

Alan F Merry

List of Publications by Citations

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The third column is the impact factor (IF) of the journal, and the fourth column is the number of citations of the article.

155
papers

6,934
citations

28
h-index

82
g-index

199
ext. papers

8,304
ext. citations

3.3
avg, IF

5.47
L-index

#	Paper	IF	Citations
155	A surgical safety checklist to reduce morbidity and mortality in a global population. <i>New England Journal of Medicine</i> , 2009 , 360, 491-9	59.2	3597
154	Combining paracetamol (acetaminophen) with nonsteroidal antiinflammatory drugs: a qualitative systematic review of analgesic efficacy for acute postoperative pain. <i>Anesthesia and Analgesia</i> , 2010 , 110, 1170-9	3.9	400
153	Changes in safety attitude and relationship to decreased postoperative morbidity and mortality following implementation of a checklist-based surgical safety intervention. <i>BMJ Quality and Safety</i> , 2011 , 20, 102-7	5.4	307
152	Global operating theatre distribution and pulse oximetry supply: an estimation from reported data. <i>Lancet, The</i> , 2010 , 376, 1055-61	4.0	274
151	Cerebral ischemic lesions on diffusion-weighted imaging are associated with neurocognitive decline after cardiac surgery. <i>Stroke</i> , 2008 , 39, 1427-33	6.7	155
150	International Standards for a Safe Practice of Anesthesia 2010. <i>Canadian Journal of Anaesthesia</i> , 2010 , 57, 1027-34	3	127
149	Multimodal system designed to reduce errors in recording and administration of drugs in anaesthesia: prospective randomised clinical evaluation. <i>BMJ, The</i> , 2011 , 343, d5543	5.9	117
148	Bivalirudin versus heparin and protamine in off-pump coronary artery bypass surgery. <i>Annals of Thoracic Surgery</i> , 2004 , 77, 925-31; discussion 931	2.7	94
147	Implementation of the World Health Organization surgical safety checklist, including introduction of pulse oximetry, in a resource-limited setting. <i>Annals of Surgery</i> , 2013 , 257, 633-9	7.8	90
146	A new, safety-oriented, integrated drug administration and automated anesthesia record system. <i>Anesthesia and Analgesia</i> , 2001 , 93, 385-90, 3rd contents page	3.9	79
145	Error, blame, and the law in health care--an antipodean perspective. <i>Annals of Internal Medicine</i> , 2003 , 138, 974-9	8	71
144	Combined acetaminophen and ibuprofen for pain relief after oral surgery in adults: a randomized controlled trial. <i>British Journal of Anaesthesia</i> , 2010 , 104, 80-8	5.4	66
143	The incidence of hypoxemia during surgery: evidence from two institutions. <i>Canadian Journal of Anaesthesia</i> , 2010 , 57, 888-97	3	66
142	A New, Safety-Oriented, Integrated Drug Administration and Automated Anesthesia Record System. <i>Anesthesia and Analgesia</i> , 2001 , 93, 385-390	3.9	66
141	Clinical assessment of a new anaesthetic drug administration system: a prospective, controlled, longitudinal incident monitoring study. <i>Anaesthesia</i> , 2010 , 65, 490-9	6.6	58
140	Sleep loss and performance of anaesthesia trainees and specialists. <i>Chronobiology International</i> , 2008 , 25, 1077-91	3.6	58
139	World Health Organization-World Federation of Societies of Anaesthesiologists (WHO-WFSA) International Standards for a Safe Practice of Anesthesia. <i>Anesthesia and Analgesia</i> , 2018 , 126, 2047-2053	3.9	57

