Gordon D Schiff

List of Publications by Year in descending order

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CORDON D SCHIEF

#	Article	IF	CITATIONS
1	Looking back on the history of patient safety: an opportunity to reflect and ponder future challenges. BMJ Quality and Safety, 2022, 31, 148-152.	1.8	12
2	Latent Class Analysis of Prescribing Behavior of Primary Care Physicians in the Veterans Health Administration. Journal of General Internal Medicine, 2022, , 1.	1.3	3
3	Characteristics of Disease-Specific and Generic Diagnostic Pitfalls. JAMA Network Open, 2022, 5, e2144531.	2.8	13
4	Development and Usability Testing of the Agency for Healthcare Research and Quality Common Formats to Capture Diagnostic Safety Events. Journal of Patient Safety, 2022, Publish Ahead of Print, .	0.7	2
5	The American Public Health Association Endorses Single-Payer Health System Reform. Medical Care, 2022, 60, 397-401.	1.1	2
6	Anatomy of diagnosis in a clinical encounter: how clinicians discuss uncertainty with patients. , 2022, 23, .		12
7	The impact of clinical uncertainty in the graduate medical education (GME) learning environment: A mixed-methods study. Medical Teacher, 2022, 44, 1100-1108.	1.0	3
8	Feedback on Missed and Delayed Diagnosis: Differential Diagnosis of Communication Dilemmas. Joint Commission Journal on Quality and Patient Safety, 2021, 47, 71-73.	0.4	1
9	Measuring and Improving Diagnostic Safety in Primary Care: Addressing the "Twin―Pandemics of Diagnostic Error and Clinician Burnout. Journal of General Internal Medicine, 2021, 36, 1404-1406.	1.3	10
10	Terminations in Primary Care: a Retrospective Observational Study of 16 Primary Care Clinics. Journal of General Internal Medicine, 2021, , 1.	1.3	0
11	Personal Formularies of Primary Care Physicians Across 4 Health Care Systems. JAMA Network Open, 2021, 4, e2117038.	2.8	4
12	Systems Analysis of a Dedicated Ambulatory Respiratory Unit for Seeing and Ensuring Follow-up of Patients With COVID-19 Symptoms. Journal of Ambulatory Care Management, 2021, 44, 293-303.	0.5	1
13	Ensuring Primary Care Diagnostic Quality in the Era of Telemedicine. American Journal of Medicine, 2021, 134, 1101-1103.	0.6	3
14	Patient engagement in system redesign teams: a process of social identity. Journal of Health Organization and Management, 2021, ahead-of-print, .	0.6	1
15	Systems engineering analysis of diagnostic referral closed-loop processes. BMJ Open Quality, 2021, 10, e001603.	0.4	5
16	Laboratory-Generated Urine Toxicology Interpretations: A Mixed Methods Study. Pain Physician, 2021, 24, E191-E201.	0.3	1
17	Indication alerts to improve problem list documentation. Journal of the American Medical Informatics Association: JAMIA, 2021, , .	2.2	2
18	Provider Misinterpretation, Documentation, and Follow-Up of Definitive Urine Drug Testing Results. Journal of General Internal Medicine, 2020, 35, 283-290.	1.3	15

