

Humor in Health Care

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FROM THE EDITOR

Humor in Health Care

Edward J. Lee

Reflecting upon my medical school experience in my final year, I realized that my last two have been very different from the first two. The first 2 years were not much different from my undergraduate years, spent mostly in an auditorium or in nearby cafes where I flipped through giant files of flashcards or stared at metabolic pathways on PowerPoint slides. My third year, on the other hand, felt more like an induction into a secret society. As I observed how resident physicians spoke and behaved, I began to mirror their phrases, jargon, and mannerisms. The induction even came with a uniform. I went from feeling like an **impostor** in hospital scrubs to wishing I could wear them every day.

I adjusted to this new environment and found myself privy to a new kind of humor. I observed a physician, who was just yelled at by a patient, **make fun of that patient** later. Members of the consultation team would joke about physicians in other specialties who asked **“stupid” questions**. I heard resident physicians on intensive care unit rotations laugh about absurdly dismal prognoses of some of their patients. “Great job treating 13’s laboratory abnormalities,” they would sarcastically congratulate each other, just prior to telling the family in room 13 about this patient’s impending death. Also during my third year, I read “Our Family Secrets”¹ and “Gallows Humor in Medicine.”² In “Our Family Secrets,” an anonymous author describes their experience as a student with an attending obstetrician who, only seconds after performing life-saving internal uterine massage on an unalert patient with uterine bleeding, dances in place with his hand still inside the patient. “Gallows Humor in Medicine” recounts a story of emergency department (ED) resident physicians who, after a failed resuscitation attempt of a delivery boy who had been mugged while delivering a pizza ordered by those same residents, volleyed quips about how much they should tip him. Although initially shocking, the perspectives of these articles’ protagonists became more and more relatable.

I felt conflicting emotions when observing these kinds of humor, but I found myself participating. After a few clinical rotations, I had learned not only the names of antibiotics but also slang for describing long-term inpatients and patients seen frequently in the ED. I still let these terms slip during conversations with other students, perhaps to fit in and affirm to myself and others that I am a legitimate part of this new community into which I`m being socialized. Or perhaps it`s just because these one-word terms are easier to say. Regardless, I`ve surprised myself with my own carelessness.

My experience is not unique. Reading fellow students' quotations about their experiences with derogatory humor in studies such as Wear et al³ or Parsons et al,⁴ for example, I could be reading a continuation of conversations I have had with friends. One student quoted in Parsons et al states: "I was so shocked at the way doctors talked about people in the beginning. But having just finished a month of being that tired and sleep deprived, and being up all night for really stupid things ... it's no longer inconceivable to me why people talk that way about patients and families."⁴ I realized that, like me, other trainees grapple with conflicting emotions about humor in clinical practice. I'm simultaneously reassured I'm not alone and concerned by how so many of us seem to be affected by humor's lessons and how they're taught in our hidden curriculum.

Yet, I also appreciate when humor was used to **strengthen patient-clinician relationships**. During my anesthesia rotation, I followed multiple anesthesiologists as they spoke with patients in preoperative waiting areas. Each had a set of jokes they recycled with patients to try to make them feel more at ease. One anesthesiologist would joke that midazolam was "a margarita before going off to a dreamland vacation to Hawaii," and I couldn't help but roll my eyes the tenth time I heard it. An important lesson was that this reused line was one of the important anxiolytics the anesthesiologist used to try to help patients relax.

Other specialists also seem to have their own ways of using humor. A pediatrician **might joke with patients** during an office visit⁵ or a clown might service patients in children's hospitals.⁶ But humor is also found in unexpected places, like cancer care settings. For example, one oncologist quoted in Penson et al notes: "I find if you joke about yourself, it definitely dethrones the doctor and relaxes the patient, particularly since I take care of women with ovarian cancer, and I'm a guy."⁷

Medicine's social and cultural sanctity—combined with myriad conditions that affect our health, the intensity and stress of training, and the awkward intimacy and universality of bodily functions—makes for abundant opportunities for humor in health care. Thus, I feel obligated to be thoughtful about how I approach humor when I practice medicine. Aristotle considered wit to be a virtue.^{8,9} Prior to being reminded of this fact during an ethics course, I had not before taken seriously the notion that wit and humor could be moral; I had dismissed this idea as some sort of ancient Greek anachronism. After I started clinical rotations, other Aristotelian ideas began to resonate as well, especially the idea that one might be missing an element of *eudaimonic* (typically translated from the Greek as "happy, fulfilling") life by being overly serious or overly eager to joke.

In this theme issue of the *AMA Journal of Ethics*, contributors seriously consider humor, explore its intersections with ethics, and consider what constitutes humor and its appropriate or inappropriate, kind or ill, and beneficial or problematic uses in health care. Clinicians seeking practical suggestions or wondering how to ethically incorporate humor into their practice might discover some possibilities here. Although explaining jokes typically ruins them, my hope is that the contributions to this issue will help me and all readers engage with humor in our day-to-day lives thoughtfully and intentionally.

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CASE AND COMMENTARY

Does Using Humor to Cope With Stress Justify Making Fun of Patients?

Julie M. Aultman, PhD and Emily Meyers

Abstract

This article considers 3 reasons for derogatory humor in clinical settings and argues that when such humor is directed at patients without understanding their complex histories, it can diminish the therapeutic relationship rather than serve as a coping strategy. This article also investigates how narrative medicine can guide deeper understanding of the motivations for using humor in clinical settings, why humor is directed at a particular person or group, and why derogatory, cynical, or dark humor might be unethical and unprofessional. Colleagues and mentors are essential for guiding students' and trainees' professional development and for helping them cultivate coping strategies that do not cause harm.

Case

Having heard 2 fellow students, JR and CC, joking about a patient's looks and demeanor, MK asks CC, "Don't you think it's unprofessional and inappropriate for JR to be making fun of a patient like that?"

"He's just venting because the patient has been so frustrating to deal with," responded CC. "Now that he's got that off his chest, he'll be less stressed the next time he sees that patient."

"Yes, I've heard that line of thought before, but I don't think you can just make jokes like that about patients without it affecting the way you interact with them." MK continues, "Aren't there better ways to deal with stress without making patients the butts of jokes?"

Commentary

Focusing on the ethics and professionalism of using humor in clinical settings, particularly in situations in which health care professionals and students make fun of patients, we explore possible reasons for using **derogatory and cynical humor** and argue that when such humor is directed at patients without understanding their complex histories and idiosyncrasies, it can not only diminish the therapeutic relationship, but also exacerbate feelings of anger, resentment, and stress among health care professionals rather than help them cope. Furthermore, we describe the importance of taking a narrative approach to better understand why such humor is being used among

peers and others and to encourage deeper examination of why patient behaviors often become subjects of jokes.

Diminishing the Therapeutic Relationship With Derogatory Humor

Although certain kinds of humor can be a useful and effective coping strategy in clinical settings,¹ whereby health care professionals and students can release stress or let off steam,² recover from compassion fatigue,³ and develop better cohesion,⁴ directing derogatory and cynical humor at patients is unprofessional and unethical, due to its potential to harm rather than **improve relationships with patients**, colleagues, and others. Our working definition of derogatory and cynical humor is intentional or unintentional humor that is cruel, malicious, or disrespectful, which undermines a person's capacity to see good in others. Wear et al state that one physician they interviewed likened distinguishing "gallows humour and derogatory humour ... to 'the difference between whistling as you go through the graveyard and kicking over the gravestones.'"⁵ Watson describes gallows humor, in contrast to derogatory humor, as "humor that treats serious, frightening, or painful subject matter in a light or satirical way."⁶ In this case, JR appears to be using derogatory and cynical humor in a conversation with CC (although the context of the joke does matter, as will be clear on further examination).

We recommend that students such as JR develop alternative coping strategies when confronted with difficult patient encounters because the use of derogatory and cynical humor for emotional survival, even in an undeniably challenging clinical environment, is not ethically justifiable. Nonetheless, it is important to recognize that such humor exists and to understand why health care professionals and students like JR use derogatory and cynical humor before developing criteria for guidance on when it is professionally and ethically appropriate to use humor about patients when releasing stress and when it is inappropriate.

Motivations for Derogatory Humor

When a patient's race, ethnicity, sex, personality, appearance, behavior, or circumstance is the subject of a joke, such that stereotypes and cynical attitudes are perpetuated, peers and mentors might find it difficult to see the humor or to find the humor funny, particularly when the intent is malicious or misaligned with the goals of patient care. While gallows humor might be ethically appropriate in circumstances wherein a clinical situation is cleverly poked fun at, humor maliciously directed at some attribute of a patient because of a personality conflict, nonadherence to recommended care, or some physical feature is not ethically justifiable but simply cruel and disrespectful, even if the caregiver who uses humor as a coping strategy genuinely feels helpless.

Given the recent pandemic and panic buying of toilet paper in the United States, a physician, after his patient died from COVID-19 respiratory failure, was overheard by the medical team saying, "at least there will be more toilet paper for the rest of us." This example of gallows humor contrasts with a more personal attack on a seriously worried, overweight black female patient with flu-like symptoms. Within earshot of the patient's family, the health care team yelled, "Code Madea," before entering the patient's room. These 2 words, in reference to the popular film, *Diary of a Mad Black Woman* (2005), poked fun at this patient's "hysteria" or "madness" stemming from her fear of COVID-19, large stature, masculine features, and race. Given the seriousness of the illness, the fear of the general public, and the clear racial disparities in clinical settings where black patients are already hesitant to seek out medical treatment, saying "Code Madea" in the

presence of a worried family is disrespectful and ethically unjustifiable, even among helpless, overburdened, or stressed health care professionals. The social cost of using derogatory humor outweighs the benefits of relief or validation for stressed, frustrated, or helpless health care professionals.

There are 3 common theories about why derogatory and cynical humor is used: the relief theory, the incongruity theory, and the superiority theory.^{7,8,9} In the relief theory, humor is used as a release or escape from negative or stressful situations; in the incongruity theory, humor is generated because the reality of certain situations or people do not match what is expected; and in the superiority theory, humor is used as a way to achieve power over others.^{7,8,9} In the case scenario, JR might not be able to cope with the stressors associated with medical training and so uses humor for relief and to be able to continue delivering patient care. This theory is also applicable to health care professionals in a pandemic who might be feeling overwhelmed by patient fears and a lack of critical resources, among other relevant stressors. Additionally, in the case scenario, the particular patient's behavior might seem odd or abnormal to JR—that is, incongruous with what he expects. Finally, JR's desire for acceptance or to follow his mentors' lead could be interpreted as demonstrating his and his colleagues' **shared superiority over the patient**. In our pandemic example, racial differences, body shape and size, and being vulnerable differentiate the patient from the clinician and often create a power differential in which the clinician might feel superior (eg, healthy, privileged, physically fit) and thus use derogatory jokes to establish this superiority.

JR might also be learning how to cope with difficult patient encounters by modeling his mentors' behaviors and overall cynicism in using derogatory and cynical humor.¹⁰ In a survey of medical students, it was found that physicians in power use such humor in the presence of their students, who feel as though they are expected to laugh at jokes told by those in positions of higher status or rank even when they are not funny or are **offensive** or cynical.¹⁰

Ethical Implications of Derogatory Humor

For health care professionals. Some students witness their mentors' ability to detach themselves from their patients and to provide care without becoming too emotional. It would seem as though this detachment can improve patient care; negative attitudes and feelings are suppressed during patient encounters and then released in the telling of a joke, typically only among peers or colleagues. However, unless the reasons for negative attitudes and feelings are examined, the negative attitudes and feelings that are suppressed and released through humor to temporarily cope with a difficult patient encounter can lead to burnout and moral erosion (ie, loss of a moral conscience and a sensitivity to potential moral harms, such as stereotyping, that can erode our humanity), patients' victimization, and clinicians' lack of hope and trust in patients and others.¹¹ Derogatory and cynical humor can further lead to the development of inherent biases among health care professionals who are no longer looking objectively at vital signs, admitting diagnoses, or laboratory values but instead focusing on patients' "negative" characteristics, which are likely not as pertinent to treatment. We argue that the use of derogatory and cynical humor directed at patients can have a negative impact on the emotional well-being of health care professionals and students, particularly when humor is used as a quick fix to alleviate discomfort, as a way to ignore personal biases, or as a diversion from more complex problems or limitations in patient care.

For patients. If patients are within earshot of derogatory or cynical jokes directed at them, they not only might be emotionally hurt by the joke itself but also might feel betrayed by the very person telling the joke, who is expected to be compassionate and caring. What emerges is a lack of patient trust and faith, which potentially leads to nonadherence to recommended treatment and a lack of continuity of care or a patient's refusal to seek medical help due to an overall distrust of doctors.

For relationships. Even when patients are unaware of jokes being made at their expense, derogatory or cynical humor can equally impair relationships between health care professionals and students, between students and their patients, and among student peers. When members of a student peer group, like MK in the case scenario, are unable to find humor in what is being said about a patient, the group is unable to achieve cohesion. Thus, while we do not deny that there are known benefits to the use of humor in clinical settings, the use of derogatory and cynical humor can have adverse effects regardless of whether patients are unaware of the humor.

Addressing Derogatory and Cynical Humor Through Narrative

Narrative medicine can guide a deeper understanding of the motivations for using humor in clinical settings, why humor is directed at a particular person or group, and why derogatory and cynical humor is, as we argue here, unethical and unprofessional. The narrative approach prompts us to examine each character's story and how these stories entwine and are shared in a dialogical chorus.¹²

In the case scenario, the elements of the patient's story—including medical history, relationships, values, and circumstances informing why the patient sought medical help—are all important features to uncover and understand in terms of why that patient might be "frustrating" or different in ways that prompt JR to use derogatory and cynical humor. It is equally important to understand JR's own story, including his relationship with this patient, his past and current experiences as a medical student, issues he may be facing in his personal life, and his goals and ambitions that might explain his expressed negative feelings and use of this type of humor. What we might find is that JR has negative attitudes and biases regarding certain features of patients or that he lacks confidence in complex patient cases and therefore diffuses his discomfort through cynical and derogatory humor. Thus, he possibly needs emotional support and better coping skills. JR might also be using such humor because he previously witnessed his attending physicians or mentors, whom he deeply respects, telling derogatory and cynical jokes to cope with and detach from difficult situations. Understanding the nature of the joke and its motivations can lead to important insights about JR; if he does have certain biases, these can be addressed through further discussion, peer support, and cultivating self-awareness.

Furthermore, MK and CC can encourage JR to closely "read" the patient's story and the nature of the difficult clinical encounter, enabling him possibly to see the patient not as someone who is necessarily difficult but as someone who is in genuine need of help and support. MK and CC, as supportive peers, can **create a safe space** in which JR feels comfortable disclosing his attitudes and feelings while the three of them collectively explore JR's underlying motivations for using derogatory and cynical humor and the negative effects it might have on the entire medical team (eg, perpetuating patient stereotypes and overall cynicism). By forming a peer support group, MK and CC, as well as JR, might be more comfortable sharing their experiences, including why certain patients make them frustrated or angry or their feelings of inadequacy or

powerlessness. Collectively, they might identify best practices to cope with a rigorous medical education and training program, including difficult patient encounters. Such practices might include appreciative inquiry, a collaborative methodology that focuses on (1) creating a shared vision toward change; (2) affirmation and positivity, such as seeking out positive mentors and educators; and (3) being mindful of why the patient is seeking help in the first place rather than focusing on the patient's negative behaviors or attributes.¹³ This approach allows students and health care professionals to reset their frame of mind by becoming more tolerant and accepting of their patients and better able to cope with challenges in the clinical environment.¹³ And while humor has its place in the clinical setting, appreciative inquiry might reduce the need to target patients with cruelty and cynicism.

