SPECIAL ARTICLE

Humor in the Physician-Patient Encounter

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Medicine is serious business, but physicians have always tried to balance the heavier aspects of their work with humor and lightness. Hippocrates,[1] for example, wrote that physicians should cultivate a serious and respectable image, but at the same time he advised them to use wit in interacting with their patients because "dourness is repulsive both to the healthy and to the sick." While humor is frequent in the clinical setting, much of it occurs among professionals, rather than within the physician-patient relationship. Such humor arises in response to the difficult and stressful situations that occur in medicine and takes the form of irony, "put-downs," and gallows humor. In this article, we focus on the use of humor as a timeless mode of communication between physicians and patients, and we review the benefits and risks of humor in today's pressured physician-patient encounters.

THE POWER OF HUMOR

Destructive Gallows Humor

The emotional intensity of medical training, combined with long hours and chronic fatigue, promotes gallows humor—grim, ironic, "sick" wit—as a way of diminishing the reality of negative feelings. Unfortunately, gallows humor can become a pernicious habit, an ingrained mechanism for distancing oneself from unpleasant or emotionally taxing situations, rather than just an occasional escape. Such gallows humor can lead to emotional numbness. Samuel Shem's[2] popular novel, *The House of God*, describes a hospital culture in which hurtful humor distances and objectifies patients, while serving as a cultural bond among physicians, residents, and medical students, thus distinguishing "insiders" from "outsiders" and separating providers from patients. Medical students begin their clinical training with the ability to see themselves both as outsiders and insiders, but gradually develop the insider hospital culture. In this process, gallows humor and the hospital slang often used to express it become habitual.[3] While such humor plays an adaptive role for the group members who share it (and many patient groups may share equivalent kinds of empowering "sick jokes" at the expense of the medical establishment), its exclusory function precludes any therapeutic role for it within the physician-patient relationship. Fortunately, there are also other kinds of humor at play in medicine.

Therapeutic Humor

Humor in medicine, however, may also be grounded on a recognition of the human condition that is shared by patient and provider. Such humor relies on empathy and compassion rather than on irony and avoidance. It embraces rather than excludes. Medical practice provides frequent exposure to human frailty and personal disappointment. One of the biggest lessons the physician can learn from such exposure is, or ought to be, that as human beings we are all in more or less the same boat: "There, but for the grace of God, go I." Humor based on empathy is gentle, not hostile; it tends to connect across, rather than within, particular categories, bridging in-

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stead of reinforcing "us" and "them." Pain, anger, anxiety, and sadness may be emotions that are too difficult to be scrutinized directly. Empathic humor may serve the helpful function of looking obliquely, rather than directly, at such feelings, thereby helping both physician and patient to acknowledge and cope with them.[4]

Within the physician-patient relationship, humor may have more than one therapeutic function. Some authors have argued that humor has potential efficacy as a therapeutic modality in its own right. At the same time, empathic humor may, by fostering a stronger physician-patient relationship, enhance the effectiveness of other, more traditional forms of therapy.

Can laughter itself make patients better? Therapeutic humor, according to Sultanoff,[5] is "any intervention that promotes health and wellness by stimulating a playful discovery, expression or appreciation of the absurdity or incongruity of life's situation." Norman Cousins[6] played a major role in popularizing the belief that humor can be intrinsically therapeutic. In his famous book *Anatomy of an Illness as Perceived by the Patient*, Cousins describes his own experience with a severely debilitating case of ankylosing spondylitis. Although standard medical therapy was not helping him, Cousins noticed that his symptoms lessened after he watched funny movies. Therefore, he decided to seize control of his own treatment and embark on a self-designed regimen of laughter therapy, which, he believed, ultimately led to his cure. Since that time, many popular writers have advocated humor as a form of therapy, arguing that it favorably alters the "chemistry of the will to live."[7] In its strongest form, as in the writings of Bernie Siegel,[8] this will to live translates into a belief that positive personal characteristics (eg, love, humor, and a positive attitude) can generate a broad range of healing powers. Patch Adams[9] is a physician (and also a professional clown) who has systematically applied comedy as an independent therapeutic modality.

