Tumor Humor?

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A 64-year-old man was referred to me to discuss therapeutic options for his recently diagnosed prostate cancer. His wife told me that “John was paralyzed by the choices.” Because the urologist sent a detailed note along with magnificent MR images, the patient expressed reluctance when I gestured that the time had come to perform a digital rectal examination of his gland. Then, just as my gloved finger anticipated palpation of the nodule, he thunderously farted. “Is this what they mean by being in the cloud?” I asked. Rather than retorting with an I-told-you-so, he craned his neck backward and cheerfully reciprocated: “It just goes to show you that physicians aren’t the only ones who offer *sound* advice these days.” Approximately 90 minutes later, at the end of the visit, the patient consented to receive a course of external beam irradiation and hormonal therapy under my direction.

Although admittedly low-brow, the anecdote illustrates how both patients with cancer and their oncologists might resort to humor even at the outset of their relationship. “Humor” and “cancer” are words that rarely exist in the same sentence. Yet though it is risky to conjoin the two, there are moments when nothing could be more appropriate.

According to Martin and Lefcourt [1], the “humor-health hypothesis” suggests a beneficial link between humor and health that may occur by direct or indirect processes. Proponents of the direct variant assert that humor brings positive physiologic changes that may manifest in altered pain thresholds, immunopotentiality, and even extension of survival for patients with certain diseases. In contrast, the indirect humor-health hypothesis implies that humor may moderate feelings of misery or be socially beneficial. Although humor has been studied in numerous clinical settings, very little literature exists to guide cancer physicians on how best to use humor in practice.

Neither giggles nor belly laughs are likely, on their own, to vanquish the malignant cells lurking within our patients, but humor can make its contribution toward combating malignancy. Humor can soothe a patient’s tension, unmask hidden sentiments, or reveal subconscious beliefs, providing important information for physicians. Even in the absence of rigorously proven health benefits, humor can improve the patient-doctor relationship and enable both partners to proceed more effectively together through decision making and treatment.

Oncologists have only recently contemplated how to integrate humor into their workflow. Penson et al. [2] contended that humor may be an indispensable clinical tool because it can lighten the mood of a difficult consultation, soften feelings of isolation, and unite patient, caregiver, and family. The authors share tips for inserting humor into medical practice. They suggest using “safe” one-liners—for example, ridiculing popular targets, including lawyers and politicians—or encouraging lighthearted behavior—for instance, allowing a child to paste disposable tattoos on the patient’s bald scalp to soften the starkness of alopecia.

Many of us can similarly draw from our own basket of playful gimmicks. One that works for me, particularly during a first encounter in my radiotherapy practice, is to sketch the anatomical regions through which x-ray beams will travel. Typically, a puzzled look accompanies my patient’s effort to decipher my drawing (“Is that a heart or a pancreas?”), whereupon I reassure, “I’m a much better physician than I am an artist.” Next, as I illegibly label my primitive diagram, I ask the squinting viewer, “What do you call someone who can read a doctor’s handwriting?” then I quickly provide the answer, “A pharmacist!” Admittedly, in our era of electronic medical records, the relevance of that quip is diminishing, but even when the response is a wince rather than a smile, most patients recognize that I am trying to put them at ease and will generously contribute to the building of bonds between us.

In a survey of women treated for ovarian cancer at the University of Wisconsin, Rose et al. [3] noted a willingness of patients to hear traditional jokes and amusing stories from their gynecologic oncologists. More than 75% of respondents remark that humor helped them to cope with their diagnosis and alleviated anxiety. The investigators caution, however, that rapport with the physician appears necessary before humor can be invoked. The authors deem humor to be appropriate only after a climate of trust, a critical component of the therapeutic relationship [4], has been established. But I wonder. In order for humor to be effective, must trust pre-exist, or can humor effectively build trust?

