

Medical slang in Rio de Janeiro, Brazil

Trambiclínicas, pilantrópicos, e mulambulatórios

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Abstract *The author analyzes medical slang in Rio de Janeiro based on the view of interactive or live metaphor proposed by such authors as Black and Ricoeur, applied to puns and other jokes from medical work, with the goal of unveiling what physicians mean by this linguistic register. The article classifies medical slang in three broad areas, pertaining to the physician's relations with professional training and knowledge, patients, and health care services. Comparing his empirical material with previous studies focusing on hospital slang for patients, the author identifies, in addition, a range of slang terms for health care services themselves. The article points to interfaces between medical slang and the Brazilian "health hypercrisis" identified by Schramm.*
Key words *Medical Language; Medical Slang; Medical Ethics*

Resumo *O autor analisa a gíria médica carioca a partir da visão de metáfora interativa ou viva proposta por autores como Black e Ricoeur, aplicada a trocadilhos e outros chistes do cotidiano médico, com o objetivo de desvendar o que os médicos significam ou "querem dizer" com esse registro lingüístico. O artigo adota uma classificação da gíria em três áreas temáticas, i.é., na relação do médico com a formação profissional, com os pacientes e com os serviços de saúde. Comparando seu material empírico com o de estudos americanos que enfocam chistes para pacientes, o autor identifica, além destes, uma série de trocadilhos para os próprios serviços de saúde, levando-o a sugerir interfaces entre a gíria médica e a "hipercrise sanitária" identificada por Schramm.*

Palavras-chave *Linguagem Médica; Gíria Médica; Ética Médica*

Apertura

"Clavicle?..."

One hesitant word from a more daring medical school freshman breaks the nervous silence and bounces off white tile walls in the amphitheater of the musty Instituto Anatómico, in response to the first question of what promises to be a grueling six-year course. On the eve of this inaugural class, the sly professor left a human bone on the stainless steel table as part of the same ritual he has performed for the last thirty years to launch his course, Human Anatomy I, along with the question, "Would someone please care to identify this?"

"Clavicle," the freshman blurts out for a second time, by now more sure of himself.

"Clavicle, indeed. In Latin: 'little key'. Would one of you doctors care to tell me why? Might it be the similarity in shape?..."

From a distance, sixty future physicians search anxiously for a formal similarity between this solitary bone and some key – any key – from their daily routines. With a generous, ceremonial gesture, the professor marches over to the front row of the amphitheater and hands the bone to the young students, who pass it around, stealing skeptical, embarrassed glances at each other.

"...Perhaps. Yet the ancient anatomists also believed that the 'clavicle' is the first bone to be formed in the fetus, and the last to die in the cadaver. Thus, the clavicle is the little key that opens and closes life itself."

Silence falls over the amphitheater. Some of the freshmen have tears in their eyes. But it's only the smell of formaldehyde on the walls. They'll soon get used to it...

Introduction

In his inaugural class, the professor gives his students a lesson in both anatomy and metaphor by provoking them with the classical question of the distinction between *similarity* in the direct, narrow sense (between objects themselves, in this case a bone and a key) and *analogy*, or relational similarity (between *opening* and *closing* life and opening and closing something with a key). For a better understanding of the professor's metaphor, we could turn to other metaphors (some would say this is only natural, since in order to talk about language, we have to use it). That is, in an etymological, *archeological* exercise, the professor sweeps the dust of the centuries from a human bone, evoking the ancient anatomist who first em-

ployed all his classificatory genius to coin the metaphor *clavicle* – 'little key'. The professor has taken that inert bone, whose name has long since become a dead metaphor (that is, the figurative meaning has become its literal sense) and given it life.

Without begging poetic license from our anatomy teacher, we have used the *little key* to open our discussion on another metaphorical field in medicine, which we will call medical slang, the object of this essay. Before closing this discussion, we will return to questions raised by the clavicle during that inaugural class.

Medical slang: metaphor as the basis for a paradoxical discourse

Medical discourse is prescribed and permeated by both scientific discourse – oriented by the methodological rules of biomedical research and confined to the literal meaning of words – and deontological discourse – based on traditional or Hippocratic medical ethics (Almeida & Schramm, 1998), dealing with physicians' duties, including how and when they should communicate with patients and family members and their own colleagues. Yet these two discourses fail to express the totality of medical ethos. There is another semantic field, which we call 'medical slang', which expresses this ethos in a way not sayable by the two orthodox discourses. Using examples from interviews taped with doctors from Rio de Janeiro over the last three years (see Appendix I), we suggest what medical slang signifies (i.e., that is, what doctors 'mean' by it) and how it is constructed (i.e., how the tropes acquire meanings shared by a speech community). We compare Carioca medical slang with a study on California hospital slang by (Gordon, 1983), where two contrasts stand out: 1) the author from California refers only to hospital jokes for patients, while doctors in Rio de Janeiro employ a wide lexical range of puns to refer to health care services and 2) the same author suggests that the principal function of hospital slang is to promote rapport amongst health care professionals, while we focus on the creation of meaning by Carioca medical slang. Such rich meaning is underestimated by the common-sense notion that doctors use this speech register primarily to 'maintain a distance' in the physician-patient relationship (a role better played by medical *jargon*) or to relieve the inherent tension in medical work (a role played equally well – as observed by a female plastic surgeon we interviewed – by other forms of hu-

mor, like jokes about sex and conversation about football, money, etc., not to mention other, non-verbal forms of tension-relief enjoyed by physicians). We intend to demonstrate that medical slang creates new meanings in the relationship of physicians not only to patients, but also to their own acquisition of clinical knowledge and expertise and above all to the health care system itself.

