

The Butt of the Joke

Humour and Queer Care at an Anal Dysplasia Clinic

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Abstract

Based on 12 months of ethnographic fieldwork I conducted at an anal cancer prevention clinic in Chicago, USA, this article considers queer camp humour as a care practice to better understand how providers and patients navigate clinical interactions centred around a stigmatised disease in a taboo body part. Humorous moments infused daily life at the clinic, and I came to see them as a critical feature of the clinic's uniquely queer environment and a central aspect of the staff's queer care practices. I argue the campy queer style of humour in the clinic was a vital tool for providing culturally appropriate care, and describe how humour mediated patient-provider interactions, had palliative effects, and managed dirt and bodily excess. The article concludes with a brief discussion of the importance of anthropological attention to humour and joking as forms of care.

Keywords

Humour, Queer care, Anal cancer, HPV, LGBTQ health, Clinical ethnography.

Introduction

'Vince?' I called out into the waiting room as I pushed the hallway door open. A figure stood up and tossed a magazine back on the table. He looked younger than I expected for someone in his fifties. 'Come on back,' I said as I held the hallway door open for him.

Vince was a gay Latino cisgender man who had come to the clinic to undergo an anal cancer prevention procedure. He was wearing a white sleeveless undershirt, and a bedazzled white and black bandana wrapped around his shiny bald head. His black jeans, also bedazzled, sported a long silver wallet chain that jingled loudly as he walked toward me. A pair of silver aviator sunglasses covered his eyes despite being indoors, and I noticed a small teardrop tattoo under the corner of his left eye as he passed by me. He walked down the hallway toward the exam room with swagger and a swish.

Chatty and outgoing, Vince's humorous demeanour lasted his entire visit. As I collected his weight and vital signs, he joked about having gained a little bit of weight and patted his tummy: 'but my husband likes me a little chunky.' While taking his blood pressure, he facetiously asked if I heard anything interesting as I listened through the stethoscope. Each clinical activity elicited some kind of sarcastic, flippant, or otherwise humorous comment.

After collecting his bodily details, I left him in the exam room for Erick, a straight Latino cisgender man and the clinic's research coordinator, to collect blood samples. I returned to my desk and updated Vince's electronic medical record with the information I had collected. A few minutes later, Erick came into the office and sat down at his neighbouring desk.

'His bandana is weird. It was all bedazzled. Haven't seen that before.'

'Why is it weird?' I asked.

'I don't know,' Erick replied in a meek tone.

I jokingly retorted, '*Cholos* can be gay, too, Erick!'¹

He laughed. 'Yeah, I guess you're right.'

Several minutes later, Noah, a physician's assistant who was a gay white cisgender man in his late thirties, asked me to assist with the procedure. During

1 'Cholo' is a slang term referring to an urban Chicano/Mexican-American aesthetic, usually associated with a particular clothing ensemble that includes a white ribbed tank-top shirt under plaid flannel, baggy pants, sneakers/trainers, and head bands. This was how Vince was dressed, except he added campy features to his clothing.

the exam, Vince exuded an over-the-top campy personality. He was inquisitive and loquacious, talking loudly about anything and everything that came to mind. He wore his aviators the entire time. At one point, he asked for more details about my project, and I gave them and mentioned I was looking for patients to interview.

‘Would you be interested?’ I asked.

‘Oh, hell yeah!’ he exclaimed enthusiastically. ‘I’ll be great at it. I’m very talkative and have a lot to say!’

‘I can tell,’ I teased with a hint of sarcasm. ‘I’ll add you to my list and contact you soon’.

After the exam, as Noah and I were leaving the room, I heard Vince say to Noah, ‘Tell him to stay!’

‘Oh, do you have a question for him?’ Noah asked. Halfway out of the room, I turned to look back at Vince from the doorway, curious about why he wanted my attention.

After a moment of awkward silence, he smiled deviously. ‘Nah, I’m just playing!’ He let out a boisterous laugh.

Confused, I smiled uncomfortably and continued out of the room. Noah followed, closing the door behind him. Down the hallway in the lab, I asked Noah, ‘What was that about?’

‘Oh, he was flirting with you. I think you’re his type: tall, bald, and bearded.’

This being my second week in the clinic, I chuckled at the thought that a patient would flirt with medical staff, naively unaware of how often I would experience similar events in the coming year.

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This Research Article considers humour as a care practice. More specifically, I examine a particular style of humour—camp humour—that was remarkably ordinary during my fieldwork at an anal cancer prevention clinic in Chicago, USA. Within the first few weeks there, I was struck by the amount of humour and joking in the clinic. Humorous moments infused daily life at the clinic, and it was impossible to document all of it. I analyse the campy humour at the clinic to discuss how providers and patients navigate clinical interactions centred around a stigmatised disease (anal cancer) in a taboo body part (the anus). I came to see the campy humour that occurred every day at the clinic as a critical feature of the

clinic's uniquely queer environment and a central aspect of the staff's care practices.

I begin with a description of the setting and methods to help situate my findings. I then review relevant scholarship on humour and healthcare, highlighting anthropological studies of humour and care, humour in biomedical contexts, and camp humour. Next, I analyse three effects of humour in the clinic: it mediated patient-provider interactions, had palliative effects, and managed dirt (Douglas [1966] 2002) and bodily excess. I conclude with a call for more anthropological attention to humour and joking as forms of care. Throughout this article, I argue that not only is humour an important component of the delivery of care, but that culturally specific styles of humour can further develop relations of care within relevant contexts. Here, a campy queer style of humour was a vital tool for providing culturally appropriate care for queer and trans people undergoing procedures fraught with stigma and taboo, and it was that specific style of humour that led to a deepening of care relations within this specific clinical context.

