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On Slanderous Words and Bodies Out-of-Control: Hospital Humor and the Medical Carnivalesque

"Laughter is the best medicine."
Traditional proverb

As Deborah Lupton recently summarized, all studies of the social and cultural dimensions of medicine, health, and illness ultimately attend to issues of the human body, and human bodies are sites of struggle over the production of meaning.[i] In 1973, the translation of Michel Foucault's The Birth of the Clinic outlined how seventeenth and eighteenth century French medical practitioners were taught to see and hence organize patients' bodies.[ii] Since that translation, how bodies are controlled, disciplined, monitored, contained, and presented in biomedical contexts has been the subject of vast amounts of research across both the humanities and the social sciences. Western biomedical models attempt to achieve complete knowledge/control of the body by routinely objectifying and dehumanizing patients through any number of techniques common to most totalizing institutions, including the regulation of sleep, food, activity, environmental setting, and dress.[iii] Although such procedures are done under the guise of disease management—attempting to achieve balance between perceived states of normalcy and dysfunction—research reveals that biomedical models constitute a powerful means by which knowledges and ideologies, particularly about gender, race, and other measures of "normal" bodies, are produced and circulated.[iv]

The discourses produced by totalizing institutions not only affect clients, patients, and inmates but also those who work there.[v] Physicians, nurses and other health care workers are shaped by modern medical institutions—perhaps even more so than patients since, while patients eventually leave the hospital one way or another, doctors spend their entire working lives there. Modern medicine defines the perimeters of normality in terms of the body; additionally, it frames the hospital as the rationalized institution for the production of health and doctors as the omniscient and omnipotent managers. Yet, perhaps better than anybody, physicians and other health care workers understand the vast difference between the ideology of biomedicine and reality. While biomedicine seeks to control patients' bodies, for example, those bodies don't always follow institutional scripts. They don't necessarily heal in spite of good medical care, they decay or simply die. Even more importantly, bodies have ideas of their own—patients don't always follow their doctors' orders, or they do so in novel ways. Further, as a location for the enactment of life and death, the hospital is stressful and chaotic, despite the posture of rationalization and order. The hospital functions inefficiently and caregivers make mistakes, they guess, or are simply incompetent. Moreover, in the ideal model, doctors are not only supposed to be competent but caring, especially during times of extreme duress.

Humor, which is found in a number of high-stress or dangerous occupations, is unsurprisingly a primary communicative strategy for doctors and health care professionals in hospital settings. Humor occurs particularly in the backstage realms of hospitals such as call rooms, hallways, medical rounds, and curb-side consults. Scholars across a variety of disciplines have previously recognized the prevalence of medical

humor.[vi] As will be illustrated, medical humor is notoriously off-color, scatological, sexual, or gallows-oriented. Much of this humor is directed at patients, their diseases, their bodies, necessary medical procedures, and even medical workers themselves. To the casual observer, medical humor can appear inappropriate, disrespectful, disciplining, or even cold-hearted. Because of its somewhat disreputable nature, most interpretations in the past have uniformly suggested that medical humor functions to relieve stress, to express hostility towards patients and co-workers, to express irritation at having to provide useless care, or to address the social taboos that physicians routinely break during the course of medical procedures. Importantly, humor and humorous narratives also play an important role in the socialization of medical students.[vii]

Folklorist Peter Narváez notes that in spite of—or perhaps because—of its ability to shock, paradoxical juxtapositions of humor and death are on the rise in the modern world, manifested in joke cycles such as Dead Baby jokes, disaster event jokes like those about 9-11, and festive juxtapositions of death in calendar customs and popular culture.[viii] Building on this growing awareness of the importance of death, humor, and the body, we utilize Mikhail Bakhtin's notion of carnival laughter to suggest that humor in medical contexts indexes what we call the "medical carnivalesque."[ix] Found most obviously in laughter, jokes, and humorous slang but also in asides, insults, and ritual abuse, the medical carnivalesque acknowledges the body as a site of struggle over the production of meaning, mediating the emergent tensions between powerful institutional discourses, profound cultural ideologies and actual social realities. For Bakhtin, carnival laughter was inherently ambivalent. Drawing on combinations of exaggerated imagery of flatulence and excrement, fertility and sex, gluttony and violence, it mocked, degraded

and destroyed but at the same time it also was a source of endless renewal. Given the constant tension between life and death that pervades the hospital environment as well as the totalizing nature of the institution itself, it is not surprising to find a modern form of carnivalesque laughter in this context. Drawing on a variety of resources including literature, published scholarship, collectanea, television and personal observations, we suggest that the medical carnivalesque indexes an essential but heretofore unrecognized perspective in medical culture, a perspective that tacitly acknowledges the absurdity of the project of modernity, while at the same time participating in it.