As we will see over the course of this article, Carioca medical slang reflects and creates interfaces with what Schramm (1995) has called the “*the Brazilian health care hypercrisis*”, with complex and often conflicting characteristics. A survey of over 3,000 medical doctors by Machado (1996) refers to a steady “*deprofessionalization*” of Brazilian physicians, characterized by the relentless (but unevenly distributed) invasion of clinical practice by technology, along with the dismantling of public health care services (under the aegis of the neoliberal, market-oriented wave and betraying the current government’s promise that funds from the privatization of key sectors of the Brazilian economy would be used to improve health care and education), physician over-specialization, and technical and professional subjugation to modern health care plans with their various formats. Prata (1992) describes Brazil’s “*incomplete epidemiological transition*”, in which diseases characteristic of ‘backwardness’ occur simultaneously with those of ‘modernity’, with special emphasis on emerging and reemerging infectious diseases (Marques, 1995) and ‘epidemic’ social violence (Minayo, 1994). According to official World Bank statistics, Brazil has the greatest disparity in the world in terms of wealth and income, and this gross inequality is reflected in the distribution of resources for health, including remuneration of physicians. With universal health care formally guaranteed by the 1988 Constitution, the country is thus a paradigm for the unresolved moral dilemma between the goal of equitable care versus the finitude of material and political resources to provide it (Engelhardt, 1996:375-410). Interacting with all of the above is what Almeida & Schramm (1998) describe as a paradigmatic transition, or metamorphosis of medical ethics.

The main theoretical references for analysis of our taped interviews were the historical reviews of metaphor by Black (1962:25-47) and Ricoeur (1972), based on which we identified the *living metaphor* as the prime instrument for creation of new meanings by medical slang, establishing interfaces between the following: (1) metaphor as word (trope); (2) metaphor as

enunciation (or metaphor at the core of the phrase), and (3) metaphorical discourse (in this case, slang).

Substitutive and comparative explanations of metaphor and their limitations

We begin our discussion of medical slang by briefly illustrating the difference between the three historical views of metaphor, namely substitution, comparison, and interaction, using a phrase from one of our interviewees (the entire excerpt is provided in Appendix II). During the course of the interview, the physician, a 34-year-old male anesthesiologist from a public hospital in Rio, states: “*The ICU is a torture room.*” The listener tends to focus his attention on the term *torture room*, which Black (1962:28) thus calls the *focus* of the metaphor, while the rest of the phrase serves as the *frame*. If the phrase is interpreted as substitution (i.e., according to the classical view of metaphor, prevailing since Aristotle, whereby a term’s literal or proper sense is replaced by a figurative meaning), it would mean ‘The ICU is a place of pain, isolation, etc.’. Interpreted as comparison, or simile, it would mean ‘An ICU is *like* a torture room (with regard to pain, isolation, etc.)’. Both substitution and comparison imply that in order to understand the metaphor, listeners need only translate backwards until they reach the proper meaning of the metaphor’s focus. According to the substitutive and comparative views, metaphor serves to embellish discourse, as a source of surprise and delight, but does not create any new meaning.

Metaphor as interaction

According to a third view of metaphor, espoused originally by Richards (as analyzed by Black, 1962:38), “...we have two thoughts of different things active together and supported by a single word, or phrase, whose meaning is a resultant of their interaction.” In the metaphor quoted above, just as listeners chose from amongst a multiplicity of attributes pertaining to *torture room* those which they ascribe to *ICU*, thereby modifying the latter, *ICU* likewise presents a range of attributes that modify *torture room*. To shed light on the interaction in our example, we recall the Holy Inquisition, which *purged* its victims by torture, while the Inquisitor insistently reminded the supposed sinners: “*What we are treating here is the health*

of your soul..." (Vainfas, 1997:202). This example was taken from the Inquisition in late-16th-century northeastern Brazil, but readers may recall a similar therapeutic approach by Inquisitor Bernardo Gui in Umberto Eco's *The Name of the Rose*. In other words, while calling an Intensive Care Unit a torture room portrays it in a cruel light, the same metaphor makes the torture room appear more therapeutic. Such interactive modification is all the more apparent in our interviewee's little slip, when he uses the term 'torture room' (*sala de tortura*) rather than the customary 'torture chamber' (*câmara de tortura*). By adopting metaphor as the basis for slang and interaction as the concept that best expresses the semantic power of metaphor, we affirm that medical slang is irreplaceable as a significant of medical ethos, even though it may interact with other references for this ethos, like scientific and deontological discourse. Medical slang is thus essentially connotative (Ducrot & Todorov, 1979:23), to the extent that the significant element is the use of the linguistic register per se. Over the course of this article, although the challenge of investigation demands that we 'translate' or dissect such medical metaphors as *trambiclínica*, *pilantrópico*, *Embromed*, etc., we attempt not to lose sight of the limits of this 'translation'. The notion of loss of meaning in the attempt to translate metaphor into literal meaning is expressed by Robert Frost (Britto, 1989: 111) when he defines poetry as "that which gets lost in the translation" and Freud (1905:86), who cautions that "...if we undo the technique of a joke it disappears."

