

Making Fun of Patients: Medical Students' Perceptions and Use of Derogatory and Cynical Humor in Clinical Settings

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Abstract

Purpose

It has long been known that medical students become more cynical as they move through their training, and at times even exhibit “ethical erosion.” This study examines one dimension of this phenomenon: how medical students perceive and use derogatory and cynical humor directed at patients.

Method

The authors conducted five voluntary focus groups over a three-month period with 58 third- and fourth-year medical students at the Northeastern Ohio

Universities College of Medicine in 2005. After transcribing the taped interviews, the authors analyzed the data using qualitative methods and identified themes found across groups.

Results

The categories that emerged from the data were (1) categories of patients who are objects of humor, including those deemed “fair game” due to obesity or other conditions perceived as preventable or self-inflicted; (2) locations for humor; (3) the “humor game,” including student, resident, and faculty

interaction and initiation of humor; (4) not-funny humor; and (5) motives for humor, including coping and stress relief.

Conclusions

The authors offer recommendations for addressing the use of derogatory humor directed at patients that include a more critical, open discussion of these attitudes and behaviors with medical students, residents, and attending physicians, and more vigorous attention to faculty development for residents.

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Editor's Note: A Commentary on this Research Report appears on page 415.

You can't use our inside jokes with the ones outside all this. . . . Some things have to be kept private, Basch. You think parents want to hear schoolteachers making fun of their kids?

—the Fat Man in *House of God*¹, p.268

Cynicism: An attitude of scornful or jaded negativity, especially a general distrust of the integrity or professed motives of others.²

Medical educators know that medical students become more cynical as a result of their medical education, and have known this for some time. For almost half a century, investigators have consistently found that medical students' expressions of cynical attitudes increase as they progress through medical school.^{3–10} Cynicism and “ethical erosion” should not surprise medical educators when they see its

manifestations in third- and fourth-year students. Why, then, were we so puzzled about the derogatory and cynical humor third-year students reported during a module we taught in their psychiatry rotation?

John Dewey was right: The beginning of inquiry is a “felt difficulty.”¹¹ Something felt different in the module we were teaching at the Northeastern Ohio Universities College of Medicine (NEOUCOM), and we came to realize that the derogatory and cynical comments students described and sometimes used were less about the usual conditions related to their training, e.g., the long hours of study, fatigue, lack of a “life,” mounting debt for an uncertain future, and more about patients themselves. During one classroom discussion in particular, we heard vivid descriptions of derogatory and cynical comments and jokes about particular groups of patients that students claimed were fairly commonplace in clinical settings and were, most often, initiated by some residents and attendings. The particular groups to whom these comments and jokes were usually directed included patients whose illnesses and health problems were perceived to be “brought on” by their own behaviors,

which “inhibited” doctors' abilities to take care of them. In other words, students reported, these groups were not considered “good patients.” This phenomenon—making fun of patients—was our “felt difficulty” and became the focus for our inquiry.

Background

In his early research on the effects of medical education on students' attitudes, Eron defined cynicism in the following way: “A contemptuous disbelief in man's sincerity of motives or rectitude of conduct, characterized by the conviction that human conduct is suggested or directed by self-interest or self-indulgence.”^{6,p.25} Medical students' cynicism is often directed toward contradictions and inconsistencies in the structure and complex challenges of training institutions. Double messages abound in hallways, at the bedside, and in conference rooms as students struggle with balancing grades, competing with one another, and impressing anyone who evaluates them; with interpreting interprofessional roles and responsibilities; with caring “too much” or “too little”; with the unanticipated world of “difficult” patients; and with role models who disappoint them.^{12–16}

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Two models are often used to explain how medical students become cynical.⁹ The first is the *intergenerational transmission model*, where behavior is learned from and passed on by residents and faculty role models who are cynical and abusive themselves. The second is the *professional identity model*, wherein cynicism is a “temporary byproduct” of the more disturbing, abusive aspects of medical education that “corresponds with the student’s struggle to develop a professional identity while surviving demanding academic and clinical challenges in a complex and ambiguous ethical environment.”^{9,p.543} Some investigators interpret students’ development of cynicism as “adaptive” to the stress of medical school, responses “that can be exacerbated by fatigue or by responsibilities for which they feel unprepared.”^{12,p.2007} In fact, some argue that the development of cynical or derogatory humor can actually “serve important functions in the psychological well-being and survival of trainees.”¹⁷ Coombs and colleagues found that slang, often used in cynical and derogatory ways about patients, is a way for students to “deflect feelings” such as anger and disgust that are incompatible with the attitudes they are instructed are appropriate for physicians, and is a “safety valve for ‘letting off steam,’ a way to criticize patients who create stress perceived as unnecessary.”^{18,p.996}

