

Laughing At, With, About or for? Medical Students' Understanding of Aberrant Humour

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Abstract

Background Humour is a fundamental aspect of communication and is evident in healthcare interactions. Although often perceived as a stable expression of personality in humans, humour is a complex, dynamic, phenomenon and can be rehearsed or spontaneous. A 'sense of humour' is generally viewed as a virtuous quality but there are both positive and negative imports to humour use. We explored medical students' experiences and perceptions of humour use in healthcare settings in the Arabian Gulf.

Methods We used a qualitative approach, recruiting a purposive sample of medical students with previous exposure to clinical settings to two audio-recorded focus groups. A previously developed interpretative and illustrative framework was used to interrogate the data using what was *known* about humour e.g. humour theories and allowing for what was *unknown*. Data was illustrated via a transcription system that highlighted the prosodical features of speech including how and where humour arose in the interaction.

Results The medical student participants provided unprompted examples of humour from their experiences of communication in clinical settings, demonstrating an awareness of humour but with a limited understanding of its import. Aberrant humour - humour that departs from an acceptable standard - a kind of tendentious or superiority humour was most evident creating confusion, doubt and potentially threatening self-worth. At best aberrant humour is non-therapeutic, at worst it is inappropriate and potentially problematic. When medical staff included students in the expression of aberrant humour then students were more likely to justify the practice.

Conclusion We demonstrate how a nuanced, 'layered' approach to analysing humour events is important in understanding spontaneous humour and *making that explicit to others*.

All medical faculty and students need to be cognisant of humour *per se*, how it may emerge in nuanced interactions and its subsequent impact upon participants. A starting point for medical curricula could be for example, simple awareness-raising, by applying some aspects of the interpretative and illustrative framework we used to analyse the data reported here.

Communication is fundamental to healthcare and humour is an integral part of healthcare work. Consequently, we believe medical education needs to start taking humour seriously.

Background

Communication is fundamental to modern patient-centred healthcare¹ and humour is an integral aspect of communication². Humour is a complex dynamic phenomenon involving cognitive, emotional, physiological and social aspects^{3,4} that mainly occurs (spontaneously) in interactions between two or more individuals⁵. Yet humour in healthcare interactions is a relatively under-researched area and tends to focus on rehearsed as opposed to spontaneous humour⁶. Accordingly, there appears to be limited interest in the relevance of humour to medical education^{7,8}

Humour in healthcare has invariably been posited as a positive phenomenon. Consequently, the humour-health hypothesis; the concept that humour has a positive indirect or direct impact on health – is the preferred area of debate among academic researchers as well as applied humourists⁹. Nevertheless, humour is not an entirely positive phenomenon with Michael Billig^{10,11} noting the potentially detrimental aspects of humour.

There are over 100 humour theories in existence although three tend to prevail¹². Superiority/Tendentious, Incongruity and Gallows/Release. The tendentious theories of humour including self-defeating, self-disparaging and self-deprecating humour (SDH); humour use against oneself (SDH) – have been particular areas of interest over the last two decades as potentially negative indicators of humour. For example, Kuiper et al¹³ building upon previously identified ‘negative’ aspects of humour, Kirsch and Kuiper¹⁴ suggests there are adaptive and maladaptive forms of humour with SDH falling into the latter category. It is unlikely however, that such a relationship would be fixed or stable. Nevertheless, despite the emergence of positive psychology¹⁵, there is increasing evidence that humour is not a wholly positive entity and that some types and uses can be dysfunctional and indicative⁴.

Humour is a fundamental aspect of communication and healthcare, can be both positive and negative, is integral to coping and resilience^{16,17} and is culturally challenging with eastern and westerners holding differing perspectives^{18,19,20}. It is therefore, important to be able to identify different types of humour use and carefully consider their role in healthcare. We explored medical students’ experiences and perceptions of humour use in the clinical setting with a view to enhancing their awareness and understanding of humour use and its fundamental role in communication and patient care.

