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Meaning of Folklore

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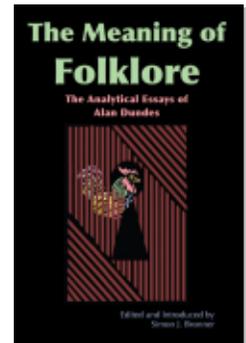
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MEDICAL SPEECH AND PROFESSIONAL IDENTITY

(A) The Gomer: A Figure of American Hospital Folk Speech

(B) “When You Hear Hoofbeats, Think Horses, Not Zebras”:
A Folk Medical Diagnostic Proverb

Introduction

Showing that medical professionals constituted a folk group, with a complex of subgroups (physicians by specialty and school background, residents at different stages of development, and nurses assigned to different units), fit into Dundes's general goal of demonstrating that elite scientific groups defined their group identity through folklore. Their communication is replete with slang and story that express their relation to one another, and to patients. One approach to identifying and interpreting the material heard from medical professionals, therefore, was to gauge folklore's capacity to convey values within the group, and to express attitudes toward those outside the group. In other words, it not only defined the group, but also marked the boundaries and hierarchies within a sociocultural system of which patients were generally unaware.

The hospital setting separated Dundes's analysis of medical professionals from others he did of elite groups. Scholarship often distinguished folklore by cultures of region, religion, ethnicity, age, and gender, Dundes saw the medical professional in a distinct institutional context, one that differed, inside its doors, in its visual appearance and social world. It was a world of emergency and stress, with life and death at stake, and therefore provided an excellent test of folklore's function to express and mediate anxiety. Indeed, as the first essay shows, different types of hospitals (Dundes discussed the distinction of Veterans Administration hospitals) had their own lore, reflecting their institutional culture. Dundes hypothesized that the more stress a group faced, dealing with life and death issues in the hospital complex, the more likely it was that folklore, often of a morbidly humorous nature, would arise or would be needed.

An early indication of Dundes's interest in the subject was in his interpretation of several legends in *American Folk Legend* (Hand 1971). There, he reinterpreted the legend, known as “The Cadaver Arm,” circulating in medical schools. In this legend, medical students put

a coin in a cadaver's hand and drive through a toll booth. The attendant is startled when the driver leaves that arm behind as the medical students speed away. Dundes pointed out that the story was one of many about cadavers among medical students. He concluded that among professional groups, this unusual concentration of narratives around the theme of dead bodies provided "an outlet for the anxiety initially felt about treating a dead human body, as a mere 'nonhuman' object." One of the story's lessons is that doctors cannot get too attached to their patients' ailments. In addition to separating the would-be doctors in the narrative from their previous identities as part of the public, offering the cadaverous arm with a coin attached reversed the normal roles of patient and doctor. This, according to Dundes, functioned as a way to deal with the anxiety of taking money from sick or dying people. (See Dundes's summary of this interpretation in "Getting the Folk and the Lore Together" [1976a], presented in the next chapter).

In the first essay, Dundes collaborated with a nurse, Victoria George, to collect materials—printed in the form of photocopied sheets as well as communicated orally—by questionnaire and interview. Dundes compared the stereotypes patients had of doctors and nurses with the lore devised by hospital staff for patients. According to Dundes, the "gomer" was a prime example of staff slang. It referred to a chronic problem patient, offering a safety valve for ritual reversal—turning human tragedy into comedy. In addition, Dundes extended the interpretation of the socioeconomic gap between the figure of the gomer (as the "dregs of society") with the affluent doctor (begun with his treatment of the "Cadaver Arm") to one of "critical differences in class and values." Here, the stress is the ethical responsibility of the doctor to treat all patients equally, despite his or her class biases.

The second essay is about a proverb—"If you hear hoofbeats think horses, not zebras"—used in hospital instruction. Published twenty-one years after the Gomer piece, it was also written with health professionals. One was his daughter Lauren Dundes, a medical sociologist at Western Maryland College, and the other was Michael Strieff, a physician with the Johns Hopkins University School of Medicine. Indicating the divide between the proverb, as part of "esoteric" hospital lore, and the public, the senior Dundes explained to the editor, "I don't think the majority of proverb scholars know the proverb despite its widespread popularity among doctors" (Mieder 2006a, 153). Of interest in interpreting the proverb is the fact that it can hold multiple meanings, in changing socioeconomic contexts, for the professional medical community.

An advertising campaign by the Carcinoid Cancer Foundation, begun at the start of the twenty-first century, may change the esoteric nature of the proverb, although the campaign is primarily aimed at healthcare professionals. Using the zebra and its stripes as logos, the advertisement gives "The Story Behind the Zebra": "Physicians are taught 'If you hear hoofbeats think horses, not zebras.' Zebras, like Carcinoid Cancer, are less common. Therefore we want to remind the medical community to also 'think zebras.'" Following the custom of displaying different colored ribbons for various causes (pink for breast cancer, yellow for soldiers abroad), carcinoid cancer advocacy groups brandish black-and-white striped ribbon pins, stuffed zebra dolls, and car magnets. Fundraisers include "The Zebra Ball: Stars for the Stripes," and a book, *Carcinoid Cancers, Zebras and Stardust* (Girsch-Bock 2006). Audiences of the hit television show *CSI: Las Vegas* (featuring scientific details of forensic science) may have wondered about the zebra proverb, used in a segment ("Pirates of the Third Reich" in 2006) to refer to an apparently outrageous theory by the lead medical investigator, which of course turned out to be right. It also remains to be seen whether

another proverb suggested by the Carcinoid Foundation takes hold in the medical community: "You must suspect it to detect it."

For further folkloristic work with the culture of healthcare professionals, see Tangherlini 1998; Hufford 1989; Berkman 1978; Burson 1982; Burson-Tolpin 1989; Winick 2004; and Meehan and Bronner 2006.

The Gomer: A Figure of American Hospital Folk Speech

ONE OF THE GROUPS LEAST studied by folklorists is the medical profession. To be sure, there has been a long-standing scholarly interest in folk medicine, but this refers primarily to medicine practiced by patients themselves or by healers not usually considered to be part of the "scientific" medical establishment. Folk medicine, in fact, is often contrasted with so-called scientific medicine. This has perhaps tended to suggest that scientific medicine is devoid of any folkloristic content. Yet doctors and nurses not only constitute an important occupational folk group, they constitute one which by its very nature involves an unusually great amount of anxiety. It is to be expected that matters of health care which are literally concerned with life and death create nervous tension—not just for the patient but also for the dedicated medical personnel who are charged with the responsibility of treating the patient. In most hospitals, a rich albeit esoteric folklore flourishes providing a much needed outlet for doctors and nurses who are under almost continual round-the-clock pressure.

