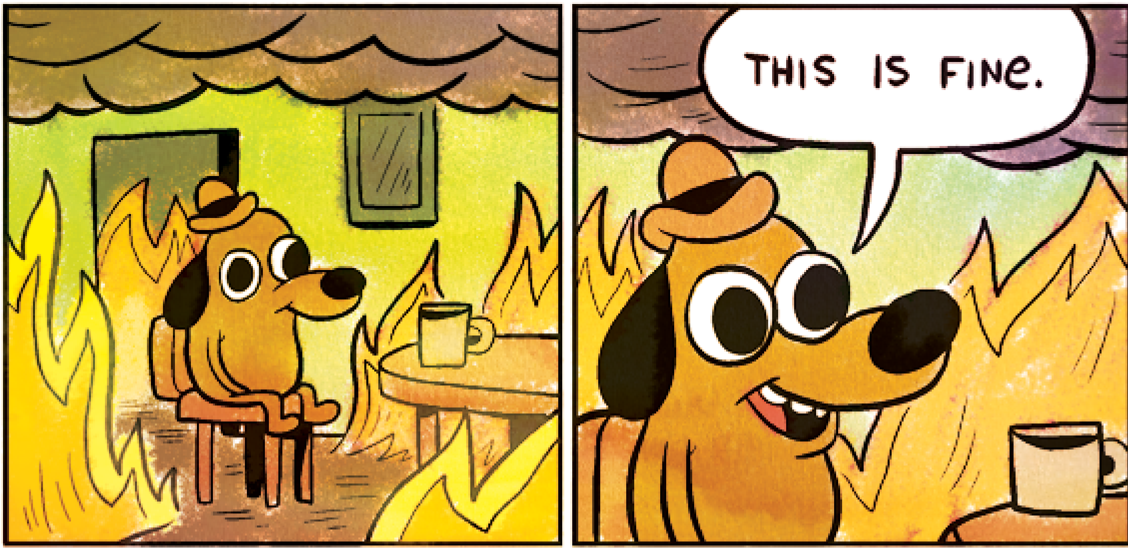

Michelle Munyikwa //

"The secret source of Humor is not joy but sorrow."

— Mark Twain, as quoted in *Laughter Out of Place*

"You know, Michelle," my senior resident said, in that didactic tone of voice that educators often use when they are about to drop some wisdom, "*humor is a mature defense*."

We had been laughing all week. It had been a difficult week in a season composed entirely of difficult weeks. So little felt intimate in the hospital at that time. So little felt human. Attempts to forge clinical intimacy were often thwarted by the physical separations that COVID made necessary. Many were still on edge, worried about catching the virus, or worse still bringing it home to their unprotected families. There wasn't space, exactly, to express that odd mixture of anxious vigilance, existential dread, and despair. And so, we laughed. Somber moments on rounds counseling patients and their families were punctuated by brief eruptions of mirth in our workroom. A meme, well-timed, might set us off. An awkward gaff. Spilling our much-needed coffee. Anything, really, could spur giggles.

We needed it.

In truth, I *especially* needed it. I grew up in a religious community that was fond of saying that the Lord never gives you anything that you can't handle. If that's the case, then in the wake of my father's sudden death a few months before and amidst an ongoing societal disaster, the Lord saw fit to hand me challenges that would unsettle me, confronting me daily with the fact of mortality. Exactly 2 months to the day after my father died, for example, I found myself standing in a quiet hospital room a few feet away from a bed where a man roughly the same age as him lay quietly. He was at the center of a delicate orchestral dance, three physicians working their way through a death exam with skill and reverence. They were confirming what we all knew in that room, which is that the man in front of us was gone. But there are times when, despite all the evidence, you don't feel like you know until you *know*.

It felt too close; all of it did, but there was no time or space for those feelings. There was always something else to do.

When I first started rotating in the hospital, I was struck by how my seniors would tell jokes amongst themselves. Truthfully, I found it jarring. Medicine was a serious profession; I, earnestly, felt that it should be serious all the time. For me, there was no space for irreverence in the profession I held so dear. I vowed to myself, somewhat naively, that I would never wield such a dark and caustic humor.

Years later, I found myself grasping for that very same humor, the safest escape valve.

I found myself grappling with this while caring for Carrie's father, Keith.[1] From the moment I met her, I knew that Carrie loved her dad. You could see it in the way she held his hand, her eyes faraway but loving, as he rambled on. Despite the fact that Keith had long since stopped making sense when he spoke, she listened to his every word, gently correcting him and patiently working her way towards comprehension long after someone else would have given up. She came to visit him in the hospital every day, sneaking 40 minutes here or there on her breaks from work. Every evening, if she hadn't yet heard from me, she would call asking for an update.

Carrie was a devoted daughter, a hard worker, and a mother who had entirely rearranged her life to be able to care for her ailing father for every last minute of his life. Which is why it surprised me when, a week into caring for him, I realized that Carrie did not want to take her father home.

It wasn't so much that she didn't want to, it turned out. It was that she couldn't. During the first long conversation I had with her, she cried. Despite her love for him, she was exhausted. She had two young children whose at-home schooling she was managing, an aspect of their life this year that she — like all of us — could never have anticipated. She was worried about how her kids were faring, not to mention that she had another child on the way. Her father was the light of her life, but he was increasingly struggling with dementia and admittedly a handful to care for. She needed more help, but their budget was tight. As it was she was already paying cash for what little help they had, not to mention that the pandemic had made having other people in the house increasingly perilous.

