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IN THE OPERATING ROOM

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My Life as an International Relief Doctor, from Haiti, to South Sudan, to the Syrian Civil War

A Memoir

CECILY WANG, M.D.

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No Crying in the Operating Room: My Life as an International Relief Doctor, from Haiti, to South Sudan, to the Syrian Civil War A Memoir

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Note: Some names and identifying details have been changed.

Introduction

I'm a trauma surgeon and an ICU doctor based in Hawaii. I've also spent the last decade working as a doctor on international medical missions, with Médecins Sans Frontières (Doctors Without Borders) and other relief groups. I wrote this book to share how my views on medicine have changed as a result of my experience on these missions.

In medical school and residency, I became disillusioned by how regulations and the bottom line compromised the care we offer patients. On international medical relief trips I have found medical practice as it should be, with the patient's health all that matters. This is not to say that there are not extensive problems with how international medical aid is conducted, but somewhere along the way I have rediscovered the idealism that first encouraged me to become a doctor.

I also wrote this book to try and capture how I've been changed by my experiences in witnessing both the best and the worst of what humanity has to offer. When we're willing to be changed by our experiences, we open ourselves to becoming better humans.

For those considering a career in medicine, I offer these simple lessons learned: maintain a balance between emotional control and compassion in the operating room and ICU. Even if you believe you have made no mistakes, it's an important

practice to review your work at the end of each shift. The key to success lies in the details; make sure to focus on doing the basics well.

Cecily Wang, M.D.
Honolulu, Hawaii
May 1, 2023

To Rocky and Kayla

I'm so grateful to have you in my life.

Rocky, you make the world a better place

and I'm incredibly lucky to be your sister.

Kayla, you amaze me every day and I'm proud of you.

Thank you for always thinking of everything and everyone.

I love you both very much.

Chapter One
Haiti Changed Everything

The houses swept past, ramshackle, windows smashed, yet in vibrant shades—deep violet, lemon yellow, cobalt blue, lime green—as if to defy their condition. Children were running everywhere, chasing our bus, the older ones with younger kids hoisted on their backs, none of them wearing pants, screaming and laughing as if we had interrupted a vast and private celebration.

Leaving the airport, we'd been warned: "Don't give them money. Don't pass out food. If you do, we'll be mobbed!"

We obeyed the instructions, but the moment we climbed off the bus at our hospital, swarms of kids, most of them no more than four or five years old, engulfed us, shouting in English:

"*Give me one dollar! Give me one dollar!*"

When we didn't give in, they lost none of their joyous abandon.

That was my first and lasting impression of Haiti—the joy, the laughter and squealing, the beaming smiles of bright white teeth. I remember it like it was yesterday. It was 2006, my first international mission as a doctor. Dr. Edward, one of my favorite surgeons, had agreed to let me and two other surgery residents join his Haitian American team on their annual mission to Haiti.

Every hospital has a distinct and unmistakable feel the moment you walk into it—welcoming, like a warm home, or institutional and unhappy. Hospital Sacre Coeur, our station in the town of Milot, was the warm and welcoming kind, though from the outside it appeared modest, even impoverished.

Our team stayed a couple of blocks away in dorm-style accommodations, where we doubled up and shared rooms. We spent the first day sorting out supplies and making a plan for the week. We scheduled more complex cases during the first half of the mission so we would be around during the patients' acute recovery phase. We also arranged to do longer cases in the mornings and wrap up the evenings with simple procedures.

The Haitian medical staff gave us updates from the previous year. They had prescreened patients to make our mission more efficient, already identifying who we would potentially be operating on. The next day there were already hundreds of people waiting for us at the clinic, with hernias and thyroid goiters, lumps and bumps.

From the start it was hectic. We worked long hours to get as much done as possible while also being mindful of not overworking our local Haitian colleagues. We'd be gone after a week or so, but this was their permanent assignment. Fortunately, we could perform most of the minor procedures without them.

As hectic as it was, it was far less mentally exhausting than medical school. On my first day in Haiti, as I finished seeing our

final clinic patient, I said to myself: *This is what medicine should be. This is why I became a doctor in the first place*.

At that point I had my MD and was nearing the end of my surgery residency but wasn't yet fully trained. Even so, I had already seen a lot in the practice of medicine that didn't sit well with me. It's okay to make money as long as it's in line with providing quality care for everyone. And it's okay to follow rules and regulations, as long as they serve rather than harm the patient.

But too often during my training that wasn't my experience.

For the first time, in Haiti, I had none of those misgivings. I was practicing medicine as it should be. The most important person was the patient, and the patient's needs were our priority. I wasn't handicapped by an excess of guidelines and regulations created by health care corporations or insurance companies. A sick person showed up with a problem, we took care of it, and that was that. Medicine as a straightforward human service. The patient was all that mattered.

