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Debunking the myth that the majority of medical errors are attributed to communication.

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Optimizing communication during handoffs in the operating room and many other contexts within health care is key to maintaining patient safety. Although prior research has shown that communication breakdowns frequently contribute to adverse events, the degree to which medical errors can be attributed to communication failures as the primary cause remains unknown. In this systematic review, researchers found three dominant categories of medical error: errors of commission, errors of omission, and errors resulting from communication deficiencies. Of the 42 articles that met inclusion criteria, errors of communication were common in 3 studies. They conclude that medical errors more often result from errors of commission or omission rather than miscommunication. A past WebM&M commentary described an incident involving miscommunication in the operating room that led to an error in patient care.