

8 Eghigian, Making Security Social, *supra* note 1, at 83-86.

the notion of dialogue is taken to mean an external relationship between two independently existing and well-defined disciplines, by pointing to the various ways in which legal procedures and changes played both an etiological as well as a therapeutic role, while doctors came to play a central role in the legal arena and adopted legal forms of behavior toward patients. Thus, the historical account of this paper should be taken as illustration of a more general, historiographical argument that in the course of its interaction with medicine, law does not remain law in its original form but becomes a kind of medicine, while, in one way or another, medicine turns into a discipline using legal procedures and making legal recommendations.

In *Phenomenology of the Spirit*, Georg Wilhelm Friedrich Hegel uses the term understanding (*Verstand*) to designate a non-dialectical approach, satisfied by fixed notions, firm distinctions, and entities that are enduring and exist in themselves. Understanding, in the Hegelian sense of the term, is dominated by the category of identity, which refers to everything as identical to itself and determined in its specific nature: law is law and thus not medicine, while medicine, since it is medicine, cannot be law, and hence, what happens in medicine is of little interest to legal history.

According to Hegel, this view of things is true, but only partially so. Though entities are identical, to attain truth in Hegelian terms, which means to come to grips with the totality of being, thinking must go beyond the stage of understanding (*Verstand*) and become reason (*Vernunft*), which captures the complex and continuous self-transformation, interpenetration, interdependence, and interrelation of things. These dialectics include, therefore, not only what the law makes of other practices, but also what other disciplines make of the law, what happens to medicine when it comes into contact with the law and to workers when they confront both as claimants. A dialectical perspective on the law, this paper suggests, sparks not only an inquiry into the manifold ways in which the law impacts on medicine, juridifying the practices and thinking of doctors involved in the legal process, but also an analysis of the way in which this juridification of medicine allows an intrusion of medicine into the legal domain, thus medicalizing the latter.

Hegel, who was a great believer in the march of history toward truth and the absolute, argued that what is annulled in the course of a dialectic is false and fragmentary with respect to the truth and that what is safeguarded is essential or universal, so that a superior level of knowledge and unity can be reached. As will become evident in the course of the discussion in this paper, though one may share Hegel's view of the dialectical nature of historical developments and interactions, one may still remain exceedingly skeptical

about Hegel's optimism concerning the outcome of dialectical processes in general.

The dialectic at stake in this paper is conceived as a development that transposed and transformed professional practices as well as structures and dynamics of power. But as will be shown, though practices and power relations were *aufgehoben* — mediated, transcended, or sublated — within the framework of the emerging welfare state, it is evident that this dialectic did not resolve the welfare state's underlying conflicts. Instead, it created, inverted, or reinforced new hierarchies — of etiologies, classes, and professions — thereby leading to new conflicts and struggles, which will not be dealt with within the limits of this paper, since here we follow the debate only until 1914, when conditions of war substantially changed the coordinates of the medico-legal debate on traumatic disorders.[9]

I. TRAUMA FACES THE LAW

At ten o'clock in the morning of Friday, June 17, 1887, Wilhelm H., a thirty-seven-year old construction worker standing in a pit on the ground of a building site, was hit in his face by the handle of a fully loaded wheelbarrow, which fell over. Despite his injury, H. continued to work until lunchtime but then went home suffering from increasing pains, having consulted with the trade-union physician, who prescribed cold compresses. Since these alleviated some of the pain, H. went back to work on Saturday and Monday, but returned to the doctor on Tuesday because of the return of the pain. He complained of headaches, vertigo, hearing difficulties in his right ear, and insomnia. After being treated for some time at an outpatient clinic, he was referred to the neuropsychiatric clinic of the Charité, the training-hospital of the Friedrich-Wilhelms-Universität in Berlin, where he was hospitalized for seven weeks, but released without having been cured.

H. remained in medical care as an outpatient for another year-and-a-half, until July 1889, when his doctor declared that his health had been fully restored and that he was capable of working again. As a worker who had been injured and completely disabled by an accident at the workplace, H. had received a full insurance pension throughout this period, which amounted to two-thirds of his salary. Once the physician decided that his

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9 *But see* José Brunner, *Will, Desire and Experience: Etiology and Ideology in the German and Austrian Medical Discourse on War Neuroses 1914-1922*, 37 Transcultural Psychiatry 295 (2000); Brunner *supra* note 4.

health had been restored, H. lost his pension. He appealed against the termination of the pension payments to an arbitration court, which rejected his appeal in October 1889. A month later, H. hospitalized himself again at the Charité, where he remained for almost two weeks. During this period, he petitioned the Imperial Insurance Office (*Reichs-Versicherungsamt* — "RVA"), the top echelon of the insurance hierarchy, to recognize his complete working disability. His petition was supported by a report written by Berlin neurologist Hermann Oppenheim, Director of the Neuropsychiatric Clinic (*Nervenklinik*) at the Charité. According to Oppenheim, H. suffered from a severe nervous illness caused by his head injury in June 1887, the symptoms of which were, by and large, the same as had been observed during his earlier hospitalization, though partly with increased severity. In January 1890, the employers' association submitted a contrary expert opinion, asking the RVA to reject H.'s claim, since his ailments stemmed from earlier rheumatism and did not disable him.

In March 1890, Oppenheim submitted yet another expert opinion, explaining that H. was suffering from traumatic neurosis whose exclusive cause was the accident in June 1887. Oppenheim's report was received with reservation by the RVA, since it did not fit their impression of H. Thus, the RVA turned to the Medical School of the Friedrich-Wilhelms-Universität for an expert opinion,[10] with the request to examine H. extensively if necessary. As a result, H. was hospitalized at the Charité for another five weeks, during which he underwent a series of examinations.

According to the final expert opinion, signed by the "Dean and Professors of the Medical School" and published six years later in full in the periodical of the RVA, the *Amtliche Nachrichten des Reichs-Versicherungsamts*, H. was found to tremble easily, was pale, had a perturbed facial expression, seemed sad, startled easily, and suffered from insomnia and a feeble memory. These symptoms led the members of the Medical School to conclude that H. was suffering from "a functional nervous disorder, a form of neurasthenia, respectively hysteria, which because of its connection with a prior injury will be called traumatic neurosis."[11] They argued that H.'s symptoms had disabled him completely, diminishing his working capacity to nil for an indeterminable

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10 *Obergutachten der medizinischen Fakultät der Universität Berlin*, 10 Amtliche Nachrichten des Reichs-Versicherungsamt 474-87 (1897) [hereinafter *Obergutachten*].

