Transcript of Interview with Michael Chow by David Dunkin

Interviewee: Michael Chow
Interviewer: David Dunkin
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Location (Interviewee): Los Angeles, California
Location (Interviewer): Santa Cruz, California

Abstract: In this interview, David Dunkin interviews Michael Chow about his role as a resident during the COVID-19 pandemic. Michael shares what it was like to work in a hospital during COVID-19 and discusses some of the challenges that the pandemic imposed on his work.

Michael Chow 0:00
Good to see you buddy.

David Dunkin 0:02
All right, we we are live. All right, this is David Dunkin. We're recording an oral history interview over Zoom with Dr. Michael Chow. It is August 21, 2020, 5:15. I am interviewing from Santa Cruz, California, and Michael is in...

Michael Chow 0:22
Los Angeles, California.

David Dunkin 0:23
Los Angeles. All right. Thank you, Mike. So just to get started, can you tell me a little bit about your occupation and where you live, where you live normally, I know you're not where you normally live right now.

Michael Chow 0:35
Gotcha. So I'm a resident, and basically what that means is I'm a physician who's still part of a training program. Um, after completion of residency, one can, like, you go onto their final path. I'm training in otolaryngology, which is your nose, throat, head and neck surgery. I'm a first year resident, and I normally live in Manhattan, in New York.

David Dunkin 1:01
Nice. So would you say that the kind of medicine you specify in, does it have any relevance to dealing with people that have COVID-19? Or is there any, any connection there?

Michael Chow 1:12
Absolutely. So um, we're a surgical specialty. So in some, in many ways, we're not like a frontline physician like emergency medicine, internal medicine, or critical care. But given that this is a respiratory disease, we do a lot of airway surgery. And in these patients tracheotomy, or an incision in the neck that allows people to breathe from a ventilator without being intubated by mouth is something that has been really controversial, but it's been an up and coming procedure. So we've been involved quite uh, thoroughly with their care.

David Dunkin 1:45
Interesting, okay. Um, and just thinking back, when would you say the first time was that you heard about COVID-19, just in any capacity?

Michael Chow 1:56
Any capacity, probably late December, early January, you know, just, just like anyone else, you kind of hear news reports, and then you kind of once you hear news reports, you start hearing kind of mullings around the hospital. Hard to really pin down, like, what's fact and what's not. But I probably, yeah, that's when I first heard.

David Dunkin 2:20
When you, when you first heard about it, would you say it was something that, you know, that you thought you would maybe cross paths with in your work? Or was it just something you'd heard about?

Michael Chow 2:31
Ah, I was certainly on the more nonchalant side of most people. I mean, as with any kind of infection, there's always a, you know, there's always the risk of, like running across it, you know, like, whether that be like bird flu, you know, any kind of, like contagion, you say, you know what, like, if it becomes widespread enough, like I'm at, I'm at like a premier center, you know, like, people will come here, and these physicians are like, really wants to be involved, and want to be helpful. So if it gets to America, New York is one of the main cities that would like a, you know, main travel hub, you know, if it hits the US, I will encounter it. And I just wasn't, I just wasn't sure when or if it would.

David Dunkin 3:17
Sure. And then when, when would you say that transition from being more nonchalant about it to taking a little more seriously, do you, what was that transition like?

Michael Chow 3:28
Uh, for me, even after it hit America, I was still on the more nonchalant side. As a surgical resident, basically, our entire life revolves around the number of cases we do per day. And that kind of, and that's also like a major funding point for hospitals. That's where most hospitals make their money. So, for me, I specifically held the criteria in my head, as long as surgical centers are doing elective cases, which are cases that are not to save a life, or not imminently need, that need to be imminently performed within the next three months or so, then, in my mind, we were not in a state of emergency, we're not really threatened, as long as we're doing these, these cases, because I, in my mind, that was still if you're at a hospital that's going to support a major, you know, pandemic or epidemic, you wouldn't be wasting facilities, time, funds, and staff on elective procedures. So that was my line of transition.

David Dunkin 4:36
Sure. Okay. Yeah. I mean, that makes a lot of sense. And I don't, it's totally up to you if you want to name what hospital you're at by name or not, but when, I assume there was a transition with your hospital to not elective, right?

Michael Chow 4:49
Yes. So I'm a resident at NYU, Langone Health. It's a great hospital. Great training program. We, I think that the situation was being monitored very closely. Um, I think that New York is, you know, obviously a very dense, like population-dense area and there's many large academic centers there. And so I think even within the city of New York, there was a different experience between different centers. But I felt there was relatively good communication between all the leadership and the understanding of when to transition from, like, performing elective to the cancelling of elective surgeries.