Beth, who was a year ahead of me in training, assisted Dr. Edward with the first major surgery. Before starting, she asked, "Where's the dictaphone?" Surgeons in the US use voice dictation to record their procedures.

One of the Haitian nurses set her straight: "Doc, we're at a rural hospital in Haiti—there is no dictation phone! We don't even have a *regular* phone!"

Back in the States we dictated an entire composition for each surgery, documenting every step—the sutures we used and each cut we made. In Haiti, no one cared for extraneous information. We simply jotted "right inguinal hernia repair without mesh" on a piece of paper and stapled it to the chart. Why would anyone need to know more than that?

Surgery in the US requires permission from insurance companies. If a procedure is delayed, the patient can suffer. And sometimes permission is refused. In Haiti, there were no such roadblocks.

There was also no VIP treatment. In the US I've seen patients like a politician's spouse or a local celebrity receive more antibiotics or get checked on more frequently than "regular" patients, simply because of their status. Some have multiple consulting specialists or personal doctors who stray from standard of care. This type of VIP treatment can have the paradoxical result of worsening a patient's situation. I saw none of it in Haiti.

Another stark difference was that Haitian patients had different expectations for the types of postoperative pain medications they would receive. We'd perform major procedures on them—exploratory laparotomies for bowel obstructions, excisions of large ovarian masses, chest tube insertions for deflated lungs—and all they expected afterward was over-the-counter pain medicine. Most American patients wouldn't tolerate these procedures without IV narcotics. My patients at

home consistently receive more and stronger pain medications than patients who undergo equivalent surgeries in Samoa and Nigeria, South Sudan and Syria.

Pain is a universal experience. It's not that patients outside the US feel less pain, but their perceptions of it are different.

In some cultures, pain is a hardship to be overcome. In others, pain is a natural part of life, something that everyone experiences and that doesn't need to be feared and defeated. Understanding how different cultures perceive pain helps us better treat our patients.

Once during a mission in Myanmar, a patient presented to our clinic with a fungating cancer that took over 80 percent of his left hand. I overheard our nurse Tanny say, "Too bad we can't help this poor man."

"Why not?" I asked. "We can remove his hand, right?"

"Our surgeons don't do that procedure," she said, giving me a sidelong glance. "Or do they?"

I went to see the patient. After a brief assessment and some small talk, I offered him surgery as an alternative to wound care and antibiotics. "I can amputate your hand. Do you want me to do that?"

He immediately perked up.

"Yes," he said, grinning.

I consulted the oncologist on our team, who agreed. "If you're comfortable doing this type of procedure, I say go ahead."

I don't perform elective amputations at home, but on missions I'll do procedures that are not routinely done by general surgeons in the US. I would not attempt to do brain surgery in the States because there are neurosurgeons at my hospital. If I'm draining a head bleed on a mission, it's because I'm the only doctor around who has had the training. Same with managing patients with fractures—when there's no orthopedic surgeon on the team, I'll do what I can to stabilize fractures and salvage limbs. My patients might have a limp, but they'll be able to walk.

To do the amputation on the cancer patient I would need the proper equipment, but we hadn't packed a surgical saw. Arriving at the airport in Myanmar some of us had laughed at a poster of forbidden items; one was a carpentry saw with a thick red slash through it. Now I could use one.

I explained the situation to Cheryl, our local nurse and liaison. She eyed me suspiciously.

"What kind of saw do you need?"

"Ideally, an electric saw, but I don't expect we have that. I'd *like* to use a Gigli saw. But if you can't find a Gigli, then a plain carpentry saw would work fine."

Cheryl gave me a double take but a few hours later returned with one.

"I got you the saw. It's being sterilized right now."

Sure enough, it was a twenty-two-inch hand saw, something you'd pick up at Home Depot. It wasn't the sharpest, but it would do.

Since this was my first elective hand amputation, I planned it out in my head. I had to cut through skin, fat, and muscle, clean everything up, leave enough muscle and tissue to cover the stump, and then saw through two bones. I had to amputate far enough from the cancer so that he wouldn't need another amputation later, but also leave a long enough stump to fit a simple prosthetic. I knew the techniques for closing leg amputations and thought they should be transferable to the forearm. I was confident this could be done but wanted to think it through, so I drew out the amputation on paper to make the steps clear.

A good surgeon has to have the right combination of confidence and humility. She must have complete faith in her ability to do a procedure flawlessly and manage any complications. If she's going to operate on someone, she must believe she is the best surgeon available for the procedure or refer them to someone better. But she also needs to be humble because she's serving the patient and not her ego.

If you were to ask a room of surgeons who is the best among them, they would have no trouble naming number one. But they'd have to think for a while about who was number two and three.

