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What Goes Around Comes Around: The Circulation of Proverbs in Contemporary Life

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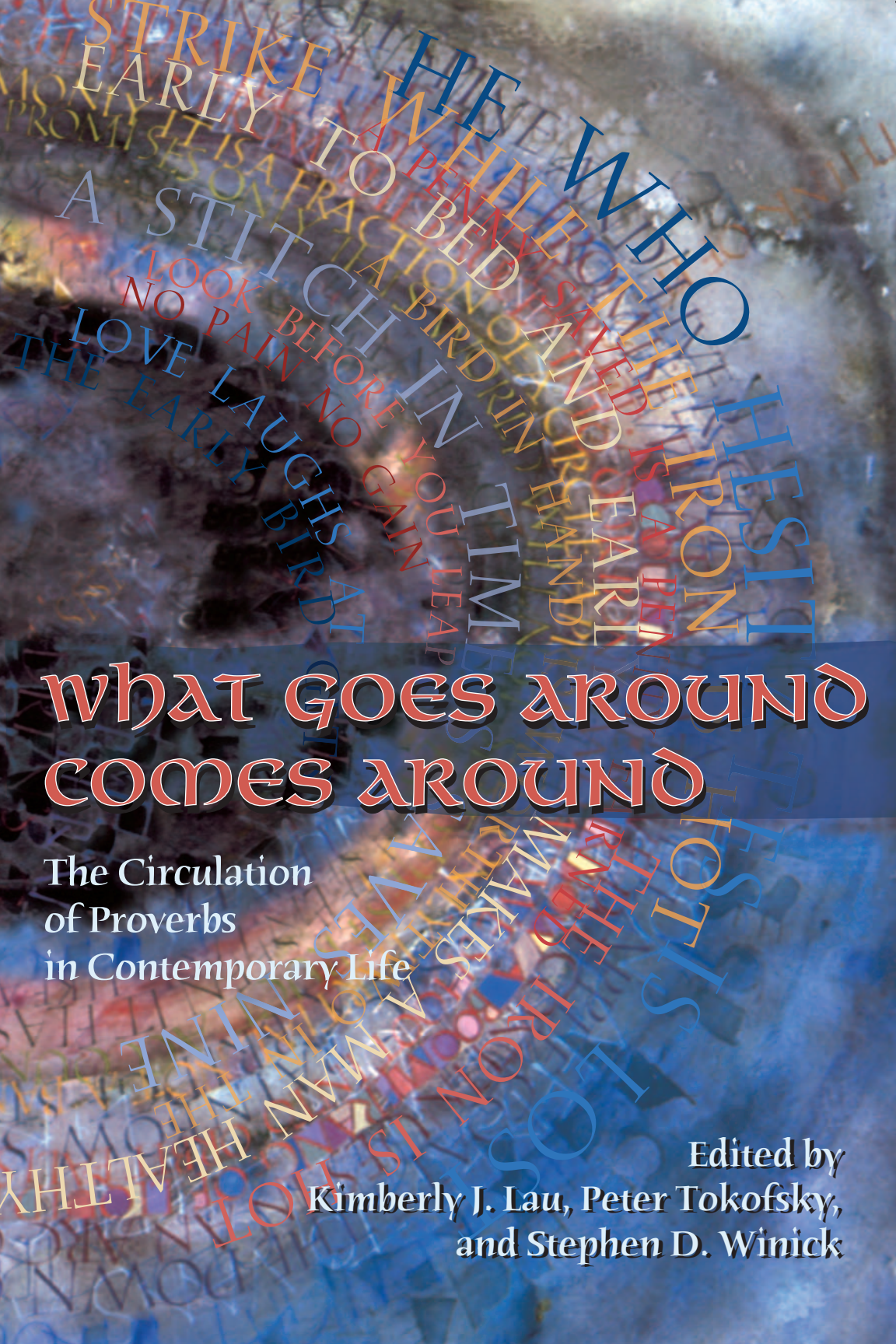
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what goes around comes around

The Circulation
of Proverbs
in Contemporary Life

Edited by
Kimberly J. Lau, Peter Tokofsky,
and Stephen D. Winick

“You Can’t Kill Shit”

Occupational Proverb and Metaphorical System among Young Medical Professionals

Stephen D. Winick

Introduction

During the 1990s, I observed several folklore forms at work among young medical professionals in New York City and Philadelphia. Among them were the proverb “You can’t kill shit,” and its variants “Shit never dies” and “Scum never dies.” These proverbs proved fascinating not only in themselves but as a theoretical window into the workings of occupational proverbs, both as a subset of the proverb genre and a subset of occupational folk culture. On the one hand, the existence of such proverbs suggested that mainstream proverb theory needed some refinement. On the other, the specific meanings of these proverbs, and their situation within a system of metaphorical folk speech, indicated that the prevailing understanding of medical folklore also required some revision.¹

“You Can’t Kill Shit,” Occupational Proverbs, and Proverb Theory

At the time I first encountered “You can’t kill shit,” occupational proverbs were sadly neglected within the field of proverb studies; only recently (e.g., Dundes, Streiff, and Dundes 1999) have proverbs restricted to an occupational community been widely studied.² Indeed, until quite recently, the prevailing definition of proverbs, and its attendant methodology, precluded the existence of specifically occupational examples. Archer Taylor (1985, 15), writing in 1931, concluded that “the trades and mercantile

pursuits have coined almost no proverbs," and the reason for this conclusion lies in his assumptions about what constitutes a proverb in the first place. Proverb scholars of Taylor's era insisted that a saying be generally disseminated among the population before they called it a proverb. Most proverb scholars were students of literature and looked there first for the evidence of an expression's proverbiality; compilers of the generally accepted proverb dictionaries used literary references as their foremost means of confirming proverbiality. But occupational proverbs are often too esoteric to migrate into the general population. They are unlikely to be found in literature (at least the literature proverb scholars usually read) and therefore were rarely represented in the dictionaries Taylor perused as he wrote his classic text. This explains his impression that very few occupational proverbs existed.