David Dunkin 5:31
Sure, um, I know you don't have a lot of free time as a resident. But do you, was there any noticeable shift within, by living in the city of New York, where you saw kind of the virus start to change the day to day in the city also?

Michael Chow 5:46
Oh, absolutely, absolutely. New York, New York changed immensely. Um, my cousin actually got sick. She's a nursing student at NYU, and she got sick, probably had COVID, but it was, what, during these times, it was hard to get testing. I think I had it at some point. But it's, but it's like hard to get testing and given like the CDC guidelines, it was hard to kind of define how and when to test and what, what uses it served. But when I went to visit her she was really feeling sick. I went to the store, I got her some like Pedialyte and some like hydration things, some Tylenol, you know, she didn't want to leave the house and get anyone sick. So I, I biked down to the lower east side to drop off the stuff for her. And what really struck me was the darkness. Normally, like the streetlights kind of light up the street, but it's not streetlights that make the area bright. It's all of the lights from the businesses that are open all the time, that kind of make the streets so bright and make the place feel so alive. And I was riding just my bike down there and, and it was the quiet and it was the darkness, and my bikes, a fixed gear. So it doesn't click when you, when you pedal, and I just was, all you could really hear was just like the rumbling of the road and it was just, I'd never heard silence in New York before. So that was very surreal for me.

David Dunkin 7:11
Sure, yeah, that sounds surreal. And you were living in a hospital provided housing? Correct?

Michael Chow 7:18
Correct.

David Dunkin 7:18
It was attached to the hospital?

Michael Chow 7:21
Yeah, I'm kind of the creature in the attic.

David Dunkin 7:24
Was that, did you feel or was there anything talked about additional risk for people living in that housing situation?

Michael Chow 7:31
No, it was next to the, well, no, it is not connected to the hospital, and that there's no medical personnel, no patients that would be crossing over or through incidentally, it's pretty well separated from the hospital. Um, I mean, the only time you would think about an increased risk, is that there are people who work in the hospital who live in this building. And so in that sense, yes, there is an increased risk. But no, I did not feel threatened or endangered by living there.

David Dunkin 8:01
So then, could you talk a little bit about when your, when your, your job started to change a little bit, when your duty started to change?

Michael Chow 8:09
Mm hmm. Um, so I was in, I had a three month block where I was on my home service at the private side. And so we had three months of EMT, so for the first two months think, it was essentially businesses normal, surgical cases, consults and my days were long and, but everything was running just about as it should. In the last month, then, we kind of, or like the beginning of March, started to really hear more of the kind of rumblings that you know, this is, this is really gonna, like, shake things up, things are gonna change immensely, like, people are in danger, like, our hospital's gonna be taken over, there won't be enough ventilators. But we hadn't really seen like, like the the major burden of disease hadn't quite hit yet. So you know, you had a couple patients, like come through the ED. A lot of people went home, most people went home. And so it's still, but then you're hearing horror stories from Europe and like, a lot of our attendings are international, like physicians and they, they've met with people from over in Europe, Italy, South China, Middle East, and they're saying like the disease is tearing through hospitals at an alarming rate, people are dying. And I think kind of, like everyone's kind of thinking, ah, but like not here. Yeah, like, you know, that's there, you know, and I think we're all kind of subject to that, I mean, but at every level, you know, like, I think a lot of people are saying, oh, like, it happens elsewhere, but it probably won't happen the same here, and then I think in the hospital we also say well, care's different, we can separate people better, we have like containment rooms and… But, so I think a lot of people were kind of measuring like, how seriously do we take this what, what's the, what is the next step and then, and I was still at that level, I said, as long as we're doing cases for profit, people whose job it is to worry are not that worried, and my job is to just survive this intern here. So I'm not gonna, I'm not gonna, like lose sleep over this, like, I'm not going to be irrational. I mean, I'm not gonna do risky things, like I'm not going to go lick doorknobs, but, but you know, I'll worry about it when I have to. And then, about a week or two after they started can--they canceled cases. And it was a pretty abrupt change. We came in Monday, they said, no longer, like, are you performing cases, you can do your cases today, but as of tomorrow, every case unless a patient, unless, unless you and the patient, you as the physician and the patient, agree that the case can be delayed by three months, you must cancel it. This was a bit tough. I mean, I mean, and it's, and that's fair, you know, because you as a physician may say, this is not a case that needs to happen. But it's also, you know, but then a patient may say, no, I, I need I need this. And that was a point of contention in some way. It's because like, you know, you can look at someone's look, you don't need your tonsils out. For like, you can live for three months, like you're not gonna die, it's not a threat to your life, like your quality of life may suffer, but the risk here in the hospital is actually greater,