I guided the scalpel across healthy forearm skin, tracing the simple "fish mouth" pattern that I had marked out. I found the arteries and tied them off before dividing them, so blood

wouldn't spurt all over the place. Then I split tissues, fat, and muscles down to bone.

Surgery isn't as bloody as people imagine. That's not what's extraordinary about it. What's extraordinary is how intimate it is. We cut someone open, and our hands are in their guts.

If you swiped through the photos on my iPhone, you'd find multiple rainbows, a beautiful sunset, and a bright green lizard. And then you'd see a gallstone, a tumor, and a leg. My friends have photos of turtles, kids riding bikes, and sailing with friends. I have the double rainbow outside my window, followed by a thyroid, a ruptured appendix, a brain bleed, and then a plant my friend got me.

It's not a normal collection for most people, but for doctors it is.

On one trip to Haiti, we brought along a photographer named Faith to document the mission. She told me that she wouldn't be able to stomach taking pictures of anything gory. I invited her to watch my first surgery—I think it was a hydrocelectomy with hernia repair—and she was game.

"Okay, I'll see if I can take it."

She found the procedure fascinating, particularly the part where we removed a large hydrocele without causing it to rupture. Soon she was photographing surgeries all the time. I said to her, "Faith, don't forget you have stories outside the operating room to document too."

I didn't know how I was going to react to my first surgery in med school. I had seen two of my classmates faint while watching their first incision, so I was a little nervous. I made it through several surgeries before I finally passed out during a longer case. Not from queasiness, but because I was standing in the same spot for too long with my knees locked—a rookie's mistake.

I learned that good posture during surgery is crucial, because you're often standing in the same spot for six to eight hours or more. I also learned that the OR table needs to be at the correct height. On some missions the table height can't be adjusted, and I've had to operate while standing on a large suitcase.

How time passes during surgery and in the ICU fascinates me. A forty-five-minute appendectomy where I dissect out an obstinate appendix can feel intolerably long, while a four-hour surgery to remove a near-obstructing rectal cancer, biopsy the liver, and place a feeding gastrostomy tube can go by quickly. A twelve-hour day where four patients are admitted, three are transferred out of the ICU, and two pass away can fly by in a blink. Another twelve-hour day of managing twenty critically ill ventilated patients with sepsis or heart failure passes by in slowest motion.

Operating puts me in a flow state where I'm making moves without paying attention to my body. Sometimes I'll feel neck and shoulder aches at the end of a case. I'll do some stretches to loosen tensed-up muscles. This isn't always enough. If I've

had an emotionally challenging day, the physical manifestations tend to persist.

Surgery residency was grueling, like being in boot camp for six years. Some of my classmates were weeded out; others realized it wasn't the life they wanted. To prepare us for the physical demands, every third day we pulled a thirty-six-hour shift. The last twelve hours were in the operating room. We learned to function with little or no sleep. We learned that amateurs practice until they get things right, but professionals train until we cannot get it wrong, because a surgeon's mistake can cost a human life.

Of course, we do make mistakes. But we train like mistakes aren't an option and, like most surgeons, I became obsessed with not making one. When I make a bad decision, I berate myself harshly. But I need to move on from it so my future performance isn't affected. If I can't stop thinking about the last patient, I won't be able to function.

Once I reached the radius and ulna, I scratched lines on the bones with a scalpel, dented them with the chisel, and sawed away. I had to use extra force, like cutting tough knotted branches. It took a couple of minutes. Then I filed the edges of the cut bones smooth and covered them with muscle and skin.

Tanny, the nurse who had introduced me to this patient, checked on him in the men's ward that evening, asking through a translator, "Do you want any pain medicine?"

"No."

Tanny asked, "Doesn't your arm hurt?"

He laughed. "Of course—Doc cut part of it off today!" His attitude wasn't *I'll tough it out,* but rather, *why would I want pain medicine?*

She gave him a couple of ibuprofens. "You can take two more before you go to sleep for the night." He seemed amused that we had offered them and didn't ask for the second dose.

To be on the safe side, we closely monitored his pain indicators. Both heart rate and blood pressure were normal. He didn't appear uncomfortable. He was calm and smiled often. He felt the pain, but his vital signs were normal.

Our pain sensors do not differ from person to person, but two people feeling similar pain can have widely diverse reactions. One patient has an elevated heart rate while the next patient does not. Even though our physical brains are similar, the way I see and experience reality is not the way you do. Even if we come from the same culture and have similar upbringings, we differ in all our perceptions and that includes pain.

On the Myanmar mission I operated on another patient to separate fingers fused together from an old burn. A few days later when we needed help loading equipment onto our bus, who showed up to lend a hand? The recent amputee and the man with the previously fused fingers, his hand bandaged, having been warned not to use it.