Unless readers have had professional training in medicine, they will probably not be familiar with in-group hospital folk speech. In some instances, the terminology is specifically designed to conceal information from patients. "Code Blue," for example, is used in some California hospitals to alert personnel that someone is *in extremis* and that emergency assistance is needed immediately. If "Code Blue 123" is announced on the public address system, it creates far less anxiety for the general patient population than would an announcement that the patient in room 123 is suffering cardiac arrest. Similarly "Dr. Red" (or in some versions Mr. Firestone) is paged to indicate that a fire has broken out. "Mr. Strong, Mr. Strong, 456" means that help is needed in room 456 to subdue an unruly or difficult patient. By using this "secret" code language, hospital staff members can communicate effectively and at the same time they can reduce the chances of causing widespread panic and alarm among patients.

Acronymic initials used by doctors in the admission process are also a part of hospital folklore. FLK, for instance, means "Funny Looking Kid." This might be put on the record to indicate that the admitting doctor noticed something odd about the appearance of a child but also that he was unable to pinpoint exactly what it is. (It would not necessarily be written on the permanent record but rather on a temporary card in the Kardex file which is commonly used for quick reference by the staff to determine at a glance a patient's condition, diagnosis, prescribed medication, etc.) FLK is not really derogatory; it suggests rather that the diagnosis is incomplete. Such a label on the admitting card would alarm neither the patient nor the patient's parents.

Similar to FLK is the code acronym TSTSH which stands for "Too Sick To Send Home." This could also be used by a doctor in the admitting process when he finds himself unable to diagnose accurately the patient's condition. The code initials indicate only that the patient appeared to be too ill to be released and that the lack of a proper full-fledged

diagnosis should not be construed by a doctor entering the scene later to be grounds for assuming there was nothing wrong with the patient. Some of the acronymic folklore is never written. For example, there is ECU, Eternal Care Unit, which is a euphemism for death or the afterlife. Among hospital personnel, the question “Where is patient so-and-so?” might be answered, “He went to the ECU.” Another example of a traditional acronym is the triple H. HHH, at least in the past when enemas were quite commonly prescribed, stood for “high, hot, and a hell of a lot.” This term, in contrast to the preceding ones, could be revealed to patients.

Among the most interesting examples of hospital folk speech are those items which refer to patients, especially those patients who are incapacitated or who present particular problems for the hospital staff. A patient who has suffered extensive brain damage, for example, as the result of a severe stroke, may be termed a “vegetable.” The term suggests that although the patient is technically alive, he or she may be totally unable to speak and perhaps even unable to think. This term may be known by some members of the general public, but the term “gork” which means much the same thing is probably not. Thus a “gork ward” is a “vegetable garden.” Neither “vegetable” nor “gork” would ever be used in front of a patient or his family. According to one apocryphal story, a doctor visiting such a patient would daily ask the nurse, “Did you water the gork today?” and he did so in front of the patient. As it happened, the patient’s speech was impaired but there was nothing wrong with his mind. Eventually he recovered his speech faculties, and he brought suit against the doctor for having subjected him to unnecessary mental anguish, namely being termed a gork. This cautionary tale not only warns medical staff members about using in-group folklore in front of patients but it also expresses the increasing concern of doctors with the dangers of being named in malpractice or negligence suits filed by disgruntled patients. Clearly the term “gork” would never be put on a patient’s medical chart—unlike some of the acronyms discussed above.

Of all the terms used by hospital staff members to refer to patients, one of the most fascinating is “gomer.” The gomer is a stereotyped patient character known reluctantly by most doctors and nurses who work in what are called “high stress areas.” High stress areas are those units in a hospital where severely ill patients are found. Such areas include the intensive and coronary care units and, of course, the emergency room. Nowhere in the hospital are the energies and skills of the medical staff more in demand, and this is why there is great resentment among the staff if they feel their talents and dedication are being wasted on individuals whom they consider to be malingerers and hypochondriacs.

What precisely is a “gomer?” He is typically an older man who is both dirty and debilitated. He has extremely poor personal hygiene and he is often a chronic alcoholic. A derelict or down-and-outer, the gomer is normally on welfare. He has an extensive history of multiple admissions to the hospital. From the gomer’s standpoint, life inside the hospital is so much better than the miserable existence he endures outside that he exerts every effort to gain admission, or rather readmission to the hospital. Moreover, once admitted, the gomer attempts to remain there as long as possible. Because of the gomer’s desire to stay in the hospital, he frequently pretends to be ill or he lacks interest in getting well on those occasions when he really is sick. Often he appears to be confused and hostile—though he may be genuinely grateful for the care and attention he does receive. One must remember that most patients look forward to the day when they are able to leave the hospital. In contrast, the gomer looks forward to the day when he is readmitted to the hospital and dreads the day he may have to leave. This presents a frustrating problem for the

hospital staff, and it is no doubt this frustration which has encouraged the development of the folk figure of the gomer.

The gomer is reported in hospitals all over the United States.¹ Since the gomer is familiar primarily to doctors and nurses who work in high stress areas, he is found mostly in large county hospitals, Veterans Administration hospitals, and university teaching hospitals. The gomer is rarely encountered in private hospitals, which usually screen their patients very carefully before admitting them. Because of the gomer's inevitable lack of adequate financial resources, he is customarily rejected by private hospitals and sent to charity or public hospitals.

Informants were unsure about the origin of the term "gomer." Some mentioned Gomer Pyle, the name of the central character of a popular television series in the 1960s still shown on reruns in the 1970s. According to the *Dictionary of American Slang*, *gomer* or *gomar* is an Air Force slang term meaning "A first-year or naive Air Force cadet."² In the television series, Gomer Pyle was portrayed as a bumpkin and a loser (although sympathetically). The loser connotation would be akin to the gomer as he appears in hospital folklore. Other informants suggested a biblical source for the gomer (see Genesis 10:2-3; 1 Chronicles 1:5-6; Ezekiel 38:6; and Hosea 1:3), but this seems unlikely.³ It is possible though by no means demonstrable that the term derives from an older English slang abbreviation GOM meaning Grand Old Man. It is also conceivable that "gomer" is a modern derivative of such older words as Scottish *gomerel* meaning fool or simpleton or Anglo-Irish *gomus* meaning fool.⁴ There is also a word *gome* which may be cognate with Latin *homo* meaning man. A second word *gome* has a dialect meaning (listed as obsolete) referring to heed, attention, notice, or care. "To take *gome*" would thus mean to give heed or to pay attention to, or to take care of. If this is relevant, then a gomer might logically be an individual who needed attention and care, a meaning quite close to the current usage in American hospital folklore.

Several folk etymologies have been proposed for "gomer." Differing interpretations of the word as an acronym seem to fall roughly along geographical lines. On the east coast of the United States, gomer is explained as an acronym for "Get Out of My Emergency Room." On the west coast, the interpretation more usually advanced is "Grand Old Man of the Emergency Room." There is agreement, however, that gomer always refers to a man. (One informant claimed that the female version of a gomer was a "gomerette.")

