Alan F Merry

List of Publications by Year in Descending Order

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 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.. *Anaesthesia and Intensive Care*, **2021**, 49, 422-429	1.1	0
154	Legal and Regulatory Responses to Avoidable Adverse Medication Events, Part II: Practical Examples **2021**, 236-264		
153	Introduction to Medication Safety in Anesthesia and the Perioperative Period **2021**, 1-17		
152	Legal and Regulatory Responses to Avoidable Adverse Medication Events, Part I: General Principles **2021**, 215-235		
151	Why Failures Occur in the Safe Management of Medications **2021**, 87-105		
150	Interventions to Improve Medication Safety **2021**, 156-190		
149	Barriers to Improving Medication Safety **2021**, 265-280		
148	Checklists for image-guided interventions: a systematic review. *British Journal of Radiology*, **2021**, 94, 20200980	3.4	0
147	Clinicians' experiences of inquiries following mental health related homicide: a qualitative study. *Australasian Psychiatry*, **2021**, 10398562211009260	1.7	1
146	A prospective observational study of emboli exposure in open versus closed chamber cardiac surgery. *Perfusion (United Kingdom)*, **2021**, 2676591211023897	1.9	1
145	The conduct of inquiries: a qualitative study of the perspectives of panel members who investigate mental health related homicide. *Journal of Mental Health*, **2021**, 1-10	2.7	1
144	Surgical Teams Attitudes About Surgical Safety and the Surgical Safety Checklist at 10 Years. *Annals of Surgery Open*, **2021**, 2, e075	1	0
143	General Anaesthesia Shifts the Murine Circadian Clock in a Time-Dependant Fashion. *Clocks & Sleep*, **2021**, 3, 87-97	2.9	5
142	Improving the Safety of Pediatric Sedation: Human Error, Technology, and Clinical Microsystems **2021**, 721-752		
141	We Asked the Experts: The WHO Surgical Safety Checklist and the COVID-19 Pandemic: Recommendations for Content and Implementation Adaptations. *World Journal of Surgery*, **2021**, 45, 1293-1296	3.3	2
140	Impact of Medication Errors on the Patient and Family **2021**, 56-67		
139	Medication Safety during Anesthesia and the Perioperative Period **2021**,		2

138	Failures in Medication Safety during Anesthesia and the Perioperative Period **2021**, 18-42		
137	Errors in the Context of the Perioperative Administration of Medications **2021**, 106-129		
136	Violations and Medication Safety **2021**, 130-155		
135	Reporting of Clinical Outcomes After Endovascular Aortic Aneurysm Repair: A Systematic Review. *Annals of Vascular Surgery*, **2021**,	1.7	2
134	Persistent opioid use and opioid-related harm after hospital admissions for surgery and trauma in New Zealand: a population-based cohort study. *BMJ Open*, **2021**, 11, e044493	3	1
133	Analysis of medication errors during anaesthesia in the first 4000 incidents reported to webAIRS. *Anaesthesia and Intensive Care*, **2021**, 310057X211027578	1.1	1
132	Mental Health Inquiries in the Case of Homicide. *Psychiatry, Psychology and Law*, **2020**, 27, 894-911	1.3	3
131	Global PRoMiSe (Perioperative Recommendations for Medication Safety): protocol for a mixed-methods study. *BMJ Open*, **2020**, 10, e038313	3	0
130	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. *BMJ Open*, **2020**, 10, e032997	3	4
129	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. *BMJ Open*, **2020**, 10, e033336	3	3
128	Families of victims of homicide: qualitative study of their experiences with mental health inquiries. *BJPsych Open*, **2020**, 6, e100	5	3
127	Sustaining multidisciplinary team training in New Zealand hospitals: a qualitative study of a national simulation-based initiative. *New Zealand Medical Journal*, **2020**, 133, 10-21	0.8	1
126	Aspiration during anaesthesia in the first 4000 incidents reported to webAIRS. *Anaesthesia and Intensive Care*, **2019**, 47, 442-451	1.1	9
125	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. *Trials*, **2019**, 20, 342	2.8	1
124	Criminalisation of unintentional error in healthcare in the UK: a perspective from New Zealand. *BMJ, The*, **2019**, 364, l706	5.9	10
123	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. *BMJ Open*, **2019**, 9, e022625	3	4
122	Capturing the experience of the hospital-stay journey from admission to discharge using diaries completed by patients in their own words: a qualitative study. *BMJ Open*, **2019**, 9, e027258	3	7
121	Measurement of patient-reported outcomes after laparoscopic cholecystectomy: a systematic review. *Surgical Endoscopy and Other Interventional Techniques*, **2019**, 33, 2061-2071	5.2	2