How much has modern proverb scholarship changed since Taylor? On the one hand, as I have indicated, scholars have begun to recognize occupational proverbs as an important category. On the other hand, many modern proverb scholars still insist on a certain degree of "age and currency" for any text to be considered a proverb and in practice, therefore, still restrict their analyses to proverbs that they can find in many different places and times. Reading through general literature, advertising, newspapers and other sources, they compile dictionaries of proverbs that have occurred frequently in writing (e.g., Whiting 1989), or they use survey data that solicits proverb texts from a broad sample of the population (e.g., Mieder, Kingsbury, and Harder 1992). They then use these dictionaries as guidelines to decide which expressions are proverbs and which are not. These methods of defining the proverb will always fail to apprehend a good proportion of proverbial speech, namely whatever is not found in "general" readings or known to the "general" public.

Why do scholars insist on age and currency as characteristics of the proverb? Wolfgang Mieder (1993, 42) writes that "any proverb must 'prove' a certain traditionality and frequency to be considered verbal folklore," suggesting that this view of proverbiality relies on a definition of folklore as traditional material repeated from the past. But as a discipline, folklore has moved away from variant-distribution models and toward a paradigm of analyzing emergent verbal performances. Since the 1970s, the discipline has for the most part rejected definitions of folklore based on age

or currency, and the notion of tradition has expanded to include much more than repetition from the past.³ Therefore, few folklorists today would claim that the only way for a segment of discourse to be considered folklore is for it to be repeated many times.

The restriction of proverbs to generally known sayings also begs another question: Which population must know and use the proverb? It was long ago established that any complex society is divided into innumerable overlapping social groups, each of which uses folklorically patterned communication. These groups were dubbed “folk groups” by Dundes (1980, 8) and include families, occupational groups, hobbyists, church or religious groups, ethnic or national groups, and many other potential congregations.

Do small folk groups have proverbs? Indeed, it is surprising to me how many friends have spontaneously shared proverbs known only to their families, hobby groups, or professions. Among single-lens reflex photographers, for example, it is customary to note that “If you saw it, you missed it.”⁴ Among medical doctors, a common admonition runs, “When you hear hoofbeats, think horses, not zebras.”⁵ There are even proverbs restricted to students writing doctoral dissertations, including “The only good dissertation is a done dissertation.”⁶ The medical proverbs I introduced at the beginning of this article fall into precisely this category.

Because of the small numbers in these folk groups, and because the efficacy of these statements is restricted to these groups, it is unlikely that any of these esoteric proverbs will be widely cited in the literature searched by proverb scholars. But they share the forms and functions of proverbs and thus are, by almost any definition, proverbs among the relatively small communities which use them. Taylor’s statement about the absence of proverbs originating in certain occupational groups therefore stands as an example of the inadequacy of a variant-distribution model, or a model based on age and currency that uses a list of many citations as its primary form of evidence. This is simply too limiting to encompass the multiplicity of proverbs that are spoken in the innumerable folk groups of the world. I have elsewhere suggested another possible model for defining proverbs, removing the age and currency requirements retained by such scholars as Mieder (Winick 2003); however, models other than mine that better account for occupational and other groups’ proverbs are also

certainly possible, and this is an important direction for proverb studies to take. Considering proverbs like "You can't kill shit," then, can prove important in advancing proverb scholarship into new areas of theory and practice.

"You Can't Kill Shit" in a System of Medical Filth Metaphors

I first encountered the proverb "You can't kill shit" in the context of other medical metaphors. Describing an experience he had had in the hospital, a friend whom I will call Dr. X mentioned the acronym *SHPOS* (pronounced *shpoz*, to rhyme with the plural of "spa"), which he said stood for "subhuman piece of shit." (Dr. X and others also used *SHPOS* as a plural; following them, I will use the same acronym in this article for the singular and plural forms.) Describing his experience with a patient that he referred to as "a real *SHPOS*," he summed up his attitude toward the encounter with the statement that "You can't kill shit."

As a folklorist with a keen interest in proverbs, I was intrigued by the appearance of what was clearly a proverb restricted to a small occupational group, whose meaning was not immediately obvious. This drew me into researching the use of proverbs and other metaphorical speech among doctors.⁷

It is generally accepted that folklore pervades the world of modern professional medicine. Among others, David Hufford (1989), Anne Burson-Tolpin (1990), and Kathleen Odean (1995) have noted mnemonics, proverbs, photocopy lore, jargon and pseudojargon, euphemisms, practical jokes, dramas, songs, legends, and slang collected from medical practitioners. Among these, the genre that has probably received the most attention is doctors' derogatory slang terms for their patients—for example, *SHPOS*. Folklorists, linguists, and sociologists have all examined these expressions of hostility, and scholars have informally collected terms of abuse (e.g., George and Dundes 1978; Scheiner 1978; Monteiro 1980; Taller 1981; Gordon 1983; Liederman and Grisso 1985; Burson-Tolpin 1990; Odean 1995).