The use of slang points to another aspect of such cynical or derogatory humor, namely, its exclusivity. Philosopher Ludwig Wittgenstein proposed that human beings all participate in what he called a “language game.” To understand and be understood when they communicate, humans follow certain rules. Joking, for example, is itself a language game “that players only play successfully when they both understand and follow the rules.”^{19,p.4} Wittgenstein asks, “What is it like for people not to have the same sense of humour? They do not react properly to each other. It’s as though there were a custom amongst certain people for one person to throw another a ball which he is supposed to catch and throw back; but some people, instead of throwing it back, put it in their pocket.”^{20,p.83} Humor, then, is a form of cultural insider-knowledge, “its ostensive untranslatability endow[ing] native speakers with a palpable sense of their cultural distinctiveness or even

superiority. In this sense, having a common sense of humour is like sharing a secret code.”^{19,p.68} The epigram from *House of God* opening this article clearly illustrates the “insider” dimension of derogatory and cynical humor about patients: these “humor games” cannot, and should not, be played with “outsiders.”

We can see, then, that derogatory and cynical humor directed toward patients is a complex, multifaceted phenomenon. During a literature and culture module we taught in the third-year psychiatry clerkship, the first alert to our “felt difficulty” arose unexpectedly during one discussion concerning language used to describe psychiatry patients. As the discussion deepened, students also noted the disparaging comments and jokes they had encountered about morbidly obese patients. As more students offered their observations and experiences, we learned that these patients, among others, were often considered “fair game” for such remarks, and that students learned the acceptability of such attitudes from a number of residents and attendings.

In addition to the landmark *Boys in White*,³ Mizrahi’s provocative study, *Getting Rid of Patients*,¹⁶ confirms that this is not a new phenomenon. Mizrahi found among residents that “patients whose afflictions were the consequence of self-abuse were evaluated as less ‘worthy’ of care than those whose pathology was perceived as no fault of their own”^{16,p.70}; “self-abusers” included those who used alcohol, tobacco, drugs, or food to excess. Other studies consistently find medical students, residents, and attending physicians to have negative stereotypes about obese patients, believing them to be lazy and lacking in self control,^{21–23} associating them with “poor hygiene, noncompliance, hostility and even dishonesty,”²⁴ and deeming treatment futile.^{25,26} In fact, Teachman and Brownell²⁷ found that “negative attitudes expressed by medical professionals are directed not just toward obesity as a health condition, but also against *people* who are obese.”^{27,p.1521} Another recent study involving 122 physicians found that “physicians play a significant role in lowering the quality of health care that both overweight and obese patients receive.”²³ With these data alone, it should come as no surprise that medical students had witnessed derogatory and

cynical humor regarding obese patients in all facets of care, as well as toward “self-abusers” of all kinds.

Our felt difficulty more clearly articulated, we designed a study of medical students’ attitudes toward, use of, and motives for using cynical and derogatory humor regarding patients. Specifically, how do students interpret and respond to such humor? Where and by whom is it enacted? How do students decide if they will participate in such humor? What does this behavior mean? Finally, what is our response as medical educators?

Method

After securing institutional review board approval, two of us who are full-time, nonclinical faculty (DW, JMA) conducted five voluntary focus groups over a three-month period in 2005 with 42 third-year and 16 fourth-year medical students at NEOUCOM. The third-year students were largely in their psychiatry rotations, whereas four were from primary care clerkships; the fourth-year students were doing a humanities elective. The gender and race/ethnic composition of the focus groups roughly corresponds to NEOUCOM’s overall student population, with a higher percentage of males (47% overall, 52% study) and white students (57% overall, 65% study) participating in the study. The Asian and Asian/Pacific Islander population was lower than the overall population (35% overall, 29% study). No African American students participated in this study, although NEOUCOM’s overall African American student population is 4%.

We used focus groups because they characteristically promote interaction among participants and provide a forum for addressing sensitive topics. Such groups overtly use group interaction as part of a method whereby participants are encouraged to talk to one another, ask each other questions, exchange anecdotes, and comment on each others’ experiences and points of view.²⁸ Moreover, focus groups generally do not inhibit students’ responses relative to fears of breaches in confidentiality. Indeed, Kitzinger²⁹ argues that the opposite may be true, that focus groups can “actively facilitate the discussion of taboo topics because the less inhibited

members of the group break the ice for shyer participants. Participants can also provide mutual support in expressing feelings that are common to their group. . . . This is particularly important when researching stigmatized or taboo experiences.”

Each focus group took place in a classroom at the medical school or a seminar room at a teaching hospital. We provided students with an information sheet informing them that their participation was voluntary, they were under no obligation to answer any questions once in the focus group, and their responses could not be traced back to them in the ensuing publication. We also stressed the importance of maintaining confidentiality regarding what was said during the group. We informed students that they would be audiotaped and that the two of us conducting the focus group would be the only persons with access to the tapes and transcripts. Once transcribed and analyzed with all voice identifiers removed, we would then share our analysis with the other two investigators (JZ, JV), both clinical faculty directly involved in teaching medical students. Their task was to help us interpret what we found and craft recommendations.