given the current situation. But so I think there was about a week of this overlap of these kinds of cases where, like, some were still happening, because of these disagreements, but overall, as the pandemic became worse, people understand, began to understand the hospital is actually the last place you wanted to be. And then it kind of tapered off. After that week of kind of overlap and confusion, we went into what was more of like the final form of what we've seen in terms of a sustained effort from our service. As people started to perform trachs on these patients, it was a bit controversial, at first given data from the international side. But they were finding that a lot of, a lot of the critical care attendings were finding that there was improvements in these patients, in these patient's care. And you know, and where we do trachs a little differently, we can help with some of the more challenging patients. So we wanted to be involved and helpful in every way we could. But with procedures done by us or done by others comes complications. And so we were involved, I think most heavily in the complications of other people's procedures. And so, and that's, and that's, I think, where things started to really change, we were being consulted at a much higher rate. And like, we weren't doing any procedures, but we're still running into the hospital frequently. And of course, tensions are high, people are nervous or scared. And it's certainly been a long ordeal. But otherwise, the hospital also started running out of doctors basically. And so half of our service got conscripted, well, half volunteered, half conscripted to other services to be helpful. I personally volunteered to go to the emergency, like the emergency room, I figured, given my experience, and given my more like technical skill set, that's where I could probably be the most helpful, be the most independent and free up other people to do the more important stuff. So I sent them like I sent them the survey back, I said, oh, yeah, like, I all volunteer for the emergency room. Like, take me as long as you need me. Like, I'm just an intern, there are people in my service who can do a better job than me, like I'll, I'll do whatever. But like, and they said, where do you wanna go? I said, I'll go to the emergency room. And then I got an email and said, welcome to internal medicine. And then the next day, I was working night shift on internal medicine at the VA. So, there was all kinds of changes.

David Dunkin 14:17
Um, so back a little bit about how your department changed. So would you say, so, you were, you were correcting, like more complicated tracheotomies, is that, is that correct, or?

Michael Chow 14:32
Um, so, there's two kinds of trachs that are traditionally performed. One is a percutaneous, which is basically a puncture. It doesn't, usually doesn't go to the operating room and can be performed bedside, it's not as extensive a procedure, and then there's an open, which is what our department and I think the bulk of otolaryngologists kind of prefer, just prefer in the sense that just what you're trained in and comfortable with, and that's where you actually take an incision, you open the skin, you get down to the airway and you make an incision with a blade rather than like a, like a punch through. Um, of course this like given the fact that it's a procedure, it's a little more involved. A lot of critical care, people don't perform open trachs, they usually do the percutaneous ones because they don't have, they don't go to the operating room. And so in this particular instance, the original set of trachs were often percutaneous. And we, the only issue with a percutaneous tracheotomy is that the, when you go through the skin fat and into the airway, you aren't opening, like you aren't making an incision. So the tube that goes through is kind of fit flush with the skin. And when you punch through, there are vessels that naturally kind of can meander, and sometimes they are compromised during a percutaneous puncture. They're

also compromised during an open tracheotomy. And this is a normal part of the procedure, they're usually coagulated with electrocautery, basically sear it a little bit and the vessels close off. And it's usually not an issue at all. But with a percutaneous trach, you don't have that opening to kind of see the vessels, so usually they just get punctured. And in a normal non-coagulopathic person, they will clot off on their own. And it's no problem. But in a lot of these patients who are incredibly sick, they can become coagulopathic, mainly for the ones who go on ECMO, who basically are having their blood oxygenated by a machine that has to be anticoagulated in order for the blood to run through the machine without creating a lot of clots. So these patients are naturally have very thin blood, and they bleed and ooze much more easily. And so with these percutaneous trachs, with combination of this anticoagulation, there was a lot a lot of bleeding issues, which are at no fault of a provider performing them, but are just unfortunately, a natural consequence of these things in combination. And unfortunately, with such a severe respiratory disease, it's hard to you know, you can't, there's not a lot of ground to compromise on when trying to keep these patients oxygenated and allow their lungs to recover.

David Dunkin 17:24
And is it, is the, what's the name of the more complicated trach again?

Michael Chow 17:28
Ah, well, not more or less complicated, but different. So there's an open and then a percutaneous.

David Dunkin 17:33
Open. Okay, does a, does the open trach, does it have, is that a more complicated procedure to recover from for the patient, or is it?

