# Gallows Humor in Medicine

BY KATIE WATSON

Medical professionals regularly joke about their patients' problems. Some of these jokes are clearly wrong, but are all jokes wrong?

*IT WAS 3:00 AM and three tired emergency room residents were wondering why the pizza they'd ordered hadn't come yet. A nurse interrupted their pizza complaints with a shout: "GSW Trauma One—no pulse, no blood pressure."*

*The residents rushed to meet the gurney and immediately recognized the unconscious shooting victim: he was the teenage delivery boy from their favorite all-night restaurant, and he'd been mugged bringing their dinner.*

*That made them work even harder. A surgeon cracked the kid's rib cage and exposed his heart, but the bullet had torn it open and they couldn't even stabilize him for the OR. After forty minutes of resuscitation they called it: time of death, 4:00 a.m.*

*The young doctors shuffled into the temporarily empty waiting area. They sat in silence. Then David said what all three were thinking.*

*"What happened to our pizza?"*

*Joe found their pizza box where the delivery boy dropped it before he ran from his attackers. It was face up, a few steps away from the ER's sliding doors. Joe set it on the table. They stared at it. Then one of the residents made a joke.*

*"How much you think we ought to tip him?"*

*The residents laughed. Then they ate the pizza.*

David told me this story fifteen years after he finished his residency, but the urgency with which he told it made it seem like it hap-

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pened last night. "You're the ethicist," he said. "Was it wrong to make a joke?"

Gallows humor is humor that treats serious, frightening, or painful subject matter in a light or satirical way. Joking about death fits the term most literally, but making fun of life-threatening, disastrous, or terrifying situations fits the category as well. There is a fair amount of literature on humor in medicine generally, most of which is focused on humor in clinician-patient interactions or humor's benefit to patients.[1] There is relatively little specifically addressing the topic of this article: gallows humor in medicine, which usually occurs in interactions between health care providers.

Gallows humor is not a feel-good, Patch Adams kind of humor, but it is not synonymous with all cruel humor, either. As one physician put it, the difference between gallows humor and derogatory humor is like "the difference between whistling as you go through the graveyard and kicking over the gravestones."[2] Many health care providers witness or participate in gallows humor at some point. After reviewing over forty medical memoirs, Suzanne Poirier reports that "Anger and gallows humor are generally accepted forms of expression among undergraduate and graduate medical students . . . but expressions of serious self-doubt or grief are usually kept private or shared with only a trusted few."[3]

David's question intrigued me as a bioethicist because it is about moral distress, power imbalances between doctors and patients, and good people making surprising choices. But it also piqued my interest as someone who enjoys joking around—when not teaching bioethics, I teach improv and sketch writing at Second City, where I'm an adjunct faculty member. But David didn't ask me if the tip joke was funny. He asked about it in ethics' normative terms of right and wrong.

In this article, I consider whether some joking between medical professionals is actually unethical. The claim that being a physician is so difficult that "anything goes" backstage misuses the concept of coping as cover for cruelty, or as an excuse for not addressing maladaptive responses to pain. However, blanket dismissals of gallows humor as unprofessional misunderstand or undervalue the psychological, social, cognitive, and linguistic ways that joking and laughing work. Physicians deserve a more nuanced analysis of intent and impact in discussions of when gallows humor should be discouraged or condemned in the medical workplace. They also deserve deeper consideration of physician health than the professionalism lens might provide. Surely we can advocate for the humanity of patients without denying the humanity of those who treat them.

## How Clinicians Joke about Patients, Illness, and Death

Many groups develop a backstage language not meant to be understood by outsiders.[4] It's how they talk "when it's just us." Teachers in the teachers' lounge, firefighters in the firehouse, war correspondents in the hotel bar—none of what they say "backstage" is meant to be heard by anyone outside the group. Backstage humor might be a demographic postscript on "you had to be there" to think it's funny; it's also "you had to be us." Asking who exactly is "us" can reveal subtle divides within medicine: a rehab physician told me she feels rehab physicians are entitled to joke about disability, but she gets angry when she hears surgeons do it; a senior psychiatrist told me she sometimes jokes about patients, but she feels young physicians have not earned the right to do it yet. But the larger "us" is health care providers, in contrast to people not working in medicine.