Tanny couldn't help whispering to me, "Isn't anyone with two good hands available?"

We have more in common than we realize, but we are also much less alike than we often presume. When communicating with someone, I have to be sensitive to the fact that they will interpret what I say based on their personality and life experiences. This is especially true on international missions. When I sense that a patient or medical translator doesn't understand what I'm saying, I'll rephrase it, coming from a different angle.

Some families want a lot of autonomy in making medical decisions; others want less. Some patients and their families want me to tell them what to do. In that case I'll sometimes say, "If it was my father, I would …"

I had a patient around my father's age who presented with a large bowel obstruction from colon cancer. When I told his wife what I would do if he was my dad, she was relieved.

"Please treat him like your father," she said to me.

As we make our rounds in the ICU back home in Hawaii, I tell my medical students: "When it comes to medicine, we must take into account our patients' individuality and cultural differences. A fresh post-op patient in Myanmar may not expect pain medication, whereas in America this would be considered routine."

I introduced my students to Rafael, a patient in his early forties who had come to the ER because he suddenly lost sensation in his right leg. Rafael had an aortic dissection and was rushed to the operating room. The surgery went well, but we kept him intubated postoperatively while monitoring him closely in the ICU.

When we went to see Rafael, he couldn't speak because of the endotracheal tube. So he wrote on a clipboard we gave him, "What's wrong with me?" He remembered calling 911 and arriving at the hospital but nothing more.

Sasha, his nurse, gave him the news that he had had emergency surgery.

"And if you're wondering why you still have a breathing tube," she explained, "it's because there's a chance you'll need another surgery, and we don't want to keep taking it in and out."

Rafael was remarkably calm for someone who had a tube down his throat the size of a garden hose.

"His right radial a-line isn't working anymore," Sasha said to me. "It's clotted off or something."

I told her I'd place a new one on the left side.

"Hey, Rafael, I'm going to do a new IV in your wrist after we give you a little more sedation. That all right?"

He gestured at me, trying to write on his clipboard.

Sasha told him, "You can write to us after Dr. Wang is done with the procedure."

He scooted over to the edge of the bed and stuck out his left arm for me.

"So you're going to sit there and lie still and let me do it?"

Rafael nodded.

That was pretty cool because more often than not we have to tie people down or sedate them before putting in an arterial line. It took me a few pokes to get the a-line in his left wrist, but the entire time he was giving me thumbs-up with his free hand.

Rafael was the first US patient in a long while who reminded me of those I cared for on missions.

As attitudes toward pain are starkly varied among cultures, so are attitudes toward death. On my international trips, death is a part of life and not something to be afraid of. I don't know why so many Americans don't know that.

In the US, we obtain legal consent from our patients, especially before performing surgery, because of the potential risks involved. On international missions we continue this approach to protect ourselves, even though patients in other cultures are not usually as concerned about death or legal liability.

I'll explain to them: "I'm going to take out your tumor, but there's a possibility you might lose a lot of blood or even die as a result."

They'll respond with something like: "I don't need to hear all this. You're the doctor; I'm here to let you do whatever you need to do."

Sometimes I'll tell a patient, "I think it's risky to operate on you."

"That's okay," one woman said to me. "If I die, I die, but I want to take a chance on getting better."

Sometimes, if the risk is too high, I'll choose not to operate.

One patient in Myanmar died from uncontrolled bleeding after surgery for thyroid cancer. Her family was heartbroken, but they were also grateful.

"Thank you for trying," they said to her surgeon. "She wanted you to try."

Tanny told me, "We were all in tears, and the surgeon was beside himself. But the family took it better than the team!"

Occasionally we see this attitude in the States, but it's rare. Usually what we encounter is extreme resistance to the reality of death.

Don't misunderstand—the families I've encountered on missions aren't less sad than American families who've lost loved ones. They love and miss their family members who've died just as much as we do, but they don't react to death in the same way. Other cultures seem to have a greater acceptance of what they see as a natural part of life, as something we will all someday face.

When patients pass away in US hospitals, it's not uncommon for there to be a huge emotional scene as family members catapult from the "denial" stage to the "anger" stage. Relatives are sometimes so overwrought that we have to call security to keep them from lashing out at the staff.

In our society, death is seen as something to avoid at all costs. No one wants to talk about it, think about it, or see it. We perceive death as a failure, something that could have been prevented. So we do everything possible to keep someone alive—often barely alive—even if it means prolonging their suffering for months or sometimes years. We have the technology to do this, and we have the insurance companies to pay for it. So we do it.

We have specialists who focus on a particular part of the body. They may be able to fix that part, but that's not necessarily the best thing for the patient. It's like we're trying to keep a machine going even when it's clear the machine is no longer working.