Among these terms, the single word *gomer* has been studied more than any other. In concentrating on this word, scholars have neglected an important aspect of medical slang, one which connects slang terms to medical proverbs. This neglected area is the crucial place of filth in the metaphorical system of doctors. Terms such as "dirt", "shit" and "scum" appear repeatedly in the

metaphorical speech of young doctors, showing their proverbs to be deeply connected to a wide-ranging system of metaphor and belief about filth and pollution.

Indeed, *gomer* seems to be a brief and anomalous exception to an otherwise common rule: The most insulting medical slang terms employ filth metaphors. In a personal communication with Anne Burson-Tolpin (1990), Renée Fox, an expert in the sociology of medical students and young doctors, expressed the opinion that *gomer* was merely the latest in a series of derisive terms. It had replaced *crock* as “the ultimate expression of hostility toward the patient” (p. 50 n. 9). *Crock*, according to almost all the relevant ethnographers as well as nonfiction authors like Melvin Konner (1987, 382) and all of my informants, is short for “*crock of shit*,” although that full phrase is never voiced in the hospital. After *gomer* replaced *crock*, Burson-Tolpin believes that it was in turn replaced by *dirtball*, which, along with its variant, *dirtbag*, I myself encountered among medical students and doctors during both formal interviews and informal socializing. Since that time, SHPOS appears to have gained the dubious honor of “most hostile epithet.”⁸ This reveals a clear pattern: Among the four terms that have probably held sway between the 1960s and the late 1990s—*gomer*, *crock*, *dirtball*, and SHPOS, *gomer* is anomalous because it does not compare the patient to dirt or filth.⁹ Thus, by concentrating on *gomer*, scholars have missed the importance of filth in medical folklore.¹⁰

Mary Douglas, Barbara Babcock, and Victor Turner have contributed to our understanding of filth as a symbol, and their work has important implications for this article. Douglas points out that our general societal ideas about dirt predate the discovery of pathogenic organisms. In modern hospitals, however, the consciousness of the pathogenic theory of disease is higher than it is anywhere else, and the pathogen is included within the pollution system of the culture. Indeed, the pathogenic organism is forcefully stamped out and therefore by all rights should not even be present in the hospital. Rooms, instruments, and personnel must be sterile to avoid spreading infection. Doctors’ ideas of dirt are often bound up with infectious diseases. Thus, doctors speak of the *dirty case*, one in which a serious infection has occurred, and the *dirty room*, a hospital room that has housed seriously infected patients and must be thoroughly sterilized (Monteiro 1980, 56).

This equation of dirt with potential infection is a serious side of the symbolic system of filth addressed in this article. It helps explain why dirt and filth are such powerful symbols among the community of medical professionals.

However, it is clearly not only the fear of the infectious that dominates this symbolic system. If it were, the most infectious patients would be the ones to whom filth metaphors were assigned. In fact, this is not the case. To get to the root of hospital rules of filth, we, like Douglas, must go beyond the pathogenic model of disease.

According to Douglas (1966), dirt, filth, and pollution (including exudations of the human body such as excrement) are to be understood symbolically as the contravention of a system of order. Thus, those items that do not fall within the categories prescribed by society, items that exist but violate the rules of order in a culture, are frequently tabooed, labeled abominations, and avoided. Douglas's theories, as outlined in her book *Purity and Danger*, apply to what she calls "primitive societies," in which ideas about dirt are highly structured. Although the modern hospital is not a primitive society in Douglas's sense, some of her insights also relate to hospitals.

The connection between dirt and the "shit" of "You can't kill shit" may itself not be obvious, for dirt and feces are not the same thing. Douglas explains this as a symbolic connection. Dirt, she says, is "a kind of omnibus compendium which includes all the rejected elements of ordered systems. . . . In short, our pollution behavior is the reaction which condemns any object or idea likely to confuse or contradict cherished classifications" (1966, 35-36).

Dirt, seen in this light, is metonymically linked to feces and any bodily exudation by its quality of anomaly or ambiguity. Feces, blood, mucus, and other bodily products, at once part of the body and removed from it, "of and not of the self" (Babcock-Abrahams 1975, 174), are profoundly ambiguous, anomalous phenomena that are practically always subject to taboo, or, as in our culture, considered "disgusting."

Given that dirt and filth are such negative concepts, is it likely that people would be compared to filth simply because they evaded easy categorization? Indeed, according to Turner (1967, 97), this is a widespread, cross-cultural phenomenon. People in the transitional, liminal phase of rites of passage, whose "condition

is one of ambiguity and paradox, a confusion of all customary categories,” are “nearly always and everywhere . . . regarded as polluting.” Because of this, he points out, they are often forced to go literally filthy and symbolically compared to dirt, decay, and such bodily exudations as menstrual blood (p. 96). In other words, these people are treated much like the *crock* and SHPOS in the modern hospital.