11 All German sources have been translated by the author.

period.[12] Nevertheless, four years later, for some unexplained reason, H.'s payments were reduced to twenty-five percent of the full pension.[13]

H.'s insurance claim, medical examinations, legal decisions, and pension payments were part and parcel of the medico-legal practices engendered by a pioneering example of social legislation: the 1884 German Accident Insurance Law (*Unfallversicherungsgesetz*). The Law enabled workers and state employees (*Beamte*) to claim part of their salaries as compensation for disability following an accident without having to prove negligence on the part of the employer.[14] As Greg Eghigian details, in the beginning, accident insurance was restricted to blue-collar workers in industrial plants, mines, pits, shipyards, and quarries, as well as civil servants who did not earn more than 2000 Marks per annum. In 1885, the first year in which the accident insurance had a practical effect, almost 200,000 enterprises had to insure themselves so as to fund the accident insurance scheme, which covered about three million workers out of a total German population of more than forty-six million. But every so often, the law was amended to extend the scope of the insurance scheme to include additional workplaces. In 1886, almost four million workers were insured; in 1900, accident insurance covered five million enterprises and eighteen million workers; and by 1913, twenty-five million workers were covered. By that point in time, accident insurance was compensating already more than one million individuals with cash payments and pensions, totaling more than 153 million Marks.[15]

By means of this comprehensive insurance scheme, Bismarck sought both to prevent pauperism and sever the link between the entitlement of a worker to compensation for being injured at work and employer liability. On the one hand, establishing fault on the part of the employer was difficult, and often workers were left without any means of income after an accident at the workplace. On the other hand, when an employer's negligence could be proven in court, this was taken as the victory of the working class over capitalists.[16] Thus, industrialists feared that whatever the outcome, public interest in court cases increased class conflict, since some of the cases focused attention on working conditions and the sad fate of injured workers, while others endowed workers with a feeling of power over employers, if the latter were obliged to accept court decisions forcing them to pay large sums of

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12 *Obergutachten, supra* note 10, at 478.

13 *Id.* at 474.

14 Rabinbach, *supra* note 1, at 228.

15 Eghigian, *The German Welfare State, supra* note 1, at 69; Heinz Barta, Kausalität im Sozialrecht 178 (1983); Schmiedebach, *supra* note 1, at 40-41.

16 Barta, *supra* note 15, at 153.

compensation.[17] The Accident Insurance Law served employers by relieving them of the burden of having to justify working conditions in court, as well as protecting workers from the direst misery, while limiting compensation payments to a minimum, for pensions compensated workers for, at most, two-thirds of their lost earning capacity. Often this fell below the minimum a family needed to subsist.[18]

The Accident Insurance Law was part of Bismarck's extensive policy of social integration and stabilization, which sought to stem the rise of socialism by means of laws intended to curb the frustration and dissatisfaction of workers and which would limit the appeal of socialist parties and trade unions. At the same time, by removing workplace accidents from the scope of tort law, Bismarck also protected employers from the need to confront workers in court, the threat of large compensation claims, and adverse publicity of one kind or another. The enactment of the Accident Insurance Law was preceded a year earlier by compulsory health insurance legislation, which covered treatment of patients for thirteen weeks of illness and compensated them for lost income. In fact, the Accident Insurance Law covered injured workers only from the fourteenth week after the accident. Finally, Bismarck also passed an invalid and old age pension law in 1889, which completed his social legislation program. When these three laws were codified in 1911, they provided extensive welfare coverage for practically all wage earners in Germany.[19]

The political agenda lying behind this social legislation is evidenced by the fact that it coincided with the enactment of the Socialists Law (*Sozialistengesetz*), which suppressed socialist trade unions and other associations and prohibited their publications from 1878 to 1890, without, however, barring the Socialist Party itself. Bismarck's aim was to tie the workers into the state and turn potentially revolutionary socialists into conservative pension recipients.[20] Hence the workers had no say in the administration of the insurance funds, which were in the hands of

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17 Monika Breger, *Der Anteil der deutschen Grossindustriellen an der Konzeptualisierung der Bismarckschen Sozialgesetzgebung, in* Bismarcks Sozialstaat: Beiträge zur Geschichte der Sozialpolitk und zur sozialpolitischen Geschichtsschreibung 27 (1994).

18 Gerhard A. Ritter, Social Welfare in Germany and Britain, Origins and Development 87-88 (1986).

19 Eghigian, Making Security Social, *supra* note 1, at 26-28.

20 Breger, *supra* note 17; Bismarcks Sozialstaat (Lothar Machtan ed., 1994); Eghigian, Making Security Social, *supra* note 1, at 25-66.

employers and administered through self-governing industrial syndicates (*Berufsgenossenschaften*).[21]

The German notion of the work accident (*Betriebsunfall*) for which pension could be claimed required only that the accident had to have occurred within the precinct of the *Betrieb*, that is, in the physical domain of the workplace, in contrast to the British approach, under which compensation for an accident was contingent on the accident having arisen from a work-related activity. In this respect, therefore, it was relatively easy for injured workers to win an insurance claim. If their claim was rejected or they wanted to dispute the degree of disability and the amount of pension determined by the insurance officials, they could appeal to especially established arbitration courts (*Schiedsgerichte*), which were composed of two representatives of the employers, two worker representatives, and one civil servant. The accident insurance apparatus was directed by the *Reichs-Versicherungsamt*, a senate composed of civil servants as well as representatives of the workers and the employers, whose task it was to supervise the arbitration courts run by the syndicates. Moreover, as noted, it was possible to appeal to the RVA against the decisions of the arbitration courts. In such cases, the RVA would ask prominent doctors or an entire medical school, as in the case of H., to provide an expert opinion,[22] which could prevail over that provided by the experts in the arbitration courts.

In the first years following the enactment of the Accident Insurance Law, no need arose for the RVA to request such medical reports. However, by 1888, it had already been provided with fifteen reports; in 1889 this number had more than doubled; by 1890 ninety-five reports had been submitted; and in 1896, the number rose to 451 reports. In view of the great importance of the medical expert opinions for its decisions, the RVA decided in 1897 to release all the reports (*Obergutachten*) in its journal, with the detailed report concerning H. the first one published on proceedings concerning a traumatic neurosis. Periodically, the RVA also invited physicians to give talks at its offices in Berlin, which it published in its journal in order to inform the arbitration courts of current medical opinions.

Most of the insurance claims concerned purely somatic injuries and disabilities, which often could be settled according to tables and calculations that the two sides could more or less agree upon; but in a minority of cases, accident compensation was claimed for disabilities caused by traumatic disorders that had no discernible somatic causes and that

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21 Eghigian, Making Security Social, *supra* note 1, at 54.

22 *Obergutachten, supra* note 10.

necessitated a medical expert opinion.[23] Such claims became possible only in 1889, five years after the passing of the Accident Insurance Law, when the RVA obligated industrial corporations to recognize traumatic neuroses as an illness for which a pension could be claimed.[24] From thereon, neurologists were called in frequently to examine working-class patients for arbitration proceedings. Among other matters, they had to determine whether a worker's disabling symptoms for which no anatomical basis could be found could have been caused by an accident and what effect they had on the working capacity of the worker. In this context, doctors played a truly central role as experts and referees, as is evidenced in the decisions of the RVA in such cases, which were published in its journal, the *Amtliche Nachrichten des Reichsversicherungsamts*. These decisions tended to be short, only a few lines in length, and generally conformed with the view of the medical expert. As Heinz Barta has argued, the medical expert dominated the domain of causation, an assertion certainly even more valid with regard to cases of trauma than physical injuries.[25]

II. MEDICINE FACES TRAUMA

As we saw in the case of H., one of the diagnostic categories used in legal disputes was that of "traumatic neurosis" (*traumatische Neurose*), which had been introduced into German discourse by the neurologist Hermann Oppenheim in a lecture given at the Association for Internal Medicine in 1888 and which later was published as an article.[26] In 1889, Oppenheim published a controversial monograph, *The Traumatic Neuroses (Die traumatischen Neurosen)*, in which he further elaborated on the notion of traumatic neuroses — in the plural — turning it into the central category of late nineteenth-century German discourse on nervous disorders.[27] Oppenheim's book provided the most elaborate and multifaceted theory of traumatic disorders in Wilhelmine Germany, constituting a focal point of the debate and a reference point for allies and adversaries alike.