Setting and methods

This article is based on 12 months (June 2018–May 2019) of ethnographic fieldwork at Anal Dysplasia Clinic MidWest (ADC), located in the affluent Lincoln Park neighbourhood of Chicago. ADC is a for-profit clinic privately owned and operated by Dr Gary Bucher, a gay white cisgender man in his mid-fifties. During my fieldwork, there were six staff members in addition to Dr Bucher at ADC: Noah (physician's assistant; described in the opening), Brad (physician's assistant; gay white cisgender man in his mid-twenties), Cynthia (registered medical assistant; straight black cisgender woman in her early fifties),² Erick (clinical research coordinator; described above), Keith (receptionist; gay white cisgender man in his late forties), and Arminius (office/business manager; gay white cisgender man in his mid-fifties). To situate myself, I am a queer white male-presenting nonbinary person in my late thirties at the time of fieldwork.

The clinic and staff's first names have *not* been anonymised for a few reasons. First, at the beginning of my fieldwork Dr Bucher requested I use the clinic's actual name, and I confirmed this decision with him before I left the clinic. None of the staff opted to use pseudonyms; I only use their first names so that if people search online for them, their names and participation in my project do not come up. Second, ADC is the only clinic in the region that offers these specialised procedures and is easily identifiable. And, most importantly, Dr Bucher and the staff are proud of their work, active in the community, and publicly advertise their

2 Cynthia identified as straight during my fieldwork; however, about a year after I finished fieldwork she began dating a woman, to whom she is now married. She's identified here using her self-described identity at the time of data collection because it impacted our conversations as described in this article.

services all over Chicago, so they felt no need to conceal their identities and in fact see this as a way to fight stigma toward anal-sexual healthcare.

Patient names, however, are pseudonyms. A few patients granted permission to use their real names, but I have opted to still use pseudonyms to protect confidentiality. All the patients described here were middle-aged, ranging from mid-forties to mid-sixties. For each patient I note some particular identity categories (race/ethnicity, gender, and sexual orientation) because these were the categories most often used by clinicians and patients during my fieldwork. These categorical labels were self-ascribed, usually pulled from medical charts or elicited in medical histories, though when they were unclear, I asked people about their identities. I include these identity descriptions to note the varying intersectionalities and preserve a more accurate (if superficial) mental picture of who the patient participants were. Other factors such as socioeconomic status, education level, and disability certainly shaped clinical activity in many ways, but they were less obviously relevant in the moments I describe.

I spent my time in the clinic working as a medical assistant and as a research assistant for the ANCHOR study, a national longitudinal anal cancer prevention clinical trial.³ Patients were informed of my double role as a clinic assistant and as an anthropological researcher and were asked for consent for me to observe their interactions with care providers. My clinical duties included assisting the clinicians during procedures, processing specimens in the lab, data entry, consenting patients into the ANCHOR trial, doing retention calls with study participants, and maintaining exam rooms. In addition to participant observation, I conducted 35 interviews with the clinic staff and several patients.

There were three reasons why patients made appointments at ADC: they encountered advertising about the ANCHOR study, were referred by another clinician, or experienced symptoms. Patients came from all over the city. Most did not live in Lincoln Park. A few travelled from the suburbs and even fewer from out of town. Patients were of diverse socioeconomic status, though most were working- or middle-class. Payment for services differed depending on patient status: for example, patients not involved in ANCHOR were required to pay for care services through insurance or out-of-pocket, while ANCHOR participants did not pay anything and were in fact paid incentives when they visited the clinic. According to the clinic's metrics, 70% of the patients at the clinic were white, 28% were black, 2% were Latin/Hispanic, and less than 1% identified as another racial category.

3 For more information on the ANCHOR study, see: <https://anchorstudy.org/>.

Anal cancer

ADC specialises in a highly technical procedure called High Resolution Anoscopy (HRA), which is used to detect pre-cancerous lesions (known as dysplasia) and cancer in the anal canal. Anal dysplasia is caused by human papillomavirus (HPV), the same virus that can cause cervical cancer. During the procedure, patients remove their trousers and underwear and lie on their left side with knees pulled up toward their chest and both feet resting on a single stirrup, giving access for the care provider. The HRA procedure involves inserting a small plastic anoscope into the anal canal (only about the last 3–8 cm of the gastrointestinal tract), which the provider can view through a magnifying camera. The patient can also see the procedure on a nearby computer monitor. Any patient in whom cancer is detected is referred to surgery and/or oncology—ADC clinicians do not treat cancer, though they do treat pre-cancerous dysplasia. Additionally, the clinic provides HPV vaccinations and tests for other anal infections (e.g., chlamydia and gonorrhoea).

Anal cancer is a drastically understudied health equity issue that disparately impacts LGBTQ+ people, especially those living with HIV. According to the National Cancer Institute (2022), anal cancer incidence rates in the general US population have been steadily increasing over the past 40 years, having doubled since 1980 from 1 to 2 per 100,000. While anal cancer remains a rare form of cancer, LGBTQ+ people make up a disproportionate number of cases diagnosed. For example, among HIV-positive men who have sex with men (MSM), the incidence rate is estimated to be 85 per 100,000, in contrast with the estimated 19 per 100,000 among HIV-negative MSM (Clifford et al. 2021). Accordingly, over 90% of patients at ADC are members of the LGBTQ+ community, per the clinic's metrics.

Humour, care, and medicine

Humour and joking provide profound insights into people's lives and worldviews. Anthropologists have been interested in humour since the beginning of the discipline (e.g., Mauss [1928] 2013), though the first in-depth cross-cultural study of humour emerged in the 1980s (Apte 1985). Of special relevance here is Mary Douglas' consideration of humour, that emerged in tandem with her theory of dirt, which she argued is 'like an inverted form of humour' ([1966] 2002, 151). Douglas (1968) pushed philosophical and psychoanalytical theories of joking beyond individualistic perceptions of particular utterances. She advocated for more attention to the social dimensions of humour, laying out a theory of jokes as 'anti-rites' with disorganising effects that 'denigrate and devalue' (369) dominant norms and values—a point that dovetails with the queer styles of camp humour I discuss later.

