The use of pejorative terms to describe patients: "Dirtball" revisited

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Background: The use of pejorative terms for patients is well documented. Reasons include frustration and anger in managing certain patients, fostering group solidarity among caregivers under stress, and the alleged "dehumanization" of medical training. Medical students were surveyed to document and understand the phenomenon.

Methods: The 1988, 1989, 1990, and 1996 Johns Hopkins University Medical School graduating seniors were asked about their attitudes towards such use and about the nature of medical school.

Results: Class response rates varied from 75% to 95%, with 8% to 13% of respondents recording having heard no pejorative terms. The reported number of different terms declined during the period from 75 to 55, as did use of "dirtball" and "gomer." Only 2% to 13% of particular classes considered such usage to be helpful, whereas 30% to 50% considered it harmful. Pejorative terms were used most frequently for self-destructive or abusive patients. From 12% to 24% of students thought medical school to be humanizing; 10% to 24%, dehumanizing; and 38% to 59%, both.

Conclusion: Most students had heard pejorative references to patients, but few thought the practice useful. Monitoring such usage may help identify individual or institutional problems and lead to better management strategies for certain subgroups of patients.

"Dirtball" (1), written pseudonymously in 1982, resulted from a meeting with a student seeking an internship recommendation. Asked about an instance in which medical care had proved frustrating, he used the term "dirtball" to describe a patient who had signed out against medical advice. Our discussion prompted reflections on why otherwise compassionate caregivers used such pejorative terms and why the 1978 book, *The House of God* (2), had achieved cult status among houseofficers.

The book's narrator recounts his internship and idolatry of the "Fat Man," a cynical resident who promulgates 13 laws including "the only good admission is a dead admission." The houseofficers refer to patients as "gomers" (translated as "get out of my emergency room" and taken to mean "a human being who has lost—often through age—what goes into being a human being") (2). Gomers, who according to another law "don't die," are to be "turfed" to another service because "they can always hurt you more." The opposite of a female "gomere" is a "LOLINAD" (a little old lady in no apparent distress). To someone inculcated with the philosophy of Peabody (3) and Seegal (4), this roman à clef (5) seemed both offensive and unrepresentative of my housestaff training 2 decades before. Yet, the president of our Alpha Omega Alpha honor medical society chapter, a caring medical resident, said he had read the book 3 times and that it helped him through his internship. He was not alone (6); after selling 1 million copies, the book was recently reprinted with a glowing introduction by John Updike (7).

"Dirtball" elicited an enormous response from readers (8), supporting the belief that the use of pejorative terms is widespread (6, 9–12). The behavior is said to be a form of "distancing" or self-protection, akin to gallows or black humor (13), prevalent in situations of extreme stress, especially in those who repeatedly confront death (9–14). Housestaff contests to rate the most "repugnant" gomers (10, 11) have been called a means of venting anger and frustration while achieving group solidarity (11).

One can deny or ignore the phenomenon because of the potential public relations fallout, condemn it reflexively and self-righteously, or attempt to understand it and to remedy it, where possible. In service of the latter, this article summarizes surveys of 4 exiting medical school classes regarding the use of pejorative terms to describe patients, as well as their attitudes about the practice and the nature of their medical school experiences.

METHODS

In preparation for the required medical ethics course, students entering Johns Hopkins University School of Medicine from 1983 to 1990 were surveyed on ethical and medical care issues. For the cohorts graduating from 1988 through 1990, the dean and the senior class presidents approved the administration of a similar survey to determine relevant medical school experiences and any attitude differences among exiting seniors. The following questions were added to the survey:

1a. Many pejorative terms have been used to characterize patients such as "turkey," "gomer," "dirtball," etc. List those, if any, that you heard used with patients. [Six blank spaces were provided.]

1b. Do you think these terms are

1. Useful because they relieve stress and anger in caring for difficult patients
2. Harmful because they distance physician and patient
3. Both

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4. Neither
5. Other (specify)

2a. Recently, a number of books have appeared recounting medical school experiences and supporting the much-quoted allegation that medical school is dehumanizing. Based on your experience, did you feel that medical school was humanizing, dehumanizing, both, or neither?

2b. Please comment on your choice and, if you thought medical school was dehumanizing, how it could be made better.

In the winter of their fourth year, students were asked to complete the survey and return it in a self-addressed, stamped envelope. On receipt, the students' names were recorded and $10 credited toward their graduation expenses. The envelopes, which bore the only identifiers, were then discarded to maintain survey anonymity. Survey summaries were forwarded to the dean responsible for curriculum. In 1991, course leadership changed and the surveys were discontinued. The results were used to support enactment of an honor code by the medical students. In 1995, the dean asked that the next graduating class be surveyed to determine if there had been any change in behavior and attitudes in the intervening 5 years.