Recommendations

We must understand that patients rarely have the health literacy of medical professionals. Only 12% of the US adult population has been deemed to be proficient in health literacy.¹⁴ Moreover, patients might communicate poorly for various reasons. Patients are likely to become frustrated at their own situation and seeming lack of control over their own body. Patients might also find themselves fearful for various reasons, whether because of an upcoming procedure, a new diagnosis, or a projected prognosis. Whatever the reason, these feelings can manifest in patients' anger or animosity towards their health care team. Such responses may then result in their being deemed a "difficult" or "troubling" patient. Clinicians can alleviate some stress wrought by difficult encounters with patients in more respectable ways than by turning to humor and impairing the patient-physician relationship.

Thus, the first proposed mechanism for halting the use of harmful humor in medicine is to promote awareness of the different types of humor and of humor's benefits and burdens—specifically, the negative impact of derogatory and cynical humor on oneself and others. Time ought to be given to health care professionals and students to discuss not only issues that arise during clinical rotations, but also the acceptability of some types of humor (eg, dark humor) when kept within the confines of the health care team and the unacceptability of derogatory and cynical humor that can exacerbate stereotypes and bias, if not directly harm the subjects of such humor and their caregivers (including JRs' peers who might be offended by such humor). Many students like JR might believe this type of humor is harmless, so we must work to promote awareness of the harmful effects of this type of humor and best practices for patient care. Also, simply being aware of one's surroundings (ie, the clinical environment) can prevent an offensive joke hitting its target—the patient.

Second, we must ensure that students are provided with adequate role models who do not engage in derogatory and cynical jokes about patients and who use humor in more positive or less harmful ways (eg, poking fun at themselves or at a general situation) that can be beneficial as a coping strategy while enhancing relationships with patients and colleagues. These role models set the stage for how emerging health care professionals formulate their practice.

Finally, utilizing practices such as appreciative inquiry can prompt health care professionals to recognize the best attributes in people—including patients who seem to be difficult, mean, or rude—and allow them to understand "what is going well" rather than "what is going wrong."^{15,16} Appreciative inquiry, along with a narrative approach to understanding the patient's story and the student's or health care professional's own

story, can build more positive therapeutic and collegial relationships. These alternatives can reduce if not replace the use of derogatory and cynical humor that negatively impacts emerging physicians, the health care team, patients, and their families. Such positive change needs to occur within health care settings to promote better patient care and clinician wellness.

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The people and events in this case are fictional. Resemblance to real events or to names of people, living or dead, is entirely coincidental. The viewpoints expressed in this article are those of the author(s) and do not necessarily reflect the views and policies of the AMA.



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CASE AND COMMENTARY

Are “Other Doctors Are Stupid” Jokes Appropriate?

Joshua Nagler, MD, MHPed and Rebekah Mannix, MD, MPH

Abstract

Humor can serve as a potent social bond, offering an easy shortcut for positive interaction in the context of fast-paced medical encounters. However, humor in clinical environments can also be wielded as a means of distancing or alienating others, often to promote the assumed superiority of the individual or group weaponizing the humor. This article explores the role of humor in promoting and potentially mitigating tribalism in medicine.

Against the assault of laughter, nothing can stand.

Mark Twain¹

Case

LC and JJ are third-year resident physicians in obstetrics and gynecology on their way to grand rounds. “Guess what I got called for yesterday?” asks LC. “There was a pregnant woman in the emergency department suspected of having meningitis, and the intern called to ask if a lumbar puncture would pose any risk to her baby.”

JJ rolls her eyes. “Did you tell them that when pregnant women get lumbar punctures, their fetuses instantly liquify?”

LC responds, laughing, “I should have. That’s definitely a new one for the bulletin board tally sheet of stupid consultation questions.”

Commentary

In medicine, some of us are funny (like the second author), and some of us are not (like the first author). Humorous dispositions are unequally distributed among colleagues; yet, for a profession steeped in the gravity of caring for the ill and injured, humor is remarkably and ironically pervasive. At its finest, humor in clinical workplaces has potential to mitigate some stress and pressure from our emotionally laden jobs. When the timing or type of humor is off, however, costs to relationships can be high.

During a recent professional development exercise on humor, one participant shared that she heard a description of the drape that separates an anesthesiologist from members of a surgical team as “the blood-brain barrier.” Such specialty-specific jokes

that reinforce harmful stereotypes are widespread, can influence training, and can be deleterious to relationships.^{2,3} In another example, a seasoned lecturer spoke about a study published 15 years ago and asked whether learners in the room had been born yet. Although quips like these might be perceived by some as momentarily clever, they might not be very wise, as they can be hurtful and divisive. We discuss potential benefits and harms of humor in clinical settings and focus specifically on how what we'll call "other-doctors-are-stupid" jokes can **undermine collegiality** by contributing to an "us vs them" environment.

Benefits of Humor

As clinicians, we might be drawn to the **health benefits of humor**, both for our patients and for ourselves. Data suggest that humor can boost immune function, support effective metabolism, and facilitate release of endorphins, resulting in improved pain control, better sleep, and enhanced mood.⁴ In addition to its physiological benefits, humor facilitates connections among people and thus can be a useful and potent social tool, particularly in a workplace.⁵ Laughing together fosters better communication and can improve cooperation and empathy among people of different backgrounds.^{5,6} Laughter might also help us signal to others that we share a similar worldview, which can strengthen our relationships. This signaling effect was demonstrated in a study that measured facial expressions associated with laughter in subjects who had completed implicit association tests (ie, timed tests in which subjects categorize items quickly, revealing unconscious or semiconscious associations). The results showed that subjects laughed more in response to humorous stimuli that accorded their implicit biases or preferences regarding racial groups or social roles.⁷ These results suggest that seeing someone else laugh at jokes that make you laugh evokes a shared connection, even when you are not physically close to the person you are laughing with. Research with video partners also found that shared laughter consistently increased participants' sense of similarity with their video partner and desire to affiliate with him or her.⁸

As mentioned, humor can have valuable roles in fast-paced health care environments where intense relationships form.^{9,10} Keller and Koenig showed that humor⁹ is one of the most effective strategies employed by emergency medicine physicians to prevent adverse psychological sequelae of their work, including burnout.¹¹ Humor helps caregivers deal with stress, fosters collegiality, and improves morale.¹² Humor can also signal a person's general receptiveness to social interaction: clinicians greeting colleagues with a smile usually get one in return.¹³

Harms of Humor

Although there is obvious benefit to the use of humor, it can be harmful. Ferguson and Ford define *disparagement humor* as "remarks that (are intended to) elicit amusement through the denigration, derogation, or belittlement of a given target (eg, individuals, social groups)."¹⁴ Ridicule (ie, laughing at someone else for the purpose of demeaning that person) is a kind of disparagement that leverages primal negative emotions and reinforces harmful stereotypes. Humor driven by the desire to ridicule is weaponized humor, designed to demote the target to a humiliated state of "otherness," such as "other doctors are stupid," as in the opening case with the emergency medicine intern and the obstetrics residents.

"Us-vs-them" divides have a long history. Aristotle believed that we laugh at people we perceive as ugly or stupid to express the joy we feel about our apparent superiority.¹⁴ Socrates added that we laugh at those who are delusional about their own abilities,

which allows us to demonstrate—or so we think—that we’re more clear-sighted. Thomas Hobbes also claimed that laughter provides a moment of “glory,” in which we feel ourselves to be superior to others.¹⁴ These thinkers built the foundation for what modern psychologists describe as the *superiority theory* of humor: “our” self-esteem derives from downward social comparison with “them,” whom we dislike, perceive to be inferior, and disparage for “our” amusement.¹⁴ An ethical problem with superiority-based humor, however, is that it is by its very nature a zero-sum game. If “other doctors” are stupid, then “we” must save our patients from “them.”

The Case for “Harmless” Humor: Prepositions Matter

Not surprisingly, illusions of superiority perpetuated by disparagement humor get us nowhere when we’re trying to take good care of patients. Tribal clinical practice impedes collegiality, allowing us to devalue colleagues’ viewpoints. Poor interprofessional collaboration, possibly due to tribalism, impedes understanding of others’ roles and responsibilities and is a potent barrier to better patient care.^{15,16} Moreover, “professional tribalism” can influence professional decision making, contributing to unplanned admissions.¹⁷ Dysfunctional tribalism is seen in the case when one intern’s concern about the implications of lumbar puncture for a pregnant woman is mocked by 2 residents. The consulting resident’s disdain for the question and for the clinician who posed it certainly doesn’t serve the patient or the team’s collective efforts to help the patient.

What does this consultation **teach the intern**? Perhaps the intern now perceives lack of knowledge as a source of shame, although clinicians *are supposed to* consult specialists when they have important questions. One can imagine that this interaction might influence the intern’s willingness to initiate consultations in the future, even in a case in which emergent intervention is needed. The intern likely feels the separation between “us” (the emergency medicine team) and “them” (the obstetric team), and both groups’ subsequent use of and subjection to derisive humor will reinforce these tribal loyalties. We’d do well to remember here that the words *humor* and *humiliation* have the same etymological root; disparagement humor reminds us that the border between them is thin.

In our experience, clinicians who create a culture of fear through their practices are those whom we tend to try to avoid, even when their expertise could benefit both patients and other clinicians. What’s important to note is that we can use humor in medicine without creating or endorsing dysfunctional tribalism. The desire to socially identify oneself with a group is a natural human impulse with many positive effects, including team building and stress relief, and we can embrace these positive effects while mitigating the negative effects. We must seek opportunities to share rather than weaponize humor in order to break down barriers between “us” and “them.” Laughing *at* a colleague is unlikely to create productive collaboration, but laughing *with* a colleague can align interests, promote well-being, and optimize our capacities to deliver good, team-based patient care.

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The people and events in this case are fictional. Resemblance to real events or to names of people, living or dead, is entirely coincidental. The viewpoints expressed in this article are those of the author(s) and do not necessarily reflect the views and policies of the AMA.



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MEDICAL EDUCATION

How to Use Humor in Clinical Settings

Paul Osincup

Abstract

Abundant evidence documents positive physical and psychological health benefits of humor. Humor and laughter researchers at the Association for Applied and Therapeutic Humor (yep, that's a real thing) not only study why humor helps, but also how it can be applied in health professions settings where patients are ill, injured, or otherwise vulnerable. Along with briefly outlining some health benefits of humor and pitfalls to avoid when using humor, this article provides actionable strategies for enhancing one's humor skill set and applying humor deftly (without doing harm) in clinical settings.

Benefits of Humor

My being kicked out of my philosophy 101 ethics course in college taught me a lesson about humor. The professor asked, "What is philosophy?" I said, "A bunch of old white guys arguing about things that don't matter and nobody understands." He forcefully replied, "Do you not understand because it doesn't matter? Or does it not matter because you don't understand? You can leave this class until you have an answer!" In addition to ethics, he also taught me a great lesson about the application of humor. Before you can be a smart ass, you first must be smart.

In the 25 years since my philosophical funny fail, I began to see the power of humor not only to get a laugh, but also to connect with people and even **enhance health and well-being**. We know that humor and laughter are shown to decrease levels of stress hormones,^{1,2} lower blood pressure,³ strengthen the immune system,^{4,5,6} decrease pain,^{7,8,9} and decrease inflammation.¹⁰ Laughter is an excellent addition to treating almost any condition—with the exception, perhaps, of urinary incontinence.

Today, as president of the Association for Applied and Therapeutic Humor (AATH),¹¹ I study and apply humor to enhance health and human performance. At AATH, we define therapeutic humor as an intervention that promotes health and wellness by stimulating playful discovery, expression, or appreciation of the absurdity or incongruity of life's situations.¹¹ It can enhance health or be used as a complement to treatment to facilitate healing or coping. This article discusses strategies for implementing humor in clinical settings, including how to develop humor habits, use improvisation as a tool, be

intentional about using humor, avoid common pitfalls, and assess risks and rewards of using humor.

Humor Is a Habit

You might be thinking, “This is great, but I’m just not that funny.” If you’re thinking that to yourself, you’re probably right. You might not be that funny, but you are self-aware and modest, both of which are important parts of becoming funny.

A great thing is that you don’t have to be naturally funny to get good at using humor. A first step is to train your brain to have a *funny focus*. You can develop this mindset by incorporating humor habits in your life, including those discussed below.

- *Comedy commute.* Listen to comedy or humorous podcasts on your commute rather than news. Listening to more comedy on your commute will expose you to a variety of types of humor, which will help you learn more about what types you enjoy. You might not know that you like funny stories, observational humor, satire, slapstick, or impersonations until you give humor programs a try.
- *Three funny things intervention.* Each day write down 3 things that happened that you found funny, amusing, or humorous. One of our AATH researchers found that people who daily wrote down 3 funny things that happened for only one week increased their overall happiness and decreased depressive symptoms for up to 6 months!¹²
- *Play the “what I could’ve said” game.* If you’re the type of person who always thinks of the funny thing you could have done or said after the moment has passed, that’s okay! Go with it. Come up with various humorous ways that you could have handled a situation or greeted a patient. The more often you do this, the more quickly your brain will start making these connections.
- *Five-minute funny.* Set an alarm to take a break to watch a funny video. Not only will this keep your brain in funny-focus training, it will keep you sharper and more productive for the rest of the day. In fact, people who take a break and watch a funny video are twice as productive when returning to work as those who took a break with no humor.¹³ Humor has also been found to be one factor that can mitigate and counteract the effects of mental depletion.¹⁴
- *Follow funny.* Like and follow funny pages on social media. This practice will increase the amount of humor that organically appears in your feeds, thus increasing your exposure to humorous triggers.

Sharpening your funny focus by developing humor habits follows Hebbian theory that “neurons that fire together, wire together.”¹⁵ In fact, the findings of one study suggest that the more experience people have using humor, the more they will shift from relying on prefrontal cortex executive functioning to guide searches for humorous associations to relying on the temporal lobe, which facilitates spontaneous and remote or abstract associations.¹⁶ Training your brain to have more of a funny focus is about being intentional and not simply hoping for but harnessing humor. It’s okay if you aren’t naturally funny. Humor is not a talent. Humor is a habit.