Donna Goldstein (2003) clearly demonstrates the value of using humour as an organising thread to study race, class, and sexuality. She began fieldwork in the shantytowns of Rio de Janeiro, Brazil, expecting to write straightforward analyses of transnationalism, the state, and urban poverty. But as she immersed herself in daily life of Rio, she noticed laughter was ubiquitous. She notes how this humour felt ‘oddly familiar’ because it shared an aesthetic with the Jewish humour she grew up with. She describes these kinds of humour as ‘rendered darkly through the glass of their collective experience, mask[ing] a certain loss of innocence’ (2003, 3). Like Goldstein, I did not consider the importance of humour before going into the field, but it was an immediately obvious—and familiar—feature of everyday life at ADC. However, I do not use humour as a central organising force in my project but as one way to better understand the fundamental issue of care.

Over the last two decades, medical anthropologists have become increasingly interested in care as an analytical framework, conceptualising care as a relational practice. Annemarie Mol (2008) developed a practice-oriented theory of care that attends to issues of embodiment, labour, and relationality. Along with Ingunn Moser and Jeannette Pols, Mol proposes the idea of ‘tinkering’ (Mol, Moser, and Pols 2010) to examine the flexible, experimental, and adaptive aspects of care in practice. Other anthropologists, following Arthur Kleinman (2013, 2015), have emphasised the affective and ethical dimensions of care. Recent anthropological work on care underscores important issues of gender, race/ethnicity, class, age, ritual, and geography (e.g., Stevenson 2013; Plemons 2017; Yarris 2017; Buch 2018; Aulino 2019). My own work (Robertson 2021) aims to push anthropological attention to care beyond its common heteronormative assumptions, which often ignore or marginalise queer and trans subjectivities and experiences. I see the (campy) humour at ADC as such a tinkering practice, one that enabled the providers to engage in affirming care practices that reflected patients’ affective, ethical, and aesthetic values back to them, which had a variety of effects on patients.

Much of the general literature on health and humour is aimed at medical audiences. It lacks theoretical depth and instead offers descriptive findings and/or normative guidance for clinical practice. Humour in patient-provider interactions, a commonly studied topic, reportedly has a range of effects on patient-provider interactions, including increasing provider empathy toward patients (Berger, Coulehan, and Belling 2004; Scholl and Ragan 2003; Scholl 2007) or increasing social distance by emphasising the asymmetrical social status of patients and providers (West 1984). Humour has been shown to increase social cohesion (Yoels and Clair 1995) and patient satisfaction (Wrench and Booth-Butterfield 2003; Sala, Krupat, and Roter 2002), though some scholars warn of potential harms resulting from poor use of humour (Francis, Monahan, and Berger 1999;

Proyer and Rodden 2020; Piemonte and Abreu 2020; Hardy 2020). There have been mixed findings on the impact of gender on medical humour, showing both positive and negative effects (Squier 1995; Sala, Krupat, and Roter 2002; Granek-Catarivas et al. 2005). For instance, humour has also been a strategy for desexualising patient-provider encounters (Giuffre and Williams 2000). A further small body of scholarship examines the palliative effects of humour, describing how it increases comfort and decreases pain and can have positive benefits for patients' relatives and medical professionals (Livingston 2012; Linge-Dahl 2018; Pinna et al. 2018). Further, humour can function as a coping mechanism among both patients and providers, especially in emotionally fraught circumstances (Inêz, José, and Capelas 2018; Issler 2016; Rosenberg 1989; Dueñas, Kirkness, and Finn 2020; Wear et al. 2006).

Anthropology lacks a significant examination of the interactions of health, humour, and medicine (cf. Burson-Tolpin 1988; Evans 2009; Livingston 2012; Wright 2018), while sociological research on humour in clinical contexts dates to the mid-20th century (Cosser 1959, 1960; Emerson 1963). Social theory around humour has mostly been published in social science or humanities venues rather than medical journals, and it tends to focus on psychological, psychometric, or communicative issues. Medical anthropologists have a unique opportunity to contribute to this literature by providing deep, cross-cultural, theoretically rich ethnographic accounts of everyday uses of humour in medicine. This article calls for more medical anthropological attention and theorising around humour and joking as important aspects of care, and advocates for attention to the culturally specific styles of care that enrich relations and practices of care.

Camp: Queer(ing) humour

Before turning specifically to camp humour, I want to briefly discuss the term *queer*. The concept is notoriously slippery and has been the subject of endless debate in and out of academia. Staying true to this lubricious history, I use 'queer' as both a practical analytical tool and an umbrella term for non-(hetero)normative gender and sexual identities. Queer theory emerged in the early 1990s as an analytical approach for deconstructing heteronormativity and exposing the hegemonic and naturalised workings of 'heterosexual culture' (Berlant and Warner 1998). Under this rubric, 'to queer' means to question and challenge dominant discourses of gender and sexuality that treat cisgender heterosexual subjectivities as the natural default for human beings. 'Queer' has been extended beyond its explicitly sexual origins to refer to different kinds of anti-normative analytical practices, and it is this anti-normativity that 'queer' has remains closely associated with (Sedgwick 1993; Freeman 2010; Weiss 2016).

During my fieldwork, queer styles of humour permeated the clinic. It was an ‘oddly familiar’ (Goldstein 2003) aesthetic because my prior immersion in queer culture gave me fluency with it. Learning ‘how to be queer’ (Halperin 2012) in my early twenties involved picking up the linguistic repertoires of other queer people, especially regarding styles of humour and how to appropriately make cultural references. I did not struggle with the outrageous, shady, irreverent, or catty comments made in the clinic because I recognised them as a markedly queer style of humour to which I am accustomed: camp.