BIOMEDICAL MODELS AND IDEOLOGIES OF CONTROL

The reductionism and impulse towards complete bodily control inherent in contemporary biomedical models evolved from a mingling of Christian traditions and early modern scientific perspectives. Drawing on Rasmussen, George L. Engel notes that early Christianity separated the mind from the body by proscribing the "view of the body as a weak and imperfect vessel for the transfer of the soul from this world to the next."[x] In believing the body as such, what belonged to the body was science and to the mind /soul was religion or spirituality. Coupled with dualism and reductionism in foundational thinkers such as Galileo, Newton and Descartes, Christianity, Western science, and philosophy profoundly affected the development of modern medicine as a system for the investigation of disease, rather than illness, experience or suffering.[xi]

Today, modern western biomedicine is what Giddens calls an "expert system."[xii] Expert systems, in which people depend on the technological expertise of strangers, are characteristic of late modernity. Indeed, biomedicine is often considered to be

modernity's apex. The biomedical system depends heavily on specialized and expert knowledge of disease, meticulous and disciplined scientific reasoning, and the discovery and application of technology in an effort to understand, influence, and manage it. Disease is defined as deviancy from an idealized model of health and is explained by focusing on physiological processes and biochemical mechanisms. "In narrow biological terms of the biomedical model, this means that disease is reconfigured *only* as an alteration in biological structure or functioning."[xiii] Origins are sought through a focus on a single, somatic/physical cause. According to this reductionist model, illness is reshaped into disease, symptoms translated into signs, subjective experience expressed as objective data.

The biomedical reductionist model serves as the educational, training, and practicing backbone for physicians, who are an important point of contact with the expert system. Medicine's power relies on its ability to take control of the body by reducing it to parts composed of physiological processes and biological/organic functioning. The medical community does this partly by creating a language that allows them to better understand details and data so that they can find patterns to aid in the diagnosis and eventually treat the patient. Part of a physician's responsibility is to transform an ill person into a patient with a disease—that is, into an entity that is objective and scientific in order to lead to a diagnosis and therapy. In other words, "[M]edicine [is characterized] as an ideological system that 'calls' the patient to be an identity that medicine maintains for him; the diagnosis is the most prevalent form of this identity. The ideological work of medicine is to get the patient to accept this diagnostic identity as appropriate and moral."[xiv] Patient bodies are entextualized, for example, through charts and the case

history; here, illness is reduced to particular signs. In the chart and case history, physicians retell patient narratives in a form that identifies patterns and trends by focusing on individual parts, transforming the experience of illness into an authoritative medical history.[xv] These numbers become more reliable than the patient him/herself.[xvi]

The greatest strength of the biomedical model is also its greatest weakness. While a physician can transform a person with an illness into a patient with a disease, s/he may be unable to transform the patient back. The medical model enables the physician to study the body but not necessarily care for the person. The biomedical reductionist model has trained generations of physicians to contemplate and confront disease, but has it trained generations of physicians to address issues of suffering? Eric Cassell writes that non-medical providers were "shocked to discover the problem of suffering was not directly addressed in medical education . . . The relief of suffering, it would appear, is considered one of the primary ends of medicine by patients and laypersons, but not by the medical profession."[xvii] The medical carnivalesque, which often entails laughing at a patient's expense, is one way in which physical suffering is acknowledged by medical consciousness, and from a Bakhtinian perspective it also is one way in which it is conquered.

THE MEDICAL CARNIVALESQUE

'You gave her what?' asked Fats.

'Thorazine.'

Fats burst into laughter. Big juicy laughs rolled down from his eyes to his cheeks to his chins to his bellies, and he said, 'Thorazine! That's why she's acting like a chimp. Her blood pressure can't be more than sixty. Get a cuff. Potts, you're terrific. First day of internship, and you try to kill a gomer with Thorazine.'[xviii]

This passage, taken from Samuel Shem's novel The House of God exemplifies the medical carnivalesque. The book satirically tells the story of the inculcation of medical trainees. Here, the intern Potts has mistakenly given an elderly patient improper medication. His supervisor, a seasoned resident commonly known as the Fat Man or Fats, responds with "big, juicy laughter," showers both praise and abuse on Potts by calling him "terrific" while at the same time identifying the patient as a "chimp" and a "gomer." Fats' laughter, the name-calling and abuse, the absurdity of the mistake, and the bulk of Fats' own corporeal being, particularly his "bellies," all suggest the presence of carnivalesque laughter.

Bakhtin's notion of carnivalesque laughter depends on grotesque realism and images of the grotesque body for its effect. The grotesque body is out of control; it is a body that resists closure and exists in the act of becoming.[xix] Exaggerated, overabundant and excessive physical images predominate, including gigantic sexual organs, huge bellies, large noses and other protuberances, the gluttonous consumption of both food and drink, references to ingesting urine and excrement, and images of beatings, bodily dismemberment, blood, disease and death. By thrusting all that society exalts or idealizes downward into the body's "lower stratum,"[xx] carnivalesque laughter mocks and overturns established social orders and offers a mechanism for change, renewal and rebirth. At the same time, because it renews at the same time it destroys, carnivalesque laughter is inherently ambivalent.