It is difficult to determine just how long "gomer" has been a part of American hospital folklore. One report took it back at least to 1964 when it was used by medical students at the University of Washington in Seattle.⁶ Several informants thought they remembered its being used in the 1950s. Some doctors and nurses suggested "gomer" might be of recent coinage because until the advent of Medicare and comparable state programs, a "gomer" would not have been able to afford extensive and expensive medical treatment. Presumably as socialized medicine increases, the folklore of individuals perceived to be abusers of the system will develop. To the extent that a form of subsidized medicine has existed for some time, as in Veterans Administration hospitals (not to mention the venerable tradition of charity wards in major public hospitals), it is quite likely that "gomer" or some analogous folk expression has had a much longer life in tradition than we are able to document.

Although "gomer" appears to be the most common term in hospital argot for an unkempt, unsavory, chronic problem patient, there are others. Among the near synonyms are: "turkey," "crock," "trainwreck," "lizard," and "reeker."⁷ Three informants, all staff members of San Francisco General Hospital's Emergency Room, mentioned "grume" defining

it as a filthy “gomer,” in other words, an individual whose condition was even worse than the average “gomer.” “Grume” which comes from the Latin *grumus* meaning “little heap” can in medical parlance refer to a clot (as in blood). Folklorists may know the term from the phrase *grumus merdae* referring to the curious custom of some burglars leaving a “calling card” or pile of feces behind at the scene of the crime.⁸

Gomer’s pre-eminence as a term is attested to by its occasional occurrence in song⁹ as well as by its serving as the inspiration for derivative expressions. For example, one informant, a doctor who had worked in the emergency room at San Francisco General, reported that he had seen nurses there make what are called “gomersicles.” A gomersicle, an obvious popsicle oikotype, is made by freezing the patients’ orange juice on tongue depressors (which results in something resembling the various frozen desserts on a stick available commercially). These improvised snacks are then eaten by the doctors and nurses while they make rounds on patients they consider to be gomers. Normally doctors and nurses wouldn’t eat in front of patients, so the eating of gomersicles suggests a certain lack of respect toward gomers.

Generally speaking, “gomer” is a term used more by younger staff members. As a matter of fact, older hospital staff members and senior administrators tend to resent the use of the term. For example, a forty-one year old head nurse from the Yale-New Haven Hospital said, “The use of the term says more about the user than about the patient. It would be nice to think that it is only used by professionals when they are *very* tired and discouraged.” Older informants understood the reason for the term gomer, but they considered its use to be unprofessional and excessively cruel.

The resistance to the term—as well as to letting the outside world know about the existence of the term—created definite obstacles to the conduct of fieldwork. After Victoria George distributed questionnaires at a Veterans Administration hospital in the Bay Area, she received an irate telephone call from the Chief Nurse of the hospital, demanding to know who she was—she is in fact a Licensed Vocational Nurse although not at that hospital and what she was doing circulating such a disgusting questionnaire in *her* hospital. The Chief Nurse contended that the questionnaire and the proposed study were distasteful because “gomer” had such negative connotations. When Miss George suggested the possibility that the gomer may have originated in Veterans Administration hospitals, the Chief Nurse replied, “I’ve worked in hospitals in the midwest where I tried to stop people from talking about ‘gomers’ and having just arrived here [the San Francisco Bay Area] I have found that everyone talks about ‘gomers’ in the west too.” She continued, “It is the university doctors who bring the expression ‘gomer’ to the Veterans Administration hospitals, and I wouldn’t think my staff would say such things. It must have come from the University!” (This sentiment could, of course, have been partly a reaction to the fact that we were individuals from the University of California, Berkeley, who were making the inquiry about the gomer. In terms of projection, this makes perfect sense. Rather than have the University point an accusing finger at members of the medical profession for using such a calloused concept, a member of the profession was suggesting that it was the university community which was responsible for the term.) After the questionnaires—most of which were blank—were retrieved from this Chief Nurse, an interesting additional one was received through the mail from a nurse in the very same hospital. This nurse elected to answer the question “Where do you work?” by writing, “The V.A., home of the gomer.”

The particular association of the gomer with V.A. hospitals was confirmed by an expression elicited from a female intern who had been a medical student at a Veterans

Administration hospital in Omaha, Nebraska, in 1974. The expression “gomer patrol” referred to a group of rehabilitated gomers who came back to the V.A. hospital to take volunteer jobs sweeping the floors and the like because they very much wanted to be around the hospital and to be with their gomer friends. Other informants who knew the phrase “gomer patrol” indicated they had not heard the expression anywhere except in V.A. hospitals. The point is that even if the gomer did not originate in V.A. hospitals, there can be no question that the term is in common use in these hospitals. Administrators in such hospitals may do their best to stamp out such folklore (on the grounds that it is not in the best interest of projecting and protecting a favorable public image of doctors and nurses) but the gomer lives on—in fact and in folklore!

By a strange coincidence, it was in the same San Francisco Bay Area V.A. hospital where most of the questionnaires were returned blank that a “gomer assessment sheet” had been collected several years earlier in 1974.¹⁰ This assessment sheet was circulated to doctors and medical students on Sunday morning rounds which are often especially long and tedious. The gomer point list is a prime example of in-group xerographic folklore. Through humor, a feeling of in-group solidarity is achieved. The humor is at the expense of the patient and it is for this reason that many doctors and nurses would prefer the gomer point list to remain strictly within the group.

The gomer point list surely functions for medical students as a remarkable enumeration of many of the things which can go wrong in patient care or rather things that patients can do to make life difficult or unpleasant for the hospital staff. The list also reassures the medical student or intern that he is not the only one who has to contend with the array of problems and frustrations caused by gomers. The premise of the gomer point lists is that the examining doctor is supposed to grade the patient as to his degree of gomerism. No doubt this parody also provides a form of revenge for all the required charts and records that conscientious medical personnel are constantly filling out for gomers and other patients. There are many gomer point lists; no two are identical. Some have special rules; for example, point values may double after midnight. The following 1974 version is representative. Many of the abbreviations and terms will not be familiar to the lay person, but some, like “Pt.” for patient, or “dx” for diagnosis, will probably be intelligible enough without further explanation.

Gomer Assessment

<i>Characteristic</i>	<i>Assessed point value</i>
1. Transferred to another service on day of admission ¹¹	2
2. Stool found under dressing at first post op dressing changer ¹²	10
with no B.M.'s recorded	14
3. Chart weighs over two pounds ¹³	2
4. No known address other than other V.A. hospitals	6
5. Develops new complaint on evening of discharge ¹⁴	4
6. Returns from leave with hematoma beneath incision ¹⁵	4
7. Attempt at discharge by resident fails	6
each additional failure	2
8. Pt. has seizure or hematemesis while checking out clothing for discharge ¹⁶	5
9. Pt. sent to ward by admitting physician with dx which pertains to organ system actually involved	-3