Because of its central role in Carioca medical slang, we focus especially on the *pun* (or *trocadilho* in Portuguese), a special form of interactive metaphor. By way of example, a speaker at a recent conference in Rio de Janeiro on pediatric respiratory diseases showed a slide of an infant with a perforating wound in the cervical region and punned, "While other countries have the Ebola virus, we here in Brazil have the 'É bala!' ['It's a bullet!'] virus." The wound had been caused by a stray bullet, a common accident for a metropolitan population caught in high-powered crossfire between police and drug gangs. The interactivity of the two terms leads the listener to simultaneously associate an emerging infectious agent and epidemic social violence, a scenario of horror experienced by Rio de Janeiro physicians receiving patients "at the door to the emergency ward" (Pinheiro, 1994). Note that from 1985 to 1995, the two Brazilian cities whose income disparity worsened the most, Rio de Janeiro and Recife,

were the same ones that suffered the greatest increase in social violence (Souza & Minayo, 1995). According to figures for 1995-96, the homicide rate in Greater Metropolitan Rio de Janeiro is 4.7 times that of Chicago and 9.1 times that of New York City (Moreira, 1998). And physicians in Rio are aware of the problem not only because they deal with it in the emergency ward. In the last five years the local physicians' union has filed 20 complaints of threats against hospital administrators and physicians working in public hospitals and clinics, all of whom were attempting to eliminate corruption from bidding on medical supplies (Conti, 1998:19). Three of these physician/administrators were murdered, and a fourth, a surgeon, was permanently disabled by a gunshot wound in the hand. Thus, puns such as *Ebola/É bala* are semantically agile, since a single term conveys both the focus and frame of the metaphor.

Eco (1974:83-84) defines pun as "a forced contiguity between two or more words...made of reciprocal elisions, the result of which is an ambiguous deformation...[releasing] a series of possible readings...[which become] mutually substitutable." The Portuguese-language equivalent of pun, the *trocadilho*, derives from *trocar* ('to trade') and could be transliterated as 'tradelet'. It is thus etymologically metalinguistic, since it denotes this process of reciprocal elision and mutual substitution. As a metaphor concentrated in a single word, pun/*trocadilho* facilitates its own incorporation into slang, circulating and 'trading' around simultaneously as condensed joke and new lexeme. To date we have found no theoretical reference to the use of the *trocadilho* in Portuguese, despite its rich presence in the spoken and written language. For broad segments of the Brazilian population, the *trocadilho* plays a founding role: fathers and mothers combine syllables from their own names to name their newborn, as if to signify the genetic recreation launched nine months previously (mirroring semantic practice in the field of genetics, which is frequently portrayed as *language*, where genetic sequences are *words*, chromosomes are a *book of instructions* to be *read*, the complex movements occurring during redistribution of genetic *information* are *translation*, *deletion*, *editing*, etc.) (examples taken from editorial in *Science* by Gall, 1995:1551).

To facilitate the analysis and presentation of tropes from medical slang, we have adopted a thematic classification in three areas. Each area corresponds to a watershed in the medical ethos and focuses primarily on one

lexical form. These areas are: 1) medical training and the relationship between knowledge and the various fields of medicine (using mainly proverbs with an imperative and realistic base – (Ducrot & Todorov, 1979:155) constructed in the form of chiasmas (Ducrot & Todorov, 1979:277), whose point of inflection is the medical specialty itself; 2) patients, or the physician-patient relationship (using mainly onomatopoeic acronyms and nonsense words, but also puns); and 3) health care services (where puns prevail). For economy of space, the current paper makes only brief reference to the first group, concentrating on the other two, due to their greater relevance for the “*Brazilian health care hypercrisis*”.

Metaphor and medical knowledge

This first group of tropes shows how metaphor accompanies physicians’ relationship to acquisition of knowledge and choice of professional specialty, illustrating the notion of catachresis as a dead metaphor, i.e., the repetition of old, worn-out jokes, the target public of which are medical students, known as *Acades vulgaris*, and interns, or *bagrinhos* (‘bullheads’). The proverbs constituting the main thrust of this group of jokes, like “*The clinician knows everything, but solves nothing, while the surgeon knows nothing, but solves everything.*” provide a mock reinterpretation of the roots of proto-modern (19th-century) medicine, with a burlesque correlation to the historical literature (Starr, 1982; Friedson, 1988; Rego, 1996), in addition to serving as a form of provocation between the different medical specialties.