Improv to Improve

While the purpose of improvisation (improv) isn't necessarily to generate humor, it can be a joyful consequence of being present, listening, and building upon what others offer. "Yes, and" is commonly thought of as the **first rule of improvisation**.¹⁷ While "Yes, and" is a crucial part of doing improvisation well, one must first be present in the moment and listen. If you're a clinician going through the motions, distant, and not listening, it's very easy to miss opportunities for humor. Your patients might open the door for humorous interactions themselves. The question is whether you notice those open doors. One study found that patients initiate humor in a clinical setting at about the same rate as clinicians.¹⁸ The bad news, however, is that not all clinicians follow the first rule of improvisation as much as they could. In one study, clinicians only elicited the patients' agenda 36% of the time, and, when they did, in 67% of those encounters the clinician interrupted the patient in a median time of 11 seconds.¹⁹

Humor can sneak its way into a clinical situation if you remain open to it. For example, Sarah Bryson, a licensed clinical social worker in Arkansas, was meeting with a client and talking about depression and suicide. When Sarah told her, "I'm concerned that you've been thinking about suicide," they heard the deep sound of the tympany drums from a music therapy room down the hall ("*Bum bum, bum bum, bum bum!*"). The client began laughing hysterically, and Sarah followed suit. This spontaneous moment of humor led to the client opening up with Sarah. Now, any time their conversations take a more serious tone, one of them will say, "*Bum bum, bum bum, bum bum!*" (S.W. Bryson, oral communication, December 10, 2019). A key is to listen and follow patients' lead. If they're using humor with you, then it probably makes them more comfortable. Just like in improvisation comedy, you listen for opportunities and then proceed with positive intentions: "Yes, and!"

Humor by Choice, Not Chance

Now that you've got some humor habits and your improvisation listening skills are on point, here are some strategies to help those of you who are clinicians to intentionally incorporate humor in the clinical setting.

Prime the pump for positivity. In order to increase the chances of having a lighthearted and **positive interaction** with your patient, add humorous reading material to your waiting area, tune into funny shows on the TVs, display a funny photo of your pet or kids in your office that might spark conversation, or even place funny signs in public areas. For example, one doctor's office had a small sign that read, "From '1 to stepping on a Lego,' how much pain are you in?"²⁰ The signs don't even need to be medically related to get a smile. Why not have the boring "Please wash your hands sign" in the restroom be a picture of Han Solo that says, "Wash Your Hans?" Anything that is a little funny or different could have a positive effect on the emotional state of your patients prior to them even seeing you.

Conversation starters. Try something different by creating a list of questions—or a stack of cards with questions on them—and having the nurse tell each patient to choose one question that the doctor will answer upon entering the room. The following questions might be helpful conversation starters: *What's the weirdest thing you've ever eaten? If you built a themed hotel, what would the theme be and what would the rooms look like? What would a world populated with clones of you be like?* This quick dose of fun is sure

to lead to some humor and easier dialogue. If it feels like the patient is comfortable with you, then you can ask the patient the question.

Find humor in pain points. Humorist Charlie Chaplin once said, “To truly laugh, you must be able to take your pain, and play with it.”²⁴ Most comedians focus on the pain points in life to generate humor. Think about annoying things that are universal to your patients, such as long wait times, long lists of side effects, complicated insurance forms, or that loud crinkly paper covering the exam table. You might even draw some humor out of the patient’s pain by asking a slightly different question. After asking about symptoms or how they’re feeling, you could ask, “What’s been the most annoying thing about dealing with this condition so far?” Sure, the patient might share something that isn’t funny, but it could spark a humorous response that you can run with!

Exaggeration. This is a commonly used, simple tool of comedy. In fact, this year alone, use of exaggeration has gone up a million percent. (Sorry, I had to.) Anyway, all you do is take a concept and exaggerate it to a ridiculous level to make it funny. Let’s take one of the aforementioned pain points of long wait times. Rather than coming in and saying, “I’m sorry about the wait,” you could exaggerate it. “I’m sorry about the long wait. So, the chart says you’re 43.... Is that still the case or have you celebrated a birthday since you got here?”

Comic triple. This is another simple comedic technique. You just list 3 items in a row with the first two being serious and the last one being funny, surprising, or different. For example, if you just treated a broken leg and are telling the patient what to expect, you could say: “In the first week, you can expect some swelling, itching, and constantly being asked, ‘OMG what happened!’?”

Laughter yoga. Incorporate laughter exercises in your practice. At AATH, many of our members are certified in leading laughter yoga, which consists of a version of yoga breathing exercises (pranayama) done in the form of laughter. The laughter leader could have participants breathe in deeply and breathe out with guided “*ha, ha, ha’s*” or “*hee, hee’s*” with movement. Designed to help people reap therapeutic benefits of laughter and humor, laughter yoga is being practiced at some senior living facilities, workplaces, and hospitals.^{22,23,24,25,26,27} One study suggests that laughter yoga is a promising addition to the hemodialysis regimen and might enhance some dialysis patients’ quality of life.⁹

Avoiding Pitfalls

We know that humor builds trust and that when 2 people (even strangers) laugh together, they are far more likely to like one another,²⁸ so humor is a great way to get those patient satisfaction survey scores up! Keep in mind, however, that people may not be looking for humor in their health care experience. That’s why, as a clinician, the most important thing you can do is listen, connect with a patient, and follow their lead. One of the best ways to avoid pitfalls with humor is to start with yourself and your own experiences rather than trying to focus the humor on a patient or their situation. And be careful when using self-deprecating humor. A self-deprecating joke can be a way to reduce social distance between you and a patient, but be sure it isn’t about skills necessary to do the job well. For example, you might tell your patient about dropping your jelly donut on your white shirt this morning, which could get a chuckle. What you don’t want to do is to add, “I can be so clumsy sometimes” or “talk about butterfingers!”

The last thing a patient wants is to picture their clumsy clinician not being able to hold a jelly donut right before their vasectomy.

Another way to avoid pitfalls is to remain positive and inclusive. Aiming humor at common human annoyances is a much safer bet than **aiming at specific people** or groups of people. For instance, if you know that parking at your facility is difficult, parts of the building are under construction, traffic nearby is brutal, or the rain has caused a bad hair day for you, those are all common annoyances that most people relate to. Before using humor, you can always ask yourself the question, “What’s the risk?” If there is a reasonable risk of someone taking offense, then in a professional setting the cost is too high. When in doubt, leave it out. Remember, if you have to say, “It was just a joke,” then you haven’t told one.

Risk vs Reward

Using humor is not a requisite qualification for being a good clinician. I’m a humor advocate, and even I don’t want my clinicians spending more time trying to figure out how to make me laugh than staying current on best practices in their field. Intentional, strategic use of humor in a clinical setting need not be for every clinician in every circumstance and is a skill carefully and deliberately learned and enhanced over time. As with many things in life, using humor with an intention to connect with patients, decrease their stress, or provide a moment of relief from their concerns does not come without risk.

If I want to run a marathon, I incur risk of injury, and I greatly reduce that risk by training properly, taking things slowly, and getting better at the craft. If using humor in the clinical setting is something you would like to try, but it isn’t a natural part of your repertoire, then begin with easy, low-risk strategies. For instance, as mentioned, having a funny photo on the wall or funny reading material in the lobby are low-risk ways to begin to see whether patients engage with it and comment on it. You might decide you’re simply going to try to intentionally notice and listen for moments when patients are attempting to use humor and give them an encouraging smile or laugh. The “what I should have said” or “3 funny things” interventions described above are personal exercises nobody needs to know you’re doing, but they might lead to your sharing a humorous anecdote or two from your week with a patient.

Starting with the lowest risk strategies that feel comfortable for you can result in the humor you use being more reflective of your own personality and engagement style. Perhaps that is why one study published in *JAMA* (albeit a study published when the Backstreet Boys were topping the charts) found that primary care physicians who had zero **malpractice claims** against them used more statements of orientation with patients, laughed more, and used more humor than primary care physicians who had a history of malpractice suits.²⁹ When used in combination with professional empathy, compassion, and knowledge, humor can be a low-risk way to positively influence some patients’ experiences.

In Conclusion

By using some humor habits, you can train your brain to have more of a funny focus and then begin to intentionally, deliberately create humor—not by chance but by choice. At AATH, we believe in humor’s power to compliment clinical practice and aid physical and psychological healing and recovery processes. Whether you think you’re the clinic

comedian or a humor novice, incorporating humor in your life and practice is a skill that can be learned and leveraged.

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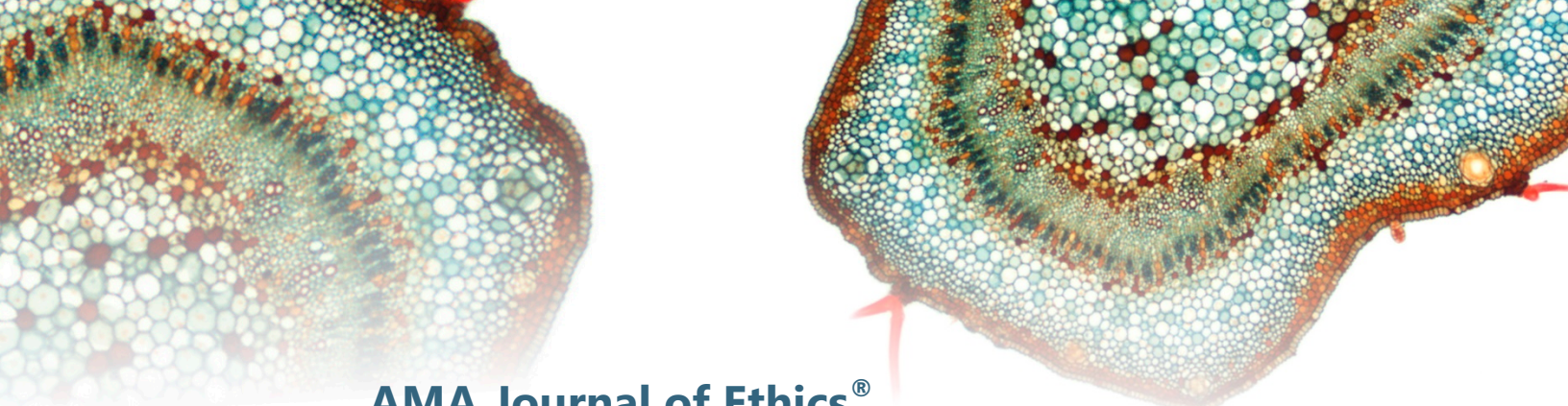
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HEALTH LAW

Could Humor in Health Care Become Malpractice?

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Abstract

Humor in the practice of medicine carries with it both benefits and inherent risks. Included within the risks are legal risks. Traditional causes of action involving the use of humor are breach of contract, defamation, trademark infringement, harassment or hostile work environment, and intentional or negligent infliction of emotional distress. However, in the medical context, there is precedent for humor or jokes used during the patient-physician encounter serving as a basis for medical malpractice claims as well. Physicians should be aware of the potential legal liabilities of humor and approach its use with caution and mindfulness.

Introduction

Medical research underscores the value of humor in the practice of medicine—specifically, the use of humor between physician and patient. In the medical practice setting, the value of humor is recognized both for patients—“as a coping mechanism to reduce the anxiety and frustration associated with being in the hospital”—and for physicians—as a tool to “deal with the stress of caring for patients who are in pain” while also helping to foster “good working relationships among colleagues.”¹ Despite these benefits, using humor in medical practice has real risks. From a legal standpoint, the risks of humor may manifest in the form of legal action or liability. Traditional forms of legal liability associated with jokes or humor are breach of contract (eg, was a statement a joke or a promise?), defamation, harassment (eg, sexual harassment or hostile work environment claims), trademark infringement cases (eg, parody of a protected mark), or intentional or negligent infliction of emotional distress.² In the medical context, another potential legal action remains possible: medical malpractice. Jokes or humor as the basis of a medical malpractice claim may seem, at first glance, to be outside the purview of what constitutes **medical malpractice**, as a claim must necessarily involve conduct stemming from the practice of medicine itself.³ Can humor or jokes ever be considered part of the practice of medicine? The answer is debatable and without a simple answer that covers all scenarios. However, there is legal precedent suggesting that, in certain instances, humor or jokes may be within the scope of medical practice and might be used to support medical malpractice claims. Such precedent is a reminder to physicians of the risks associated with using humor and that, depending on the

circumstances, a joke has potential to become the basis of a medical malpractice claim—pushing the legal risk of humor into a sphere beyond traditional legal claims.

Traditional Legal Risks Associated With Humor

As noted above, legal risk associated with jokes and humor has traditionally taken the form of legal claims, such as breach of contract, defamation, trademark dilution or infringement, harassment, and infliction of emotional distress. Regulation of humor by law—as these causes of action allow—is a complicated and controversial subject. As Laura Little notes, “regulation of expression risks muting outlying values and tastes, which society might beneficially evaluate and debate.”² Note that these causes of action are ones for which all members of society share risk of liability, not only medical professionals. However, while none of these claims are medically oriented in a general sense, physicians should still be mindful of them because—depending on the clinical situation involving humor between physician and patient—any of these claims may be possible in the medical context.

Breach of contract. With regard to humor, a breach of contract claim may arise from a dispute about whether a joke or jesting by one party was taken as a serious offer or acceptance by another party in order to establish an enforceable contract.³ A famous example was a Pepsi promotional campaign wherein consumers could redeem gifts by collecting Pepsi Points. The advertising campaign featured a teenager winning a Harrier fighter jet by amassing 7 million Pepsi Points. A lawsuit emerged when a plaintiff accumulated 7 million points and demanded a Harrier jet.² The debate centered on whether the advertisement was a “joke” or whether it was a valid offer to win a Harrier jet; the court ultimately found in favor of Pepsi, deeming the advertisement as humor and not a valid contractual offer.² However, a joke may sometimes form a contract; a Virginia court once held a “comedic exchange” of a contractual nature to be enforceable, as it found “persuasive evidence that the execution of the contract was a serious business transaction rather than a casual, jesting matter.”⁴

Defamation. Defamation is another cause of action often associated with humor or jokes. In US common law, a defamatory statement is one that harms the reputation of another; key elements of the claim are that the statement at issue be both defamatory and false.⁵ When evaluating the actionable defamatory nature of a humorous statement, the requirement of falsity brings complexity to the analysis. As Little notes, humor or jokes do “not fit easily into the paradigm of truth and falsity. Humor is by definition not ‘serious,’ thus suggesting that it operates outside the realm of anything one could verify.”⁵ There is recent precedent for **defamation liability** in the medical context, as occurred in *D.B. vs Ingham*, in which a Virginia anesthesiologist made disparaging and untrue statements about her patient undergoing a colonoscopy while he was under anesthesia.⁶ These remarks may have been intended to be jokes between colleagues; however, a jury awarded the patient a six-figure award for his defamation claim against the physician.⁶

Trademark infringement. Trademark cases are also relevant because humor, like parody, may be a defense against a claim of trademark infringement. Little notes that such claims are “designed to protect against harm both to consumers who may be misled into buying something they did not expect and to trademark owners who are deprived of sales.”² She adds that with regard to “a true parody, an infringement cause of action will not succeed,” as consumers would understand the alleged infringement is

merely parody and “would not likely confuse the protected product with the challenged product or communication [ie, the parody or joke].”²

Harassment or hostile work environment. Harassment and hostile work environment claims are particularly relevant in society, as there is greater recognition and awareness of these claims. There are many cases in which jokes, banter, and humor in the workplace amounted to legally cognizable claims of harassment or of a hostile work environment. As Robert Gregg notes, jokes in the workplace about “race, sex age, ethnicity, religion” are risky and generally “not appropriate.”⁷ Mindfully approaching such risks, Daniel Sokol recommends that physicians ask themselves before making any such jokes or banter in the workplace (either with patients or other colleagues): “‘Would a reasonable, impartial observer consider this remark to be inappropriate?’ If the question cannot be answered with conviction, it is best not to crystallise the potentially offensive thought into words.”⁸

Intentional or negligent infliction of emotional distress. The common law tort of infliction of emotional distress (either intentional or negligent), consists of 4 elements, summarized by Constance Anastopoulos and Daniel Crooks as “(1) intentional or reckless conduct that is (2) outrageous in nature, beyond the bounds of human decency, and intolerable in a civilized community, and that (3) causes emotional distress that is (4) severe such that no one should be expected to endure it.”⁹ In the context of humor and jokes, Richard Bernstein notes that “[c]ourts have already held that derisive humor, parody, unorthodox religious doctrine, and abhorrent political ideas can be found extreme and outrageous” and that “[j]udges and juries will be more likely to find the joke extreme and outrageous and impose liability when they find the speaker’s underlying point of view objectionable.”¹⁰ *Abadie vs Riddle Memorial Hospital*, a Pennsylvania case, provides an example of an emotional distress claim arising in the context of humor and medicine, wherein a patient (Abadie) sued a hospital (Riddle) for intentional infliction of emotional distress when the patient was distressed by hospital employees’ loud and disruptive birthday celebration that included noisy laughter, vulgar language, and a hired stripper in a gorilla costume—all of which may have been humorous to hospital employees but were offensive to the patient.¹¹ Although the hospital ultimately prevailed in the case because the plaintiff did not allege any physical injury (Pennsylvania requires an allegation and finding of physical injury to prevail on a claim of emotional distress),¹¹ the case still serves as a cautionary reminder for medical professionals that jokes between colleagues may also cause emotional distress to patients.