I vote in favor of the latter. Unfortunately and too frequently, tall barriers (e.g., fears of transference) and deep moats (e.g., indifference) separate patients and doctors. Along with eye contact and attentiveness, humor serves as one of the most useful wall-scaling and moat-leaping devices that we tote

in our amorphous black bag. Humor, provided it makes space for subjective tastes and cultural diversity, can be used to gently probe the convictions of those who seek our expertise. There is much to be learned about another human being when we delicately sprinkle the discourse with subtle sarcasm or occasionally resort to wryness and even eccentricity. Sometimes, we welcome humor by just recognizing another person's efforts to be funny and their willingness to be vulnerable. Such moments are precious and fragile. When I notice someone giving humor a try, I cannot help but discard my pretenses and become engaged. In almost any relationship, when one player is willing to lighten up, the other is able to open up.

Last week, I made a self-deprecating remark concerning my hospital's cuisine. This prompted a patient to free-associate about how all food repulsed her lately. We smiled—and sighed with relief. Because even though she had been diagnosed with gastric cancer, she was reluctant to reveal details about her daily eating habits. As trust began to build, we could come to a decision regarding which adjuvant therapy to select. Specifically, we chose the regimen that was less dependent on her caloric intake. Humor need not be laugh-out-loud funny to have value.

When I inform colleagues that I consciously attempt to engraft humor into my medical practice, I am sometimes greeted with startled looks. I realize that there is something about the admixture of humor and illness that the human sensibility strains to assimilate. And of course, there are hazards in using humor. Some patients may feel that I am not earnestly relating to their ordeal. Others might conclude that I have crossed an invisible line of propriety or judge me to be less competent and therefore incapable of helping them. I hate to generalize, but physicians are by nature perfectionistic and proper. We cringe when humor—*womp-womp*—falls flat. Several years ago, a patient did not like one of my quips. “Why does everyone have to be a comedian?” she exclaimed. I apologized, yet the experience still stings. But what to do? To use humor is to assume risk.

I am encouraged when I observe patients lead the way by displaying iconic bumper stickers (“I had chemo today—What’s your excuse?”), by wearing provocative T-shirts (“DO NOT DISTURB—Busy kicking cancer in the butt”), and by attending the one-woman shows of Tig Notaro and Julia Sweeney (*God Said Ha!*). I vividly remember, during my internship, an engineer I treated for a glioblastoma that had

replaced much of his cerebral cortex. He dangled the waiver that the hospital made him sign, consenting not to use mobile phones while admitted...because they may *cause* brain tumors. He is no longer alive, but the ironic interlude that we shared lingers.

During an interview on a late-night talk show, comedian Jerry Seinfeld remarked that the hardest thing to do in life is to make someone laugh. I doubt that we will ever be able to measure whether a comedian's work is more arduous than that of a neurosurgeon, coal miner, or Middle East diplomat, but Seinfeld's point, I think, is that the challenge of eliciting laughter demands getting to know another individual and his or her circumstances. Therefore, humor, I believe, can be a deeply human device.

When we strive to introduce humor into the patient-doctor relationship, we are acknowledging the “personhood” of those we hope to heal [5]. We are suddenly seeing people in terms of who they are rather than exclusively in terms of whatever ailment they have. At a time when modern medicine is accused of being sterile and routinized, the respectful pursuit of humor announces that we are not prepared to be detached. When we endeavor to ascertain what a patient deems humorous, we are taking an interest in another person: what matters to them and who they are.

Humor, including the black humor that so many of us exchange behind the scenes, need not be an adaptive response to mediate career-related stress or a prophylaxis against burnout. Humor must not arise from the power differential that separates physicians from patients but, ideally, emerge from the points of vulnerability that both harbor [6]. As such, humor is an emotional connector, and I believe that patients who are the recipients of such quests for humor feel cared for and find renewed belief in their doctors.

The vignette presented at the start of this article could have dissolved into shame or alienation. Instead, mutual willingness to consider humor helped bring a happy end. I am still not sure of how best to harness and apply humor, an intricate, context-dependent phenomenon. But that prostate cancer case, and so many others like it, have convinced me that clinicians who sincerely advocate humor are truly committed to celebrating the personhood of others and not just tooting their own horns.

DISCLOSURES

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