

# JOKING WITH DOCTORS. PLAYFUL INTERACTION IN ILLNESS CONTEXTS

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It is a pleasure for me to participate on this panel about humour and conversation in the country of birth of Arthur Koestler, who wrote such brilliant pages about humour in critical situations.



I would like to begin by commenting on these illustrations from the early decades of the twentieth century published in Barcelona in 1995. They represent an intelligent way to contemplate medical humour, with their simplicity and power. I would like to emphasise the exaggeration of features, the strict division of roles appreciable in the dress and facial expressions, the deepening of the patient's expression of fear or sickness, the doctor's expression of concentration or aggression, the exaggeration of the surgical aggression,

the blood and butchery. These illustrations are the work of Catalan artists from the early twenties and were in all probability collected for an exhibition before the Civil War. The humorous stereotype or comic that they portray shows many of the features that appear verbally in the fieldwork that I will present. Curiously, last February, I saw the same stereotypes while observing a float in the Carnival in Lleida, Catalonia. There were the same references to medical aggression, to the exaggeration of the patient's suffering, to the white coats generously spattered with blood; the instruments, such as thermometers or syringes provocatively enlarged, to the nurses' insinuations, to the speculative examination by the doctor. I would like to draw your attention to these aspects, as they constitute the backdrop to medical humour, with all the variations that must be registered.

The illustrations also show the close relationship between humour and medicine, and insinuate that it is an old relation, one that on the other hand is well studied and tackled in the contemporary studies of humour. In the same measure that humour studies diversified and specialised, during the second decade of the twentieth century, medical humour was expanding and constructing its own discourse. Mention must be made of the pioneering work by Emerson (1962), and later, in the eighties, also worthy of mention is the note about *Healthy Irreverence* by Chandler (1988), on humorous and ironic narrations about disease, and the different approximations by John Morreall to humour and work, as well as the more strictly sociological approximations of Powell & Paton (1988) or Mulkay (1988). In all these studies, humour is seen in terms of experience and within social activity and its emergence in difficult situations (perhaps many of us do not associate humour and medicine at first glance) form part of the analysis. Researchers have often preferred to talk about therapeutic humour, insisting specially on the curative and health value of the humorous expression, both from the point of view of human relations and the biologic and psychological side. But there is more. On one hand, medical humour is related to sick humour, to its component of overcoming the badness and misfortune that it contains, and its appearance in critical situations; on the other hand, medical anecdotes are related to humour as an expression of taboos and the inexpressible, and as a genre faced with conceptual difficulties. The note by Ryan (1997), *Reclaiming the body: the subversive possibilities of breast cancer humour*, explores these circumstances correctly. The specially gross humour attributed to the doctors and nurses who work in ICUs, that is not dealt with in this paper, also seems to be a demonstration of this conflict at the limit of what is expressible.

Thus our field of study has different sub-classifications. For me, Robinson (1991)

continues to be the most comprehensive study of the different possibilities of analysis. Written more from the nursing than from the medical angle, it tackles the use of humour in different situational contexts, including the observable and simply conversational. Robinson is very clear when she notes that the role of the doctor and the nurse is to deal "with blood, guts, naked bodies, excrements, intimate activities, trauma, disabilities, crisis, and death", and then "humor becomes relevant to the situation and the hostile, raunchy, gallows humor emerges and increases as the stress level rises" (Robinson 1991:151). Outstanding merits of her study are its evaluation of "gallows humour" as a specific product of confinement and hospital care, the appreciation of strictly medical humour (that produced between professionals, for private consumption), and as a description of the frontier that separates the professional from the patient, and the way that humour tempts the relation between the two.

As Robinson herself indicates, during the last decades, hospitals have begun to create Therapeutic Humour Units to face hospital life from a different stance. At the same time, the medical and nursing journals are full of articles about the therapeutic value of the comic perspective, widening the already traditional tendency of doctors to explain anecdotes about their experience, with examples of frequent confusions with situations and vocabulary, as they experienced them with patients. Since 1991, the *Journal of Nursing Jocularity* has been published, and there is talk of a growing tendency in this field. This year, within the Catalan-speaking lands, two large hospitals in Valencia have incorporated a troupe of clowns (*PayaSOSpital*) that slip into the children's wards, the therapeutic units, and oncology, demolishing the sanitary rigidity and introducing slip-ups (literally), big noses and false doctors.

In parallel with to these practices, field observations have also appeared about humour in hospitals, which complement the often-voluntary collection of anecdotes from the same doctors and nurses, also forgotten or tucked away in a lost drawer of the filing cabinet to be forgotten. At least two relatively recent studies fit in with the study that I wish to present here. One is the study by Mallet & O'Hern (1996), with continuous direct observation in a haemodialysis unit, and other the study by Tatano Beck (1997) based on the ethnographic analysis of narrations by nursing staff, selecting themes and the treatment of these themes.

This type of research has to be included in a wider context: that of the interesting relationship between medicine and discourse, already present in the humanist tradition. The recent dissociation of this tradition, with the "technification" of the doctor-patient

relationship --diagnostics have been transformed into spread sheets, digits and decimals-- has meant that many doctors reclaim the human aspect of the interaction and that turn their attention towards clinical interviews, the social interpretation of disease, and the same social concept of the doctor's role. The long humanist medical tradition had contemplated all this, and had provided the genesis of the medical vocabulary with content, its relations with the vernacular and the description of disease. Peter Medawar's extensive work is a good example of this tradition, but we could find examples of the recent practice of medical humanities in the different national traditions both within, and certainly also outside, Europe.

Pragmatics research is partially linked to this. There are interesting compilations about clinical interviews, such as that in Pragmatics 1998, which includes recent fieldwork covering both the organisation of the interview and aspects of the patients' narrative. Doctors are also interested in the clinical interview as a communicative act, and have K. M. Hunter's excellent study available (Hunter 1991). In this conjunction of interests and perspectives, the anthropologists also claim their place. The work by Le Breton (1990, 1993, 1995) is at least sufficient to fill a programme: the social role of the body, the sense and expression of pain, the historical examination of surgical practice, as aggression, as spectacle and recently as commerce. It is not the first time that the medicine has been placed under examination this century. We know that S. Sontag wrote about cancer and AIDS. Her study is still a valuable contribution to the construction of the contemporary metaphor of exclusion and about the values associated with bodily suffering. For Sontag, the fundamental preoccupation was the over-interpretation of the disease, its creation of sense. Here more than ever, the notions of loss of purity are present and applicable. The works by M. Douglas (1966, 1994) still help to orientate us in this field. They remind us that the hygienic caution that the doctor applies is the material transposition of purity rituals, that the doctor inverts the established roles worrying about the depositions and the presence of the body, that his special attributions form part of the trust we invest in conventions. In 1994 Douglas wrote: "All sickness and bodily impairment are grounds for demanding justification and so superb material for the blaming and justifying process. In the most extreme form, every illness affords scope for an accusation. If someone is sick, they can be accused of not taking proper care of their bodies. The sick person is not necessarily the one who is accused: if it is the children, the parents are accused, or the school, or the public health. In this context of mutual recrimination the body is a medium for exerting control; pointing to a sick body is a potential threat against anyone who can be held accountable" (1996:36). These terms seem correct if we wish to consider the social

perception of sickness, the medical world and relations with patients. It is obvious that the type of humour that we produce will depend on that, and I think it would be an error to tackle the abundant humouristic narrations and medical humour in general outwith these social representations that support and validate them.