138	World Health Organization-World Federation of Societies of Anaesthesiologists (WHO-WFSA) International Standards for a Safe Practice of Anesthesia. <i>Canadian Journal of Anaesthesia</i> , 2018 , 65, 698-708	3	56
137	Cerebral protection by lidocaine during cardiac operations: a follow-up study. <i>Annals of Thoracic Surgery</i> , 2009 , 87, 820-5	2.7	54
136	Medication errors--new approaches to prevention. <i>Paediatric Anaesthesia</i> , 2011 , 21, 743-53	1.8	51
135	Errors, Medicine and the Law 2001 ,		51
134	Interdisciplinary team interactions: a qualitative study of perceptions of team function in simulated anaesthesia crises. <i>Medical Education</i> , 2008 , 42, 382-8	3.7	48
133	Sustainability and long-term effectiveness of the WHO surgical safety checklist combined with pulse oximetry in a resource-limited setting: two-year update from Moldova. <i>JAMA Surgery</i> , 2015 , 150, 473-9	5.4	34
132	The contribution of labelling to safe medication administration in anaesthetic practice. <i>Baillieres Best Practice and Research in Clinical Anaesthesiology</i> , 2011 , 25, 145-59	4	33
131	Microbiological Contamination of Drugs during Their Administration for Anesthesia in the Operating Room. <i>Anesthesiology</i> , 2016 , 124, 785-94	4.3	32
130	Building the evidence on simulation validity: comparison of anesthesiologists' communication patterns in real and simulated cases. <i>Anesthesiology</i> , 2014 , 120, 142-8	4.3	29
129	Randomized comparison between the combination of acetaminophen and ibuprofen and each constituent alone for analgesia following tonsillectomy in children. <i>Canadian Journal of Anaesthesia</i> , 2013 , 60, 1180-9	3	28
128	Chronic extra-aortic balloon counterpulsation: first-in-human pilot study in end-stage heart failure. <i>Journal of Heart and Lung Transplantation</i> , 2010 , 29, 1427-32	5.8	27
127	An iterative process of global quality improvement: the International Standards for a Safe Practice of Anesthesia 2010. <i>Canadian Journal of Anaesthesia</i> , 2010 , 57, 1021-6	3	27
126	A simulation design for research evaluating safety innovations in anaesthesia*. <i>Anaesthesia</i> , 2008 , 63, 1349-57	6.6	27
125	Assessing the similarity of mental models of operating room team members and implications for patient safety: a prospective, replicated study. <i>BMC Medical Education</i> , 2016 , 16, 229	3.3	25
124	Improved scores for observed teamwork in the clinical environment following a multidisciplinary operating room simulation intervention. <i>New Zealand Medical Journal</i> , 2016 , 129, 59-67	0.8	25
123	Reporting of complications after laparoscopic cholecystectomy: a systematic review. <i>Hpb</i> , 2018 , 20, 786-794		24
122	Refining Target-Controlled Infusion: An Assessment of Pharmacodynamic Target-Controlled Infusion of Propofol and Remifentanyl Using a Response Surface Model of Their Combined Effects on Bispectral Index. <i>Anesthesia and Analgesia</i> , 2016 , 122, 90-7	3.9	24
121	Data sharing for pharmacokinetic studies. <i>Paediatric Anaesthesia</i> , 2009 , 19, 1005-10	1.8	23

120	Anaesthetic drug administration as a potential contributor to healthcare-associated infections: a prospective simulation-based evaluation of aseptic techniques in the administration of anaesthetic drugs. <i>BMJ Quality and Safety</i> , 2012 , 21, 826-34	5.4	23
119	Merry and McCall Smith's Errors, <i>Medicine and the Law</i> 2017 ,		22
118	Improving Anesthesia Safety in Low-Resource Settings. <i>Anesthesia and Analgesia</i> , 2018 , 126, 1312-1320	3.9	21
117	A randomized comparison between records made with an anesthesia information management system and by hand, and evaluation of the Hawthorne effect. <i>Canadian Journal of Anaesthesia</i> , 2013 , 60, 990-7	3	20
116	A behaviourally anchored rating scale for evaluating the use of the WHO surgical safety checklist: development and initial evaluation of the WHOBARS. <i>BMJ Quality and Safety</i> , 2016 , 25, 778-86	5.4	19
115	Retesting the Hypothesis of a Clinical Randomized Controlled Trial in a Simulation Environment to Validate Anesthesia Simulation in Error Research (the VASER Study). <i>Anesthesiology</i> , 2017 , 126, 472-481	4.3	18
114	A new infusion syringe label system designed to reduce task complexity during drug preparation. <i>Anaesthesia</i> , 2007 , 62, 486-91	6.6	18
113	Extra-aortic balloon counterpulsation: an intraoperative feasibility study. <i>Circulation</i> , 2005 , 112, 126-31	16.7	17
112	Can team training make surgery safer? Lessons for national implementation of a simulation-based programme. <i>New Zealand Medical Journal</i> , 2016 , 129, 9-17	0.8	17
111	Lifebox: A Global Patient Safety Initiative. <i>A & A Case Reports</i> , 2016 , 6, 366-9		15
110	Bivalirudin, blood loss, and graft patency in coronary artery bypass surgery. <i>Seminars in Thrombosis and Hemostasis</i> , 2004 , 30, 337-46	5.3	15
109	Clinical tolerability of perioperative tenoxicam in 1001 patients--a prospective, controlled, double-blind, multi-centre study. <i>Pain</i> , 2004 , 111, 313-322	8	15
108	The effects of the general anaesthetic isoflurane on the honey bee (<i>Apis mellifera</i>) circadian clock. <i>Chronobiology International</i> , 2016 , 33, 128-33	3.6	14
107	Use of a new task-relevant test to assess the effects of shift work and drug labelling formats on anesthesia trainees' drug recognition and confirmation. <i>Canadian Journal of Anaesthesia</i> , 2011 , 58, 38-47		13
106	Patient safety in an interprofessional learning environment. <i>Medical Education</i> , 2005 , 39, 512-3	3.7	13
105	A 'paperless' wall-mounted surgical safety checklist with migrated leadership can improve compliance and team engagement. <i>BMJ Quality and Safety</i> , 2016 , 25, 971-976	5.4	13
104	A framework of comfort for practice: An integrative review identifying the multiple influences on patients' experience of comfort in healthcare settings. <i>International Journal for Quality in Health Care</i> , 2017 , 29, 151-162	1.9	12
103	How does the law recognize and deal with medical errors?. <i>Journal of the Royal Society of Medicine</i> , 2009 , 102, 265-71	2.3	12