Michael Chow 17:44
Usually not. So the trach, I guess it depends on why you're doing the tracheotomy. If you do a tracheotomy for someone who requires a lung or for someone who has like a mass in their airway, it's going to be long-term trach. It's something that they're going to, it's going to be their airway, which they breathe from for a long time. It's quite an adjustment, people will have to learn to breathe differently, they have to get used to managing this tube, when they cough, people will still cover their mouths, even though the air, and it's, it's a huge change, and me, as someone who is well educated in it, and I too, I'm sure would really struggle in those first couple day because it's you, you live your whole life, like breathing, like, you know, there's some things you take for granted, I breathe, I walk, I eat, I smell, like, I hear. And when you change something so fundamentally, at once, you know, it's not like long term loss of hearing, I hear a little bit like, it's you lose a lot at once. And so it can be a big change for a lot of people. However, sometimes it's for airway protection in a complex procedure, and it's only there for a couple of days. And yes, it's a shock. But the recovery is actually usually quite, quite easy. You basically just put a bandage over it, you don't have to suture it. You don't I mean, except in extreme scenarios, you don't have to suture, you just put a bandage, a little gauze, you ask people to cover it when they're coughing or speaking, which prevents the air pressure from holding the wound open, and it'll close in a couple days usually completely.

David Dunkin 19:22

Interesting. So was it, was there a lot of preparation with your department and saying, you know, we're going to transition where we're going to be doing mostly this kind of procedure to, to kind of cover for the increased number of COVID patients?

Michael Chow 19:38
Uh, yeah, I think that in any time you're trying to compensate for a new situation like this, obviously, this is unprecedented but as a department, we tried very hard to... again, it's, it's hard for me to speak for the department as I'm just a resident, but from my observation of how they responded, there were many meetings. We as residents were involved in the meetings, it was kind of hosted by the, obviously the attending physicians who really wanted to include everyone's experience, reach out to others who, what had people heard, what do people think, what, is there any research we have on it, and who, like can teach us more about it. And so I was actually very pleased with my department's response to it, I think they always every day when they were re-evaluating, you know, how can we be helpful? Is this indicated, is this smart to do? And then at the end of the day, like, are we making patients better? And, and I was really proud to be a part of that, and, like, really proud to see it. And, um, and I mean, I think as long as we're trying to do that, you know, that's, you know, you can't really regret much. And, as this has kind of dragged on and become like, more and more, you know, and, you know, become like a longer process, it wasn't just like a one month kind of thing. I've been, like, we've had a lot of discussions about like, you know, the frustrations of usually like, usually in a hospital, it's kind of if you do a procedure, you're going to evaluate it first, and you manage your own mistakes. And if you need help with your mistakes, we're always here. And this goes for anyone, whether it's us or a thoracic surgeon, or colorectal, like, if you if there's a problem you like, try to fix it yourself, because you caused it, like, you know, or it's your, it's your responsibility as the person who operated and then if you need help, there are specialists to help you. And in this scenario, in this emergency scenario that has kind of been thrown to the wind, because there's so much, you know, there's like, such a burden of disease and so many patients and, and I think, ultimately, that's for the better. Um, but I think it also, like raises tension sometimes. And it makes it like, tough when you come in and you say, like, look, I didn't do it, like, I don't know what happened at the time of the procedure, and I'm trying to figure it out. But it's not like, when you've done the procedure, you're like, okay, I these are the things that could have gone wrong, or the like, I know where I was, and I know where I wasn't. And so I think that there's certainly a fatigue of like going in every day and trying to fix something that you don't always know, like, where it could have gone wrong. And so I think it takes a lot more thought sometimes to try to make it happen. But I think overall, like, the department's done a pretty good job in trying to just do our best to be helpful.

David Dunkin 22:36
Sure. And yeah, that kind of goes into my other question that I mean, you know, hospitals have personalities, and moods and vibes, you know, of their own.

Michael Chow 22:46
Yeah.

David Dunkin 22:46

And I'm curious, what kind of changes if any, you've noticed in just the environment of the people you work with and the, and the vibe in general?