Other jokes from this group reflect the problem of diagnostic and therapeutic uncertainty, disguised by the med student with an air of bravado known to superiors as *doutorite* (‘doctoritis’) and betrayed by more experienced physicians when their *parecer* (‘expert opinion’) is transformed paronomastically by their subordinates into a hesitant *parece ser...* (‘it appears to be...’). Prince et al. [1982] focus on this issue of hedging in physician-physician discourse. Medical slang lexiconizes such doubt both vertically in the hierarchical chain of medical work and horizontally between specialties. However, the entire staff is sometimes forced to bow to the effects of a unique enzyme called *esculhambina*, never mentioned in the scientific literature, but to which is frequently ascribed the unexpected recovery of a patient with a particularly somber prognosis, especially if he is poor and/or black. The enzyme’s

name derives from *culhão*, or ‘testicle’ and connotes the medical staff’s ‘emasculatation’ or ‘demoralization’.

Metaphor in the physician-patient relationship

It has become common sense that the physician-patient relationship is the main locus for jokes from the medical field, due in part to the popularization of Austrian physician Sigmund Freud’s *Jokes and Their Relation to the Unconscious* (1905), which includes several jokes on disease, all of which focus on this relationship. A novel by Crichton (1968) and a study by Gordon (1983) on hospital slang in California also refer to terms for patients, without mentioning other possible targets of medical humor.

It has also become a common-sense notion that medical work is a source of tension (or even ‘stress’) for its practitioners, varying not only from one individual to another but also according to the special field (more for emergency care physicians, less for dermatologists, etc.), or in parallel, according to the type of procedure (more for emergency interventions, less for selective procedures, etc.). Physicians verbalize this tension through metaphors by which they define themselves, using such terms as the following from our interviewees: *Boeing pilot, football goalkeeper, crucified, on the tightrope, firefighter, etc.*

Under the tension of medical work, and despite the conscious affirmation that the physician-patient relationship is the most important element to be preserved in one’s professional career (Machado, 1996:145), patients may sometimes become the object of jest by professionals in charge of their care, as witnessed by our interviews, corroborating the two sources cited above (Crichton, 1968; Gordon, 1983). The immediate motives for such joking may vary. Patients may be perceived as belonging to a lower socioeconomic class. Examples from Rio include *mulambo* for poor patients in public outpatient clinics (literally ‘rag’ and figuratively ‘beggar’, the term is of African origin, perhaps not coincidentally, since most poor patients in the city are black or mixed-race, while the vast majority of doctors are white). *PIMBA* is an acronym for *Pé Inchado Mulambo Bêbado Atropelado* (or “*swollen-footed drunk run-over beggar*”), for poor trauma patients brought in from public byways (while patients of higher social status suffering accidents in similar circumstances are referred to as ‘victims’). The word *pimba* itself can also mean ‘small penis’,

besides being used as an onomatopoeic interjection of surprise, referring to one object bouncing off another (in this case, a human body that has bounced off a speeding motor vehicle – *pimba!*). *Estropício* ('jeopardy') refers to a poor obstetric patient, defined by an interviewee as "an unkempt woman". And *trubu-fu* ('fat, ugly black woman') may be used for African Brazilian obstetric patients.

Yet the patient's socioeconomic status is not the exclusive determinant of slang. Before a cesarean section of an obese obstetric patient of any social or ethnic origin, the surgeon may request that the instrument tray include *meat hooks*. A patient of any socioeconomic class with multiple trauma may be referred to as *poliesculhambado*, as witnessed by the frequent cry in the emergency ward: "Hey, we got a *poliesculhambado* here!" (roughly translatable as "multi-fucked-up", the term has a vulgar etymology, from the root *culhão*, or "testicle", connoting the patient's emasculation).

Although the possible rejection of certain patients by some health care professionals is not the focus of this study, interested readers are referred to the review by Galizzi (1997) on chronic patients, especially those displaying what in Brazil is referred to as *hospitalismo* (i.e., the *revolving-door patients* referred to by US authors). Briefly, several terms express the impatience experienced by some physicians towards severe, terminal, and/or frequently hospitalized patients. For example, the metonymical use of the verb *engessar* ('to place in a cast', in the proper orthopedic sense) can also mean to orient treatment in such a way that the patient does not complain. For terminal patients, the cynical term *síndrome JEC* (where the acronym stands for *Jesus Está Chamando* or 'Jesus is calling') replaces the more literal acronym from medical jargon, *FPT* (*Fora de Possibilidade Terapêutica* or "beyond possibility of treatment", similar to the US acronym DNR, or "do not resuscitate"). One physician reported that the following comment is common: "No, that patient should not have gone to the OR. He should have gone directly to Pathology. They sent the patient to the wrong ward!". The acronym *DPP*, originally *Descolamento Prematuro da Placenta* (or *abruptio placentae*), used cynically means *Deixa para o Próximo Plantão* (or "leave her for the next shift"), when a patient is in late-stage labor near a change in shifts.

Slang for patients is not exclusive to Brazilian physicians. Michael Crichton, graduated from the Harvard School of Medicine and better known to Brazilians as scriptwriter for the television series *ER*, reports examples of Amer-

ican medical slang like the cryptographic diagnosis SHA, or "Ship His Ass", for patients who avoid or refuse to be released from the hospital, and FLK, or "Funny-Looking Kid", an acronym used by the pediatric staff in the presence of the parents of an aesthetically challenged patient (Crichton, 1968:406-407).