RESULTS

The response rates for the classes 1988, 1989, 1990, and 1996 were 89%, 79%, 96%, and 75%, respectively. The percentage of students who recorded hearing no pejorative terms varied from 8% in 1989 to 13% in 1996. The remainder submitted as many as 8, with the majority listing 2 or 3. The number of different terms varied from 75 in 1990 to 55 in 1996. Not all terms were considered to be pejorative. For example, some students considered "shooter" and "SWAF" ("shooter with a fever") to be accurate descriptions of an intravenous drug user. Likewise, "hurt" and "hit" were considered appropriate for the way overworked housestaff felt about yet another admission. *Table 1* lists those terms mentioned by at least 5 students in any year. The reported frequency of the terms "dirtball," "gomer," and "turkey" decreased, whereas that of "hit" and "shooter" or "SWAF" increased. Other terms mentioned no more than 4 times spanned the alphabet from "a" ("an abortion" and "a—hole") to "y" ("yellow torpedo" and "Yo-Yo" ("you're on your own") and its variant "AMF ('adios, mother-f—er') YoYo." They included such terms as "rock" (patient who never leaves), "citizen," "LOLINAD," "troll" (as in "flogging trolls" [15]), "frequent flyer" (16) for recidivists, and "free willy" (the movie whale).

As shown in *Table 2*, only 2% to 13% of students considered the practice to be useful, whereas 30% to 50% considered it to be harmful. The remainder believed that it was both useful and harmful or inconsequential. Explanatory comments were added by 26% of the respondents. Representative verbatim quotes follow:

> Both useful and harmful. While the use of pejorative terms is generally offensive, especially when used in a general sense to describe indigent patients, there are circumstances where these terms are accurate. To me, a patient in the ER at 3 AM with a needle broken off in his neck calling me a "mother f—er" is a dirtball. That's the way I feel about him or her and hence I may as well use the term. Care will not be compromised.

Table 1. Frequency of listing specific pejorative terms by graduating seniors (if 5 or more in any year)

	1988	1989	1990	1996
Dirtball	76	59	57	10
Dirtbag	5	7	3	6
Gomer	76	66	54	25
Hit	6	6	4	20
HONDA*	7	9	1	0
Hurt	2	0	7	3
Player	3	8	8	2
Scumball/variant	12	19	19	6
Shooter/SWAF	0	3	4	28
SHPOS†	6	2	5	0
Sleaze/slimeball	8	7	12	4
Train wreck	3	6	9	5
Turkey	6	9	8	2

*Hypertensive obese noncompliant diabetic alcoholic.
†Subhuman piece of s— (1).

> Harmful and display lack of respect and bigotry.

> Useful when used in private and in moderation. It's not true that they are harmful because they distance physician and patient. Talk to Dr. "X" about his "lesbian story." (Moral: those who vent the most in private are often most able to care for patients well and kindly.)

> Neither. The distancing between physician and patient occurs before these names are used. The distancing comes from the antagonism, anger, hostility, apathy, self-destructive behavior, etc., that certain patients carry with them. How can we be sympathetic and caring when we are physically and verbally threatened, spit upon, and insulted?

> Harmful, other. Recognizing the extremely important matter of respecting a person regardless of his station, I have often found that a caregiver's use of, say, "dirtball" to describe a patient's behavior was accurate. Although it can be treading on thin ice to use that name, it is no virtue to be a blind and ignorant Pollyanna.

> Harmful because they create a hostile attitude among others on the health care team toward the patient by creating biases and prejudices.

> Descriptive in the case of gomer; indicating a cognitive situation in a particular patient type. I do not think it is linked to the particular acronym anymore.

> Harmful because they represent personal and social conflicts, class/cultural ones in particular.

> They serve little if any purpose and are demeaning. One should find the key to every patient and not be judgmental.

> Although I try not to be pejorative with patients, I have felt very negative about many of them. I have felt many of these people are "a—holes," "demanding," "creeps," etc., although it is possible to call a patient a "gentleman" or "lady" in a sarcastic tone of voice and the same meaning is appreciated. We often are angry at patients and we all express it in some way.

> Ridiculous. If one feels this way about anyone, they're obviously in the wrong profession.