The first set of questions we asked medical students are called “grand tour” questions, which “encourage informants to ramble on and on . . . to generalize, to talk about a pattern of events.”^{30, p.87} We then asked increasingly direct questions (“specific” grand tour questions). The questions we asked in each focus group were:

- Describe the various kinds of cynical or derogatory humor directed toward patients you’ve witnessed in hospitals (e.g., joking, slang, or other kinds of remarks). Are there categories of patients more likely to have humor directed toward them? What are these categories? Are there categories of patients to whom humor is rarely directed?
- Who participates in the joking/humor? Who initiates it? Where does it take place?
- What kinds of rules surround joking/humor about patients? (E.g., Limits? Recipients of the jokes/humor?)
- How does the joking/humor make you feel?

- Do you participate in the joking/humor? Do you ever initiate it? How do you decide whether or not to participate in the joking/humor? What is the nature of your participation? (E.g., laughter? additional joking/humor?)
- What do you see as the motive behind joking/humor about patients?
- What are the effects of joking/humor about patients?

We individually analyzed the transcripts using qualitative methods by identifying concepts, themes, and trends through a close line-by-line reading, searching for repetitions of words and phrases students used to characterize their experiences with and attitudes toward derogatory and cynical humor leveled at patients. We worked together to find common agreement for the categories that frame the discussion below. All of the comments we report here duplicate the exact language students used.

Before moving further, we offer the following important qualifications. First, we do not make the case that the observations and explanations of these 58 students reflect the opinions of all of our students or of medical students in general. Second, most of the language reported below represents what students *heard*, not what they used themselves. However, a small number of students (several per focus group) did in fact disclose that they had participated in derogatory and cynical humor directed at patients, and some of those remarks are found below. Thus, it is important for readers to remember that the majority of derogatory words and phrases reported here were used by residents or attendings as reported by medical students, unless otherwise noted. Finally, we propose that the descriptions that follow are one snapshot of an academic clinical culture and raise many interesting and provocative questions for further inquiry.

Results

The categories that emerged from our analysis were (1) objects of humor, (2) locations of humor, (3) the humor game, (4) not-funny humor, and (5) motives for humor.

The objects of humor

In response to the initial set of “grand tour” questions, we immediately

discovered that students had no trouble coming up with many categories of patients who were consistently the objects of derogatory or cynical humor.

Obese patients. Students indicated as their first response, and with nearly total agreement in every group, that morbidly obese patients were the most common target of derogatory humor by attendings, residents, and students, and that this occurred most frequently in surgery and obstetrics–gynecology. We then asked increasingly direct questions to understand more fully *why* obese patients were the objects of such widescale derision.

Some students’ answers reflected their and a number of their teachers’ disdain for the obese person’s actual body. Many students offered clinical slang they had heard designating an obese patient, some of it coarse. Other students gave examples of “games” they had witnessed tied to obese patients, such as one fourth-year student who recalled an event in gynecological surgery where he assisted in the removal of the pannus, the large fold of fat on a person’s stomach, in order to do a hysterectomy. While the residents, attendings, and scrub nurses did not directly make fun of the patient lying on the surgical table, they nonetheless would play “the pannus game,” where each “player” would place dollar bets on how much the pannus weighed. Other examples of making fun of obese patients were the circulating stories about objects found in the folds of their bodies, as one student described: “There’s lots of stories about larger older women who when you lift up their fat, and you see Oreo cookies, a remote . . . [all] hospital urban legends.”

But most students reported that denigration of obese patients had more to do with such patients’ perceived “lack of control.” One student pointed out that “you cannot question that obesity is a health risk factor. So, we assume that it is their own fault that they have this as opposed to some skinny person who gets, say, diabetes.” Another third-year student explained that patients’ morbid obesity is “their own fault, because they had to eat to get that way. You look at them in a disgusted way, like ‘you can’t take care of yourself, now I have to get all these other people to help me out, do a procedure for you and you’re probably not going to take care of yourself afterwards.’”

This perceived “lack of control” invariably led to “difficulties” in taking care of obese patients. Two students’ comments, for instance, were that “extra people in [the OR were needed] to hold up the extra skin and fat. . . . Obesity makes an easy 20 minute surgery a difficult 80 minute surgery” and “this one patient required two operating tables pushed together. . . the frustration is with all the extra work that needs to be done just because of their habits.”

Additional “it’s their own fault”

categories. In general, patients whose health problems can be attributed to smoking, excessive drinking or drug use, driving recklessly or under the influence, practicing unsafe sex, engaging in criminal behaviors, being noncompliant, or just about anything that can be viewed as “their own fault” are potential objects of derogatory or cynical humor. Instead of feeling empathy for such patients, many students we interviewed were generally cynical or indifferent toward them. One stated a simple formula: “If it’s their own fault for getting into that situation, then you can make fun of them. If someone is walking down the street and gets hit by a car, then you’d NEVER make fun of him.” No one raised the possibility during any of the focus groups that “fault-bearing” patients receive inferior care.