Humor and Malpractice

While physicians (and all members of society) must be mindful of the traditional legal risks of humor outlined above, it is possible that a physician’s use of humor could give rise to a medical malpractice claim. When analyzing whether humor could be part of a medical malpractice claim, it is important first to understand the elements of the claim. The common law elements of medical malpractice are as follows: “(1) the existence of a duty running from the physician to the injured party; (2) the physician’s breach of this duty; (3) an injury to the patient that is proximately caused by the doctor’s breach of duty; and (4) damages arising from the injury.”¹² Essential to the physician’s duty to the patient is that the physician “use reasonable skill in his or her professional practice,” thus requiring that “any negligence for medical malpractice must necessarily arise out of the practice of medicine and the physician’s treatment of the patient.”³ The key question then becomes what constitutes the practice of medicine such that it legally

falls within the scope of the physician's duty to the patient in a medical malpractice claim. For example, a "doctor's sexual relationship with the patient's spouse" would not allow for a valid claim of malpractice, as such conduct falls outside the practice of medicine.³

It may appear controversial to consider humor coming under the scope of what constitutes the practice of medicine, but there is some precedent for the notion and for allowing such a medical malpractice claim to be possible. *D.B. vs Ingham* is a prime example. In that case, as mentioned above, the patient (D.B.) was undergoing a colonoscopy and the anesthesiologist (Ingham) made several severely insulting comments about the patient to the gastroenterologist she was working with.⁶ Ingham's statements regarding D.B. were vitriolic, mean-spirited, and extreme; she insulted the patient repeatedly and made false allegations about his sexual orientation and the presence of hemorrhoids. The jury found in favor of the plaintiff and awarded him 2 six-figure awards (along with punitive damages)—one award for a claim of defamation and the other for medical malpractice, presumably because such "jokes" between treating physicians were closely attuned enough to the patient's medical procedure to be considered within the scope of practice for medical malpractice purposes.⁶

Another example of malpractice involving humor is the Washington State Supreme Court case, *Woo vs Fireman's Fund Insurance Co.*¹³ While this case is technically one of insurance contract law, it has persuasive relevance for medical malpractice regarding what constitutes professional practice. In *Woo*, a surgical dentist (Woo) is suing his insurance carrier (Fireman's) for failing to defend him against a professional malpractice claim. The malpractice case arose because Woo, during a dental surgical procedure, placed boar tusk flippers in the patient's mouth as a "practical joke" at the patient's expense. Fireman's argued that it should not defend Woo, as such a "joke" clearly falls outside what constitutes the practice of dentistry under the policy. However, the Washington State Supreme Court concluded that "Fireman's had a duty to defend under Woo's professional liability provision because the insertion of boar tusk flippers in Alberts' [the patient's] mouth conceivably fell within the policy's broad definition of the practice of dentistry," reasoning that the "acts that comprised the practical joke were integrated into and inseparable from the overall procedure."¹³ While this holding is technically an interpretation of the insurance contract, it clearly demonstrates the Washington State Supreme Court's willingness to view such a practical joke as within the scope of professional practice.

However, there is reasonable debate over whether a medical practitioner's joke may validly fall within professional practice. For example, the dissent in *Woo* made a strong argument against the notion of including jokes within the scope of medical practice. The dissenting opinion—drawing a distinction between the joke and dental practice—explained that "the actionable behavior [of Woo] was the unauthorized porcine 'joke,' not the eventual and separate proper replacement of Ms. Alberts' [the patient's] teeth," concluding that "Woo was not practicing dentistry" while conducting his practical joke and that the joke itself "was not intended to treat any 'disease, pain, injury, deficiency, deformity, or physical condition.'"¹³ The dissent in *Woo* demonstrates the controversial nature of allowing jokes or humor to be part of the basis of a medical malpractice claim, and, while not all instances of jokes involved in the practice of medicine may allow for a malpractice claim, practitioners should be mindful that, depending on the facts, potential for such liability exists.

Conclusion

The above discussion serves as a cautionary reminder to physicians and other health care practitioners that jokes or humor in medicine can carry legal risks. While some legal risks may be obvious (eg, sexual harassment claims), some legal risks are not so intuitive. One notable example is that of medical malpractice in which a joke may indeed be deemed within the scope of the practice of medicine and give rise to a claim of malpractice in the right set of circumstances.

While considering these legal risks, it is important to remember that humor in medicine can have noteworthy positive and **therapeutic benefits** for the physician, patient, and the patient-physician relationship.^{14,15} Jeffrey Berger et al note that “careful use of humor can humanize and strengthen physician-patient encounters” but that physicians “should be assiduously conservative in selecting the content and manner of humor.”¹⁵ Caution and mindfulness are key when employing humor in the physician-patient encounter. As May McCreddie and Sheila Payne note, while initiating humor in the practice of medicine is a risk, it may just be “a risk worth taking.”¹⁶

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STATE OF THE ART AND SCIENCE

The Science of Comedy (Sort of)

Anne Libera

Abstract

From an academic point of view, humor studies have traditionally lived in the rather unfunny world of philosophy departments. More recently, psychologists and neuroscientists have begun to study mechanisms of humor and laughter. An argument can be made that approaching humor studies from the perspective of comedy creation offers practical tools for using comedy and humor in everyday communication and connection.

Understudied Humor

For purposes of this article, think of *laughter* as sounds humans make when amused. People also laugh for many other reasons: we laugh because others laugh, we laugh to demonstrate agreement, or we laugh when we are embarrassed or uncomfortable. *Humor* is the state of being amused, although it might not be accompanied by laughter. Humor and laughter were not seen as valuable topics for philosophical or scientific study until the 1980s,^{1,2} perhaps due to their assumed connection to body instead of mind and because laughter, like other bodily functions, is often difficult to control. Humor is also often thought of as “low”—that is, enjoyed by the people as opposed to the elite.

Recently, scientific research on the neuroscience of laughter has showcased the potential intellectual benefits of a brain wired to find humor and the connections between humor responses and common biases and heuristics.³ As will be discussed, my own work on the pedagogy of *comedy*—which I define as an intentionally created event or work designed to evoke laughter or humor in an audience—appears to provide a practical roadmap for leveraging the positive benefits of some theory-based tools for generating humor and laughter without falling into some of the obvious potential downsides, such as causing unintentional offense or creating divisions between groups.

Theories of Laughter and Humor

Early philosophers focused on the negative elements of humor and laughter. The superiority theory of humor attributed to Plato and later promoted by Thomas Hobbes, among others, holds that the primary motivator for humor is triumph or pleasure at the pain, flaws, or indignities of others.¹ The superiority theory also implies that laughter and humor are inherently negative, in that humor requires ridicule or disparaging others. We are thought to laugh “at” something or someone because we see that person as

genuinely lesser than ourselves. Certainly, laughter borne of derision, insult, and **ridicule** are still common today, from playgrounds to televised roasts and social media sites.

A second major theory of humor is tension and release.¹ Based on Sigmund Freud's theory of the unconscious, it suggests that repression of sexual or aggressive thoughts and urges creates a buildup of energy released in the form of laughter. Freud saw laughter and humor as providing a kind of release valve and thus the types of material that generate laughter are necessarily base and appealing to the id,¹ the childlike portion of the human psyche. Although the psychological ideas behind this theory have been largely debunked,⁴ it is worthwhile to note that modern comedy makes deliberate use of tension and release. For example, cringe comedy television shows—like *The Office* or *Curb Your Enthusiasm*—or the antics of comedians like Andy Kaufman or Eric Andre eschew traditional release via punchline, instead building tension through deliberate provocation and awkwardness during performances as well as by creating discomfort among audience members.

The third and currently most broadly popular of the major philosophical theories of humor is the incongruity theory, developed by Immanuel Kant.¹ Later adherents included Arthur Schopenhauer and Søren Kierkegaard.¹ This theory holds that humor results when our brains perceive 2 things as coexisting in a manner that does not at first appear to make logical sense and that laughter or humor occurs when the discomfort caused by this incongruity is resolved in some way. A simple example of this is a pun. Humor results when we discover that a word that initially appears incongruent in the context in which we first encounter it has another meaning that makes logical sense when a different context is revealed. In the joke, “Light travels faster than sound. That’s why some people seem bright until they speak,”⁵ an initial mental image of a person glowing “brightly” makes more sense when we understand it as referring to intelligence.

Variations on incongruity theory include Henri Bergson's silent film-inspired contention that humor is created when a human being behaves rigidly like a machine⁶ and Mikhail Bakhtin's surmising that humor results when social roles are reversed: the powerful are taken down or the powerless become powerful, as occurred during medieval carnivals when a peasant became a carnival king for the day.⁷ Another theory combining the superiority and incongruity theories but with a more specific focus on resolution and release is social scientist Peter McGraw's benign violation theory, which posits that a joke or a moment can be perceived as humorous if it is seen simultaneously as a violation of norms and as benign.⁸

Scientific Thought on Laughter and Humor

Incongruity theory has been bolstered by the study of heuristics and biases and by neuroscience. To use the terminology of Daniel Kahneman, the brain has 2 separate systems: System 1 (the fast brain) is primarily automatic and intuitive, and System 2 (the slow brain) proceeds deliberately and logically.⁹ Neuroscientists have suggested a possible genetic advantage to laughter and humor, theorizing that pleasurable experiences of discovering and resolving incongruity rewards the brain with dopamine and trains us to use System 2 to test (potentially incorrect) conclusions, to which our faster, but less diligent System 1 jumps.⁴

Animal studies have shown that apes and dogs use sounds similar to laughter when participating in activities that mimic real life, such as play fighting.⁴ This finding suggests that we humans might also laugh to signal others about our intentions and that we are

rewarded through humor and laughter for using play to practice certain kinds of social interactions. There is perhaps no better example of what might be called the play theory at work in the world of comedy than the humor and laughter generated by those watching or participating in **improvisational games** used on The Second City stages and in its training programs.

A Theory of Created Comedy

My personal theory of created comedy reframes existing humor and laughter theories into a set of tools that comedians manipulate to create work that generates humor or laughter.¹⁰ I propose that in generating and refining their work, comedians use 3 elements. The first element is *recognition*. It could be argued that recognition is implicit in most traditional theories of humor, but for the work of comedy it is primary. One of the easiest ways for a comedian to get an audience to laugh is to describe something familiar; it can be a local landmark, an impression of a public figure, or a reference to the television show that everyone is currently watching. Even more likely to incite laughter are references specific to or particularly salient for a given audience. When I was writing corporate comedy shows, we referred to this as “Bob from Accounting”: inserting an actual employee’s name into a comedy sketch would invariably get huge laughs. Social science research suggests that the strongest laughter is generated when a comedian shares an observation that supports or reflects audience members’ experiences of the world.¹¹ Genuinely shared laughter creates bonds through mutual understanding.

I label the second element needed for comedy *pain*. The tension and release, incongruity, and superiority theories involve this element either directly or indirectly in the form of tension, cognitive dissonance, and embarrassment or shame, respectively. A technique frequently used in generating comedy is to begin by listing recognizable elements (events, people, occupations) and then applying some element of pain. For example, listing several occupations and then improvising questions, such as “What would the world’s worst version of each of those occupations do or say?” can illuminate common pain points. Or a standup routine can be created by brainstorming common experiences that already contain elements of pain, such as terrible first dates.

The third element is a context that allows us to reflect on these experiences with some degree of objectivity, equanimity, or sense of safety, perhaps making them benign. I prefer to describe this element as *distance*. Distance can be temporal, as in the phrase “Tragedy plus time equals comedy,” attributed to Steve Allen and others.¹² Or it can be spatial and psychological, as evident in Mel Brooks saying that “Tragedy is if I’ll cut a finger, I go to Mount Sinai, get an X-ray, have to change bandages. Comedy is if you walk into an open sewer and die.”¹³

Comedians use these 3 elements almost as one would use faders on a mixing board in a sound studio. Something particularly recognizable requires just a light level of cognitive dissonance to provide distance and pain, such as seeing your personal experience reflected in a comedy routine. Very painful or highly taboo subjects require a great deal of distance in order to feel funny. I warn my college-age comedy students that they have a much higher tolerance for and distance from “edgy” takes on topics like sex, death, and religion than their parents in the audience. In the same way, comedians visiting campus might find that their privileged distance on issues of race and gender is not reciprocated by similar feelings of safety and recognition in a more sensitive student group.

Using Comedy Theory Tools to Better Use Humor in Real Life

As a teacher of aspiring comedians, I am often asked whether I can teach someone to be funny. My goal is to provide the tools that allow for better and more intentional comedy creation. I have also seen that understanding the tools of comedy creation can allow those in other settings to reap some of the **benefits of humor**. Below, I suggest how these tools of comedy can be brought into interactions to strengthen connections and diffuse tensions.

Practice recognition and self-disclosure. Recognition and self-disclosure are at the heart of good comedy and are the easiest to implement safely. Professional comedians mine their own lives for material and often some of the most resonant comedy created by my students stems from very specific details taken from their own lived experiences. An exercise I created for a workshop on diversity and inclusion, which had participants share the details of how they personally go grocery shopping, consistently generated a large amount of shared laughter. When our daughter was hospitalized for cancer treatment, my husband and I deliberately used this training when interacting with her physicians and other caregivers. We found that the combination of a tiny bit of vulnerability related to sharing a piece of personal information and the recognition of common experiences provided one of the strongest and safest ways for us to use the tools of comedy to make deeper connections with care team members.

Think about comedy and humor as more than just jokes. While it is fine to share what my students now term “dad jokes”—the kind of old-school setup and punchline jokes rarely used in contemporary comedy—you can share humor just by releasing tension and by recognizing awkwardness or discomfort without making any kind of formal joke. Laughter is inherently social and shared laughter creates more points of connection.