As a demonstration of the way in which Douglas and Turner’s ideas may apply to our medical proverbs and phrases, let us look first at the term *crock*, short for the metaphorical or proverbial phrase “crock of shit.”¹¹ Most scholars who have analyzed this term have found it has the following consistent meanings: “a patient who complains continually of multiple symptoms, many of which are either imaginary or of psychic origin” (Monteiro 1980, 56); “has no organic disease, but has constant physical complaints” (Gordon 1983, 175); or, more succinctly, “patient with nothing physically wrong” (Konner 1987, 382). Dr. X defined *crock* similarly: “If somebody comes in, complaining of abdominal pains, and comes to the emergency room every other night, and they get the full work-up, and it’s always negative . . . they may have something, or it may totally be psychiatric; who knows? But eventually someone says, oh, he’s just a *crock*. . . .” (tape-recorded interview by the author, 1995).

What we see here is that the *crock* or “crock of shit” is a patient who has symptoms, or who claims to have symptoms, but who cannot be diagnosed by his physician. Diagnosis is itself the most important way in which doctors categorize their patients. As Burson-Tolpin (1990, 100) notes, “Diagnosis can be viewed as a process of imposing order on disorder.” There is nothing natural or acultural about diagnosis; indeed, Burson-Tolpin stresses “the order-imposing aspects of the diagnostic process and its socially constructed nature” (p.102). Like the taxonomies of Douglas’s primitive societies, diagnoses are socially constructed ways of categorizing the chaos of experience. Using diagnoses, medical professionals neatly categorize their patients and thus reduce the chaos in the hospital environment. Those who do not fit into this scheme, i.e., those for whom doctors cannot find any organic cause of symptoms, are assigned to the category of *crock*.

As a clue to how *crock* fits into this environment, it is interesting to note that the diagnosis, converted to a noun, often becomes

the name for the category of patient. Patients with stab wounds are frequently referred to as "stabs," those who overdose are referred to as "O.D.s," etc. Thus, in conversational speech, the term *croak* fills the same syntagmatic slot as the diagnosis. Indeed, two of my informants used the term "diagnosis" to describe the term *croak*.¹² Even if not a diagnosis, *croak* is certainly a category that, like an individual diagnosis, preserves the integrity of the diagnostic system as a whole; patients who seem to have symptoms but no diagnosis, thus those who threaten the system, are called *croaks*.

Like "dirt" in Mary Douglas's analysis, then, *croak* (of shit) is "a residual category" that contains those outcast and ambiguous elements "rejected from our normal scheme of classification" (1966, 36). Indeed, one fascinating facet of the term *croak* is that its lexical meaning mirrors its social function. As a residual category, it is a container for the filth that might otherwise pervade and destroy the system. Like a literal "croak of shit," a *croak* keeps the pollution inside, containing it and rendering it harmless to the outside environment.

It can be argued that the metaphorical phrase "croak of shit" is simply borrowed from nonmedical folklore, where its meaning is "a lie." Indeed, it is likely that that is the ultimate source of the expression. However, two things indicate that the medical community has adapted this term and applied it in a new way. First, while the nonmedical usage of "croak of shit" refers to an utterance, as in "That's a croak of shit," the medical use refers to the person who makes the complaint, not the complaint itself. Also *croak* does not necessarily express an intent to deceive or a lie. As Dr. X points out in the interview quoted earlier, "They may have something . . . who knows?" It is the inability of the doctor to find the problem, the uncertainty of "who knows?," that is the root of the term *croak*.¹³

Some doctors use *pot* as a synonym for *croak*. It is tempting to explain this merely as the extension of *croak* to "Crock-Pot," but this overlooks the fact that *pot* is sometimes used as a synonym for toilet. (This could easily have originated with the chamber pot and been transferred to the toilet. Indeed, a "croak of shit" most plausibly refers literally to a chamber pot.) This metaphor is extended when *croaks* are said to have "high serum porcelain" (Taller 1983, 39). The word "porcelain" in American folklore is often

a code word for toilet, as in “worshipping the porcelain God” and “driving the porcelain bus,” both of which refer to throwing up in the toilet. Thus the crock (of shit) has become the basis of an extended metaphorical system referring ultimately to containers that prevent the spread of bodily filth.

Having demonstrated that crock is a case of a filth metaphor being applied to a patient who “breaks the rules” of classification, let me pause to examine more filth metaphors, using the work of David Paul Gordon, who provides us with succinct definitions of several of the terms, consistently using his definition of *gomer* as a point of reference. This definition (quoted almost verbatim from George and Dundes’s earlier article (1978)) is “an alcoholic or derelict with extremely poor personal hygiene and a record of multiple admissions to the hospital. Symptoms are predictable, and illness is often feigned. When sick, shows lack of interest in recovery; is often disoriented or hostile” (Gordon 1983, 175).

Most of the terms in Gordon’s sample comparable to his use of *gomer* are filth or pollution metaphors. A *blivet* is “ten pounds of shit in a five-pound bag (=a *gomer*),” a *dirtball* is “much worse than a *gomer*,” and a *SHPOS* is a “subhuman piece of shit; a *gomer*.” Also intriguing is the term *grume*, which is here defined as “patient dirtier and in worse condition than usual *gomer*. (See *dirtball*)” (Gordon 1983, 175–76). The *grume* was first noted by George and Dundes and is descended from the Latin term *grumus*, meaning “little heap.” In medical terms, this usually refers to a blood clot, a bodily exudation and therefore a profound ambiguity in Douglas’s sense. Furthermore, blood clots occur most often when blood gets where it does not belong, i.e., when, in Douglas’s analysis, blood itself becomes a pollutant (1966, 35–36). According to George and Dundes (1978, 572), the only other common usage of *grumus* is as part of the expression “*grumus merdae*,” or “pile of shit.” Thus, in either of its common uses, it refers to a by-product of the body removed from the body, a powerful form of pollution.