Students cited other examples of patients who are blamed for having “caused” their injuries, diseases, or illnesses who are the most likely recipients of derogatory or cynical humor. One student explained the nuances of deciding if a patient is “fair game” for humor by the example of a patient she had cared for who was a quadriplegic IV drug user: “In medicine we had a lot of IV drug users. . . . A couple of them had spinal abscesses, one of them a quadriplegic who had to have his opened, and I don’t think anyone felt bad for him”; it seemed that the IV drug use trumped any sympathetic feelings for him as a quadriplegic person. A few students conveyed how trauma patients are often the objects of derogatory humor when they “get themselves into bad situations.” A third-year student described it this way: “It’s the kid who is walking through the ghetto looking to buy crystal methamphetamine who gets beat up by three guys and comes into the ER. . . . It’s not the kid who was just sitting in his house and someone breaks

in and just beats him with a baseball bat.” Another student provided an even clearer contrast: “There’s nothing potentially funny about a sinus infection or earache. They’re not amusing. But . . . if somebody comes in with an object lodged in their anus, that’s entertaining.”

Difficult patients, psychiatric patients, “house” patients, sexually appealing, or “different” patients.

Students reported that “difficult” patients are often targets of derogatory or cynical humor. They define such patients as having one or more of the following characteristics: “noncompliant,” “demanding,” “aggressive,” “talkative,” “disrespectful,” “persistent,” or “periodic.” Another group of patients frequently the objects of derogatory or cynical humor are those who have psychiatric disorders, including suspected hypochondriacs. One student explained that “it’s just so easy for people to find humor” in psychiatric patients, particularly those who are psychotic. Several students explained that they could not help but joke about the mentally disabled patients who were difficult to work with on a general surgery rotation. Types of jokes or comments made about this group of patients include name calling, imitating abnormal or unusual behaviors, and making fun of their stories and beliefs. One third-year student reported, “We had a couple of these patients on one side of the [psych] floor and the common reference to that side was the ‘retard hallway’ because they had trouble communicating and things like that.”

Many students reported that “house” or clinic patients are sometimes objects of cynical humor arising from preconceptions surrounding their hygiene, insurance and job status, mental/cognitive status, or probability for adherence. A few students elaborated that house patients are the objects of derogatory humor because of the difficulties caring for patients who, in their minds, as one student put it, have “poor hygiene and do not comprehend or listen to what the physician is telling them.” When multiple categories are present, such as obese house patients, even more derogatory humor is used.

The last group of patients viewed as potential objects of humor are those who are sexually attractive or who possess particular or unusual physical features

associated with their sexuality, e.g., breast or penis size. One student reported that the comments aimed at attractive patients, typically female, are less malicious but are still dehumanizing: “They’re not people anymore. They become a set of T&A.” This category seemed to be an outlier in that while most of the students we interviewed did not rail against the appropriateness of the derogatory or cynical humor leveled against, say, obese or psychiatric patients, they were more apt to remark about the inappropriateness of joking or commenting about the sexual features of patients, both men and women. One student described a surgery setting “when the patient is out and people will come in and remark about her knockers being fabulous. I’ve actually had these experiences . . . completely inappropriate.” Another reported that on her surgery rotation “they [residents and one of the attendings] would rate penis size. Like, ‘don’t look at this guy’ or ‘look at this guy because he will make us all look good.’”

Patients off-limits for derogatory or cynical humor.

Patients who are not objects of derogatory humor and who are almost always off-limits to any joking or inappropriate comments are the terminally ill. In one focus group a student stated categorically, with universal head-nodding in agreement, that no one would say anything inappropriate about “someone who’s dying. Anyone with a terminal condition, no one makes fun of them.” Even if a terminally ill patient acquired his or her disease by engaging in risky behaviors, complains, or is rude, jokes are rarely, if ever, made about that patient.

In addition to patients who have a terminal diagnosis, one student cited other categories “off limits,” including loss in pregnancy, cancer, and children. Several students expressed disagreement with this list, however; one commented that “fat children get it. Teenage psych patients get it. But cancer in children? You’re not going to make fun of that kid no matter what.” When one person suggested that all cancer patients are always off limits, an extended discussion followed, which we report in small part:

Student: The only time I have ever heard a resident get yelled at was when a cancer patient lost the ability to talk and the resident said, “Well, they can’t complain

anymore.” That is the only time I have ever heard of someone getting yelled at for making a joke.

Interviewer: So cancer trumps everything else? What if there was a morbidly obese cancer patient?

Student: We would still make fun of them for being obese.

Student: I think they make fun of the disease more than the person. They pick on parts of the person.

Student: [in agreement] They don’t even know the person.

Student: You just know their disease. And they pick at the disease and make fun of that.

Student: I think even some aspects of cancer can be picked on. I have seen people talk about lung cancer if the patient smoked like a chimney all of their life. So then it goes back to being your own fault. It’s not like a ha, ha, they are dying of cancer . . . it’s more cynical, like “what do you expect?” If someone has pancreatic cancer or colon cancer, that’s different.