As I have mentioned, the relation between medicine and discourse is the right interpretative context. I believe that we are tackling correctly the age and the interest of the relation if we think that doctors, teachers and lawyers are the three old "professions" related to the use of the word. In the case of doctors, and in crucial contrast with the case of the lawyers, the discourse is as necessary as it is insufficient. The discourse contributes to creating both confidence in doctors and trust in their knowledge, in the peculiar translation of the medical knowledge about the body. But the discursive intentions in the doctor-patient relation do not rely completely on the word; they are directed especially towards the sequence of corporal warning, towards the language of the body. The rhetoric pride of the lawyer is thus transformed into the humiliation of the rhetoric. The word of the doctor is insufficient; no discourse could cure more than the necessary confidence and the self-esteem. The diagnostic, the prognostic, the treatment, are applied circumstances. The doctor practices a minimalist rhetoric. He knows that he needs the discourse, in the double role of creator of confidence and depository of knowledge, but this task is undermined. Its focus is magic: it depends on the curative action. This is where humour can provide explanations where conceptual difficulties abound. Humour is not only distraction from pain, or the necessary companion of the therapy and the confidence, but also the genre that can deal with what is really difficult to express. By inversion, it reestablishes the necessary rhetoric. I would like to say that this is its pragmatic value, as a discursive genre.

My study is based on a set of 110 open interviews, each approximately one hour long, with doctors, nurses and healthcare personnel in hospitals and private clinics, held during 1999 and the first six months of 2000, in the Spanish province of Lleida, in the interior of Catalonia, among a mainly Catalan-speaking population. The interviews were carried out by students of pragmatics and conversational analysis, after prior contacts with hospital institutions in the city, the School of Nursing and the Faculty of Medicine of the University of Lleida, and also through acquaintances. To guide the interview, the students had a pre-prepared questionnaire that covered the different areas of the doctor/nurse-patient relation: the visit, the medical checks, the treatment, day-to-day dealings, hospitalisation, the slang used by doctors and other health personnel, or the problems of expression and

lexis. As well as this, the students were asked to maintain as lively a conversation as possible with their subjects, informally inviting them to explain first or second-hand anecdotes about their profession and their relations with patients. In general lines, the interviewees were extraordinarily collaborative, clearly and simply narrating anecdotes, of very varied quality and consistence, experienced in different ambits of their work. The task of the members of the pragmatics and conversational analysis seminars has consisted of ordering, classifying and analysing the ethnographic material obtained, which obviously, without coming from direct observation, constitutes high quality material for studying the formation of the humoristic narrative in the context of ordinary conversation. I know of no other such studies in Spain done from the pragmatic or conversational perspective about medical humour, but there is at least the work, which I would like to cite, by Felix Diaz Martinez about the oncologic clinic, from the point of view of conversational analysis, published in *Discurso y Sociedad*, 1999.

I have tried to complement this research with other sources, with unequal results. I have examined patients' narratives obtained for an interview programme on Televisio de Catalunya. These were specifically patients who had suffered heart attacks. Curiously, the examination of these narratives, also informal and simple, has provided no relevant data on humour --the interviews kept to a rigorously descriptive style, without daring to demythicise or attack the illness and its repercussions. My complementary research has also led me to review 19<sup>th</sup> and 20<sup>th</sup> century Catalan literature, with rather surprising results.

I have found a substantial gallery of characters agonising, or in a precarious condition, sick people who dragged their melancholy from city to city. There is even a splendid first person narration, by a hypothetical doctor, Dr. Rip, by S. Espriu, written in the thirties, but not a drop of medical humour. Espriu's Dr. Rip, in many ways comparable to Beckett's Malone Dies, never reaches the Irishman's surprising humour and the understanding. The tone of Catalan writers, especially in the symbolist narrations of the early twenties, is markedly more serious and dramatic. Likewise, one of the most important twentieth century writers, Josep Pla told the story of the heart attack he suffered at the beginning of the seventies in a simple and entertaining journalistic register, full of rhetorical zigzags. His story is still used (in Spanish and Catalan versions) in clinical interview courses. There is no humour in the story, but there is an elegant irony, as in the open allusion to the recovery of the patient, when confronted with the nurses' short skirts ("On arriving at the Corachán clinic, I entered under my own steam. Then the lift whisked me to the sixth floor: a rather delicate

section --whose technical --technical!-- name I don't recall, but that doesn't matter. It immediately seemed to me that there was considerable discipline. (...) After three or four days of discipline I had made notable progress. My heart had rested and the work of disintoxication had been highly visible. Sixty-five tears of intoxication are a lot. Five or six days after entering the clinic, the nurses' miniskirts surprised me agreeably. I could almost have said that I was on the road to recovery" (Pla 1974: 537-538) ). The students also know how to appreciate the irony of at least this complicated reference to what could simply be the "elbow": "Meanwhile the joints in my arm began to hurt me, especially the central joint, that which links the biceps to the forearm and the joints of the hands" (Pla 1974: 531). The story is splendid, and considerably improves on the descriptive gallery of the authors who preceded him. In any case, in Europe as a whole, the best (and best known) reference to medical humour is still possibly *Le Malade Imaginaire*, by Moliere, with its pretentious and rather forced doctors and a supposed patient prepared to submit himself unconditionally to the medical rigmarole. In the handout I cite the invitation to witness a dissection as though it were a spectacle, and the ironic commentary that it provokes, because to me they seem to be an amusing and good quality sample of the perception of medical humour.

We are currently working on the analysis of the interviews. The work is unfinished as yet. This presentation is accordingly merely informative. We still have to create all the variables, which will allow us to capture / understand the differences between the narrations by doctors and nurses, or the narrations from hospital environments with those from clinics, or those obtained in small towns from those in the city. I would also like to cross variables of details, such as styles and narrative rhythms, and thus quantify the results, as far as this is possible. Finally, I would like to cross-reference and compare the results of the information from the interviews with those from fieldwork based on direct observation in hospitals. In any case, here I would like to present the analysis of the themes and the conversational styles in the production of the humoristic narrative.

I have also used another type of parallel material, namely some collections of jokes and medical anecdotes that circulate around the universities, that also await a more detailed analysis and a comparative approximation. Doctors' habit of collecting and explaining professionals anecdotes, and medical jokes form part of any collection of more or less popular humour, be it thematic or not, (the handout cites one of the best known recent collections; the collections are mainly in Spanish, in contrast to the material obtained in the interviews. That creates the typical problems of translation, principally when dealing with

verbal humour). It has surprised me to follow the trail of this written tradition back to early times. One of the oldest registers cited is by Philogelos, from the sixth century, which appears to contain around thirty doctor jokes, of which I have reproduced one (easily understood) in the handout ("Doctor, when I get up in the morning I feel sick for at least half an hour, after that I feel better"; and the doctor responds: "Well, get up half an hour later"). The most surprising thing about these popular joke collections is their resemblance to the narrations obtained through the interviews: This resemblance is thematic, and in a good part, also formal. The written jokes dispense with the typical contextualisation signals / cues of conversation, and the narrative structure can be more complex, but the substantial resemblance shows that the linguistic usage works on the same presumptions and against the same conceptual and situational context. I believe that we could learn a lot from this syntony between canned jokes and spontaneous oral narrations --a syntony that is often explicit in the same doctors who have collected jokes and anecdotes.