120	Global health and anaesthesia: An exciting time. *Anaesthesia and Intensive Care*, **2019**, 47, 322-325	1.1	1
119	Practice patterns and perceptions of Australian and New Zealand anaesthetists towards perioperative oxygen therapy. *Anaesthesia and Intensive Care*, **2019**, 47, 288-294	1.1	3
118	Towards a safer culture: implementing multidisciplinary simulation-based team training in New Zealand operating theatres - a framework analysis. *BMJ Open*, **2019**, 9, e027122	3	5
117	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	
116	In reply: Encouraging a bare minimum while striving for the gold standard: a response to the updated WHO-WFSA guidelines. *Canadian Journal of Anaesthesia*, **2019**, 66, 129-130	3	1
115	New Visions and Current Evidence for Safety in Anesthesia. *Anesthesia and Analgesia*, **2018**, 127, 308	3.9	0
114	Reporting of complications after laparoscopic cholecystectomy: a systematic review. *Hpb*, **2018**, 20, 786-794	3.9	24
113	Improving Anesthesia Safety in Low-Resource Settings. *Anesthesia and Analgesia*, **2018**, 126, 1312-1320	3.9	21
112	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. *Health Policy*, **2018**, 122, 783-790	3.2	1
111	World Health Organization-World Federation of Societies of Anaesthesiologists (WHO-WFSA) International Standards for a Safe Practice of Anesthesia. *Anesthesia and Analgesia*, **2018**, 126, 2047-2055	3.9	57
110	World Health Organization-World Federation of Societies of Anaesthesiologists (WHO-WFSA) International Standards for a Safe Practice of Anesthesia. *Canadian Journal of Anaesthesia*, **2018**, 65, 698-708	3	56
109	Is Conventional Bypass for Coronary Artery Bypass Graft Surgery a Misnomer?. *Journal of Extra-Corporeal Technology*, **2018**, 50, 225-230	0.4	3
108	Ward calls not so scary for medical students after interprofessional simulation course: a mixed-methods cohort evaluation study.. *BMJ Simulation and Technology Enhanced Learning*, **2018**, 4, 133-140	1.1	4
107	Improving the quality of administration of the Surgical Safety Checklist: a mixed methods study in New Zealand hospitals. *BMJ Open*, **2018**, 8, e022882	3	1
106	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	
105	Medical students, sensitive examinations and patient consent: a qualitative review. *New Zealand Medical Journal*, **2018**, 131, 29-37	0.8	4
104	Incorrect representation of aseptic techniques. *European Journal of Hospital Pharmacy*, **2017**, 24, 192	1.6	
103	Medication Errors in the Perioperative Setting. *Current Anesthesiology Reports*, **2017**, 7, 320-329	1	4

102	Retesting the Hypothesis of a Clinical Randomized Controlled Trial in a Simulation Environment to Validate Anesthesia Simulation in Error Research (the VASER Study). *Anesthesiology*, **2017**, 126, 472-481	4.3	18
101	A framework of comfort for practice: An integrative review identifying the multiple influences on patients' experience of comfort in healthcare settings. *International Journal for Quality in Health Care*, **2017**, 29, 151-162	1.9	12
100	Merry and McCall Smith's Errors, Medicine and the Law **2017**,		22
99	Student-led intervention to inNOvate hand hygiene practice in Auckland Region's medical students (the No HHARMS study). *New Zealand Medical Journal*, **2017**, 130, 54-63	0.8	1
98	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.'. *New Zealand Medical Journal*, **2017**, 130, 30-38	0.8	1
97	Lifebox: A Global Patient Safety Initiative. *A & A Case Reports*, **2016**, 6, 366-9		15
96	In Reply. *Anesthesiology*, **2016**, 125, 820-1	4.3	
95	The Bare Minimum Requires Caution. *World Journal of Surgery*, **2016**, 40, 2821-2822	3.3	4
94	Microbiological Contamination of Drugs during Their Administration for Anesthesia in the Operating Room. *Anesthesiology*, **2016**, 124, 785-94	4.3	32
93	Fake and expired medications in simulation-based education: an underappreciated risk to patient safety. *BMJ Quality and Safety*, **2016**, 25, 917-920	5.4	7
92	Assessing the similarity of mental models of operating room team members and implications for patient safety: a prospective, replicated study. *BMC Medical Education*, **2016**, 16, 229	3.3	25
91	Refining Target-Controlled Infusion: An Assessment of Pharmacodynamic Target-Controlled Infusion of Propofol and Remifentanil Using a Response Surface Model of Their Combined Effects on Bispectral Index. *Anesthesia and Analgesia*, **2016**, 122, 90-7	3.9	24
90	A behaviourally anchored rating scale for evaluating the use of the WHO surgical safety checklist: development and initial evaluation of the WHOBARS. *BMJ Quality and Safety*, **2016**, 25, 778-86	5.4	19
89	A 'paperless' wall-mounted surgical safety checklist with migrated leadership can improve compliance and team engagement. *BMJ Quality and Safety*, **2016**, 25, 971-976	5.4	13
88	The effects of the general anaesthetic isoflurane on the honey bee (Apis mellifera) circadian clock. *Chronobiology International*, **2016**, 33, 128-33	3.6	14
87	Improved scores for observed teamwork in the clinical environment following a multidisciplinary operating room simulation intervention. *New Zealand Medical Journal*, **2016**, 129, 59-67	0.8	25
86	Improved compliance with the World Health Organization Surgical Safety Checklist is associated with reduced surgical specimen labelling errors. *New Zealand Medical Journal*, **2016**, 129, 63-7	0.8	5
85	Can team training make surgery safer? Lessons for national implementation of a simulation-based programme. *New Zealand Medical Journal*, **2016**, 129, 9-17	0.8	17

