

## Communication practices on 4 Harvard surgical services: a surgical safety collaborative.

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Communication failures are a common cause of patient harm in both [medical](#) and [surgical](#) settings. [Patterns](#) of communication breakdown in surgical settings have led to implementation of [checklists](#) and [briefings](#) as interventions to reduce such harm. This prospective study examined communication breakdowns between surgical residents and their supervising attendings in the pre- and postoperative periods to identify opportunities for improvement. Investigators discovered that one-third of critical patient events were not communicated to attending surgeons. The residents reported no barriers to calling their attending, but felt that this was not necessary for safe patient care in 76% of the events. When discussions did occur, the attendings changed management in 33% of cases. The authors conclude that residents fail to adequately engage their attending surgeons in patient care despite the attending surgeons' receptiveness and interest in being contacted. Further research is required to determine if these findings represent pure communication failures, [challenges](#) in trainee oversight, or a [culture of safety](#) issue.