Until now, we have found medicine, humour and anthropology in this confluence of interests. The contribution of conversational analysis is the other important aspect. When we face humoristic narrations, we are faced with a problem of contextualisation. We know that humour originates coherently with the situation, according to Douglas (1968), if it can present a formal inversion through a situational inversion. Trivial humour functions in trivial situations; gross humour arises from more complex situations; doctors often make jokes about patients' lexical errors; patients' humour is based around solidarity (more or less mistaken) with other patients; humour about the the-first-time-I- can be a simple mistake many years later. This situational correspondence is the key to the interpretation of humour: it also implies a correspondence of values and beliefs, and thus is what can and cannot make us laugh. In conversation, and in humoristic narration, contextualisation plays the role of the situational correspondence. The jokes and the witticisms are told to people, and appeal to the complicity of the interlocutors. The speakers effectively show the cues of the humoristic narration so the listeners can accede to the comic interpretation. So conversational analysis provides new information about how we construct the humoristic situation. In our interviews, the narrators often declare explicitly "that was really funny", or "what a laugh", or "that was really amusing" to situate the listener (who is not sure to collaborate decidedly) into an adequate narrative frame. Norrick's conversational analysis (in this congress) of the adhesion of oral joke-telling to conventions of its own, in encouraging multiple processing, fits perfectly with what we find in the narratives of medical humour.

As I have mentioned, I will deal with three questions: a) the topics of the humoristic relationship, preferably those that are orientated towards reformulating the social roles of the doctor, the nurse and the patient, and the consideration that the illness merits, b) the perception of the body, including sexuality and scatology, and c) humoristic narratives and the conversational styles they transmit. The material collected on the first question, the "topics" emerging in the humoristic relationship, give a glimpse of the partitioning of social roles, beginning with the distance established between doctors and nurses. The topics of genre stereotypes intervene when it is a question of identifying the doctor --if he is a man-- and the nurse --if she is a woman. Equally, male patients tend to look for the woman behind the nurse's uniform, while female patients tend to work towards the feminine solidarity, the uniform aside. As always, the characteristic inversions are favourite themes for humour: the doctor who injures himself, the patient who is a doctor, the relative who is taken for a patient ("Hey, I'm her aunt!"), the patient that renounces his/her role and flees the hospital, the injection or the delicate examination. A companion who sleeps while the patient is examined is a cause of humour; as is a policeman who faints instead of the injured criminal: "{(L2) Well, let me take a blood sample \_ } I don't know what\ ok he'll put it in: that\_ the marks to press [...] he begins to put it in\_ and a policeman begins to turn white and then\_ you know what\_ he falls down right there\ [...] and instead of worrying\_ first the patient 'cos normally it's the patient who faints \_ [...] but then the policeman goes and faints on you!\_ mm eh/ " (ACDALA7). A patient who is mistakenly taken into hospital when he is leaving with his luggage and all; the companions that want to take the opportunity to weigh themselves, now that they are here; the patients who play with the bell and the nurses; the doctors who send patients away with surrealist annotations, in all these cases the social roles are transformed, and the individuals escape from their assigned roles. Doctors and nursing staff classify the patients (especially in A and E) according to their attitudes and their mode of communication, with names in Catalan and Spanish that evoke Indian tribes: "the black feet", for questions of hygiene, the "*poyaqui*", from "*pos ya que estoy aqui*" ("well, as I'm here"), the "*arapahoe*", from "*ahora p'a joder, perillosos porque et venen a la matinada*" ("now to fuck us around, these are dangerous because they come in the middle of the night"), the "*yanobami*", from "*ya nos vamos, i no acaben mai*" ("we're off then, and never finish"), or the "*pasopago*", of "*para eso pago a la Seguridad Social*" ("that's what I pay my social security for") (ACCAB1). Here the classifications suggest and reinforce the strict patient-doctor partition. The use of vocabulary generally serves this purpose. The doctors have to write reports and specify the diagnosis and the treatment with the specialised lexis of their discipline, which the patient logically doesn't know.

Familiarity with the illness normally leads the patients to equip themselves with their own lexical alternatives. More or less consciously, the patients rework the medical vocabulary, and in doing so oblige the doctors to learn it and to live with it: "gasoline", for "insulin", "*la propina*" ("tip") for "*atropina*", "Asiatic" for "sciatica" ("I've got an Asiatic, an Asiatic\_ [...] instead of saying lumbalgia\_ they say an Asiatic\ like they could say African, couldn't they!" (POND5) ). It is typically verbal humour, difficult to translate, but which forms a substantial part of any collection of medical humour, and also of the narratives that we have collected. The associations suggested by these verbal deformations incorporate imagination and new meanings into the relationship with the disease and at the same time confirm the frontier between specialised and profane user.

Patients employ their own codes: the pills are green, red or blue, large or small. The doctors and the nurses know that this way of referring to the pills is erroneous. Humour is produced in the same dialogue between the doctor and the patient, when the two perspectives collide. In the narratives that we have collected we observe that the confusion would probably not be comic in itself, but the speaker transforms it into comic by relating it as a personal story, with the fresh dialogue provoked by the situation. It is that situation of dialogue that also illustrates the social roles; the doctor interrogates; the patient has to get it right to make himself understood properly, and in accordance with the situation: "Let's see granddad\_ \_ when you go to the toilet \_ when you go/ hey\_ that's the wife\_ the wife [...] well\_ let's see if you can clear this up\_ no/ he says\_ because we're asking your husband \_ when he goes to the lavatory how are his movements\_ and the wife says\_ the wife\_ ah well right\_ says\_ well, he goes to the toilet and he sits down!" (PMD1). In the humorous dialogue the speakers forget the role they have to play, they forget to answer as they are expected to. A doctor seems very solicitous asking the patient, an elderly woman, she says yes, that she would accept a coffee. Another patient, in a hospital, asks if the pain of the next patient is catching. On another occasion, the doctor, asked by a patient if the treatment is painful, answers that he has applied it many times and that he has never felt any pain. Amongst themselves the doctors and the nurses recover functions through humour. If there is no work in the accident ward on the "Day of the Innocents" (December 28<sup>th</sup>, corresponding to April Fools' day), a dummy may run up and down the corridors of the hospital to cheer up the duty staff. A doctor with a special mania would not operate unless he had one foot in a bucket when he was in the theatre. Another would sing in the same situation, or impersonate actors from television. In these cases, the group humour also undoes the established roles and introduces unexpectedness and ambiguity.

Doctors' humour is effectively group humour on many occasions. In that humour the patients are the butts of the jokes, and it is sure that they would not want to be there when these are told. In our narratives, the doctors and the nurses exploit the doubles entendres they are aware of and comment on comic situations that are related with what they perceive in function of their work. Talking about a hepatitis patient, they explain: "well\_ the doctor came and said\_ ha ha\_ want to see a canary?/ well go to room such and such\" (PCOA1); that "canary" would put on a long face if the nurse came out with the same in front of him. But we are dealing with reversible situations. The patients can use the same derisory humour to ridicule the situation. This self-mockery contributes to making the situation more fluid. In all cases, that type of situational humour springs from contact and from the inverted perception of some important value relevant to the interaction between participants. Both doctors and patients tempt / test their social roles, negotiate their credibility and their range. A doctor comically explained his surprise the day that he arrived at the village surgery and it was completely empty. A doctor without ordinary patients is a strange inversion. That day there was football on TV and his patients had stayed in to watch it.

The second question is that of the perception of the body, and includes principally, but not only, sexuality and scatology. Here, like above, the jokes in our corpus coincide exactly with the collected narratives. The themes are the same, as is the approximation of the participants. Only the narrative styles differ, because in the oral the narrator explicitly offers more cues for comic interpretation. The oral narration is often cruder and allows scatology or sex to be dealt with more openly. Proximity or manipulation of sexual organs are characteristic themes. If the patient is a priest, who, in Christian culture, has to maintain distance, the inversion is provoked by the situation itself. There is danger when there is proximity or manipulation (the same when the question is scatological aspects) and the humour arises offering ambiguity and explanations. The patients often have to manipulate urine or faeces. A mother mixed up the correctly wrapped sample jar for the laboratory with her son's sandwich. A patient presented semen and urine samples in the same jar for analysis. It is not only confusions: the narrators perceive the inversion as an assault on the logic of the profession, as the same profession inverts the ordinary logic in that point. The duty doctors search for a "Tampax" lost in a woman's body. The shower is always a place to invite an attractive nurse. The breast can be for the infant or for the adult. Jokes of that type make up the daily experience of many doctors, and some good-humoured patients.