84	Reducing harm from falls. *New Zealand Medical Journal*, **2016**, 129, 89-103	0.8	8
83	Response to: Improving the Quality and Safety as Well as Reducing the Cost for Patients Undergoing Cardiac Surgery: Missing Some Issues?. *Journal of Cardiothoracic and Vascular Anesthesia*, **2015**, 29, e47-8	2.1	
82	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. *JAMA Surgery*, **2015**, 150, 473-9	5.4	34
81	Paperless anesthesia: uses and abuses of these data. *Paediatric Anaesthesia*, **2015**, 25, 1184-92	1.8	9
80	Measuring the Repeatability of Simulated Physiology in Simulators. *Simulation in Healthcare*, **2015**, 10, 336-344	2.8	6
79	Improving the Safety of Pediatric Sedation: Human Error, Technology, and Clinical Microsystems **2015**, 587-612		1
78	The Health Quality and Safety Commission: making good health care better. *New Zealand Medical Journal*, **2015**, 128, 97-109	0.8	1
77	The measurement of New Zealand health care. *New Zealand Medical Journal*, **2015**, 128, 50-64	0.8	1
76	A new surgical site infection improvement programme for New Zealand: early progress. *New Zealand Medical Journal*, **2015**, 128, 51-9	0.8	3
75	Reducing perioperative harm in New Zealand: the WHO Surgical Safety Checklist, briefings and debriefings, and venous thrombembolism prophylaxis. *New Zealand Medical Journal*, **2015**, 128, 54-67	0.8	3
74	Clevidipine compared with nitroglycerin for blood pressure control in coronary artery bypass grafting: a randomized double-blind study. *Canadian Journal of Anaesthesia*, **2014**, 61, 398-406	3	9
73	Improving the quality and safety of patient care in cardiac anesthesia. *Journal of Cardiothoracic and Vascular Anesthesia*, **2014**, 28, 1341-51	2.1	9
72	Incident reporting at the local and national level. *International Anesthesiology Clinics*, **2014**, 52, 69-83	0.6	6
71	Building the evidence on simulation validity: comparison of anesthesiologists' communication patterns in real and simulated cases. *Anesthesiology*, **2014**, 120, 142-8	4.3	29
70	A Brief History of the Patient Safety Movement in Anaesthesia **2014**, 541-556		2
69	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	
68	A randomized comparison between records made with an anesthesia information management system and by hand, and evaluation of the Hawthorne effect. *Canadian Journal of Anaesthesia*, **2013** , 60, 990-7	3	20
67	Randomized comparison between the combination of acetaminophen and ibuprofen and each constituent alone for analgesia following tonsillectomy in children. *Canadian Journal of Anaesthesia* , **2013**, 60, 1180-9	3	28