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23 Eghigian, *Die Bürokratie, supra* note 1, at 202.

24 *Id.* at 203.

25 Barta, *supra* note 15, at 523.

26 Hermann Oppenheim, *Wie sind die Erkrankungen des Nervensystems aufzufassen, welche nach Erschütterung des Rückenmarkes, insbesondere Eisenbahnunfällen, entwickeln?*, 9 Berliner klinische Wochenschrift 166 (1888).

27 Hermann Oppenheim, Die traumatischen Neurosen, nach den in der Nervenklinik der Charite in den letzten 5 Jahren gesammelten Beobachtungen (2d ed. 1892).

According to Oppenheim, the symptomatology of traumatic neuroses was composed of a wide range of subjective and objective phenomena, some of which hitherto had been classified under the title of hysteria, while others were generally said to belong to neurasthenia. Oppenheim's book contains fifty pages of detailed descriptions of a wide range of symptoms, including: partial paralyses; a decrease in sexual desire; depression; sadness; numbness; fear; guilt; facial expressions of being lost; restlessness; a quickened pulse and other irregularities of heart functions; insecurity; procrastination; doubt; physical hypersensitivity; hypochondric tendencies; vertigo; increased sensitivity to light; diminution of the visual field; lack of reflex functions; partial anesthesia; rigidity of the back and the neck; tremor; pathological gaits of various kinds; and stuttering and other speech disturbances.[28] Oppenheim argued that since the symptoms of traumatic neuroses were both varied and mixed, the disorder was often misdiagnosed, for it could, at first glance, be taken for either hysteria or neurasthenia, while belonging to neither.

What was the meaning of hysteria and neurasthenia at the time? Hysteria and neurasthenia figured as the two most prominent degenerative neuroses in the European medical literature of the late nineteenth century. They were assumed to afflict those with a hereditary taint. "Mental degeneracy," a term introduced into European medicine in 1857 by the Frenchman Bénédict-Augustin Morel,[29] was understood as a long-term effect of modernity — especially urbanization and industrialization — whose vices, pressures, demands, speed, and noise were said to impose an inordinate burden on the nervous system, lead to fatigue, and bring people to seek consolation in drink, sexual perversion, or crime.[30] Though European doctors defined both hysteria and neurasthenia as nervous disorders with a hereditary component, they regarded them as "functional" disorders, that is, disorders that did not derive from anatomic damage to the nervous system.

The notion of hysteria was popularized from the 1860s to the 1880s

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28 *Id.* at 125-76.

29 Bénédict A. Morel, Traité des dégénérences physiques, intectélectuelles et morales de l'espèce humaine et des causes qui produisent ces variétés maladives (1857).

30 Robert A. Nye, Crime, Madness and Politics: The Medical Concept of National Decline (1984); Degeneration: The Dark Side of Progress (Edward J. Chamberlain & Sander L. Gilman eds., 1985); Daniel Pick, Faces of Degeneration: A European Disorder, c. 1848-c. 1918 (1989); José Brunner, Freud and the Politics of Psychoanalysis 6-15 (1995); Simon Wessely, *Neurasthenia and Fatigue Syndromes, in* A History of Clinical Psychiatry: The Origin and History of Psychiatric Disorders 509 (German E. Berrios & Roy Porter eds., 1995).

by Jean-Martin Charcot of the Salpêtrière in Paris, who was one of the fathers of modern neurology and whose theories, though controversial and ultimately unfounded, were highly respected, translated into German (Freud, for instance, translated Charcot's famous *Leçons due Mardi* in 1894), and widely read and debated by his German colleagues.[31] For Charcot, hysteria denoted a functional disorder of the brain marked by a host of symptoms, such as: rapid and extreme changes of mood; lethargy and fainting; localized losses of sensation and paralysis; narrowing of the visual field (tunnel vision) and loss of speech; difficulties in walking and standing; epileptoid seizures and convulsions; uncontrollable shouting and weeping; as well as reveries, deliria, and hallucinations.[32]

Oppenheim, who himself referred extensively to Charcot, argued that the fact that, from the mid-1880s on, traumatic disorders often were diagnosed as hysteria in Germany was due to the influence of Charcot's book, which had been published in German in 1886.[33] However, unlike Charcot, many German physicians considered hysteria as bordering on malingering and therefore as a less "legitimate" disease than neurasthenia. The term neurasthenia — literally, "weakness of the nerves" — was applied to manifestations of nervous exhaustion, such as migraines, indigestion, insomnia, depression, impotence, and muscular weakness. Other, less prominent symptoms were unstable emotions and chimerical thoughts, somnambulism, and, sometimes, religious ecstasy.[34] The illness was given its name by New York physician George Miller Beard in 1869, who considered it an American illness caused by overwork and the intensity, tension, and stress that are part of life in the big city.[35] In the beginning, neurasthenia was regarded as an affliction of the

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31 *See, e.g.*, Jean Martin Charcot, Neue Vorlesungen über die Krankheiten des Nervensystems (1866).

32 For a comprehensive history of hysteria, see Mark Micale, Approaching Hysteria: Disease and Its Interpretations (1995).

33 Oppenheim, *supra* note 26, at 169.

34 George F. Drinka, The Birth of Neurosis: Myth, Malady, and the Victorians 184-97 (1984); Tom Lutz, American Nervousness, 1903: An Anecdotal History (1991); Francis G. Gosling, Neurasthenia and the American Medical Community, 1870-1910 (1987).

35 George Beard, A Practical Treatise on Nervous Exhaustion (Neurasthenia): Its Symptoms Nature, Sequences, Treatment (2d ed. & rev. ed. 1880); George Beard, American Nervousness: Its Causes and Consequences. A Supplement to Nervous Exhaustion (Neurasthenia) (1881); Charles E. Rosenberg, *The Place of George Miller Beard in American Psychiatry*, 36 Bull. Hist. Med. 245 (1962); Barbara Sicherman, *The Use of a Diagnosis: Doctors, Patients, and Neurasthenia*, 32 J. Hist. Med. & Allied Sci. 33 (1977).

modern, professional middle-class, the overeducated and overworked, living in the big cities, surrounded by much commotion and machinery. Originally neurasthenia was not considered a danger for the lower classes, since their work involved their limbs and muscles rather than the brain. But with time, it became "democratized" and was used also in the diagnosis of working-class patients.[36] Neurasthenia was said to be long-lasting and difficult to cure, but not to cause any significant fatalities. Thus, its treatment consisted mainly of rest and extended vacation at the sea and in the mountains.