In any case, and apart from sexuality and scatological inversions, the body, perceived in

function of the malady, is an object of redesign and conceived as a place of entries and exits that have to be controlled. Beginning with the skin: a narration explains the patient's fear of losing his black colour when he recovered from burns. The colour, the dimensions of the body ("an enormous patient, huge"), or the examination of the liver (an inflated liver is good for making foie gras): the body is submitted to revision bit by bit, inch by inch. Symmetry is simply a motive for humour: if there is an error when shaving a body and the right side is shaved instead of the left, or if someone asks to examine the right foot which hasn't been washed when the left one has already been examined. The same sanctions occur when dealing with taking pills and suppositories and receiving injections. The metaphor of the aggression here becomes a mock attack. The pills, the suppositories or the injections suppose, in different ways, an assault on the ordinary means of feeding or bodily maintenance. A woman discovers with stupor that her husband did not take his pill yesterday (because they were finished) but instead took a button of similar dimensions (ACCA16); the suppositories are hard to chew because of the paper they are wrapped in; the ear drops are not dissolved in water; there is no need to take more pills than necessary just because they are small. In all these cases the hypothetical corporal aggression is a mock attack. The body confuses its routes. Exits become entrances, strange objects become familiar when they cross the bodily frontier.

All these situations contain fantasy. The body stops being that humble place we inhabit to become a place of fantasy. Humour reinforces that double interpretation. When external utensils intervene in body management the imagination increases and the situations multiply. The administration of serum, a routine practice nowadays, is the source of many ritual jokes: There are patients "that have six or\_ five or six little bottles and we say\_ come on, that looks like a tree - a Christmas tree\ (ACMALB10); or, "the drip will go with you everywhere while you're here, like if it was your bridegroom\ and when I leave\_ what do I do\_ do I stick it in my pocket/" (ACBLA11). As the drip is food, it is easy for it to evoke more bodily substances: "the poor man is on an strict diet \_ [...] well look\_ [...] the drip\ well, now that is ham \ [...] look now that is the soup and that is\ [...] well now I'll bring you the whisky\ (ACBLA10). An old man who was complaining because they hadn't given him food was caught biting the drip and trying to drink it "directly instead of through the vein" (PLLAB6). The ethereal evokes the corporal; humour, here as before, uncovers the two interpretations.

Electrical apparatus suggest another kind of danger, one that patients and doctors skirt cautiously round on metaphorical tip toes. Only the X-ray "photos" are inoffensive, they

represent the benign magic. Among all these, the laser is the one that raises most eyebrows, perhaps, by inversion, because of its clean work, "almost a miracle". In contrast, the patients come to terms as well as they can with the "tunnel", the "coffin" or the "washing machine" (other names for the magnetic resonance machine) and they reasonably get alarmed when faced with cables and tubes of various types. Seeing yourself hooked up changes one's habitual perception of the body, and produces suggestive metaphors and daring comparisons.

There are associated semantics fields in all these cases. Those who suffer fractures ask the nurses to go and dance a mambo (PCOA2); a man that suffered a heart attack while cycling continued homeward on the bicycle and then went to the doctor (PALA2); a completely plastered patient slipped down inside the cast and the nurse thought he had disappeared (PLLAC4). The figurative sense is associated with the type of bodily problem implicated. In any case, this generates an alternative fantasy world, an inversion of values and contexts. The narrators use these circumstances to roll out the humour. The imagination of the body works of hard on these themes and illness loses its pejorative connotations.

Fantasy can also simply appear in the description: a patient argued that the cancer that he had had in his bladder had now gone up to his throat (ACCAA1), another talked about a "heart attack in the head" and a third of "Alzheimer in a leg", to refer to a paralysis (ACDALA10). Here the parts of the body are reorganised, circulate internally and one part serves for the description of the other. Diseases are conceived in terms of simple metaphors that move around and the body is redesigned in function of that. The doctor has to be alert for this redesign and manoeuvre in consequence. An old woman asked for birth-control pills, but was too old to need them; after the pertinent questioning, the old woman declared that she took them because they helped her to sleep. There is a benign fantasy and a more delicate fantasy, in accordance with more delicate contexts. The most critical situations, that I have not explored in this first work, also demand a more critical humour, as reported in ethnographic work carried out in Oncology Units. The notion of coherence with the situation reimposes itself here. A doctor was very happy to write a prescription for "cigars and herring" for a patient who was going home although the latter would not find these in the chemist's (PPAA6). Cigars and herring seems a nice prescription, it incorporates real condiments into the chemical-pharmaceutical fantasy. Provided in the most difficult situations, this would acquire a deeper meaning and would create unexpected associations. The meanings depend, of course, on the situations, and

we extract humour from what we perceive as relevant.

The third of the questions is related to the narrative circumstances. As I have said, the speaker, through telling the story as if it were a personal experience, often makes an effort to make something comical out of a situation that is related a) to the social roles implicated in his or her work, b) the necessary changes of register, or c) the perception of illness or the body. The narratives are crucial in the production of humour because they deploy the skills necessary for comic interpretation and give key clues about the dialogue and the pertinent situational context where the comic situation supposedly took place. In the handout, I present eight examples of narrative, of different length, tone and content, so we can examine how they have been constructed. The first six crucially include situations of dialogue as a key part of the comic effect. All these cases are reported situations that speakers transmit in direct style and the punch line is usually behind the last of these reported steps. I'll now give you some time to read the examples.

## JOKING WITH DOCTORS (INTERVIEWS)

### HANDOUT

1. Amb una noia jove\_ fent-li la història em vai trobar que\_ pregunto\_ quin RH ets/ la noia pensa una mica\_ pensa una mica\_ i al cap d'un rato\_ diu em sembla que sóc piscis\ PPAB22

*With a young girl\_ doing the case story\_ I ask\_ what RH are you/ the girl thinks for a bit\_ thinks for a bit\_ and after a while\_ she says I think I'm Piscis\*

2. An la UVI\_ també una vegada vam comentar\_ que am una senyora que estave bastant malament\_ que li tenien que canviar la vàlvula mitral\_ no/ perquè no li tancave bé\_ i li tenien que ficar una pròtesi\ tot s'ha de dir que no ere gaire: intel.ligent\_ pues si no firme el paper no s'opere\ bueno\_ total que:: que la dona després d'explicar-li tot no estave gaire segura\_ [...] el metge va tindre que intentar pue::s ajudar-la a decidir\_ no/ allò donar-li arguments i pues {(DC) que serie molt beneficiós per ella\_ perquè si no encara seria pitjor\_} total que am això va sortir pues que: que les estadístiques a vegades\_ pos això\_ que poden ajudar\_ la gent que les entén pot ajudar a decidir-se\_ pero bueno\_ va sortir que en aquesta an aquestes operacions\_ pues\_ només hi havia una:\_ que ere un noranta-cinc per cent segura\_ no/ que un cinc per cent podie sortir malament\_ [...] después la malalta\_ después de: de pensar-ho una llarga estona això això del noranta-cinc per cent\_ {(AC) això del cinc per cent/} va preguntar\_ i això del cinc per cent què vol dir a ve(u)re\ i el metge i nosaltres li vam explicar\_ pues miri que: el norantan-cinc per cent surten bé de les operacions\ vol dir això\ la dona\_ preguntave encara\_ bueno\_ pero ia\_ i el cinc per cent aquest què vol dir/ [...] aquest cinc per cent que quede\_ i al final pos clar li vam dir\_ pos miri que un cinc per cent vol dir que de cada cent malalts que s'operen\_ cinc no surten tan bé\_ o quede alguna lesió: o fins i tot es poden morir\_ no/ al que la dona ia al cap d'una estona pensant-s'ho va dir\_ la dona molt decidida\_ miri sap què doctor\_ vostè m'envie cap a casa\ i quan se li haigi mort aquestos cinc\_ después m'avise que io vindré a operar-me\_ pero fins que no se morin no me vingui a cridar que no sigui que io siré una d'aquestes cinc\ (..) {(DC o sigui la gent lo que pense eh/} ACCAA15