66	Two open access, high-quality datasets from anesthetic records. *Journal of the American Medical Informatics Association: JAMIA*, **2013**, 20, 180-3	8.6	1
65	Doctors' willingness to give honest answers about end-of-life practices: a cross-sectional study. *BMJ Open*, **2013**, 3,	3	4
64	Implementation of the World Health Organization surgical safety checklist, including introduction of pulse oximetry, in a resource-limited setting. *Annals of Surgery*, **2013**, 257, 633-9	7.8	90
63	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. *BMJ Quality and Safety*, **2012**, 21, 826-34	5.4	23
62	Campaigning for safety. *Journal of Extra-Corporeal Technology*, **2012**, 44, P16-9	0.4	
61	Medication errors--new approaches to prevention. *Paediatric Anaesthesia*, **2011**, 21, 743-53	1.8	51
60	Medication errors: time for a national audit?. *Paediatric Anaesthesia*, **2011**, 21, 1169-70	1.8	1
59	The contribution of labelling to safe medication administration in anaesthetic practice. *Baillieres Best Practice and Research in Clinical Anaesthesiology*, **2011**, 25, 145-59	4	33
58	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. *Canadian Journal of Anaesthesia*, **2011**, 58, 38-47	3	13
57	Changes in safety attitude and relationship to decreased postoperative morbidity and mortality following implementation of a checklist-based surgical safety intervention. *BMJ Quality and Safety*, **2011**, 20, 102-7	5.4	307
56	Multimodal system designed to reduce errors in recording and administration of drugs in anaesthesia: prospective randomised clinical evaluation. *BMJ, The*, **2011**, 343, d5543	5.9	117
55	The Professor Merry Lecture: Endings and beginnings. *Journal of Extra-Corporeal Technology*, **2011**, 43, P17-22	0.4	
54	To do or not to do?--How people make decisions. *Journal of Extra-Corporeal Technology*, **2011**, 43, P39-43	0.4	1
53	Clinical assessment of a new anaesthetic drug administration system: a prospective, controlled, longitudinal incident monitoring study. *Anaesthesia*, **2010**, 65, 490-9	6.6	58
52	The WHO Surgical Safety Checklist. *Medical Journal of Australia*, **2010**, 193, 486-487	4	
51	Role of anesthesiologists in WHO safe surgery programs. *International Anesthesiology Clinics*, **2010**, 48, 137-50	0.6	4
50	Combined acetaminophen and ibuprofen for pain relief after oral surgery in adults: a randomized controlled trial. *British Journal of Anaesthesia*, **2010**, 104, 80-8	5.4	66
49	Chronic extra-aortic balloon counterpulsation: first-in-human pilot study in end-stage heart failure. *Journal of Heart and Lung Transplantation*, **2010**, 29, 1427-32	5.8	27

48	Global operating theatre distribution and pulse oximetry supply: an estimation from reported data. *Lancet, The*, **2010**, 376, 1055-61	40	274
47	Combining paracetamol (acetaminophen) with nonsteroidal antiinflammatory drugs: a qualitative systematic review of analgesic efficacy for acute postoperative pain. *Anesthesia and Analgesia*, **2010**, 110, 1170-9	3.9	400
46	The incidence of hypoxemia during surgery: evidence from two institutions. *Canadian Journal of Anaesthesia*, **2010**, 57, 888-97	3	66
45	An iterative process of global quality improvement: the International Standards for a Safe Practice of Anesthesia 2010. *Canadian Journal of Anaesthesia*, **2010**, 57, 1021-6	3	27
44	International Standards for a Safe Practice of Anesthesia 2010. *Canadian Journal of Anaesthesia*, **2010**, 57, 1027-34	3	127
43	How does the law recognize and deal with medical errors?. *Journal of the Royal Society of Medicine*, **2009**, 102, 265-71	2.3	12
42	Data sharing for pharmacokinetic studies. *Paediatric Anaesthesia*, **2009**, 19, 1005-10	1.8	23
41	Postoperative ischemia and cognitive impairment in cardiac surgery patients. *Annals of Thoracic Surgery*, **2009**, 87, 672-3; author reply 673-4	2.7	2
40	Cerebral protection by lidocaine during cardiac operations: a follow-up study. *Annals of Thoracic Surgery*, **2009**, 87, 820-5	2.7	54
39	A surgical safety checklist to reduce morbidity and mortality in a global population. *New England Journal of Medicine*, **2009**, 360, 491-9	59.2	3597
38	Safety in anaesthesia. *Journal of Perioperative Practice*, **2009**, 19, 348-51	0.4	1
37	Lignocaine: neuro-protective or wishful thinking?. *Journal of Extra-Corporeal Technology*, **2009**, 41, P37-42	0.4	3
36	Safer cardiac surgery. *Journal of Extra-Corporeal Technology*, **2009**, 41, P43-7	0.4	2
35	Has anesthesia care become safer and is anesthesia-related mortality decreasing?. *F1000 Medicine Reports*, **2009**, 1,		5
34	Interdisciplinary team interactions: a qualitative study of perceptions of team function in simulated anaesthesia crises. *Medical Education*, **2008**, 42, 382-8	3.7	48
33	A simulation design for research evaluating safety innovations in anaesthesia*. *Anaesthesia*, **2008**, 63, 1349-57	6.6	27
32	Sleep loss and performance of anaesthesia trainees and specialists. *Chronobiology International*, **2008**, 25, 1077-91	3.6	58
31	Cerebral ischemic lesions on diffusion-weighted imaging are associated with neurocognitive decline after cardiac surgery. *Stroke*, **2008**, 39, 1427-33	6.7	155