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19	Connecting With Patients—The Missing Links. JAMA - Journal of the American Medical Association, 2020, 323, 33.	3.8	198
20	Using a Machine Learning System to Identify and Prevent Medication Prescribing Errors: A Clinical and Cost Analysis Evaluation. Joint Commission Journal on Quality and Patient Safety, 2020, 46, 3-10.	0.4	35
21	Professional-Patient Boundaries: a National Survey of Primary Care Physicians' Attitudes and Practices. Journal of General Internal Medicine, 2020, 35, 457-464.	1.3	6
22	The Invisible Epidemic: Neglected Chronic Disease Management During COVID-19. Journal of General Internal Medicine, 2020, 35, 2816-2817.	1.3	129
23	Crossing Boundaries—Violation or Obligation?. JAMA - Journal of the American Medical Association, 2020, 323, 1674.	3.8	7
24	What If?: Transforming Diagnostic Research by Leveraging a Diagnostic Process Map to Engage Patients in Learning from Errors. NAM Perspectives, 2020, 2020, .	1.3	4
25	COVID-19: making the right diagnosis. Diagnosis, 2020, 7, 377-380.	1.2	1
26	Missed diagnosis of cancer in primary care: Insights from malpractice claims data. Journal of Healthcare Risk Management: the Journal of the American Society for Healthcare Risk Management, 2019, 39, 19-29.	0.3	14
27	Automated detection of wrong-drug prescribing errors. BMJ Quality and Safety, 2019, 28, 908-915.	1.8	7
28	How often do prescribers include indications in drug orders? Analysis of 4 million outpatient prescriptions. American Journal of Health-System Pharmacy, 2019, 76, 970-979.	0.5	15
29	Effect of Restriction of the Number of Concurrently Open Records in an Electronic Health Record on Wrong-Patient Order Errors. JAMA - Journal of the American Medical Association, 2019, 321, 1780.	3.8	29
30	Drug formulary decision-making: Ethnographic study of 3 pharmacy and therapeutics committees. American Journal of Health-System Pharmacy, 2019, 76, 537-542.	0.5	2
31	Comparison of a Prototype for Indications-Based Prescribing With 2 Commercial Prescribing Systems. JAMA Network Open, 2019, 2, e191514.	2.8	16
32	Ten Principles for More Conservative, Care-Full Diagnosis. Annals of Internal Medicine, 2019, 170, 823.	2.0	12
33	Morbidity and mortality conferences as medical student learning tools. Clinical Teacher, 2019, 16, 527-529.	0.4	1
34	Screening for Adverse Drug Events: a Randomized Trial of Automated Calls Coupled with Phone-Based Pharmacist Counseling. Journal of General Internal Medicine, 2019, 34, 285-292.	1.3	9
35	Incorporating medication indications into the prescribing process. American Journal of Health-System Pharmacy, 2018, 75, 774-783.	0.5	28
36	Outpatient CPOE orders discontinued due to â€~erroneous entry': prospective survey of prescribers' explanations for errors. BMJ Quality and Safety, 2018, 27, 293-298.	1.8	13

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37	Reasons for computerised provider order entry (CPOE)-based inpatient medication ordering errors: an observational study of voided orders. BMJ Quality and Safety, 2018, 27, 299-307.	1.8	16
38	Learning optimal opioid prescribing and monitoring: a simulation study of medical residents. JAMIA Open, 2018, 1, 246-254.	1.0	5
39	A Prescription For Enhancing Electronic Prescribing Safety. Health Affairs, 2018, 37, 1877-1883.	2.5	43
40	Ten Principles for More Conservative, Care-Full Diagnosis. Annals of Internal Medicine, 2018, 169, 643.	2.0	37
41	Reduced Effectiveness of Interruptive Drug-Drug Interaction Alerts after Conversion to a Commercial Electronic Health Record. Journal of General Internal Medicine, 2018, 33, 1868-1876.	1.3	39
42	Using drug knowledgebase information to distinguish between look-alike-sound-alike drugs. Journal of the American Medical Informatics Association: JAMIA, 2018, 25, 872-884.	2.2	3
43	The global burden of diagnostic errors in primary care. BMJ Quality and Safety, 2017, 26, 484-494.	1.8	225
44	Primary Care Collaboration to Improve Diagnosis and Screening for Colorectal Cancer. Joint Commission Journal on Quality and Patient Safety, 2017, 43, 338-350.	0.4	7
45	Analysis of variations in the display of drug names in computerized prescriber-order-entry systems. American Journal of Health-System Pharmacy, 2017, 74, 499-509.	0.5	11
46	Integrating. Health Care Management Review, 2017, 42, 213-225.	0.6	13
47	A national survey assessing the number of records allowed open in electronic health records at hospitals and ambulatory sites. Journal of the American Medical Informatics Association: JAMIA, 2017, 24, 992-995.	2.2	14
48	Screening for medication errors using an outlier detection system. Journal of the American Medical Informatics Association: JAMIA, 2017, 24, 281-287.	2.2	63
49	Learning from errors: analysis of medication order voiding in CPOE systems. Journal of the American Medical Informatics Association: JAMIA, 2017, 24, 762-768.	2.2	14
50	Automated detection of look-alike/sound-alike medication errors. American Journal of Health-System Pharmacy, 2017, 74, 521-527.	0.5	23
51	Exploring the potential for using drug indications to prevent look-alike and sound-alike drug errors. Expert Opinion on Drug Safety, 2017, 16, 1103-1109.	1.0	10
52	Randomized Trial of Reducing Ambulatory Malpractice and Safety Risk. Medical Care, 2017, 55, 797-805.	1.1	14
53	Computerized prescriber order entry–related patient safety reports: analysis of 2522 medication errors. Journal of the American Medical Informatics Association: JAMIA, 2017, 24, 316-322.	2.2	56
54	What do Australian consumers, pharmacists and prescribers think about documenting indications on prescriptions and dispensed medicines labels?: A qualitative study. BMC Health Services Research, 2017, 17, 734.	0.9	14

