

The Other Side of the Park: Reflections From a Mobile Medical Team

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My stomach turns with the stop-and-start of the mobile medical van through Bronx traffic, and with the awareness that the care we are about to offer may soon be undone. “We’re heading to the park. We’ll go see if we can meet the couple living there,” a team member calls out from the front.

Our destination, with serene green spaces tucked between enormous boulders, feels beautifully out of place against the backdrop of the bustling city. As we approach, I notice dump trucks lined up together. At first, I’m confused — how did they even get up there? Then the confusion sharpens into alarm: an encampment sweep.

I had only visited the park a handful of times before, but our street outreach team regularly checks on a small group of people who have made a community on the hill. Some are siblings or spouses; others have found each other through shared circumstances. My patients describe how being alone can be dangerous out here—vulnerable to assaults, theft, overdose. Being together offers a fragile but essential sense of safety. Nights are particularly hard—sleeping in tents or on the bare ground, braving whatever weather comes between the hard pavement below and the sky above.

On this Friday, our team includes an outreach worker, a substance use counselor, and me, a family doctor. We bring sandwiches, water, and donated socks and hats. We carry alcohol pads, drug-testing strips, and naloxone. We offer medical care for those who want it, often focusing on substance use and wound care. It is the kind of medicine I always imagined practicing, medicine that meets people where they are.

Some of my loved ones ask about my job with at least one eyebrow raised. I’ve come to appreciate those moments as they give me a chance to talk about the physician who built this team and shaped how I understand this work. As a resident, I would shadow her and watch how she listened, prioritizing personal connection over the idea of a perfect clinical encounter. She taught me to recognize and respect the expertise of patients, and to offer care that fit their realities: feasible, accessible, acceptable. Raised eyebrows don’t always soften, but I feel the space open to make room for curiosity, for concern, and for seeing the resilience of our unhoused patients more clearly.

People sometimes ask whether giving out these supplies makes things worse. Out here, the reality begs different questions. We are not deciding whether people use drugs or sleep outside — we are helping our neighbors survive another day. The small items we offer are a way to remain useful, reducing risk and harm, and to remain human with one another. The work asks us to stand in spaces of uncertainty, showing up again and again. The work asks us to engage slowly enough that trust can take shape, and offer care that is consistent and grounded in dignity.

At the park, we walk up the hill cautiously as we take in the scene. A half-dozen uniformed park and sanitation workers stand waiting while a patient, whom I will call Lisa, scrambles to gather what she can before the rest is tossed. Watching her move quickly, I imagine how I would be paralyzed if I had only minutes to choose what parts of my home to carry with me.

We ask how we can help. Mostly, she wants us nearby, explaining that “they will be nicer if a doctor is here.” One worker taps his watch, signaling for her to hurry.

“Hi, I’m Dr Kumar,” I say quietly. “Lisa is my patient, and she is going as fast as she can.” The counselor and I begin folding and stacking her belongings into half-broken suitcases and plastic bags.

“I can’t find my pump,” she whispers.

We dig through what remains and find her albuterol.

Nearby, I see a young man doing the job he has been assigned. “This is a park,” he says plainly. “They have shelters where they can go.”

“And what does that tell you,” I ask, trying to keep my voice steady, “about why someone might choose this?” I continue, gesturing gently around us. The worker’s shoulders loosen a fraction, his weight shifting back in subtle acknowledgement.

The familiar frustration and sadness settle in again. I am not trying to win an argument. I want him to imagine the calculations Lisa makes every night: trying to stay safe from violence, stay with her husband, hold onto her belongings, avoid painful withdrawal, and preserve whatever autonomy she still has. I want him to see what I see: whatever stability she managed to build, dissolved in minutes; the future she was working toward, suddenly derailed.

The sweep ends quickly. Lisa is displaced, again. But she isn’t going to a shelter or to a drop-in center. She is just going to the other side of the park.

This day stays with me. There is a particular ache that comes as a physician when witnessing suffering we cannot treat. I feel Lisa’s urgency, the quiver in her voice, the fear beneath it. I feel the tension between what I can offer and what I cannot stop.

In cities across the country, encampment sweeps are often framed as solutions. But in my work, I have watched them function instead as cycles of displacement, moving people from one precarious place to another, without addressing the conditions that led them there. Too often, I have treated wounds worsened by sweeps, managed withdrawals intensified by sudden disruption, and watched patients lose lifesaving medications during hurried clear-outs. I am left wondering what it will take to see the people we meet on the street not as problems to be removed, but as neighbors who need room to breathe, to heal, and to belong.

I think of Lisa walking to the other side of the park, carrying what she could salvage. *What would it mean if, for once, the ground beneath her didn’t keep disappearing?*