"Humor is what happens when we're told the truth quicker and more directly than we're used to," writer George Saunders observes in his analysis of the gallows humor in Kurt Vonnegut's war novel *Slaughterhouse Five*. "The comic is the truth stripped of the habitual, the cushioning, the easy consolation. . . . This rapid-truthing is what Vonnegut does with the war."[5]

I love that term—"rapid-truthing." It made me think differently about a joke I heard a senior neonatologist tell years ago:

*A group of medical professionals and ethicists were considering the case of a neurologically devastated newborn. The discussion focused on the medical facts for an extended period of time (but what about this test, what about that test, how can you predict A, B, and C . . .) until Bill ended the debate by saying, "Look. He's more likely to* be *second base than play second base."*

As someone new to these types of conversations, I was shocked. But I also noticed that this crude summary of the baby's medical status served the function of moving the conversation on to other issues, like what range of options should be available to parents in situations like these. A few fleeting expressions of disapproval were shot Bill's way (miniature head shakes, eye rolls, and sighs), but no one seemed to disagree on the merits, and it seemed to free them to move the analysis forward. So maybe this neonatologist was playing the role of Court Jester, using a joke about a tragic circumstance as functional shorthand to speak a truth no one else was willing to say. Maybe this is an example of gallows humor serving the function of rapid-truthing.

Or maybe it isn't. As a nonphysician, I cannot independently confirm or reject the neonatologist's summary of that infant's medical status. Freud points out the danger of humor as a form of rhetoric: "While argument tries to draw the hearer's criticism over on to its side, the joke endeavors to push the criticism out of sight. There's no doubt the joke has chosen the method which is psychologically the more effective."[6]

Opinions, thoughts, and arguments framed as jokes bribe and

confuse our powers of criticism—if we laugh at them, by definition we're not in a critical mode. And if I say, "Wait, wait, I want to respond to that joke with a rational counterstatement challenging its underlying suppositions," then I'm a drag and everyone laughing will resent having to stop playing. So positions promoted through jokes somehow seem stronger than those supported by arguments. They also have a built-in protection against criticism: "Hey, it was only a joke."

Another analysis of backstage joking like Bill's focuses on humor as deployment of power. Bullies use jokes as weapons of humiliation, and brainy victims of physical aggression sometimes retaliate with humor, shifting the fight to terrain where they stand a chance. Since laughing renders us physically vulnerable for a moment, even the innocent pleasure of making a friend laugh can be understood as an act of (consensual) physical dominance and submission, and it is often observed that the language of comic performance is one of physical destruction (he killed, we slayed them). The teller of a spontaneous joke or funny story also wields the narrator's power to frame and interpret events. When someone wonders if "it was wrong to make a joke" backstage, perhaps they are really asking about the use and abuse of the power that comes with asserting oneself as the (comic) narrator of someone else's tragedy.

But a sophisticated analysis of power and humor includes assessment of relative power. This is captured in the concept of "joking up"—the idea that it's okay for the less powerful to make fun of more powerful individuals or groups, but the reverse (joking down) is not. Joking up is what allows medical students to publicly mock their professors in the annual variety show; joking down is why professors doing a show that mocked students would be shocking. In clinician-to-clinician gallows humor, those most likely to suffer direct harm (in Bill's case, the neurologically devastated child's parents) are not backstage to hear the joke, but in jokes about people less powerful than the teller, the "punch" of the punchline can feel too literal.

In focus groups conducted by Delese Wear and colleagues, medical students, residents, and attending physicians agreed that patients who were perceived as "difficult" (including the noncompliant) and whose medical problems were perceived as "their own fault" (including obese patients) were "consistently the objects of derogatory or cynical humor."[7] An intuitive objection to this is that it's joking down: healthy medical staff are more powerful than sick laypeople. But more complex power dynamics might be at play, too—when physicians need to change patient behavior instead of biology, they often feel powerless to heal. If people who need (and resist) behavior changes are framed as patients like any other, then physicians are framed as failures. By reframing these people as less than full patients, derisive joking does the unspoken work of reframing physicians as blameless for their inability to help.

The fact that bullying jokes might be motivated by an underlying sense of powerlessness does not make them healthy or desirable. But understanding that possibility may explain why for some otherwise upstanding clinicians they seem to be reflexive. Power might even be relevant to the senior psychiatrist who said younger doctors have not "earned the right" to joke about patients. Why would seeing something a lot earn one an entitlement to make jokes about it? Perhaps the senior physician's underlying justification is that ongoing exposure to this type of patient or situation has worn her down over time, and "earning it" is actually a reference to a *reduction* in physician power relative to patients—a reduction in their power to defend against feelings of frustration or despair over time, and an increased need for levity to compensate.