Play a game. Many of the games used in improvisation can be adapted to other situations. You can use the improv game “Last Word” in any communication situation, but it can be particularly useful as a way to **encourage listening** between colleagues. The goal is to use the last word said to you as the first word in your response. Once you are comfortable with the technique, it could even be brought into interactions with patients. Physicians should give themselves the additional challenge of playing the game without patients noticing. It will both force physicians to fully listen and connect as well as create a sense of play that can short-circuit negativity or argument.

Understanding the comedic element of distance can also help those in the medical community be more aware of when their own use of humor or comedy might entail more risk. Just as comedians need to be aware that college students tend to have more psychological distance on sexual topics than their parents, so those in a medical field need to be aware that they might have greater comfort in joking about certain topics than patients due to their greater intellectual distance (based on repeated exposure).

A strong case can be made for more rigorous academic research on the applications of comedy. All human beings use various forms of comedy to communicate. In a time when our political leaders and the media can't seem to agree on when a joke is a joke, perhaps we need more academic experts in comedy to call upon.

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MEDICINE AND SOCIETY

Responding to Callous Humor in Health Care

Nicole M. Piemonte, PhD and Shawn Abreu, MD

Abstract

Although humor in health care can facilitate relationship building between patients and clinicians, callous humor used to deflect or dismiss distressing emotions undermines relationships, erodes trust, and expresses disregard for vulnerability. Because it affects collegiality, training, and patient care, callous humor should not be tolerated, especially when directed at patients. This article considers why it is important to respond to colleagues who make callous jokes and suggests how to do so.

Functions of Humor in Health Care

It's likely that humor is as old as healing. Hippocrates, for instance, advised his patients to "contemplate on comic things" to facilitate recovery.¹ Today, one would be hard-pressed to find many physicians prescribing laughter and humor for patients, although clinicians frequently use humor. Indeed, humor in clinical settings can be welcomed by patients, and understandably so: humor and joking can put some patients at ease, level power imbalances, facilitate relationship building, and help patients articulate things they might otherwise be afraid to say.^{2,3,4,5} Humor can also help clinicians relieve tension, make people on a health care team feel better, and even alleviate burnout.^{6,7} Ultimately, humor can bring feelings of levity, pleasure, and connection as well as mutual understanding to situations that might otherwise feel bleak, tragic, or lonely.

Humor also has drawbacks with which many clinicians are familiar.⁸ Gallows humor or jokes that are callous, derogatory, or cynical are common, although usually shared out of earshot of patients and their loved ones.⁹ While some see this kind of humor as useful in a work environment plagued with suffering and death,⁹ others have argued that it dehumanizes patients, undermines trust in practitioners, erodes the character of health care as a sector, and fosters cynicism and detachment among trainees during crucial phases of their professional development.^{10,11,12} Indeed, callousness, whether manifest in a joke specifically or in an insensitive demeanor more generally, might indicate that one has experienced moral damage or distress—and such distress can cause health care practitioners to become less responsive to the needs and concerns of others.¹³ Moral distress—the deep anguish practitioners feel when they are aware of not acting as they are motivated to act—can result from persistent, systemic issues like productivity and efficiency pressures, feelings of powerlessness in the face of patients'

chronic or terminal conditions, or time and resource constraints that make it difficult to adequately address patients' needs.^{14,15} Interestingly, when practitioners reflexively respond to these constraints by making callous jokes, moral distress can be intensified or even increased, especially when practitioners are aware that they are responding callously to others.¹⁴

In what follows, we explore what happens when jokes don't bring people together but instead distance health care professionals from patients, from colleagues, and from their own feelings of vulnerability. Drawing on our experiences in medical education and end-of-life care, we specifically focus on how we might respond to a colleague who uses callous humor in a way that undermines compassionate care.

Not Everyone Is Laughing

Jokes are funny because they create a tension between what we expect someone to say and what is actually said or, as philosopher Simon Critchley describes, a "disjunction between the way things are and the way things are presented in the joke."¹⁶ According to Critchley, jokes are funny because they break causal chains, upend social practices, and tear holes in commonsense rationality.¹⁶ Given this explanation, it makes sense that humor is used so often in medicine, a world where causal chains and common sense are frequently distorted on their own by the indiscriminate and unpredictable nature of illness and injury. Just as the punchline of a joke defies our expectations, so the absurdity of death and meaningless suffering can leave us reeling from the tension between the lived reality of health care and the way we think it ought to be.

For this reason, some physicians and trainees will resort to humor when they feel they lack control. In a study of medical students' use of derogatory and cynical humor, for instance, Delese Wear and colleagues found that students commonly identify patients who are "fair game" for callous jokes—namely, those perceived as "difficult," "noncompliant," or sick as a result of "their own fault."¹¹ The authors discuss some possible motives for such humor, including incongruity theory, which explains humor whose source is the tension between expectations and reality. As they put it, students enter medicine optimistic, only to encounter cynical faculty, unappreciative patients, and their own unanticipated emotional responses—and "humor may be one way of managing these incongruencies."¹¹ In reframing patients as "difficult," negligent, or less-than-whole people, derogatory joking serves to reframe students and their clinical mentors as blameless for their inability to help.⁹ When one is confronted with the caprice of illness and death, using humor can help one reconcile—albeit crudely—**feelings of powerlessness** that arise when reality falls short of expectation.

Although the students in Wear et al's study had no trouble listing types of patients who were consistently objects of derogatory humor, they also uniformly agreed that patients with terminal illnesses or those who were dying were "off limits."¹¹ In our experience, however, we have found that this prohibition is, unfortunately, not universally shared. Two years ago, one of the first author's (N.M.P.'s) medical students came to her office to talk because he was so upset after his first code blue. He told N.M.P. that even though it was disturbing to take part in resuscitation efforts only to watch that person die, what was more devastating was overhearing a member of the code team making fun of how the patient looked during the process. He told her that he never expected that someone could laugh at a patient who was dying. "What if that had been my dad on the table?" he asked her.

What seemed to unsettle this student the most was that this experience was not at all what he expected; it flew in the face of the assumptions he'd made about the kind of care he'd see within the walls of the hospital. Even N.M.P was shocked to hear of this experience. Ultimately, she told this student (and herself) that this was a one-off event, that he'd likely never see it again. Yet, just last month, another student who'd experienced her first code at a different hospital told N.M.P how disturbing it was to see her attending physician and a nurse laughing loudly enough for people in the hallway to hear. She said she didn't know what they were laughing at but that it didn't matter. What was so upsetting to her was the juxtaposition of the caregivers' laughter and the wails she heard coming from the patient's daughter and mother who were huddled together in the hallway just outside the room.

Reflecting on incidents like these, some might draw on the relief theory of humor, the idea that "if we didn't use humor, we'd cry"⁷ or that, as physician Simon Oczkowski put it, "In the face of inevitable death, sometimes the only emotional outlet[s] available are jokes."¹⁷ It is true that mainstream medicine's ethos—an ethos too often defined by stoicism, clinical detachment, and a narrow focus on biological intervention—seems to leave no emotional outlet except joking. And yet, in relying on jokes for relief from painful emotions, clinicians might fail to consider the effect that such jokes have on others—on patients and families, as well as on medical trainees who are almost always present for behind-the-scenes jokes. Using humor in this way simply perpetuates the idea that expressions of fear, powerlessness, and uncertainty are unwelcome in the world of medicine.

Because callous humor has the potential to both undermine patients' trust in medicine and perpetuate the idea that clinicians' expressions of vulnerability are unacceptable, there is a serious need to address this kind of humor in the clinical setting. But just how should one go about doing that?

Responding to Callous Jokes

It should be stated at the outset that addressing callous jokes and jokers in medicine is not intended to be a prudish campaign to eliminate fun and levity in the workplace. Indeed, in his work in end-of-life care, the second author (S.A.) relies on humor nearly every day, both with his patients and with his colleagues. It would be difficult to navigate countless conversations about mortality, pain, and suffering without experiencing moments of joy and connection along the way. This need for levity is why S.A. engages in humor and laughter that is intentional and reflective—in a way that considers audience, context, and varying senses of humor—and not merely a means to deflect distressing emotions. S.A. loves to joke, for example, with one of his favorite patients, a 98-year-old woman whom he sees in his outpatient palliative care clinic. Recently, when S.A. was examining this patient's feet, she told him how "awful" her "old, tired feet" looked. "Nah," he told her, looking up at her during the exam, "these here pretty feet don't look a day over 95." S.A.'s colleague, who is an occupational therapist at an in-patient physical rehabilitation facility, loves to get a laugh from his patients when they ask him what their first session together will be like, telling them that they will start with an easy 4-mile run followed by 200 or 300 push-ups. Even in circumstances in which patients can no longer fully participate in the humor themselves, laughing with family members about patients to recall funny memories or silly quirks that made their loved ones so special—like S.A.'s patient in hospice who insisted his whole care team sing Christmas carols to him in September or another of S.A.'s patients who loudly proclaimed that his last act on this earth would be to take a swig of his favorite whiskey—can be a way to

honor these patients and create the kind of atmosphere that patients would want for their families and friends who are struggling with impending loss and anticipatory grief.

That said, while laughter is often the best medicine (at least for S.A.), it never feels good to be laughed at. Joking that comes at the expense of patients or is used in ways that diminish, dehumanize, or objectify patients is unacceptable and should be addressed, regardless of whether joking is done behind the scenes. However, given the obvious power dynamics within interprofessional health care teams, lower-ranking team members cannot be expected to address the joke. Because trainees, for instance, might fear their grades or evaluations are at stake, they are unlikely to call out callous jokes made by their supervisors—and some students might even reluctantly participate in the joking out of this fear.¹¹ Likewise, other team members might hesitate to speak up for fear of workplace retaliation. We therefore encourage leaders—managers, directors, and physicians—to shoulder the **responsibility for addressing callous humor** while also empowering others on the team to do the same, especially since trainees and interdisciplinary team members tend to have a keen sense of the way things ought to be.

Regardless of who addresses callous jokes, how it should be done will depend on context. In a situation like the one of a code described above, or when a joke is made in front of patients or patients' loved ones, it might be necessary to immediately disrupt the joking and reorient the team back to the care of the patient. A colleague told S.A. recently that when someone on her team made an inappropriate joke during a code, she simply asked the team to quiet down so that they could better focus on what they were doing. Given the intensity of the clinical situation, she decided it was best to talk directly to her teammate about the joke later when they could speak one-on-one.

In general, talking to a person about an inappropriate or poorly timed joke should happen in a private setting. Only when joking is egregious should it be called out publicly, and, even then, the feedback should never be given in a way that shames the person. Rather, it should be offered in a nonabrasive way that redirects the focus toward patient care and with the understanding that people often make jokes out of feelings of discomfort or vulnerability (eg, *I know this situation is uncomfortable and might even seem funny. Let's focus on our patient and what he or she needs right now*).

In one-on-one discussions, some people immediately recognize that their joke was inappropriate or ill-timed, while others need to be told directly and explicitly that their behavior was inappropriate. Such feedback, however, should comment not on *assumptions about a person's character* but rather on *observable behavior*—and the potential effects that behavior can have on others, especially impressionable trainees¹⁸ (eg, *I've noticed that you tend to make a lot of jokes about patients. I'm worried that your joke earlier made some people feel uncomfortable*). In other words, the conversation should be approached with the understanding that the use of callous humor usually comes from difficulty coping with distressing situations and rarely from the fact that people themselves are callous.

In an article exploring how clinicians can respond to patients with cancer who use jokes that belie how they really feel, physician James Hillard suggests that doctors should ask themselves: "What are the impulses, hopes, or fears that the patient may be hiding through humor?"¹⁹ We believe that the same question might guide the approach a health care professional takes when addressing inappropriate humor with a colleague.

Letting the person know that it is okay to acknowledge the emotional difficulties—and even the absolute absurdities—that arise in medicine might help to normalize the emotional intensity of caring for people who are sick and suffering and help to destigmatize expressing emotions in the workplace (eg, *It's hard to know what to say or how to act during a situation like this, but sometimes talking about what you're really thinking can help*). Acknowledging difficult, painful, and even beautiful moments in health care, whether in the moment—right after a patient's death, for instance—or later with others in a private space can help create an environment in which vulnerability is welcomed rather than hidden beneath the surface of callous jokes. Given the emotional intensity and high stakes inherent to medical practice, it is our belief that *not* allowing for expressions of vulnerability can cause, or at least intensify, moral distress.

We know that some people who unthinkingly make callous jokes immediately realize that they've made others uncomfortable and are open to discussing ways to approach things differently. However, we are not naive enough to believe that such conversations are going to reveal to everyone that callous humor is used to hide our discomfort with the fragility of life and the inherent vulnerability of being mortal. Nor do we assume that addressing a colleague's callous humor is going to change the normative **culture of mainstream medicine** that tends to minimize the existential suffering of both patients and practitioners. Rather, we merely hope that offering such feedback might encourage our colleagues to **be more reflective** about the jokes they use and become more aware of who is around to hear those jokes—even if they do these things simply to avoid enduring another conversation with either of us!

Conclusion

Moments in medicine that grant us insight into intense suffering, absurd tragedy, and unspeakable loss are times when our responses can deeply affect those around us, including patients, families, colleagues—and trainees who are learning how to care well for people when they need it most. Rather than simply accepting callous humor as a method for coping with tragedy, those of us in medicine and medical education should encourage our colleagues and learners to reflect on the moments in medicine that shape them, to confront vulnerability, and to acknowledge feelings of powerlessness in the face of death. Sir William Osler once said that “laughter is the music of life.”²⁰ When it comes to humor and medicine, we just need to make sure we're laughing for the right reasons.

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MEDICINE AND SOCIETY

Virtuous Humor In Health Care

René T. Proyer, PhD and Frank A. Rodden, MD, PhD, MS

Abstract

This article offers an overview of what humor is—and of how it can be used as a positive tool in dealing with patients and coworkers. After presenting a recent model for categorizing comic styles, which, among other things, separates “light” and “dark” humor, this article examines humor as a virtue in the context of health care.

*To become conscious of what is horrifying and to laugh at it
is to become master of that which is horrifying....*

*The comic alone is capable of giving us strength
to bear the tragedy of existence.*

Eugene Ionesco¹

Humor Explorations

For some philosophers, moral philosophy without humor is incomplete.² Two nineteenth-century philosophers, Friedrich Nietzsche and Søren Kierkegaard, considered humor to be central to the understanding of moral psychology. Zarathustra (a literary creation of Nietzsche) calls himself “the laughing prophet,” as he enthusiastically affirms life in the face of suffering, ambiguity, and death, expansively encouraging everyone to “learn to laugh at yourselves.”³ And Kierkegaard asserts:

The matter is quite simple. The comical is present in every stage of life ... for wherever there is life, there is contradiction, and wherever there is contradiction, the comical is present. The tragic and the comic are the same, in so far as both are based on contradiction; but the tragic is the suffering contradiction, the comical, the painless contradiction.⁴

Not everything is funny, however. Certainly, there are situations in health care in which using humor is either inappropriate or comes at a risk; **derogatory and cynical humor** can indeed be disrespectful or dehumanizing.⁵ Nonetheless, we argue here that by respecting differences in their various manifestations, humor is irreplaceable in establishing and facilitating good relationships in the health care setting. We will first provide an overview of categories or types of humor and then discuss their use in health care settings. This discussion will also cover some caveats and recommendations.

