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As I slid the butterfly into the nearly-filled sharps box, the delicate tubing curled back on itself as if refusing to enter, and the business end plunged deep into my ungloved thumb. Stunned, I quickly pulled away and pulled the needle out. I wasn't bleeding, but there had definitely been blood in the needle from the blood gas I had just performed on my patient with DKA. In the ensuing moments I had an out-of-body experience. The Bellevue ER sights, sounds, and smells faded into the distance and all that existed was my throbbing thumb, the guilty sharps box, and my mortality.

In 1990 the beds in Bellevue hospital were filled with HIV infected, IV-drug-abusing, frequently homeless men and women. They came in with PCP and Kaposi's sarcoma, but they also came in with fevers of unknown origin ("shooter with a fever") and lots of bread and butter medicine.

In 1990, as a third-year clerk at Bellevue, my pockets were filled with the paraphernalia of everyday medical ward work. While students at some other schools carried pocket guides of differential diagnosis, Glasgow coma scales, and Snellen eye charts, at Bellevue you carried equipment and supplies or you didn't survive. The words "ancillary services" didn't exist in our vocabulary. We drew all the bloods, put in all the IVs, collected and measured urine and stool, transported patients, checked fingersticks, you name it.

And gloves? They just got in the way. We always wore them for procedures that didn't require fine manual dexterity: a central line or lumbar puncture. But try to find a fluttering radial artery or a tiny vein on the dorsum of an addict's foot with a gloved hand. Perfectly executed "scut" was indispensable if you wanted honors, and no one was going to jeopardize that by wearing gloves for every little thing.

The drawback to Bellevue was that I spent hours every day doing scut instead of learning. My day revolved around the daily labs that had to be drawn and my week revolved around a schedule of every-third-day IV changes for all my patients.

The benefit (far outweighing the drawback) was that I became expert at scut. I could draw blood from a stone, produce clear spinal fluid (the "champagne tap") from the most combative patient, get a Foley past the biggest prostate. Even more important, the scut put me in constant contact with my patients. I spent more time with them, got to know them, cajoled, pleaded, and threatened them on a daily basis for the sake of yet another CBC or a new IV.

How else would I have discovered that "Doc" was my new patient's street moniker? He came in with fever and not much else, which to him meant a safe, clean bed and three square meals a day, at least until his blood cultures came back negative.

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He was calm and cooperative during my admission H&P, letting me attempt the requisite three sets of blood cultures. But this time my painstakingly honed skills actually failed me. I tried the dorsum of his hands, his wrists, his antecubital veins, forearms, feet, and groin. He was scarred down from a lifetime of injecting and skin-popping drugs. I was about to try an arterial stick when he said good-naturedly, "Can I try before you really hurt me?" When I looked at him in disbelief he explained that on the street he was known as Doc because of his ability to find a vein in even the most hardened addicts.

Every clinical and social instinct I had was telling me not to, but I found myself handing him my butterfly needle and blood culture bottles. He looked at the butterfly and said, "Don't you have a real needle"? When I produced a handful of 10 cc syringes with inch-and-a-half-long 20-gauge needles, he smiled and pointed to a patch of skin midway up his inner right thigh. Not a vein in sight, but I dutifully applied the betadine and prepped the area. He uncapped the needle and without hesitating plunged it deep into his thigh. Pulling back on the syringe he easily filled it, earning him my undying gratitude and admiration.

I was called away to my next admission, a young woman with Type 1 diabetes and DKA. This was what I had been waiting for—a chance to impress my resident and attending, review my pathophysiology, and monitor her acid-base status by performing lots of ABGs (the way things were done in the "days of the giants"). I gloated to everyone within earshot about my new admission but, because I was so excited, did not notice the grins and knowing glances I was getting from the senior residents.

The patient was perfect—sick enough to require careful metabolic monitoring but not so sick that she'd keep me up all night. She was young, attractive, intelligent, and gave a good history. She had been symptomatic for several days, wasn't sure why she slipped into DKA, and was more than happy to comply with any test or procedure I wanted to perform.

We spent some quality time together over the next six hours while waiting for a bed to open up on the ward, she gradually improving while I reviewed urinalyses and blood gases. When a passing ER attending greeted her with unusual familiarity I realized I might get some valuable past history from him. But when I asked he looked at me in disbelief, amazed that I had no idea who I was treating.

She was apparently known to every intern and resident in the hospital. Despite routinely maintaining excellent control of her diabetes as an outpatient, she managed to get herself admitted almost monthly for DKA. This was because her only source of income was prostitution, and turning tricks in the hospital was safer and cleaner than doing it in the streets. All it took was a few missed doses of insulin to land her in one of those coveted safe, clean beds. I learned from the attending that she was a model patient on admission, but later would rarely be found in her own

bed during her hospital stay. She was typically working other patients' rooms and counted the prison-ward guards among her clientele.

I was stunned. Now I understood all the knowing looks I had gotten from the housestaff.

The very next blood gas was the one that ended up in my thumb, with subsequent visions of HIV and non-A, non-B hepatitis floating in my head. She had reported being HIV negative when I had taken her initial history, but had also denied any major risk factors for contracting HIV or hepatitis. I didn't know what to believe.

Was I really at risk? Was I supposed to tell someone what happened? And was I willing to risk looking sloppy and uninformed, possibly even incurring the wrath of my resident for (1) not wearing gloves, (2) overstuffing a sharps box, and (3) slowing us down on an on-call night?

In 1990 we didn't talk about needlesticks and tried not to think too much about contracting anything serious from our patients. This was especially ironic at Bellevue, where practically every patient we cared for either had AIDS or was at high risk for contracting it.

So I told no one except my wife, who accepted it with the quiet fortitude that got us through medical school and residency, and I did nothing except check my patient's blood for HIV and hepatitis. She was negative for both but somehow that did not provide much solace in the ensuing months.

My first needlestick was, happily, my only one. It helped me develop a newfound respect for sharps boxes and a more deliberate approach to procedures. Since then I have taught hundreds of students and residents how to do procedures, always insisting that wearing gloves must be their first priority. But I still struggle with the need to wear gloves all the time. Physical contact with patients, not to mention the quest for those tiny arteries, still seems too important to sacrifice to a layer of latex.

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