Even *The House of God*—a physician's dark comic novel about residents in the late 1970s trying to survive the hell of hospital life that's still read today—benefits from an analysis of relative power.[8] Some readers see the characters as joking down, as bullies who use cruel humor to (rhetorically) beat up on patients and nurses. But 1978 was the height of a particular kind of physician powerlessness: physicians were able to sustain life with new machines, but still lacked legal authority to withdraw noncurative treatment (even when unconscious patients' families begged them to stop), and hospitals profited from continuing treatment that felt like torture to the physicians administering it. Readers who think the characters' gallows humor is driven by an underlying helplessness may see them as victims joking up, mitigating their vulnerability by expressing it as bravado.[9]

One reason the risqué joking that comprises gallows humor typically travels backstage among peers is the risk inherent in joking across categories. Joking and laughing together can establish or affirm intimacy. But when joking reveals that we do *not*

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see the world similarly, it can harm relationships.

Yet sometimes a health care provider takes the risk of crossing categories and initiates a joke with a patient about a topic that the patient might find painful or frightening—the patient's medical condition. When the joking is successful, one reason it might feel good is that the exchange puts them in a peer relationship for a moment: they share inside information and they see it the same way—there's a spin on the patient's condition that makes them both laugh. But who defines whether provider-initiated joking with a patient is successful? A few years ago my sister and I had radically different reactions to a provider's joke about my medical condition:

*A porcelain shower handle broke in half as I was turning it off, and the deep gash in my thumb quickly pumped enough blood on the shower curtain to make me feel like I was reprising Janet Leigh's role in Psycho.*

*I sobbed as I threw on clothes and drove to an ER a few blocks away (not my own institution). I was still weepy when I met the medical student, who told me she'd never done the halo block anesthesia stitching my thumb would require. The supervising nurse teased the student about how gently she was draping my hand. "I'm not gentle," Nurse Toughlove quipped. "My dog runs when she sees me coming with a Q-tip."*

*The first needle stick in the base of my palm was so painful that sparks showered behind my closed eyes like a rocket on reentry. I panted through the shock, tears streaming down my face. My sister had arrived, and I squeezed her hand. Nurse Toughlove stepped in to demonstrate proper technique, jamming the second shot in fast and deep. The medical student tried again . . . and again . . . and again. I gasped as the needle probed my cut, and Nurse Toughlove laughed.*

*"Have you ever had a baby?"*

*"No."*

*"May I suggest you don't?" Nurse Toughlove joked.*

*"Hey!" my sister barked. "That isn't nice! She's being very brave."*

*"I'm just saying! There are a lot of nice ones out there to adopt."*

The nurse's joke about my pain reaction may have been a form of rapid-truthing intended to give me perspective ("C'mon lady, you're fine"). Or maybe it was intended for the medical student, a coded way to say, "Don't freak out, her tears are out of proportion to the physical pain you're actually causing her." (Though honestly the proportion seemed about right to me: turns out there are a lot of nerves in there!) My sister interpreted the joke as kicking me when I was down—that someone who should be helping me was making fun of me—and she thought I should file a complaint. I thought the nurse was trying to help me by teasing me, to cheer me up or distract me out of my tears. She did not succeed, but I was not offended. I did, however, wonder why crying was unacceptable. I was mostly talking and joking while the tears streamed down my face, but it was oddly liberating to weep at pain and surrender to care, and I resented being pulled away from a coping mechanism that was working for me.

Sometimes patients initiate jokes about their medical conditions with their doctors, crossing categories in the reverse direction of the power differential. An emergency department physician I'll call Ben told me this story:

*A thief escaping from a bank robbery crashed his car, and the police brought him to Ben's emergency room for a trauma evaluation on his way to jail. That includes a rectal exam, and Ben expected the prisoner to object, as many of the big tough guys he treats do. Instead, when Ben said, "I need to do a rectal exam," the prisoner looked out at the sea of cops and said, "I guess I have to get used to it."*

I don't know if this joke is about prison rape or cavity searches, but either way it covers a topic I generally classify as not funny, and if the doctor made that joke to the patient it would have been horrific. But as writers of their own lives patients have authority to turn their tragedies into comedies, and those who joke about the saddest or hardest elements of illness may make the physician's job more pleasant. Freud suggests the reason the unafflicted like it when victims joke about their plight is that it relieves us of the burden of sympathy.[10] In Ben's case, the prisoner's joke humanized the patient, and this ordinarily jovial doctor did not laugh. I asked Ben what happened in that moment, and he said, "The joke bridged the us-him divide. Here's a guy who has the same dark sense of humor as me. It made me think perhaps in a different time we could be friends." Instead of relieving Ben of sympathy, the patient's joke seems to have created some.