For example, an ER doctor might call a surgeon to see a patient with trouble swallowing from side effects of chemotherapy for metastatic lung cancer. The surgeon may offer to give the patient a feeding tube for nutrition, a treatment that might not help and could even hurt an outcome.

As unbelievable as it may sound to those who don't work in the medical field, surgeons will sometimes say, "The surgery went well, but the patient died." This is not meant sarcastically. The surgery may have been technically perfect, but it didn't

save the patient. A "good surgery" is much more than excellent technical skills and deft hands. It's also about knowing when an operation could improve the patient's overall condition.

The basic steps of surgeries are not difficult to learn: cutting, suturing, tying. Next is knowing how much pressure to apply to the incisions, how much tension to allow when suturing tissues so they can properly heal without being squeezed so tightly that they lose blood supply. Surgeons need to know how to link together multiple small technical movements in the proper order, and when to adjust the order to fit the operation at hand. It can be very complex.

I remember a very intricate operation in Haiti on a baby boy who had necrotic bowel from late intussusception (a portion of the intestine had telescoped into itself, cutting off blood supply). The patient was tiny, and the operating room lights were unreliable. I needed to think quickly and work fast. I decided to do the surgery in two phases. In the initial surgery, we resected the necrotic portion of the intestine—instead of connecting the two ends together, we sutured the ends closed so stool wouldn't spill into the abdomen. Leaving the intestines "in discontinuity," we used plastic cut from a sterile IV bag as a temporary abdominal closure (and as a window to check the viability of the remaining intestines). With the dead bowel removed, our pediatric intensivists were then able to properly resuscitate the boy and get him stable enough for the second surgery. Two days later, we reconnected his intestines and closed his abdomen.

"Good surgery" starts with whether the patient should have surgery in the first place. If someone suffering from cancer or septic shock and multi-organ failure receives technically flawless surgery but dies anyway, maybe surgery was not the solution for this patient. A good surgeon knows how to operate; a better surgeon knows when to operate and when not to.

Outside the US, it's more acceptable to allow death when life has exhausted its natural course. This is not to say that everything is better in other cultures. If that were the case, our presence on international missions wouldn't be needed. There is much that I prefer about practicing medicine in the US. We have excellent facilities and very well-trained doctors and nurses. But so often we're distracted by regulations and irrelevancies that prevent us from practicing medicine in the best way possible.

On my first mission in Haiti, I got a taste of what it was like to practice medicine without these distractions. It was just me and the patients. There were no bureaucrats standing over my shoulder with checklists of metrics and regulations that might or might not apply to the person I was treating. I regained the enthusiasm that made me want to become a medical doctor.

A week or two after I returned home from the trip, the paradigm shift I felt began to fade. I returned to the struggles of working in the medical industry: fighting with insurance companies, dealing with excessive paperwork, and facing angry patients who demanded pain medication.

"*You didn't give me enough—I need more!*"

Although I didn't show or voice it, I was angry back at them. I fulfilled my professional responsibilities, giving everyone the best possible care. However, I couldn't help silently screaming at the more irritating patients. Someone wanted an IV for pain meds because they had a small lump removed in the clinic. *I did a major surgery two weeks ago on a patient in Haiti and he wanted nothing! Not even an ibuprofen!*

I love practicing medicine, and it doesn't matter who my patients are. I love them as my patients, though I might hate them as my neighbors. Such divided feelings are common among physicians. In truth, I would prefer to be a doctor only for the people I like, but I believe everyone deserves health care. The person who has ruined their health through neglect or bad choices deserves the same medical treatment as everyone else, even if those choices are indefensible. I can easily separate my personal feelings from my professional responsibilities.

Still, that first mission to Haiti created a deep divide within me that only grew wider as the weeks and months went by, until it eventually became a permanent rift beyond repair. It wasn't as severe as the break that would come later on, when I returned from natural disasters or war zones and felt disconnected and even alienated from life and loved ones back in the US. I didn't experience post-deployment trauma when I returned from Haiti as I would after future trips, but the mission created a rupture nonetheless. I knew in my heart that I was meant to do international work on a regular basis, but every trip cost me time away from the work that paid the bills. How could I

manage to do what I now loved most? I had to find a way to make it happen.

Chapter Two
Unwilling to Speak

I was born in Taiwan and grew up there with my parents and younger brother Rocky. We lived in a two-bedroom apartment on either the third or fifth floor. (There was no fourth floor in our building because Chinese people consider the number to be bad luck.) My brother and I shared one room, and my parents occupied the other. I remember playing with Rocky and our cousins, making up adventure stories as we crawled around behind our couch.

When my grandparents were young, they moved their families from mainland China to Taiwan to give their children greater opportunities and freedom. My parents met in college and got married after they graduated. My father worked at a printing shop and my mother stayed home to take care of us.