Clearly, deciding when to joke or offer a cynical comment is a matter of contextual nuance and circumstance. As one student characterized “fair game” and “off limits,” “I don’t know of anything that’s totally off limits. . . . It’s all situational.”

Locations of humor

According to students, derogatory or cynical humor generally can be found anywhere in the hospital but is never intended to be within earshot of patients and their families (“never in elevators” is a rule, for example). We heard variations on the following statement in every focus group: “It’s important to know that no one makes fun of a patient directly in front of the patient.” While all students reported that they are often exposed to derogatory or cynical humor before or after rounds, in lounges or in conference areas, or, less frequently, on the floors outside of patients’ rooms, the most common place they find it is in the operating room. Students cited a variety of reasons for this, one noting that “in the OR it happens because those people all know each other . . . the kind of atmosphere, the patient is asleep.” Another suggested that the length of surgeries lends itself to both gossip and joking: “What else are you going to do? Oh yeah, that’s a nice tibia . . .? You have

to say something.” In surgery in particular, several students pointed out that in their rotations “everyone” usually participated: attendings, residents, medical students, scrub nurses and techs, and so on, but “only after you’re certain the patient is under [does anyone] say something about their fat or a tattoo.”

In addition, derogatory humor occurs within different group configurations. For example, an attending or a resident may make a cynical or derogatory joke in front of a group of students or a single student. Or, such joking can occur in groups of medical students as a continuous derogatory banter about a particular patient. Yet students reported rarely, if ever, initiating a humorous comment or joke in front of a resident or an attending.

The humor game

Recall the “secret code” or insider status conferred on humor, parallel to the “language game” identified by Wittgenstein—how students learn the acceptable and unacceptable circumstances for expressing derogatory and cynical humor in clinical settings. When we asked students to describe the “rules,” most reported that the residents are usually the first to initiate humor. We asked if students ever initiated such joking, and most said never (“There’s nothing a med student can gain by doing this,” one reported); a few said occasionally, that it was entirely contextual. We asked, then, *how* they know if and when their participation was acceptable. One student explained the simplicity of the rules, with widespread head-nodding in agreement: “If the ice has been broken by someone of a higher level, then it is okay to say anything.” One student said that she found attendings’ initiation of such humor troublesome: “I think it is different when I hear it from the attending first. Because I am like ‘whoa’ that is kind of weird that the attending just said that about the patient. . . . For some reason it is more acceptable when the resident does it.”

Another “rule” students reported was that when someone at a higher rank uses derogatory humor, those of lower ranks, including medical students, may not always appreciate or find the humor to be funny, but in some settings they are still expected to laugh or at least not object. One student explained, “Whoever’s

senior in a group, you conform to their rules of play. If they’re not jokers, there’s not going to be any joking while you’re with this group.” Others noted that during rounds “you can tell within the first 5 or 10 minutes how it’s going to be” regarding joking; another said the environmental cues are more subtle, and sometimes you know not to add any levity because “you just don’t feel comfortable doing it.”

When humor isn’t so funny

Just as quickly as they gave examples how derogatory and cynical humor was accepted as part of the clinical culture, students offered scenarios when humor was unacceptable, where it did not work. One third-year student explained:

I had one attending in particular who went across the line and pissed off everyone in the OR. He walked into the OR and he was having a bad day. . . . It was another obese patient, probably 350, 400 pounds, a C-section, and he walked into the room, walked over to the woman (she was under), got in her face and said, “Jesus Christ, why can’t you lose some goddamn weight and make my job a little easier?” He was pissed off, and everyone in the entire room stopped and the scrub tech said, “That was really inappropriate.”

Moments before, students had almost uniformly agreed that morbidly obese patients were “fair game”; we asked them about this apparent contradiction. The student who told the story replied that part of it was his tone; another student explained that “it’s different when you’re right up in their face than when you leave the room and say it.” Still, not all of the students in this focus group agreed the physician’s comment was inappropriate, and one student believed that “with a different delivery, it would have been funny.”

Another not-funny use of derogatory and cynical humor students mentioned was how they felt about its use by their role models, attendings in particular. A third student explained:

The big thing for me personally is when you go into a room with an attending and they are talking to the patient real empathetic and they are discussing these problems appearing like they really care. As soon as you walk out of the room the attending says “that patient is a nut job.” [His behavior] wasn’t even real. I am going to be there one day and want to see myself as someone who really cares. But if

my role models are like that, I question, “Am I going to become like that?”

Other students were in agreement about attendings who participate either directly or through their silence in derogatory humor. One third-year student was surprised when a group of residents did not get in “trouble” for derogatory comments and “the attending just went along with it, and in fact she laughed, and I thought that a little bit strange.” Another student reported, “I get the feeling that the person in charge of this person [i.e., the attending] doesn’t really care. . . . I would prefer not to hear it because it diminishes my faith in their ability to care for the patient.”