## Why They Joke

Freud argued that the jokes we make are as revealing as our dreams. In *Jokes and Their Relation to the Unconscious*, he hypothesized that joking serves the psychological function of avoiding both internal and external obstacles.[11] Internal obstacles are inhibitions like shame or fear. Freud claimed that joking about death (and other anxiety-provoking topics like sex, excrement, race, and religion) releases psychic tension through laughter. It does an end-run around prissy superegos saying, "You can't talk about that!" and makes us laugh in proportion to how anxious we are.

External obstacles are powers beyond our control, and when you can't address your problems directly, laughter's a more helpful response than anger. Joking about the boss is a substitute for fighting with the boss—and if we can get other people to laugh with us, we might feel our relative power grow. A joke is a rebellion against oppressive authority, and

few authorities are more oppressive than death, illness, and injury. In one of the ultimate examples of external obstacles, Viktor Frankl describes concentration camp prisoners who "cracked jokes" about their horrible circumstances: "Humor was another of the soul's weapons in the fight for self-preservation. It is well known that humor, more than anything else in the human make-up, can afford an aloofness and an ability to rise above any situation, even if only for a few seconds."[12]

Philosopher Ted Cohen argues that sometimes we joke not for distance but for connection. If you laugh at my joking, it means that we are alike in some way, that we see the world similarly.[13] In Cohen's terms, humor serves the vital psychological and social function of confirming or cultivating intimacy, and establishing or reinforcing community.[14] Another function of joking Cohen considers is acknowledging and integrating painful absurdities: "When we laugh at a true absurdity, we simultaneously confess that we cannot make sense of it and that we accept it. Thus laughter is an expression of our humanity, our finite capacity, our ability to live with what we cannot understand or subdue. We can dwell within the incomprehensible without dying from fear or going mad."[15]

Freud and Cohen focus on the emotional reasons we joke, but some laughter is better explained by cognition: incongruity is another reason health care providers might laugh at moments involving patients, illness, and death. This is illustrated by Rachel Sobel's account of a hospital cafeteria snack break in her essay, "Does Laughter Make Good Medicine?"

*The medical teams eating ice cream together got on the topic of "funniest beeper pages in the middle of the night"—for example, "Doctor, your patient is on fire"—and "laughed until we could barely breathe."*[16]

In her analysis of the exchange, Sobel dutifully chastises herself for failing her professionalism oath: "the purist's definition of professionalism dictates that patients should be respected at all times, even behind closed doors." She concludes by wondering how we can ever reconcile "human imperfections with our desire to abide by the highest standards of professional conduct."

Forget deep analyses of coping, bonding, and callousness for a moment—there's a structural reason people might laugh at the page, "Doctor, your patient is on fire," and that's a cognitive reaction to incongruity. The first incongruity is content: people do not usually catch on fire, especially in hospitals—or so one might hope. A patient on fire is surprising; it does not quite add up. The second incongruity is delivery: "[Someone we know] is on fire" seems like something you'd hear screamed, not receive as a matter-of-fact message through the same medium we use to say, "See you at 3:00!" The third incongruity is linguistic: the present tense ("your patient is [currently] on fire") frames the text's sender as a blasé person typing this information while they stand next to someone in flames. A character's underreaction (and overreaction) are standard comic scenarios, both a variation on incongruity.

Sobel does not say incongruity is why she laughed at the page's retelling, but her intuitive knowledge of how incongruity triggers laughter may be why she says *not* laughing at things like this is "Suppressing our natural reactions." Human brains trained in pattern recognition quickly spot pattern disruption and jump to the startle response of laughter. So when students in focus groups say things like, "You are not really making fun of the patient but the situation,"[17] they might in some cases be referring to a cognitive/linguistic reaction to that situation. When information is intentionally (dis)ordered to make us laugh, it's called comedy writing. When it's delivered that way by chance, it's called a funny day at work. Labeling Sobel's laughter unprofessional is not a purist interpretation of her oath to treat patients "with respect and dignity, both in their presence and in discussions with other members of the health care team," it's an inaccurate interpretation of the laughter, because its object was not the poor flaming patient. And I disagree with Sobel's characterization of this laughter as human imperfection—in physicians, a rapid and consistent ability to spot what's wrong with this picture is actually a mark of perfection. The professionalism movement should not be confused with a priggish campaign against pleasure, which it surely is not.

Moments when health care providers suddenly see the enormous gulf they're straddling between medical and lay culture are one source of gallows humor. Being off-balance can make us laugh, and sometimes laughing is what keeps us from falling over.