Though at first it was mainly used in the United States, the concept of neurasthenia crossed the Ocean in the course of the 1880s. By the 1890s much of the German literature on nervous disorders referred to neurasthenia as one of the dangers generated by the noisy, rapid, and demanding lifestyle engendered by features of modernity such as an advanced and highly specialized division of labor, capitalist competition, technological innovation, increasing urbanization, and industrialization.[37] As mentioned above, in contrast to Beard's approach, European medicine regarded it also as a degenerative illness. German doctors also related it to sexual excesses, masturbation, and, especially, to the ambiguous idea of "inbreeding" (*Inzucht*), which hinted both at intra-racial heredity and incest. Such views can be found, for instance, in the *Handbuch der Neurasthenie (Handbook of Neurasthenia)* from 1893, which declared the illness to be "the mark of our cultural era [*Signatur unserer Culturepoche*]."[38]

Although the German medical literature discusses female neurasthenics, it presents the illness mainly as a danger looming for the male, oversensitive, over-creative, too enterprising, and too-hard-working professional in a modern environment. In contrast, hysteria was the German physicians' diagnosis of choice for traumatized women and members of the lower classes.[39] According to Hannah Decker, "German doctors believed that even if men did have hysteria, there were fewer such men in Germany than in France. Hysterical disease was basically un-Germanic."[40]

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36 Gosling, *supra* note 34.

37 Joachim Radkau, Das Zeitalter der Nervosität: Deutschland zwischen Bismarck und Hitler 185-250 (2000).

38 Handbuch der Neurasthenie (Franz C. Müller ed., 1893); *see also* Richard von Krafft-Ebing, Nervosität und neurasthenische Zustände (1895).

39 Doris Kaufmann, *Neurasthenia in Wilhelmine Germany: Culture, Sexuality and the Demands of Nature, in* Cultures of Neurasthenia: From Beard to the First World War (*Clio Medica* 63) 162 (2000); Schmiedebach, *supra* note 1, at 43-45.

40 Hannah S. Decker, *Freud in Germany: Revolution and Reaction in Science 1893-1907*, 11 Psychol. Issues 80 (1977).

One should note, however, that despite the etiological, clinical, moral, and ideological differences that separated neurasthenia from hysteria in the late nineteenth century, the two conditions were by no means always clearly distinguished from one another, as the passage from the report (*Obergutachten*) on H. illustrates, in which H. was declared to suffer from "a functional nervous disorder, a form of neurasthenia, respectively hysteria, which because of its connection with a prior injury will be called traumatic neurosis." This quote also shows that the notion of traumatic neurosis was not taken to denote a novel, hitherto-unknown illness. As Oppenheim explained in the introduction to his book, the term was supposed to describe "forms of illness that developed in the wake of accidents and injuries, which did not directly affect and damage the central nervous system, but impinged on it by means of a commotion and reflex."[41] Oppenheim explicitly denied that he had uncovered a previously unknown disorder and acknowledged that it was possible in some cases of traumatic disorders to arrive at an unequivocal diagnosis of traumatic hysteria or traumatic neurasthenia. The category of traumatic neuroses, he stressed, applied only to cases of functional disorders in the wake of accidents, whose symptoms made it difficult or impossible to decide whether the disorder was hysterical or neurasthenic.[42]

However, one should not be misled by Oppenheim's ostensible modesty. By conjoining traumatic neurasthenia and traumatic hysteria under the heading of traumatic neuroses, Oppenheim elevated the status of traumatic disorders to that of an encompassing nosological category, thus abolishing some of the gender and class differentiations involved. For instance, Oppenheim pointed out that he did not regard traumatic neuroses to be class-related and that he reported mainly cases of working-class patients only because they were referred to him to be examined in the context of compensation claims. Wealthier people, he explained, could suffer from the same disorder, but might not seek compensation.[43] Moreover, Oppenheim explicitly argued against Charcot's assumption that hysteria had a hereditary basis and that traumata played only the contingent role of *agent provocateurs* in its genesis. In contrast to Charcot, Oppenheim strongly marginalized the role of the patients' constitutional predisposition in the etiology of traumatic neuroses. Mostly, he argued, traumatic neuroses developed in men who previously had been "completely healthy." Only in cases where a minor injury had led to a severe neurosis could one assume a pre-existing

41 Oppenheim, *supra* note 27, at 1.

42 *Id.* at 8-9, 182.

43 *Id.* at 121.

neuropathic taint.[44] Thus, for Oppenheim, traumatic neuroses were highly democratic: they afflicted the rich and the poor, men and women, impacting on patients independent of any prior existing weakness of the nervous system.

Generally, Oppenheim's case studies presented his patients as subject to a serious illness with severe, only rarely curable symptoms. Among the thirty-three cases in the first edition of his book, only six are said to have shown a marked improvement and there is not even one case of a complete cure or remission. Their dire prognoses placed traumatic neuroses closer to neurasthenia than to hysteria. By and large, Oppenheim constructed his new nosological entity by assimilating elements of hysteria into the logic of neurasthenia. He also located traumatic neuroses in the social environment of neurasthenia, that is, in the realm of labor, transport, and industrial production. Thirty-eight of the forty-two cases in the second edition involved industrial workmen or railway employees injured at work. Some of the cases referred to patients who had been in railway collisions, got caught in-between two railcars, were in a railcar that derailed, or fell off a railcar. Others were traumatized by a falling telegraph pole, an engine wheel in a factory, or an explosion in a gasoline factory.

Oppenheim explains that traumatic neuroses could be traced only in part to accidents as a physical event, for accidents do not have only a physical impact on their victims. In his use of the term, trauma refers to the physical impact of an accident in which the patient's body, including his brain, is severely shaken or suffers a blow. As he explains, the industrial environment as well as other blue-collar workplaces, such as building sites, provide a source for many such accidents.[45] However, he points out that such accidents mostly also lead to an "intense psychic upheaval" (*heftigen psychischen Erregung*).[46] He stresses that, in many cases, psychic factors, among which he explicitly mentions "fright" (*Schreck*) and what he terms a "mental commotion" (*Gemüthserschütterung*), play an important and sometimes even the primary role in the etiology of traumatic neuroses.[47] The fact that "psychic shock" (*der psychische Schock*) could constitute an exclusive cause of a traumatic neurosis is evidenced by cases such as those of a fireman who thought he was locked in a burning house or a train driver who was frightened by the prospect of an imminent collision, but which he managed to avert at the last moment.[48] For this category of

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44 *Id.* at 184.
45 *Id.* at 120.
46 *Id.* at 121.
47 *Id.* at 178.
48 *Id.* at 121-22; *see also* Oppenheim, *supra* note 26, at 170.

cases, Oppenheim also uses the notion of a "psychic commotion" (*psychische Erschütterung*), by which he means a fright-induced stimulus strong enough to effect a "lasting psychic alteration" and instill pathogenic ideas that manifest themselves in psychically determined paralyses. Oppenheim refers to Charcot as the author on whom he relied for the most elaborate and experimentally-grounded version of the doctrine that the idea of paralysis is sufficient to actually cause paralysis.[49]

Charcot, of course, used this ideogenic etiology of hysterical paralysis in order to explain hysterical symptoms. However, Oppenheim not only sought to integrate Charcot's insights into his theory of traumatic neuroses, but also to transcend them. Hence, he also argues, in contrast to Charcot's claims, that events in which patients fall, are jolted, thrown backward or forward, or hit or battered by a machine cause a commotion in the periphery of the nervous system, indirectly paralyzing nervous centers, where mental representations are located. According to Oppenheim, patients can be paralyzed partially not only because they imagine themselves to be paralyzed, but also because a physical trauma — a commotion of the brain — blocks access to the mental images he assumes to be necessary to move a limb or completely wipes out such memory images.[50] In addition, Oppenheim mentions that the continuous physical pain that could be the result of accidents also could become pathogenic by exerting a decisive pull on the patient's attention, leading to the emergence of "pathological ideas" (*krankhaften Vorstellungen*).