Methods

We undertook a qualitative approach to exploring medical students’ experiences and perspectives of humour use in clinical settings in the Arabian Gulf. Participants were purposively recruited to two audio-recorded focus groups (n=4 in each) with a constant comparison approach to data collection and analysis. Only students who had previous exposure to clinical settings were recruited.

Setting and recruitment

The setting is a large international university in the Arabian Gulf where medical students are largely recruited from overseas for a 5 – 6 year programme. Participants were recruited through ‘opt-in’ consent via public advertisement of the study within the institution (email, noticeboards, interactive screens, Virtual Learning Environments (VLE) announcements etc). Prospective participants were informed that the topic for review was their experiences of ‘communication’ in clinical settings. All interested participants were provided with a Participant Information Leaflet (PIL) and consent form with prospective dates through their institutional emails. Participants had a minimum of 48 hours to consent

Humour in healthcare is a largely spontaneous and subjective phenomenon, hence participants' may not necessarily recognise when humour occurs. We therefore, commenced the focus group with an open question asking for participants' experiences of 'communication in the clinical setting' (doctor-patient, peer-peer, doctor-student). This elicited a number of unprompted examples of humour. Thereafter, we explored participants' specific humour accounts in more detail, allowing humour as a spontaneous phenomenon to be explored authentically. Two researchers moderated the audio-recorded focus groups. Participants were also asked to complete a post focus group anonymized brief questionnaire to provide contextual information on ethnicity, schooling, country of origin [table 1]

Table 1: Participants

FG	n=	Genders	Time	1st	2nd	Religion	Origin
Focus Group 1	4	2 male 2 female	70 minutes	Mixed	English/French	2 Islam	Various: UK, Asia, North America, Local
Focus Group 2	4	3 females 1 male	58 minutes	Arabic	English	3 Islam	2 local 1 Africa 1 Asia

Ethics

Ethical approval was provided by the institution's Research Ethics Committee (REC). Focus group participants were asked to use first names only. All audio-recordings were transcribed verbatim. Following transcription, all first names were replaced with pseudonyms. Any references to identifying information (people, places etc) was deleted/replaced. All data (soundfiles, transcripts and paper questionnaires) were retained in one password protected computer in a locked office with additional password protected files and will be retained for 5 years. The software programme 'Audacity' was used to manage and anonymise soundfiles, obscuring voice recognition and place/people names where appropriate.

Data collection and analysis

Data collection and analysis took place concurrently via the constant comparison method. All data was subject to five (audio and script) passes. A previously developed illustrative and interpretative humour framework was used to analyse the verbatim transcripts^{6,21}. We therefore, attempted to account for what was *known and unknown about humour*. Thus, the coding paradigm of Strauss²² and Strauss and Corbin²³ was also used to examine the social process and provided concepts, categories and dimensions on three levels: open, axial and selective (*unknown*). Moreover, we used the Jefferson system of transcription²⁴ which highlights the prosodical features of speech on specific data segments (*unknown*,

known). In turn, the three main (motivational) humour theories (Superiority, Incongruity, Gallows/Release) and Jennifer Hay's²⁵ non-laughter based implicatures of humour support: recognition of humour, understanding of humour, appreciation of humour, agreement with humour - were also utilized (*known*). At the level of axial coding Martin's⁴ psychological overview of humour assisted in the abstraction of data (*known/unknown*).

Table 2 outlines the interpretative and illustrative questions asked of the data in relation to the social process generally and humour specifically.

The external factors of the Holy Month of Ramadan (May 2019) and Medical Examinations partly determined the conclusion of data collection. However, theoretical sufficiency²⁶ was evidenced by no new patterns emerging in the data, increasing theoretical sensitivity, decreasing interrogation of data and increasing abstraction.

We will now review the 'aberrant humour' reported by the focus group participants by providing three examples.