Thomas Kuhlman pushes the incongruity concept deeper in his detailed description and insightful analysis of how he and his colleagues deployed gallows humor in a maximum-security psychiatry unit for assaultive patients.[18] Kuhlman asserts that gallows humor "flourishes when all else fails and where there is no reasonable hope for improvement," and that one characteristic of such settings or moments is existential

incongruity—"a senseless hopeless aspect that justifies the psychological shift from a goal-directed frame of mind to a playful one."[19] This existential incongruity may lie in the clash between idealized social expectations and what can reasonably be achieved, a great imbalance between one's efforts and actual outcomes, or an existential paradox like saving wounded soldiers so that they can return to battle to face more harm. Kuhlman argues that gallows humor "offers a way of being sane in an insane place."[20] Joan Sayre came to a compatible conclusion in her study of psychiatric unit meetings: gallows humor was one part of "the basic social process of facing a series of ultimately unresolvable problems."[21]

Charles Bosk offers a different perspective—after observing rounds and conferences of surgeons and pediatric intensive care unit pediatricians and anesthesiologists, he identified gallows humor as one of eight key strategies physicians use for managing uncertainty in diagnosis and treatment.[22] Another strategy is what Bosk calls "hyperrealism," which he defines as "gallows humor without the bravado."[23] Of both these strategies, Bosk reports, "Residents learn through rounds that there are times when laughter is the only response to an absurd situation. They also learn that there are times when one recognizes a situation as absurd and goes from there."[24]

Finally, I wonder if there is a relationship between gallows humor and physical deprivation. Both David's and Sobel's stories revolve around weary young physicians eating during overnight shifts. Sleep is another basic need that goes unmet in early years of practice. In her review of medical student and resident memoirs, Suzanne Poirier documents a recurring theme of utter exhaustion and notes a pattern in which physical vulnerability leads to loss of compassion: we are not our best selves when we are tired.[25] Young physicians may be low on emotional resources as well: a senior physician told me that he observed younger physicians using gallows humor for tension relief more often than older physicians, which he attributed to the fact that residents are the brunt of a lot of anger from patients, families, and superiors—emotional assaults attending physicians rarely have to endure firsthand. When you lack control over meeting basic needs like food, sleep, and emotional safety, perhaps laughter provides a little compensatory nourishment.

## Changing Standards?

One of medical training's first requirements is the violation of strong cultural taboos around death and dead bodies. Dissecting corpses has generated "cadaver antics" that many older physicians recall fondly—making jokes, clowning around with body parts, and pulling pranks to scare labmates. Joking like this helps turn corpses into cadavers by framing bodies as objects. Until recently, cadaver antics were a rite of passage, initiation, and enculturation into an ethos that said a doctor is a tough person who can laugh at death. Not just not cry about death. Laugh. Today cadaver antics are rarely tolerated, and the modern approach frames cadavers as former people. Students are commonly asked to imagine lives lived before these bodies died, and to journal or discuss their emotional reactions in small groups.[26] Many classes end with a memorial service students create to thank the people they have dissected for donating their bodies, and sometimes they even meet the donor's family members.[27] The concept of performativity is helpful here: how must a person change the way she or he looks, acts, and feels to both perform the social role of doctor and to be recognized as one? The modern approach to anatomy lab represents a dramatic shift away from a macho joke-about-death performance of the role of doctor, and toward compassion and connection as being performative elements that help define the role of doctor.

The medical workplace may be changing, too. I've heard older physicians lament that the workplace is not as funny as it used to be, that practicing physicians do not joke around together like they used to. If that's true, perhaps one reason is that the easy in-group joking they remember was based not just on being physicians, but on the broader bond of being straight white male physicians. The increasing diversification of medicine narrows the meaning of "it's just us" to what's truly distinctive about providing health care, versus simple differences in physician and patient demographics. It's also possible that the dramatic increase in women physicians has unique effects on gallows humor. It's a generalization rife with individual exceptions, but if there are differences in stereotypically male and female forms of humor, it stands to reason that the increased presence of women might cause a cultural shift in when and how backstage gallows humor is used in the workplace. This gender shift may also have made coping mechanisms that substitute for joking about fear and sadness (like verbal expressions of these emotions) more acceptable in the medical workplace.

I applaud the cadaver lab changes, and I strongly support the backstage changes that make a diverse workforce welcome. I also support efforts to define what I think of as HOG talk ("*House of God* talk") as unprofessional because shallow bullying and derogatory slang coarsen the moral enterprise of medicine and cut providers off from healthier means of coping.