In sum, for Oppenheim, the main causes of neurotic symptoms in the wake of accidents are both neurological (a commotion in the brain that was brought on by the physical impact of the accident) and psychological (the fright that overcame its victim). Oppenheim's etiology of traumatic neuroses explains the disorder as caused either by the loss of or barred access to ideational representations in the wake of an accidentally caused commotion of the nervous system, as well as by the impact of pathogenic representations in response to fright and physical pain. Thus it provides a complex, synthetic etiology, integrating both references to the pathogenic absence of ideas, which echoed notions associated with neurasthenia, as well as references to the presence of pathogenic ideas, which generally were assumed to underlie hysteria. To understand the role Oppenheim's notion of traumatic neuroses played in the legal context of accident pension insurance, it is important to note that his etiology of disabling symptoms of traumatic neuroses turned the latter into a legitimate medical condition.

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49 Oppenheim, *supra* note 27, at 179.

50 *Id.* at 180-81.

It does not trace traumatic disorders to a weakness in the patient's will, his or her desire for a pension or to remain idle, and removes these from the patient's conscious control.

Oppenheim had three groups of opponents in German medical discourse on accident neuroses, all of which questioned the accuracy and value of the construction of a new nosological entity for patients suffering from neurotic symptoms in the wake of trauma. First, there were those who diagnosed such symptoms as signs of traumatic neurasthenia, thus justifying the payment of pensions, though even this diagnosis seems not to have led medical experts to declare their patients as completely disabled.[51] However, like Oppenheim, these doctors did regard their patients as honest and severely disabled, as suffering from a long-lasting illness beyond the control of their will that turned them into *bona fide* candidates for pension payments, albeit limited ones. Hence in the medico-legal context of Wilhelmine Germany, there was little conflict between this group of doctors and Oppenheim, for as mentioned earlier, in many ways, Oppenheim constructed his new nosological entity by assimilating elements of hysteria into the logic of traumatic neurasthenia.

Since the notion of traumatic neurosis made it impossible to point simply to hysterical symptoms in order to argue that a patient is hysterical, it is not surprising that Oppenheim's opponents belonged, above all, to a second group of physicians, who insisted on regarding traumatic disorders as hysterical, that is, as ideogenic, deriving from a pathogenic imagination and autosuggestion associated with a weak will and self-deception. Though traumatic hysteria was considered a disorder with consequences that were less severe than those of either traumatic neurasthenia or traumatic neuroses, since it disabled patients, it still could justify granting pension claims.[52]

But Oppenheim's most radical opponents belonged to a third camp of doctors, whose members dismissed pension claimants without physical injuries as malingerers. Since in Wilhelmine Germany traumatic disorders inevitably involved the possibility of financial gain for patients, doctors could not avoid addressing the question of whether the person whom they

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51 *See, e.g.*, Ph. F. Becker, *Ein Fall von neurasthenischem Schütteltremor nach Trauma*, 6 Aerztliche Sachverständigen-Zeitung 371 (1900); *Gerichtliche Entscheidungen*, 17 Aerztliche Sachverständigen-Zeitung 200-01 (1895) [hereinafter *Gerichtliche* 1895]; *Gerichtliche Entscheidungen*, 1 Aerztliche Sachverständigen-Zeitung 20-21 (1900) [hereinafter *Gerichtliche* 1900]; A. Leppmann, 9 Aerztliche Sachverständigen-Zeitung 190 (1896).

52 *See, e.g., Gerichtliche Entscheidungen*, 12 Aerztliche Sachverständigen-Zeitung 248-49 (1900).

were examining was ill or only producing the symptoms at will. Hence the figure of the malingerer hovered over the debate on traumatic disorders like a shadow, even though estimates of the frequency of malingering varied widely. Some physicians estimated the percentage of malingerers among claimants for traumatic disorders as not exceeding five to ten percent, while others estimated it as ranging from a quarter to a third of all claims. The latter also argued that long-lasting symptoms could not be observed in patients who could not or did not demand pensions. In response, some doctors presented cases of patients who could not be accused of malingering because they had nothing to gain by faking their symptoms or whose symptoms continued even after their claims had been settled.[53] Moreover, while some doctors regarded it as their moral duty to unmask malingers in order to prevent idleness and illicit gain, others, like Franz Müller, stressed that they are obliged "rather to let pass ten malingerers than doing an injustice to one ill person."[54] Müller added, however, that those who are unmasked as pretenders should be handed over to the criminal court.

III. Medicine into Law

While their role as auxiliaries in the legal process led all doctors to adopt some investigative practices associated with law rather than medicine, they differed from one another in the degree to which their medical gaze gave way to a legal one and the extent to which their encounters with patients were influenced by suspicion rather than empathy and by considerations of the will, rights, and duties of workers rather than treatment and cure. There was thus a yawning deep among German physicians: one the one side, those who regarded it as their duty as citizens and court experts to defend society against malingering and, on the other side, those who considered it their moral duty to protect from suspicion and unjustified accusations those suffering from nervous disorders. These two sides clashed during the 1890s in the so-called *Simulationsstreit* ("debate on malingering").[55]

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53 *See, e.g.*, Georg Flatan, *Traumatische Neurosen ohne Entschädigungs-Ansprüche*, 12 Aerztliche Sachverständigen-Zeitung 309-10 (1896); Ignaz Knotz, *Zur Frage der traumatischen Neurose* 8, 155-59 (1902).

54 Franz C. Müller, *Ueber die traumatische Neurose*, 18 Aerztliche Sachverständigen-Zeitung 125 (1907).

55 Esther Fischer-Homberger has given a most detailed and instructive account of this debate, Fischer-Homberger, *supra* note 1, 56-73; *see also* Schmiedebach, *supra* note 1, at 46.