*At ICU\_ once we also commented\_ that there was a woman who was pretty ill\_ they had to change the mitral valve\_ ok/ 'cos it wasn't closing properly\_ and they had to give her an artificial one\ she wasn't all that: intelligent\_ so if she didn't sign the paper she wouldn't be operated on \ well\_ so anyway:: the woman wasn't very convinced after they had explained everything\_ [...] the doctor had to\_ you know\_ help her to make up her mind\_ ok/ all that about explaining why and so on {(DC) it'd be very good for you\_ if not it'll be even worse\_} so anyway with all that he came out with: well the statistics sometimes\_ well so that\_ they can help the people who understand them to help them to decide\_ so then\_ he came out with that of these operations\_ well\_ there was only one:\_ that it was ninety-five percent safe\_ ok/ that five percent could not work out\_ [...] then the patient\_ after: thinking about it for a while that that of the ninety-five percent\_ {(AC) and that of the five percent/} she asked\_ and what about the five percent let's see what does it mean\ and the doctor and us told her\_ well look: ninety-five percent come out of the operation well \ does that mean\ the woman\_ still asking well\_ so right\_ and that five percent what does it mean/ [...] that five percent that's left\_ and well obviously in the end we told her\_ well look the five percent means that out of every hundred patients we operate on\_ five don't work so well\_ or there is some lesion: or they could even die\_ ok/ after thinking for a while about what we had said the woman making up her mind comes out with\_ look, you know what doctor\_ send me home again\ and when those five have died\_ then tell me and I'll come for the operation\_ but until they have died don't tell me to come back 'cos I don't want to be one of those five\ (..) {(DC so you see how people's minds work eh/}*

3. lo una que és molt bona\_ que és la següent\ d'un malalt no/ que a casa pren una medicació\_ pren tot lo que faci falta no/ llavons arribe aquí\_ està mo- molt malalt\_ i se li pose el suero no/ tu li dius\_ ara li poso: la medicació per via intravenosa\_ molt bé però dongui'm la pastilla\_ [...] i tu li dius\_ [...] perdoni la pastilla\_ li han posat per via intravenosa\_ perquè és més ràpida\ molt bé però vostè dongui'm la pastilla si no no esmorzo\ ACMALB1

*This one's a good one\_ it's this\ about a patient ok/ who takes medicine at home takes everything he's given/ so then he gets here\_ he's really ill\_ and so they put him on a drip/ you tell him no I'll put it in: the medicine intravenously\_ fine but give me my pill\_ [...] and you tell him\_ [...] sorry but you've had your pill intravenously your pill\_ because it's faster\ fine but give me the pill if not I won't have breakfast\*

4. Hi ha lo típic del malalt\_ que li preguntes\_ on li fa mal/ i te diu\_ tot\_tot/ me fa mal a tot arreu\ però que hi ha algun lloc que li fa més mal o així/ no\_ no\_ que me fa mal tot\_tot\_tot i tu a la història apuntes totalgia\ PGONA3

*There's the typical patient\_ when you ask\_ where is it sore/ and he says\_ everything everything/ it's sore everywhere\ but is there something that's sorer than the rest/ ok\_ ok\_ everything everything. everything is sore and so you write everyalgia on the case history\*

5. Una altra vegada també\_ vam 'nar a passar visita an un altre metge\_ an una dona que li feie molt mal la panxa\ {(L2) ai me duele mucho la barriga y hace muchos días\} i es veu que la seua filla ere farmacèutica i ere una mica sabelotodo també\ estàvem la malalta\_ la filla\_ lo metge i io\ {(L2) y que me duele mucho la barriga y hace muchos días\} i el metge li diu\_ {(L2) pero se hace\_ ventosidades/ hombre\_ algun meteorito sí que me he tirado\_ algun meteorito sí\_ pero nada\_ sólo dolor de barriga y hace días que no voy de vientre\ ai mamá\_} li diu la filla\_ {(L2) (AC) no seas tan fina meteoritos\_ pedos mujer pedos\} PME7

*Another time\_ we did the rounds with another doctor\_ a woman who had a really sore stomach\ {(L2) ooh it's so sore it's been sore for days now\} and so you see her daughter was a chemist and a bit of a know-all\ there were the patient\_ the daughter\_ the doctor and me\ {(L2) ooh my tummy's so sore it's been sore for days now \} and the doctor says\_ {(L2) but do you have\_ windiness/ well\_ I've done some meteorites\_ some meteorites yes\_ but nothing\_ only a sore tummy and it's days since I went \ ooh mum\_} says the daughter\_ {(L2) (AC) don' be so fine mum\_ meteorites\_ farts woman farts\}*

6. [CAST.] Una vez vino una chica a operarse de\_ de la nariz\_ a hacerse una septoplàstia y digamos estaba tan nerviosa\_ tan nerviosa que decidimos gastarle una broma [...] para romper el hielo para que no estuviera tan angustiada\_ no/ claro\_ [...] llegas allí cuando está en la cama y le preguntas\_ hola fulanita como estás\ què tal\ y ella\_ bien\_bien\_ claro\ [...] entonces dices\_ bueno va\_ no te preocupes\_ todo irá muy bien\ esta rodilla te la vamos a dejar de primera\ claro\_ el susto que se lleva es terrible\_ no/ oiga\_oiga que a mi no tienen que operarme de la rodilla eh/ que me tienen que operar de la nariz eh/ pues entonces claro\_ no luego nos ponemos todos a reir\_ y la chica entonces se relaja\ P MEC3

*[CAST.] Once a girl came for an operation on her nose\_ on her nose\_ for a septoplastia you could say she was so nervous\_ so nervous that we decided to play a joke on her [...] to break the ice to make her feel less worried\_ ok/ well\_ [...] you get there when she's in the bed and you ask her\_ hello so-and so how are you\ how's it going\ and she\_ well\_well\_ obviously\ [...] then you say\_ well let's see\_ don't worry\_ everything'll be all right\ we're going to leave this knee as good as new\ of course\_ she gets a terrible fright\_ no/ listen listen it's not my knee that has to be operated on eh/ you've got to operate on my nose eh/ so anyway obviously\_ ok we all started laughing and then the girl relaxed\*

