

Douglas E Paull

List of Publications by Year in descending order

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Version: 2024-02-01

65
papers

2,169
citations

361045

20
h-index

223531

46
g-index

67
all docs

67
docs citations

67
times ranked

1792
citing authors

#	ARTICLE	IF	CITATIONS
1	Sharing Lessons Learned to Prevent Adverse Events in Anesthesiology Nationwide. Journal of Patient Safety, 2021, 17, e343-e349.	0.7	1
2	Root Cause Analyses of Reported Adverse Events Occurring During Gastrointestinal Scope and Tube Placement Procedures in the Veterans Health Association. Journal of Patient Safety, 2020, 16, 41-46.	0.7	2
3	A Review of Adverse Event Reports From Emergency Departments in the Veterans Health Administration. Journal of Patient Safety, 2020, Publish Ahead of Print, e898-e903.	0.7	3
4	Wrong Site Spine Surgery in the Veterans Administration. Clinical Spine Surgery, 2019, 32, 454-457.	0.7	6
5	How Well Do Incident Reporting Systems Work on Inpatient Psychiatric Units?. Joint Commission Journal on Quality and Patient Safety, 2019, 45, 63-69.	0.4	7
6	Handovers During Anesthesia Care. JAMA - Journal of the American Medical Association, 2018, 319, 125.	3.8	11
7	Retained Guidewires in the Veterans Health Administration. Journal of Patient Safety, 2018, Publish Ahead of Print, e911-e917.	0.7	5
8	Curriculum Development and Implementation of a National Interprofessional Fellowship in Patient Safety. Journal of Patient Safety, 2018, 14, 127-132.	0.7	8
9	Examining Wrong Eye Implant Adverse Events in the Veterans Health Administration With a Focus on Prevention: A Preliminary Report. Journal of Patient Safety, 2018, 14, 49-53.	0.7	7
10	Anesthesia Adverse Events Voluntarily Reported in the Veterans Health Administration and Lessons Learned. Anesthesia and Analgesia, 2018, 126, 471-477.	1.1	18
11	The effects of crew resource management on teamwork and safety climate at Veterans Health Administration facilities. Journal of Healthcare Risk Management: the Journal of the American Society for Healthcare Risk Management, 2018, 38, 17-37.	0.3	21
12	Root Cause Analysis of Oncology Adverse Events in the Veterans Health Administration. Journal of Oncology Practice, 2018, 14, e579-e590.	2.5	9
13	Assessment of Incorrect Surgical Procedures Within and Outside the Operating Room. JAMA Network Open, 2018, 1, e185147.	2.8	15
14	Root Cause Analysis of Reported Patient Falls in <sc>OR</sc>s in the Veterans Health Administration. AORN Journal, 2018, 108, 386-397.	0.2	9
15	Incorrect Surgery and Invasive Procedures: Internet Videos Fail to Depict the Full Story. Advances in Intelligent Systems and Computing, 2018, , 469-476.	0.5	0
16	Resident Well-Being and Patient Safety: Recognizing the Signs and Symptoms of Burnout. Journal of Oral and Maxillofacial Surgery, 2017, 75, 657-659.	0.5	8
17	Virtual Patient Simulation. Proceedings of the Human Factors and Ergonomics Society, 2016, 60, 533-537.	0.2	0
18	Department of Veterans Affairs Chief Resident in Quality and Patient Safety Program. American Journal of Medical Quality, 2016, 31, 598-600.	0.2	9

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19	A Theory-Integrated Model of Medical Diagnosis. Journal of Cognitive Engineering and Decision Making, 2016, 10, 14-35.	0.9	7
20	The Human Factors of Continuous Subcutaneous Insulin Infusion: Modeling Insulin Pump Use Issues. Proceedings of the International Symposium of Human Factors and Ergonomics in Healthcare, 2015, 4, 124-128.	0.2	0
21	Effective followership: A standardized algorithm to resolve clinical conflicts and improve teamwork. Journal of Healthcare Risk Management: the Journal of the American Society for Healthcare Risk Management, 2015, 35, 21-30.	0.3	24
22	Investigating Medical Diagnosis: Qualitative Results from a Virtual Patient Simulation Pilot Study. Proceedings of the International Symposium of Human Factors and Ergonomics in Healthcare, 2015, 4, 92-96.	0.2	3
23	Errors upstream and downstream to the Universal Protocol associated with wrong surgery events in the Veterans Health Administration. American Journal of Surgery, 2015, 210, 6-13.	0.9	25
24	Board #151 - Research Abstract Training for Time-Outs Prior to Invasive Procedures. Simulation in Healthcare, 2014, 9, 426.	0.7	0
25	Wrong-Side Thoracentesis. JAMA Surgery, 2014, 149, 774.	2.2	26
26	Institutional disclosure: Promise and problems. Journal of Healthcare Risk Management: the Journal of the American Society for Healthcare Risk Management, 2014, 33, 24-32.	0.3	5
27	Retained Guidewires. Proceedings of the International Symposium of Human Factors and Ergonomics in Healthcare, 2014, 3, 214-216.	0.2	4
28	Surgical Programs in the Veterans Health Administration Maintain Briefing and Debriefing Following Medical Team Training. Joint Commission Journal on Quality and Patient Safety, 2014, 40, 235-239.	0.4	2
29	Surgical Stapler Adverse Events in the Veterans Health Administration. Proceedings of the International Symposium of Human Factors and Ergonomics in Healthcare, 2014, 3, 153-156.	0.2	0
30	Work Domain Analysis Applied to Medical Diagnosis. Proceedings of the International Symposium of Human Factors and Ergonomics in Healthcare, 2014, 3, 157-161.	0.2	2
31	Preventing Wrong-Site Invasive Procedures Outside the Operating Room. Simulation in Healthcare, 2013, 8, 52-60.	0.7	5
32	Root Cause Analysis Reports Help Identify Common Factors In Delayed Diagnosis And Treatment Of Outpatients. Health Affairs, 2013, 32, 1368-1375.	2.5	68
33	Improving Patient Safety through Educational Initiatives. Proceedings of the Human Factors and Ergonomics Society, 2013, 57, 1527-1530.	0.2	0
34	Nursing Crew Resource Management. Journal of Nursing Administration, 2013, 43, 122-126.	0.7	19
35	The Effect of Simulation-Based Crew Resource Management Training on Measurable Teamwork and Communication Among Interprofessional Teams Caring for Postoperative Patients. Journal of Continuing Education in Nursing, 2013, 44, 516-524.	0.2	39
36	Failure to obtain microbiological culture and its consequence in a mesh-related infection. BMJ Case Reports, 2013, 2013, bcr2013009123-bcr2013009123.	0.2	3