Carrie's reluctance to take her father home was not unheard of. Previously reported cases reflect a not uncommon situation in the United States, where we often make it difficult — if not impossible — for families to get the help they need. Families drop off their elders at hospitals once they are, for a variety of reasons, unable to continue to care for them. COVID has made that worse, crunching already scarce resources and making it hard for families to make ends meet.

While Carrie's situation did not change, Keith did get better. With each passing day, he recovered a little more from the infection that had brought him into the hospital. He was more alert; his fever came down. His lab values, highly abnormal when he came in, began to stabilize. We started to talk about sending him home. At the same time, during each daily call, Carrie would surface a new concern about his return. She worried about his mobility or that he would require further

antibiotics too difficult to administer at home. She had a sense that he wasn't yet quite his normal self. I attributed her concerns to wanting her father to get the best care possible, and we shared the goal of maximizing his wellness at home.

So with her guidance, we worked to get him ready. Physical and occupational therapists monitored his gait and his ability to feed himself. He switched to oral antibiotics, administered only twice a day. We monitored his mental status — *what day is it, Keith? Do you know where you are? How are you?* — and watched as he slowly gained his awareness of who and where he was. Soon, the rest of the team and I were satisfied: he could go home. Carrie told us that she recognized him again; he seemed so much better. She felt ready. Despite our agreement that he would return home the next day, I heard a lingering doubt in her voice. Later, I'd wonder if I should have probed that more, leaned into my gut feeling that something still wasn't right. As it turns out, I wouldn't have to.

Not long after hanging up with her, we received a call; an anonymous complainant had reported elder abuse, citing concerns in the home. The timing was, to put it mildly, suggestive. Only then did I realize that note of hesitation was deeper than I'd given it credit for: she wasn't ready. She couldn't. Yet, she couldn't say that either. She loved him too much. He stayed; eventually, he went home.

The truth is, Carrie wasn't the only one. At that time, many of our patients and their families were in the same position: untenably stuck between a rock and a hard place, burdened by a society that already makes care so hard to perform and afford. Our team had several patients who may have been well enough to leave but whose families couldn't do it anymore. It was awful. We also knew it was unnecessary. It could be different; in a different world, every family would have the resources they need. In a country with a wider, more sturdy safety net, Carrie might have been able to have him home. We didn't live in that place, and we were forced to contend with the systems that made it impossible to do anything else.

The situation was not so much funny as it was absurd. We laughed; not at Carrie or at Keith, but at the world we live in, and at how painful it is that we lived in a world in which produced such situations.

Humor in medicine is a profoundly ambivalent thing. In a deeply unequal society, laughter in a clinical setting always threatens to slip into lapsed professionalism. There is always, always the possibility that we will find ourselves laughing at our patients' expense. And yet, we also "laugh because we feel, because we are still sentient creatures." And so, as I found myself laughing about the absurd, structurally violent country I live in, I found myself wondering how to discern the ethical use of humor from the darker, more troubling impulses that often emerge in clinical settings. Toeing the line between acts of humor which punch up at the systems that make life unlivable for patients and providers alike — and not down, at marginalized communities — marks that difference.

I noticed that my reluctance to joke had shifted with time. These acts of laughter, which often felt startlingly out of place when I was first in the clinical setting, offered valuable release. This

discrepancy between the "frontstage" and "backstage" selves we displayed offered us the space to express our grief and anger in a way which allowed us to continue to give compassionate care. Not all humor in clinical settings functions this way, of course; yet, some of it does. As part of a generation that also grew up watching news packaged in humor, I also understand humor as a way of building community.

The pandemic has affected all of us, some more than others. One of the ways it affects families is in cases like Carrie's. Structural inequality makes itself known, sometimes in spectacular ways. It can be found in the disproportionate burden of death and illness in communities of color, poor communities, and the Global South. It also becomes clear in more quotidian ways, in silent epidemics of neglect and harm, exhaustion and overwhelm. Carrie loved her father, so much so that she could barely bear to say aloud, "I can't do this anymore."

Privately, my team had a moment of collective recognition of the absurdity of this world; then, we went to work finding the help that Carrie needed. I have come to understand moments of collective laughter — drawn not from mirth but from sorrow whose expression has no place in the team workroom (this, too, could be otherwise) — can offer us spaces of emotional recognition. They are a way of pointing out the forced absurdity of our systems. We laughed our way through the day to cope with what had happened. We laughed at ourselves to cut the tension as we worked our way to a recognition of our own complicity: I should have waited longer, followed the hesitance in her voice, taken a step back from the machine of the hospital to give Carrie space to grieve the turn and for us to strategize.

I am still wary of humor, the ways it creeps in; the ways it can slip into the space of cruelty; how it threatens to erode our professionalism. Yet, I no longer feel that mirthlessness is the only just way to inhabit a clinical self. When this is all over, and we are accounting for this long season of loss, I hope we all remember the silent suffering of communities and their unspeakable losses. In the meantime, finding collective expressions of our rage, grief, shock, disbelief, exhaustion, and so much more may give us the strength to find paths towards other futures.

1. *Carrie is, like all names in this essay, a pseudonym; her story is also a composite of several patients and their families.*

Image credit: "On Fire," from Gunshow Comic by KC Green