7. Una vegada estant de guàrdia\_ se'ns presente\_ eh\_ se'ns presente::\_ a l'àrea d'urgències\ una noia\_ vestida de núvia/ de cap a peus\_ eh/ amb el amb el\_ acompanyada de to::t un reguitzell de familiars\ [...] i resulte que estaven fent la cerimònia de la de les\_ de noces i 'm mala pata\_ i amb la mala sort\_ que (a)questa noia patie de migranyes\_ [...] i va tindre la mala pata\_ i amb la mala sort\_ {(AC) de que en el moment en què tenien\_ estaven la parella\_} devant de l'altar\_ devant del capellà\_ li comence el seu mal d- la seua migranya\_ en (a)quell moment\_ de tal manera que\_ allò en pocs minuts va anar augmentant va anar augmentant\_ li va començar a venir sensació de basques\_ [...] i noi/ aquella cerimònia no es va puguer acabar\ [...] venint cap a quí al CAP\_ allavons clar\_ per anar per la via ràpida\_ pos punxem no/ posem un parell d'injeccions intramusculars\_ una que li calmi el dolor\_ l'altra que li calmi el basqueig\_ les ganas de vomitar que li va agafar\ {(P) llavons també vage\_} allò també va ser una mica de número no/ perquè és clar\_ u:n vestit de núvia\_ home\_ no és fàcil de treure ni de posar\ total que: hi havia una infermera que posava la injecció\_ un altre que aguantave un tros de roba\_ i {( @ ) i io que aguantave un altre tros de roba\} i la cua eh/ ACPUA8

*Once being on duty\_ there was a\_ eh\_ there was a::\_ in the A and E\ a girl\_ dressed as a bride/ from head to foot\_ eh/ with the with\_ accompanied by a::ll the family\ [...] and what happened was they were in the ceremony\_ the wedding and unfortunately\_ and with really bad luck this girl had*

problems with migraines\_ [...] and she had such bad luck and so unluckily {(AC) that just when they had to \_ just when they were \_ } in front of the altar\_ in front of the priest\_ her sore head begins- her migraine\_ at that moment\_ so much so that\_ in a few minutes it got worse and worse\_ she started to feel sick\_ [...] well man/ they couldn't finish the ceremony \ [...] coming here to the clinic\_ so of course\_ to get on with it\_ well we gave her an injection/ we gave her a couple of intramuscular injections\_ one to stop the pain\_ the other to stop her sickness\_ her wanting to throw up\ {(P) for God's sake\_ } that was a bit of a to-do ok/ 'cos obviously\_ a wedding dress\_ see\_ it's not easy to take off and put on\ so anyway: there was a nurse giving her the injection\_ another who was holding a piece of cloth \_ and {( @ ) and me holding up another piece of cloth\ } and the train eh/

8. Aquella fee pocs dies que estave\_ que havie començat a la planta\_ i claro\_ no tenie gaire experiència en los parts\ nantros tenim que estar allí a ajuda:r\_ perquè ve la matrona i el metge\_ però tu els ajudes an ells\ (.) i aquella noia treballave de nits\_ i ere potser la segona o tercera nit que treballave\ i va vindre una noia que anave de part\_ que anave de part\_ i que ràpid\_ que vingués lo metge\ i aquella\_ ah sí sí\_ justet arribe al puesto per 'nar a trucar al ginecòleg {(AC) i tornen a trucar de l'habitació\} la senyora embrassada\_ ai vine corre corre\_ xiquet va a l'habitació\_ {(AC) i ia sortie 'l crio per allí\} i va parir al llit\ i aquella\_ {(F) ah\_ socorro socorro\} PMEA10

That girl had only been there a few days \_ a few days since she had started on that floor \_ and obviously\_ she didn't have all that experience in labour \ we've got to be there to help\_ 'cos matron and the doctor come\_ but you've got to help them \ (.) and that girl was on nights \_ and it was maybe her second or third night \ and a girl came in in labour\_ who was about to give birth\_ and quick \_ get the doctor\ and that one\_ ah yes\_ yes\_ just in time to call the gynaecologist {(AC) and the woman calls from the room\} the pregnant lady\_ oh come here quick quick\_ so guess what she goes to the room\_ {(AC) and the baby was already there\} she has the baby in the bed\ and that one\_ {(F) ah\_ help help \}

The first and shortest of the examples is a dialogue in a clinic. The "RH", the jab line, in Attardo's words, is the doctor's question. Note how the narrator dilates the answer, "the girl thinks, thinks". The punch line delivered at the end in direct style contains the disjoint element that leads the sequence to another interpretation. "Pisces" belongs to another script, that of the horoscope. Both scripts, that of the doctor and that of the patient, are talking at cross purposes. That appears to justify the time lapse between question and answer, the time to think. This time is necessary in the narration, and the narrator expresses it, although in the same brief form that the joke requires. The two scripts correspond, respectively, to distinct universes that of the doctor's discourse and the ordinary, colloquial discourse of the patient. The novelty appears when we see that the latter considers that her horoscope could be an important part of her clinical record.

The fourth example, which is also brief, inverts this sequence of interaction. The doctor asks about the state of the patient and gets the sure but highly inaccurate answer: "everything" / "everywhere". After various requests the patient repeats the same: "everything" / "everywhere". That exchange could go on, but twice is enough for us to understand the insistence of both the doctor and the patient. "Everything", repeated several times, forms the jab lines. The dialogue, apparently, seems correct, and so we reach the punch line: the doctor notes down the diagnostic. "Everyalgia" is a neologism; here it is the doctor who responds to the patient's colloquial description with technical vocabulary. Note also the maintenance of the discursive voice: beginning with a generic "there's the typical patient" coherent with the impersonal second person, "you write down". The joke evokes a typical, generalised case, but needs this second person to put the narration into direct speech, especially when the end is not part of the dialogue, but rather the doctor's writing in the case history. That change of frame, from oral in the dialogue to written by the doctor, is also substantial for understanding the misplacing of the neologism.

The fifth example, the following one, presents an amusing variation on the same theme. It is also in surgery, with two people, mother and daughter, a doctor, and the nurse who explains the anecdote. This time there is a presentation that serves to introduce the medical problem in the direct voice of the patient. The switch to Spanish (L2) emphasises the theme of the visit even more. A background marker, "so you see", serves to warn us about the character of her daughter, present in the surgery, as the following rubric announces. The dialogue between the doctor and the patient follows immediately after, in Spanish in the narration. The doctor questions using a neutral expression in Spanish,

"windiness", but the woman changes to a probably euphemistic metaphor that suggests, by inversion, even more, the random and brusque character of her intestinal expansions. Note how the woman insists in the description, "well I've done some meteorites", although she denies a direct relationship with her medical problem. These lines are thus an excellent narrative to construct an alternative script about the clinical interview: the metaphor (the patient's descriptive lexis) may be original, but it is still not --by a long shot-- part of the problem that has to be explained to the doctor. Here is when the daughter intervenes, constructing the punch line, "don't be so fine, mum", appealing in first place to the mother's expression. At that point, it seems that the daughter, who has been presented to us some lines earlier as a "know-all", is prepared to solve the communication problems between the doctor and the patient. And butts in abruptly: "farts, woman, farts". Firstly, note the change of appellation, from the strictly co-operative "mum", to the openly supportive "woman". Last, but not least, there is the switch to the strictly colloquial. The narrative, thus, becomes an exercise in style in the medical surgery. From the doctor's "windiness", through the mother's brusque and metaphoric "meteorites", to the daughter's diaphanous translation. Observe how the daughter repeats "meteorites" before coming out with the end of the punch line. This last appearance of the metaphor is obviously ironic. I believe that, through this three-stage lexical reformulation, it is perfectly clear to see the movement from literal to metaphoric, from metaphoric to ironic, and from ironic back to literal again. Speakers encourage multiple processing through the dialogue. The last line goes from the mother's suggestive metaphor, which is funny in itself, to the ironic interpretation, repeating out of context. Finally, the last lexical switch inverts the earlier ("meteorites, what a way to talk!"), going back to reclaim the literal expression 'although it is a question of (and here humour is also found) a literal "patients" expression, thus opposed to the neutral expression of the doctor above. The three connected words 'necessary for textual cohesion' work on different states (including the intermediate, more suggestive, metaphor) on different interpretation processes, in accordance with the speakers' roles and their participation in the interaction. That is what we expected to see and find in humoristic narratives.