Bakhtin's ideas are entirely applicable to medical contexts, which by definition deal with issues of life and death, control and chaos. Etymologically, the word "carnival"

is derived from the word *carne*, which refers to flesh, while the original meaning of "humor" stems from premodern physiology and referred to the four main fluids of the body that determined a person's mood and disposition.[xxi] As noted above, western biomedicine not only seeks to know intricate and complex physiological and pathophysiological relationships, but also tries to control them with surgical interventions, medical therapies, and pharmacological interventions. As the patient becomes more ill, physicians attempt to exert more control of basic bodily functions such as breathing, eating, urinating, and defecating. Thus, the grotesque, "out-of-control" body constitutes a powerful image that counter the modern project of staving off death at all costs. This [process / transformation / image] calls attention to this project as absurd, and making mockery of the sacrosanct nature of modern medicine.

Additionally, as a metacommunicative strategy, the use of humor and carnivalesque laughter go directly against the instrumental use of language among medical staff, commenting on and reframing ongoing situations in alternative ways. This is language that is doubly voiced, speaking to official ideologies of medical control while at the same time subverting them for its own purposes.

Degradation is key to grotesque realism and excrement is the most suitable material for that purpose.[xxii] Indeed, references to excrement and the anus are so prevalent in medical humor and medical slang that an entire article has been published on the matter.[xxiii] *Bobbing for apples* or *scooping poop*, for example, are terms used to remove impacted feces, while a *Code Brown* refers to a patient's fecal incontinence; alternatively it can also mean that a patient needs an enema.[xxiv] As a constant source of work for doctors and as suffering people who are supposed to be treated with utmost

respect, patients often are a prime object of degradation. Indeed, the fact that they often are degraded, which is accomplished in the following jokes by relating them to feces or the rectum, suggests their importance in the medical world:

> Q: Doctor, why do you have that thermometer behind your ear?
> A: Damn. Some asshole must have my pen.[xxv]

Doctors might also diagnose patients as having "rectal-cranial inversion,"—in other words, the patient has his head up his ass.[xxvi]

The medical carnivalesque, however, mocks and degrades all participants, not merely patients. Doctors, nurses, and other hospital staff also are subject to scatologically inclined humor, which subverts their hierarchical status positions. A "High Sphincter Tone," for example, is an uptight attending physician, while a "stool magnet" is a doctor who has bad luck when on call.[xxvii] The following example implicates doctors, nurses and patients:

> Q: What's the difference between a nurse and a toilet seat?
> A: A toilet seat only has to deal with one asshole at a time.[xxviii]

References to excrement, however, have multiple functions of which degradation is but one. Eating excrement, for example, conflates what normally are construed to be oppositional bodily processes into ambivalent images that link fertility and life with dismemberment and death. *Scrubs*, a popular television comedy about physicians-in-training, provides many linkages between ingestion and defecation. In one episode of *Scrubs*, eating and feces are linked by the sardonic comment "my favorite chips cause anal leakage." In another episode, Carla, a nurse, is ridiculed for carrying around a beaker of urine as she attempts to find its owner. She takes the beaker to the cafeteria

and is accused of trying to steal some "apple juice" while a co-worker next in line actually does try to steal apple juice by placing it in several urine beakers. This may not be so far from reality as indeed, both authors have observed health care workers using beakers as drinking cups. Robinson also acknowledges the linkage of food and viscera in the following one-liner:

> Liver again! Pathology must have had an oversupply this week![xxix]

In these examples, ingestion, reproduction, and death are drawn into the same framework, suggesting that these processes are but two sides of the same coin

The use of billingsgate—that is, foul or profane language, particularly as found in oaths, curses and *blaison populaire*—also draws heavily on scatological references but for purposes of blasphemy. In the work of Rabelais, the most profane swearing is accomplished by rending apart the body of Christ.[xxx] In contemporary medical contexts, both patient and physician bodies are torn asunder. In one *Scrubs* episode, the aptly-named Dr. Cox, a supervising attending, tells Dr. Kelso, the Chief of Medicine "I know that the very idea of you doing a favor for me makes those ass cheeks clinch up so tight that you could shove a lump of coal up there and probably crap out a diamond, right?" In the same episode, Dr. Cox complains that Dr. Kelso was "so far up my ass I can taste Brillo cream in the back of my throat." Rending apart of the body of Christ was useful for Rabelais, because Christ was the most sacred body available; as such, its rendering was a most blasphemous act. That both physician and patients bodies are torn verbally apart in medical work contexts suggests a kind of sacred nature to how they are constituted in modern work contexts; their rendering apart contributes to the overall blasphemous thrust of the medical carnivalesque.