A study by Gordon (1983) analyzes hospital slang in California, displaying noteworthy similarities to Carioca medical slang for the physician-patient relationship. Gordon defines four categories, and we include their approximate equivalents in Portuguese (after which we comment on the author's conclusions): (1) "*patients who demand more attention than is warranted by their physical condition*", such as "*goldbrick*", (equivalent to *pitiático* in Brazilian slang, derived from *petit mal*, suggesting that such patients are feigning a "lesser ill"); (2) "*patients who are members of socially stigmatized groups*", like 'dirtball', (see *mulambo* or 'rag' in Brazil); (3) "*patients who are physically unresponsive or comatose*", like 'pre-stiff' (the 'Jesus-is-calling syndrome' in Brazil); and (4) "*patients whose conditions are referred to by descriptive terms or are viewed positively*", like 'good patients' (or 'placed-in-a-cast' in Brazil).

Gordon draws several curious conclusions. The first is that categories 1 to 3 include patients "*who claim more attention for their conditions than is warranted*" (1983:179), a value judgment that defies both common sense (one would have to ask, for example, how a comatose patient can claim anything, except in the figurative sense) and medical ethics. The second is that category 4 represents patients seen in a positive light by the physician, an affirmation belied by the very examples quoted by the author: 'pale face' for a child with leukemia and severe anemia, 'Zorro belly', for a patient with a history of multiple laparotomies, etc., in addition to the potentially ambiguous use of 'good patient', more akin to the Brazilian 'patient-in-a-cast'.

The author concludes that the "*social function*" of slang for patients is to "*promote group rapport at the same time that it maintains individual distance*". This entails a substitutive view of metaphor, with slang as a source of delight among members of a professional category, as if there were no other raw material for jokes or no other source of intra-staff rapport than joking about patients. Individual distance can be maintained equally well by medical *jar-gon* (i.e., by scientific language used with its literal meaning, but in a cryptographic or impersonal way). We contend that slang makes patients more thing-like than distant. Galizzi's

study (1997) on the rejection of certain patients makes this area of medical humor more understandable in light of the following statement by Freud: “*Brutal hostility, forbidden by law, has been replaced by verbal invective...By making our enemy small, despicable, or comic, we achieve in a roundabout way the enjoyment of overcoming him...*” (Freud, 1905:122).

Gordon mentions in passing that hospital slang is not used in the presence of patients or their families, yet fails to see the hospital as a multiple, heterogeneous linguistic setting. In fact, what allows physicians to employ slang without openly betraying ethics in the physician-patient relationship is a change of style in the speech act, a phenomenon known as “situational shift”, based on whether the conversation takes place in the presence of patients and their families, in the private office or hospital ward, etc. Situational shift was defined as follows (Blom & Gumperz, 1968 apud Fishman, 1972:49): “*Members of social networks sharing a linguistic repertoire must (and do) know when to shift from one variety to another... A shift in situation may require a shift in language variety. A shift in language variety may signal a shift in the relationship between co-members of a social network, or a shift in the topic and purpose of their interaction, or a shift in the privacy or locale of their interaction.*”

Without using the actual term ‘situational shift’, one of our interviewees explains the phenomenon as follows: “*...jokes are usually just between doctors...amongst the health care staff. And patients are not in on the joke. Patients come in sick, and they need to be treated! In the office you deal directly with the patient. It’s just you and the patient. You can’t joke around with the patient. But in the hospital it’s different, you have the group, you have the patient (...). With the patient you have to keep that physician-patient relationship. It’s different when it’s one doctor with another, you can joke, curse, say whatever you want. But not with the patient. You have to treat the patient according to those norms that we learned...*” (anesthetist, male, 54).

In the operating room, even with the patient physically present, a situational shift occurs depending on whether the patient is under spinal block (‘awake’) or general anesthesia (‘asleep’). During a cesarean section, the two different stages in the same surgical act (before and after the delivery) are accompanied by different speech styles, whereby the tone and content of the jokes vary: “*...an anesthetist in obstetrics should not use sedative drugs, because of the fetus, so he has to use papoterapia [from *papo*, or ‘chitchat’, and *terapia*, or ‘therapy’] to*

calm the patient, telling her little jokes, giving her a lot of attention, trying to relieve that tension, because all pregnant women are very nervous, very anxious, you know, they’re feeling pain. But after the baby is born, then...then we’re free...” (anesthetist, male, 33).

Another anesthetist explains the situational shift in the two stages of a cesarean: “*...you rarely put the patient to sleep. You just give her a spinal block. So you can talk, but in a different way. You can’t just go and say to the surgeon, ‘Hey man, she’s dying! She’s... I don’t know what all! She’s bleeding!’ You have to talk more subtly. You limit the jokes, and there’s some things you can’t say. But with the patient sleeping, you can turn to the surgeon and say, ‘Shit!’ If you want to give him a hard time, you say, ‘Hold on man, we’re losing her!’ But if the patient is awake, you have to keep up a more professional dialogue...*” (anesthetist, male, 54).

Gordon’s notion of the ‘social function’ of slang as an adjuvant to the professional relationship (by promoting group rapport, maintaining individual distance) entails a substitutive view of medical metaphors that overlooks their potential for creating new meaning. In the case of Carioca medical slang, it would be as if calling a patient a *mulambo* could be reduced to a literal translation ‘ragged, poor, and black’ skirting the interaction of the metaphor with the physician’s own socioeconomic and cultural world (according to the interactive view, metaphor does not merely express an existing meaning; on the contrary, it creates new meaning). Thus, the metaphor *mulambo* does not merely express social exclusion; it helps to create it.