10. If diagnosis by admitting physician is correct	-5
11. Unemployed because of low back pain since: ¹⁷	
Korean War	1
WW II	3
WW I	8
Spanish American War	15
Civil War	25
If due to arrow wound	50
12. Pulls I.V. out ¹⁸	6
If in full restraints with teeth	15
If edentulous	20
13. Removes Foley catheter with bag inflated ¹⁹	9
5 cc bag	10
30 cc bag	30
In full restraints	additional 10
14. Urinates on physician	10
on nurse	8
on orderly	6
on medical student	4
15. Defecates in doctor's bag	with honors 23
16. Patient visited by American Legion	1
each additional visit	1
visited by VFW	1/2
by VFW auxiliary	3
17. Pt. writes irate letter to American Legion on discharge	8
to Congressman	10
18. Pt. gets Foley drainage tube tied into pajama tie	10
19. Pt. has tracheotomy performed because of inability to trigger IPPB ²⁰	12
20. Past history reads "See old chart" ²¹	1
21. Concentration of Airwick required in patient's room causes conjunctivitis among visiting personnel ²²	4
22. Patient answers all questions asked to any other patient on open ward	11
23. Patient drinks from urinal	12
from another patient's urinal	14
24. Resident irately calls admitting when patient arrives on ward ²³	6
25. Pt. fractures hip while leaving hospital	8
26. Remains in hospital through entire resident rotation ²⁴	10
each additional rotation	15
27. Service connected syphilis contracted before 1935	13
28. Unable to do B.E.; pt. returned to ward ²⁵	7
29. Films have to be repeated more than twice	2
each additional repeat	2
30. Films acceptable on first try	-5
31. Admitted with diagnosis of ataxia manifested by scratch marks on forehead secondary to attempts at nose picking ²⁶	13
32. Refused admission at another VA hospital before being admitted	2
each additional hospital	2

33. If Foley catheter is under more than 10 lbs. of traction without complaints from patient	11
34. Toenails cannot be cut with clippers, chisel or drill	7
35. Semiformed guaiac positive stool found more than 7 1/2 ft. from bed of source ²⁷	9
each additional foot, add	1
each wall or window, add	3
on sidewalk below window near bed	14
36. Any two of the following: beard, lice, jaundice, disorientation, dacubiti, fecal impaction, ETOH on breath ²⁸	4
37. Regulates his own I.V.	4
other patients' I.V.'s	4
38. Bites bulb off of oral thermometer	3
rectal thermometer	4
another pt.'s rectal thermometer	11
39. Found in another patient's bed ²⁹	3
each additional pt. in bed	3
40. Drinks after shave lotion purchased in canteen	5
each additional bottle	3
41. Pt.'s status prompts investigation by American Legion	6
42. Frequently overlooked on rounds ³⁰	3
43. Asks for schedule of American Legion movies on initial workup ³¹	1
44. Source of admitting history is patient's mistress	4
patient's mother	7
45. Admitting orders include, "Bath, STAT" ³²	5
46. Patient eats pajamas	11
another patient's pajamas	13
47. Found in hallway without pajama bottoms	10
48. Loses more than 20 lbs. of adm. weight when put on diuretics ³³	14
49. Found with dentures in upside down	7
50. Develops chemical tracheitis secondary to aspiration of a fly ³⁴	11
51. Decubitus on occipital protuberance ³⁵	11
52. Defecates in or on bed of another pt.	14
if while in bed with another pt.	19
53. Pt. irately asks "on what grounds" when told that he is going to be discharged ³⁶	10
54. Pt. states "I'm a disabled American Veteran" when irate resident, intern or medical student is called at 3 AM to restart I.V. pt. has pulled out while having the DTs ³⁷	17

Gomer point lists circulate in typewritten or xerographic form. It would be truly astonishing to find any individual who had committed to memory any of the more extensive versions. At Presbyterian Hospital in San Francisco in 1976, informants in the absence of a written list could remember only the following gomer items (which one can easily see are much less detailed than are the analogous offenses in the preceding text).³⁸

1.	Drinking own urine	2
2.	Drinking roommate's urine	4
3.	Drinking from urinal while restrained	6
4.	Having a seizure without dropping a cigarette ³⁹	10
5.	Admitting note ends with "sorry"	10
6.	Climbing out of bed	2
7.	Climbing out of roommate's bed	4
8.	Biting through intravenous tubing	8
9.	Long yellow fingernails	6
10.	Toenails that curl under	6
11.	Covered with feces that is five or more days old	10
12.	Attempting to eat plastic silverware	8
13.	Admitted to nursing home before the age of 40	10
14.	Wearing patient gown backwards	4
15.	Positive O sign ⁴⁰	6
16.	Positive Q sign ⁴¹	8
17.	Pulling out Foley catheter	5
18.	Pulling out Foley catheter with balloon up	7
19.	Defecates in medical student's bag	15
20.	BUN higher than IQ ⁴²	10
21.	Drinks out of toilet when NPO ⁴³	10
22.	Lice on patient survive 5 Kwellings ⁴⁴	12

These gomer point lists provide a very vivid and graphic portrait of the gomer. Several informants mentioned "gomer Olympics" with awards (medals) for patients who vomited the farthest or for patients who made the greatest number of suicide attempts in one week. This may be sick humor, but it is, after all, humor which is literally a response to sickness. Doctors and nurses are humans like everyone else and they need folkloristic outlets for the expression of their anxieties just as the members of any folk group do.

It is not hard to understand why medical practitioners might feel anger and hostility toward individuals who demand and often receive a disproportionate amount of the precious time and energy of the hospital staff. Why should doctors and nurses have to care for someone who evidently cares little or nothing about himself? No matter what is done for such patients, they will only return again and again to the hospital admitting room in the same miserable, unfortunate condition. In fact, the logic could easily be: the better the care in the hospital, the sooner the gomer will return to plague the staff once more. In contrast, there is presumably an incentive to cure a normal pesty or pesky patient. The sooner he or she is cured, the sooner he or she can be released from the hospital. This is decidedly not the case with the gomer. There seems to be no way of escaping permanently from such patients. Creation of the gomer figure and compiling gomer point lists is one of the few available defenses against this deplorable situation.

Other possible factors contributing to the tension existing between hospital staff members and gomers include critical differences in class and values. On the whole, doctors tend

to come from affluent families, and they may not be accustomed to seeing or interacting with the “dregs of society” on a regular basis. Like other members of the middle or upper class, doctors may resent the gomer in part because he is perceived to be a creature or product of the welfare state. The gomer is considered to be a Medicare abuser, and it is the tax monies paid by doctors themselves, among others, that presumably pay for the care of such patients.

Gomers create stress in the hospital setting. In theory, doctors and nurses are pledged to offer the finest medical care they can to patients regardless of these patients' ethnic, religious, social and personal characteristics. Yet in practice, the personal hygiene and habits of the gomer are so repugnant and distasteful as to prove offensive even to the most hardened and dispassionate staff member. The inevitable stress in any doctor-patient relationship resulting from the anxiety which accompanies illness and its treatment is greatly exacerbated by the wretched and foul condition of the gomer. As folklorists we know that the greater the stress, the greater the need for folklore to relieve the pressures caused by that stress. The gomer as a figure of American hospital folk speech provides an esoteric socially sanctioned outlet for such pressures. The gomer as a shared folk concept tends to unite the hospital staff. Any in-group is likely to be strengthened by concentrating upon creating a stereotype of the out-group. So doctors and nurses need to have stereotypes of patients. It has long been known that patients need to resort to stereotypes about doctors and nurses. For example, it has been observed that patients' jokes such as the story of the nurse who wakes you up to give you a sleeping pill are not new, but are part of hospital folklore.⁴⁵ The point is that it is just as necessary and normal for medical practitioners to have folklore about patients.