Why is the type of patient in question so frequently referred to by a filth metaphor? A definition of *SHPOS* given by Dr. X is “slimy, skanky, drug-abusing, nasty personalities who come into the hospital and then don’t let you do anything” (interview, 1995). In this hostile but almost poetically vivid description, several dimensions to *SHPOS* are apparent. First of all, they are called

slimy and skanky. This refers to their physical state: They are dirty, smelly, and practice poor hygiene. Thus, the first level at which these patients are ascribed filth is a literal one; they are really filthy and so are metaphorically compared to a piece of filth.

SHPOS also demonstrate the conceptual link between pathogenic infection and dirt that I mentioned earlier. These patients are almost always infected with something, and the most common treatment for them is antibiotics. Thus, just like the dirty case and the dirty room, the SHPOS is either the known or the suspected carrier of infection.

After the SHPOS's literal filthiness, Dr. X also mentions their unwillingness to undergo treatment or to follow the doctor's orders. It is in this sense that they "don't let you do anything." Typically, they refuse to allow blood samples to be taken or antibiotics to be administered. Contrasting SHPOS with other patients, Dr. X states, "Other people have genuine problems, and they come in, and you fix 'em, and they try and keep 'em fixed, and they try and stay out of the hospital, whereas . . . SHPOS don't care. You know, if they end up back in the hospital, what the heck? It's a nice warm bed and free meals." On the other hand, if a visit to the clinic is suggested by the doctor, Dr. C tells me that "the SHPOS never come back because they go back out on the street and shoot up again. . . . it becomes a joke even giving them an appointment" (tape-recorded interview by the author, 1995).

The unwillingness of the SHPOS to fulfill what doctors see as their part in the doctor-patient role relationship is also a defining characteristic, at least for some doctors. Dr. X states, "Even the drug abusers who come in with pneumonia . . . and say, 'Been coughing up this green stuff; help me out,' and you say, 'Okay, you're going to need IV antibiotics, and I'm going to have to draw cultures,' and they say, 'Okay, doc, go ahead. . . .' That's not SHPOS."

Another characteristic for which SHPOS are reviled is that, while other patients are the victims of circumstances beyond their control, the SHPOS's illness is entirely self-inflicted. The typical diagnosis for a SHPOS, according to several of my informants, is "drug overdoses complicated by infections." While normal patients suffer from accidents or violence or illness through no fault of their own, SHPOS are usually responsible for their own conditions. One clear indication of this is that, no matter

how dirty or grimy, no matter even if their condition is technically self-inflicted, children, who are usually considered too young to be responsible, are never called SHPOS. “There’s really no such thing,” Dr. W told me, “as pediatric SHPOS” (tape-recorded interview by the author, 1995).

It is important to note that the “shit” of the proverb “You can’t kill shit” and the metaphorical phrase/acronym, “subhuman piece of shit/SHPOS,” refer to the same patients. The proverb also emphasizes the self-abusive nature of this type of patient and his or her unwillingness to comply with the doctor’s recommendations. Asked to give me a sample context in which this proverb may be used, Dr. C reports,

These real hard-core drug abusers come in . . . when you’re trying to treat ‘em, a lot of times you’re nervous when you’re just starting out as an intern: ‘Since he’s not letting me draw any blood cultures, what if I hang the wrong antibiotic? What if I do this, what if I do that?’ and the response from the more senior residents who have dealt with this before is always, ‘Don’t worry; there’s nothing you can do to these people that they haven’t done worse to themselves already.’ And that’s basically the meaning of [‘You can’t kill shit’]. They’ve abused themselves so badly they’re indestructible! (interview, 1995)

The unwillingness of the patient to allow cultures, the description as “hard-core drug abusers,” and the suggestion that they have done “worse to themselves already” are all characteristic of all of my informants’ descriptions of SHPOS, and part of most explanations of “You can’t kill shit” and “Shit never dies.”

For some doctors, frequent visits to the hospital are also a defining characteristic of SHPOS. Scheiner (1978), in fact, notes two acronyms, POS for “piece of shit” and SHPOS for “subhuman piece of shit.” The former refers to “patients medically ill because of their failure to care for themselves” and the latter to “a chronic POS. A patient who, after intensive medical care and rehabilitation, fails to follow medical instructions, and is readmitted to the hospital in his previous critical condition” (p. 69).

While I never encountered POS on its own in my research since 1993, most informants agreed that the SHPOS was a repeat visitor to the hospital. As Dr. J noted, “Your goal when you treat them is that you want to get them out and not have them come back”

(tape-recorded interview by the author, 1995). SHPOS continually thwart this attempt. Thus, while there are more literal levels at which these patients are worthy of filth metaphors, it seems that two of the most important are responsibility for their own illnesses and an unwillingness to get better.¹⁴

The SHPOS and his ilk can be considered the worst violators of the hospital's classification system. Dr. X, when confronted in 1994 with an older doctor's dislike of terms like dirtball and SHPOS, commented that for the older physician, anyone who comes into the hospital for treatment automatically earns the title of "patient." For many of the younger staff members, however, dirtballs and SHPOS never achieve that honor; they are only referred to as patients when senior staff members are present.