From 12% to 24% of respondents considered medical school to be humanizing; 10% to 24% considered it dehumanizing; and 38% to 59% considered it both humanizing and dehumanizing

Table 2. Student opinions regarding pejorative terms and medical school

	1988 n = 101	1989 n = 101	1990 n = 99	1996 n = 85
Pejorative terms are				
Useful	7 (7*)	13 (13)	9 (9)	2 (2)
Harmful	29 (30)	45 (45)	29 (30)	41 (50)
Both	33 (34)	27 (27)	42 (43)	25 (30)
Neither	23 (23)	13 (13)	10 (10)	11 (13)
Other	6 (6)	2 (2)	8 (8)	3 (4)
Blank	3	1	1	3
Medical school is				
Humanizing	13 (13)	23 (23)	12 (12)	19 (23)
Dehumanizing	20 (20)	24 (24)	22 (23)	8 (10)
Both	47 (47)	38 (38)	57 (59)	42 (51)
Neither	20 (20)	15 (15)	6 (6)	14 (17)
Blank	1	1	2	2

*Percentage of respondents in parenthesis was calculated after excluding those who left answer blank.

(Table 2). Explanatory comments were added by 79%. Factors considered "dehumanizing" included rote memorization in the basic sciences, excessive competition, a lack of respect by housestaff and attendings (with 3 mentioning the "art of pimping" [17]), the expectation of perfection, and long hours that interfered with a healthy and balanced personal life. Selected verbatim comments follow:

> Humanizing—Delight of interacting with patients, seeing new birth/death, helping them at a crucial point in their lives.
>
> Humanizing—I am much more aware of how people are affected by disease and poverty. I have become more understanding through this, and my empathy is genuine.
>
> Humanizing—It all depends on your attitude. Medical school is difficult for everyone. If you react well in stressful situations and keep from taking it out on patients, nurses, and staff, you become closer to humanity and your own happiness.
>
> Dehumanizing—After going through so many years of education, it becomes difficult when faculty, nurses, etc., treat you as though you know nothing. Mutual respect would certainly help.
>
> Dehumanizing—Less "pimping" and public (i.e., on rounds) humiliation and condescension.
>
> Dehumanizing—One's approach to other people all depends on one's attitude towards others. Sleep deprivation, hard work, etc., strip away all super-ego and allow one's true attitude to come out. This process need not be dehumanizing unless you let it.
>
> Both. Humanizing—Witnessing death and disease is a humbling, enriching experience. One appreciates how little we know, how small we are. Dehumanizing—Medicine is highly stratified; the pecking order is well defined. Sycophants are frequently rewarded.
>
> Both—It's dehumanizing to work with exhausted, overworked, burned-out interns who are too tired to care about patients. If the system were more humane to housestaff, it would be less dehumanizing for medical students.
>
> Neither—I think desensitizing is a better word. I became less compassionate for alcoholics, intravenous drug abusers, and patients with insignificant complaints and retained most of my compassion for the terminally ill or functionally impaired.
>
> Neither—I maintained a home life separate from my training experience.
>
> Humanizing—Although it was an exhausting 4 years, I felt I "grew up" in medical school. I became more confident and developed a list of life priorities. While medicine was near the top, so was my husband, my family, my goal of starting my own family in the future. I learned I couldn't be perfect, that what I expected from myself was to do my best, nothing more! I learned not to base my self-image on my grades, that a lot of other things, dealing with people, etc., made a good physician and person.

DISCUSSION

The survey results indicate that the majority of students in 4 separate graduating classes had heard pejorative terms used to refer to patients. No attempt was made to quantify use, so no conclusion about its pervasiveness is possible. The sharp decrease in the number of terms reported and in the use of "dirtball," "gomer," and other pejorative terms in 1996 is encouraging; however, the lower survey response rate and the rise in concern about political correctness are potential confounders. Furthermore, the report should be considered merely descriptive.

Although the results cannot be generalized to other institutions, anecdotal evidence suggests that the phenomenon is widespread (6, 8–12, 14, 15, 18). The study's major usefulness is to focus attention on a largely unreported part of the informal or hidden curriculum (19–21) in which medical students model the attitudes of housestaff and attendings, as opposed to the formal curriculum outlined in medical school catalogs. The intent is to encourage clerkship directors and clinical department heads to explore honestly and objectively the existence and extent of such practices in their institutions.