102	Educating for healthcare quality improvement in an interprofessional learning environment: a New Zealand initiative. <i>Journal of Interprofessional Care</i> , 2006 , 20, 555-7	2.7	11
101	Focus on thrombin: alternative anticoagulants. <i>Seminars in Cardiothoracic and Vascular Anesthesia</i> , 2007 , 11, 256-60	1.4	11
100	Criminalisation of unintentional error in healthcare in the UK: a perspective from New Zealand. <i>BMJ, The</i> , 2019 , 364, l706	5.9	10
99	Aspiration during anaesthesia in the first 4000 incidents reported to webAIRS. <i>Anaesthesia and Intensive Care</i> , 2019 , 47, 442-451	1.1	9
98	Clevidipine compared with nitroglycerin for blood pressure control in coronary artery bypass grafting: a randomized double-blind study. <i>Canadian Journal of Anaesthesia</i> , 2014 , 61, 398-406	3	9
97	Improving the quality and safety of patient care in cardiac anesthesia. <i>Journal of Cardiothoracic and Vascular Anesthesia</i> , 2014 , 28, 1341-51	2.1	9
96	Paperless anesthesia: uses and abuses of these data. <i>Paediatric Anaesthesia</i> , 2015 , 25, 1184-92	1.8	9
95	Reducing harm from falls. <i>New Zealand Medical Journal</i> , 2016 , 129, 89-103	0.8	8
94	Capturing the experience of the hospital-stay journey from admission to discharge using diaries completed by patients in their own words: a qualitative study. <i>BMJ Open</i> , 2019 , 9, e027258	3	7
93	Fake and expired medications in simulation-based education: an underappreciated risk to patient safety. <i>BMJ Quality and Safety</i> , 2016 , 25, 917-920	5.4	7
92	Measuring the Repeatability of Simulated Physiology in Simulators. <i>Simulation in Healthcare</i> , 2015 , 10, 336-344	2.8	6
91	Incident reporting at the local and national level. <i>International Anesthesiology Clinics</i> , 2014 , 52, 69-83	0.6	6
90	Has anesthesia care become safer and is anesthesia-related mortality decreasing?. <i>F1000 Medicine Reports</i> , 2009 , 1,		5
89	Towards a safer culture: implementing multidisciplinary simulation-based team training in New Zealand operating theatres - a framework analysis. <i>BMJ Open</i> , 2019 , 9, e027122	3	5
88	General Anaesthesia Shifts the Murine Circadian Clock in a Time-Dependant Fashion. <i>Clocks & Sleep</i> , 2021 , 3, 87-97	2.9	5
87	Medical accountability and the criminal law: New Zealand vs the world. <i>Health Care Analysis</i> , 1996 , 4, 45-54	2.3	5
86	How safe are our hospitals?. <i>New Zealand Medical Journal</i> , 2002 , 115, U268	0.8	5
85	Improved compliance with the World Health Organization Surgical Safety Checklist is associated with reduced surgical specimen labelling errors. <i>New Zealand Medical Journal</i> , 2016 , 129, 63-7	0.8	5