As discussed above, modern medicine seeks to produce good health through the control of patient bodies. But when bodies cannot be neatly managed, medicine invents absurd procedures to exert control, usually based in the lower body. The bowel prep is one such measure:

> 'What is it with this GI workup?' I asked. 'She says she's depressed and has a headache.'
> 'It's the specialty of the House,' said Fats, 'the bowel run. TTB – Therapeutic Trial of Barium.'
> 'There's nothing therapeutic about barium. It's inert.'
> 'Of course it is. But the bowel run is the great equalizer.'
> 'She's depressed. There's nothing wrong with her bowels.'
> 'Of course there's not. There's nothing wrong with her, either.'[xxxi]

Another invented procedure is "required" the rectal exam as outlined by Odean: "There are only two reasons not to do a rectal exam: 1) the patient has no rectum; 2) the intern has no finger."[xxxii] This constitutes a particularly carnivalesque example, conflating both patient and intern dismemberment with absurdity and lower stratum references. In both cases, the humor underlying the invented absurdity is doubly voiced, speaking to both the kind of control from which modern medicine derives its power while at the same acknowledging that power as potentially fragile and incomplete.

Bodily dismemberment also figures in jokes, many of which depict physicians but are not necessarily blasphemous, but again indicating the physicians' normally revered status. One joke based on stereotypes of medical specialties refers to body parts that certain kinds of doctors don't use or need; these are the parts used to save an elevator door. The joke complex is told in its entirely; the final exchange concerns hospital administrators, who are often perceived by medical staff as cold-hearted and distant. The

fact that the hospital administrator is *not* dismembered is particularly telling in terms of how they are perceived in the workplace.

Q: How does a surgeon save the elevator door?
A: Uses his foot.

Q: How does an internist save the elevator door?
A: Uses his hand.

Q: How does an orthopedist save the elevator door?
A: Uses his head.

Q: How does a medical administrator save the elevator door?
A: Uses somebody else.

The medical carnivalesque also is a constant source of renewal and rebirth; hence, references to fertility, birth, exaggerated sexual organs and other images of sexual reproduction are an essential dimension. In Great Britain, for example, a TUBE stands for a Totally Unnecessary Breast Examination.[xxxiii] In one episode of *Scrubs*, the brother of the primary character, a third-year resident named J.D., masturbates on the top bunk while J.D. lies on the bottom, while in The House of God Dr. Basch and Runt, a sex-obsessed medical intern, have sex with multiple nurses in the same call room simultaneously.[xxxiv] Nurses are an unending source of sexual innuendo. There is, for example, the proverbial "theory of action-potential." This is based on a real scientific theory called the action-potential theory, which postulates that the more energy invested in an object, the more potential it has for movement. When applied to nurses, the theory of action-potential is summed up by the proverbial saying "where there's more action, there's more potential," suggesting that when there is a lot going on, such as the O.R., there is more potential for sex. Robinson also suggests that the O.R. is a common arena for sexual references, as in the following joke told by an assisting O.R. doctor:

Q: Do you know what happened to the nurse who swallowed a razor blade?
A: She performed a tonsillectomy, a hysterectomy, and circumcised an intern.[xxxv]

Yet, while sexual references, images of fertility, and joking references to male and female bodies indicate renewal and rebirth, they also indicate that maleness is associated with medical competence and femaleness is associated with weakness, passivity and failure. In *Scrubs*, Turk's girlfriend Carla assists him as a nurse in the operating room. Once in the operating room she treats him as her partner, demanding, for example that he say please and thank you when asking for surgical instruments. Carla explains to the other surgeons that she makes Turk (who is bald) wax his head. In response, the attending surgeon asks Turk, "Does she make you wax your vagina as well?" In yet another episode, Dr. Cox writes J.D. a mock prescription.[xxxvi] The prescription, which is for "two testicles," is to be filled out immediately, implying that Dr. Dorian (J.D.) lacks maleness and hence, competence as a doctor. In these examples, male doctors' bodies are "out of control" and they are told to obtain control by asserting masculinity.

Since it both destroys and renews, carnivalesque laughter is inherently ambivalent, reaching its height of ambivalence with respect to death. At its most basic level, the totalizing nature of a modern hospital exists to control and contain death, which is in fact inevitable, unknowable and uncontrollable. The absurd nature of this modern project is evident in the passage below, which graphically conflates humor, suffering, blood, death, and feces as manifested in a patient's uncontrollable body.

The nurse came in and said, 'Mr. Lazarus has just had a bowel movement that is all blood.'
'Hey, that's really funny, Maxine. You got a great sense of humor.'
'No, I'm serious. The bed is solid blood.'

They wanted me to go on, and I could not. The world became the world just before the head-on crash. It could not be what it was. 'I can't do anything more tonight,' I heard myself say. 'I'll see you in the morning.'

'Look, Roy, don't you understand? He's just bled out a gallon of blood. He's lying in it. You're the doctor, and you have to do something for him.'