There is no question that humor is a useful coping and defense mechanism that helps us to accommodate emotional conflict and to reduce the effect of external stressors.[10] Despite the popularity and attractiveness of the concept that humor heals, though, there is very little evidence at present to support a significant effect of humor in ameliorating physical disease or in changing the physiological parameters or clinical features of illness, such as tolerance of pain, perceived stress, or self-reported symptoms.[7] With regard to such research, we must distinguish between self-efficacy—mastery of the situation (which, as in Cousins' case, might include choosing to embark on humor therapy)—and the direct effects of humor as such. For example, the beneficial effects attributed to humor might be more related to factors such as optimism and locus of control than they are to laughter itself.

The Clinical Encounter

The role of humor in the physician-patient relationship is, however, far more complex and highly nuanced than the question of whether humor itself has a therapeutic function. The clinical importance of empathic communication, patient-centered interviewing, and the maintenance of good physician-patient interactions are well known.[11-19] In the aggregate, they promote patient satisfaction, enhance the accuracy of clinical data, improve adherence with therapeutic regimens, and, in general, generate a more therapeutic environment.[20-23] Although time management is always a concern, there is substantial evidence that attention to patients' feelings, ideas, and values can actually make the physician-patient encounter more efficient.[24,25] Likewise, there is evidence that physicians are able to improve their interactive skills if they are provided with an appropriate intervention.[26,27]

Given this body of knowledge, it is commonly accepted that the judicious use of humor is a useful technique that can facilitate communication, promote bonding, and enhance patient satisfaction.[28,29] Patient-centered interviewing techniques are challenged by today's fragmented medical care system, which is characterized by subspecialization, lack of coordination, and the frequent disruption of physician-patient relationships. Economic and sociological factors, such as shifting insurance arrangements, and increasingly mobile populations of patients and physicians mean that patients and physicians have less time than ever to get to know each other. Humor may be less effective, or even harmful, under these circumstances, owing to a lack of familiarity. But it is also plausible that the careful use of empathic humor may foster connection and "jumpstart" the development of a therapeutic relationship or help assuage feelings of anger and frustration and, hence, may even have added value in the contemporary medical practice environment. In this article, we explore the uses of humor in the physician-patient encounter of today and, in particular, its potential to enhance communication, facilitate bonding, and improve patient satisfaction and adherence to therapy.

VARIETIES OF HUMOR IN THE CLINICAL ENCOUNTER

The value of humor in the physician-patient encounter is determined by its clinical context. Different situations, different patients, and different physician personalities determine whether an attempt at humor will be therapeutic, or alienating, or simply fall flat. Part of the context is the model or style of the physician-patient relationship at play. Emanuel and Emanuel[30] describe several models of interaction, each of which has an important place in clinical care. The benefits and perils of humor differ from model to model.

In the paternalistic style of interaction, exploration of patient values and goals is ignored or minimized and physicians assume that patients share their medical goals. Paternalism may be appropriate in many urgent or emergency situations, and physician-generated humor may quickly and deftly create a connection with the vulnerable patient and serve as a source of reassurance and support. Alternatively, however, emergently ill patients may perceive joking around as off-putting and dismissive, particularly if the physician fails to use

other, more sober bonding techniques as well (eg, hand-holding, listening, and quiet reassurance). In the interpretive model, the physician elucidates "the patient's [established health-related] values and what he or she actually wants."[30] In the deliberative model, the physician helps the patient to identify and develop his or her health-related values. In each of these situations, humor offers modes of intimate communication through which these objectives can be achieved. Physicians' use of quiet, respectful humor may provide patients with the "social license" to enter personal or sensitive content areas.

Physician-Generated Humor

Physicians' presentation of "self" influences their relationships with patients. As part of this presentation, they may use humor to disarm patients, to humanize the encounter, to establish and maintain a degree of intimacy, or to use self-deprecation to attenuate the power differential inherent in the vulnerable sick-healer dynamic. Often, a single humorous comment or interchange may accomplish several of these effects. Not all humor is equally therapeutic, however. It is possible to distinguish between constructive and destructive instances.

Constructive Physician-Generated Humor. The following 2 interchanges are examples of disarming and empathic uses of humor.

Example 1: An obviously acutely ill patient sits in an examination room. A physician enters the room and in a pleasant manner says, "Hello, how are you?" and the patient reflexively responds, "Fine." The physician counters, "Not true," and the patient laughs.

