We are emergency physicians. We resuscitate the dead and dying, and then we keep them alive. We work up, clear, and discharge patients. We tidy up the board, sign out, and then go home. Right?

Historically, our scope of practice has been confined to the hustle and bustle of the emergency department (ED), and the appeal for many is the ability to walk away at the end of the shift. Things have changed though, and our specialty is evolving. The pandemic has codified our place on the frontline of population health. For many individual patients, as well as the greater public good, the ED is all that stands against the growing number of societal harms. This obligation does not end with infectious diseases but encompasses all the worsening public health crises: firearm deaths; homelessness; unmanaged mental health; and more. Embracing our role in addressing the needs of our local communities, such as the worsening opioid use disorder crisis, is now an essential part of our job. This truth may be no more evident than during a walk right outside the ED’s front door. As the saying goes, a picture speaks a thousand words…

On a frigid winter day with just a few minutes to spare, the opportunity to step outside during a busy shift presented itself. After turning the corner onto a familiar street, the sidewalk was found to be obstructed by piles of used syringes. There were unfolded cardboard boxes, empty food containers, and dirty clothes spilled across the sidewalk among the syringes. Community members, excluded from the photo, were actively using intravenous (IV) drugs as they huddled in a doorway within the brick wall of the hospital—as visible to the public as the sun’s light.

These photos were taken in a neighborhood within the poorest congressional district of the United States. On one side of the street was a school, and on the other, the hospital. Here was a nearly impassable mess of used syringes and the remnants of a frozen winter campsite, juxtaposed between the two pillars of society meant to empower individuals to lead fuller lives. The painful irony
of these images is demoralizing. There were emergency physicians working tirelessly to save the lives of patients inside, while just on the other side of the wall other patients were struggling to get by.

These needles are discarded after a clean single use, the empty boxes left behind as proof. There are filters and sterile saline. They have come from a local harm reduction program meant to mitigate the infectious mortality and morbidity associated with opioid use disorder. There are discarded fentanyl test strips and empty naloxone atomizers among the debris, too, likely given just on the other side of those brick walls meant to prevent the next lethal overdose. These are hopeful details, partially hidden within the instilling dread of this social blight but keenly evident to an observant eye.

This is not a battle lost, but a fight that has just begun. Physicians in all specialties are feeling the burden of new social imperatives, and the field of medicine as a whole is on its own so-called winter walk right now. Despite the current biting cold of a dysfunctional healthcare system, the embers of hope must be kindled. As emergency medicine evolves, it must continue to embrace the imperative needs of the most vulnerable. Our patients need us inside and outside the ED, and our specialty continues to rise to the occasion.

Figure 3. A snapshot of the hardships that some of our most vulnerable patients face after discharge from the emergency department.

Address for Correspondence: Corey S. Hazekamp, MD, MS, NYC H+H/Lincoln, Department of Emergency Medicine, 234 E. 149th St., Bronx, NY 10451. Email: corey.hazekamp@gmail.com.

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