84	Examining reliability of WHOBARS: a tool to measure the quality of administration of WHO surgical safety checklist using generalisability theory with surgical teams from three New Zealand hospitals. <i>BMJ Open</i> , 2019 , 9, e022625	3	4
83	Evaluation of the effect of multidisciplinary simulation-based team training on patients, staff and organisations: protocol for a stepped-wedge cluster-mixed methods study of a national, insurer-funded initiative for surgical teams in New Zealand public hospitals. <i>BMJ Open</i> , 2020 , 10, e032997	3	4
82	The Bare Minimum Requires Caution. <i>World Journal of Surgery</i> , 2016 , 40, 2821-2822	3.3	4
81	Medication Errors in the Perioperative Setting. <i>Current Anesthesiology Reports</i> , 2017 , 7, 320-329	1	4
80	Doctors' willingness to give honest answers about end-of-life practices: a cross-sectional study. <i>BMJ Open</i> , 2013 , 3,	3	4
79	Role of anesthesiologists in WHO safe surgery programs. <i>International Anesthesiology Clinics</i> , 2010 , 48, 137-50	0.6	4
78	Ward calls not so scary for medical students after interprofessional simulation course: a mixed-methods cohort evaluation study.. <i>BMJ Simulation and Technology Enhanced Learning</i> , 2018 , 4, 133-140	1.1	4
77	Medical students, sensitive examinations and patient consent: a qualitative review. <i>New Zealand Medical Journal</i> , 2018 , 131, 29-37	0.8	4
76	Mental Health Inquiries in the Case of Homicide. <i>Psychiatry, Psychology and Law</i> , 2020 , 27, 894-911	1.3	3
75	Practice patterns and perceptions of Australian and New Zealand anaesthetists towards perioperative oxygen therapy. <i>Anaesthesia and Intensive Care</i> , 2019 , 47, 288-294	1.1	3
74	Ethics, industry, and outcomes. <i>Seminars in Cardiothoracic and Vascular Anesthesia</i> , 2008 , 12, 7-11	1.4	3
73	Is directed donation misguided?. <i>Clinical and Experimental Ophthalmology</i> , 2004 , 32, 5-8	2.4	3
72	The right membrane for the job. <i>Filtration and Separation</i> , 2001 , 38, 16-18	0.1	3
71	Lignocaine: neuro-protective or wishful thinking?. <i>Journal of Extra-Corporeal Technology</i> , 2009 , 41, P37-42	2.4	3
70	Is Conventional Bypass for Coronary Artery Bypass Graft Surgery a Misnomer?. <i>Journal of Extra-Corporeal Technology</i> , 2018 , 50, 225-230	0.4	3
69	Maximising comfort: how do patients describe the care that matters? A two-stage qualitative descriptive study to develop a quality improvement framework for comfort-related care in inpatient settings. <i>BMJ Open</i> , 2020 , 10, e033336	3	3
68	Families of victims of homicide: qualitative study of their experiences with mental health inquiries. <i>BJPsych Open</i> , 2020 , 6, e100	5	3
67	A new surgical site infection improvement programme for New Zealand: early progress. <i>New Zealand Medical Journal</i> , 2015 , 128, 51-9	0.8	3