Motives for humor

A consistent and common thread in the focus groups were students’ beliefs—disclaimers, almost—about derogatory humor targeting certain patient populations or individuals. Two students’ comments are representative: “[it] is not meant to be mean . . . you’re not thinking about the *person* when you’re saying it, you’re just saying it because it’s funny,” and “You are not really making fun of the patient but the situation.” One third-year student claimed that humor helps students “get through” their training: “Life is hell anyway, but it’s less hell if you’re joking about it. . . . Our attending barks at us all day, and if we don’t laugh . . . I just might go home and shoot myself.” Another student maintained that “humor is a more socially acceptable way of saying things that would not be seen as polite things to say, but because it’s said in jest, it’s more acceptable to us.”

Most students believed that those who use such humor do so as a coping mechanism or an “outlet” to deal with frustrating or depressing situations, particularly when patients do not take care of themselves in spite of the time, care, and resources spent on them. One student explained how “repeat offenders” are resented by the residents and attendings because “they’re drains on the resources of the hospital . . . they come in with problems because they don’t take their medications, and we often say, ‘So and so is in again, who wants to take him, Not me! Not me! Not me!’”

Another motive several students cited for using derogatory or cynical humor was to keep sick people at arm’s length. That is,

humor creates a barrier between the caregiver and the patient, whereby the patient can be seen as a case rather than a person. One third-year student stated, “it’s a lot easier if you’re joking, making it as though they’re not a person, like an object. . . . You don’t want to think, oh this is someone’s grandma ’cause then you’d be caught up with your emotions.”

Saying something funny, then, about that “old lady” keeps caregivers separated from their patients when there is the threat of their patients becoming too familiar. As one student put it, “You’d go crazy if you connected with every patient.” One third-year student asked her peers:

Do you think that we joke about certain things amongst each other because we do not know how to talk about them in a serious manner? . . . If I make a joke about it, it brings it there and then we both [another peer, for example] can be on that level and discuss something that would have not been [discussed]. And maybe it needs to be discussed.

Discussion

Medical sociologists have long studied various aspects of the phenomenon we describe here, such as the use of slang, cynicism, and derogatory humor in clinical settings. Becker and colleagues’ *Boys in White*³ is one such important study. In a more recent assessment of how students make distinctions among types of patients, Becker observed: “When members of one status category make invidious distinctions among the members of another status category with whom they regularly deal, the distinction will reflect the interests of the members of the first category in the relationship.”^{31, p.127} That is, Becker learned that residents and students viewed certain patients with such disdain because they took so much time and “gave you much less of anything you wanted for your trouble,”^{31, p.129} similar to the “fair game” category students in this study described.

Becker, then, would probably argue that medical students and residents (one status group) make derogatory or cynical jokes about certain categories of patients (another status group) because the former’s interests are not being served. That is, medical students want to maximize “the chance to learn things that would be useful when they entered

practice.”^{31, p.128} Their perception is that seeing “fair game” patients who often do not take care of themselves, who sometimes do not follow “orders,” and whose illnesses will probably not get better will not add significantly to their knowledge of such patients or their ability to help them. That is, they quickly adopt a “what’s the use, they won’t change, there’s nothing we can do” attitude. Patients so characterized by their caregivers become far more likely to be the butt of jokes or cynicism than those with whom students (or residents, or attendings) become invested.

Similarly, Mizrahi¹⁶ found that physicians constantly engage in evaluating patients both medically and socially, and that the “results of their calculations affect both their attitude and their behavior toward those patients at all stages of training and beyond.”^{16, p.69} Residents in her study indicated that “ideal” patients were intelligent, cooperative, and compliant; they had diseases that could be helped; they were clean; they didn’t talk too much; they were “good historians.” What Mizrahi calls “despised” patients had the opposite traits, very similar to the “fair game” category the students in this study described. In fact, first on her list were “self-abusers.”

Still, even with sociological descriptions of this phenomenon, we are left with questions as to why *humor* was the vehicle for expressions of frustration and derision toward patients. We turned to philosopher John Morreall,³² who theorizes humor in three categories. The *superiority* theory is just that, when one laughs or jokes from feelings of superiority over others. Given the social status of physicians (which includes the power arising from their knowledge/educational status and their economic status compared to many of their patients), this may be one dimension of students’, residents’, and attendings’ choice of humor as a response to “frustrating” patients. Having so little in common with the disadvantaged patients through whom medical students and residents often learn medicine, including many who were damaged early in life and have limited options, trainees tend to overestimate the actual “choices” or “opportunities” these patients have.

In addition, studies of personality characteristics of medical students have

shown “neatness” and “orderliness” as valued traits,³³ as well as “conscientiousness.”³⁴ These are characteristics often not present in those categories of patients described above who are “fair game” for humor. When these traits are added to the potential gulf between physicians and patients created by differences in social status, we might speculate that trainees’ use of derogatory and cynical humor does arise in part from unspoken feelings of superiority.