My dad used to tell us, "I learned everything from my father," even though his father, an artist, died when my dad was only eleven or twelve. I don't know much about my mother's early life. If I did, maybe I would have a better understanding of some of her ways. I do know she had seven brothers and sisters, and there may have been more siblings who didn't survive into adulthood.

My parents were in their thirties when they decided to move to the US. I was eight at the time and didn't understand why they were making this decision. All I knew was that I loved my cousins and didn't want to leave them. I had no inkling that we lacked anything in Taiwan.

What I did know was that my mom saw how hard I worked in private Catholic school and thought it was too demanding. "I saw you, a tiny girl in the second grade, carrying a heavy backpack full of books and assignments, doing your homework all the time," she said to me. "That's not how I thought it should be. That's why I wanted us to come to the US."

Opportunity for my parents meant less schoolwork for their children, not exactly the stereotype of the achievement-driven Asian immigrant family.

Before we left Taiwan, my cousin Lisa gave Rocky and me a crash course in English.

"How are you?"

"My name is …"

"I'm from Taiwan …"

That was about it. Maybe some Americans would know where and what Taiwan was, or be curious to find out.

When we arrived in San Francisco, we lived in my aunt's basement. Then we moved to a single room in the home of my dad's college friend. Eventually we rented our own place.

At my new public school in California, I was amused to see such a diverse mix of students—white, black, Latino, and a few Asian kids. It wasn't until I reached junior high and high school that there were more Asians in my classes. One of the first things I noticed was the strange variety of hair colors. Back in Taiwan, everyone had black hair. But at my new school there were all sorts of different hair colors—blond, brown, red, and even purple!

From the start I wasn't saying much. One day my classmate Yoshiko, who was Japanese American, carried a box of board games over to me during recess.

"Wanna play one of these?"

I nodded.

"You can pick one."

I scanned the games in the box and said, "Bingo." I didn't care much for the game, but it was the only one I recognized.

Yoshiko burst out laughing, and I was confused as to why.

"It's not pronounced 'bin-go'! It's 'biiing-go'!"

I stood there, unable to speak. I couldn't believe I was being made fun of because of my accent. I was so embarrassed that I didn't speak for the rest of the day. In fact, I stopped speaking English altogether for the next two years. I spoke Mandarin at home, but no English came out of my mouth until we moved to Maryland a few years later. Instead, I practiced in my head,

vowing not to speak again until I was certain my accent had disappeared.

I doubled down and worked extra hard to read English at the level of my classmates. I was consumed with catching up to them, and I kept bringing home A's and O's for outstanding work. The teacher even gave me passing grades in communication although I didn't speak. The irony was that I was working as hard or harder than I had in Taiwan, which was what had disturbed my mom and prompted our move.

I was already a quiet and introspective child before the incident with the bingo game. I didn't speak much because I didn't have a lot to say. I believed that I wasn't as bright as my classmates. It wasn't until much later that I understood that being outwardly expressive isn't a measure of intelligence.

My dad tells this story about me. When I was around two or three years old, we moved to Tokyo because he got a job there. I knew some "baby Japanese" back then, but not much more. Dad was holding me on the balcony of our apartment, talking to one of his friends. That friend was also holding his son, who was about the same age as me, but much more animated. He kept babbling away while I didn't say a word.

"My son knows what airplanes are," said Dad's friend, beaming. "When an airplane flies overhead, he'll make an airplane noise."

"That's so cool," Dad said. Not long after, an airplane flew over us and the boy made airplane sounds. I burst out, "Look, an airplane!" I'm not sure whether I said it in Japanese or Chinese,

but I knew the words. I was quiet, not because I didn't know the words, but because I preferred not to speak them.

Years later in medical school I learned about "selective mutism," a severe anxiety disorder where a child can't speak in certain settings while speaking fine in others. It described my experience exactly. For those two years in elementary school, I could speak only at home. I didn't think there was something wrong with me. Maybe if I had been given help, I would have been diagnosed with selective mutism. Maybe that would have gotten me talking sooner. But I'll never know for sure.

I'm glad that my teachers didn't try to get me professional help when I was younger. They let the problem resolve itself. Had I been diagnosed, labeled, and therapized, I might not have learned valuable lessons during my nonverbal years.

I wasn't miserable being mute. I simply wanted to sound like my American classmates and not be laughed at. My thought process was quite rational: "Okay, the problem is that I speak with an accent. I don't want to go through the rest of my life with one."

I thought it would be harder to lose my accent as an adult. I'd seen Chinese family members who'd moved to America when they were older struggle to lose their accents. I didn't want to go through that arduous process.

I was actually grateful to Yoshiko for pointing out my accent. I had no idea I had one. We ended up playing Bingo that day and became good friends.