Labeling patients is certainly not new. During my residency, commonly used terms included "crock" (18), on whom "serum porcelain levels" were sought; "gomer"; and "turkey" (often used good-naturedly for fellow residents). Since then, a number of other pejorative terms have been added to the lexicon of patient descriptors. Beginning in the late 1960s, "telling it like it is," "letting it all hang out," and profanity became much more acceptable in "polite society." Indeed, it is no longer shocking to hear innocent-appearing children, professionals, and others use language once considered the preserve of the proverbial longshoreman (22). Airline employees have reported a sharp escalation in physical and verbal abuse as well as inappropriate behavior by passengers (23). The practice of "bashing" those who do not share or conform to one's beliefs or expectations by people at all points in the political, intellectual, and socioeconomic spectrum has contributed to a climate of incivility (24).

Popular movies, books, and television regularly portray people in high-stress occupations, such as police officers, using terms like "dirtbags" and "scumballs." The term "dirtball" has even entered political discourse (25). Given the stressful nature of teaching hospitals (26), and especially urban emergency rooms, occasional breakdowns in civility should not be surprising. Although the "dirtball phenomenon" does not reflect the best that's in us, it is a reality. As Mark Twain said: "Every one is a moon, and has a dark side which he never shows to anybody" (27). That dark side may be revealed when, as one student suggested, "all super-ego is stripped away." If anything, the results of the surveys illustrate that students are fully cognizant of the dangers of allowing negative

attitudes to affect the care of patients. Monitoring the use of pejorative terms as well as unspoken hostile attitudes might provide clues not just to individual character flaws, but to potentially remediable problems in the care of specific subgroups of patients as well as in the institutional culture and environment.

The first potential remedy involves developing better care strategies for selected patients. Student responses suggest that patients who care about their health and participate in their care are unlikely targets of such terms. The converse is true where teams of strangers care for certain categories of patients in what Alvin Toffler called "short-duration" relationships (28). The most common recipients of pejorative terms included the following: 1) the physically and verbally abusive; 2) those who repeatedly sought care but persisted in self-destructive lifestyles such as substance abusers; 3) those who were completely lacking in personal hygiene; and 4) the elderly, especially those who were incontinent and severely impaired neurologically. This group overlaps somewhat with Groves' 1978 categorization of what he called "hateful" patients (29): "dependent clingers," "entitled demanders," "manipulative help-rejecters," and "self-destructive deniers." Attempting to identify such patients and, where possible, to develop more targeted management strategies, including preventive services for disorders such as substance abuse, may be better for the patients and caregivers as well as a more efficient use of resources. The proposals to shift training to more organized longitudinal care in ambulatory and long-term care settings may help achieve this goal (30).

The second potential remedy involves caring for the caregivers by paying more attention to the institutional culture and environment. The importance of enhancing self-esteem was evident in comments, suggesting the occurrence of the medical student "abuse" described by Silver and others (31–33). This was compounded by students' feelings of inadequacy and a reported emphasis by their superiors on perfection and knowing trivia (17) rather than on admitting error (34) and ignorance (35). Clearly, the potential existed for some to pass on the abuse to patients and later as houseofficers to their clinical clerks. Programs to support housestaff, students, and faculty in managing anger and stress in caring for difficult and "hateful" patients (29, 36) may be especially important in areas of high prevalence of drug abuse and violence. The aim should be to create an atmosphere where the better nature of all concerned is maximized and caregivers are encouraged to try, as one student said, "to find the key to every patient." Indeed, focusing on those who maintained a healthy perspective, such as the last student quoted, would appear most beneficial (37).

Studies over the years have shown that the cynicism quotient of medical students rises dramatically during medical school and does not recede appreciably until the end of training (38, 39). In some respects, this is a means of coping with what has been called the "traumatic deidealization" (40) that occurs as students progress through informal curricula like that delineated in *The House of God* (2). If pejorative terms are used for abusive patients or unwanted "regulars," some students will emulate this as an entry to the "club." Others may not model such behavior, but, as subordinates, they are unlikely to confront it. Indeed, combating it requires a willingness by academic leaders to acknowledge its existence without self-righteous indignation or preaching. This may serve merely to drive it further underground, because faculty (11) and practicing physicians (38) are often seen as being protected, i.e., able to avoid certain patients or situations and to manage their time more effectively. Faculty modeling of appropriate behavior under difficult circumstances is more likely to sustain a community where respect for persons is prized. Then and only then will the informal or "hidden" curriculum (19–21) be brought more in line with the medical school's formal curriculum and the noble sentiments that fill orientation and graduation speeches.