Michael Chow 22:56
That's a really tough question. It's a good question. And I think that I, and I, and I'd love to give you like a really satisfying, like one liner, but they get, that's impossible, right? Like, I mean, I think every hospital you have, like CEOs, you have deans and you have kind of like the face of a hospital. And the face will always try to put on the best face for the public. And that's, you know, not and that's not wrong, you know, you, it's, you're trying to give hope to people, like people look to you to, to, you know, for safety and comfort, and, you know, just want to know that everything's gonna be okay. So, I mean, there's like lots of uplifting emails you get, you know, as with anything, you know, like, oh, this is, everything's gonna be fine, it's great. But then I think there's you also have to look at like the morale of the people who are working and the morale of the people who are kind of on the frontlines, and, and that can be parsed out in so many ways, like as, like, as a consulting provider, you know, like, I wasn't necessarily in the hospital, like every day with the same patients like, and I actually, like, was really like, I'm friends with some of the ICU nurses who got pulled to these COVID floors. And, and I think that the people who are kind of in on these primary services every day really suffered an enormous blow in ways that I like, can't really describe. And there are many ways people try to counteract that. There was lots of like, they do the clap. Like when they're like the clapping outside the hospital. At 7pm, the fire department would come by, people were writing in chalk on the sidewalks and, and I think that like, I don't know, maybe I'm, maybe I'm cynical, but I think that at times, it's like sugar. Like it'll provide you energy, it'll make you feel good. And you'll enjoy it for some time, but like, you can't live on sugar. And like I, like I, and even in my, like limited time working on the internal medicine side, like, a lot like patients were like dying. And I like hated every second of it. In the sense, in the sense that like big, especially as someone who went into a surgical field, like I came here to, like, do things, fix things, and make people better. And like watching something that I had very little control over, it was very difficult and very frustrating.

David Dunkin 25:47
No, it makes makes complete sense. And I think also, too, and you can take, take this question as you will, but I feel that even though, even though the day to day working in medicine is different, and there is change, I feel like most of the time when there's big changes, you know, and like people, people resist that. And I imagine that to have kind of the ebb and flow of the hospital change so dramatically, would create a negative reaction from the people working there. Is that, does that ring true, do you think to your experience?

Michael Chow 26:26
Yeah, I mean, I think that, I think it's, I think it's tough. And I think, especially with people like losing out on personal protective equipment, you know, like people, like felt that, and I think this is, you know, not specific to one hospital, I think it's something where people are, I think people in health care, you, I know, you being in healthcare yourself, like, there's a, there's a duty and an honor to it. And that like, and you, everyone wants to serve. And that's like why we did this, is to be helpful, and to be there for people when they needed us. But, and I think that is more sustaining than the chalk on the sidewalk. But even that, like has its limits. And people I think, feel burnt out. There was like a large discrepancy, like a, like not a discrepancy. There's like a

big issue at our institution, I won't personally add my own thoughts about it into this, but I will say what has happened, there was a lot of residents who felt that like, the reason residents get paid like the lowest salary despite being physicians is because, is because you are being trained, and your reward is becoming an attendant like a certified physician and whatever field you have, you're choosing. And so you know, you work hard, you work terrible hours, and you get paid close to nothing in a city that costs an arm and a leg, because, because of that reward, and that's just like a known, like, that's just a known cost, no matter where you do residency, you know, you're not going to get paid great. And you're, you will be trained, and that's something we all, you know, kind of agree with. And it's like a known quantity. But in this particular instance, you know, nurses who are working overtime, physician's assistants, nursing practitioners who were being transitioned to these COVID floors, they were being pulled off of the services they signed up to work on, they were being paid one and a half, two and a half times like to compensate for these changes, to compensate them for overtime. So some of like the these extended, like, like NPs, PAs, nurses are making more in a couple days than I would in a month. And I think some of the residents felt that, like we also were being drafted over, we also were being exposed to these risks, we also were at a lack of PPE. And residents, you know, frequently make a very, like very low amount given the work hours, and there was no compensation for us changing services, which essentially negated our educational benefit. You know, like if someone comes to train for heart surgery, and then they're on internal medicine, you know, it's, it's not part of their training. That's not why they came here. And so I think some of the residents felt they were being used as a provider, which, which they were you know, they're a doctor, and they're allowed to provide care but they were still being paid the same. There was no work hours like, like, like the work hour restrictions were lifted. In some cases for the pandemic, there was no hazard pay, no over, there's no such thing as overtime for residents. And, and even before residents for like retirement, I think I believe that like every other person in the hospital is matched for their retirement funds, residents are matched 0%. And so I think that there's kind of was a boil up of that underlying feeling of that we're given the fact like, there's always two things that kind of keep us there, one, you're being trained. So do like, do your work, you know, like you, like, and then two you're a physician, you have an honor, you have a duty, you swore an oath. And, and I think a lot of people felt like, did anyone else, is no one else supposed to have the same honor and duty or we can also get rewarded for fulfilling our honors and duties. And so there was, I think, some feeling of like, lack of support and like feeling of, you know, being the only group that's just expected to be quiet and do their work. And so I think there was some discontent on that front. I know that like a lot of people like were feeling burned out. And that's, you know, on all, like nursing, PAs, NPs, physicians. Like, I was, like there was a nurse who I think I've only met once in my life, and she like came out of a room and I said, oh, man, like the, these new doors in this new building, when you close it all the way becomes perfectly clear, but you hit a button and it'll, the glass will become opaque. And I was like, wow, like, welcome to the future. This is freakin' incredible. And so as I like commented to her, I said, wow, that is like crazy like that, you can just change the glass, like, how does that even work? And she's like, I'm not like, I'm not a scientist, I don't know. I'm like, I don't know, either. Like, I just thought it was really cool. And she's like, yeah, but sometimes, like, I could be in there for like, an hour and a half by myself and you just don't even know if anyone knows you're in there. And like, she just got really quiet and her eyes got like, 1000 yard stare. And then again, people everywhere just feeling like lost and burnt and for different reasons. It's, it's, that's a tough one.