For about half of my informants, SHPOS and dirtball were 100 percent synonymous. The others expressed a sense of gradation, with dirtbags or dirtballs being slightly less repugnant than SHPOS. But the basic features of the two groups were always the same. Dirtballs and SHPOS, then, are self-destructive people with no concern for getting better. They defy the very category of patient, which to these doctors means a sick person who wants to get better. These are the most antistructural people in the hospital because it is unclear whether they should be considered patients at all. At this deep level, then, the dirtbag and SHPOS (and, I expect, the grume and blivet as well) disrupt the categorization attempts of the hospital in the severest way possible.

Contrasting dirty case and crock with the more caustic dirtball and SHPOS, we find a number of interesting differences. First let us note that crock and dirty case, while both metaphors of pollution, are mitigated by their wording. Crock, by eliminating the overtly filthy part of the metaphor, suggests filth without saying it outright. Dirty case, while mentioning dirt directly, connects it with the case rather than the patient, a subtle difference but one that any medical practitioner will appreciate; a "difficult case" is by no means the same as a "difficult patient," as my informants readily confirmed. Furthermore, while crock and dirty case are straightforward terms relating to a fairly simple type of patient, SHPOS and dirtball are defined by much more complex clusters of physical and behavioral characteristics.

It has become clear that the metaphors of filth in the case of the more severe terms are overdetermined, meaningful on more

than one level; they are appropriate because of the patients' literal filthiness, because of their penchant for infection, and because they seriously violate the rules of order that govern patient behavior. Any one of these characteristics would be enough to earn them a filth metaphor, as crock and dirty case demonstrate. All three characteristics make a filth metaphor almost inevitable.

Filth Metaphors in Medicine: Function and Meaning

The observation that filth metaphors apply mainly to anti-structural patients who violate the system of order in the hospital environment suggests certain refinements to the accepted wisdom about such language. One reason often given for the existence of such derogatory metaphors is the young intern's and resident's position near the bottom of the hospital hierarchy. This unenviable position, it is argued, causes this group to seek in-group cohesion as well as direct hostility down to the patients, the only people lower than themselves in the hierarchy. Because the hostility is frequently expressed in scatological terms, Odean (1995, 149) calls this the "shit rolls downhill" model. This theory is certainly valid and does explain to some extent why patient-directed pejoratives, including proverbs such as "Shit never dies," exist. However, it overlooks the fact that not all patients are the objects of hostility. In fact, many of the young doctors I know try their best to empathize with patients and reserve their hostility for a chosen few. This explanation thus fails to account for a significant feature of hospital life: the selectivity with which epithets and pejorative proverbs are deployed.

Like the "shit rolls downhill" model, the generally accepted "stress-relief model" of medical folklore also doesn't account for this selectivity. It observes that the hospital is a very high-pressure environment and produces a lot of stress, particularly among the younger doctors. It offers this stress as the primary reason for the existence of hostile patient-directed pejoratives. In one of the first analyses of doctors' slang for patients, for example, Victoria George and Alan Dundes (1978) argue that the derogatory term *gomer* is used by doctors and nurses to refer to patients whose "personal hygiene and habits . . . are so repugnant and distasteful as to prove offensive even to the most hardened and dispassionate staff member." In explaining this phenomenon, the authors foreground anxiety and stress as the factors that cause doctors

to become frustrated with certain patients: "The inevitable stress in any doctor-patient relationship resulting from the anxiety which accompanies illness is greatly exacerbated by the wretched and foul conditions of the *gomer*." This frustration, they believe, causes the doctors to retaliate by using derogatory slang. "The greater the stress," they argue, "the greater the need for folklore to relieve the pressures created by that stress" (p. 580). In George and Dundes's estimation, these factors all contribute to giving *gomer* "pre-eminence as a term" of abuse (p. 572).

I agree with George and Dundes that the stress of being responsible for the lives of others—and the extra pressure created by "professional patients" like the *gomers* they describe—is certainly one overarching reason for the existence of medical professionals' derogatory speech about patients. This is supported by my fieldwork; my older informants, who cited their own common-sense version of the stress-relief model when discussing their younger colleagues' behavior, all pointed out certain facts: Stress tends to be greatest when doctors first begin to take responsibility on themselves, that is, during internship and residency, a liminal period when doctors are qualified to practice medicine but not yet considered fully functioning specialists.¹⁵ During these years, doctors typically make the first life-and-death decisions of their careers. They work long, grueling hours, often skipping meals and missing sleep. They are, quite simply, under constant pressure and stress. It is during these years that doctors are most often observed using pejorative epithets and proverbs. Furthermore, the younger doctors with whom I spoke also used the stress-relief model as an explanation and justification for their own behavior.

However, like the "shit rolls downhill" model, the stress-relief theory does not account for all the evidence. As David Paul Gordon (1983) was the first to point out, George and Dundes's logic—that the stress experienced by doctors making life-and-death decisions is the cause of medical slang—would lead us to the conclusion that the patients who are the most severely ill, and thus cause the doctors the most stress, get tagged with these derisive nicknames. In fact, that proves not to be the case. Furthermore, as Odean (1995, 144) has noted, and my informants confirmed in interviews, the use of these expressions is often fundamentally against the young doctor's principles but encouraged by peer pressure. This suggests that the use of these terms is the *cause*

of anxiety and stress. Indeed, both Odean's informants and my own reported urban legends about doctors being sued for writing SHPOS or dirtball on a patient's medical chart (see Odean 1995, 144). Urban legends most frequently express a group's anxieties, and this legend suggests that these slang terms are the source of worries as well as an outlet for them. Gordon thus rejects stress as an explanation and points to empathy. He states that patients with whom it is difficult to empathize are the ones who receive pejorative nicknames: "For patients likely to produce empathy, slang terms will be rare; for those with whom it is difficult to empathize, slang is more likely" (1983, 177).