My teachers left me alone, thinking I was slow to pick up English. I had no trouble communicating with the other kids. Talking is overrated. I pointed and gestured. I'd nod or shake my head or shrug. If the teacher asked me direct questions, I wrote my responses on a piece of paper.

If there had been a professional tutor available to get me up to speed in speaking, reading, and writing English, I would've jumped at the chance. If someone could have helped me speak accent-free English, I would have quickly signed up. But those kinds of services, if they were available, weren't offered to me.

I had a good friend in school named Judy Miller. She asked me straight up: "You can understand everything but just don't feel like talking, right?"

I nodded in agreement.

"That's cool," Judy said. No judgment from my good friend.

When I brought in my pet hamster for Show-and-Tell, I stuck a label on her cage: "Daisy, female Siberian hamster, eight months old."

"Does she let you pick her up?"

I put my hand in the cage and Daisy hopped on. The kids laughed.

Still, some of my classmates called me weird and tried to bother me. They would move my books around the classroom to see how I reacted. I just rolled my eyes and retrieved them. A boy named Caesar kicked my legs under the table when no one was looking.

I knew my vocal cords functioned just fine and that I was perfectly capable of speaking up if I wanted to. But I chose to remain silent and let them laugh.

As an adult, I'm quiet. I don't engage in conversations unless I have something to say.

When I was an intern, the chief of surgery told me that he liked me because I was a hard worker, but wasn't sure if I had the personality to do surgery because I was so shy. I was with Dr. Williams at the time, who broke out laughing. He was a general surgeon in his seventies, the kind of doctor who never retires. He said to the chief, "She's not shy at all! She just doesn't talk much."

I felt understood by that comment. I was quiet as a surgery intern because what was I going to say? Everyone knew more than me. I was there to learn. If I had a question, I had no problem asking it. I wasn't a silent nine-year-old anymore. I didn't talk simply for the sake of it.

Over the years I've learned that people are uncomfortable with silence, but as a kid I didn't know that people thought it was weird. I could spend hours reading a book or figuring out a

math equation in my head. It may have looked like I was sitting there doing nothing, but that wasn't the case.

"Don't you have a book report due tomorrow?" Mom would say to me. "Shouldn't you get to work on it?"

"Yeah, I'm doing it."

"I don't see you doing it."

"But I am."

I was writing the report in my head before putting it on paper. That's what Dr. Williams understood about me. He knew that silence wasn't a problem, that there was a lot going on beneath the surface.

My brother Rocky, in contrast to me, liked to talk. He wasn't concerned about having an accent, and it went away very quickly.

While practicing English in my head, I spent a lot of time observing other kids and trying to read them. I learned how to tell a lot about a person from their body language. I could see in their eyes or in their walk that something was going on at home. I learned that nine-year-olds who share classrooms can have vastly disparate inner worlds.

Now, as a doctor, I use this skill to help my patients. Sometimes I struggle with verbal communication. I can't think of the right words or terms, and I have trouble describing or explaining things. But with my patients I have a felt, unspoken sense of how they're doing. I know when to pause and let them

talk. And I can gauge how much information they want or need from me. For example, if someone has cancer, how much of their prognosis do I need to describe to them? Some people just need to hear me say, "You're really sick." Other people might want more information: "You have stage four metastatic cancer in your spine and there's a 95 percent chance the chemotherapy won't work."

Some doctors have no intuitive sense of their patients' feelings. My mom's gastroenterologist was one of them. He ate his lunch in front of us, talking about my mom's biopsy results with a fork in his hand. He said her prognosis was horrible and showed us graphic images of another patient's stomach cancer.

"Soon your stomach is going to look like this," he said, shoving a bite of sandwich in his mouth.

He had no clue that my mom didn't want to look at the images. All she wanted was for him to make the nausea go away. I was so angry I wanted to grab the fork and wave it in his face.

By not talking, I understood my classmates in a deeper way. I learned early on that "difference" bothers some people. We're threatened by things that we don't understand or that don't conform to what we think should be "the standard."

I didn't feel caught in some strange inner world or that I needed to talk more to make people comfortable. I wasn't thinking any of that. I felt like a normal kid, with a somewhat strange plan to sound like an American.

Two other incidents in elementary school had a profound impact on how I saw myself.

Not long after we moved to San Francisco I took a math test, probably in the fourth grade when I was eight or nine years old. That evening the teacher called my parents and told them I had cheated—I finished first, way ahead of everyone else, and answered every problem correctly.

"The only way your daughter could have done that was by stealing the answer key."