Although the expression “gomer” would never be used directly to a patient or even in front of him or members of his family, it is possible notwithstanding that at times the gomer does sense the attitude of the staff toward him. In any case, the idealized stereotypes of doctors and nurses held by most patients and to some extent the doctors' and nurses' own professional behavioral code requires the suppression of emotion. Doctors and nurses are supposed to be cool and calm no matter what the medical crisis may be. The patient known as a gomer severely tests this professional facade with its requisite politeness and “bedside manner.” As long as such patients exist, the gomer and other forms of American hospital folklore will continue to thrive. Like so much of folklore, the gomer and specifically the gomer assessment point list offer a safety valve opportunity for ritual reversal. The more disastrous and disgusting the behavior, the more points are assigned. Unrewarding activities are rewarded through the magic mirror of folklore, and for a much needed moment in the unremitting strain of hospital routine, human tragedy is miraculously translated into human comedy.

Notes

1. Information was obtained by sending questionnaires to eight hospitals in five major American cities. Sixty-three questionnaires were filled out and returned by personnel from Yale-New Haven Hospital, Albany Medical Center, Millard Fillmore Hospital in Buffalo, University of Utah Medical Center in Salt Lake City, and from the following four hospitals in San Francisco: University of California Medical Center, Veterans Administration Hospital, San Francisco General Hospital, and Presbyterian Hospital of the Pacific Medical Center. We wish to thank all of the individuals who were kind enough to take the time to complete the gomer questionnaire. It should be noted that the geographical range of the data collected is much greater than that suggested by the list of hospitals above inasmuch as doctors and nurses move relatively

- freely from one part of the country to another. Responses to the question where the informant had first heard of the gomer elicited no less than thirty-six different places.
2. Harold Wentworth and Stuart Berg Flexner, *Dictionary of American Slang* (New York: Thomas Y. Crowell, 1967), p. 687.
 3. Nevertheless, it is interesting that Andrew Borde in 1552 in *The breviary of health* claimed that “gomer passion,” by which he apparently meant such supposed sexual anomalies as masturbation and nocturnal emissions, was derived from the earlier sin of the people of Gomorrah. See Robert H. MacDonald, “The Frightful Consequences of Onanism: Notes on the History of a Delusion,” *Journal of the History of Ideas*, 28 (1967), 431. The more general connotations of “self-abuse,” a conventional euphemism for masturbation, might well apply to the modern gomer who makes little effort to take care of himself.
 4. We have relied upon the *Oxford English Dictionary* (1933) for our discussion of *gomerel* and *gome*. For *gomus*, see also J. S. Farmer and W. E. Henley, *Slang and Its Analogues* (New York: Arno Press, 1970).
 5. This might seem to suggest that the west is a bit more tolerant and hospitable than the east! One informant could recall only a portion of what she remembered of a different acronymic referent: “Goes Out _____ Repeatedly.” The variation in alleged referents of course confirms the overall traditionality of the word “gomer.”
 6. This information was collected in December 1964, by M. Patricia Miller from Susan Halverson who was at that time a Registered Nurse in Oakland, California.
 7. A turkey is a patient who is feigning illness and/or has an obnoxious personality. A crock is also a patient pretending to be sick. Crock implies lie, as in the more general idiom “a crock of shit.” A trainwreck is someone who is *very* sick. He has several medical problems simultaneously and he is usually comatose. A lizard is a physically dirty patient with scaly skin. A reeker is a dirty patient with a strong disagreeable body odor.
 8. See Albert B. Friedman, “The Scatological Rites of Burglars,” *Western Folklore*, 27 (1968), 171–179; and Theodor Reik, *The Unknown Murderer* (New York: International Universities Press, 1945), pp. 76–81.
 9. The following parody of the “Twelve Days of Christmas” was collected by Victoria George from the San Francisco General Hospital Emergency Room in 1977. Written by nurses Lauren Lockridge and Philis Harding, it contains a number of examples of hospital folk speech:

On the twelfth day of Christmas
 Central sent to M.E.H.
 Twelve ‘terns a’flailing
 Eleven blades a’cutting
 Ten grumes a’scratching
 Nine turkeys seizing
 Eight pelvics waiting
 Seven psychs a’screaming
 Six stabs a’swearing
 Five P.I.D.s
 Four D.O.A.s
 Three flail chests
 Two “H” O.D.s
 and a gomer in the D.T.s

For the benefit of readers unfamiliar with medical argot, Central Emergency has sent the following to Mission Emergency Hospital: Twelve interns are flailing about, that is, acting in a frantic way to no useful purpose. Eleven surgeons are performing with scalpels. Ten grumes (extra filthy gomers) are scratching to relieve their itching. Nine turkeys are having or are pretending to have seizures. Eight women are waiting to have pelvic examinations. Seven psychotic patients are screaming. Six victims of stabbing are cursing. Five women have pelvic inflammatory

disease. Four individuals are brought in "Dead on Arrival." Three individuals are brought in with flail chests, that is, with crushed rib cages. Two drug users who overdosed with Heroin are admitted. A gomer suffering from delirium tremens is the first to enter the emergency room, a fact which signals the importance of the gomer in hospital life.

10. This excellent text was collected in March 1974, by Jo Anne Morrow from William Cory who was then a medical student in San Francisco.
11. Rather than burden those readers who may already be acquainted with hospital routine by repeatedly interrupting the text with bracketed explanations, we have chosen instead to place brief explanatory remarks in footnotes for those who desire further information about abbreviations and medical procedures. The transferral to another service means that the patient upon admission presented a complaint, but the doctor later found something entirely different. (Or it could refer to the fact that when an examining doctor investigated an initial complaint he found it to be groundless, whereupon the patient registered a new complaint requiring a transfer to another service and a different examiner.)
12. This means that the patient somehow managed to place feces under his sterile dressing after surgery and before the doctors changed it a few hours later. Such a patient would probably be in a confused state.
13. The excessive weight of the chart implies that the patient has been in the hospital a long time, long enough to have accumulated a very extensive chart.
14. When the patient discovers he is scheduled to be released, he finds another symptom so that he can stay longer in the hospital.
15. A hematoma is a tumor containing effused blood or what in lay terms is called a bruise or swelling. The implication is clearly that the patient didn't take very good care of himself.
16. Hematemesis means vomiting blood. This and seizures are considered serious medical problems, and either would require additional hospitalization.
17. Many doctors and nurses tend to consider low back pain as an attention-getting device rather than a legitimate complaint.
18. I.V. means intravenous.
19. A Foley catheter is a tube inserted into the urethra extending into the bladder for the purpose of draining the bladder of urine. A balloon is attached to the end of the tube that is in the bladder to hold it in place. It is quite painful to pull out.
20. A tracheotomy is the surgical creation of an opening into the trachea (windpipe through the neck. Through a tube which is inserted in this opening, the patient breathes. IPPB is an abbreviation for the Intermittent Positive Pressure Breathing machine which is started by the patient taking a deep breath through a mouthpiece. If a patient were unable to do this, doctors might well perform a tracheotomy.
21. Old chart is a record of past hospitalizations. If a patient came in with the same problem repeatedly, a doctor might make this notation. The implication is also that the patient has a very extensive past history. In theory, a doctor should always make a new examination and record a current history, but when confronted with a gomer, a doctor might be sorely tempted not to bother.
22. Conjunctivitis is an irritation of the mucous membrane of the eyes. Airwick is a commercial brand-name air freshener designed to remove or conceal unpleasant odors. A strong deodorizing agent, Airwick in *very* concentrated form could cause eye irritation. The reference is, of course, to the foul smell of the gomer caused by his poor personal hygiene.
23. The doctor is angry because he feels that this patient has been admitted unnecessarily.
24. A resident's rotation is usually of six weeks duration which would mean a fairly protracted hospital stay for the patient.
25. B.E. refers to a barium enema. Barium sulfate is used in a standard X-ray procedure to visualize the digestive tract including the colon. In order for a clear X-ray picture to be taken, the colon must be free of fecal matter. Most patients are easily prepared for this through diet and/or laxatives. Some gomer types, however, are very full of stool and the test has to be repeated again and again. Not until the gomers have evacuated their colons completely are there likely to be

