

## A PIECE OF MY MIND

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## A Pitiful Sanctuary

**I never anticipated** spending so much of my clinical time in bathrooms. But drug overdose is the leading cause of death among the homeless individuals I take care of at a health center in Boston—and without homes or access to supervised consumption sites, people who are homeless frequently inject drugs behind the closed doors of public bathrooms, including ours.

Despite the housekeeping staff's relentless efforts to keep them clean, these bathrooms can be desolate spaces. I try to imagine what it might be like for a person as he or she approaches the restroom; it's painful to think that this bleak space could be a person's only sanctuary. A trail of desperate attempts at patient education and clinician preparation lines the hallway: a fentanyl alert poster several doors down; an overdose prevention fact sheet a little closer; another sheet asking, "Do you know what to do if a friend overdoses?" I imagine people shuffling past these warnings and pleas. As they enter, the bathroom door clicks decisively behind them. Escaping from the bustling clinic lobby, they are alone, finally hidden to do

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what their mind and body are demanding: dissolve the pain and stem the symptoms of withdrawal.

An alarm sits on the wall above the bathroom door. When a person in the restroom does not move for 2 minutes and 50 seconds (an amount of time we have gradually titrated down in the fentanyl era), the alarm sounds loudly throughout the building, alerting us to a possible overdose. One foot from the door is a naloxone kit on the wall and a bag-valve mask.

Compared with the chaotic street corner outside our front doors or the clinic's busy waiting room, the bathroom is hushed. This sanctuary, however, is a dreary one. Fluorescent light falls upon teal, bare walls, and drab floors. Stains darken the wall and stray hairs cling to the sink. A metal sharps container with a hefty lock is secured to the wall, but the cotton and cooker from someone else's fix may be seen discarded atop the garbage lid. A sour smell permeates the air.

The person takes the only seat: on the toilet.

A few minutes later, when the alarm echoes through our building, we know what has happened. A team of clinicians rapidly coalesces outside the bathroom and security staff swing open the door after knocking and receiving no response. The first thing we see is the person contorted on the floor, having fallen from the toilet.

Their skin is a grim, blue hue. It's common to see the syringe still stuck in the person's arm, bouncing eerily mid-air, or it has dropped into the toilet or on the ground. We use metal mesh gloves to do a quick sweep of the floor and the person's belongings, scanning for more sharps.

We administer naloxone and rescue breaths and then wait, typically for several long minutes. Meanwhile, we try to force ourselves to think of a differential diagnosis beyond overdose, but this is challenging given the crushing wave of multiple overdoses every week in these bathrooms. It's not uncommon that people who have overdosed require placement of an oral airway and lately that's usually been my role. One of the first signs of response is a single spontaneous respiration, and then gradually some fitful gagging and coughing out of the oral airway. Large, saucer-like eyes eventually open and stare up at us; the person is disoriented, petrified. He or she shivers and shakes, breaking out in a profuse sweat, and gradually begins to recoil from the clinicians crouched nearby. We attempt to calm these patients, to assure them

that they are safe, that we care about them, and that, despite their fears of the police, nothing bad will happen to them for being here. We try to convince them to connect to our clinical services, to our overdose monitoring room for people who have used opioids, or to emergency medical services for transport to the hospital. Sometimes they begin to cry, and almost always, they immediately exhibit signs of withdrawal.

Afterwards, so often, the terrified, revived person walks out our door before we can even learn his or her name.

After the person leaves, I find myself trying to imagine what happened moments earlier, what these individuals were experiencing that day or in their lives more generally. What traumas may be tied to their

abject poverty and drug use? What lives does fentanyl allow them to escape? I assemble clues from artifacts, trying to understand lives by observing what they left behind. Some people we have met before in the clinic, but many we have not: without a name, we can't even enter the overdose event into our medical record. The scene is rapidly vanishing—the person has taken off, used injection equipment is discarded, and stray clothes are being gathered from the floor. I feel helpless as the clues begin to evaporate around me. I attempt to reconstruct the scene and reconstruct the individual, to place him, to hold onto her, to not let him vanish. We may never see her again.

I've responded to hundreds of overdoses in recent years. For a long time, I was able to sleep at night. But lately I find myself turning the details over

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in my head for days. I feel haunted, wondering where the individual has gone next.

When I return to the scene in my mind in the coming days, fresh details become visible—things I didn't notice initially—but the emerging contours of the picture become only bleaker. For one, a syringe cap is often still wedged in people's mouths while they're unconscious. The syringe cap is still there because they have bitten it off, and the overdose has happened so quickly that there is no time to spit out the cap. When I work the oral airway into their throat, I must retrieve the cap and maneuver past their teeth and tongue. The sight of their teeth haunts me: they often have multiple loose teeth or just jagged tooth tips left. Recently, one young woman had only a mouth full of rotted tooth tips. Her life had been short, yet it was evident that she had experienced long-term poverty without fluoride or regular tooth brushing, or that she had chronically used methamphetamines. The intersection of poverty and drug use plays out dramatically on the bodies of my patients.

Perhaps the most gruesome detail is that some people often have their pants down around their knees when we find them unconscious. Without a proper surface to place the injection equipment and prepare the syringe, they use their underwear, stretched between their knees, as a makeshift table.

I imagine what it is like for the person to wake up and to similarly attempt to reconstruct what has happened, who we are peering over him or her, why we are there, and what has happened to us in the preceding moments. We are left creating imperfect and incomplete images of one another.

Narratives of doctors becoming hardened to such experiences are commonplace. We learn to detach, to refrain from showing that we are deeply affected by our patients' or our own experiences of trauma. We learn to show we are unaffected by sleep deprivation

or having to deliver heart-rending news to people who had turned to us as their last hope. We learn to erase our suffering.

Lately, the tightly wound threads of this hardening are coming loose in me. I have been permitting myself to hold on to, and even reconstruct, the human details of each of these overdoses. I find myself looking and listening for anything that could indicate who these people are and what they are experiencing. This is a good thing—a humane thing—but I recognize it is also one of the effects of vicarious trauma. I don't only notice; I am haunted.

There is both frustration and satisfaction in responding to bathroom overdoses. The bathroom alarms, security officers, and rapid response teams have helped to keep alive people who may have overdosed alone in nearby alleys or behind bushes. We've not yet lost any lives in our bathrooms. But I despair at the fact that, despite trying to know these people, I cannot know them—not fully. I can only grasp at these fragments and try to assemble a hazy image of who they are. I wish I could be with them before they injected, that I had more chances to really know them before I'm hovering over them on the grimy bathroom floor, sliding an oral airway into their throat.

What haunts me the most is that our hands are tied. We are not allowed to do what we know we need to do. We need to be able to be with a person—not abandon them—when their disease is at its worst. We need to be able to say, "Stay here. We'll be with you." We need to be able to show them we care, to earn their trust, especially as their lives have unraveled completely and fentanyl is the only relief in sight. We must be able to create cleaner, safer spaces for people to consume drugs and be connected to help. Supervised consumption sites would not only play an important part in stemming the tide of opioid overdose deaths for people downstream in this epidemic, but they would also reduce the trauma associated with injection drug overdoses—for both people who use drugs and the people who care about them.

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