Yet in some areas, perhaps the hand wringing has gone too far. Condemnation of gallows humor is sometimes premised on a category mistake (such as lumping it together with all making fun of patients[28]) or a double standard. For example, an article titled "Humor in the Physician-Patient Encounter" contrasts a short treatment of "Destructive Gallows Humor" between providers, which frames all gallows humor as "'sick'

wit and hurtful humor used to separate providers from patients," with a long treatment of "Therapeutic Humor" between providers and patients, which is "grounded on a recognition of the human condition that is shared by patient and provider."[29] What the article fails to acknowledge is the human condition that is shared by provider and provider. Critics of backstage gallows humor who are admirably concerned with empathy for patients sometimes seem curiously devoid of empathy for physicians. Medicine is an odd profession, in which we ask ordinary people to act as if feces and vomit do not smell, unusual bodies are not at all remarkable, and death is not frightening. Moments when health care providers suddenly see the enormous gulf they're straddling between medical and lay culture are one source of gallows humor. Being off-balance can make us laugh, and sometimes laughing is what keeps us from falling over.

Empathy for clinicians does not mean anything goes; it means clinicians must be conceptualized as human beings rather than as robotic systems for care delivery. Laughing and caring for others are both sources of joy. Suggesting physicians can only enjoy one of these pleasures in certain circumstances costs them something, and therefore deserves thoughtful justification.

## Should They Joke?

Insights from the humanities and social sciences supply the context required to fully analyze David's ethics question: Was it wrong to make the tip joke? When is behind-the-scenes gallows humor okay, and when should it cause concern? Underlying all this, the ethics question may be, "When is joking a form of abuse?"—abuse of a patient, abuse of trust, or abuse of power.

To answer, I would first want to think about who is harmed by the joking.[30]

- Within the text of the joke, who or what is the true target? Does close reading reveal it to be a defenseless patient? Or is the joke really aimed at a doctor who is defenseless against death, decay, and chronic illness?

- Could the joke harm the way future care is delivered? By using the power of humor to frame the patient in a way the patient cannot challenge, could the backstage joke bias listeners' future interactions with that particular patient? Does the repetition of stereotyping jokes about "patients like these" contribute to making the health care provider calloused toward a particular demographic?

- Could the joke harm the profession by diverting anger caused by structural problems (like caseloads so high that patients feel like the enemy, or scheduling that results in chronic sleep deprivation) and releasing it on the easy punching bag of patients rather than using it to make productive changes?

- Who is listening to the joke? Gallows humor that seems ethical backstage can become unethical in front of patients, families, or others because it has the potential to harm them directly.

Next, I would want to ask about the health care provider's relationship to the joking.

- What's the clinician's underlying intent in joking? Is gallows humor being used as a helpful defense mechanism when circumstances limit the options for processing something difficult? Is the intent to get through the day by trying to lighten an oppressive situation, or is the intent to be a jolly bully?

- What impact might this joking have on the clinician? Is it the type of joking that helps clinicians open up to difficult experiences or frees them from intolerable burdens? Or is it the type of joking that cuts clinicians off from experiences or patients that healthy clinicians should be able to engage with?

- How often does the health care provider joke like this? If a doctor is joking about patients and death constantly, then (even if each can be justified individually) does she need help expanding her range of coping mechanisms? Or is this joking part of an ongoing pattern (say, of objectifying vulnerable patients) that suggests deeper provider biases?

When is behind-the-scenes gallows humor okay, and when should it cause concern? Underlying all this, the ethics question may be, "When is joking a form of abuse?"—abuse of a patient, abuse of trust, or abuse of power.

David and his colleagues scattered across the country after residency, but in the fifteen years that passed before he told me the tip joke, they talked about the night the delivery boy died several times. The whole thing made them sad for years, he said. "Wasn't that terrible?" they'd ask each other on the phone. "How could we eat the food that poor kid dropped?"

In the process of trying to do good, did they become bad? I do not think so.

To me, the butt of the doctors' tip joke is not the patient. It's death. The residents fought death with all they had, and death won. Patient care was not harmed—the patient in this case had received the best medical care they could deliver, and he was dead. It's hard to imagine the joke hardening these residents toward a type of patient he represents (delivery personnel?) in the future. The neighborhood's staggering rates of crime and poverty might represent an external obstacle upsetting the residents, but residents are usually powerless to alter that type of structural factor.

I think the motivation for telling the joke was to integrate this terrible event and get through the shift. This teenager lost his life bringing these young doctors dinner. "How much you think we ought to tip him?" is a macabre summary of all that's owed in this world and all that can never be repaid. And it looks forward—it's a moving-on question. In a situation that horrific and absurd, a joke is the rock you throw after the bad guy's already gone—an admission of loss, and a promise to fight again another day.