Gordon's argument against George and Dundes's explanation appears convincing, and his empathy model appears to hold true in many cases. Indeed, the empathy model provides another reason why SHPOS and dirtballs have earned themselves metaphors of filth. However, although these strongest pejoratives are reserved for the most unpleasant patients, not all filth metaphors are restricted to patients with whom doctors cannot empathize. My informants often expressed empathy for their crocks, whom they believed to be experiencing real pain and symptoms, even if only psychosomatic ones. Indeed, some were convinced that crocks were sometimes suffering from genuinely unknown syndromes, but they still used the term crock without any apparent resentment. Thus, empathy alone, I think, is not the answer.

The solution, I believe, is that a certain kind of stress causes filth metaphors to be applied to patients; George and Dundes are quite correct that stress is the major force behind these terms, but they fail to specify what type of stress. The stress of caring for a critically ill patient who urgently needs help does not cause doctors to use filth metaphors. Doctors' medical training has prepared them to deal with this stress; that is the whole point of being a doctor.

It is the stress that results from a loss of control that ultimately translates into filth metaphors. The dirty case and dirty room represent a failure to keep the hospital antiseptic and thus to control infection. The crock, dirtball, and SHPOS, similarly, represent violations of the system of categorization through which doctors control their environment. This can result in feelings of powerlessness and futility. The crock makes doctors powerless by taking away their ability to diagnose, their ability to assign people to meaningful categories and thus order the universe neatly; their

ability to heal the patient is likewise hampered by the crock. The dirtbag, dirtball, grume, or SHPOS makes doctors powerless by directly or indirectly thwarting their efforts and by being a non-patient, a person who has no desire to be helped by the doctor in the first place. All of these types of patients cause stress by being outside the doctors’ control and thus thwarting the doctors’ attempts to be doctors.

Only now does it become clear how filth metaphors help to relieve some stresses, even as they create others. Doctors do not generally feel good about calling patients SHPOS or commenting that “Scum never dies.” As already stated, their fears of getting caught and their own moral squeamishness cause them unease that surfaces in contemporary legends and rumors in which doctors are punished for using these terms. Nevertheless, the stress of disorder in the basic system of categorization that defines hospital life, and from the resulting powerlessness of doctors to do their job, is much greater. Through proverbs, proverbial phrases, and epithets, doctors can create new categories to hold their uncategorizable patients—patients who “may have something . . . who knows?” (crock). They can also express their outrage at those who are not even patients and “don’t let you do anything” (dirtbag, SHPOS, “You can’t kill shit”), and who, like the infection in a dirty room, do not belong in the hospital at all. Because it reorders the hospital environment, this form of stress relief is greater than the residual anxiety caused by the terms themselves and the fear of being caught using them.

This structural argument takes away some of the sting of the filth metaphors themselves, for these emerge, at least in part, as a common cross-cultural way of handling anomaly. Still, one issue raised by this metaphorical system is essentially ethical: Is it unethical or otherwise inappropriate for doctors, charged with the care of patients, to think and speak of them in these terms? Among many older physicians, the answer is often yes; stories abound of older physicians chastising younger ones for using these terms. The urban legends already alluded to suggest that younger doctors, too, worry about the ethics of stating that “Scum never dies” in reference to their patients. Although they feel some shame and certainly worry about getting caught, however, they do not generally think of themselves as unethical even though they clearly know their statements are derogatory.

It is on the subject of ethics that David Gordon's article makes the strongest argument. Gordon asserts that "hospital slang for patients principally expresses frustration and irritation at having to provide care when it is not felt to be needed or useful" (1983, 179). Based on my own experience with doctors, I agree with Gordon. In the case of crocks, the time and resources spent testing the patient are not justified by any results, and although the patient cannot be considered culpable, the doctor's frustration is understandable. In the case of those considered dirtbags, dirtballs, or SHPOS, the doctors believe the patients to be the unethical ones, consuming precious hospital resources until they are well enough to leave, then returning again and again, never attempting to get better. Dr. W, recounting a story in which a SHPOS was competing for his attention with a severely injured but very cooperative woman whose frightened child was outside waiting for her, shook his head in anger and said, "They just suck up medicine, take up space, and tire you out with annoying whining while you have real patients to treat" (interview, 1995).

In this sense, as in the societies described by Mary Douglas and Victor Turner, the ambiguous or anomalous item is credited not only with pollution but with danger. By sapping the hospital's resources and the doctors' strength, the dirtball and SHPOS threaten to wreak havoc. From the doctors' point of view, then, the use of these insults takes on a quality of righteous indignation against dangerous invaders, rather than unfair deprecation of sick people.

Gordon even implies that, far from being unethical, the derogatory slang employed by doctors reinforces their strong sense of ethics. For the doctors, "Frustration over giving care to patients who do not need it implies concern for other patients . . . and a wish to care for the most needy" (1983, 179). Again, I agree with this conclusion. My own informants' stories of the competition between SHPOS and "real patients," like the one already quoted, make it clear that their concern is not only for themselves but also for their genuinely sick patients.