#	ARTICLE	IF	CITATIONS
37	Sharing Lessons Learned to Prevent Incorrect Surgery. American Surgeon, 2012, 78, 1276-1280.	0.4	19
38	Sharing lessons learned to prevent incorrect surgery. American Surgeon, 2012, 78, 1276-80.	0.4	5
39	Association Between Implementation of a Medical Team Training Program and Surgical Morbidity. Archives of Surgery, 2011, 146, 1368.	2.3	105
40	Association Between Implementation of a Medical Team Training Program and Surgical Mortality. JAMA - Journal of the American Medical Association, 2010, 304, 1693.	3.8	859
41	Medical team training and coaching in the veterans health administration; assessment and impact on the first 32 facilities in the programme. Quality and Safety in Health Care, 2010, 19, 360-364.	2.5	43
42	The Role of the Operating Room Nurse Manager in the Successful Implementation of Preoperative Briefings and Postoperative Debriefings in the VHA Medical Team Training Program. Journal of Perianesthesia Nursing, 2010, 25, 302-306.	0.3	11
43	Briefing guide study: preoperative briefing and postoperative debriefing checklists in the Veterans Health Administration medical team training program. American Journal of Surgery, 2010, 200, 620-623.	0.9	65
44	The Relationship Between Beer Consumption and Lung Cancer. , 2009, , 657-668.		0
45	Predictors of successful implementation of preoperative briefings and postoperative debriefings after medical team training. American Journal of Surgery, 2009, 198, 675-678.	0.9	58
46	Choice of First Intervention is Related to Outcomes in the Management of Empyema. Annals of Thoracic Surgery, 2009, 87, 1525-1531.	0.7	88
47	Invited commentary. Annals of Thoracic Surgery, 2007, 84, 202.	0.7	0
48	Gene Expression Profiles from Needle Biopsies Provide Useful Signatures of Non-Small Cell Lung Carcinomas. Biomarker Insights, 2007, 2, 117727190700200.	1.0	0
49	Gene expression profiles from needle biopsies provide useful signatures of non-small cell lung carcinomas. Biomarker Insights, 2007, 2, 253-9.	1.0	1
50	Determinants of quality of life in patients following pulmonary resection for lung cancer. American Journal of Surgery, 2006, 192, 565-571.	0.9	39
51	Invited commentary. Annals of Thoracic Surgery, 2006, 82, 1204.	0.7	0
52	Positron Emission Tomography in Well Differentiated Fetal Adenocarcinoma of the Lung. Clinical Nuclear Medicine, 2006, 31, 213-214.	0.7	11
53	Alcohol Abuse Predicts Progression of Disease and Death in Patients with Lung Cancer. Annals of Thoracic Surgery, 2005, 80, 1033-1039.	0.7	34
54	Complications and long-term survival for alcoholic patients with resectable lung cancer. American Journal of Surgery, 2004, 188, 553-559.	0.9	28

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55	The Effect of Alcoholism on the Prognosis of Stage III and IV Non-small Cell Lung Cancer. Chest, 2004, 126, 769S.	0.4	1
56	Thoracoscopic Talc Pleurodesis for Recurrent, Symptomatic Pleural Effusion Following Cardiac Operations. Surgical Laparoscopy, Endoscopy and Percutaneous Techniques, 2003, 13, 339-344.	0.4	5
57	MYCOBACTERIUM KANSASII EMPYEMA IN A RENAL TRANSPLANT RECIPIENT CASE REPORT AND REVIEW OF THE LITERATURE. Transplantation, 2003, 76, 270-271.	0.5	15
58	Detection of Occult Thymoma During Exercise Thallium 201, Technetium 99m Tetrofosmin Imaging for Coronary Artery Disease. Chest, 2000, 118, 550-551.	0.4	8
59	Oxygen free radical scavengers decrease reperfusion injury in lung transplantation. Annals of Thoracic Surgery, 1990, 50, 204-210.	0.7	42
60	Management of aortobronchial fistula with graft replacement and omentopexy. Annals of Thoracic Surgery, 1990, 50, 972-974.	0.7	21
61	Reperfusion injury in the lung preserved for 24 hours. Annals of Thoracic Surgery, 1989, 47, 187-192.	0.7	45
62	Improved lung preservation using a dimethylthiourea flush. Journal of Surgical Research, 1989, 46, 333-338.	0.8	20
63	Occult Diaphragmatic Injury from Stab Wounds to the Lower Chest and Abdomen. Journal of Trauma, 1989, 29, 292-298.	2.3	111
64	Evaluation and Management of Massive Lower Gastrointestinal Hemorrhage. Annals of Surgery, 1989, 209, 175-180.	2.1	164
65	Results from a simulation based medical team training curriculum utilizing an observational learning model. MedEdPublish, 0, , .	0.3	0