Filled with hate, trying to get rid of thoughts that Lazarus wanted to die and I wanted him to die and I had to break my ass to stop him from dying, I went into his room and was face-to-face with black putrid sticky wet blood. On autopilot, I went to work."[xxxvii]

This example illustrates that according to institutional scripts, doctors are supposed to stave off death at any cost and some doctors consider it a personal failure when their patients die. On the other hand, doctors are more comfortable with death than the general population and a patient's immanent death often is a source of stress between doctors and patients' families. Families often want to prolong the patient's life as long as possible, while both the doctor and patient may consider it more humane to allow nature to take its course. The medical carnivalesque performs this ambivalence through the extensive use of euphemisms and jokes about this inevitable finality of the human condition, laughing at the condition of human suffering and frailty. In the following joke, for example, human suffering and sadness are rendered comical; death is the preferred outcome.

A woman collapses in her home. Her son takes her to the hospital. The doctor returns and says to the son, "I have both good news and bad news."

Son: Well, give me the bad news first.

Doctor: Well, your mother has had a severe stroke and is completely incapacitated. You'll need to care for her every need for the rest of her life. You'll need to feed her, get her out of bed to go to the bathroom. You'll have to wipe her after she goes to the bathroom. You'll have to bathe her. She'll never speak again and she can't see or hear either. She can't walk, so you'll have to exercise her every day. Her nursing and medical needs will drain every penny you have. In fact, you'll be so stressed out from taking care of her, you will probably die first.

Son: Oh my god. That's horrible. What's the good news?

Doctor: HA! Just kidding. She's dead.

Further illustrating medical ambivalence toward death, there are a number of humorous terms for the elderly and other people who are about to die. An elderly patient who fails to thrive, for example, is said to be "dwindling," or has a case of the "dwindles." The dwindles stands for a series of health problems such as dementia, weight loss, inactivity, poor nutrition, depression and others. Patients who are nearing death—such as one with a bad case of the dwindles—are said to be "circling the drain" or merely "lingering." In Britain, an elderly patient might be called a "wrinkly" or a "crumble"; s/he may also have a case of TMB (Too Many Birthdays) in which case, they may be sent to the "departure lounge" (geriatric ward).[xxxviii] The Brits may also call a patient T.F. BUNDY, which stands for Totally Fucked But Unfortunately Not Dead Yet, a term that conflates vulgar language, sexual references and death.[xxxix] Those who have died have gone to the ECU, or the "eternal care unit."[xl]

Doctors perhaps are most ambivalent about those patients who don't improve but also who don't die; the medical carnivalesque acknowledges the absurdity of trying to cure, heal, or otherwise "save" those patients who cannot be controlled. This ambivalence can be understood as the consequence of "creeping normalcy." Creeping normalcy refers to the acceptance of a major, otherwise intolerable change as normal over time. After years of ongoing attempts to control the uncontrollable (death), physicians begin to accept these attempts as somehow normal. The incongruity resulting from creeping normalcy results in ambivalence.

From a doctor's perspective, the best possible situation is a patient who gets well and is discharged from the hospital. The patient is healthy and happy, and the doctor has less to do. But there are some patients who not only cannot be discharged, they don't seem to improve at all. In this case, the second best option is to move them to another doctor's service or onto another team. The terms "buffing" and "turfing" refer to ways in which this is accomplished. One "buffs" a patient—makes him/her look like they are suitable for a different service—in order to "turf" them—move them out. These references to buffing present the patient's body as "polished" in order to look good—at least on the outside.

Some sick patients really do belong on one's service and are too sick to be discharged, remaining there for a long period of time. These patients are known as "rocks." The implication is that you can't move them. Particularly obese patients who can't be moved are "boulders." These patients tend to come in waves. Doctors with a lot of rocks on their service are known as "rock collectors," or as having "rock gardens." "How's the rock garden?" is a question these caregivers endure.

The most well known patient who cannot be discharged is that of the "gomer." The term gomer refers to an elderly male patient, often a veteran, who never dies but also who never seems to leave the hospital. George and Dundes point out that this is the patient from whom one cannot escape and therefore one of the most uncontrollable kind of patients that exist. In the 1970s, the classic gomer figure was unkempt, missing teeth, alcoholic, and dirty;[xli] today the term refers to a debilitated, elderly, senile patient who cannot be healed.[xlii] In *Scrubs* gomers are described as old people "who don't have the decency to die," while the term "Gomer Pile" refers to the care unit for these chronically

sick patients.[xliii] In The House of God, Gomer is also an acronym for Get Out of My E.R.,[xliv] suggesting that the patient is wasting the doctor's time, an idea illustrated by the following discussion between Fats and Potts.