David Dunkin 32:01
No, yeah, I would imagine. You know, what do you think about, I mean, this is, this is kind of a unique time where people in the, in the medical field are getting extra public attention. And even more so now with everything on social media and the way it's being reported on and, and how is that, the way the public is kind of perceiving this pandemic, how has that affected or changed your work, would you say?

Michael Chow 32:30
How, the sorry, the field of medicine as a whole or like us as providers?

David Dunkin 32:36
I would say you as providers, or even your own, your own kind of mentality when dealing with the public.

Michael Chow 32:42
Um, I feel like, there's been a really interesting, like, set of dialogues, that's come to light in the midst of this, and it's very, it's, it's, and I'm as like, you know me, I'm not usually someone who pays much attention to dialogue, I'm like, let's all shut up and do our work. But given that I've been at home, so, you know, I mean, like, like, sitting like, socially distancing so much, you know, I've had much more, too much time on my hands to pay attention to, you know, even in the hospital, you know, like, well, what else is there to talk about? And I think on one hand, there's kind of the lauding of these providers as heroes, and I'm honestly not sure how I feel about that. I don't know. I don't, like, I think I may be in a minority on this one, but I don't like it. I feel like, like we showed up and we did our job. Like we're and, and they're, you know, and I don't, like I don't know, in my mind, in my mind, like, being a hero feels better than this. And there was people that like, you know, didn't do great.

David Dunkin 34:11
Sure. Is it...

Michael Chow 34:12
And, uh...

David Dunkin 34:13
No, go ahead.

Michael Chow 34:13
Yeah, no. I just, yeah, it is, it, I don't know, I just, I don't know how many people feel like heroes.

David Dunkin 34:23
Sure. What, I mean, I'm sure with your family having medical backgrounds as well. How has that been different with, you know, their outreach to you or talking about it?

Michael Chow 34:36

Ah, I've been consistently thankful that my family was in medicine. I worked weird hours, I'd be, I wouldn't be able to call for weeks especially with the time change. And I'm so thankful that they were understanding and like from, from like an understanding standpoint of like, you know, like, you can't call or you can't see us, like, the people are like, okay, I get where you're coming from. However, my dad, you know, you, who you also know, uses his medical knowledge to say you can't trick me or fool me in doing, you know what I mean? Like, some parents are like, oh, I told my parents to stay home, they're like, you're the doctor. But then I'm like, Dad I probably should stay home. He's like, shut up, Mike. Like, I remember who the original Dr. Chow was. And I was like, yeah. So, um, but I think it's also taken a lot of burden off of me in the sense that I don't feel the need to protect my parents, like, I don't have to tell them like, don't, don't go outside or like, don't go to the market, or, like, I view them both as intelligent, knowledgeable, and like consensual adults who can make their own decisions. Um, and so like, God forbid, if my dad, like, went to Costco, got himself the COVID, you know, and didn't, and like, and got really sick, I wouldn't feel like I should have stopped like, I should have stopped knowing full well, if you want to go to Costco, he's gonna go to Costco. If he wants to go to wherever he wants to go, he's going to do it. And he's like, a knowledgeable, smart guy who can make that decision. And I'm actually feel really lucky that I don't have to, like, you know, make that decision for, or like, edge him on like in terms of like, push them one way or the other.

David Dunkin 36:30
Sure.

Michael Chow 36:31
Same, same goes for my mom.

David Dunkin 36:33
Is there, have you, do you have any, have you had any friends that are not in medicine reach out to you? I know, most of your friends are probably in medicine now. But any non medical friends reached out to you, and have you had any interesting interactions in that regard? Or your sister, your sister's not in medicine.