- successful X-ray films. (The reference in the next entry to repeated films has to do with the same problem.) The time required for the gomer to prepare himself sufficiently for the barium enema may thereby entail an extra day or two in the hospital.
26. Ataxia is a failure of muscular coordination resulting in irregular muscular action. Presumably a patient with this condition desiring to pick his nose might miss, causing scratches on his forehead. The image evoked is similar to the Polack joke: How did the Polack get 35 holes in his head? Trying to learn to eat with a fork. See Alan Dundes, "A Study of Ethnic Slurs: The Jew and the Polack in the United States," *Journal of American Folklore*, 84 (1971), 201.
 27. Guaiac is a test to determine whether there is blood in the feces. Guaiac positive means that blood is present. Most gomers are alcoholics and bleeding problems are common enough among severe alcoholics.
 28. A decubitus ulcer is a bed sore. It is caused by prolonged pressure resulting from a patient's confinement to bed for a long period of time. ETOH means alcohol.
 29. This refers to a patient's being disoriented or confused.
 30. This suggests the patient has been there so long that the doctors have nothing more to say about him and see little point in checking him.
 31. The implication is that if a patient is well enough to want to know what movies are playing, he is probably not sick enough to warrant being admitted, and he is simply using the hospital as a recreation center.
 32. STAT means immediately if not sooner—from the Latin *statim*. The patient is so dirty that the admitting doctor is unable to examine him thoroughly.
 33. While it is likely that a gomer might be suffering from fluid buildup, losing twenty pounds through diuretics is probably a facetious allusion to the gomer's having been on a liquid diet before coming to the hospital, the liquid being some form of alcohol!
 34. The patient has an infected trachea (windpipe) as a result of having inhaled a fly.
 35. This is a bed sore on the back of the head. It implies that the patient has been lying down in bed absolutely supine for an extended period of time.
 36. The patient does not want to be released from the hospital.
 37. D.T.s means delirium tremens, a condition marked by sweating, trembling, hallucinations, etc., caused by excessive drinking of alcohol.
 38. This gomer list was collected orally by Victoria George from her colleagues. The various details were elicited individually from different informants.
 39. If an individual were really having a seizure, it would be impossible for him to hold on to a cigarette. The description means that the patient is only pretending to have a seizure.
 40. This refers to the mouth positioning of a sleeping or comatose patient. Specifically, the mouth is slightly open and more or less in the shape of an O. In some versions, it signifies that the patient is totally unresponsive and that he may be about to die.
 41. This is a variant of the previous sign. The patient's mouth hangs open in the shape of an O but in this case his tongue is hanging out, suggesting an overall configuration of Q. The Q sign indicates a more serious condition than the O sign inasmuch as the protrusion of the tongue may signify the loss of muscular coordination.
 42. BUN, an abbreviation for blood urea nitrogen, is a test which provides an index of renal function. Since many gomers have poor renal function, their BUN would be high. Normal results are 18–22 so that even a high BUN figure would be far less than the average IQ of 100. An IQ lower than a BUN would be low indeed.
 43. NPO means nothing by mouth (*nihil per os*), that is, the patient is to have nothing to eat or drink.
 44. Kwell is a commercial brand of lindane, a preparation used in treatment of scabies and pediculosis (lice infestation). It is a fairly strong agent which normally kills lice with one application.
 45. Rose Laub Coser, "Some Social Functions of Laughter: A Study of Humor in a Hospital Setting," *Human Relations*, 12 (1959), 176. For more examples of hospital folklore see Lois A. Monteiro, "Nursing-Lore," *New York Folklore Quarterly*, 29 (1973), 97–110.

B

“When You Hear Hoofbeats, Think Horses, Not Zebras”: A Folk Medical Diagnostic Proverb

IN 1995, A CASE HISTORY was reported in the *Journal of Clinical Endocrinology and Metabolism* entitled “Sometimes the Hooves Do Belong to Zebras! An Unusual Case of Hypopituitarism.” In 1993, a guest editorial “Horses and Zebras” in *Regional Immunology* offered alternative explanations for immune regulation in lungs. In 1992, Drs. Stephen G. Pauker and Richard I. Kopelman published a case history in the *New England Journal of Medicine* “Interpreting Hoofbeats: Can Bayes Help Clear the Haze?” They recommended the use of “Bayes’ rule” which refers to the likelihood of disease in a patient with a given set of findings being estimated as the proportion of patients with the same findings who also have the disease, and this inspired a letter to the editor by Dr. Otto Kuchel. This letter, accompanied by a response from the authors, appeared a year later in the same journal. In none of these three instances is the reference to hoofbeats, horses and zebras in any way explained. The clear implication is that readers of these technical case histories, that is, members of the medical profession, are thoroughly familiar with a traditional metaphor involving hoofbeats, and that therefore no explanation of the metaphor is necessary.

In 1993, a case history contained originally in Kenneth Klein’s *Getting Better: A Medical Student’s Story* (1981:93, 95–96) was reprinted in *Health* but with a new title: “When You Hear Hoofbeats, Think Horses, Not Zebras: Case No. 1478.” The title is not explained, but the case well illustrates the sense of the expression. It involved a woman who hadn’t had a period for over three months. At the time Klein was a young inexperienced medical student who tried to impress his supervisor by rattling off a series of possible diagnoses along with various tests that might be run in order to confirm or disconfirm them. His supervisor’s response: “Whew! That’s a very nice differential diagnosis, but you forgot an important cause of secondary amenorrhea, in fact the most common one. Remember, in medicine common things are common. What’s the first test to do before you get all those fancy hormone assays?” Klein racked his brains but could not think of anything else. His supervisor had to tell him which test to run. “Half an hour later, the pregnancy test came back positive.” The moral is clear: Klein had proposed zebras when he should have been thinking horses!