It's important that the tip joke was told in an empty area with no family, friends, or other patients who could be harmed by overhearing. I'm usually a fan of sunshine tests and total disclosure, so I find the idea of secrecy as an ethical plus startling. But when a compassionate professional gets overwhelmed, gallows humor may be a psychic survival instinct, and that's why it is not an abuse of patient trust when it's done backstage and for the right reasons. Something that looks maleficent toward one patient may actually be an act of beneficence toward the patients who will come next. So yes—if the delivery boy were my son and I heard the joke, I would want to tear their eyes out. But if I was the person in the next ambulance, hurtling toward their emergency room after my car wreck, my heart attack, my rape, I'd be glad they made that joke. Because they needed to laugh before they could eat, and they needed to eat to be at their best when it was my turn.

David is a brilliant, compassionate physician who will serve patients his whole life, so I told him two things about the tip joke: I'm glad he did what he needed to do to treat every patient he'd see that night. And I'm glad it still bothers him. Because it's good to carry that tension that tells you when you're on thin ice. When a terrible joke is the only bridge between horror and necessity, gallows humor can be a show of respect for the work that lies ahead. So tell your jokes. Tell them somewhere I cannot hear. Then treat me well when we're together.


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3. S. Poirier, *Doctors In the Making: Memoirs and Medical Education* (Iowa City: University of Iowa Press, 2009), 117.

4. See E. Goffman, *The Presentation of Self in Everyday Life* (Garden City, N.J.: Anchor-Doubleday, 1959).

5. G. Saunders, *The Braindead Megaphone* (New York: Riverhead Books, 2007), 80. Thanks to physician-writer Jay Baruch for directing me to this concept.

6. S. Freud, *Jokes and Their Relation to the Unconscious*, standard edition (New York: Norton, 1960), 163.

7. D. Wear et al., "Making Fun of Patients: Medical Students' Perceptions and Use of Derogatory and Cynical Humor in Clinical Settings," *Academic Medicine* 81 (2006): 454-62, at 456-57; Wear et al., "Derogatory and Cynical Humor Directed Towards Patients," 37.

8. S. Shem, *The House of God* (New York: Dell, 1978).

9. For an excellent challenge to the contention that gallows humor is driven by physicians' fear, as opposed to their privilege and need for control, see A. Barrett, "Our Language, Ourselves," *Journal of Medical Humanities* 15, no. 1 (1994): 31-49.

10. Freud, *Jokes and Their Relation to the Unconscious*, 286-87.

11. Ibid., 144-145, 164.

12. V. Frankl, *Man's Search for Meaning: An Introduction to Logotherapy* (New York: Simon and Schuster, 1984), 56, 54.

13. T. Cohen, *Jokes: Philosophical Thoughts on Joking Matters* (Chicago, Ill.: University of Chicago Press, 2001), 29. Cohen's book addresses scripted jokes, but many of his insights apply to spontaneous joking as well.

14. Ibid., 28-31.

15. Ibid., 41.

16. R.K. Sobel, "Does Laughter Make Good Medicine?" *New England Journal of Medicine* 354 (2006): 1114-15.

17. Wear et al., "Making Fun of Patients," 459.

18. T.L. Kuhlman, "Gallows Humor for a Scaffold Setting: Managing Aggressive Patients on a Maximum-Security Forensic Unit," *Hospital and Community Psychiatry* 39, no. 10 (1988): 1085-90.

19. Ibid., 1086-87.

20. Ibid., 1085. Julie Aultman offers an outstanding challenge to the coping model in her analysis of a different category of humor ("derogatory and cynical"). Aultman calls "the need to satisfy self-interest (relieving *my* stress) at the expense of another's interest (for example respect)" a transparently immoral attitude and belief. However, this framing fails to consider the possibility that relieving clinician stress could also benefit patients through improved clinician performance. J. Aultman, "When Humor in the Hospital Is No Laughing Matter," *Journal of Clinical Ethics* 20, no. 3 (2009): 227-33, at 231.

21. J. Sayre, "The Use of Aberrant Medical Humor by Psychiatric Unit Staff," *Issues in Mental Health Nursing* 22 (2001): 669-89, at 674. However, I must note my disagreement with much of the terminology

and categorization Sayre uses; for example, I find the label "aberrant" humor unhelpful, and the author offers no explanation for this provocative choice.

22. C.L. Bosk, "Occupational Rituals in Patient Management," *New England Journal of Medicine* 303 (1980): 71-76.

23. Ibid., 74.

24. Ibid.

25. Poirier, *Doctors in the Making*, 88-90, 119-121. See also G. Noone Parsons et al., "Between Two Worlds: Medical Student Perceptions of Humor and Slang in the Hospital Setting," *Journal of General Internal Medicine* 16 (2001): 544-49, at 546.