Michael Chow 36:52
Yeah, yeah. And I haven't talked to her recently though. I should call her. Not, not necessarily. I think a lot of it, a lot of people I've interacted with are from, are in medicine. I think the most inn-, like interesting interactions has been kind of looking at their experience, like other people's experience. But no one's called me like, hey, like, what do you think like, what do you think about this? Or like, like, you know, no one's called me asking for advice. I actually had like, a really fascinating interaction with my fiancee's friends who were talking on like a Zoom call, and I was just the, you know, the fly on the wall. And people, people's lives are just so different than ours in, in good, in good and bad ways. Like on one hand, people are just bored out of their minds, like truly trapped at home and like, I'm working at the hospital. Yeah, I'm, I'm, I'm trapped too. But, and I mean, I live in hospital. So God, I'm really trapped. But I still walk out my front door every day, and there was some level of normalcy to that, that I don't think a lot of people got. And that was something that I didn't fully appreciate until I'd kind of overheard the way people were dealing with it. On the flip side, people have, especially people who are in states that are not that affected, California, even, not very affected. People have no idea how bad

it can be. Like I, I think there is kind of like a bit of doom and gloom, like in the media, like if you get COVID, like, you're kind of, like you're gonna die, which is certainly a falsehood. But I think that on, like, some people swing too far the other way, and they're like, Oh, this is all, you know, this is a hoax, or, like, you know, or like, you know, they're s-, like, we're social distancing, we're gonna stay safe, but they just have no concept of like, you know, people, like I just like walk through the hospital and we had floors and floors, literally hundreds of people, on ventilators, and the ICUs don't even look the same. They like, wheeled the bed, so they face the doors and you just see patients, like all the wires are running out under the doors, so there's no contamination and all the machines are outside in the hallway, like it's just nothing like I've ever seen, like the, it's like unrecognizable. And people have no concept of like, how scary it is. Like and, and that's good. I mean, that means that we're doing a relatively good job containing it. But I was just, you forg-, you know, you're just around it so much, you just forget that other people are just sitting at home, like trying to find workouts to do, trying to find out what their next hobby is. And that was shocking for me.

David Dunkin 39:38
Sure. Is there any, um, trying to figure out how to phrase this. I mean, what would you say is the, is the biggest difference you've noticed between what you imagine to kind of be the public perception of what's going on versus like what you're seeing?

Michael Chow 40:01
I actually was really impressed by people's willingness to social distance. I am really, really amazed at how this has caught on and become such a thing. I mean, in some places, like, you know, like some parts of LA or like, you know, like up in the bay like Berkeley, like, you, like, there's some things that like you totally expect, you're like, someone who doesn't know a whole lot about this is gonna be like, social dis--like, you know, is gonna be like the social distancing police, you know what I mean? Like, you're not wearing a mask, or like, you're not staying six feet away from me, like, what the hell's wrong with you? And like some things you expect, and you expect some extremes, but I felt like, and conversely, like you expect some people to storm the Capitol Building and be like, you can't stop us from you know, and you expect those extreme parties. But on the flip side, I was like, again, really impressed to see kind of the general public, accept the stay at home order. And people take this relatively seriously. And I guess, you know, that's part of the necessity of being pretty aggressive with the media coverage of it and make it seem pretty scary. I mean, it is scary, but like, I think you need to kind of take a firm line, and I think people have actually responded relatively well.

David Dunkin 41:30
You know, is there, this is this something I just thought of...

Michael Chow 41:33
Lay it on me.

David Dunkin 41:34
What?

Michael Chow 41:35

I said lay it on me.

David Dunkin 41:36
Oh, I don't know if you feel this way. But I always felt in the, in the medical field, I've, you know, everything is very compartmentalized, in my mind and everything and you know, you, you see things on TV or whatever they're, we're sort of similar to, to work, but now I feel like if I'm imagined myself still in the medical field, that, you know, hearing about COVID-19 at work and then hearing about it at home, and that's all people are talking about, is it, does that kind of disrupt that compartmentalization for you, or?

Michael Chow 42:06
Um, so, I don't know if this is a product of being a resident, but I think that my compartmentalization is essentially non-existent. There just isn't really an avenue for me to escape medicine even before COVID hit. Like if I screwed up something in the hospital during the day, like, you bet, I would hear about it. Regardless of the time at night, I would get a text or call of like, what do you do? Or what's going on with this patient? Like, was it, so I sound, like I don't know if this is like an extreme way to say it, but like, I always live in fear of getting a call about like a patient, you know, like, their patient's not doing well. You know them better than me, like what's going on? You know what I mean? And I always need to be ready to respond. And that's kind of just the nature of training like you're just never really off. Except right now, I'm on vacation. But, but you're, you're just not really off and even now like, I like, I look through the like, I look through our residency threads and like making sure I'm like, advanced and checklists and things to do. And so I never was really compartmentalizing before. So I think for me, relatively business as usual, in terms of not being a very good, normal human being but, but I think for some people who are further along in their career, yeah, I think it certainly would be less compartmentalized.