Camp is a term with a contentious and sordid history, the meaning of which—much like ‘queer’—is disputed. Camp originated as a gay survival mechanism (Newton 1972; Core 1984; Bergman 1993; Meyer 1994; Medhurst 1997; Cleto 1999; Halperin 2012) and is associated with an ironic aesthetic that queers heteronormative sensibilities. Susan Sontag’s (1964) widely cited essay ‘Notes on Camp’ brought camp to mainstream attention. Her account of camp erases its queer origins however and situates it instead as a bohemian sensibility of playfulness that unsettled hierarchies and promoted enjoyment of under- or unappreciated aesthetics (Medhurst 1997). The essay is still considered a canonical description of camp, though it has been subjected to both reparative and paranoid (Sedgwick 2003) critiques (Medhurst 1997; see also Newton 1972; Core 1984; Bergman 1993; Meyer 1994; Cleto 1999; Hotz-Davies, Vogt, and Bergmann 2018).

Although camp remains a significantly understudied topic among anthropologists (for examples of anthropological attention to camp, see van de Port 2012; Schnepf 2020), its presence in the discipline stretches back 50 years. In her classic ethnography of drag queens (considered the first ethnographic study of a queer community), Esther Newton (1972) argued camp ‘signifies a *relationship between things, people, and activities or qualities, and homosexuality*’ (105, original emphasis). She posited three aspects of camp: incongruity, theatricality, and humour. Incongruity refers to the absurd or ridiculous. Newton explained that camp is created either by pointing to or creating incongruity, especially through juxtaposition. Theatricality refers to those aspects of camp involving incongruous and over-the-top styles, forms, and roleplay (as exhibited by Vince’s clothing and comportment described in this article’s opening vignette). Humour, for Newton, means that ‘camp is for fun; the aim of camp is to make an audience laugh’ (109). Camp is thus ultimately a system of humour that involves ‘laughing at one’s incongruous position instead of crying. That is, the humour does not cover up, it transforms’ (Ibid.). It is exactly this transformative energy of camp that enables it to work as a caring practice at ADC.

Cultural Studies scholar Andy Medhurst describes camp as a gay male sensibility that ‘is a configuration of taste codes and a declaration of effeminate intent ... [that]

revels in exaggeration, theatricality, parody and bitching. It both vigorously undermines and rigorously reinscribes traditional gender roles ... Camp is not an entity but a relationship—a relationship between queens and their circumstances’ (1997, 276). Some examples of camp include drag (a form of artistic expression that parodies gender normativities and cultural extravagance); John Waters movies like *Pink Flamingos* (1972) and *Hairspray* (1988) (that revel in ‘bad taste’ and deviance); the quasi-religious canonisation of gay icons like Madonna, Whitney Houston, Lady Gaga, and Nicki Minaj; and the use of queer/trans-specific linguistic and gestural tools such as emphasising an overly affectatious feminine tone, wagging a finger in the air to express approval, or winking wryly to evoke a sense of playfulness (Schnepf 2020).

Today, camp is less associated with a specifically gay male sensibility and more grounded in a broader queer/trans cultural milieu. Yet, camp retains many of its original key identifying features: a ‘weapon of the weak’ (Scott 1985) that helps trans/queer people cope with living in a heteronormative society; a celebration of bawdy humour, absurdity, and parody; a method of challenging rigidity and tradition, especially concerning gender and sexuality; an aesthetic of playfulness and nonconformity; a prizing of ‘bad taste’; and an ‘unexpected simultaneity of glitter and grime’ (Hotz-Davies, Vogt, and Bergmann 2018, 2). At its core, camp humour revels in excess, farce, frivolity, and irreverence. Camp remains a quintessentially queer phenomenon given its impetus to question and make fun of normative cultural values and practices.

Two aspects of camp are especially relevant to my analysis. First is the issue of taste, particularly the idea of ‘bad taste’. Bourdieu (1984) elaborates ‘taste’ as a form of cultural capital based in class, a mode of consumption grounded in specific hegemonic cultural logics concerning aesthetic preferences. Taste, Bourdieu argues, is a source of distinction, enabling people to classify themselves and others. Camp, as a ‘configuration of taste codes’ (Medhurst 1997, 276), queers such classifications and works to subvert their naturalisation. The ‘good taste of bad taste’ (Sontag 1964, no. 54) associated with camp stems from its mode as a form of resistance to such distinctions, but it also works to reinscribe new (queer) distinctions. Much of the humour in the clinic subverts ideas about what kinds of humour are ‘appropriate’ for work and/or medical environments. Indeed, some of the humour I encountered and engaged in would be considered ‘bad taste’ in most medical or work environments.

The other relevant aspect of camp is its celebration of dirt (Douglas [1966] 2002). This is an underexamined area of camp humour because scholarship on camp often emphasises glamour (e.g., drag queen culture) rather than the abject. However, dirt is a fundamental aspect of camp. Drawing on Douglas ([1966] 2002),

Hotz-Davies argues that ‘homosexuality, within a system of meanings which has decided to make [the] distinction [of differing types of sexuality], would be sex in the wrong place both in terms of its object and of the body parts involved’ (2018, 20). Camp’s celebration of the queer, the marginalised, and the absurd subverts the cultural valorisation of heterosexuality. This heteronormative artifice was often the butt of the joke in the humorous discourses at ADC, which worked to manage dirt in an effort to destigmatise anal healthcare.

Humour in an Anal Dysplasia Clinic

In what follows, I discuss three important ways humour and joking played out at ADC: it mediated patient-provider interactions, had palliative effects, and managed dirt. Across these contexts, camp was an important aspect of the clinic’s care practices, working to resist stigma, create a queer/trans-affirming space, and disrupt/reinscribe notions of appropriate humour.

Patient-provider interactions

The care providers differed on how important humour was for their engagements with patients. Each had a unique humour style that was consistent among both patients and staff, but there was less inhibition when only staff was present. Further, each provider had a slightly different view of the role of humour in patient-provider relationships, but all of them spoke about how humour helped build rapport with patients when used properly rather than indiscriminately.