Potts: "'I've got some work to do.'
Fats: 'Well, you won't believe this either, but most of the work you do doesn't matter. For the care of these gomers, it doesn't matter a damn.'"[xlv]

George and Dundes also found the term "grume" in use at the time of their article. A grume is worse than a gomer and refers to a blood clot or a pile of feces.[xlvi] A female gomer may be called a gomere, or she may simply be a LOL in NAD (Little Old Lady in No Apparent Distress).[xlvii]

Gomers are identified by exaggerated, debased physical characteristics and their ability to evade hospital release. In one of several "Gomer Assessment Sheets" collected, points are assigned to assess gomerdom. If a patient has been unemployed since WWII for lower back pain, for instance, he (gomers are mostly male) is assigned 3 points while if he has been unemployed for lower back pain since the Spanish American War, he is assigned 15 points. A patient wins 10 points if he urinates on a physician, 12 points for drinking from a urinal, and 4 points for biting the bulb off a rectal thermometer.[xlviii]

Derisive, carnivalesque laughter is the best way to deal with such uncontrollable patients. In The House of God, Dr. Basch narrates, "A shriek came from the gomere: REEE-REEE-REEEEE . . . and all I did, while they stared at me, was lie on the tile floor and laugh. . . . these gomers had won."[xlix] Early in Dr. Basch's training, he quickly discovers the sad state of these patients:

When I [Dr. Basch], laughing, told her [Berry, his girlfriend] about Harry the Horse, and the farting Jane Doe, she didn't laugh.

"How can you laugh at that? They sound pathetic."
"They are. . . ."[l]

Gomers are not only pathetic, they are absurd. As living absurdities, they embody the futility of the modern medical project, and deserve mockery and scorn. *Scrubs* illustrates gomer status by the patient's inability to say anything but the word "pickles." The episode opens with J.D. heaping mocking abuse on the patient. J.D. asks the gomer a series of questions, to which the patient responds "pickles." J.D. finally asks him "Peter Piper picked a peck of pickled—what?" When the gomer responds "pickles," J.D. mocks him saying "*NO*, the correct answer is *pepper*. Peter Piper picked a peck of pickled *peppers*." Upon discovering J.D. ridiculing the patient, Dr. Cox praises him saying, "God, I've never felt closer to you before."

The comic praise and abuse illustrated above are two sides of the same coin. In Rabelais, abuse occurs in a variety of forms, including verbal invectives as well as actual physical beatings, which Bakhtin understood as a means of revival and regeneration. While symbolic abuse may not necessarily be a form of renewal in the medical carnivalesque, it occurs frequently enough to warrant notice.

Pott's head turned to watch the Fat Man go, and somehow, her left hand free, Ina slugged him again. Reflexively Potts raised his hand to hit her, and then stopped himself. The Fat Man nearly keeled over with laughter. / 'Ho ho, did you see that? I love 'em, I love these gomers, I do . . . ' And he laughed his way out the door.[li]

Comic abuse not only occurs with patients but between doctors. In one episode of *Scrubs*, Dr. Cox punches Dr. Kelso in the nose, and follows this show of aggression with a verbal attack of a sexual nature: "That felt so good I changed my pants afterwards."

The rest of the episode revolves around the comical result of the punch, which is that Dr. Kelso's nose squeaks as he breathes.

Comic abuse and debasement occurs in jokes and slang as well, as in the following examples:

> Q: What's the difference between a pile of shit and an intern [or medical student]?
> A: You don't go out of your way to step on a pile of shit.[lii]

The acronym BOHICA, which stands for Bend Over Here It Comes Again, conflates abuse with anal sex.[liii] While of course no doctor would tolerate the actual abuse of patients or colleagues, humor is used as an effective tool to establish or remind those entrenched in the medical community about dominance, power, hierarchy, and roles. No one person or position is beyond reproach.

CONCLUSION: A THEATER OF THE ABSURD

Western biomedicine both embodies and drives modern understandings of life, health and death and it does so through technologies of the body. According to biomedical ideologies, death is understood as existing in opposition to life, the result of life's failure rather than its culmination or end result. Beliefs of "death as the enemy" and "death as a failure" pervade the medical community, indicating a shift from the notion that death is a part of life to the idea that death can be avoided or indefinitely delayed.[liv] The idea that death can be avoided illustrates the powerful influence of creeping normalcy□ inherent in current medical culture and society in general. "Youth is celebrated as the ideal; longevity is desired, and remains a primary standard for evaluating health-care systems; and when a friend or relative is dying people commonly avoid the person feeling that 'I

don't know what to do or say.' The focus has been on avoiding problems and stopping bad interventions rather than on a positive ideal of a good death."[lv]

As instantiated in hospital settings, the biomedical project ultimately wields power over death by offering a rationalization of it. Since death cannot be avoided completely, the goal becomes commanding, containing, and controlling it. In pursuit of this goal, human bodies are analyzed, manipulated, managed, and mastered through technology and medicine, resulting in surreal and often ridiculous situations. If medicine has at times been likened to a theater,[lvi] these situations reveal its occasional absurd nature.

The medical carnivalesque acknowledges the irrationality deeply rooted in this very modern project. Drawing upon the grotesque out-of-control body as a traditional symbolic resource, the medical carnivalesque conflates excrement, sex, disease, disability and death to mock and deride human attempts to control life and death. In doing so, the medical carnivalesque challenges biomedical ideologies of control by turning them on their ear and rolling them on their bellies. If the hospital is a rationalized institution, the medical carnivalesque points out the cracks in its foundations. If patients are sacrosanct, the medical carnivalesque points out the futility of their battle to prolong life or stave off death. If medical trainees are managers, the medical carnivalesque shows them as barkers in a three-ring circus. If the attending physicians are the performers, the medical carnivalesque flaunts them as the ring masters. No part of the institution is immune to its laughter.

