The Masked Asian Psychiatrist

Category: Stories
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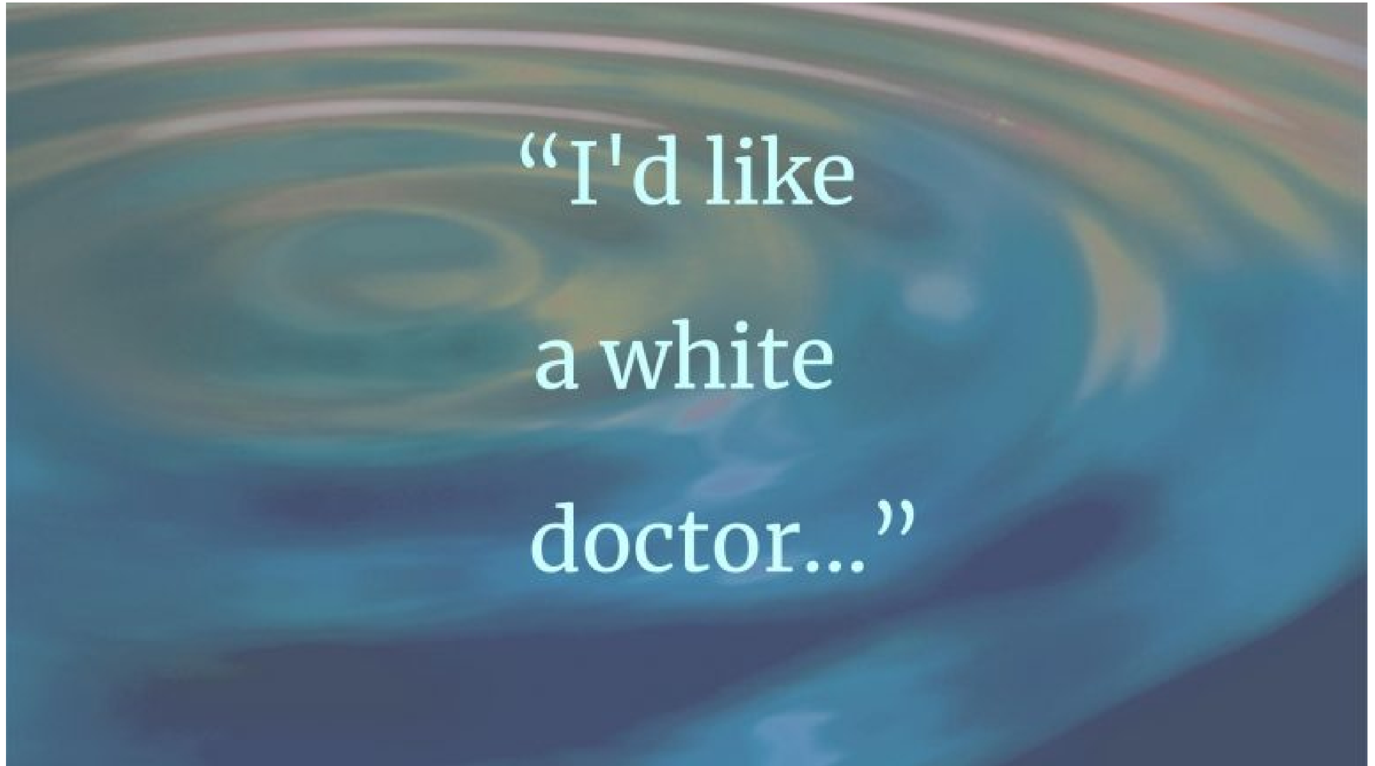

About three months ago, I had a Definitely Racist Interaction at work. A patient—we'll call him Allan—said to me: "I'd like a white doctor. Is there a white doctor available?"

Allan's voice was even, but his attitude was provocative, as if he were testing me. I felt a flash of fury, but kept my face expressionless. Presumably the surgical mask I wore also helped to hide my feelings.

"Well, actually, you're stuck with me," I replied in the most unperturbed tone I could muster.

I am a resident physician in psychiatry, working on an inpatient psychiatric unit among ethnically diverse colleagues, treating a diverse patient population. I am also Chinese-American. The COVID-19 pandemic has revealed, to my surprise, that some patients see my Asian identity as my defining characteristic. I have been forced to confront how my race may affect how I care for my patients.

Since starting residency, I have felt racially profiled exactly six times. This does not include instances when a non-Chinese-speaking patient said *"Ni hao"* ("Hello") or *"Xie xie"* ("Thank you") to me. Such comments are typically delivered with overabundant enthusiasm but no apparent malice, so I think of them as Just a Little Racist, as distinct from Definitely Racist.

All six Definitely Racist Interactions occurred in the first three weeks after my hospital's "universal masking" policy began. All six Interactions

were unexpected; some were amusing.