Categorizing Humor

Humor is not a uniform category but has many facets. Recently, Ruch and Ruch et al introduced 8 comic styles.^{6,7} The *lighter* styles are those that we enjoy most: fun (ie, “spreading good mood and good comradeship”); (benevolent) humor (ie, “arousing sympathy and an understanding for the incongruities of life, the imperfections of the world, the shortcomings of fellow humans”); nonsense (ie, exposing the ridiculous and playing with unresolved incongruities); and wit (ie, humorous remarks “with a surprising punch line that uses unusual [word] combinations created on the spot”). The *darker* ones consist of irony (ie, “creating a mutual sense of superiority toward others” by saying the opposite of what is meant); satire (ie, “improving the world” and correcting wrongdoing through ridicule); sarcasm (ie, using humor to hurt others); and cynicism (ie, “devaluing commonly recognized values” through negative comments or mockery).

Humor in Health Care

The use of humor in health care generally entails the lighter comic styles; the use of the dark comic styles requires more caution. Fun, or good-hearted humor, is contagious and has a positive impact on other people’s moods. Benevolent humor can be useful in facilitating social interactions and building social bonds. The darker comic styles, however, also have their place. Irony and satire can help health care professionals cope with stressors they encounter (eg, when dealing with administrative issues or general regulations that can influence patient care) and might also help in facilitating interactions with patients (eg, when commenting on behavior they both consider amoral). Sarcasm and cynicism warrant more caution, as they are often used as weapons to hurt people’s feelings. They can, however, help patients cope with adversity and be helpful in certain situations (eg, when interacting with someone who shares a sarcastic and cynical worldview or view of a particular topic).

In the day-to-day work of health care personnel, the style of humor used with a particular patient may vary over time. The lighter comic styles that help establish and sustain a positive relationship might be appropriate on the first day of treatment, and the darker styles might be appropriate at a later stage in the patient-physician relationship when patient and physician know each other well. Authenticity is absolutely essential for humor to nurture relationships. Canned laughter in a TV sitcom sounds different than the laughter you share with your close friends, and, similarly, nonauthentic humor frequently sounds and “feels” different and somehow wrong. As Norman Cousins remarked about his illness, “Laughing together is also an indication of a shared mindset and values. And because laughter typically arises spontaneously in reaction to eliciting conditions, laughter is a difficult-to-fake, difficult-to-stifle expression of what one does and does not value.”⁸

Hence, general rules for using humor in health care settings might include the following:

1. Be *authentic* in the use of humor and be *cautious* if your humor is high in darker styles. Light humor is, in most situations, desirable. If, however, you are not familiar with the patient’s humor preferences or if the patient is in a worrying situation (eg, when waiting for the results of a test), the darker comic styles are risky. Dark humor is more liable to the ever-present possibility of misunderstanding (eg, overlooking how humorous exaggeration could exacerbate a patient’s fears). When a misunderstanding occurs, a genuine, understanding apology is always appropriate.

2. Use tact in understanding what your patient's humor preferences are and never forget to be flexible: humor and laughter are not always enjoyable to all people. So-called gelotophobes⁹ have an elevated fear of being laughed at and, with such patients, the use of humor and especially laughter must be very closely controlled and regulated.

General rules are important but will not fit all situations. Laughter-related interventions will appeal differently to different people at different times. Sensitivity to the needs, pathologies, and tastes of individual patients and the gift for sensing the right time for humor are absolutely essential if humor is to build and sustain relationships.

Virtuous Humor

An issue that has gained attention in humor research is the virtuousness of humor—its morally positive value. Benevolent humor expresses a worldview in which mishaps and individual weaknesses are accepted as part of daily life¹⁰; good intentions are taken for granted. Satire (corrective humor) identifies problems and morally wrong actions; it points to the need for change. A positive change in attitude can be facilitated by using satire in the gentle process of correcting a colleague who talks down to patients or colleagues or by good naturedly ridiculing substandard elements in the health care system.

The careful and tasteful use of lighter comic styles can help to keep the pressure down in health care institutions. Having a benevolently humorous outlook on the world can aid in coping with daily hassles in the lives of both patients and health care professionals. In sum, humor can be used both to deal benevolently with others and to facilitate morally good behavior by correcting or highlighting others' errors without overdramatizing them.

Conclusion

The generous and sensitive use of humor in health care settings is both appropriate and desirable. The lighter comic styles are usually appropriate, but the darker varieties of humor (used carefully) have their place. We maintain that beneficent, good-hearted humor **facilitates communication** between patients and health care workers—and certainly among colleagues. Humor can also aid in coping with stressful events (eg, the loss of a patient) or in encouraging other health care workers as they struggle to meet demands. Given Nietzsche's and Kierkegaard's insight on the relation between humor and tragedy, humor invites and compels patients and health care workers to take themselves with ultimate seriousness—but, by engaging in humor, not to take themselves *too* seriously.

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MEDICINE AND SOCIETY

Improvised Caregiving or How a Famous Comedy Theatre Found Itself in Health Care

Kelly Leonard, Anne Libera

Abstract

For more than 60 years, The Second City has used the techniques of improvisation to train some of the world's funniest and most famous people—among them Bill Murray, Tina Fey, Amy Poehler, Jordan Peele, John Belushi, and Joan Rivers. The same skills that generate laughter are just as powerful and potent in any situation that requires human beings to navigate complexity, solve problems in group settings, and listen with the intent to hear. Collaborating with Caring Across Generations, Cleveland Clinic, and other organizations, The Second City has developed training modules that give individuals and groups more agency in the health care space. This article details how the program was developed, provides key insights into the benefits of such training, and offers takeaway exercises readers that can use with their teams and students.

Development of The Second City's Partnership With Caring Across Generations

In August 2015, The Second City (the famed comedy theatre and school of improvisation) in Chicago almost burned to the ground. A grease fire in the restaurant below the theatre sent flames shooting up to the roof of the facility in Chicago's Old Town neighborhood that has been home to The Second City for more than 50 of its 60 years. The firefighters were able to save the actual theatre venues, but a good chunk of the corporate offices was destroyed. The office of the first author (K.L.) was one of those destroyed. K.L. had worked at The Second City for more than 30 years and had moved to that office a week earlier. We begin this story with the fire for a reason. We and our colleagues at The Second City have long believed that our best work comes from mining very uncomfortable places. We contend that innovation is, in fact, born in discomfort. It turns out, of course, that the behavioral sciences tend to agree with this point of view. When Nobel Prize winner Richard Thaler and co-author Cass Sunstein claim that "People have a strong tendency to go along with the status quo or default option,"¹ they're noting the difficulty that people have in leaving their perceived comfort zone. In improvisational practice, exercises based on the *yes, and* concept provide a way to eschew the default option and instead explore and heighten unusual ideas that generate humor as a vital dynamic in the process of creating. The Second City teaches improvisers to "follow the fear," "see all obstacles as gifts," and "make mistakes work for you" in order to spark

innovative practices.² Nobel Prize winner Daniel Kahneman touches on these teachings when he notes that “an inability to be guided by a ‘healthy fear’ of bad consequences is a disastrous flaw.”³

Displaced to a sad coworking space in downtown Chicago that we and our colleagues at The Second City dubbed the “beige palace,” K.L. was sitting in a cramped office that he shared with 3 colleagues when the phone rang. On the line was Adam Grant, a professor at the Wharton School of the University of Pennsylvania who has written a host of bestselling books, including *Give and Take*, which presents the science behind the success of people who give more and take less.⁴ When Grant calls with a favor, you do it, lest you wish to be cast as the villain in his next *New York Times* bestseller. A friend of his by the name of Ai-jen Poo, who is associated with the nonprofits Caring Across Generations and the National Domestic Workers Alliance, was moving to Chicago, and he thought K.L. should meet her. A lunch was set.

Meeting Poo sparked a years-long journey that would become more valuable and important than either of us ever could have guessed. At lunch, not knowing much about each other, K.L. offered to share with Poo the work that he and the second author, A.L., had done that morning. A.L. and K.L. were codeveloping a program at the Center for Decision Research at the Booth School of Business at the University of Chicago with the Center’s then-executive director, Heather Caruso. We called our program The Second Science Project. In short, this program looked at **behavioral science** through the lens of improvisation and vice versa. In developmental labs and executive education programs, we linked evidence-based science on self-regulation, gratitude, and individuation to existing **improvisational exercises**, such as the “Yes, and” exercise, and created exercises with new experiential learning formats to bring new behavioral science findings to life.⁵

Poo then explained that in her roles with Caring Across Generations and the National Domestic Workers Alliance (which seek support and policy change for home caregivers and domestic workers), she was trying to change the national conversation around aging, care, and caregiving. Within seconds, we saw the overlap between the exercises we had been creating and the kind of skill building that the caregiving community needed. Within weeks, we were collaborating on creating a live workshop that could help home caregivers **develop personal resiliency**, improve their communication skills, and create ensembles of support with patients, friends, and family members. Within a few months, we presented our ideas during the Spotlight Health portion of Aspen Ideas Week (the opening segment of the annual summit that convenes experts and innovators in the health and medicine field). Ruth Almen from the Cleveland Clinic Lou Ruvo Center for Brain Health-Las Vegas was one of the participants in our inaugural workshop. She became our champion and commissioned the development of a 6-week program called Improvisation for Caregivers.

Skills Explored and Related Exercises

The following skills are among the many explored and developed through associated exercises as part of the Improvisation for Caregivers curriculum.

Skill 1: Creating a caregiving ensemble. In improvisation, an ensemble is a group of people that works to create something greater than what each person could have created alone. We think of ensembles as a practice or behavior. As a practice, ensemble is a way of working with others that acknowledges their contributions and strives to

make it easy for everyone to contribute at their best level. At The Second City, we and our colleagues say that if you make your partner look good, then you will look good.

Exercise 1: “Pass the Clap.” A simple improvisational exercise that we taught to illustrate the idea of ensemble is called “Pass the Clap.” The group is brought into a circle, and each member’s task is to clap at exactly the same time that the person next to them turns in their direction and then to turn to the person next to them in the circle, such that the group members continue to pass the clap around the circle. It is not easy for everyone to do, and, in the debriefing, we talk about the many ways that participants truly need to focus on others in order for the group activity to become seamless. Such intense focus does not come naturally to people, and it is rarely practiced as a skill.

Skill 2: Sharing and listening (“yes, and”). One of the basic concepts in behavioral economics is that human beings have a default setting to do nothing or to say no.¹ Recognizing this tendency, the founders of The Second City created the concept *yes, and*—the idea that, in order to tap the full creativity of any ensemble, space must be created for each person in a group to collaboratively build upon everyone else’s ideas, whether innovating new processes or products, problem solving, or working in crisis mode. The *yes, and* concept fosters an orientation towards openness to change rather than the status quo.

Exercise 2: “Plan a Party.” The “Plan a Party” exercise pairs individuals whose “job” is to plan a party. In round 1, person A offers planning suggestions and person B offers as many different ways of saying no as possible. In round 2, person B offers suggestions for the party, and person A begins responses to all of the suggestions by saying “yes, but.” In round 3, both person A and person B offer suggestions that are enthusiastically accepted and built upon by using the words *yes, and* in response to every idea.

Skill 3: Embracing mistakes and change. The caregiving space is filled with stress and uncertainty; therefore, it is even more vital that individuals enter that space with a heightened understanding of what it feels like to operate in that uncertainty. Caregivers need to have practice in finding alternative solutions when faced with a situation that doesn’t turn out as expected. A certain level of mindfulness and flexibility is required when navigating the complexity of the caregiving experience.

Exercise 3: “New Choice.” The “New Choice” exercise provides a fun and potent way to practice being more agile in the moment. In groups of three, participants are given a situation and a location (for example, friends having brunch or coworkers hanging decorations for an office party). At any point during the improvised conversation, the facilitator rings a bell and the participant who most recently spoke has to make a new choice of what to say. This kind of rapid ideation is difficult to do when participants are fixated on or anchored to their original idea. It becomes easier when individuals allow themselves to exist in a state of flow.⁶ Because people often underestimate their ability to handle new information, this exercise encourages the understanding that playfulness and achieving flow can support our capacity to deal with the unplanned or the unexpected.

Insights

When K.L. is asked by others why The Second City provides training for such a wide variety of organizations—from health care providers to financial institutions—he asks if their business involves human beings interacting with other human beings, because

improvisation bolsters the skills of individuals working in teams and team environments. Although we are still in the early stages of developing the Improvisation for Caregivers curriculum, attendees of the first few workshops overwhelmingly found that they were better able to deal with their burdens after completing the 6-week program.

Improvisation is a pedagogy. The reason why so much comedy arises from the teachings of improvisation is that it is rooted in the essence of human behavior. People laugh at the things they recognize; they laugh at the things they share with other human beings; they laugh at things because those things are surprisingly true.

In an early meeting with Poo and her team at Caring Across Generations, we talked about fighting the robot narrative. In a world that is becoming increasingly reliant (hooked?) on technology, the skills that will become the most valuable are the skills of an improviser: storytelling, divergent thinking, problem solving, and innovation. Our work gives individuals a space in which they can explore their own discomfort to discover all their untapped agency. In her recent book, *Rebel Talent: Why It Pays to Break the Rules at Work and in Life*,⁷ behavioral scientist Francesca Gino writes, “When we challenge ourselves to move beyond what we know and can do well, we rebel against the comfortable cocoon of the status quo, improving ourselves and positioning ourselves to contribute more to our partners, coworkers, and organizations.”

Bringing improvisational training to the caregiving community has implications for the well-being of all caregivers. In *Compassionomics: The Revolutionary Scientific Evidence That Caring Makes a Difference*, Stephen Trzeciak and Anthony Mazzarelli write:

Decades of rigorous research has identified 3 hallmarks of burnout: emotional exhaustion (being emotionally depleted or overextended), a lack of personal accomplishment (the feeling that one can't really make a difference) and depersonalization. Depersonalization is the inability to make that personal connection.⁸

These concepts are exactly what lay at the heart of the Improvisation for Caregivers program. Our society needs to give everyone in the caregiving space—be it doctors, nurses, administration, patients, or family members—practice in becoming more resilient, engaged, and connected. These skills don't appear like magic. They have to be honed, developed, and practiced over time.

There is another improv adage that counters the idea that “your team is only as good as its weakest member.” We and our colleagues at The Second City say that an ensemble “is only as good as its ability to compensate for its weakest member.” In our version, the onus is put on the team, not on the individual, because at some point each person will be the weakest member of some group. When that inevitably happens, won't all of us want the team to pick us up in those moments rather than leave us behind? In any case, any clinical team's patient or loved ones probably would.

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Kelly Leonard is the executive director of insights and applied improvisation at Second City Works in Chicago, Illinois, where he also hosts the Second City Works/WGN podcast, *Getting to Yes, And*. He began his career at The Second City in 1988 and has produced hundreds of original revues with talents such as Stephen Colbert, Tina Fey, and Keegan-Michael Key. He is a coauthor of *Yes, And: How Improvisation Reverses “No, But” Thinking and Improves Creativity and Collaboration—Lessons from The Second City* (HarperCollins, 2015), and he coleads a partnership with the University of Chicago Booth School of Business that studies behavioral science through the lens of improvisation. He has also appeared at the Aspen Ideas Festival, Chicago Ideas Week, and TEDxBroadway.