Following Bakhtin, we suggest that the medical carnivalesque does not merely mock or degrade but also renews. Carnivalesque laughter is regenerative, offering a way

out of impossible situations, at least on the symbolic level. While previous scholars have acknowledged the importance of humor in medical settings to cope with highly chaotic and stressful situations, the nature of its ambivalence has escaped theorization. Doctors often are ambivalent about their work and this ambivalence emerges in humor. One can attempt to control and rationalize death but death refuses rationalization, and if one cannot laugh at these attempts, then one must cry.

In bringing together life and death within a single unified symbolic framework, the medical carnivalesque accomplishes deeply serious and important work. The ability to humorously symbolize what medical professionals do as absurd requires an awareness of their own human frailty and powerlessness. The biomedical model, which reduces caregivers to mere technicians, dehumanizes not only patients but also those who would heal. Those who can't laugh, who take themselves too seriously and perceive what they do as "normal" are the ones who are lost. In *Labyrinth of Solitude*, Octavio Paz famously noted the ability of the Mexican people to face death through laughter. While the idea of laughing at death now has become a cliché of Mexican national character,[lvii] the practice still holds sway in other arenas. As Narváez concludes, "The commingling of humor and death in informal and ritualistic circumstances appears to be a human universal, a technique for communicating and dealing with the enigma of our precarious mortality."[lviii] It is by laughing at human suffering, disease, and failure that the fear of death, if not death itself, is conquered.

A good laugh and a long sleep are the best cures in the doctor's book.
Irish Proverb

[i] Deborah Lupton, *Medicine as Culture: Illness, Disease and the Body in Western Societies,* 2d. ed., (Thousand Oaks: Sage Publications 2003).
[ii] Michel Foucault, *The Birth of the Clinic: An Archaeology of Medical Perception* (New York: Vintage Books 1994).
[iii] The term "totalizing institution" refers to institutions where the normal activities of a group of people are determined and regulated within a designated space for the purpose of achieving an overarching goal. See Erving Goffman, *Asylums: Essays on the Social Situation of Mental Patients and Other Inmates* (Garden City, N.Y.: Anchor-Doubleday 1961).
[iv] Robyn Wiegman, *American Anatomies: Theorizing Race and Gender* (Durham: Duke University Press 1995).
[v] Jay Mechling, "Children's Folklore in Residential Institutions: Summer Camps, Boarding Schools, Hospitals and Custodial Facilities," in *Children's Folklore: A Sourcebook*, ed. Brian Sutton-Smith, Jay Mechling, Thomas W. Johnson, and Felicia R. McMahon (Logan: Utah State University Press, 1999), 273–91.
[vi] Victoria George and Alan Dundes, "The Gomer: A Figure of American Hospital Folk Speech," *Journal of American Folklore* 91/359 (1978):568–81; Anne Burson-Tolpin, "Fracturing the Language of Biomedicine: The Speech Play of U.S. Physicians," *Medical Anthropology Quarterly* New Series 3/4 (1989):283–93; Jamie Moore, "Poetry, Puns, and Pediatrics: The Verbal Artistry of Dr. James L. Hughes," *North Carolina Folklore Journal* 38/1 (1991):45–71; Kathleen Odean, "Anal Folklore in the Medical World," in *Folklore Interpreted: Essays in Honor of Alan Dundes*, ed. Regina Bendix and Rosemary Lévy Zumwalt (New York and London: Garland Publishing, Inc., 1995), 137–52; Paul Grayson, "The Folklore of a Medical Community," *Louisiana Folklore Miscellany* 5 (1981):48–52; Yvette Trahant, "The Oral Tradition of the Physician," *Louisiana Folklore Miscellany* 5 (1981):38–47; Rose Laub Coser, "Some Social Functions of Laughter: A Study of Humor in a Hospital Setting," *Human Relations* 12 (1959):171–82; Robert H. Coombs, Sangeeta Chopra, Debra R. Schenk and Elaine Yutan, "Medical Slang and Its Functions," *Social Science and Medicine* 36/8 (1993):987–998; Adam T. Fox, Michael Fertleman, Pauline Cahill, and Roger D. Palmer, "Medical Slang in British Hospitals" *Ethics and Behavior* 13/2 (2003):173–189; Vera M. Robinson, *Humor and the Health Professions* (Thorofare, N.J.:Charles B. Slack, Inc., 1977).
[vii] Genevieve Noone Parsons, Sara B. Kinsman, Charles L. Bosk, Pamela Sankar, and Peter A. Ubel, "Between Two Worlds: Medical Student Perceptions of Humor and Slang in the Hospital Setting," *Journal of General Internal Medicine* 16 (2001):544–549; Frederic W. Hafferty, "Cadaver Stories and the Emotional Socialization of Medical Students," *Journal of Health and Social Behavior* 29/4 (1988):344–356.
[viii] Peter Narváez, Peter, ed. *Death and Humor in Folklore and Popular Culture* (Logan: Utah State University Press, 2003).
[ix] Mikhail Bakhtin, *Rabelais and His World*, trans. Hélène Iswolsky (Bloomington: Indiana University Press, 1984).
[x] George L. Engel, "The Need for a New Medical Model: a Challenge for Biomedicine," *Science* 196/4286 (1977):129–36, 131.
[xi] Ibid., 131.