Typical of one of the sides in the dispute was the position of Adolph Seeligmüller, a neurologist from Halle. When he referred to workers with symptoms of accidentally caused nervous disorders, he used terms that are better suited to an officer or a lawyer than a physician. He warned of the "many ... sly malingerers" who

> have completed their studies at the universities of malingering, that is, in clinics and hospitals. That's why such institutions are in no way suitable for the examination of dubious subjects. Vis-à-vis these sly, graduated malingerers one needs the expertise, experience and conscientiousness of an accomplished [*ganzen*] physician. Thus, young assistants, who usually are assigned the task of examining and observing victims of accidents who are suspected of malingering, do not have the personalities needed for this task.[56]

Seeligmüller argued that since neurological examinations were a relatively new practice, it was problematic to establish whether a patient was malingering or not.[57] He suggested the establishment of specially equipped hospitals for the examination of those suspected of malingering, with physicians particularly trained for this task. There, suspect patients could be separated from *bona fide* ones, so that the former would not be able to imitate patients with real nervous illnesses.[58] Seeligmüller's method of unmasking malingerers was rather time-consuming. By his own testimony, he never accepted more than four patients for observation at a time and hospitalized them in his clinic for at least a fortnight. A trusted assistant slept close to the observed patients and had the task of "surprising them by day and night."[59]

In fact, close surveillance of hospitalized patients was widely practiced in Germany at the time in order to unmask potential malingerers. In September 1895, a report in the first volume of the monthly of medico-legal experts, the *Aerztliche Sachverständigen-Zeitung*, tells of a claim brought by a bricklayer named Erichson, who had broken his right arm at work and demanded a pension for a traumatic neurasthenia, for, as he argued, his entire organism had been damaged by the accident. In the course of various legal proceedings and medical examinations by a number of doctors, he was hospitalized for

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56 Adolph Seeligmüller, *Weiter Beitraege zur Frage der traumatischen Neurose und der Simulation bei Unfallverletzten*, 17 Deutsche medizinische Wochenschrift 960-63, 981-83, 1001-03, 1019-20 (1891).

57 *Id.* at 962.

58 *Id.* at 961.

59 *Id.* at 981.

two months in the municipal hospital of Frankfurt, where he was "observed day and night."[60]

In 1900, in a suburb of Leipzig, the Hermann Clinic opened its doors for patients to be examined for claims pressed against the Saxonian masonry syndicate. The fact that it had been established by a syndicate and that its official designation was as a clinic for those suffering from nervous disorders in the wake of accidents (*Unfallnervenklinik*) indicates that its purpose was one of surveillance and unmasking as much as examination and treatment in the medical sense.[61] Though the Hermann Clinic did offer various forms of therapy, institutions of this type also imposed discipline on the workers and aimed to bring them back to work. Ten years earlier, Seeligmüller had already advocated establishing such special hospitals as "an act of self-defense against the increase in malingering."[62] Such projects required more than medicine. Seeligmüller, for instance, sought to base his credentials regarding accident trauma on a longstanding acquaintance with the working-class mentality:

> I worked during these years as assistant in the out-patient clinic in Halle, where in one and a half years at least six thousand patients from the lower ranks (*aus den niedrigeren Ständen*) passed through my hands. Then I was physician in a large machine repair shop, whose workers I served for ten years as the sole medical consultant. Finally, as the head of a large outpatient neuropsychiatric hospital (*Nervenklinik*) I had a lot of opportunity to thoroughly scrutinize the circles that are primarily relevant for accident injuries.[63]

In a footnote, Seeligmüller also approvingly quoted a letter that claimed that some of the clinics were centers of social-democratic activity, where patients were trained to feign symptoms of traumatic neurosis.[64] Thus Hanz-Peter Schmiedebach has rightly pointed out that Seeligmüller combined his "condemnation of allegedly simulating patients with a severe attack on the working class and the Social-Democratic Party. He attributed a perceived moral decline to the unsatisfactory attitude of workers who, he claimed, demanded benefits in excess of what they had earned."[65]

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60 *Gerichtliche* 1895, *supra* note 51, at 200.

61 F. Windscheid, *Das Hermann-Haus*, 19 Aerztliche Sachverständigen-Zeitung 389 (1902).

62 Adolph Seeligmüller, *Erfahrungen über Unfallneurosen*, 16 Deutsche medizinische Wochenschrift 663-65, 960-63, 980-82 (1890).

63 Seeligmüller, *supra* note 56, at 981.

64 *Id.* at 961.

65 Schmiedebach, *supra* note 1, at 46.

Evidently, Seeligmüller was aware that medical expertise was of little use in the moral task he had taken upon himself. The talents and skills of a detective were needed to unmask malingering workers, for they were the specter of the age of accelerated industrialization. Rather than earning a salary by contributing labor power to the productive process, malingerers sought to remain idle and get money by pretending to be ill. They were greedy instead of industrious. In the eyes of doctors like Seeligmüller, it was the physician's duty to prevent any such attempt to get pay without work or pension without trauma, in order to defend society, the law, and productivity against those who had neither dignity nor discipline and who usually were portrayed as given to the vices of idleness, drink, and sex.

The responses of Oppenheim and his allies to arguments such as Seeligmüller's also read more like arguments presented by advocates in court than medical practitioners. Oppenheim claimed that in most cases in which malingering was suspected, observation at the Charité established that there really was an underlying traumatic disorder.[66] He stated that from July 1883 to August 1890, he had observed 108 cases that had been referred to him as traumatic neuroses. Seventy-six of these stayed at the clinic. Only in six cases, that is, less than ten percent, was it necessary to assume either malingering or fraudulent attribution of a prior-existing illness to an accident. In all other cases, he stated, he had found a nervous illness that had been generated by an accident.[67] Since these data were challenged by other physicians, Oppenheim conducted a follow-up on the further development of his patients, and according to his own account, sixty-seven out of the sixty-eight cases in which he examined later reports or the patients themselves confirmed his original diagnosis.[68]

Not satisfied with medical data, Oppenheim also accused those who claimed to detect malingering where there was no physical, organic injury of a lack of medical knowledge and censured them for their prejudice against claimants.[69] The assumption of such doctors was, he argued, that any patient who demanded compensation for traumatic disabilities was feigning his illness. Inverting the logic and rhetoric of the argument of his opponents, Oppenheim gave a detailed description of a case that had been declared as malingering by another doctor, in order to demonstrate that he could reveal a real nervous illness where mistakenly malingering had been assumed.[70] In

66 Oppenheim, *supra* note 27, at 196.
67 *Id.* at 197.
68 *Id.*
69 *Id.* at 200.
70 *Id.* at 201-02.

addition, he painstakingly dissected a case presentation of another physician in order to establish that contrary to claims that the patient in question had exaggerated his symptoms, the data were typical of traumatic neuroses.[71] Oppenheim's argument was echoed six years later in a book devoted to the examination and certification of traumatic neuroses, which suggested that the more one delves into the study of accidentally caused disorders, the less one finds malingering.[72]

At the Congress for Internal Medicine in Wiesbaden in 1893, in a further turn of the debate, a doctor argued that even when a patient was caught pretending, this did not disprove the diagnosis of a traumatic disorder, since feigning symptoms was part of hysteria and, hence, of traumatic disorders. This view was by no means marginal, but, rather, endorsed by others.[73] In addition, one of Oppenheim's allies declared that the number of malingerers that a doctor claimed to have exposed is inversely proportional to his psychiatric knowledge.[74] Under this view, excessive endeavors to debunk patients reveal a doctor's own ignorance, while the reluctance to treat traumatized patients with suspicion was evidence of superior medical expertise.

Such arguments indicate that ostensibly medical arguments made in medical journals and at professional congresses originated in social anxieties and had to do with class and the aims of the legal process rather than the traditional role of the doctor. Causalities and symptoms of trauma were highlighted according to their use in justifying or denying compensation claims, rather than with regard to therapeutic possibilities. By becoming assistants to the court in their capacity as experts, some doctors had not only adopted the suspicious gaze of the law, but also its mode of argument, which is concerned with issues of honesty and pretension, duty and status, deterrence and compensation, rather than the causes and manifestations of illnesses and their cure.