An alternate meaning for one of the proverb's variants is interesting in this regard. Ms. L, the only registered nurse among my informants, revealed that "Scum never dies" or "Shit never dies" can be used in two different contexts. On the one hand is the situation already described, namely the inexperienced doctor who

worries he will harm the patient. “Don’t worry, shit never dies,” the resident may say. On the other hand, the proverb can also be used to express regret or exasperation when a genuine patient, a good patient, dies, but a SHPOS recovers. In these cases, “Scum never dies” or “Shit never dies” is used almost with regret and carries a connotation of injustice: “Why do good patients die when shit never dies”? In this sense, the proverb points us directly to the issue of compassion for one’s other patients.

The proverb “You can’t kill shit” has thus led us into a fascinating and complexly organized system of metaphors. Phrases like “crock of shit,” “piece of shit,” “pile of shit,” and just plain shit, grume, dirtball, scum, and dirtbag, and their related observations that “You can’t kill shit” and “Scum never dies,” are not randomly applied to patients, nor are they assigned according to who creates the most stress. Although they are hostile, and perhaps hurtful, they are not unethical. Instead, they can be seen as both the underbelly of a highly developed system of categorization that seeks to impose order on the frequently chaotic world of the hospital, and as the product of a code of ethical behavior by which physicians attempt to heal themselves as well as others.

Notes

1. Among other lessons, Wolfgang Mieder taught me to build upon the solid work of previous generations of scholars. I offer this paper in that spirit and dedicate it to him.
2. It has long been common to speak of Medical Proverbs and Legal Proverbs. However, these are not disseminated mostly within occupational communities. They are, rather, proverbs dealing with medical or legal knowledge disseminated among the general population.
3. For a famous definition of folklore utilizing this new paradigm, see Ben Amos 1972. For a discussion of new meanings for tradition, see Ben Amos 1985. For analysis of these ideas and their impact on the definition of proverbs, see Winick 1998, 44–55; 2003.
4. This proverb refers to the fact that while the film is being exposed to light, the camera’s shutter interrupts the photographer’s view of his subject. Therefore, anything that the photographer actually sees through the lens, he fails to capture on film, and vice versa. The metaphorical or extended meaning is that in the profession,

- nothing can be taken for granted until the film is developed and examined. This proverb was pointed out to me by Jeff Benton.
5. I first heard this proverb from my brother, Jonathan Winick, who is a neurologist; it has also been noted by Dundes, Streiff, and Dundes (1999). It means that when confronted with a set of symptoms, a doctor should consider the more likely or common causes first.
 6. Clearly, this is a variation on the older proverb, "The only good Indian is a dead Indian" (see Mieder 1997). It was pointed out to me by folklorist Xan Griswold.
 7. My primary source data includes formal interviews and informal conversations with both young and older doctors—i.e., fourth-year medical students, interns, residents, established professionals, and retirees. Formal interviews were conducted with students and younger professionals (those who use these proverbs and metaphors), and more informal checking was undertaken with older physicians, who were asked either to remember such expressions from their younger days or give their reactions to them. The most formal parts of my fieldwork consisted of a series of interviews conducted with seven main informants: three fourth-year medical students, three young M.D.s, and one registered nurse. Five were resident in Philadelphia, the others in New York. None wish to be identified by name.
 8. These terms were not necessarily new when they rose to prominence. SHPOS was noted at least as early as 1978, the same year that George and Dundes announced gomer's preeminence.
 9. Although most scholars reject the folk etymology that gomer is an acronym for "get out of my emergency room" or "grand old man of the emergency room," a satisfactory alternative has yet to be found; certainly there is no reason to think filth enters into gomer's etymology, however.
 10. It would also be possible, of course, to treat SHPOS and crock as instances of specifically anal folklore, another realm pioneered by Alan Dundes in such works as *Life Is Like a Chicken Coop Ladder*. Such an approach has been taken by Odean (1995). Her approach and mine do not preclude each other; it is certainly possible for the meanings of these terms to be multiple, at once part of a system of anal folklore and another system of filth folklore. Since SHPOS and dirtball mean the same thing, and since "Shit never dies" and "Scum never dies" mean the same thing—in other words, since both nonanal and anal filth metaphors can be used in identical situations—I consider these examples of filth folklore rather than anal folklore.
 11. While "crock of shit" itself must be classified as a metaphorical phrase or idiom, "to be a crock of shit" qualifies by most definitions

- as a proverbial phrase. This shows, among other things, how difficult it is to distinguish between such categories as traditional metaphor, idiom, proverbial phrase, cliché, etc.
12. One informant, Dr. M, was equally explicit in saying that crock was “not a real diagnosis, just a general description.”
 13. Interestingly, although some commentators have considered crock a term of hostility, my informants did not think of it that way. To them, a sweet old lady whose disease could not be diagnosed would, if she persisted in her complaints, be called a crock.
 14. Gordon (1983, 177) noted that “patients who demand more attention than warranted by physical condition” were often the recipients of pejorative epithets. Perhaps this should be expanded to “patients who take up time and resources unnecessarily”; although the infections themselves may warrant serious attention, because they are self-inflicted, it can be argued that patients are unnecessarily making themselves sick.
 15. It is the residency that prepares a doctor for specialization. The internship generally precedes it. Both together are liminal for the doctor who intends to specialize.

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