Example 2: An elderly female inpatient with metastatic cancer, anxiety, and depression sits in a bedside chair during a prolonged hospitalization. As her physician enters the room, she moves to the edge of her chair and leans forward in rote anticipation of his daily examination of her chest. After the examination, she mechanically remains in this position, while the physician chats with her and her daughter. The physician notices her awkward pose and deadpans, "You might as well make yourself comfortable and stay awhile." The patient, suddenly self-aware, laughs until tears stream. Her family joins in the laughter.

In the first example, humor arises from the physician's poking fun at the patient's unthinkingly polite response, which is grossly inconsistent with her serious acute illness. This quip helped diffuse the patient's anxiety by giving her permission to drop the "fine" façade. Furthermore, the physician reassured her patient by intimating that she is *more* aware than the patient is of her current distress. In the second example, humor diffused tension by gently making the patient aware of her paralyzing anxiety. The physician also recognized the patient's protracted hospitalization, and relieved some of the stressful feelings between family and patient. In particular, overt full-bodied belly laughter tends to release pent-up tension.

Physicians may also use humor to validate and support patients and to diminish relational distance between them.

Example 3: The physician, during an office visit, discusses a patient's abnormal test result and suggests further evaluation. The patient, exhibiting anxiety, asks, "Doctor, should I be concerned?" The physician responds, "Well, we need to evaluate this symptom. I'll tell you when it's time to start worrying. It's not time yet." The patient chuckles.

The physician empathetically recognizes the patient's distress and validates his concerns, rather than minimizing them. At the same time, the physician places these concerns in a temporal context, while communicating a commitment to reevaluation and ongoing involvement. The subtext is, "Whatever else happens, I won't abandon you." Interestingly, some recent findings suggest that having a good sense of humor correlates positively with ability to connect empathically with others; ie persons scoring highly on empathy scales also tend to score highly on instruments that measure sense of humor.[31]

Often, patients suffer as much from the social distress of being ill and of adopting the sick role as from physical or emotional symptoms. Appropriate humor may help alleviate this distress and communicate "permission" to violate otherwise expected rules of etiquette.

Example 4: During hospital rounds, the physician enters a patient's room. The patient, gowned in bed, is just finishing breakfast. The physician greets the patient, "Good morning. Looks like you ate well. Why didn't you leave any for me?" The patient chuckles.

This physician acknowledges the social discomfort that the patient may feel during a private moment (eating breakfast in bed while wearing a flimsy hospital gown) that is subject to inspection and in public purview, as well as the social irregularity of having a meal alongside others who are not eating or invited to eat. Humor is also an effective way for physicians, while remaining in their professional role, to humanize themselves, and to support and empathize with their patients.

Example 5: During an office visit, a patient distressed by a long-standing problem with obesity asks her slim physician, "How do you stay so thin?" The physician demurs, "My wife can't cook."

The physician comforts the patient by suggesting that body weight is not always attributable to blameworthy factors and joins the patient in noting life's dissatisfactions.

Destructive Physician-Generated Humor. Humor can be counterproductive when it magnifies the distance between physician and patient, when it belittles the patient, or when it is unintentionally used at an inappropriate time or in an inappropriate way.

Example 6: A patient's gynecologist tells a patient with a vulvar abnormality that she would benefit from using testosterone cream. She asks with apprehension, "Will I grow facial hair?" He retorts, "No, but you might grow a penis."

The physician perceives this retort as clever or humorous. However, the patient is likely to consider it vulgar, disrespectful, belittling, and dismissive of her concerns. The comment halts further inquiry by the patient, who feels put off; it inhibits communication and it damages trust.

Physicians must be careful of using humor to entertain the patient or others. Sometimes, well-

meaning physicians develop pat phrases or responses that they consider humorous and that become part of their standard patter, but that may be taken by the patient as egotistic or self-indulgent. Such remarks can monopolize the brief opportunity the patient has to communicate with the physician.

Example 7: A senior surgeon on postoperative rounds with the house staff has just examined a patient recovering from an exploratory laparotomy. The surgeon, grandstanding with well-worn phrases, remarks, "Well this is a good old case of 'heal with steel' and 'when in doubt, cut it out'!"