Anne Libera is an assistant professor and the director of comedy studies at Columbia College Chicago and The Second City in Chicago, Illinois. She is also the director of pedagogy for the Second Science Project and has presented on improvisation and comedy at the Aspen Ideas Festival, Chicago Ideas Week, and Chicago Humanities Festival and has been a guest lecturer at the Stanford Graduate School of Business. In the summer of 2016, she was an invited participant in one of the Imagination Institute’s retreats focused on humor at the University of Pennsylvania.

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ART OF MEDICINE

Should We Be Laughing More in Art Museums and Hospitals?

Fawn Ring

Abstract

If both art and laughter are good for your health, why aren't we encouraging more humor in museums and hospitals? We are taught to approach art with awe and respect—and to treat medicine as deadly serious business. It follows, then, that overt displays of humor, such as laughing or joking in a museum, doctor's office, or hospital, are probably in bad taste. But if viewing and making art can lower rates of anxiety and depression and help soothe chronic pain—and if laughter helps blood vessels function better and improves the flow of oxygen to the heart and brain—then perhaps we unwittingly deprive our patrons and patients of an important tool in the health and wellness toolbox.

Health Benefits of Art and Humor

Every time a new study extols the health benefits of viewing and creating art, my phone chirps for days as friends and relatives forward the good news. As a program director at the Art Institute of Chicago, I receive many articles crediting art as a healer: it can lower rates of anxiety and depression in both men and women, help soothe chronic pain, stave off symptoms of dementia and Alzheimer's disease, and accelerate brain development in young children.^{1,2,3,4,5} In a recent study, British researchers theorized that people who expose themselves to the arts are more likely to be engaged in the world around them, contributing to their overall health and wellness.⁶

Laughter, too, is heralded as good medicine—"the best medicine"—as the saying goes. A 2005 *Psychology Today* article points to numerous studies showing that laughter reduces pain, increases job performance, connects people emotionally, helps blood vessels function better, and improves the flow of oxygen to the heart and brain.⁷

If both art and humor are healing, should we encourage more laughter in museums and hospitals? Currently, both institutions tacitly or explicitly encourage quiet, and restraint is understood as a social norm. Both can limit laughter. By unintentionally muting giggles and guffaws, do museums and hospitals deprive their patrons and patients of the **positive effects** that humor could have on their health?

Art Can Be Funny

At the Art Institute, I watch museum visitors inspect the details of exquisite 17th-century Dutch drawings or the rapid brush strokes of the luminous *Stacks of Wheat (End of Summer)* by Monet and then whisper quietly to their companions. I see smiles or hear occasional chuckles, but full-throated laughter from adults looking at art is rare. Of course, most visitors don't want to distract other patrons and their quiet is meant to be respectful. The occasional exceptions are teenagers or young adults who are not fully socialized to museum culture. Their gregarious lack of restraint provokes dirty looks but also spontaneous grins from adults who recognize how freeing it might feel to loosen the expectations of gallery behavior.

From our earliest visits to museums, we are socialized to treat art as serious business and to show reverence. We learn that noise and laughter are inappropriate even when the art in question is witty, bawdy, humorously ugly, or even absurd. Or perhaps noise and laughter make us uncomfortable.

Art is an ideal medium for many forms of humor, and many artists are intentionally funny. French Realist Movement artist *Honoré-Victorin Daumier* made thousands of 19th-century Parisians laugh during his 40-year-career as a satirical cartoonist. He captured in drawing, painting, lithography, and sculpture "the characteristic look and demeanor of every segment of Parisian society, ranging from the crotchets and timidities of the urban middle class ... to the frauds of speculators ... the pomposities of lawyers ... the self-delusions of artists, the rapacity of landlords, and the vanity of bluestockings."⁸ Daumier's artistic gift and biting wit inspired many of today's most insightful editorial cartoonists, directly or indirectly. Surrealist Salvador Dalí's *Venus de Milo With Drawers*, a half-size plaster reproduction of the famous marble statue (130/120 BC; Musée du Louvre, Paris) is a visual joke, one that is deeply embedded in the popular imagination. By perforating the famous Venus with drawers decorated with silky mink pom-poms on the figure's forehead, breasts, stomach, abdomen, and left knee, Dalí engages in two of his favorite practices, defacing a classic symbol and contrasting the animate and inanimate.

Other objects in the Art Institute's collection flirt with humor, including an *18th-century* *cruet* from the Meissen Porcelain Manufactory that is decorated with fanciful roosters and Chinese figures, René François Ghislain Magritte's darkly funny 1949 drawing of caskets sitting in for people in *The Balcony*, and Maurits Cornelis Escher's witty 1948 lithograph, *Drawing Hands*, in which what is drawn is doing the drawing.

Humor in a Hospital

My 86-year-old mother, an artist, recently spent 5 days in the hospital recovering from her second heart attack. I visited every day, reading while she slept, and chatted with the nurses when they checked her vitals. I noticed a quiet restraint on the floor similar to that of the museum's galleries. It wasn't gloomy, but laughter was muffled, and doctors, nurses, and patients rarely exhibited humor. Illness and infirmity are serious business after all, and hospital employees are rightfully careful not to disturb resting patients or to appear to make light of their circumstances. Even so, every now and then, when laughter bubbled across the hushed ward, nurses and doctors smiled, the air became lighter, and patients and their families displayed a mild sense of relief.

My mother's cardiologist is deeply caring and direct, and he cheerfully applauds her efforts to stave off her advanced cardiovascular disease with a vegan diet and daily

exercise regimen. He's also boisterous and mischievous, and he makes her laugh—hard. His lack of restraint reminds me of those high-spirited students giggling in the art galleries, oblivious to (or ignoring) museum etiquette.

If “the best medicine” lightens mood, loosens the body, and dispels awkwardness, does it matter if it seems out of place? If the simple act of looking at art can reduce a museum visitor's anxiety, then it follows that easy laughter adds healthy value to the gallery experience, just as my mother recovering in her hospital bed may benefit if her doctor's cheerful irreverence improves the flow of oxygen to her heart. In either case, the healing combinations of humor plus art and humor plus medicine enrich lives.

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Fawn Ring covered the arts as a journalist and producer for public television and radio before beginning employment at the Art Institute of Chicago as the director of lectures and performance programs in 2014. In collaboration with curators and museum educators, she develops, produces, and presents public programs for adults and multigenerational audiences in the museum setting.

Editor's Note:

Visit the Art Institute of Chicago [website](#) or contact Sam Anderson-Ramos at sramos@artic.edu to learn more about the museum's medicine and art programming. Browse the AMA Journal of Ethics [Art Gallery](#) for more Art of Medicine content and for more about the journal's partnership with the Art Institute of Chicago.

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ART OF MEDICINE

Imposter Syndrome

Rebecca S. Kimyon, MD

Abstract

This self-portrait, done in bold colors, depicts the experience of “imposterhood” in medicine.

Figure. *Imposter Syndrome*



Media

Sharpie markers and colored pencil on poster board.

Imposter syndrome is a real and uncomfortable feeling for many of us who find ourselves in the midst of talented and accomplished people. This was certainly the case for me as I started my journey in medicine, constantly comparing myself to others and worrying that I did not measure up.

Imposter syndrome in medicine is a topic most often discussed from a serious psychological point of view.^{1,2,3} The use of **cartoon humor**, however, makes the concept of “imposterhood” accessible and understandable in an immediate and nonthreatening way. The drawing tries to capture at a glance medical students’ universal **feeling of insecurity**: “Am I good enough? Is my disguise working? Are people going to find out that I’m not what I should be?” At the same time, the picture shows that the artist is laughing at herself, recognizing the silliness of her disguise in the midst of a room full of people trying to disguise themselves as well. The lightheartedness and visual immediacy of the cartoon capture a kernel of truth and irony that a narrative essay could not—it allows us to laugh at ourselves, reflect on imposter syndrome as a common human experience, and perhaps breathe a sigh of relief that we are not alone.

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Rebecca S. Kimyon, MD is a recent graduate of the University of Minnesota Medical School in Minneapolis, Minnesota. She enjoys drawing as a creative outlet and looks forward to applying her artistic eye to her future career in dermatology.

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ART OF MEDICINE

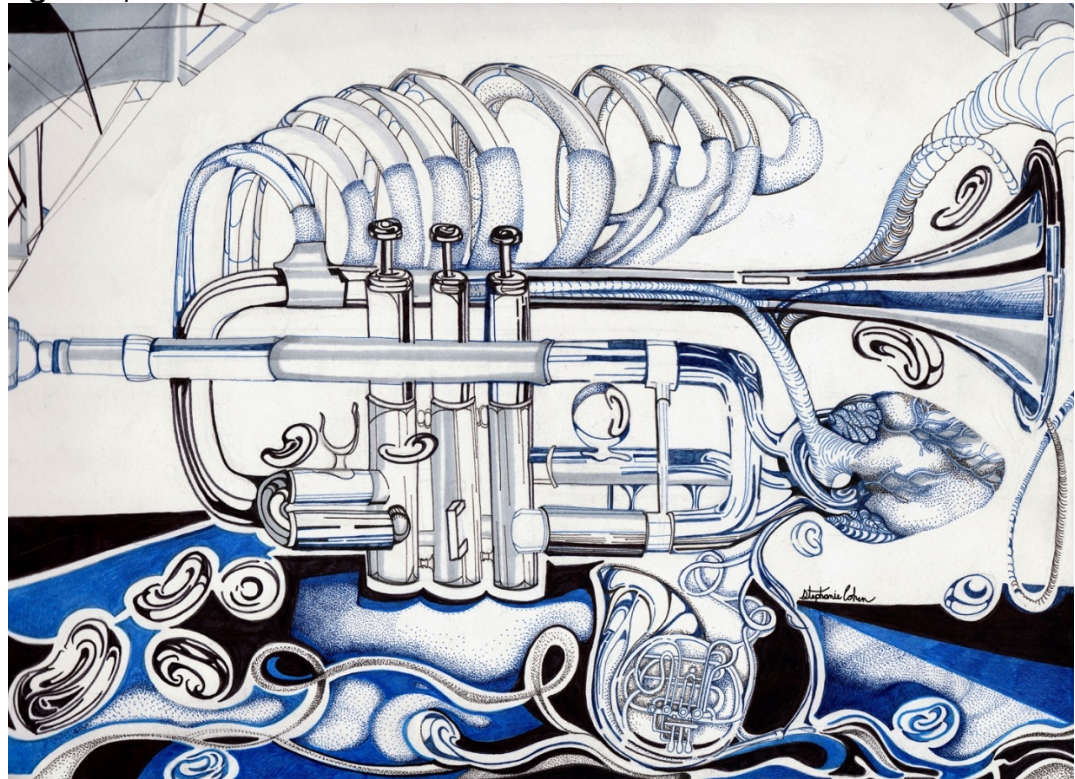
Equilibrium

Stephanie Cohen, MD

Abstract

Just as cellular imbalances on a microscopic level can have macroscopic consequences in systemic diseases, so one instrument playing out of tune in an orchestra can compromise the harmony of the entire symphony. In addition, the practice of medicine itself is a balance between science and humanism; after all, physicians are treating multidimensional human beings.

Figure. *Equilibrium*



Media

Ink on Bristol board, 17" x 11".

Caption

This drawing seeks to explore the theme of equilibrium through music, medicine, and art. In music, if a trumpeter decides to improvise and plays his own melody, the French horn player, at first, may follow along. Eventually, however, he can no longer compensate and musical dissonance ensues. Cells and organs can be thought of as the musical instruments in the biological symphony of the human body: in cancer, cells become unresponsive to their environment and also bypass internal checkpoints. As a result, there is an imbalance between cellular proliferation and apoptosis—cells begin to divide uncontrollably. In the gut, an imbalance of flora can lead to *Clostridioides difficile* pseudomembranous colitis. Neurological and psychiatric diseases can also occur secondary to neurotransmitter imbalances. Clearly, disequilibrium is evident throughout all pathophysiology. In addition, this musical metaphor can be extended to the health care system. Doctors, advanced practitioners, nurses, pharmacists, and social workers are the musicians in a symphony. Each has a particular role, and **effective communication** is absolutely necessary to deliver the best possible care. What is most important to bear in mind is that the conductor is the patient.

Stephanie Cohen, MD is a general surgery resident at Beth Israel Deaconess Medical Center and Harvard Medical School in Boston, Massachusetts. She earned a BFA degree in studio art and a BS degree in biochemistry in 2016. She has been drawing since she could pick up a pencil, and her interests include technical and medical illustration as well as developing educational tools for patients and trainees. She is an illustrator for the *National Surgery Review* and has also published drawings in *Annals of Surgical Oncology*, *Open Access Surgery*, and *Practical Radiation Oncology*.

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ART OF MEDICINE

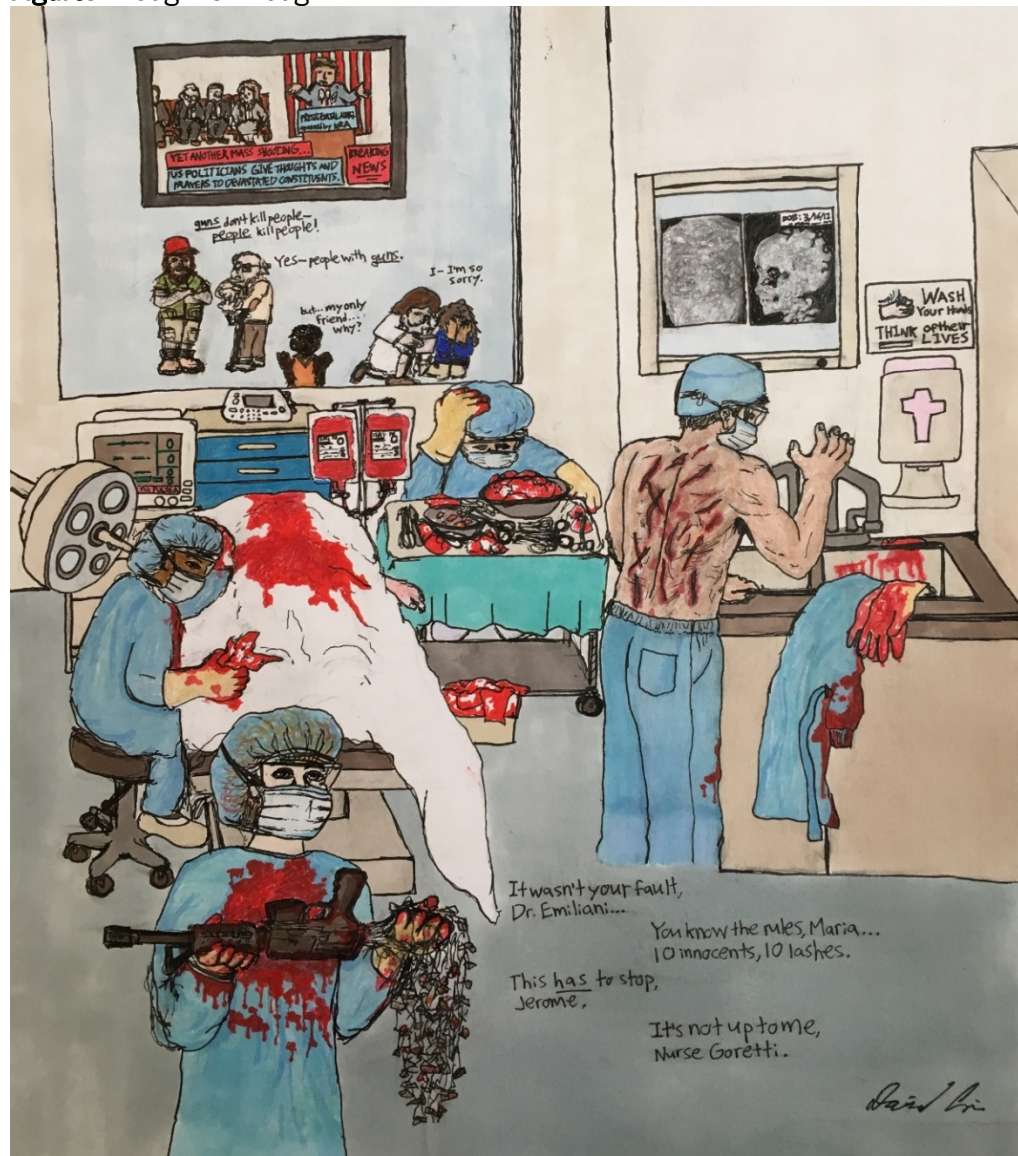
Enough Is Enough

Hwa-Pyung (David) Lim, MS

Abstract

In this cartoon, a guilt-ridden and heavily scarred surgeon prepares to self-flagellate to atone for his team's failed attempts to save the life of an innocent child victim of a mass shooting. One of his nurses, carrying an assault rifle modified to serve as his whip, attempts to stop him by reminding him that the blame is not his to bear. We in the field of medicine can and must do more for our patients than simply treating their wounds and consoling their families and loved ones after tragic, senseless losses. Solving the gun violence epidemic won't be easy, but we must try.