Results

The medical student participants provided unprompted examples of humour from their experiences of communication in clinical settings. Specifically, participants provided accounts of a potentially problematic humour use: a kind of tendentious or superiority humour that is aberrant, or humour that departs from an acceptable standard. Notably, participants did not outline any examples of potentially non-problematic humour e.g. incongruity humour use, with only one example of Self Disparaging Humour (a sub category of Superiority Humour) being used as an alignment strategy. We now review three examples of 'aberrant humour'.

Aberrant Humour: 1 – The elevator (surgeon)

The following is an abbreviated account of problematic humour that took place frontstage in a lift in X hospital. Present was a male surgeon, a junior doctor (female mentor), 3 male/female medical students and 2 others e.g. patients or relatives.

"He (the surgeon) saw me writing notes and he says, "Oh what are you writing?"

I don't know this Doctor I have never seen him, I said that I am just writing patients notes and he just takes the note book out of my hand and starts reading my notes out loud in the lift and he's laughing, he's going 'oh [laughter] or why did you write this?' [laughter]. I have never experienced anything like this.

He read [aloud] what I had written on the page, handed the book back to me and left, and he was laughing the entire time.

I didn't know what to do [laughter]. I was laughing because I didn't know how to handle it..

He (the surgeon) was laughing, so you have to laugh....

1:B: 11-372

The above account is an example of problematic tendentious humour presumably aimed at ridiculing the student in question in front of a mixed audience in a public place. The student reported initially resisting the surgeon's attempts to acquire the notebook but then acquiesced. Student B then highlights her confusion at this behaviour by (self-disparagement) laughter here but reports expressing release laughter at the time. She states later she sensed others in the lift were similarly confused and embarrassed and when pressed for more information on the laughter sequences, recounts that initial silence gave way to stilted laughter particles and then more sustained laughter particles which concluded when the surgeon stopped reading and exited the lift.

According to Hay's²⁵ humour support strategies, humour in the above sequence is recognised but not understood, appreciated nor necessarily agreed and is therefore, not wholly supported. Rather, student B eventually concurred that she laughed due to a potential myriad of reasons e.g. (a) release through her perceived embarrassment (b) confusion (c) to reduce the perceived awkwardness/embarrassment of others in the lift (d) because he (the surgeon) was trying to be funny, (e) he was a clinical 'superior' and (f) to simply get him to stop reading. Thus, the student unwittingly perhaps, provides a psychological overview of the situation (table 3) which is not as simple as it may initially appear. There is reciprocal laughter but only as an appeasement strategy to bring the problematic humour expression to a quick end for all. Prepositions that normally follow the verb 'laugh' are mainly to laugh (a) *at*, (b) *about* or (c) *with*. However, in this example the appropriate preposition is arguably 'for': not indicating a time period but someone, in this case a superior who is patently showboating at the unfortunate student's expense.

A number of medical students reported similarly embarrassing episodes of superiority humour aimed at ridiculing medical peers in front of a group. However, these episodes appeared to be exclusive to one specific hospital known which evidenced outdated medical hierarchies or approaches. Students patently recognised this as aberrant humour use albeit their cognitive appreciation was somewhat under-developed. A greater understanding of the (humour) processes taking place may have helped them to respond differently and to have been better able to cope with any potential impact upon their sense of self, especially if exposed to repeated episodes.

Aberrant Humour 2: 'He's dead' (Psychiatrist)

The following example in the same hospital is one of potentially aberrant humour that was not viewed as such by the students providing the account. In this account, the student recalls a patient knocking at an open door, asking for a particular doctor. The consultant looks at the patient and states; '*Oh he's dead* (giggling laughter)' – to which the patient replies he has an appointment. '*No can do*' says the consultant

2:477:C

'We (medical students) get a kick out of it, he (the consultant) gets a kick out of it and then he explains to the patient where to go'.....he wasn't making fun of.. or with the patient.. he was making a joke of the patients' request but then proceeded to answer the request eventually.