The *relief* theory explains humor as a release of “pent-up nervous energy.”²⁹ This theory can clearly be linked to students’ expressed motives for using derogatory and cynical humor, which one student described as the “if you don’t laugh you’re going to cry” phenomenon. Finally, the *incongruity* theory explains humor as the feeling or sense of an incongruity between what one knows or expects to be the case, and what the joke or quip expresses.¹⁹ Students enter the clinical world full of enthusiasm and optimism for what medicine can achieve and are met with obstacles of all sorts, including cynical faculty, uncooperative or unappreciative patients, and their own unanticipated emotional responses to the experience of hospital-based medicine. Every day they encounter something that should be otherwise, and humor may be one way of managing these incongruities.

Such explanations may help make sense of why students, house officers, and attending physicians use derogatory and cynical humor in clinical settings, but we are still left with the uneasy task of looking at its effects on those who use it. McCrary and Christensen maintain that its use “diminishes the humanity of patients at times when they are most vulnerable.”^{15, p.101} They further argue that although such humor may have a significant psychological benefit to those who use it, it may compromise “the aggregate character of the medical enterprise. [It has] a corrosive effect on the character of the health care team as a whole [and] a morally diminishing effect on the practice and attitudes of physicians even if no direct harm occurs in a particular case.”^{15, p.104} Hafferty and Franks similarly posit that when patients are “transformed into objects of work and sources of frustration and antagonism,” they become the enemy, and students “feel justified in their use of

negative labels and corresponding behaviors.”^{14, p.865} That said, where do medical educators go from here?

Recommendations and Conclusions

Medical students become physicians by following the lead of residents and attendings in a “process of mimetic identification.”^{17, p.548} In this process they witness, and sometimes come to accept, that derogatory and cynical humor is an acceptable response to particular categories of patients. At the same time, they also witness countless residents and faculty who do not use or sanction derogatory humor. A more vigorous search for the latter role models who can teach, advise, and generally “be with” medical students is one way to work against the moral contradictions embedded in “making fun of patients.”

Role modeling is not new to medical education, but is becoming increasingly called for as perhaps the most important factor in students’ ongoing professional development. A quarter century ago Gerber argued that the influence of role models has “implications for creating kinds of clinicians a medical school or the medical profession wants to produce.”^{35, p.660} Reuter and Nardone pointed out the significant extent to which role models “shape professional identity and commitment through promoting observation and comparison.”^{36, p.335} More recently, Kenny and colleagues argued that in spite of the available descriptive literature on role modeling, “weaknesses in physicians’ role modeling and professional character formation are evident” and that “many dimensions of the impact of negative role modeling and related communicated values on medical learners are overlooked.”^{37, p.1204} It is time, therefore, to get serious about the potential of role modeling as a *specific* strategy at the heart of professional character formation. Among others, their suggestions include faculty recruitment aimed *explicitly* at role modeling, ongoing assistance to faculty to adapt their teaching and role modeling, and the development of “safe spaces where negative role modeling can be reflected upon and translated into an effective learning experience.”^{37, p.1209}

While role modeling begins to address what can be done in terms of student–

faculty interactions, we are left with the critical distinctions some students made between the behaviors of residents and attendings. Some of the students in our focus groups were less comfortable, perhaps more disappointed, when they witnessed derogatory humor being initiated by attendings, or when attendings tolerated the behavior by residents. It appears that students hold attending physicians to a different, perhaps higher, set of expectations. It may be that medical students identify with the “hellish” existence of residents, forgive them for their transgressions, and join in as a form of empathy for their suffering. Equally plausible is that medical students recognize that the ultimate responsibility for the care of patients and for the outcomes of that care lies with the attending. Students may surmise that the patient, in the final analysis, looks to that attending as the “real doctor,” and thus is owed a higher level of respect in that relationship.

As medical educators we must pay specific attention to these critical role differences, and how each influences the socialization of medical students. We are obligated to provide to medical students experiences with attending physicians who are most likely to exhibit, by virtue of their own strongly held values, behaviors that are appropriate, indeed exemplary, with respect to the precepts of the profession. Such attending physicians should continue to be nurtured and rewarded in their educational roles. Yet, because residents most often find themselves in teaching roles as a result of their own specialty choices and rotation schedules, there is a real need for more rigorous faculty development with residents, aimed specifically at heightening their awareness of how profoundly they affect the professional development of their junior colleagues.

Residency program directors bear responsibility, too, for creating work environments and setting expectations of residents *as teachers* that promote openness to the kind of self-reflective and constructively critical analysis of how we relate to patients and each other as humanists and professionals.