IV. Law into Medicine

As illustrated by the case of H., Seeligmüller's comments, and vignettes from other cases described above, the process involved in bringing pension

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71 *Id.* at 204-08.

72 Paul Schuster, Die Untersuchung und Begutachtung bei traumatischen Erkrankungen des Nervensystems (1896).

73 Fischer-Homberger, *supra* note 1, at 126.

74 A. Kühn, *Über die Geisteskrankheiten des Corrigenden*, 22 Archiv für Psychiatrie und Nervenkrankheiten 641 (1891).

claims was immensely taxing for the claimants. If they had to prepare their case for the arbitration court or the appeal for the RVA, the claimants were seen by ten or twelve different doctors, subjected to extensive examinations and suspicious surveillance, and had to document the course of their illness.

The fact that, in the case of H., a trade union doctor was the first physician to examine him indicates that even though the *Sozialistengesetz* was abolished only in 1890, the trade unions nevertheless did maintain some kind of organizational structure throughout the 1880s. Starting in 1890, when they could operate freely again, the unions established worker secretariats, providing free legal advice to workers and helping them with appeals.[75] In individual cases, the causes and meanings of traumatic symptoms were negotiated in pension arbitration courts, while policy was decided by the RVA. As Greg Eghigian has stressed, pension claims in the aftermath of an accident were not simply a matter of medical and legal decisions; they dragged claimants through long, protracted negotiations and intricate disputes in which the meanings of their symptoms were decided.[76]

It may be reasonable to assume that doctors who became involved in these proceedings as experts examining patients and providing opinions to the arbitration courts learnt from experience about the way in which the legal process taxed the minds of their patients. This experience, in turn, shaped their medical views. In his first publication on traumatic neurosis in 1888, Oppenheim mentioned a secondary etiological factor that could aggravate and prolong traumatic disorders: the fear instilled in patients by protracted legal proceedings — something he had been involved in as a certified physician (*Vertrauensarzt*) long before the Accident Insurance Law was passed, since he examined passengers who had sustained traumatic disorders in railway accidents and had been compensated under a regime of strict liability since the mid-1870s. Since the adjudication of compensation payments and pensions concerned momentous issues of future livelihood, Oppenheim argued, they strongly agitated patients whose minds had been destabilized by a traumatic event. Above all, the unjustified suspicion of malingering was bound to be experienced as severely threatening, instilling fear in the patient and thus exacerbating the condition of a traumatized claimant. The fact that a speedy resolution of proceedings in favor of the patient could improve his health did not mean, therefore, that the patient had been malingering earlier on. Moreover, Oppenheim added, in his experience a by far greater number of patients failed to improve even after the conclusion

75 Eghigian, Making Security Social, *supra* note 1, at 98-99.

76 *Id.* at 101.

of the legal proceedings.[77] In other words, Oppenheim claimed not only that suspecting a claimant of malingering is bad medicine, but also that it could have a pathogenic effect and produce a sudden improvement following receipt of a pension. Hence, such a sequence by no means indicated that the pension was undeserved. Rather, it meant that the tension created by the legal process had finally been released.

In 1888, the same year in which Oppenheim published his first article on traumatic neurosis, Adolf Strümpell, another prominent neurologist, who founded one of the leading journals in neuropsychiatry, the *Deutsche Zeitschrift für Nervenheilkunde*, published an essay on the same topic, following Oppenheim in his view of the way in which protracted court proceedings might prolong patients' fears of the future and focus their attention on their symptoms.[78] Already in 1884 Strümpell had devoted his inaugural lecture as head of the outpatients clinic (*Polyklinik*) in Leipzig to the various causes of nervous diseases, using, on this occasion, the term "psychic trauma" for the first time.[79] Oppenheim and Strümpell were not alone in holding this position; a large number of German doctors shared their view that intimidating legal proceedings could be pathogenic by causing symptom-aggravating fear.[80] In a doctoral dissertation submitted to the Medical School of the Friedrich-Wilhelms-Universität in Berlin in 1897 (the same medical school that had provided the *Obergutachten* (report) on H. in 1891), Hugo Budde discussed the works of both Oppenheim and Strümpell. Adopting their vantage point, he argued that following an accident, patients generally suffer at first from nervous disturbances, but that persistent hysterical and neurasthenic symptoms develop thereupon only as a result of the fears created by the legal proceedings involved in pension claims.[81]

Workers coming in for an examination did not simulate their symptoms in order to gain pensions, most German physicians claimed. The patients' original nervous injury was caused by a traumatic event, but following the enactment of the Accident Insurance Law, these symptoms were reinforced because the workers no longer returned immediately to work as quickly as they could, in order to support themselves and their families. Instead, they were examined, had to fill in forms, talked to trade union advisors,

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77 Oppenheim, *supra* note 27, at 188-89.

78 Hugo Budde, Zur Casuistik der Nervenerkrankungen nach Unfall 8 (1897).

79 Adolph Strümpell, Über die Ursachen der Erkrankungen des Nervensystems (1884).

80 *See, e.g.*, Leppmann, *supra* note 51, at 189; Pielicke-Gütergotz, *Traumatische Neurose und Sachverständigenthätigkeit*, 17 Aerztliche Sachverständigen-Zeitung 348 (1898).

81 Budde, *supra* note 78, at 13.

and prepared their pension claims. By attributing secondary pathogenic qualities to legal proceedings, this two-stage etiology could explain a statistical fact about which there was no dispute, namely, that even though the percentage of pension claims for traumatic nervous disorders was low in comparison to those for somatic accidental injuries, there was a dramatic rise in the number of accident neuroses after 1889, when the RVA decided that they were compensable.[82] Moreover, it seemed that patients whose nervous disorders stemmed from workplace accidents tended to be more severely disabled by their symptoms and to recover more slowly than those who suffered from the same disorders, but were not entitled to receive a pension for their disabilities.[83]

But though there was broad medical consensus regarding the pathogenic nature of legal proceedings, not all doctors shared Oppenheim's view that the law caused fear. Rather, they argued, the promise of a pension evoked greed, an illicit desire for gain without work, and a life of idleness. Coined by Strümpell in an 1895 article, the central term used by physicians making this argument was "*Begehrungsvorstellungen*," which can perhaps be translated as "ideas of greed" or "greedy mental presentations." *Begehrungsvorstellungen*, that is, mental images that were driven by greed, suggesting a secure future and a good life based on pension payments, were said to come to dominate the minds of weak-willed workers over the course of prolonged legal proceedings, during which scheming legal advisors, family members, and friends tempted them with stories of easy gain.[84]

There is, of course, a world of difference between these two sides. Depending on whether the long-lasting symptoms of chronic trauma were attributed to fear or to greed, the distinction between primary and secondary pathogenic factors was used for or against compensation claimants. Oppenheim and other doctors who sided with him demanded that the suffering and disability of workers in the wake of trauma be recognized as a serious disorder, which was to be compensated as quickly

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82 A. Sänger, Die Beurtheilung der Nervenerkrankungen nach Unfall (1896); Robert Gaupp, *Der Einfluss der deutschen Unfallgesetzgebung auf den Verlauf der Nerven- und Geisteskrankheiten*, 46 Münchener Medizinische Wochenschrift 2233 (1906).