2:487:C

The prevailing view therefore, appeared to be this was harmless recreational humour for the students' benefit to promote inclusion (*'this one's for you guys'*) and no harm accrued as the patient was appropriately re-directed. Notably, some of the non-Arab speaking medical student participants reported feeling excluded at times particularly in hospital X. Consequently, when a consultant made an effort to include them in humour they might understandably find this gratifyingly inclusive with superiority humour having the potential to promote group inclusion²⁷ Nevertheless, some participants were perhaps unable to distinguish inappropriate/aberrant humour being used as potentially distracting, recreational, ridiculing or perhaps, as simply individual relief at not being the butt of the joke.

Aberrant Humour 3: hu::ge balloon (Psychiatrist)

The final example is a patient who was attending the same consultant in example two following 'a bleed in her brain' which had resulted in a series of psychiatric symptoms:

He was trying to explain the reason behind getting this bleeding in her brain, and he was like... listen to me, in a very sarcastic way in a very thick accent in X, he was like "listen, you have this kind of ve::ry ve::ry very hu::ge balloon"

2:508:A

The student reporting the example drew laughter from the rest of the focus group and then stated that the patient had reproached the Doctor - "*Stop being sarcastic doctor, I'm tired*" – before, she too started to laugh. The student was asked about the import of humour in this example and its appropriateness or otherwise in this situation:

Maybe it's a way for him to distract the patient from their own zone to get them out of the depression and the anxiety mood.

2:520:A

(At the) end of the day he treats anxiety and this should be managed by a neurologist..

2:526:A

You know, so if it's not well explained for her it's not his job because he is a psychiatrist not a neurologist.

2:530:A

Thus, student A – who drew agreement from her fellow participants – considered the humour used in this situation to be recreational and distracting i.e. a positive emotion, while Chung et al²⁸ notes that medical students are empathetic to their clinical trainers irrespective of possible aberrant behaviour. However, the student's assertion that the surgery and outcome was not the province of the psychiatrist and this therefore, fully justified the sarcastic explanation provided was at best tenuous.

Discussion

Aberrant, cynical or derogatory humour exists in healthcare and may arise due to challenging working contexts and interactions with the potential to erode professional integrity and competence, leading to disaffection and resentment^{7,8,29}. At best aberrant humour is non-therapeutic, at worst it is inappropriate and potentially problematic with its continual practice and tacit acceptance likely to lead to 'ingrained mechanisms'³⁰ and, or ethical erosion³¹.

Wear et al's^{7,8} studies of medical students' and residents' cynical and derogatory humour observed some specific 'rules' such as aberrant humour being the preserve of the senior medic and taking place in a 'downward trajectory'³². Nevertheless, Wear et al^{7,8} also somewhat ironically stated '*never in an elevator*', suggesting that such humour should only be expressed 'backstage', something that was clearly contradicted in all three examples presented here.

Derogatory and cynical humour may be a way of coping and to prevent burn-out⁷. However, Maslach³³ suggested burn-out is the loss of caring and the repeated use of such humour may therefore be symptomatic rather than preventative. The repetitive use of a specific type of cynical and derogatory humour - Gallows Humour³⁴ - has also been suggested as potentially violating students' expectations and in creating a reductionist approach to human interactions that encourages detachment as the default position^{35,36}. Certainly, the unremitting use of any kind of aberrant humour is the antithesis of role modelling³⁷ and may border on learner neglect³⁸.

There are some similarities here with the 'harsh humour' observed between female drug users and healthcare workers^{36,37} and aberrant humour *per se*. The negative case of 'harsh humour' - a visceral type of humour that is unpleasant and exacting to the point of being cruel in action if not necessarily in effect - is noted to be upfront, frontstage, with no subtle encoding and often couched in profane language focusing on the shared commonalities of the healthcare workers and clients e.g men, sex, drug use. This type of humour was used as an alignment and engagement strategy with a perceptibly disenfranchised group yet was ultimately therapeutic in outcome. Moreover, the healthcare workers and their peers used slightly 'harsher' humour backstage with an additional focus being the 'negligent' behaviours of the client group.