26. See D.R. Reifler, "'Poor Yorick': Reflections on Gross Anatomy," *Teaching Literature and Medicine*, ed. A.H. Hawkins and M.C. McEntyre (New York: Modern Language Association, 2000), 327-32. Describing reflective writing exercises required of anatomy students: "We discuss the role of graveyard humor as an appropriate and understandable adaptation to duress but an adaptation that quickly becomes grotesque when it oversteps certain boundaries" (p. 330).

27. See J. Warren, "A New Emotional Intimacy in a Class on Human Anatomy," *New York Times*, April 29, 2010.

28. See Wear et al., "Making Fun of Patients," and Wear et al., "Derogatory and Cynical Humor Directed Towards Patients." However, in response to the physician in their second study who raised the distinction between graveyard whistling and gravestone kicking, the researchers acknowledged the "very wide net" they had cast in categorization. The editorial accompanying the article takes a professionalism perspective on the issue, making no distinction between cynical humor and derogatory humor: "derogatory and cynical humour as displayed by medical personnel are forms of verbal abuse, disrespect and the dehumanisation of their patients and themselves. . . . Such humor is indefensible, whether the target is within hearing range or not." R. Berk, "Derogatory and Cynical Humour in Clinical Teaching and the Workplace: The Need for Professionalism," *Medical Education* 43 (2009): 7-9.

29. J.T. Berger, J. Coulehan, and C. Belling, "Humor in the Physician-Patient Encounter," *Archives of Internal Medicine* 164 (2004): 825-30, at 825.

30. For a harm analysis of a different category of humor ("derogatory and cynical") see Aultman, "When Humor in the Hospital Is No Laughing Matter," 230.

# Contributors

**Lisa Campo-Engelstein** is an assistant professor at the Alden March Bioethics Institute, Albany Medical College, and coeditor of a book on the emerging field of oncofertility. Her current research areas are contraception, oncofertility, fertility preservation technologies, embryo and parthenote research, and international bioethics.

**I. Glenn Cohen** is assistant professor at Harvard Law School and codirector of the Petrie-Flom Center for Health Law Policy, Biotechnology, and Bioethics at Harvard University.

**Rebecca Dresser** is Daniel Noyes Kirby Professor of Law and professor of ethics in medicine at Washington University in St. Louis.

**Troy Duster** is Silver Professor of Sociology at New York University and also holds an appointment as Chancellor's Professor at the University of California, Berkeley. From 1996–98, he served as member and then chair of the joint National Institutes of Health/Department of Education Advisory Committee on Ethical, Legal and Social Issues in the Human Genome Project. He is the author of *Backdoor to Eugenics* (2nd ed., Routledge, 2003).

**Lawrence O. Gostin** is the University Professor at Georgetown University and professor of global health law at Georgetown Law, where he directs the O'Neill Institute for National and Global Health Law. He is also professor of medicine at Georgetown and professor of public health at Johns Hopkins University. His latest books from the University of California Press are *Public Health Law and Ethics: A Reader* (2010) and *Public Health Law: Power, Duty, Restraint* (2008).

**Daniel Groll** is an assistant professor of philosophy of Carleton College in Northfield, Minnesota, and a former participant in case conferences at the MacLean Center for Clinical Medical Ethics, University of Chicago Hospitals. His work focuses on questions about moral knowledge, moral expertise, autonomy, and paternalism.

**Nell Burger Kirst** is a third-year resident at the University of Michigan Family Medicine Residency Program.

**Osagie K. Obasogie** is an associate professor of law at the University of California, Hastings, in San Francisco with a joint appointment at the University of California, San Francisco (UCSF) Department of Social and Behavioral Sciences. He is also a senior fellow at the Center for Genetics and Society in Berkeley, California (www.geneticsandsociety.org).

**Aron D. Rose** is an ophthalmologist in private practice in New Haven, Connecticut. He is also an associate clinical professor at the Yale School of Medicine and the Yale School of Nursing and foundation codirector of Eye Team Worldwide.

**Katie Watson** is assistant professor in the Medical Humanities and Bioethics Program, Feinberg School of Medicine, Northwestern University; adjunct faculty (improvisation and writing) at The Second City Training Center; and editor of *Atrium*. She teaches law, ethics, and improvisation as a tool for physician-patient communication to Northwestern medical students, and she is a member of the Northwestern Memorial Hospital Ethics Committee.

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