Noah, for example, told me, ‘when things are awkward or uncomfortable, most people’s natural response is to laugh about it’. Humour was an important part of his rapport-building toolkit, and his go-to style was self-deprecating jokes. I regularly witnessed Noah blame things like difficulty inserting the scope on his own ‘lack of strength’ rather than making patients feel as if their bodies were misbehaving. He explained:

I feel like it helps people—because [patients] feel vulnerable, right? So, with people who don’t like feeling vulnerable, if I can sense that, I talk about my size, or how skinny I am, or how I’m not strong. Or I’ll talk about how I have skinny fingers so it’s not that uncomfortable. Those are all *jokes*, but they’re effective to make you relatable.

Noah reasoned that when the provider is more relatable, patients will feel more comfortable. Noah enjoyed joking with patients. Compared to the other clinicians, he ‘tinkered’ (Mol, Moser, and Pols 2010) with his humour styles more because he tried to reflect patient personalities. If patients were sarcastic, Noah would become more sarcastic; if they were goofy, he would become goofier. Mirroring patient

humour styles helped Noah bring levity to the awkwardness created by the nature of the procedure.

So much of the humour I witnessed and engaged in with staff and patients was familiar to my own queer sensibilities. Its content and tone varied (sometimes quite rapidly) between bitchy, shady, irreverent, affectatious, and ironic. I easily fell into the campy humorous stylings at ADC. In contrast, Cynthia explained that she was uncomfortable with it when she was first hired. However, she came to recognise how important such humour was to good care:

You're dealing with a population of people who have had to keep secrets their entire lives, since forever, about a lot of things. And this is an environment where they can talk about that stuff. So, some patients that I've noticed *can't wait* to get to clinic so they can joke about certain things. And it would be a shame if I was such a creep or an asshole that I took that from them because ... it ain't that serious, right? Sometimes I join in, I ain't gonna lie. But at first, that was the hardest thing for me because I was really trying to understand why this was the norm here at this clinic. Then I had a patient tell me that he couldn't wait for his appointments every six months so that he could come and laugh and talk with us.

Like many people, Cynthia considered medical environments to be serious spaces, so the sheer amount of humour—let alone the queer aspects of humour she was unaccustomed to—took time to adjust to. She recognised her role in creating a space of queer-affirming care by letting patients be themselves and joke openly about their sexualities. She still occasionally felt uncomfortable with some of the queer humour, particularly when it was more sexually explicit, but she nonetheless frequently used humour with patients and regularly engaged in theatrical, boisterous joking. Usually, the reason I knew Cynthia was joking with patients was because I could hear her laughter from down the hallway. And while she lacked familiarity with queer humour styles, she had different kinds of cultural capital others in the clinic lacked.

Cynthia was the only woman, only black person, and only one of two straight people (the other being Erick) working at the clinic during my fieldwork. Further, she spent her life in black working-class neighbourhoods in Chicago, and she was the only member of the staff who did not live in one of the more affluent areas of Chicago. A significant number of patients came to the clinic because of Cynthia's word-of-mouth advertising in her community. These aspects of Cynthia's life, certainly marginalising in many ways, in this context enabled her to use humour in ways the other providers could not. Her cultural capital was a vitally important aspect of patient satisfaction at the clinic.

An illustrative example of Cynthia initiating humour with patients comes to mind. Right after a procedure, Cynthia told the black gay cisgender male patient that she had left a piece of gauze on his pants to tuck between his buttocks in case there was any bleeding. He joked that Noah and Cynthia were making him have his (menstrual) period again, and Cynthia retorted, 'Well, we're giving you a pad!' The patient laughed and then said to me, 'Whenever I come here, I get a period for a couple of days,' referring to the light bleeding some people experience after getting biopsies. Cynthia interjected sardonically, 'Just be glad it's not the real thing!' This example of camp humour highlights rapport-building based on the 'bad taste' of joking that juxtaposes (Newton 1972) bleeding from the anus with menstruation, in a way marking the bleeding experienced by a cisgender gay man as feminine.

I did witness a lot of campy joking between queer/trans people of colour and the white queer providers that Cynthia did not participate in (the above example being one notable exception). However, she could engage in humorous (and other) discourses the male, white, and more affluent staff could not. Noah recognised these facts and emphasised how important Cynthia's presence was in helping black patients have the most affirming experiences possible.⁴ I sometimes heard her joking with working-class black patients about experiences living in areas of Chicago often identified as dangerous. For example, I recall one exchange among Cynthia and a black cisgender gay male patient in his mid-fifties. Cynthia was talking about her upcoming birthday party, to which I was invited, and she was telling me where the venue for the party was located. She emphatically told me that under no circumstances was I to do anything other than take a rideshare car to and from the venue's front door. The patient chimed in and started joking with Cynthia about how out of place I would be as a white person walking around that area at night. The patient joked to Cynthia that I 'wouldn't last a minute,' to which Cynthia replied, 'Well, maybe he'd last a couple of minutes—how fast can you run?' We all laughed.

In interviews, I asked patients about their experiences and thoughts on humour at ADC. Gabriel, a bisexual black cisgender man, told me laughter helped him feel more comfortable and develop a stronger connection with the clinician:

Gabriel: Well, see, it depends on how you want to define [joking]. Joking can be taken as a negative in a medical environment. I don't know if I want to use the word joking. I think we add humour into what's going on. I think our conversations invite laughter . . . and fun. But as far as joking from the negative side, no.

4 Noah's description of Cynthia's importance in the clinic is also indicative of a form of embodied diversity (Ahmed 2009) and clinical emotional labour (Strathmann and Hay 2009) that is specifically intended to overcome such issues in organisations (like ADC) run by members of dominant sociocultural groups.

Will: Yeah. Not making fun of people or anything like that, but there's just lots of laughter happening in the clinic.

Gabriel: Yeah, I think that helps with the—I mean, we're coming to a doctor who wants to be here. But I don't necessarily find it that inviting to be working in that area [of the body].

Will: Yeah, it's not the greatest procedure.

Gabriel: You got it!

Will: [Laughs]

Gabriel: So, any little laughter helps to me.

Will: How does it make you feel then? The infusing of humour and laughter into your experience here.