66	Reducing perioperative harm in New Zealand: the WHO Surgical Safety Checklist, briefings and debriefings, and venous thrombembolism prophylaxis. <i>New Zealand Medical Journal</i> , 2015 , 128, 54-67	0.8	3
65	Measurement of patient-reported outcomes after laparoscopic cholecystectomy: a systematic review. <i>Surgical Endoscopy and Other Interventional Techniques</i> , 2019 , 33, 2061-2071	5.2	2
64	Postoperative ischemia and cognitive impairment in cardiac surgery patients. <i>Annals of Thoracic Surgery</i> , 2009 , 87, 672-3; author reply 673-4	2.7	2
63	Human factors and the cardiac surgical team: a role for simulation. <i>Journal of Extra-Corporeal Technology</i> , 2007 , 39, 264-6	0.4	2
62	What blood pressure is appropriate for cardiopulmonary bypass and how to get it. <i>Journal of Extra-Corporeal Technology</i> , 2006 , 38, 69-71	0.4	2
61	Safer cardiac surgery. <i>Journal of Extra-Corporeal Technology</i> , 2009 , 41, P43-7	0.4	2
60	We Asked the Experts: The WHO Surgical Safety Checklist and the COVID-19 Pandemic: Recommendations for Content and Implementation Adaptations. <i>World Journal of Surgery</i> , 2021 , 45, 1293-1296	3.3	2
59	Medication Safety during Anesthesia and the Perioperative Period 2021 ,		2
58	Reporting of Clinical Outcomes After Endovascular Aortic Aneurysm Repair: A Systematic Review. <i>Annals of Vascular Surgery</i> , 2021 ,	1.7	2
57	A Brief History of the Patient Safety Movement in Anaesthesia 2014 , 541-556		2
56	The effect of implementing an aseptic practice bundle for anaesthetists to reduce postoperative infections, the Anaesthetists Be Cleaner (ABC) study: protocol for a stepped wedge, cluster randomised, multi-site trial. <i>Trials</i> , 2019 , 20, 342	2.8	1
55	What happens at the end of life? Using linked administrative health data to understand healthcare usage in the last year of life in New Zealand. <i>Health Policy</i> , 2018 , 122, 783-790	3.2	1
54	Global health and anaesthesia: An exciting time. <i>Anaesthesia and Intensive Care</i> , 2019 , 47, 322-325	1.1	1
53	Two open access, high-quality datasets from anesthetic records. <i>Journal of the American Medical Informatics Association: JAMIA</i> , 2013 , 20, 180-3	8.6	1
52	Medication errors: time for a national audit?. <i>Paediatric Anaesthesia</i> , 2011 , 21, 1169-70	1.8	1
51	Safety in anaesthesia. <i>Journal of Perioperative Practice</i> , 2009 , 19, 348-51	0.4	1
50	To do or not to do?--How people make decisions. <i>Journal of Extra-Corporeal Technology</i> , 2011 , 43, P39-43	0.4	1
49	Improving the Safety of Pediatric Sedation: Human Error, Technology, and Clinical Microsystems 2015 , 587-612		1

48	Clinicians' experiences of inquiries following mental health related homicide: a qualitative study. <i>Australasian Psychiatry</i> , 2021 , 10398562211009260	1.7	1
47	A prospective observational study of emboli exposure in open versus closed chamber cardiac surgery. <i>Perfusion (United Kingdom)</i> , 2021 , 2676591211023897	1.9	1
46	The conduct of inquiries: a qualitative study of the perspectives of panel members who investigate mental health related homicide. <i>Journal of Mental Health</i> , 2021 , 1-10	2.7	1
45	In reply: Encouraging a bare minimum while striving for the gold standard: a response to the updated WHO-WFSA guidelines. <i>Canadian Journal of Anaesthesia</i> , 2019 , 66, 129-130	3	1
44	Improving the quality of administration of the Surgical Safety Checklist: a mixed methods study in New Zealand hospitals. <i>BMJ Open</i> , 2018 , 8, e022882	3	1
43	Persistent opioid use and opioid-related harm after hospital admissions for surgery and trauma in New Zealand: a population-based cohort study. <i>BMJ Open</i> , 2021 , 11, e044493	3	1
42	How Does the Law Recognise and Deal with Medical Errors?75-88		1
41	The Health Quality and Safety Commission: making good health care better. <i>New Zealand Medical Journal</i> , 2015 , 128, 97-109	0.8	1
40	The measurement of New Zealand health care. <i>New Zealand Medical Journal</i> , 2015 , 128, 50-64	0.8	1
39	Student-led intervention to inNOvate hand hygiene practice in Auckland Region's medical students (the No HHARMS study). <i>New Zealand Medical Journal</i> , 2017 , 130, 54-63	0.8	1
38	Applying ethical and legal principles to new technology: the University of Auckland Faculty of Medical and Health Sciences' policy 'Taking and Sharing Images of Patients.'. <i>New Zealand Medical Journal</i> , 2017 , 130, 30-38	0.8	1
37	Sustaining multidisciplinary team training in New Zealand hospitals: a qualitative study of a national simulation-based initiative. <i>New Zealand Medical Journal</i> , 2020 , 133, 10-21	0.8	1
36	Analysis of medication errors during anaesthesia in the first 4000 incidents reported to webAIRS. <i>Anaesthesia and Intensive Care</i> , 2021 , 310057X211027578	1.1	1
35	Global PRoMiSe (Perioperative Recommendations for Medication Safety): protocol for a mixed-methods study. <i>BMJ Open</i> , 2020 , 10, e038313	3	0
34	New Visions and Current Evidence for Safety in Anesthesia. <i>Anesthesia and Analgesia</i> , 2018 , 127, 308	3.9	0
33	A cross-sectional overview of the second 4000 incidents reported to webAIRS, a de-identified web-based anaesthesia incident reporting system in Australia and New Zealand.. <i>Anaesthesia and Intensive Care</i> , 2021 , 49, 422-429	1.1	0
32	Checklists for image-guided interventions: a systematic review. <i>British Journal of Radiology</i> , 2021 , 94, 20200980	3.4	0
31	Surgical Teams' Attitudes About Surgical Safety and the Surgical Safety Checklist at 10 Years. <i>Annals of Surgery</i> , 2021 , 2, e075	1	0