In 1996, Kathryn Hunter in an essay in *Theoretical Medicine* devoted entirely to a discussion of the proverb claims that “When you hear hoofbeats, don’t think zebras” is clinical medicine’s most frequently heard maxim (1996:225). But she astutely points out that the aphorism paradoxically contains the seeds of its own negation. There wouldn’t be any point in attempting to dissuade doctors from thinking zebras if there were not an obvious tendency to do so. It is rather analogous to understanding that the Ten Commandments plainly refer to wishful thinking on the part of all those who adhere to the religious faiths

based on the Decalogue. There would be little point in forbidding behavior for which there was no desire to indulge. Hunter describes the paradoxicality of the maxim very well indeed: “. . . the zebras are there, unforgotten, unforgettable, right in the aphorism. Not only does the advice generate its own contradiction among the young, but as a reminder to forget, it is paradoxical in itself. As long as the injunction not to think zebras comes to mind, zebras cannot be unthought. Physicians think zebras as they think not to think them” (1996:2128). And certainly the vast majority of the various communications in medical journals referring to “zebras” would tend to support Hunter’s argument.

In 1995, in a chapter of his book, *The Man Who Grew Two Breasts* which bears the title “The Hoofbeats of a Zebra,” Berton Roueché describes the sad case of a young woman whose myasthenia gravis went undiagnosed for some years until one doctor finally recognized her symptoms. The doctor who had had a long-standing special interest in the disease explained his success: “There is a saying about diagnosis—about why doctors often fail to recognize one of the less-common diseases. It goes: When you hear hoofbeats, you don’t necessarily think of a zebra. I recognized the hoofbeats of a zebra. That was my only magic” (1995:175).

In 1996, Dr. Charles Davant in an article in *Medical Economics* entitled “When You Hear Hoofbeats, Sniff the Air,” referred to “the old saw—think horses, not zebras, when you hear hoofbeats” (1996: 107). But after presenting several case histories encountered as a family physician in Blowing Rock, North Carolina, Davant takes issue with the advice articulated in the “old saw” when he concludes “As I’ve always maintained hoofbeats sometimes *do* belong to zebras” (1996:114). In 1997, virologist C. J. Peters chose to title the prologue to his fascinating autobiographical account of his lifetime of tracking virally caused infectious diseases “The Hoofbeats of Zebras.” Peters begins his book “There’s an old adage in medicine that goes something like this: *Common things occur commonly. Uncommon things don’t. Therefore, when you hear hoofbeats, think horses, not zebras* (1997:1). Hunter offers another version of the first portion of the adage: “Uncommon presentations of common diseases are more common than common presentations of uncommon diseases” (1996:227). But Peters as a medical specialist, tends to be more concerned with zebras than horses. In his words, “I didn’t want to be overly alarmist, because I knew very well that most hoofbeats in our neck of the woods come from horses . . . But what if the hoofbeats we were hearing weren’t from the proverbial horses? What if it was zebras after all?” (1997:261, 19). Pauker and Kopelman end their 1992 communication with a stronger warning: “Hoofbeats usually signal the presence of horses, but the judicious application of Bayes’ rule can help prevent clinicians from being trampled by a stampeding herd that occasionally includes a zebra” (1992:1013). Similar caution is urged by Dr. Alan J. Waldman of the Department of Psychiatry at the College of Medicine at the University of Florida. His 1992 letter to the *Journal of Neuropsychiatry*, starts with “A classic axiom taught to virtually all medical students, especially during their internal medicine rotation is ‘When you hear hoofbeats, think of horses and not zebras.’” But Waldman continues, “Yet in the practice of neuropsychiatry one must be continually aware that the hoofbeats may in fact not be horses” (1992:113). He then proceeds to demonstrate the validity of his caveat by reporting two case histories where what appeared initially to be psychiatric symptoms proved to be the results of relatively rare metabolic disorders.

In yet another attempt to counter the alleged wisdom of the proverb, this time from the area of dermatology, Dr. Richard W. Sagebiel, writing an editorial in the *Journal of the American Academy of Dermatology* in 1995 entitled “Who needs zebras?,” begins by claiming that few medical students avoid the obligatory saying, “When you hear hoofbeats, think

horses, not zebras.” He calls it a “perpetuated cliché” which encourages “sloppy thinking.” He is particularly concerned with a medical “zebra” called desmoplastic neurotrophic melanoma (DNM). Admitting that it is “uncommon, perhaps rare, and difficult to diagnose,” Sagebiel nevertheless urges his colleagues to be on the lookout for it. In his words, “Few among us look at a nonpigmented ‘scar’ and think DNM. And yet if we do not begin to pay attention to the ‘zebras’ of diagnosis, then as consultants we will be replaced by generalists who will think ‘horses’” (1995:800). Specialists’ fear that they might be replaced by generalists who are deemed incapable of distinguishing the more exotic zebras from the commonplace horses seems to be quite widespread, judging from the number of communications found in so many medical journals, especially those serving as the principal forums of specialized medical practitioners, urging that one cannot ignore the seriousness of failing to recognize life-threatening zebras. Indeed, it would appear that the original medical school aphorism advising newly educated doctors to think horses rather than zebras has been virtually repudiated insofar as the conventional wisdom seems rather to propose the opposite: think zebras, not horses!

It is difficult to ascertain just how old the hoofbeats proverb is. Samuel Shem in his best-seller *The House of God*, a fast-paced novel describing the rigors and horrors of being an intern after completion of medical school first published in 1978, refers disparagingly to a typical medical student when he “hears hoofbeats outside his window, the first thing he thinks of is a zebra” (1998:46). There can be no question about the meaning of “zebra” in this context as Shem provides a helpful glossary of terms as an appendix to his novel where zebra is defined as “an obscure diagnosis” (1998:429). Elsewhere in the novel, the protagonist doctor reports that he learned more about functioning in the intensive care unit from the experienced night nurse than he had in his “four rarefied” medical school years which were filled with details of “zebraic diseases” (1998: 335). Yet this term “zebra” most often heard initially in the course of a medical school internship or residency, that is, during the early stages of training, not surprisingly is older than 1978. A retired cardiologist in Berkeley, California, reported in 1998 that he had learned the following dictum at Cincinnati General Hospital circa 1960: “If you hear hoofbeats behind you, don’t turn around and expect to see zebras.” Hematologists at Johns Hopkins Hospital confirmed this approximate dating of the dictum, and it is very likely that the expression is considerably older than 1960.

Although the proverb seems to be largely confined to the medical community and is not widely known to the general population, there is some slight evidence that it may have diffused outside the world of medical practice. For instance, Shems Friedlander’s book *When You Hear Hoofbeats Think of a Zebra* first published in 1987 contains no reference whatsoever to anything remotely related to medicine. The book is a literary polemic advocating Sufism and the title is meant merely to encourage the reader to stop thinking in old tradition-bound ways and to start trying to gain knowledge of Allah through Islam and Sufism (Friedlander 1987:1). On the other hand, the fact that the proverb seems to be largely restricted to members of the medical profession may explain why it is not to be found in Charles Clay Doyle’s valuable 1996 listing of “new” proverbs of the twentieth century.