Gabriel: It makes me feel like I'm a part of the family. They know me, I know them to a degree. It makes it a little more welcoming and inviting, and a little easier as far as the procedures and the getting in and getting out.

Gabriel's experiences of humour at the clinic reflected a sense of rapport with the clinicians. He enjoyed the humorous moments because it made him feel welcome at the clinic, like 'part of the family'. He distinguished between joking, which he seemed to view as negative, and humour, which only had positive effects for him, especially noticeable in how much easier it made the procedure feel. Other patients noted this familiarising effect as well, and it was something I regularly noticed in patient-provider interactions. There was an obvious sense of familiarity and community among providers and many patients at ADC, and I noticed a correlation between increased levels of patient comfort and more (and campier) humour.

These experiences of humour highlight both its role in creating an affirming queer care environment (Robertson 2021) where patients encounter familiar campy styles of humour that build a sense of familiarity with clinic staff. These comedic effects that might in one instance induce a 'mirthful state of mind' (Apte 1985) translate to other aspects of these encounters and thus shape patients' affective responses in both humorous *and* non-humorous moments. Humour between patients and staff at ADC supports findings from social scientific studies of humour in clinical settings in that it works to build patient-provider rapport and develop trusting relationships (Yoels and Clair 1995; Wrench and Booth-Butterfield 2003; Sala, Krupat, and Roter 2002). Providers at ADC did not continuously joke with

patients (nor did they only ever use camp humour), but they found (camp) humour an invaluable clinical tool they could turn off when necessary. Humour was therefore a practical aspect of their care work (Mol 2008; Mol, Moser, and Pols 2010) that helped patients who often felt objectified or discriminated against in other medical settings feel humanised as familiar individuals while also increasing their comfort. Sabrina, a straight black trans woman in her early fifties, put it this way: ‘if every place that’s dealing with the LGBT community was like this ... OMG! I think the world would be a better place, you know? ‘Cause I’ve never been to an establishment where I connect with the staff [like at ADC].’ For many trans/queer patients, camp humour reflected their own cultural values and thus created a queer/trans-affirming medical space.

Patient comfort and managing pain

As Julie Livingston cogently notes, ‘pain begs a response. Sometimes that response is laughter’ (2012, 121). At ADC, both clinicians and patients brought up the palliative effects of humour. Dr Bucher explained, ‘I think when you read the [patient’s willingness to engage in humour], like *this is an okay thing to do*, I think it makes them more comfortable’.

Noah shared that he noticed changing comfort levels through his engagement with patient bodies during exams: ‘[Humour’s] a valuable tool to open the door. It’s a freer flow of information that way, and people become comfortable. And when they’re not tense, the procedure goes a lot easier. There’s less clenching and less pushing.’

The clinicians could sense reduced bodily signs of stress with their hands, which they correlated with the use of humour. As humour made patients more comfortable, their sphincter muscles relaxed. Providers could sense this through their manipulation of the anoscope, which would begin to move more easily, and patients felt less discomfort because the provider did not have to apply as much pressure to move the scope around. Humour, then, affected the bodily experiences of both providers and patients, and in this way provides an opportunity to consider its role in care as both relational (improving the flow of information and developing patient rapport) and embodied (relaxing patients so that clinicians can perform their tasks more easily) (Mol 2008; Mol, Moser, and Pols 2010).

Several patients told me they felt less pain because of humorous banter with the providers during procedures. Jada, a straight black transgender woman, explicitly linked joking to a reduction in her experience of pain:

Will: What does a procedure feel like?

Jada: It's a little painful but thank God for the jokes and thank God for the people [staff] here that understand that—they're not so serious. Because like I said, I don't think I would be able to take it like that.

Will: So, it actually helps with the pain?

Jada: Yeah. It eases the mind and not allow me to think about when the procedure's happening.

Similarly, Arnold, a bisexual black cisgender man, told me that clinicians joking with him during his procedures helped with his anxiety:

Will: Do you joke around with the providers?

Arnold: Yeah. Noah jokes. Dr Bucher jokes. I mean, that helps.

Will: How does it help?

Arnold: It just helps me relax. I was a little bit more anxious and Noah said a joke and I started laughing. You know, it kinda calmed me down. Keeps your heart from racing. Dr Bucher, he always says a joke. He says *many* jokes. That definitely relaxes the situation. It makes you feel more comfortable.

Both Jada and Arnold explicitly noted the bodily effects of clinician humour, noting it both reduced their feelings of pain and calmed them down. Many other patients expressed similar experiences. The providers demonstrated to patients through both the content and tone of their humour that this fraught procedure was, as Jada puts it, 'not so serious'. This is camp's transformative power in action. Rather than reinforce an idea that these anal cancer prevention procedures should induce anxiousness and seriousness, the clinicians made light of the situation, enabling patients to 'laugh at one's incongruous position instead of crying' (Newton 1972, 109). In this way, whether joking about specific things or using queer tones of voice or slang, providers at ADC used camp to enact care.

As with patient-provider interactions, the palliative effects of humour at ADC align with findings about humour in other care settings (Rosenberg 1989; Wear et al. 2006; Livingston 2012; Issler 2016; Linge-Dahl 2018; Pinna et al. 2018; Inêz, José, and Capelas 2018; Dueñas, Kirkness, and Finn 2020). Humour can thus be an important care practice that distracts patients from painful stimuli, consequently lowering the amount of pain they experience during procedures.

Managing dirt

Another way humour worked in the clinic was to manage dirt (Douglas [1966] 2002), when discourses or activities exceeded normative boundaries. This was most noticeable in joking amongst the staff (including me) when patients were not

around. There was a lot of workplace humour, which was only occasionally about patients. As far as I observed or participated, humour about patients was never malicious. Instead, such joking concerned uncomfortable, awkward, or extraordinary situations that occurred during some visits (for example, see Robertson 2020). Similarly to other research on humour among medical providers (Rosenberg 1989; Issler 2016; Inêz, José, and Capelas 2018; Dueñas, Kirkness, and Finn 2020), I came to see these moments of humour as a coping mechanism, a way for the providers to collectively process some of the ‘dirty’ bodily functions they encountered when providing care. But more than that, campy styles of humour called into question the very notion of ‘appropriate’ styles of humour, and offered opportunities for subverting cultural norms around dirt and bodily excess.