30	Incorrect representation of aseptic techniques. <i>European Journal of Hospital Pharmacy</i> , 2017 , 24, 192	1.6
29	Response to: Improving the Quality and Safety as Well as Reducing the Cost for Patients Undergoing Cardiac Surgery: Missing Some Issues?. <i>Journal of Cardiothoracic and Vascular Anesthesia</i> , 2015 , 29, e47-8	2.1
28	In Reply. <i>Anesthesiology</i> , 2016 , 125, 820-1	4.3
27	Errors103-140	
26	Violations141-182	
25	The WHO Surgical Safety Checklist. <i>Medical Journal of Australia</i> , 2010 , 193, 486-487	4
24	Anticoagulants and procoagulants64-70	
23	Invited commentary. <i>Annals of Thoracic Surgery</i> , 2007 , 84, 840	2.7
22	Bar codes and the reduction of drug administration error in anesthesia. <i>Seminars in Anesthesia</i> , 2004 , 23, 260-270	
21	Medical manslaughter: a reply to Paterson. <i>Health Care Analysis</i> , 1996 , 4, 229-33	2.3
20	Campaigning for safety. <i>Journal of Extra-Corporeal Technology</i> , 2012 , 44, P16-9	0.4
19	The Professor Merry Lecture: Endings and beginnings. <i>Journal of Extra-Corporeal Technology</i> , 2011 , 43, P17-22	0.4
18	Thrombin inhibitors and cardiopulmonary bypass. <i>Journal of Extra-Corporeal Technology</i> , 2006 , 38, 52-6	0.4
17	Conducting clinical trials. <i>Journal of Extra-Corporeal Technology</i> , 2006 , 38, 71-6	0.4
16	Legal and Regulatory Responses to Avoidable Adverse Medication Events, Part II: Practical Examples 2021 , 236-264	
15	Introduction to Medication Safety in Anesthesia and the Perioperative Period 2021 , 1-17	
14	Legal and Regulatory Responses to Avoidable Adverse Medication Events, Part I: General Principles 2021 , 215-235	
13	Why Failures Occur in the Safe Management of Medications 2021 , 87-105	

12 Interventions to Improve Medication Safety **2021**, 156-190

11 Barriers to Improving Medication Safety **2021**, 265-280

10 In Reply: Encouraging a Bare Minimum While Striving for the Gold Standard: A Response to the Updated WHO-WFSA Guidelines. *Anesthesia and Analgesia*, **2019**, 128, e13-e14 3.9

9 Improving the Safety of Pediatric Sedation: Human Error, Technology, and Clinical Microsystems **2021**, 721-752

8 Impact of Medication Errors on the Patient and Family **2021**, 56-67

7 Failures in Medication Safety during Anesthesia and the Perioperative Period **2021**, 18-42

6 Errors in the Context of the Perioperative Administration of Medications **2021**, 106-129

5 Violations and Medication Safety **2021**, 130-155

4 Is refractory angina pectoris a form of chronic pain? A comparison of two patient groups receiving spinal cord stimulation therapy. *New Zealand Medical Journal*, **2014**, 127, 52-61 0.8

3 The New Zealand Surgical Site Infection Improvement (SSII) Programme: a national quality improvement programme reducing orthopaedic surgical site infections. *New Zealand Medical Journal*, **2018**, 131, 45-56 0.8

2 Preventing complications1-9

1 A prospective observational study on the effect of emboli exposure on cerebral autoregulation in cardiac surgery requiring cardiopulmonary bypass. *Perfusion (United Kingdom)*,026765912210946 1.9