1-1-2021

The Subway

Rana Awdish
Henry Ford Health, rawdish1@hfhs.org

Recommended Citation
Awdish R. The Subway. Chest 2021; 159(1):435-436.

CHEST

The Subway

Rana Awdish, MD
Detroit, MI

George Tooker's *The Subway* hangs on the seventh floor of the Whitney Museum in New York. It's a small painting, only $1^1/_2$ by 3 feet wide, though the multiple, intersecting perspectives have the effect of making it appear somehow endless. The repetition of the limited color palette and anonymity of the men create a foreboding monotony. Everyone is a potential threat.

I first saw the Tooker painting during my residency training in New York. I was fittingly lost in a labyrinthine relationship that was drawing me deeper down. It wasn't until I was confronted with the painting that I realized how alienated we'd become. I fell out of the suspended state of apathy. I would find a way to leave.

Visual art can provide access to truths—and different ways of knowing. We have ways of knowing in the ICU that are based on close looking. We follow the latticed, intersecting highways of mottled lines and know the degree to which a heart is struggling to supply tissues. The faded tattoos of military veterans and the dull green ink of incarcerated men tell of the carcinogens and infectious agents to which they may have been exposed. We study coronal frames of a CT scan, until our mind reconstructs a vivid three-dimensional model. We account for what is present that should be absent, and we notice what is absent that should be present. All the while pulling in other contextual clues—the volume status, the inflammatory markers, the cough, the first-person narrative offered to us.

We receive all these things; we hold them in contemplation. As we look closely, the possible diagnoses are kept in a kind of suspension; not real or fixed until they crystallize, through our gaze.

The chart I'm reviewing tells one version of the story. It's April in Detroit, so by the patient's name and ICU room number, there is now a color-coded assessment of his mortality risk based on the modified SOFA score. The automated computer algorithm has attributed the designation Red to his case. The computer is alerting me to his low likelihood of survival, regardless of any imagined attempts at aggressive intervention.

I study each frame of his chest CT scan, looking for something that might offset his score, something the computer couldn't know. I see only pane after pane of cells of ground glass held within a maze of thickened interlobular septa. A purgatory of lung tissue unable to participate in gas exchange. I feel a profound heaviness, a sense of the weight of his lungs and a sadness that isn't about this one patient. There have been so many patients with this same CT image.

I don the protective equipment needed to enter his room and join his nurse. A resident follows. We are anonymous, with faces obscured by protective gear. The patient is supine in the bed, the dark landscape of his body rippling with each machine-delivered breath. His face is tense with discomfort or fear. We providers move independently, each occupied by a different task.

A metal window frame interrupts the early spring sunlight entering his ICU room, and a grid-like shadow forms across the patient and onto the floor. I begin to see a version of us represented in a memory—it's *The Subway*. I am immersed in the bleak, tense mood the underground painting depicts. The woman in red is holding her belly, eyes searching plaintively for an exit. I am in both places at once. The shadows

AFFILIATIONS: From the Pulmonary and Critical Care Department, Henry Ford Hospital; and Wayne State University School of Medicine.
FINANCIAL/NONFINANCIAL DISCLOSURES: None declared.
CORRESPONDENCE TO: Rana Awdish, MD; e-mail: rawdish1@hfhs.org

DOI: https://doi.org/10.1016/j.chest.2020.10.037

cast by the metal grid entrap us, and each passage seems to lead nowhere. We are alone, in an inescapable place.

"What do you see?" I ask the resident, with more desperation than I had intended. "Tell me everything you notice."

"Well, he has shiny skin from years of poor arterial circulation, nailbeds yellowed from nicotine stains, temples sunken from malnutrition," he begins.

We turn and look together at the curves of the ventilator waveforms as they narrow and stiffen; an unmistakable loss of compliance. With so many people excluded from seeing and knowing what is behind the curtain of the ICU room, we are more aware of our responsibility to represent our reality with fidelity.

"What more can you see?" I ask, wanting to find a way to lead us all out. In the painting, the only possible exit seemed to lead further down.

We study the monitors, the vitals, the hemodynamic parameters, and they help to contextualize what we see.

"Well, he's not requiring pressor support. It's only his lungs that are failing. For his age, he really is holding his own," he offers.

The patient squeezes our gloved hands firmly. We join the same reality. He could survive this.

Until that moment, the patient has been in a kind of superposition; suspended in two places at once. He is both alive and dying. We know the weight of our observation has the potential to produce collapse, by envisioning one possible outcome more clearly than another. Our gaze can make one possibility more real. For the patient, and for each other.

I live by the belief that close observation is a form of devotion.

The nurse tells us about a conversation with the family. He survived two different cancers and his daughter is due with his tenth grandchild.

We reassure him, through our masks and shields, elevating our voices over the mechanical hum of the room. "We hear you have a grandbaby coming."

The corners of his lips curl upward, and his chin pulls in toward his chest in a subtle nod.

Up close, he looks less frail. He is lean but sinewy with muscle tone we hadn't appreciated on our first pass. We learn he hasn't been eating well since his wife died. They'd been together since high school, sixty-two years. But he still walks every day. He never misses church services.

When his family gathers to read scripture to him by phone, we observe his BP stabilizing and his heart rate slowing. His eyes tear.

Mary Oliver wrote, "I don't know exactly what a prayer is. I do know how to pay attention."

The automated scoring system advised that the patient be made DNAR. Our assessment affirmed our belief that he could survive, and he did. He made it home in time to meet his grandchild, who bore his wife's name.

When we couldn't stop the surge, when the scale of the loss exceeded our ability to comprehend it and we couldn't see a way out, we had to find another way. By adjusting our scope and refocusing on the individual patient who lay before us, we were reminded of what we knew: Each patient held an endless world within them. And though we couldn't save the world, we could deliberately hold the sacredness of a single, irreplaceable life in our field of view.

And if we did that with enough devotion, each life had the power to lead us out.