Aberrant humour tends to be more prevalent in difficult or 'non-accomplishment settings'³⁸ and two of the examples presented here involve a psychiatrist. Irrespective of the setting or location, Wear et al^{7,8}

similarly noted a further 'rule': the focus or target for aberrant humour was usually patients who were perceived culpable for their illness.

The supposedly twilight areas of healthcare such as working with drug users or in psychiatric institutions proffer 'uncomfortable ambiguities'³⁹ on a daily basis whilst more mainstream settings are more likely to experience these challenges intermittently. Nevertheless, the disparity between expectations and individual limitations exists throughout healthcare and creates an existential incongruity³⁵. Some healthcare workers may therefore attempt to dilute tragedy by re-creating the situation whilst still attempting to retain a sense of self-worth. The corollary is that it remains to all intents and purposes aberrant humour. However, the work on harsh humour referred to above, suggests that if it is not the only type of humour or emotion management, is not used to purely 'showboat' or entertain, does not subordinate the work and therefore, is a necessary if not central feature, then it may be appropriately functional^{36,37}.

Conclusion

Our elevator example in particular was an unequivocally problematic use of humour that still patently troubled the student in her retelling of the incident some months hence. It created confusion and doubt and threatened her self-worth. The example presented humour as a dynamic, complex and mutable phenomenon with the relevance of the context as well as the psychological processes at work laid bare, demonstrating how a 'layered' approach to analysing such events is important in understanding humour and *making that explicit to others*. Von Frogstein et al⁴⁰ present a UK consensus of the integral components of the communication curricula, yet humour is noticeably absent. Moreover, whilst humour can play an integral part in moderating stress and social support¹⁶ and therefore, in building resilience¹⁶, it merits only a cursory mention as part of a possible resilience curricula⁴².

All medical faculty and students need to be cognisant of humour *per se*, how it may emerge in nuanced interactions and its subsequent impact upon participants. A starting point for medical curricula could be for example, simple awareness-raising. Students could be encouraged to observe and listen to video and audio recorded healthcare interactions from the initial perspective of 'communication' before being asked to focus on humour. The aims being (a) to recognize that spontaneous humour does not necessarily emerge in complete forms, or as a 'joke' (b) that the prosodical features of speech e.g. post-construction stance laughter can be very illuminating and (c) to be able to identify humour using the three main humour theories (superiority, incongruity, gallows/release). Thereafter this could be built upon by exploring humour support³⁰ and the psychological processes at work.

Communication is fundamental to healthcare and humour is an integral part of healthcare work. Consequently, we believe medical education needs to start taking humour seriously.

Reflexivity

We acknowledge the limitations of this study in that we base our findings on two small focus groups and second-hand data. Authentic, real-time data is always preferable. We also had two investigators of varying experience. However, by reviewing 'communication' as opposed to 'humour' in the focus groups helped to ensure that we did not impose our views or understanding on our participants and allowed their subjective perceptions to emerge. Moreover, our illustrative and interpretative framework provides a robust framework to interpret a complex and dynamic phenomenon.

Declarations

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Ethics approval and consent to participate

The institution's Research Ethics Committee (Royal College of Surgeons' Ireland-Medical University of Bahrain – RCSI-MUB) provided ethical approval and written consent was obtained from all participants, all of whom were over the age of 18. All methods were carried out in accordance with relevant guidelines and regulations.

Consent for publication

No identifying material provided. Consent to publication included.

Availability of data and materials

The datasets used and/or analysed during the current study are available from the corresponding author on reasonable request.

Competing interests

Authors declare no competing interests.

Authors' contributions

MMcC: conception, design, acquisition of data, interpretation of data, drafting manuscript, revision and final approval.

MN acquisition of data, interpretation of data, drafting of manuscript, revision and final approval.

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Tables

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