The following example that I would like to comment on is number two, the longest one, which, as a result, is narratively more complex. We now move from the surgery to a dialogue with a patient to ask for his confirmation for an operation, and from ordinary dialogue to special situation, because the patient's written consent for the treatment of a serious medical problem is in the balance. The narration revolves around a knowledge of statistics. Given its same social consideration, statistics are a bridge between specialised

knowledge and general knowledge, and thus, constitute a good context for facing up to the type of communicative problems in doctor-patient relationship. Here the presentation already contains two parts, one merely informative, "they had to change the mitral valve", and another evaluative, about the patient, "she wasn't all that- intelligent". The marker "so anyway" indicates the transition between the presentation and the reported doctor-patient dialogue. The dialogue, as is indicated, consists of "arguments" ("explaining why"): one of them, again introduced 'focalised-- by the marker "so anyway", is the argument of the statistics. These context markers situate the narrative and the elements of the script that will later be inverted. The narration continues reporting the dialogue indirectly, with discourse markers of resume, "ok, so then", with some change to the direct style and especially emphasising the utterance "help", "they can help". As we see, the narrator is in no hurry up to here. That serves as background to the joke itself; the polysemic marker "well", here introduces the precise description of the statistics, the "ninety-five percent" and the "five percent". The narrator states the reaction of the patient, "after thinking for a while", and changes to direct style: note the acceleration of delivery in the woman's question, "that of the five percent"; then it goes back to the indirect style, "we told her". These changes from direct to indirect style make the delay in the key of the joke possible, and allow a return to the main theme, the understanding of statistics as part of doctor-patient communication. If that is a process that requires time, the narrator also employs, coherently, time to give us the narrative key. That seems to be the value of the repetition of the numerical expressions, the "ninety-five percent" and the "five percent". We also note that two discourse markers, "well obviously, in the end" and "well look", falsely indicate the end of the narrative, they seem to repeat what we already knew in a different way. These markers work as a "misleading garden path", as we usually say. The last five lines are the resolution of the joke, five long lines coherent with the time that the narrator has taken for the presentation. They are preceded by some background information that had already appeared, "after thinking about it for a while", and from the conversational point of view, are the woman's most explicit answer, in all the narrative, to the doctor enquiries. The answer, effectively, appears framed with a "look, you know what, doctor", that expresses determination and security. All the earlier script has presented a doubting patient and with difficulties of comprehension, so that this ending surprises us by changing the script. Evidently, the answer contains an argumentation, a term used earlier in the indirect description of the value of statistics. Here we see the argumentation in progress, so that the two scripts, that of the doctor explaining, and the new one, of the patient, understanding, link up. But not linking exactly, observe the narrator's final cue, "how

people's minds work". The woman has understood that the statistics are about the real evolution of the patients, not an appreciation with predictive value. If it is about the real outcome for the patients, she could end up in the percentage of failures. If it has predictive value, there is nothing she can do. The woman's argument is a second script that inverts the previous script, and it feeds off all the jab lines that have appeared about understanding statistics. The joke is about argumentation and the communication of probabilities. That is why the final lines present an argumentative resolution, rightly introducing a new script. The woman could have argued the same simply to make a joke, and that would not change anything in our assessment of the narrative elements, the two scripts, and the multiple processing in the interpretation of the value of statistics. Note that the doctor's arguments about the value of statistics develop and become more explicit as the narration goes on. At first statistics help, help to decide; then they give more or less security, finally, after the "well, obviously, in the end / well, look", those percentages and "what they mean" are explained in some detail. This progression in the argumentation matches the resolution of the joke, which is principally argumentative. In as far as the possible death of the patient arises as a lateral theme in the joke, clearly towards the end of the narration, the joke's semantic and pragmatic value grows and it can be used as an explanation for areas of meaning where explanations are difficult to obtain.

The next two that I want to comment on, numbers three and six, are typical cases of therapeutic humour. The first, about a patient who takes a pill before breakfast and once in the hospital and with the drip, insists on the pill as a requisite for breakfast. The anecdote is preceded by a value judgement by the narrator; "this one is a good one". As in the other examples, the key of the joke is delivered through the dialogue, after a contextual presentation ("then he gets here"). The dialogue is structured around the patient's request for the pill. It is a rapid dialogue in which the nurse gives an explanation and the patient rejects it. Note the nurse's "sorry but", followed by an explanation with "because", and the patient's reply with "that's fine but", repeating the previous rubric. The key line is really the last four words, added as a complementary explanation to the request. A fast ending for a fast dialogue. The last four words introduce another causative script --the metonymic relationship between the pill and the breakfast-- that contrasts with the script about medication delivered up to then. The introduction of breakfast into the script about medication, drips and treatment also inverts the narrative frame and forces the metonymic interpretation to which I have just referred. All that complicates the interpretative framework and certainly makes the stay in hospital less cautious and worrying.

Example six, in Spanish (you will read "Castillian" in the handout), presents a more elaborated variation of a similar use of therapeutic humour. Here the narrator openly declares that it is an intended joke and that it has a therapeutic aim, "to break the ice", the well-known expression about the steps towards a more comfortable relationship. Then the narrative mode properly speaking begins, which has been preceded by a communicative contextualisation: the speaker switches to the second person singular ("you get there"), typical of a generic narration ("hello, so-and so"), and gives us the situational context, "when she is in bed, you ask her". The next step is the switch to direct reported dialogue between the doctor, the nurses and the patient, a dialogue that lasts just long enough to appear normal and cordial (in reality, calming): "we're going to leave this knee as good as new". But it is not the knee: the familiarity begins to transmit surprise. The narrator portrays the fright: "listen\_ listen\_", these markers alert us about the change of course in the script. The real punch line concludes when the patient points to the new object of the operation, "the nose", the "septoplastia" mentioned before. The narrator then signals the end of the anecdote (the laugh), going back to the first person, with conclusion and resume markers, "so anyway, obviously", and "ok", and ends with a conclusion that justifies the beginning, "then the girl relaxes". Introducing confusion, as is openly explained here, leads us to contemplate the situation differently. The complication of the first script --that of the confidence and the knee-- with the alternative script'that of the surprise and the nose'does not make communication more difficult but rather facilitates it. Participants are invited to enter into this complex interpretation. As I have said, calmness ends up transmitting mistrust 'and this incoherence begs for a comic resolution. I believe that here it is quite clear how complication can be a stimulant for changing the scene in which the interaction develops. Like before, the multiplication of perspectives --produced in the same conversation, we must remember' is a useful tool: it is a way for transmitting confidence in the basic relationship between the patient and the doctor. Inversion and ambiguity serve that object: that is why, after the punch line, we can understand the sentence "we're going to leave this knee as good as new" as ironic. If, in the previous example, a pill and breakfast were the elements that established metonymic relationship, blurring the frontiers between food and medication, here it is the body that is redesigned. It doesn't matter if the doctors operate on her knee, or perhaps her nose, it is a question of a part, a segment, no matter whether it is an upper part or a lower part.