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1. Cato 6 [pseudonym for Dans PE]. Dirtball, a piece of my mind. *JAMA* 1982;247:3059–3060.
2. Shem S. *The House of God*. New York: Richard Marek Publishers Inc, 1978.
3. Peabody FW. The care of the patient. *JAMA* 1927;88:877–882; reprinted with a commentary by Rabin PL, Rabin D. *JAMA* 1984;252:813–820.
4. Seegal D. Never a dull day for the compleat physician. *Pharos* 1963;26:7–14.
5. Fact or fiction? There is no Fat Man. *Am Med News*, September 11, 1981:15.
6. Kerridge IH, Lowe M, Mitchell KR. Surviving in the house of God. *Med J Aust* 1995;162:560.
7. Updike J. Introduction. In Shem S. *The House of God*, 3rd printing. New York: Dell Publishing, 1995.
8. Grouse LD. Readers respond to "Dirtball." *JAMA* 1983;249:279–280.
9. George V, Dundes A. The gomer. *Journal of American Folklore* 1978;91:568–581.
10. Cricket J. Gomers, a piece of my mind. *JAMA* 1980;243:2333.
11. Leiderman DB, Grisso JA. The gomer phenomenon. *J Health Soc Behav* 1985;26:222–232.
12. Cher LM. "Gomer" go home. *Med J Aust* 1989;151:602.
13. Fox RC, Lief HI. Training for detached concern in medical students. In Lief H, Lief VF, Lief NR, eds. *The Psychological Basis of Medical Practice*. New York: Harper and Row, 1963:12–35.
14. Heilicser B. Redefining "dirtball." *Ann Emerg Med* 1995;25:559–560.
15. John CC. Flogging trolls. *Ann Intern Med* 1994;120:242.
16. Crossen C. Losing it: nervous breakdowns by any other name aren't what they used to be. *Wall Street Journal*, December 3, 1996:A1, A14.
17. Brancati FL. The art of pimping. *JAMA* 1989;262:89–90.
18. Whitney FW. How to work with a crock. *Am J Nurs* 1981;81:87–91.
19. Hafferty FW, Franks R. The hidden curriculum, ethics teaching, and the structure of medical education. *Acad Med* 1994;69:861–871.
20. Hundert EM, Hafferty F, Christakis D. Characteristics of the informal curriculum and trainees' ethical choices. *Acad Med* 1996;71:624–642.
21. Anderson DJ. The hidden curriculum. *AJR Am J Roentgenol* 1992;159:21–22.
22. Trausch S. Garbage mouths, garbage lives. *Baltimore Sun*, July 28, 1992.
23. Kuntz T. Unruly passengers/high crimes and misdemeanors: the flight logs of uncivil aviation. *New York Times*, December 8, 1996:E7.
24. Associated Press. Scholars wonder why rudeness is on a rampage: group to seek causes, solutions for incivility. *Baltimore Sun*, December 9, 1996:5A.
25. House GOP memo seeks data for "expose" of Clinton, unions: Democrats call it "nasty, dirt-ball politics." *Baltimore Sun*, April 27, 1996:4A.
26. Butterfield PS. The stress of residency. A review of the literature. *Arch Intern Med* 1988;148:1428–1435.
27. Twain M. *Following the Equator*. New York: Dover Publications, 1989:654; republication of original edition by American Publishing, 1897.
28. Toffler A. *Future Shock*. New York: Bantam Books, 1971:101.

29. Groves JE. Taking care of the hateful patient. *N Engl J Med* 1978;298:883–887.
30. Kassirer JP. Redesigning graduate medical education—location and content. *N Engl J Med* 1996;335:507–509.
31. Silver HK, Glicken AD. Medical student abuse. Incidence, severity, and significance. *JAMA* 1990;263:527–532.
32. Sheehan KH, Sheehan DV, White K, Leibowitz A, Baldwin DC Jr. A pilot study of medical student "abuse." Student perceptions of mistreatment and misconduct in medical school. *JAMA* 1990;263:533–537.
33. Lubitz RM, Nguyen DD. Medical student abuse during third-year clerkships. *JAMA* 1996;275:414–416.
34. Seegal D. Editorial: I don't know. *J Chron Dis* 1962;15:329–330.
35. Bosk CL. *Forgive and Remember: Managing Medical Failure*. Chicago: University of Chicago Press, 1979.
36. Williams CB. Some patients I just won't tolerate. *Med Econ* 1996;73:178–180.
37. Glick SM. From Arrowsmith to *The House of God*, or "why now?" *Am J Med* 1990;88:449–451.
38. Kopelman L. Cynicism among medical students. *JAMA* 1983;250:2006–2010.
39. Testerman JK, Morton KR, Loo LK, Worthley JS, Lamberton HH. The natural history of cynicism in physicians. *Acad Med* 1996;71(10 Suppl):S43–S45.
40. Kay J. Traumatic deidealization and the future of medicine. *JAMA* 1990; 263:572–573.