Patient-Generated Humor

Sick persons are inherently vulnerable and occupy a disadvantaged position vis-à-vis the power of the physician. Medical care often further diminishes patients' sense of individuality and personhood. Humor may empower patients, either constructively or destructively, and may humanize them in the eyes of their physicians.[29]

Constructive Patient-Generated Humor. Patients may use humor to advocate for themselves and to provide an outlet for anger and frustration without alienating the physicians upon whom they rely.

Example 8: A tardy physician enters the examination room. The patient greets his physician with, "Doc, I was just about to send out a search party for you."

The patient's comment is an assertive yet polite communication of displeasure that at the same time incorporates an element of concern for the physician. Similarly, patients may use humor to humanize themselves when otherwise they may be objectified.

Example 9: An intern enters a darkened room late one night to draw blood from a frail elderly woman lying motionless in bed. The intern, preparing to insert the needle warns, "Now you are going to feel a little prick." The patient quips, "I'd rather feel a big one."

The patient's raunchy retort perhaps communicates loneliness or wistful longing for a different time in her life. In any case, she certainly takes control of the interaction by flustering the intern and by demonstrating her very human needs and desires.

Destructive Patient-Generated Humor. Humor may also communicate displeasure in a counterproductive way.

Example 10: As the tardy physician enters the examination room, the patient sneers, "You must have been out playing golf again!"

This comment is rude, presumptuous, hostile, belittling, and based on a stereotype. It undermines the partnering fundamental to the therapeutic relationship. Furthermore, the patient communicates his low opinion of the physician by not allowing the physician an opportunity to apologize for the delay.

Some patients who use humor for self-denigration risk undermining their care, if the physician accepts their self-assessment in a jocular fashion.

Example 11: An elderly patient complaining of her disabling osteoarthritis remarks, "I'm like the old gray mare—she ain't what she used to be." Her physician responds, "So why not just stay home in the corral where it's comfortable and stop worrying about getting out?"

In a case like this, the physician has at least 3 options in responding[13(pp26-32)]: The physician might (1) ignore the self-denigrating quip and thereby convey a lack of interest or attention; (2) use the comment to minimize the complaint (as this physician did), in which case the patient is likely to feel dismissed or put down (in essence, the physician is saying, "You might think it's a joke, but why not take it more seriously? You *are* over the hill."); or (3) offer an empathic comment, showing that he or she understands how the patient feels but not necessarily accepting the self-evaluation. The third and, we believe, preferable way of responding might be to use the patient's own metaphor (eg, "I don't agree with that. You're far from being an old gray mare.") or to step outside the metaphor by offering supportive remarks and by exploring her concerns. An astute physician will recognize this form of humor as a call by the patient for attention or assistance[31] and should therefore resist the opportunity to minimize the patient's concerns.

Humorous Interchange Between Patient and Physician. Constructive humorous interchange often indicates good rapport and trust between patient and physician:

Example 12: A patient with chronic low back pain wryly remarks, only half-jokingly, to her long-time physician, "Can't you prescribe some cyanide?" The physician replies, "I would, except it'd be bad for business–I wouldn't get any more follow-up visits out of you."

The patient uses humor to communicate frustration with her disability and inadequate pain relief. The physician empathizes and uses humor in reply. His retort conveys a fondness for the patient and a desire for continued involvement in the patient's care; it also suggests that are certain limits to the physician's professional actions.

SPECIAL ISSUES

Cross-cultural Encounters

Humor is a universal mode of human interaction despite its complexity. Some aspects of humor are broadly transsocietal, while others are culture specific and language dependent. When patients and physicians are of dissimilar ethnic or cultural backgrounds, use of humor may be more challenging and hazardous. For example, African-American mistrust of the health establishment and of physicians is clear and well-founded.[32,33] African Americans, to a greater extent than whites, express concern about not receiving their fair share of services and about being harmed by medical intervention.[34,35] In this context, humor can easily be misconstrued as dismissive and disrespectful. Alternatively, in some Asian cultures, physician authority is unquestioned and patient deference and nonassertiveness are seen as virtues.[36] Therefore, physician self-effacement through humor may be interpreted as incompetence.