The above may help explain why Gordon failed to identify other semantic fields for medical slang, i.e., why he limited his analysis to *hospital slang for patients*, overlooking *medical slang for hospitals*. As we will see in the next section, the richest metaphors emerge when doctors lexiconize their own relationship to the health care system.

Puns for health care services

“*Not all are free who mock their chains.*” (Lessing, quoted by Freud, 1905:109).

The inherent tension of medical work in constantly dealing with human suffering and life-and-death situations can be intensified to the point of malaise and discontentment as a function of the “*deprofessionalization*” identified originally by Haug in 1973 (quoted by Light & Levine, 1988) and adopted for analysis of the

Brazilian context by Machado (1996:191-193) as an explanatory paradigm for the contemporary crisis in the Brazilian medical profession: “*The medical profession has become marked by its dependence on different types of health plans and by uncertainty, pessimism, and a black and discouraging future. Physicians-in-training will soon be treating patients in institutions governed by rules, norms, and regulations following a management rationale in direct conflict with the profession's principles*” (Machado, 1996).

Once again, Freud (1905:129) sheds light on the use of medical slang as a response to this context of crisis in health care services: “...in the examples we have considered hitherto, the disguised aggressiveness has been directed against people [read ‘patients’],... but the object of the joke’s attack may equally well be institutions (...) which enjoy so much respect that objections to them can only be made under the mask of a joke and indeed of a joke concealed by its façade.” Freud calls such jokes *cynical* or *skeptical*, attributing to them the power of expose: “A joke is now seen to be a psychical factor possessed of power: its weight, thrown into one scale or the other, can be decisive... [when] it shatters respect for institutions and truths in which the hearer has believed” (1905: 162-163).

We are now ready for a closer look at some medical jokes referring to various services in the Brazilian health care system.

Many med students (*Acades vulgaris*) and interns (called *bagrinhos*, or ‘bullheads’, since they’re a nuisance to the real fishing and constantly have their whiskers in the way) get their first hands-on experience with clinical practice in what is called a *trambiclínica* (a trope well-known to all of our interviewees). This pun’s polysemy is particularly rich, since it combines *trambique*, or “*trick; fraudulent business*” (Ferreira, 1986:1698) and *clínica*, “*place of rest, medical practice*” (Cunha, 1986:189), while the word *trambique* in turn stems from *trampolim*, a ‘springboard’, both literally and figuratively a “...thing which launches someone; a step” (Ferreira, 1986:1698), thus connoting professional initiation. How does this metaphor function? To translate it literally as ‘a fraudulent clinic’ (according to the substitutive view of metaphor) would impoverish its meaning. There is an interaction between *trambique*, *trampolim*, and *clínica* whereby the terms organize each other, as we can see from the explanation provided by a physician: “*Trambiclínica is a kind of clinic which, instead of having a trained physician on ward duty, has med students working for it, in order to pay less, to get higher profits, not to mention that these physicians [sic] themselves*

are forced...no... oriented...to order all kinds of tests, unnecessarily, in order for the clinic to earn more profit” (anesthetist, male, 33).

The definition shows how the *trambiclínica* acts as kind of springboard for physicians-in-training, and how even before graduating the latter are entangled in the kinds of financial and management procedures adopted by such institutions, thus anticipating their future lack of professional autonomy. In the metaphor’s interactivity, this type of *clínica* (clinic) organizes the *trambique* (fraud), which in turn conditions clinical practice, while serving as the career *trampolim* (springboard).

Another common trope derives from the figurative use of a common descriptive term from clinical practice: *drenar* (‘to drain’) becomes the focus of ‘to drain a patient’, defined as follows: “...a person who has an outside private clinical practice takes a patient who’s in a given hospital and moves him around to where he has his private practice. This term ‘to drain’ is used, because a drain removes...and eliminates things, understand? So he moves the patient from one place to another” (anesthetist, male, 54).

Mulambulatório is a pun formed by *mulambo*, meaning ‘rag’, incorporated into the Portuguese language from Quimbondo, a Bantu language, and used here metaphorically as ‘beggar’ (Ferreira, 1986:1149), plus *ambulatório*, or ‘outpatient department’ (Cunha, 1986: 39). An interactive interpretation of this pun/metaphor suggests that such an outpatient clinic not only *treats* the *mulambos*, but also helps to *create* them. One physician identified *mulambulatório* as a synonym for public hospital, treating both the homeless and the poor and/or workers in general: “*Mulambulatório is a place that treats the mulambo in the ambulatório. They use this term for people – poor devils! – let’s say they extend the term to people who go to the public hospital because they have to, and amongst this group are some people who really have nothing to eat, while there are others who are slightly better off. So people generalize this term to include everybody who’s treated in the public outpatient clinic – but not all of them are really mulambos*” (anesthetist, male, 54).