One notable example comes from my second week in the clinic, while Erick was training me to assist with procedures. Toward the end of an exam, the patient passed a large amount of gas. It was obvious to Noah, Erick, and me because the end of the anoscope—only a few inches from Noah’s face—is shaped like a trumpet horn, so it amplified the sound and made a silly kind of kazoo sound. No one reacted; Noah continued talking to the patient like nothing had happened.

After we all left the room and were washing our hands in the lab down the hallway, Noah melodramatically said, ‘That was potent.’

‘What do you mean?’ I asked, confused.

‘It was a potent hot gust of wind,’ he responded with deliberate overenunciation. I laughed when I realised what he meant, but Noah didn’t even smile. ‘You had commented just before it happened that it was so hot in the room because the air conditioner is being repaired. I guess that wasn’t the kind of air circulation you wanted,’ I joked.

Noah finally laughed and replied in the same campy, affectatious manner, ‘No, it most certainly was not!’ as he twirled around and sashayed to his office.

The joke about the patient passing gas was not about the patient as a person, which would have been seen as uncaring, nor was the humour malicious. Instead, Noah was processing the fact that someone had just passed gas directly into his face and that he felt the body heat that accompanied it. The providers often experience these sorts of bodily excesses from very close quarters, since the procedure involves positioning the scope only about thirty centimetres away from the patient’s anus. After a day or two Noah would not even remember which patient had passed gas in his face. The involuntary nature of these bodily functions is one reason (among many) the providers do not direct humour about these moments at patients but rather at the moment’s extraordinary, uncomfortable, or odd nature.

They may retain memories of the incidents, but generally will not remember which patients were involved. One might say, following Newton (1972), these are moments of laughing instead of crying in the face of absurdity.

While such humour was used to manage or cope with bodily dirt, the humour itself sometimes became dirty. Occasionally, joking exceeded the boundaries of mainstream society's ideas of 'good taste' (Bourdieu 1984), especially when it was employed to express sexuality. I observed and participated in countless moments of humour in the clinic that exceeded these boundaries and reinscribed new ones. Here, I use the phrase 'good taste' (with scare quotes) to indicate how some of these expressions of humour might be considered crass, uncouth, or offensive, especially compared with other clinical contexts. Nonetheless, these kinds of humour were frequently employed and were part of the enactment of care through camp humour at ADC.

For instance, during one morning staff meeting, Keith announced that a patient had left a voicemail cancelling his appointment. 'He, quote, spent the weekend in the ER with a ripped colon,' Keith declared matter-of-factly. Cynthia sucked air through her teeth, a sound of pain sympathy. I raised my eyebrows in surprise. Dr Bucher joked, 'That's PrideFest for you!', referring to Chicago's annual Pride event. Everyone laughed. Through her laughter, Cynthia said, 'Noooooo! That's disgusting!'

'At least it wasn't a gerbil or hamster,' Dr Bucher retorted, and we all laughed again.⁵

Erick's heterosexuality was sometimes the focus of clinical humour. He was the only straight man in the clinic, a fact that was used to tease him. I wrote in my fieldnotes early in my time working at the clinic: 'Erick is the only straight man in the office, and I have already taken up with Noah and Keith in the activity of reminding him of this fact regularly.' This joking also happened when he was not present. For example, Noah and I had the following exchange while we waited for a patient to undress before the procedure.

'I'm glad you're here to assist,' Noah said. 'She probably wouldn't get along with Erick.'

'Oh? Why's that?'

5 This references an urban legend about the alleged practice of 'gerbiling', where people insert small live animals like gerbils, hamsters, or mice into their rectums for sexual stimulation. The legend has been traced to a story from 1984 and is linked to rumours about male celebrities hiding their homosexuality (Brunvand 2001, 81).

'Well, he's quiet—not quiet, but ...' Noah paused, clearly thinking about how to phrase his thought. 'He's straight?' I added.

'Yeah, basically. And she needs someone who's ...' Noah trailed off again.

'You mean she prefers *a sassy homosexual*', I surmised with a lilt.

'Yes. *Exactly*. Thank you for reading between the lines.'

'It's what they trained me to do!' I said as we made our way to the exam room.

Joking about Erick's heterosexuality highlights how queer humour around identity at ADC unfolded. Inside ADC, queer people outnumbered straight, but everyone knew that heterosexuality was privileged and dominant in the broader culture outside the clinic. Teasing Erick about this fact and calling attention to his 'majority-minority' status in the clinic was a 'weapon of the weak' (Scott 1985) because he was treated as the living embodiment of straight society against which we could 'fight back', for better or worse.

In other workplace environments, these kinds of humour might be considered inappropriate, since *any* discourse about sexual topics in the workplace is typically forbidden. I thought about this early in my fieldwork, especially after the first time I reflexively joined in joking about Erick's heterosexuality. Cynthia raised this point:

We hear a lot of sexual jokes—again, that in some clinics might be considered sexual misconduct or sexual harassment. I guess it depends on where you work and how you look at it. It often does not bother me. I don't have to partake in conversations that I don't want to. But I think that they [the patients] feel free to express themselves here, so I don't want any of my patients to feel like they can't do that.

In a clinic like ADC, with a mostly queer patient population and staff, humour about sex and sexuality abounded. As a queer person myself, immersed in camp culture for most of my life, I enjoyed these moments of humour and found them familiar and comfortable. However, I recognised the potential for such humour to inflict harm, particularly for people unfamiliar with camp. Cynthia initially found this style of joking off-putting but had grown accustomed to it and eventually recognised its value, especially for patients who are marginalised in mainstream society and lack other opportunities to engage in these styles of humour. And while sexual innuendoes and jokes were regularly present, there were certainly moments where they crossed a line into 'bad taste' for the staff.