Finally, training residents must increasingly include focus on the virtues of medical practice, and these virtues, when exhibited, should be further

encouraged and rewarded. Residents and medical students must be provided opportunities to practice moral courage in their work and training, to develop their moral imaginations in ways that can diminish the distance between them and even their most challenging patients, and to develop greater empathy. Inui and colleagues provide an impressive example of such an effort in their collective attempt to change the organizational culture of an entire medical school. They are doing so in spaces that “interrupt” the informal curriculum, the very framework within which derogatory and cynical humor directed at patients is learned: “We are seeking to foster a new way of being together—a new pattern of relating—that consists of noticing and talking about relational process as it is happening (*‘What’s happening here right now?’*). This capacity liberates individuals and groups from automatically reproducing existing patterns and gives them the ability to explore and change their patterns mindfully.”³⁸ During moments when derogatory or cynical humor leaks into formal and informal conversations, resident and faculty role models might raise questions about its effects without blaming or directly chastising students for mimicking what they have seen others routinely do.

At our own school we are making systematic efforts to engage students directly with the evolution of their professional identity, including the positive and negative sources and sites of socialization. The first two years of a new longitudinal course at NEOUCOM include a monthly session where two faculty—a clinician and a professor of humanities or social sciences—meet with a dozen medical students. These “Reflections on Doctoring” classes are our attempt to name out loud with our students the knotty, perplexing, and often unaddressed issues in medical education, such as the various forms cheating can take and the place of emotions in medicine. This very paper will be used with the entire class in the fourth-year iteration of the longitudinal course. We hope to open this phenomenon up for honest discussion in an arena where it can be named and where thoughtful alliances and support can be forged, free from fear of professionalism assessment. If “making fun of patients” is a coping mechanism, we hope to help students find other ways of coping, healthier for

all. Trainees need daily examples of physicians who find joy, humor, and laughter in a variety of places; who laugh at themselves and yes, patients too, when things they do and say are genuinely funny. These are role models who take the time to uncover the origins of their patients’ suffering as manifested in, on, and by their bodies. This is a culture of medical training to which we all can aspire.

The issues raised here go to the heart of professionalism in medicine, yet few of us want to acknowledge them directly. But we suggest that an honest engagement with the realities of clinical training faced by our students, even those realities that make us wince, is necessary. We must forewarn students early and consistently in their training that contradictions will abound everywhere once they begin their clinical clerkships. We must alert students that they will hear horrible, disrespectful comments about patients’ bodies, about their ability to pay for care, about their addictions. We must impress upon students that there are always choices when these moments arise—to ignore such comments, to laugh or chime in, to talk to a trusted role model about what to do, or perhaps even to risk confrontation with the sources of such humor.

Our students enter medical school never dreaming that in two years they will be in situations where derogatory and cynical humor toward patients is enacted. We contribute to their distress or acquiescence by ignoring the problem. We need to stop and ask students, “What’s going on here? How could it be otherwise?” This is professional development for us all.

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Teaching and Learning Moments

A True Group Effort

Once again, I've learned something from my students. I serve as the instructor-in-charge of the Senior Necropsy Rotation at the College of Veterinary Medicine at Iowa State University. During this two-week capstone experience of the pathology curriculum in the senior year, the students learn how to perform necropsies (autopsies of animals) and write summary reports.

Upon completion of a necropsy, the students return to the conference room to compare notes and generate the necropsy report containing descriptions and interpretations of all gross findings. Often, students work in teams to collect this information, with one student in charge of assimilating the data. Typically, this student completes the report on a computer while the other students provide written notes or verbal descriptions.

The gross pathology seminar room is equipped with an overhead projection system for displaying lesions in group discussions. On a recent afternoon, I accidentally left this system on after using it for a pre-necropsy discussion of a case. After completing that day's necropsy, I found the group of students seated around the conference table, avidly watching the projected

image of the necropsy report as their classmate typed it. For each lesion, the students actively debated the accuracy of the description, suggesting better word choices and contributing measurement data. I listened, fascinated, as the students self-edited their report until the entire group agreed on a final product. In the past, I've prodded and cajoled students to provide a full description of lesions, which usually resulted in my rewriting the report while a single student fidgeted impatiently in my office. Now, with the capability for all students to watch and contribute to the completion of the report, the group could take more responsibility for the content and accuracy of the report.

However, I noted that they were still jumping to interpretations rather than describing some of the lesions according to the assignment. I reminded them of the distinction between lesion description and lesion interpretation, which was particularly relevant at this moment, as we had only just collected tissues for histopathology and would not be able to confirm the lesions for at least 24 hours. Suddenly, thanks to the ability to visualize and provide feedback for report generation, the students had a valid reason to avoid

overinterpretations, and each student became accountable for preparing an accurate report.

During the remainder of the two-week rotation, the students became increasingly aware of using correct terminology in reports and paid closer attention to lesion observation during the necropsy. They were also less likely to overinterpret lesions than were other groups. The quality of the students' reports improved more rapidly in this rotation than that of any group I have encountered in ten years of teaching, with less talking on my part. This postnecropsy discussion of the case promotes whole-group participation via visual and auditory input. This, in turn, leads to expanded opportunities for students to critique terminology and verify accuracy of descriptions. While this responsibility makes the rotation more challenging, it may also provide a more realistic view of the role of pathologists in clinical medicine.

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