30	Ethics, industry, and outcomes. *Seminars in Cardiothoracic and Vascular Anesthesia*, **2008**, 12, 7-11	1.4	3
29	A new infusion syringe label system designed to reduce task complexity during drug preparation. *Anaesthesia*, **2007**, 62, 486-91	6.6	18
28	Focus on thrombin: alternative anticoagulants. *Seminars in Cardiothoracic and Vascular Anesthesia*, **2007**, 11, 256-60	1.4	11
27	Invited commentary. *Annals of Thoracic Surgery*, **2007**, 84, 840	2.7	
26	Human factors and the cardiac surgical team: a role for simulation. *Journal of Extra-Corporeal Technology*, **2007**, 39, 264-6	0.4	2
25	Educating for healthcare quality improvement in an interprofessional learning environment: a New Zealand initiative. *Journal of Interprofessional Care*, **2006**, 20, 555-7	2.7	11
24	Thrombin inhibitors and cardiopulmonary bypass. *Journal of Extra-Corporeal Technology*, **2006**, 38, 52-6	0.4	
23	What blood pressure is appropriate for cardiopulmonary bypass and how to get it. *Journal of Extra-Corporeal Technology*, **2006**, 38, 69-71	0.4	2
22	Conducting clinical trials. *Journal of Extra-Corporeal Technology*, **2006**, 38, 71-6	0.4	
21	Patient safety in an interprofessional learning environment. *Medical Education*, **2005**, 39, 512-3	3.7	13
20	Extra-aortic balloon counterpulsation: an intraoperative feasibility study. *Circulation*, **2005**, 112, I26-31	16.7	17
19	Bivalirudin, blood loss, and graft patency in coronary artery bypass surgery. *Seminars in Thrombosis and Hemostasis*, **2004**, 30, 337-46	5.3	15
18	Is directed donation misguided?. *Clinical and Experimental Ophthalmology*, **2004**, 32, 5-8	2.4	3
17	Bar codes and the reduction of drug administration error in anesthesia. *Seminars in Anesthesia*, **2004**, 23, 260-270		
16	Clinical tolerability of perioperative tenoxicam in 1001 patients--a prospective, controlled, double-blind, multi-centre study. *Pain*, **2004**, 111, 313-322	8	15
15	Bivalirudin versus heparin and protamine in off-pump coronary artery bypass surgery. *Annals of Thoracic Surgery*, **2004**, 77, 925-31; discussion 931	2.7	94
14	Error, blame, and the law in health care--an antipodean perspective. *Annals of Internal Medicine*, **2003**, 138, 974-9	8	71
13	How safe are our hospitals?. *New Zealand Medical Journal*, **2002**, 115, U268	0.8	5

12	The right membrane for the job. *Filtration and Separation*, **2001**, 38, 16-18	0.1	3
11	A New, Safety-Oriented, Integrated Drug Administration and Automated Anesthesia Record System. *Anesthesia and Analgesia*, **2001**, 93, 385-390	3.9	66
10	A new, safety-oriented, integrated drug administration and automated anesthesia record system. *Anesthesia and Analgesia*, **2001**, 93, 385-90 , 3rd contents page	3.9	79
9	Errors, Medicine and the Law **2001**,		51
8	Medical manslaughter: a reply to Paterson. *Health Care Analysis*, **1996**, 4, 229-33	2.3	
7	Medical accountability and the criminal law: New Zealand vs the world. *Health Care Analysis*, **1996**, 4, 45-54	2.3	5
6	Errors103-140		
5	Violations141-182		
4	Anticoagulants and procoagulants64-70		
3	How Does the Law Recognise and Deal with Medical Errors?75-88		1
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	