The ostensible meaning of the proverb in its more familiar medical context is to warn medical students about the dangers of looking too hard for esoteric rare diseases, thereby perhaps resulting in the overlooking of the most obvious and common diagnosis indicated by the symptoms manifested by the patient. There is another proverb employed by physicians which conveys the same message: “It’s always darkest at the foot of the lighthouse.”

The proverb's meaning is that things that are common and should be easy to see are often overlooked in favor of the remote. This proverb which is found in general usage, not just in a medical context, exhibits various forms, as does all folklore, e.g., "It is always dark just under a lamp" or "It is always darkest under the lantern" (Mieder 1992:134) and it is also known in Japan "The base of a lighthouse is dark" (Mieder 1986: 278).

The advice is also reminiscent of that offered by "Occam's razor." William of Occam, an early fourteenth century English philosopher, (c. 1285–1349), is credited with articulating the principle *Entia non sunt multiplicando praeter necessitatem* which literally translates roughly as "Entities should not be multiplied without necessity." However, the general agreed-upon meaning, according to the *Oxford Dictionary of English Proverbs*, is that: "for purposes of explanation, things not known to exist should not, unless it is absolutely necessary, be postulated as existing." In other words, the simpler explanation is always to be preferred over a more complex one.

The problem with Occam's razor is that simple solutions to complex problems do not always suffice. And the same holds for the hoofbeats proverb. Sometimes, it does turn out that the hoofbeats were made by zebras, not the more common horses. Some doctors have even had their own very personal experience in the fallacy of always assuming horses rather than zebras. For example, Dr. John H. Frierson writing in the *Virginia Medical Quarterly* in 1995 provides a telling illustration. "It started out," he says, "as a sore right shoulder which I attributed to a combination of golf practice and yard work." At the suggestion of a physiatrist who made a provisional diagnosis which included bursitis, he tried physical therapy which did afford some temporary relief, but soon thereafter the symptoms moved to his left shoulder and then down to both legs. "At its peak," Frierson reports, "I was a virtual cripple." Finally, a neurologist helped make the correct diagnosis of polymyalgia rheumatica (PMR), and a rheumatologist then prescribed prednisone and a single dose completely relieved all the soreness and stiffness. Frierson's conclusion: the initial diagnosis of a quite common ailment such as bursitis had been a mistake. "No consideration was given to the rarer 'zebra' diseases, i.e., PMR. As a result time was lost in making the diagnosis" (1995:79). Frierson's final advice: "So watch out for the 'zebras.' They're out there and they'll getcha!"

How the dilemma in choosing the proper diagnosis on the basis of just hoofbeats can be exacerbated is illustrated in the following narrative:

Late at night in an institution—presumably a famous teaching hospital—an internist and a family practitioner are sitting in the on-call room and hear the unmistakable sound of hoof beats in the hallway. They both look up at each other, and the family practitioner says, "My God! Horses?" And the internist cocks his head, listens for a second more and says, "No, Zebras" (Prasad 1998:19).

In this text, there is a clear opposition between the generalist and the specialist. The generalist interprets the hoofbeats as being those made by horses. This is the obvious, more common inference to be drawn. However, the generalist does not simply assert his conclusion. Rather he puts his remark in the form of a question, as if asking for confirmation from the specialist. The internist, the specialist in this instance, listens further apparently utilizing his greater knowledge of such phenomena before correcting his generalist colleague by pronouncing the hoofbeats as those made by zebras. The explosion of medical knowledge has made it more and more difficult for general practitioners to keep pace with all the new advances made in all branches of medical research. The corresponding increase in the

number of specializations in medicine has created an even larger gap between members of such specializations and the old-fashioned general practitioner. A zebra belongs to the *equus* family, but it is rather a distinctive example with its striking black and white stripes. Presumably it takes a highly experienced ear to be able to distinguish the sound of exotic zebra hoofbeats from those made by ordinary garden-variety horses. And that is precisely why the metaphor is so apt. Of course, the very idea of being able to make any kind of an educated guess as to the identity of an animal solely on the basis of the sound of hoofbeats is itself a bit of folkloric fantasy attesting to the very real difficulties faced by physicians who are often asked to diagnose illnesses without very much in the way of defining symptoms.

So what can we conclude about the dictum, aphorism, adage, proverb: When you hear hoofbeats, think horses, not zebras? Is it true folk wisdom, in this instance, true folk medical wisdom with respect to the difficult task of making diagnoses from limited data? The answer to this question turns on the very nature of the proverb genre. Proverbs contain relative, not absolute wisdom. The wisdom is always contingent on time and place, in short, on context. The very existence of contradictory proverbs in many languages and cultures demonstrates the relativity of proverbial wisdom. "Look before you leap" recommends caution before action; "He who hesitates is lost" advocates an opposite course. "Absence makes the heart grow fonder" is poor solace for the cynical "Out of sight; out of mind." Hunter reminds us: "They say you can't teach an old dog new tricks" and "You're never too old to learn" (1996:239). With the understanding that proverbial wisdom is always bounded by contextual considerations, we can see that "Think horses" might be good advice for young doctors who have just completed medical school and inevitably have been introduced to a plethora of rare and esoteric diseases. On the other hand, more experienced medical practitioners who are well aware of the greater statistical frequency of "common" diseases should remain vigilant for the possibility of a zebra occurring on occasion among herds of horses.

The importance of context also is apparent in consideration of two co-existing yet contradictory modern phenomena: defensive medicine and managed care. In the case of the former, physicians may conduct tests or procedures to investigate the possibility of a zebra which, if overlooked, could result in a lawsuit. The other force, managed care, which controls spending by closely monitoring physicians' treatment of patients, encourages the interpretation of hoofbeats as horses to avoid unnecessary spending with a low probability of finding a zebra. Thus, doctors must consider the adage amidst constraints which include the threats of malpractice if zebras are ignored and refused reimbursement if zebras are sought.

The issue of general practitioner or generalist versus specialist is not so easy to resolve. Clearly, patients need both kinds of physicians. The rapidly expanding universe of information relevant to a particular disease is such that only a specialist can possibly keep up. No one physician can possibly be expected to have total knowledge of all areas of medical practice. So by definition, a generalist's competence in any one area cannot match that of the qualified specialist. On the other hand, the whole is always greater than the sum of its parts. Partial knowledge, no matter how great, may not necessarily lead to the optimum treatment. If one asks a surgeon for advice, the recommendation is very likely to be for surgery! A general practitioner who can synthesize the sometimes contradictory counsel of specialists remains critical for ideal patient care. So in that sense, when one hears hoofbeats, one should not really choose between assuming either horses or zebras, but one should rather in the best interest of the patient consider both alternatives.

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