The most obvious examples of these 'out of place' jokes were when patients sexualised the procedure itself, something the clinicians absolutely did not appreciate. Patients occasionally made flirtatious and/or sexually explicit

comments to providers—sometimes jokingly, other times not. When this happened, the providers usually tried to redirect the discourse back to a medical-professional context, sometimes using their own humour. For example, a gay white cisgender man made numerous sexual jokes throughout his entire visit. As Dr Bucher and I entered the room for his procedure, he said to Dr Bucher in a seductive tone, ‘Ooh, he is going to *watch* us?’, referring to me assisting with the procedure.

‘He’s going to *assist!*’ Dr Bucher countered.

‘Oh, *all right,*’ the patient said in mock disappointment.

Shortly after the procedure began, Dr Bucher inserted his finger into the patient’s anal canal to perform a digital anorectal exam. Again using a suggestive tone, the patient said, ‘Ooh, you’re going to *arouse* me, Dr Bucher!’

In a deadpan tone, Dr Bucher retorted, ‘Well, at least if that happens, it will point *away from me!*’ The patient laughed, but neither Dr Bucher nor I laughed.

‘It’s been so long since I’ve had intercourse,’ the patient sighed. ‘I can’t help it’.

Dr Bucher did not appreciate these jokes, but he continued with the procedure as normal, sometimes making a comment to try to desexualise the medical encounter, at other times simply ignoring the patient’s jokes. Dr Bucher seemed mildly annoyed with the patient’s sexually explicit comment about becoming aroused by his finger, and his own sarcastic response that at least the patient’s penis would be pointing away from him was meant to desexualise the encounter (Giuffre and Williams 2000) by deflating the erotic appeal of any potential arousal. These kinds of comments, especially when associating the scope or the clinician’s finger with sexual intercourse, were uncommon and always bothered the providers, even if this wasn’t always expressed to the patient.

Sexual jokes were a common occurrence among clinic staff, and patients often made jokes about their own sexual activities or bodies that did not bother the staff. But humour sexualising the procedure itself was spurned. And in these moments, the clinicians exercised their professional power to reinscribe new boundaries around appropriate uses of humour. While it is likely this kind of joking helped patients cope with the emotionally fraught procedure, it was nonetheless treated by the providers as posing a danger to their professionalism. Comparing the scope to a penis or talking about how the provider’s finger was sexually stimulating was considered by the clinicians to be out of bounds—or in ‘bad taste’—even when done with a joking tone or in a campy style. When patients engaged in humorous discourses that threatened to destabilise their professional identities—again, even in a totally unserious campy style—they responded in ways that enacted their

professionalism and attempted to draw clear boundaries around what kinds of humour were considered acceptable at ADC. Most patients accepted these rules, but some did not, and these dynamics highlighted important power differentials between patients and staff. Thus, not all dirty and campy humour was appreciated by the clinic staff: there were still things considered out of place within ADC's humorous discourses. Where those lines were drawn was an ongoing negotiation among staff and patients.

Conclusion

Humour is fundamental to human sociality and is a vitally useful lens through which to examine and better understand sociocultural systems, including those concerning care. This article describes some ways in which patients and providers use a particular style of humour—camp—to navigate clinical activities centred around anal dysplasia, a stigmatised disease in a taboo body part (Robertson 2021) that disproportionately impacts LGBTQ+ people. Humour and joking enabled patients and providers at ADC to talk about the 'undiscussable' (Epstein 2010) topic of anal disease and helped providers enact an ethics of care (Mol, Moser, and Pols 2010; Kleinman 2013) aimed at the LGBTQ+ community that is often missing in mainstream medical contexts.

Camp humour was tightly woven into ADC's everyday care practices. When providers were campy with patients, humour became a form of queer care because it enacted a uniquely queer style of humour that reflected the queer-affirming care practices at the clinic. Queer humour was particularly effective in this clinic because most of the patient population was LGBTQ+. ADC's humorous environment, and the style and topics of humour therein, challenge notions of clinics as always-serious spaces. The ways humour happened at ADC queered staff and patients' understandings of medical environments. But more than that, camp was a strategy the clinic staff used to create a welcoming environment for queer/trans patients specifically, which made them feel comfortable and, in some cases, reduced their experiences of pain. Feeling comfortable in clinical environments is rare for trans/queer people because medical settings continue to be unsafe spaces full of discrimination and bigotry grounded in heteronormative thought styles. In this way, ADC's queer/trans-affirming practices, of which humour was only one aspect, created a rare medical setting where marginalised people felt humanised, valued, and celebrated.

Humour remains profoundly understudied by (medical) anthropologists, especially within the anthropology of care. As this article shows, humour can be an essential aspect of care. More anthropological work on care and humour is needed if we are to more fully describe and account for how care occurs. As important

anthropological work has shown, humour, joking, and laughter are fundamental aspects of human life, ones that often occur in response to suffering.

To put a finer point on it, anthropologists should expand our consideration of humour as care. In addition to exploring the mere presence of humour in care settings, anthropologists are uniquely positioned to investigate the nuanced ways humour acts as a relational care practice in and of itself. So much medical anthropological and care literature focuses on issues of vulnerability, violence, and suffering (Marino and Faas 2020), and while it is certainly important to address those issues, we must better attend to resilience, thriving, and flourishing (Willen 2022)—especially in the face of marginalisation and oppression. Camp humour exemplifies this ethos. LGBTQ+ people (like members of many other marginalised groups) have developed specific humour styles out of suffering that goes beyond mere coping to deep expressions of the shared experiences of living in an overwhelmingly heteronormative society. Perhaps by revelling in the camp aesthetics of playfulness, irreverence, parody, glitter, and grime that arise in and out of biomedical settings, anthropologists can generate richer understandings of humour as vital to care.

Authorship statement

This article was solely written by the author and was based on their original research.

Ethics statement

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