David Dunkin 43:40
Sure. All right. Well, this is this is the the final question I've, I've asked people in my previous projects. I'm going to try it out with you, Mike.

Michael Chow 43:47
Oh, I'm honored.

David Dunkin 43:49
Is there anything that you feel like I should have asked you?

Michael Chow 43:57
Hmm. I don't think so. I mean, it's, it's I mean, it's this, I think, in this particular project, it's hard. That's a tough question to answer, because this is pretty, pretty open ended. So I mean, anything you should have asked me? No, I mean, I don't, I don't think so.

David Dunkin 44:23
Well, I reserve my right to contact you again, if...

Michael Chow 44:27

By all means.

David Dunkin 44:28
Or you can contact me, if there's something you feel.

Michael Chow 44:30
If I, yeah, if I think of something, I don't know. Maybe I'll go back to New York, and it'll all be on fire. Oh, actually, you know what? I think, I think a good question if you ever interview a doctor again, I think you should ask them about their interactions with their family and friends, being someone who's exposed to COVID. I mean, I think you should ask that of any essential worker. Like I, I'm really fortunate to not have a child right now. Like I can't imagine coming back from the hospital and like knowing I had a kid at home and knowing I can be a threat to them at any moment.

David Dunkin 45:14
Sure. Did you, were you worried about that at all when you came to the west coast from New York?

Michael Chow 45:19
I was originally. I think I had like, one day where I had like, I feel kind of warm. And I had a cough, you know, and then I was like, Oh, maybe I have coronavirus. And, but that was like, a few weeks before I left New York. I had a conversation with Brittany before I left, and I said, you know, I could be a threat to you and to anyone I come into contact with, like, if you don't, like want me to come here, like I understand. And she said, you know, like, I'm also in, like health care, I too work in ICU. If you come here, like, you know, that's like a risk I'm willing to take. And so, you know, like, when I took the flight I like was constantly washing my hands, I kept a mask on my face. Like I wouldn't want to be a danger to anyone during my travel. But I like I think it's kind of weird, getting treated like you're a danger to everyone around you. And that is something that I really struggled with throughout this whole ordeal. I mean, especially like in the hospital, you hear, like as the CDC guidelines are changed, there was that period, that week where it changed like every day, it percolated down to hospital policy. So it started out like if you even think about coughing don't come to work. And then you're like, okay, so, you know, then X amount of people. Yeah, so an X amount of people don't come to work, and then they realize that they have no one left to, you know, do the job. And so then they're like, okay, okay, okay, if you cough, don't come to work. And then you're like, okay, and so then X number of people go out because they coughed and then they still realize they still don't have enough people on so then they said, okay, if you are coughing, get tested. And then if you're positive don't come to work. Or no, like or, like if like if you're a person, if you're, if you're getting tested, then don't come to work. And then they still realize that on and off and then it's just like okay, well if you're positive, come to work and wear a mask. Like and these are the, these are the things you need to do in order to get the job done. And it's not like negligent, but it's in my mind, it was I found it really tough to, it's like, I can't walk outside, like, I like, you know, I can't walk outside or go to the gro--everyone's like, don't go to the grocery store. Like you're a healthcare worker, you're a threat like this that, and I was just like, I can go like, then the CDC says I can wear a bandana and sunglasses to work like as my PPE. And then I'm like, I can walk through like a COVID ICU with a bandana and sunglasses, but I can't go to the grocery store after like, thoroughly

showering myself wearing a mask. Like, that was a huge disconnect for me. And I was just and that was an enormous point of frustration for me. Where it was just like, and I mean, I don't know, like the, it was something that was just, like tough to swallow. And I think it was interesting because like a lot of, I felt that like a lot of providers, like in, like physicians, nurses who were like very smart and like, you know, knowledgeable. Still, like would blindly like, look at these rules. And like, that's the rule like those are the rules like, that's what you got to do. And I'm like, like, six feet apart is like the farthest that we think someone could sneeze projectile spit at someone like that's like six feet. Like that's the, if you're wearing like a mask, like you're not gonna fire like COVID-ridden saliva at someone's six feet away if you're like covering your whole face like, and there's some things where like people, I think people just like turned off their brains, even people that like, and that was something that was tough. Like, it's something that frustrated me particularly.

David Dunkin 49:09
Sure. Cool. Well, thank you. Thank you. That's, I'm good to end the recording if you are.

Michael Chow 49:17
Please do.

David Dunkin 49:18
Alright, thank you, Mike.