Figure. *Enough Is Enough*



Media

Pencil, pen, and marker.

The idea for this piece came to me in February 2018 after I read a radiologist's gory account of the havoc wreaked by military-grade assault rifles on the human body.¹ Frustrated by the relentless inaction of politicians and deeply concerned about the normalization of mass shootings in the United States since Columbine, I felt compelled to frame the **gun violence epidemic** from the perspective of health care professionals who can't help but feel guilty for what is ultimately a societal failure to curb the destructive power of firearms.

In the illustration, we see a scarred and bruised Dr Jerome Emiliani—named for the patron saint of orphans and abandoned children—hunched over a sink as he waits for a

nurse to bring him a terrifying whip fashioned from an assault rifle and bullet fragments. The surgeon reminds the reluctant nurse that he has no choice but to punish himself with one lash of the whip for every innocent life lost. Nurse Maria Goretti—named for the patron saint of crime victims and other vulnerable groups, purity, and forgiveness—pushes back but ultimately cannot convince the doctor to stop punishing himself for the senseless losses.

The cartoon includes religious imagery and symbolism to draw attention to the fact that many of the most avid supporters of the Second Amendment are also devout Christians who fail to see the irony in their support for what is easily mankind's most destructive invention. Next to the radiographs of the deceased child's shattered torso and skull is a sign with an all-too-familiar message to health care workers ("wash your hands, think of their lives") that takes on a whole different meaning in this scene. Like Pontius Pilate—the Roman governor who caved to the demands of the angry masses and condemned Jesus to the cross—guns rights activists would wash their hands of countless innocent lives and instead pin the blame elsewhere. Meanwhile, the despondent surgical team members could not wash their hands of the guilt even if they tried.

In the backdrop, we see another doctor doing the only thing she can for the distraught mother—comfort her and express regret. A lonely child struggles to fathom the permanence of the loss of his only friend as 2 tone-deaf bystanders carry on the popular yet ultimately fruitless debate on the semantics of gun control. Behind them, the TV broadcasts breaking news of "Yet Another Mass Shooting: US Politicians Give Thoughts and Prayers to Devastated Constituents" as the president shrugs and members of Congress sit on their hands.

Doctors and other first responders are not miracle workers, yet much of the burden of insufficient gun control falls unjustly on their shoulders due to the inaction of public leaders crippled by fear of political backlash. When we insist on politicizing gun control, we fail to recognize it as the **public health issue** that it is. We cannot ignore not only the obvious toll that gun violence has on its victims, but also the many detrimental effects it has on survivors, family members, first responders, health care workers, and average Americans who risk their lives simply by living in a country that seems to prioritize an antiquated right over the safety and well-being of its people. Maybe it's time for doctors to push back and do more to tackle this issue once and for all.

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Hwa-Pyung (David) Lim, MS is a third-year medical student at the University of Illinois College of Medicine in Chicago. He holds an MS from Georgetown University in physiology and a BS from Yale University in molecular biophysics and biochemistry. He uses art as a medium to process and convey complex emotions and thoughts that often arise in the field of medicine, and he encourages other health care professionals to do the same whenever possible.

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ART OF MEDICINE

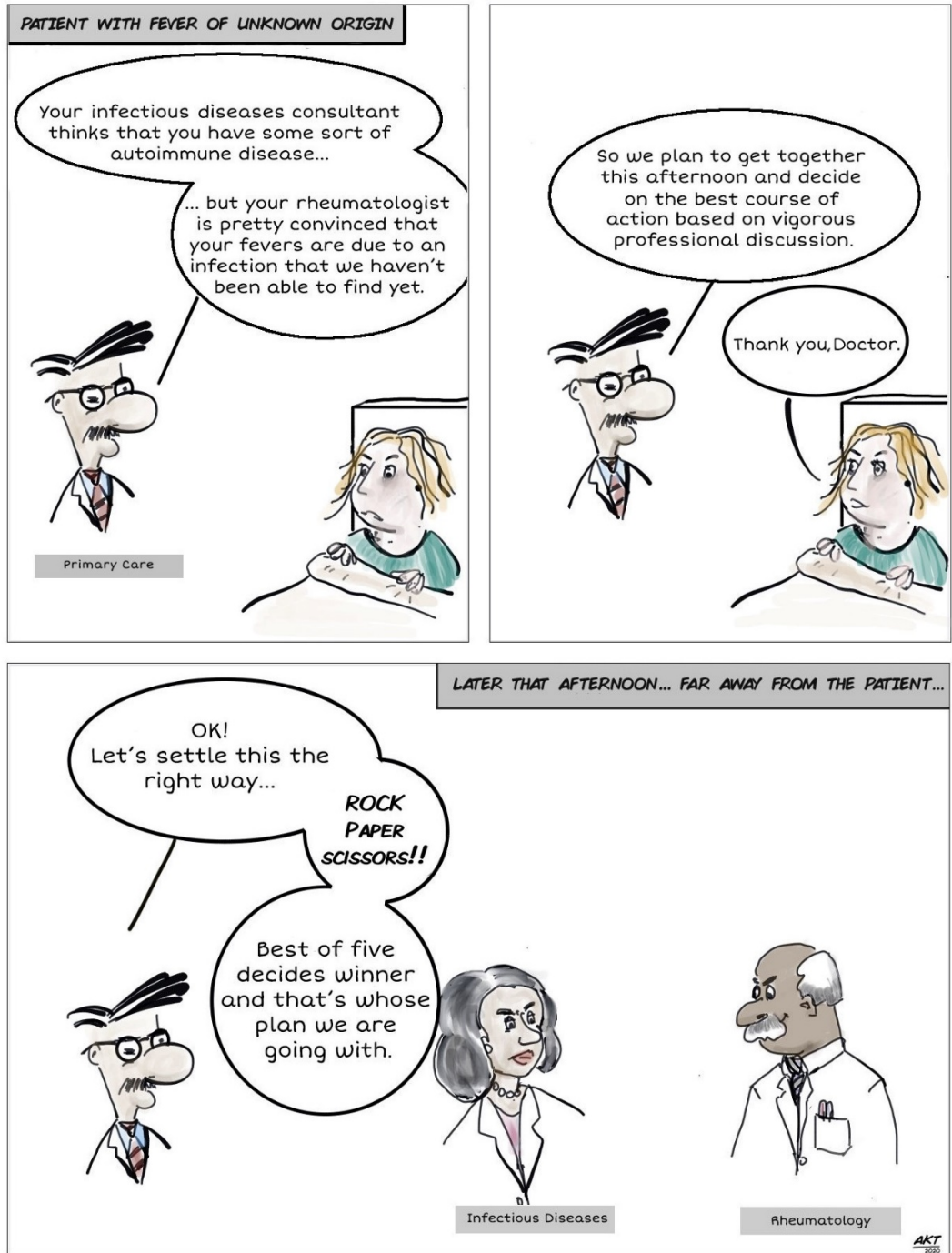
Game-Based Medicine

Abey Kozhimannil Thomas, MD

Abstract

This illustration is a humorous take on experts' disagreement about the care of a patient. Breaking the deadlock requires much effort, and a focus on the patient can restore common ground. Patients should always be the center of our care universe.

Figure. Team-Centric Care?



Media
Sketched on Paper for iPad and finished using Corel Paintshop.

Caption
Despite advances in diagnostic capability, best next steps are not always clear, and clinician-experts don't always agree about the course a patient's care should take. When deadlocked, specialists aren't always all that helpful to a patient and her primary care

clinician. Breaking deadlock in a way that's professional, collegial, and keeps a patient's well-being as a goal held in common requires much effort. This comic offers a foil to our expectation that clinician-experts resolve disagreements using reason and evidence and reminds us that patients should always be the center of our care universe.

Abey Kozhimannil Thomas, MD is an internal medicine specialist at UT Southwestern Medical Center in Dallas, Texas.

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Letter to the Editor

Response to “How Should Global Tobacco Control Efforts Be Prioritized to Protect Children in Resource-Poor Regions?” A Deliberate Public Policy Plus Naivety at Best

Alain Braillon, MD, PhD

In their recent article, “[How Should Global Tobacco Control Efforts Be Prioritized to Protect Children in Resource-Poor Regions?](#),” Bialous and van der Eijk rightly highlighted that tobacco and e-cigarette marketing “is a violation of fundamental children’s rights.” As I have noted elsewhere, smoking is a pediatric epidemic.¹ Maziak set the record straight: “Allowing this natural e-cigarette experiment on our most vulnerable and voiceless population—children—even with the best intentions for adults is not grounded in any public health or ethical values, even the most pragmatic ones.”² However, the authors’ claim that “challenges include weak implementation ... of the WHO [World Health Organization] Framework Convention on Tobacco Control [FCTC] and a lack of consensus among health professionals on how to address the tobacco industry’s health claims related to e-cigarettes” deserve comment, as the WHO and health professionals simply failed to do their job adequately.

First, why is the WHO enduringly failing to monitor the implementation of the FCTC despite parties’ obvious and major breaches, making the FCTC worth “no more than the paper on which it is written”?³

Second, why are so many experts, mainly in Europe, once more fooled by the “harm reduction” motto, just as the public was previously fooled by filters and light and low-tar cigarettes?⁴ Who could believe the industry aimed to end its business when buying e-cigarette companies and filing patents or did not aim to promote traveling to countries where [vaping was allowed](#) when, in 2010, Johnny Depp used electronic cigarettes in *The Tourist*?⁵ Vaping is not quitting. Although benefits of vaping have not been demonstrated yet, the development of lung adenocarcinomas and bladder urothelial hyperplasia has been demonstrated in *in vivo* experiments with mice exposed to e-cigarette smoke.⁶ Toxic compounds in e-cigarette vapor must be included as a carcinogen in Group 2A (“*limited evidence* of carcinogenicity in humans and *sufficient evidence* of carcinogenicity in experimental animals”) of the International Agency for Research on Cancer.⁷

Third, even in wealthy countries, pledges for tobacco control are a smoke screen to protect vested interests, although not solely those of the tobacco industry. No government has reduced nicotine content in cigarettes yet: in the 1960s, Sano was

marketed as “a cigarette with the lowest nicotine level, getting the lowest sales among 40 brands, the only commercial failure of the tobacco business ever!”⁸ At the same time, use of ammonia to “freebase” nicotine (“crack nicotine”) allowed “Marlboro sales to skyrocket,” switching first place with Winston, whose sales fell.⁸

In the United States, the 2009 Family Smoking Prevention and Tobacco Control Act gave the Food and Drug Administration the authority to regulate tobacco products, including the use of flavors and nicotine levels.⁹ Nothing has happened yet but postponed promises, allowing a free ride for the nicotine and flavor races.¹⁰ In contrast, San Francisco voters decided in June 2018 to ban the sale of flavored tobacco products, including menthol cigarettes and vaping liquids.¹¹ The functioning of democracy depends on the responsiveness of government to its citizens and the ability of its citizens to interact with their authorities.

In France, in 2014, despite the WHO’s warnings against such claims,¹² the French High Council for Public Health issued recommendations for e-cigarettes, starting by classifying them as “an aid to stop or reduce” smoking.¹³ Recently, after the epidemic of serious lung diseases in the United States, the French Minister of Solidarity and Health issued mostly reassuring claims: “We are not in the same situation as in the United States. We do not have a specific health alert ... e-cigarette is prohibited for sale under 18 years” of age.¹⁴ She overlooked a recent sting operation by a nongovernmental organization, which confirmed that one-tenth of French tobaccoists sold tobacco to those aged 12, despite the legal age being 18.¹⁵ Indeed, the law was flawed, deliberately lacking provisions for enforcement and compliance checks by the administration.

Restrictions on sales and **advertising**, even if enforced with much zeal, would be a smoke screen: no one can expect the youngest to be superheroes in rejecting a social norm, unless they are naïve at best. Simply, nicotine and flavor, gateways to addiction, must be banned. However, it will not happen: the tobacco business is the goose that laid the golden egg for the US Department of the Treasury: tax revenue. In France and the United Kingdom, as in most Western European countries, cigarette taxes represent more than 75% of retail prices.¹⁶ Taxation allows the most vulnerable, who are excluded from paying income tax, to contribute tax revenue, with savings in health care costs and retirement benefits.¹⁷ Indeed, smokers die 10 to 12 years younger than nonsmokers.¹⁸

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Letter to the Editor

Response to “A Deliberate Public Policy Plus Naivety at Best”

Stella Aguinaga Bialous, DrPH and Yvette van der Eijk, PhD

We welcome Alain Braillon’s letter, “A Deliberate Public Policy Plus Naivety at Best” in response to our article, “[How Should Global Tobacco Control Efforts Be Prioritized to Protect Children in Resource-Poor Regions](#),” in stimulating debate on how we can continue to frame the regulation of tobacco and nicotine products from a children’s rights perspective.

Several countries have imposed bans on the sale of flavored tobacco. In the United States, several states and localities have banned the sale of flavored tobacco, including menthol.¹ Several Canadian provinces have also banned flavors, including menthol.² Brazil and Ethiopia have also banned all flavors, including menthol.² Turkey, the European Union, and the United Kingdom are expected to implement a complete ban on menthol-flavored cigarettes in May 2020.^{3,4} The evaluation of these experiences will continue to inform the scientific community on best practices for implementing these regulations and for strengthening implementation of the WHO (World Health Organization) Framework Convention on Tobacco Control.⁵

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