While cultural competence requires sensitivity to these issues, stereotypes are equally damaging. Respect, thoroughness, and a willingness to learn go a long way toward

creating trust and facilitating understanding of the patient as an individual rather than as a generic representative of cultural values. Thus, gentle humor that arises from the situation itself; for example, the very misunderstandings that make cross-cultural communication difficult may paradoxically create a bond between patient and physician. Even the vagaries of language translation may serve as a source of bonding humor, as when the physician expresses comedic frustration or delayed understanding by means of facial expressions or funny gestures. Shared laughter may be a powerful equalizer of the inherent power differential, as well as an important display of the physician's willingness to accommodate the patient.

Cross-cultural experiences may, of course, also occur between patients and physicians, even when both parties appear to share many ethnic and socioeconomic characteristics. Empathic humor may be more or less effective or appropriate, depending on the patient's beliefs and values, as well as on the acuity and severity of his or her clinical condition. Physicians who share their cultural or religious background with their patients may find that humor referential to this commonality may assist in bonding. Humor in this setting may communicate an intimate understanding of the patient's sociocultural requirements or limitations or his or her culturally mediated beliefs about disease and disability. The same comment shared between parties of different backgrounds may be highly offensive and distancing.

Presence of a Third Person

In certain types of encounters with an adult patient, a third person may play a role. This is particularly true in geriatric care, although it may occur with patients of any age (eg, when the patient's spouse is present). The third person may contribute positively to the interaction, but he or she may also (and more frequently) affect the dynamics of the encounter in a negative way.[37] The patient may be less vocal and assertive and may be excluded from the thread of conversation. Consequently, if humorous comments occur, generated by either the third person or the physician, the patient is less likely to experience the humor as shared and trust enhancing and more likely to view it as distancing. Joking between the physician and a third person may further isolate the patient. Physicians who are attentive to these third-person effects can use generative humor that specifically reengages their patients; they can also use distancing quips or cajoling to moderate excessive participation by the third person.

GUIDELINES FOR HUMOR IN THE CLINICAL ENCOUNTER

Humor can be effectively used in a wide range of clinical situations from minor to serious or terminal illness.[38] However, humorous remarks involve risk, as well as potential benefit, to the involved parties. The recipient of a humorous story or comment may fail to appreciate the comedy, misperceive the intent, or simply find the occasion inappropriate. The deliverer risks embarrassment, since humor is a personal and sometimes intimate view of one's self, and also risks creating a barrier to further communication, thereby impairing the therapeutic relationship.

Despite these hazards, as we have seen, humor offers substantial potential benefit. While the short-term and unstable relationships promoted by managed care may make humor more risky, successful attempts to provoke laughter can generate trust and diffuse anger, even in these fragmented situations. Useful parameters for humor in the therapeutic relationship include the following:

- The physician should be assiduously conservative in selecting the content and manner of humor, because patients are often intrinsically power disadvantaged and may feel too inhibited to express their disapproval. Encounters based on empathy, respect, and authenticity diminish the perception of power imbalance and facilitate a deliberative model of the physician-patient relationship. While humor may assist in this process, poorly selected quips or comments may also distance the physician and serve as a barrier.
- Gently self-deprecating humor or externally focused humor (eg, weather or parking) carries the least risk, in terms of miscommunication, especially when the physician's relationship with the patient is not well developed. In such situations, a joking comment humanizes the physician and is unlikely to offend the patient.
- To minimize the impression of flippancy, the physician should not rely exclusively on humor as a mode of communication during a physician-patient encounter.
- Physician-generated humor should be grounded in empathy; ie, the physician should have a relatively accurate understanding of the patient's values, limits, predispositions, and receptivity.
- The physician should be receptive and respond in kind to the patient's attempts at constructive humor.
- To clarify the patient's meaning and to help resolve anger, confusion, or other barriers to trust and continued communication, the physician should directly confront inappropriate or destructive patient-generated humor.

CONCLUSIONS

The physician-patient relationship suffers from discontinuity and depersonalization owing to financial, bureaucratic, and sociodemographic factors. Whether the relationship is long-standing or a first encounter, whether the subject at issue is a benign or life-threatening illness, careful use of humor can humanize and strengthen physician-patient encounters.

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