[xii] Anthony Giddens, *The Consequences of Modernity* (Stanford: Stanford University Press, 1990).
[xiii] Arthur Kleinman, *The Illness Narratives: Suffering, Healing and the Human Condition* (New York: Basic Books, Inc., 1988), 5.
[xiv] Arthur W. Frank, *The Wounded Storyteller: Body, Illness, and Ethics* (Chicago: University of Chicago Press, 1995), 66.
[xv] Felice Aull and Bradley Lewis, "Medical Intellectuals: Resisting Medical Orientalism," *Journal of the Medical Humanities* 25/2 (2004):87–108; Renee R. Anspach, "Notes on the Sociology of Medical Discourse: The Language of Case Presentation," *Journal of Health and Social Behavior*, 29/4 (1988): 357–75; William J. Donnelly, "The Language of Medical Case Histories," *Annals of Internal Medicine* (December) 127/11 (1997):1045–48.
[xvi] Frank, 34.
[xvii] Eric J. Cassell, "The Nature of Suffering and the Goals of Medicine," *New England Journal of Medicine* 306/11 (1982):639–45, 640.
[xviii] Samuel Shem, *The House of God: The Classic Novel of Life and Death in an American Hospital* (New York: Random House, Inc., [1978]2003), 47.
[xix] Bakhtin, 317.
[xx] Ibid., 370ff.
[xxi] Mahadev L. Apte, "Humor," in *Folklore, Cultural Performances, and Popular Entertainments*, ed. Richard Bauman (Oxford: Oxford University Press, 1992), 67–75.
[xxii] Bakhtin, 147.
[xxiii] Odean's essay was published appropriately as a *festschrift* for folklorist Alan Dundes, who (in)famously was interested in such matters from a Freudian perspective.
[xxiv] Odean, 139.
[xxv] Ibid., 142.
[xxvi] Ibid., 145.
[xxvii] Coombs et al., 990.
[xxviii] Odean, 142.
[xxix] Robinson, 70.
[xxx] Bakhtin, 192–3.
[xxxi] Shem, 33.
[xxxii] Odean, 138.
[xxxiii] Fox et al., 188.
[xxxiv] Shem, 164–69.
[xxxv] Robinson, 70.
[xxxvi] Bakhtin associates mock prescriptions with the laughter of the quack and druggest at the fair, 185–7.
[xxxvii] Shem, 122.
[xxxviii] Fox et al., 183–89 *passim*.
[xxxix] Ibid., 188.
[xl] George and Dundes, 569.
[xli] Ibid., 570.
[xlii] Deborah B. Leiderman and Jean-Anne Grisso, "The Gomer Phenomenon," *Journal of Health and Social Behavior* 26/3 (1985):222–32, 225.

[xliii] Coombs et al., 989.
[xliv] Shem, 29.
[xlv] Ibid, 44.
[xlvi] George and Dundes, 572.
[xlvii] Shem, 33.
[xlviii] George and Dundes, 575–79.
[xlix] Shem, 286.
[l] Ibid., 24.
[li] Ibid., 36.
[lii] Odean, 145.
[liii] Ibid., 146.
[liv] Ira Byock writes specifically: "As a clinician it seems disrespectful to discuss the 'meaning and value' of death. The preciousness of life underlies all clinical disciplines and preservation of life is a paramount clinical goal. Understandably, for clinicians death is the enemy to be conquered, and when it occurs, it represents defeat and failure." Ira Byock, "The Meaning and Value of Death," *Journal of Palliative Medicine* 5/2 (2002):279–288, 279. Howard Brody writes about medicine's fascination and belief with rescue. "The rescue fantasy is a power trip: it envisions the physician having the power to snatch the patient from the jaws of death." See Howard Brody, *The Healer's Power* (New Haven: Yale University Press, 1992), 139.
[lv] Ezekiel J. Emanuel and Linda L. Emanuel, "The Promise of a Good Death," *Lancet* 351, supplement II (1998):21–29, 21.
[lvi] Erving Goffman, *The Presentation of Self in Everyday Life* (Garden City, N.Y.: Doubleday, 1959).
[lvii] Stanley Brandes, "Is There a Mexican View of Death?" *Ethos* 31/1 (2003):127–44.
[lviii] Navárez, 11.