Patients Brittany, Cory and Don told me that I looked, respectively, like (1) “the woman who donated the hospital” (Dr. Priscilla Chan, married to Mark Zuckerberg); (2) Ming-Na Wen (the actress who was the voice of Mulan) and (3) Mulan herself.

When my friends and I are together, we can laugh about racial stereotypes that others assign to us, and we may even crack a joke about our own ethnicities. My patients are not my friends, but even so, I had known Brittany, Cory and Don long enough that I felt their intentions were benign.

To Brittany I deadpanned: “Well, yes, we are both Asian.” And I considered telling Don, “Actually, I am Mulan!”

Other Definitely Racist Interactions, such as Allan’s comment, were hurtful, or at least caught me off guard. Another patient, Eddie, remarked: “You have squinty eyes…Was that rude?”

Yet another patient called me a “Chinese bitch” behind my back, but within earshot. A few days later, when he unexpectedly gave me a polite nod, I felt relieved, but also wished that I was confident enough to feel safe and whole no matter what he said or did.

Like most physicians, I pride myself on forming emotional connections with my patients. With these patients, though, I spent a minimum of time, falling back on the residency survival maxim “Sometimes good enough is good enough.”

In psychiatry, sometimes our most acutely ill patients make comments that are threatening, offensive or downright mean. Racism in itself is not clinically based; it is not a symptom of mania, psychosis or personality disorder. But mania or other emotional disturbances, including the stress of hospitalization, can let loose thoughts or behaviors that the healthy brain would suppress.

Mulling it over, I realized that I had experienced no Definitely Racist Interactions until my face was masked. Was there something about covering part of my face that reduced my patients’ inhibitions and so, paradoxically, unmasked their racism?

I am tall for a Chinese woman (5’7″), with a fairly assertive voice and demeanor. Perhaps my divergence from the stereotype of the petite, deferential Asian female had protected me from prejudice. Putting on a mask may have blurred that difference, allowing my patients to see me less as Dr. Cynthia He and more as just other Chinese woman, just other East Asian Disney princess or just another potential carrier of the “Chinese virus.”

Like my fellow psychiatrists, I embrace the idea of the patient as an individual, whose symptoms uniquely reflect their genetics, culture, childhood, environment and traumas. At the same time, my image of each patient also reflects my own background and biases, as well as my reactions to that patient’s statements and emotions. I read my patients’ verbal and visual cues to try to probe their inner states—and they, presumably, read my

cues as well. My mask robs us of some part of the expressive communication that is so crucial to our work together.

Despite these difficulties, I do know that my bicultural identity remains an asset. Recently I met Glenda, a severely depressed older Chinese woman who repeatedly asked us for “hot water, not cold water.” When we brought it, she would gulp it down, even while crying so hard that she couldn’t speak.

In Chinese culture, warm drinks and foods are considered much healthier than cold ones. Knowing this, I could better understand how a cup of hot water might be one of the few comforts Glenda could rely on to self-soothe.

If Mulan were a psychiatrist, I mused, *she might have slung a flask of hot water across her back, along with her bow and arrow.*

Last fall, I met a patient in the ER who spoke only Chinese. Mr. Howard had come into the hospital hungry and ill and had been woken again and again overnight for blood draws. He had stormed out of his room and was headed for the hospital exit.

He had a cough, so I put on a mask before speaking to him. Adopting the formal phrasing and deferential stance used when speaking with an unfamiliar elder, I said in Chinese: “Mr. Howard, I’m Dr. He. I’m sorry for how long you have had to wait. I’d very much like to know how you are feeling, so that my colleagues and I can treat your condition.” Extending my arm toward his room and inclining my head slightly, I added: “Would you please come back to the room so we can discuss?”

To my surprise, he agreed, exclaiming: “I’m so hungry, and I haven’t been able to sleep all night! They keep coming in and coming in and taking blood—why?”

As a colleague brought some food, I clarified the reasons for the blood draws and explained our team’s proposed treatment plan, and Mr. Howard agreed to stay.

Returning later that day to update him, I asked him again to remain hospitalized while awaiting his test results.

He drew himself up in his bed.

“I will stay and do what you are telling me, because I trust you,” he said solemnly. “All of us need to serve in our professions with dedication, and I know that you will be the best doctor you can be.”

It was a Definitely Racial Interaction.

I was caught off guard by the eloquence, even gravitas of this gaunt man, clad in his hospital gown and smiling his mostly toothless smile. And I felt grateful that he had given me such a benediction.

His view of me as someone striving to be the best doctor I can be, someone worthy of trust, is the ideal I want to live up to. I want to be a doctor who

listens and tries to understand, in any language, and who happens to be Chinese-American.

A doctor who makes patients feel respected and cared for, regardless of what they or I look like, regardless of where we came from—and regardless of how much personal protective equipment we are wearing.