When asked whether he was familiar with a slang-imaginary health plan called *Embromed* (from the verb *embromar*, or “*to postpone solutions to business problems by way of hoaxes*” [Cunha, 1986:291], employing paronomastic interaction with the numerous Brazilian HMOs whose names really end in ‘-med’), one doctor denied having heard of such a plan, but countered with another called *Plano Pafúncio* (Pafúncio is the name of the buffoon Jiggs in the

Brazilian version of the American cartoon strip *Bringing Up Father*, otherwise known as *Jiggs and Molly*): “*This plan involves procedures performed in a public hospital on parentes de funcionário (“relatives of employees”), and since the patients are relatives of hospital employees, they are treated better and quicker. So that’s why we say, jokingly, that the health plan is PAFÚNCIO... PArente de FUNCIONário!!*” (anesthetist, male, 33).

The *Pafúncio* pun relates directly to the physicians’ survey by Machado (1996:161):

“*The number of patients who depend on free government health care services is huge and has grown steadily in recent years, due to the dire socioeconomic conditions in which the majority of the Brazilian population live. The most valuable currency in such cases is trafficking of influence among friends, parentes (relatives), physicians, department heads, hospital directors, etc. The who-knows-whom approach, exchanging favors, agreements, and bribes all become commonplace.*”

Another pun refers to the so-called *hospital pilantrópico*, an oxymoron based on the word *filantrópico*, “*inspired by philanthropy, with love for humanity*” (Ferreira, 1986:777) and *pilantra*, or ‘crook’ (Ferreira, 1986:1328). One physician defined such dubious charitable institutions as follows: “*...in the end, they say that the hospital pilantrópico is not-for-profit, but it really is, right? Their ‘not-for-profit’ line is pretty lame. What they’re really worried about is the bottom line*” (anesthetist, male, 54).

It is important to note that the private office appears to be exempt from medical jokes, remaining untouched as the ideal for exercising clinical practice, as clearly indicated by Machado (1996:147). Brazilian physicians generically associate professional autonomy with the concept of ‘liberal profession’ (in the generic sense) rather than with medical practice per se. Although our study has not detected any puns for private practice, this ephemeral ideal was ridiculed in a film produced jointly by the Rio de Janeiro and São Paulo Physicians’ Unions in the early 1980s, called *A Day in the Life of a Doctor*. The main character is a physician, not so recently trained, who spends his day rushing from one job to another (from the *trambi-clínica* to the *Embromed* to the *Plano Pafúncio*, etc., each with its own peculiar administrative-over-therapeutic philosophy), and ends his workday in a private office which he shares with 83 other colleagues.

In addition to lexiconizing conflicts in clinical practice, some metaphors play a more active role in explaining or intervening in health-

care reality. The president of the Rio de Janeiro State Medical Board uses metaphorical irony to criticize attempts to implement malpractice insurance in Brazil. The fact that multinational insurance companies are behind this effort is critiqued by an alliteration between the original word in English, malpractice, and the effect he contends it would produce amongst Brazilian doctors, i.e., *mal-estar* (discontent or malaise): “*The chaotic situation of public medical care in our country has favored the growth of malpractice insurance, which can only lead to mal-estar (discontent; malaise), uncertainty, and preoccupation for physicians*” (Bordallo, 1996:11).

Another example is the campaign launched by the Brazilian Society of Medicine and Surgery (Carmo, 1997) against *empurroterapia*, which the Society translates literally as ‘self-medication’ (the focus of the metaphor is the verb *empurrar*, or ‘to push’, as in the common Brazilian colloquialism *empurrar com a barriga*, literally ‘to push with the belly’, i.e., “*to fail to provide, or to postpone, the proper solution to a problem*” – Ferreira, 1986: 236).

Medical slang: sign of an ethical metamorphosis?

At the semantic level, it is useful to think of the proper or literal sense of words as *doxa*, with which a metaphor establishes a paradoxical and irreducible tension (Ricoeur, 1972:37). Medical slang as a whole maintains this same tension as an ‘anti-language’ (Ammon et al., 1988:1161) vis-à-vis scientific and deontological discourse. One would then ask what implications this linguistic register has for medical ethics. Here, we turn to a study by Almeida & Schramm (1998), who point to the existence of a ‘paradigmatic transition’ or “*metamorphosis in medical ethics*”, suggesting that since the 1970s traditional (Hippocratic) medical ethics has proven incapable of dealing with the multiple ethical and professional conflicts in clinical practice during late or post-modernity, arguing for a new ethics with ‘principalist’ foundations, i.e., based on *prima facie* principles such as the following: non-maleficence, beneficence, autonomy, and justice. The very fact that such principles are ‘negotiable’ would tend to favor the recovery of professional autonomy, whereby physicians would regain their exercise of ethical protagonism. But until this transition is consolidated, the rights and duties of doctors as formulated from a Hippocratic perspective will frequently conflict with actual