Example seven also situates the design of the body in the foreground. A body that has to be pricked, without removing the wedding dress. There is no dialogue in that example, because the narrator mainly concentrates on description; the example begins with the

canonic narrative form, "once", and continues with various locative specifications, "being on duty", and "in the emergency area ("A & E")". The marker "what happened was" introduces a narrative digression situating us in the medical cause of the visit, specifically situating us in the church at the moment of the wedding ("at the altar", "in front of the priest"). The lively description of the moment when the migraines appear are accompanied by the narrator's repeated and emotive evaluations, "with such bad luck" / "so unluckily", which make up a good narrative frame for the resolution of the anecdote. The digression ends with an appellative that signals the change of frame, "man", and a resuming sentence, "they couldn't finish the ceremony". With that we enter the second part of the narration, and return to the emergency room: the narrator switches to medical language, "a couple of intramuscular injections", but, obviously, there is a bride lying on the stretcher. Here the narrator is especially elliptic, he simply says "that was a bit of a to-do", and accompanies this presentation with various discursive markers (such as "for God's sake", an indicator of surprise). This utterance, "that was a bit of a to-do", gives way to the last descriptive fragment, that of the manipulation of the body with the dress --without, prudently, going into too many details. The punch line is indicated by the laughter of the narrator, who collaborated in the manipulation of the body with the dress. As it is an incident experienced in the first person, the same narrator can indicate the comic moment, which is the one that affected her most directly. I believe that this first person laugh, as we could say, is a narrative cue that focuses the key of the joke, the nurse holding a piece of cloth, "me holding up another piece of cloth, and the train". A nurse holding the train of a wedding dress challenges our imagination about what is a sick body. It also challenges our tacit design of what is a body ready for medical inspection, in the way in which it presents the immaculate wedding dress as something incorporated into the bodily architecture, in some way untouchable. A body is not a dress. The doctors have to be able to do their work. In theory a nurse, although dressed in white, has no relationship with the white train of the wedding dress. All this explains the collision of scripts. The first part, centred in the church, informs us of the appearance of the migraines, of the sickness, of the cause of the urgent visit. The wedding and the dress are in the background. In the second part, especially after the marker "for God's sake" focusing on the finale, the work of the nurses, and the illness, are in the background, the dress, and the train, are brought to the fore. Our elliptic narrator has a good control over the information that he wants to highlight to achieve the comic effect in each case.

Example eight is about a nurse new to the work. The narrator refers to her as "that one / that girl", a colloquial / familiar demonstrative that serves both for opening and closing the

narration. The first two lines are dedicated to informing us about the new nurse and, indirectly, about the place she finds herself in, Maternity. The pronoun "we" opens a series of enunciations about the nurses' mission, including the new nurse, the actual, and the nurses that will come in the plural: "we" introduces a generalisation about the work, which is the background or the joke's jab line. The narration progresses by returning to the demonstrative singular ("that one / that girl"), and the particular story of the apprentice. In which a patient "who was in labour" arrives 'here the patient is not the cause of the story, as in other anecdotes, but rather the person who accelerates it. A series of discursive markers, including the change to direct discourse on two occasions, gives an idea of the urgency of the birth and accelerates the narration: "quick", "just in time", "come here". There is also an elocutive acceleration in an exclusively narrative line, "and the woman calls from the room". All this tells us that some kind of incident is imminent. In direct style, the patient shouts to the nurse, "Oh, come here, quick", and here the narrator crosses the narration with a "guess what", a discursive marker of warning for the listener. Once again we have an elocutive acceleration to narrate the birth and then comes the punch line, the last three words. It is here where the script changes radically. It is not the woman in labour who is in a hurry. "That one / that girl", the familiar demonstrative that had opened the narration, here introduces the change of narrative voice, without other performative verbs. At the end, two shouts, in loud voice: the nurse asks for help. The cues that the narrator was offering were ambivalent. They allowed us to read both from the point of view of the urgency of the labour (and the diligence of the nurse), and from the specific adventure of that new girl who is overwhelmed by the circumstances. The resolution of the joke displays a radical inversion. The nurse who, according to the canon established by the narrator, had to help, asks for urgent help. "Help" indicates, effectively, an emergency. But it is the person who is asking for it who had to be helped. I believe that there is no problem here to recognise the two opposing scripts, produced by the multiple interpretation of the last two words. We know that irony often consists of adjudicating the words of a first speaker to a second speaker. Through narration we can see how this is achieved in some detail, how two possible participants could fight for an expression, and how the same expression would be literal for one and ironic for another. It is interesting to note, as in previous examples, that that process occurs within a narrative, where the punch line is often in the form of a dialogue, a reply, or a direct intervention. The role of conversation as a form of contextualisation of the discourse 'here, of the humoristic discourse' seems important, and as long as we go on studying and examining this kind of data we will go on perfecting our systems of explanation.

I am finishing. There are many jokes about doctors, some good, and very many of them bad. If a joke is good it means that it has connected with the discourses that have preceded it and with the interests and the values relevant in that moment to the participants in the interaction. Here "good" means that it manages more resonance, that it gets more out of the ambiguity. A nurse more worried than a woman in labour is an inversion of values, susceptible to enter in the the-first-day jokes. I have illustrated above the importance of coherence. Dangerous situations demand risky jokes. The professional's jokes warn about circumstances in the profession. The implicit about the body fit in well with the kind of manipulation with which doctors and nurses have to work. As more implications the scripts that are mixed create, the further the joke goes and more meaning will be created. The traditional competence, explained in some jokes, between doctors and priests for the last rites to the sick, is a good semi-dramatic example of that creation of meaning. As we have seen in our narratives, ambiguity provides the necessary leeway to make the situation more comfortable, more tolerable. That game is constructed through conversation. The narrative cues are part of the conversational contextualisation and they orientate towards the humoristic interpretation. I believe that there is no doubt that, to the extent that they form part of our day-to-day activity, these practices are useful for us and shine a light on sides of our experience.

Thank you very much.

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de Lleida.

## ADDENDA

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Arribat a la clínica Corachán, hi vaig entrar també pels meus propis peus. Després l'ascensor m'hissà fins al sisè pis: secció més aviat delicada --de la qual no recordo el nom tècnic --tècnic!-- però és igual. De seguida em semblà que hi havia una disciplina considerable. (...) Al cap de tres o quatre dies de disciplina el progrés havia estat notori. El cor havia reposat i el treball de desintoxicació havia estat molt visible. Setanta-cinc anys d'intoxicació són considerables. Cinc o sis dies després d'haver entrat a la clínica, les minifaldilles de les infermeres em sorprengueren agradablement. Hauria pogut gairebé afirmar que la meva curació anava endavant.

*Un infart de miocardi*, J. Pla,  
537-538

*On arriving at the Corachán clinic, I entered under my own steam. Then the lift whisked me to the sixth floor: a rather delicate section --whose technical --technical!-- name I don't recall, but that doesn't matter. It immediately seemed to me that there was considerable discipline. (...) After three or four days of discipline I had made notable progress. My heart had rested and the work of disintoxication had been highly visible. Sixty-five years of intoxication are a lot. Five or six days after entering the clinic, the nurses' miniskirts surprised me agreeably. I could almost have said that I was on the road to recovery.*

.....

**Diafoirus:** Avec la permission aussi de monsieur, je vous invite à venir voir l'◆un des ces jours, pour vous divertir, la dissection d'◆une femme, sur quoi je dois raisonner.

**Toinette:** Le divertissement sera agréable. Il y en a qui donnent la comédie à leurs maîtresses, mais donner une dissection est quelque chose plus galant.

*Le Malade Imaginaire*,  
Molière, Acte II, Scène V

.....

"Doctor, when I get up in the morning I feel sick for at least half an hour, after that I feel better"; and the doctor responds: "Well, get up half an hour later".

*The Philogelos or Laughter-Lover*, B. Baldwin (ed.),  
Amsterdam, 1982; quoted by J. Bremmer, in J. Bremmer &  
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