Looking back now, Mom probably knew I hadn't cheated, but she apologized to the teacher anyway (her English was limited, so it was easier to apologize than stand up for her daughter). When she got off the phone, clearly embarrassed, she said to me, "Don't do *that* again." She didn't say, "Don't cheat." Nor did she scold me. I was left to figure out what "that" meant.

What did I do wrong? What was so bad about getting the highest exam score? I must have done something that upset the teacher and my mom, but what was it?

Since I finished the test before everyone else, that must have been the problem. I thought I'd probably been showing off, so I decided to change how I took a test. I didn't intentionally choose the wrong answers; instead, I made myself a bit less focused. I learned to slow down so that I didn't finish first. I allowed myself to be a little sloppy so my scores wouldn't be perfect. Yet I still did well enough to continue to earn all A's.

A year later, my parents met with my fifth grade teacher. When they came home, Mom said to me, "Your teacher said you don't have to get straight A's all the time." She was giving me permission to be a kid because that was one of the reasons we had moved to the US.

As with the "cheating" incident, the message I got really affected me. Was something wrong with me for being such a good student? As before, I continued to put in less effort.

What they didn't understand was that I did enjoy life. Mom may have thought I was suffering because I spent hours every day alone in my room with a stack of books, but I had fun learning alone. I could spend all day and night doing one thing (drawing, painting, studying a subject I cared to learn, reading a book from cover to cover). Looking back now, I had an incredible amount of self-discipline and focus for a child—the makeup and personality of a surgeon and intensivist before I knew what they were. Maybe I also had the "wandering mind" of an artist.

Mom, a very social person, cared nothing for being alone and projected onto me her distaste for solitude. Maybe she thought I'd be happier if I played more and studied less. I could tell she thought there was something not right about me, which bothered me more and more in my teenage years and on into my twenties.

After those two incidents, I learned only what I wanted to learn from classes and ignored the rest. Despite that, I continued to do well throughout elementary school and junior high.

I continued to speak Mandarin with my family at home while watching sitcoms like *Three's Company* and silently imitating the actors.

I'd ask my cousin Lisa questions.

"Why does 'circus' sound like 'circles'? Is it because circus tents are round? And why does 'yield' sound like 'yelled'?"

She didn't have the answers.

As my dad drove us around, I instructed my little brother to holler "yellow" every time the traffic light turned that color, so I could understand how it was pronounced.

Rocky went wild every time we approached a stoplight. *Yellow! Yellow!! Yellow!!!*

Dad told him to shut up, but by the time we got home I understood the pronunciation.

Occasionally, as I felt I was slowly becoming accent-free, I translated for my mom at the DMV or asked someone in the grocery store, "Can you tell me which aisle has the toilet paper?" I'd talk to the librarian or order movie tickets. The people I spoke with had no idea that English was not my native tongue or that they were the first people outside my family I had spoken to in weeks. That gave me confidence.

By age eleven, I sounded (at least to myself, in my head) like a native speaker. I was ready to use my voice in school but wasn't sure how to begin talking in an environment where I had been

mute for two years. Maybe I could start talking to my friend Judy and then everyone else.

Around this time my dad got a job in Maryland, and we moved across the country to a wealthy community so Rocky and I could attend quality public schools. We were relatively poor compared with a lot of the other families, but I never felt we lacked anything.

I left behind my mutism in California and started in my new school with no self-imposed constraints. I didn't talk much (there was no need), but I had no trouble speaking when necessary. Moving to a new school where no one knew me was a convenient way to break my silence.

People have asked me, "How did you know you didn't have an accent if you didn't hear yourself out loud?"

I learned to notice other people's slight to heavy accents, and in my mind practiced speaking without one. I could "hear" myself speak in my head. But I didn't know for sure how I sounded until I started talking two years later.

And when I did, on my own terms and timeline, I sounded "just like a real American."

Chapter Three
Aftershocks

When a catastrophic 7.0 earthquake struck Haiti in January 2010, I felt compelled to be there. The devastation I saw on TV was apocalyptic. The epicenter was just sixteen miles from Port-au-Prince, and at least two hundred fifty thousand residences and thirty thousand commercial buildings had either collapsed or were severely damaged. This included many hospitals. Port-au-Prince's morgues were overwhelmed with tens of thousands of bodies that had to be buried in mass graves.

Since my first trip to Milot with Dr. Edward's team four years earlier, I had completed my surgery training. I was now working as a trauma surgeon at a large hospital in the Midwest, where I was also the acting director of the trauma ICU. I arranged for some surgeons to cover my shifts at the hospital while I was gone, and in February went back to Haiti with a group of doctors and nurses from the Salvation Army.

When I got off the plane in what was left of Port-au-Prince, the stench hit me. Mounds of debris and rotting refuse were strewn everywhere. On the drive to our hotel we passed huge piles of rubble and buildings that were hardly standing. The presidential palace had collapsed.