**Scenario 8: Anesthesia**

You are an anesthesia resident in the OR in August. You are supervising a fourth year medical student on his anesthesia elective. He is starting an intravenous line on a three year-old boy who is having an elective cleft palate repair. The student reaches for a bag of intravenous fluid not realizing it was left in the room from the previous case. The intravenous catheter is placed perfectly and the student flushes the line with a few milliliters of fluid. Within a minute the child experiences severe muscle fasciculations and then respiratory arrest. You call a code blue, establish an airway and ventilate the patient. As you ventilate the boy, you look at the bag of fluid and notice that the bag had the letters "suc" written on it. You realize that the bag contained succinylcholine and know that the effects should wear off in a few minutes. They do and the child begins breathing again in about 8 minutes. He is very scared and cries inconsolably. The case is delayed 30 minutes in starting, and you debate whether to tell his parents about what happened. The rest of the case goes without a problem.

At lunch, you and the medical student are talking about what happened. You share your concern about the poorly labeled fluid bag with another resident, a close friend. She relates a story of her own. A week earlier, she was assisting on a case and reached into her anesthesia cart in the place where fentanyl is kept. She pulled out a syringe that she thought contained fentanyl, but it actually contained rocuronium. Although she only gave 0.75 ml, the child went into respiratory arrest. The child was intubated and the effects wore off in about 60 minutes.

Together you wonder how often these kind of events occur. You are reluctant to tell others about your mistake as you are afraid it will become part of your record. Yet, you know you have learned to always check for label on bags of solutions and syringes.