clinical practice, due to the 'deprofessionalization' and the 'finitude' of resources discussed earlier. The dilemma of physicians enmeshed within health care institutions is clarified by Freud (1905:133) when he says, "A particularly favorable occasion for tendentious jokes is presented when the intended rebellious criticism is directed against the subject himself, or...against someone in whom the subject has a share – a collective person..." But the question remains open: do medical jokes merely express a skepticism of the 'anything goes' type (Schramm, 1995:67), or are they signs of an incipient attempt by physicians to adhere to a search for new ethics? Is there a semantic chasm between medical slang and deontological principles placing physicians and patients in ethically incommunicable camps, as 'moral strangers' (Engelhardt, 1996)? Is the implicit critique in medical slang contrary to any and all morality – hence, the physician throws the patient out with the bath water – or does it merely point up the unfeasibility of prevailing medical deontology? Such moral dilemmas help explain why there are so many and such varied medical puns for health services. Suffice it to recall that many physicians would be fired (and a few in fact are) if they availed themselves of their right, guaranteed by the Code of Ethics of the Rio de Janeiro State Medical Board (CREMERJ, 1988: 9), "to refuse to exercise one's profession in a public or private institution where working conditions are not worthy or may harm the patient..." [i.e., *trambiclínicas, pilantrópicos, and mulambulatorios*]. Thus, not only would these same physicians descend into poverty themselves, but they would also fail to relieve the suffering and save the lives of countless patients.

Clausura

*The semester is over at the Instituto Anatômico. Several days ago Professor Clavicle turned supervision of dissection classes over to his staff of residents, and now that exams are over, the latter are in the annex basement, dissecting specimens for next semester's course on Neuroanatomy. The freshmen, who by now boast the name *Acades vulgaris* with a mixture of pride and shame, have left to celebrate, drinking cold draught beer at a bar near the ferryboat docks. Some are already at the bus station, on their way to a two-week break in the mountains or on the coast.*

The janitor, shuffling along in his worn-out sandals, breathes a sigh of relief as he sweeps out the amphitheater for the last time this semester, faithfully playing out a ritual established by the master-professor decades ago. He sweeps up bits of paper and pencil shavings left behind by the doctors after their final exam. He washes off the stainless steel dissection tables with a formaldehyde solution for the last time. Finally, he puts the skeletons away in the closet, whence they would have preferred never to have emerged. Closing the door, he jumps back, startled. He could have sworn that he saw a clavicle move! Might the formaldehyde fumes be affecting his eyesight after all these years? Half brooding, half resigned, he closes the closet the rest of the way and locks the door with a little old brass key, which he puts away in his duster pocket.

Appendix I

The point of departure for the tropes collected in this study was a list of puns I picked up during my own medical training at the Universidade Federal Fluminense in Niterói, Rio de Janeiro, from 1978 to 1984. In May 1995 I presented this list to seven health professionals trained at three different public universities in Rio de Janeiro: a specialist in infectious diseases, a pediatrician, an obstetrician, a psychiatrist, a psychologist trained in psychoanalysis, a geriatrician, and a registered nurse, asking that they provide their own definitions for these terms and react to the list, commenting on the definitions given by other interviewees and searching their memories for other similar examples. The initial interviews were performed by phone, and I later held group interviews with three participants each. I used the 'snowball' method to identify contacts (Becker, 1993). Other tropes were added through discussion of the list with my doctoral course classmates at the Escola Nacional de Saúde Pública. Using an open-ended interview, in July 1996 I taped six hours of interviews with four anesthetists at a university hospital in Rio. These four colleagues displayed great versatility in their use of metaphors to explain their daily professional routines. All of the subjects consented to anonymous quoting of their interviews. Interviews continue with members of other medical specialties.

Acknowledgements

This research is being conducted under a grant from the Brazilian National Research Council (CNPq). I should emphasize the importance of classes and discussions with my thesis supervisor, bioethicist Fermin Roland Schramm, Coeditor of *Cadernos de Saúde Pública* Luis David Castiel (with his good-humored reflections on metaphor in epidemiology), sociologist Maria Helena Machado, and linguists Bruna Franchetto and Jürgen Heye of the Museu Nacional and Pontifícia Universidade Católica do Rio de Janeiro, respectively. Special thanks to Editor Carlos Coim-

Appendix II

Excerpt of interview with emergency ward physician/anesthetist from the Rio de Janeiro State Fire Brigade Rescue Squad (male, 33): "*An ICU, in my opinion, with honorable exceptions, is a torture room. I would never want to go to an ICU as a patient myself, except when the patient is very well handled, in the sense of your eliminating his pain and consciousness. Because a patient in the ICU, if he is lucid, awake, and knowing what is going on, must have the same sensation as if he was being tortured. Why do I say this? Because he normally has a tube in his trachea, a nasogastric tube, a urinary catheter, several IV lines, looking more like a Christmas tree, strapped down to the bed, understand? Can't talk, can't eat, fed by a tube or IV line. So if he's awake...not to mention the noise from the motors, which causes a lot of trauma...the cries and whispers of the other patients next to him...the lights, which bother him. And not to mention the teaching part, the med students, each one wanting to perform some procedure, wanting to invent something. Many patients, unfortunately, are guinea pigs for physicians in training.*"

bra for encouraging me to publish the article in the Debate section of *Cadernos*. I wish to thank the professors from the Escola Nacional de Saúde Pública who contributed with their valuable suggestions, especially Cecília Minayo, Keyla Marzochi, Mauro Marzochi, Nilson Rosário da Costa, and Luiz Antônio Camacho. My wife Marta de Oliveira has provided me with invaluable suggestions and unfailing affection and moral support throughout. A special thanks to the health care professionals who took time from their grueling routines to be interviewed.

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