83 Jeremias-Posen, *Die Erwerbsfähigkeit bei traumatischen und bei nicht-traumatischen Neurosen*, 2 Aerztliche Sachverständigen-Zeitung 36 (1901).

84 A. Strümpell, *Über die Untersuchung, Beurtheilung und Behandlung von Unfallkranken. Praktische Bemerkungen*, 42 Münchener medizinische Wochenschrift 1137-40, 1165-68 (1895); *see also* Leppmann, *supra* note 51, at 190; Sänger, *supra* note 82.

as possible to prevent its aggravation. The opposite side insisted on placing severe limitations on the possibility of compensation, in order to restrain the potential impact of what they perceived as the workers' greedy ideas.

Though the prolonged proceedings of the arbitration courts were considered pathogenic either because they were said to be intimidating or because they carried the tempting promise of financial gain at their conclusion, for both camps, the law had become a secondary cause of the symptoms whose ramifications it was supposed to clarify, while the court had turned into a forum enhancing a pathology whose compensation it was supposed to adjudicate. The pathogenic importance attributed to legal proceedings can be illustrated, perhaps, by the fact that the first suggestion Oppenheim made in the chapter devoted to the therapy of traumatic neuroses was to lead the legal conflict to a rapid conclusion.[85] Other physicians suggested replacing the pension system with one offering lump-sum compensation, as was done under English tort law.[86]

As we see, in the eyes of doctors, the law turned into a pathogenic category, with the power to exacerbate traumatic symptoms as well as alleviate them.[87] The importance attributed to the legal struggle and the promise of a pension in the persistence of symptoms is also evidenced by the medical categories used. In the late 1880s, traumatic disorders were often called "accident neurosis" (*Unfallneurose*), and articles are listed under this term in the indices of the relevant publications. But during the 1890s, these disorders came increasingly to be called "pension neurosis" (*Rentenneurosen*) or "pension-struggle neurosis" (*Rentenkampfneurose*), and their index listing was changed accordingly.

Though it was generally accepted to relate to the legal proceedings as a secondary source of symptoms, any attempt by claimants to turn the law into the original cause of neurotic symptoms — that is to say, to present the law as the trauma underlying the disorder — was rejected by the courts. From around 1900 onward, the arbitration courts were periodically confronted with claims in which workers sought to recover compensation for a "pension-struggle neurosis," from which they claimed to suffer as a result of the distressing fight for their pension in court in which the legal system had embroiled them.[88] Not surprisingly, the courts refused to grant a

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85 Oppenheim, *supra* note 27, at 189.

86 Gaupp, *supra* note 82; Müller, *supra* note 54; Max Nonne, *Ueber den Einfluss der Unfallgesetzgebung auf den Ablauf von Unfallneurosen*, 1907 Aerztliche Sachverständigen-Zeitung 125.

87 *See* Fischer-Homberger, *supra* note 1, at 171-85.

88 Eghigian, *Die Bürokratie, supra* note 1, at 209.

pension compensating a loss of working ability sustained in the "struggle for pension" (*Kampf um die Rente*) itself.[89]

The medico-legal discourse of the time was dominated by the dual etiology, which separated the original trauma from its chronic symptoms and integrated the court into the causal chain of trauma and which was shared both by those who supported the workers' struggle for pensions and those who opposed it. This dual etiology probably reflected the experience of doctors in the legal process. Perhaps it derived from the observation of patients; perhaps it articulated doctors' own views of the tediousness of the legal process in which they served as experts. In addition, turning the law into a medical category also had its advantages for physicians. While acting as experts for or against claimants, they could use their status as medical practitioners to make recommendations on the need for a speedy conclusion of legal disputes, thereby inverting the hierarchical relationship between law and medicine that had turned them into auxiliaries to the court.

Conclusion

This, then, is the contribution this paper seeks to make to the writing of legal history: it suggests that the history of law might include not only the domain that properly is defined as legal, but also perceptions, conceptions, and practices of those who come into contact with the law in one capacity or another. Legal historians are aware, of course, of the way in which social, economic, political, and cultural conditions shape the law. They may also be familiar with the inverse relation. However, they may not always pay sufficient attention to the fact that the law affects other domains not only in a formal manner by legislation and adjudication, but also by involving practitioners from other fields in the legal process, whose experiences in court may have a formative effect on them, influencing their thinking and behavior in their own, non-legal subject matters.

To draw attention to these aspects, this paper shows that at the end of the 1880s, social legislation in Wilhelmine Germany created a legal arena for the medical examination of workers and gave rise to hundreds of publications on traumatized workers. Thus the law was crucial in triggering the modern discourse on trauma. But this paper also stresses that by employing doctors as medical experts, the law created a new experiential realm for doctors and altered their behavior toward patients, shifting their focus from therapy to

89 *Id.* at 209-10.

investigation. In the wake of their experiences in court, doctors developed a dual etiology of traumatic symptoms, which included the law itself as a pathogenic element with the power to aggravate symptoms. Even though all German doctors assimilated the law into their etiology of chronic traumatic symptoms, not all of them conceived the etiological role of law in the same way. This paper distinguishes between two approaches: Some doctors assumed that the promise of pension payments to injured workers upon the conclusion of the legal proceedings evoked their desire and greed, impelling them to hold on to symptoms in order to gain money without work. Others, however, regarded social laws as anxiety-inducing, rather than desire-producing. Pointing to the way workers had to embroil themselves in a complex network of institutions and protracted procedures in order to realize their social rights following an accident at work, this latter group of doctors stressed the intimidating effect of social legislation on claimants, arguing that fear — rather than greed — brought workers to perpetuate and exaggerate their symptoms.

As we have seen, these two perspectives on the etiology of traumatic disorders gave rise to two quasi-therapeutic approaches to legal proceedings. Those who assumed that the greed of workers had to be brought under control in order to limit traumatic symptoms and restore worker ability postulated that institutions of surveillance should be established and pension payments reduced or abolished. Inversely, those who regarded chronic symptoms at least partly a response triggered by suspicion and intimidation pleaded for legal empathy for the plight of injured workers.

Thus, the expert opinions and etiological theories of late nineteenth-century German doctors reveal their anxieties in the face of the increasing juridification of their lifeworld, a phenomenon they regarded as counterproductive. But while some were afraid that the rewards of social legislation might cause idleness by evoking greed, others feared that its daunting procedures might pressure injured workers into exaggeration by instilling fear in their minds. Evidently, these contradictory outlooks were influenced by and had an impact on the role of doctors as expert witnesses writing opinions for the arbitration courts and the Imperial Insurance Office.

Although this history of the interaction between law and medicine in Wilhelmine Germany is concerned with both law and medicine, it highlights how doctors responded to their legal roles and how these roles impacted on their conceptions of mental trauma. However, since it seeks to portray a dialectical interpretation of law and medicine, this paper is not only about how the law influenced medical thinking, writing, and practice, but also about how the law appointed medical men to serve as custodians of causation, thus — perhaps unwittingly — initiating its own medicalization.