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55	Electronic Clinical Documentation. , 2017, , 51-68.		2
56	Sick Children Crying for Help: Fostering Adverse Event Reports. PLoS Medicine, 2017, 14, e1002216.	3.9	2
57	Addressing Ambulatory Safety and Malpractice: The Massachusetts <scp>PROMISES</scp> Project. Health Services Research, 2016, 51, 2634-2641.	1.0	12
58	Cognitive tests predict real-world errors: the relationship between drug name confusion rates in laboratory-based memory and perception tests and corresponding error rates in large pharmacy chains. BMJ Quality and Safety, 2016, 26, bmjqs-2015-005099.	1.8	14
59	Methodologies for evaluating strategies to reduce diagnostic error: report from the research summit at the 7th International Diagnostic Error in Medicine Conference. Diagnosis, 2016, 3, 1-7.	1.2	4
60	An electronic alert to decrease Kayexalate ordering. Renal Failure, 2016, 38, 1752-1754.	0.8	6
61	Obesity and Management of Weight Loss. New England Journal of Medicine, 2016, 375, 1187-1189.	13.9	8
62	Medical Scribes: Salvation for Primary Care or Workaround for Poor EMR Usability?. Journal of General Internal Medicine, 2016, 31, 979-981.	1.3	21
63	Incorporating Indications into Medication Ordering — Time to Enter the Age of Reason. New England Journal of Medicine, 2016, 375, 306-309.	13.9	65
64	Characterizing the pain score trajectories of hospitalized adult medical and surgical patients: a retrospective cohort study. Pain, 2016, 157, 2739-2746.	2.0	35
65	Computerised prescribing for safer medication ordering: still a work in progress. BMJ Quality and Safety, 2016, 25, 315-319.	1.8	34
66	The vulnerabilities of computerized physician order entry systems: a qualitative study. Journal of the American Medical Informatics Association: JAMIA, 2016, 23, 311-316.	2.2	27
67	Strategies for Flipping the Script on Opioid Overprescribing. JAMA Internal Medicine, 2016, 176, 7.	2.6	8
68	Losing weights: Failure to recognize and act on weight loss documented in an electronic health record. Journal of Innovation in Health Informatics, 2015, 22, 316-322.	0.9	9
69	Teams and Teamwork During a Cancer Diagnosis: Interdependency Within and Between Teams. Journal of Oncology Practice, 2015, 11, 231-238.	2.5	72
70	Evaluating Ambulatory Practice Safety. Medical Care, 2015, 53, 141-152.	1.1	16
71	Meaningful Use of Electronic Health Records: Experiences From the Field and Future Opportunities. JMIR Medical Informatics, 2015, 3, e30.	1.3	54
72	Indication Alerts Intercept Drug Name Confusion Errors during Computerized Entry of Medication Orders. PLoS ONE, 2014, 9, e101977.	1.1	42

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73	Diagnosis and diagnostic errors: time for a new paradigm: TableÂ1. BMJ Quality and Safety, 2014, 23, 1-3.	1.8	54
74	We Have Strict Statutes and Most Biting Laws—Reply. JAMA Internal Medicine, 2014, 174, 1202.	2.6	0
75	Exploration of an Automated Approach for Receiving Patient Feedback After Outpatient Acute Care Visits. Journal of General Internal Medicine, 2014, 29, 1105-1112.	1.3	15
76	Doing Right by Our Patients When Things Go Wrong in the Ambulatory Setting. Joint Commission Journal on Quality and Patient Safety, 2014, 40, 91-AP4.	0.4	6
77	Use of health information technology to reduce diagnostic errors. BMJ Quality and Safety, 2013, 22, ii40-ii51.	1.8	115
78	Crossing Boundaries—Violation or Obligation?. JAMA - Journal of the American Medical Association, 2013, 310, 1233.	3.8	14
79	Primary Care Closed Claims Experience of Massachusetts Malpractice Insurers. JAMA Internal Medicine, 2013, 173, 2063.	2.6	70
80	Telephone follow-up in primary care: can interactive voice response calls work?. Studies in Health Technology and Informatics, 2013, 192, 112-6.	0.2	7
81	A Prescription for Improving Drug Formulary Decision Making. PLoS Medicine, 2012, 9, e1001220.	3.9	190
82	Do Package Inserts Reflect Symptoms Experienced in Practice?. Drug Safety, 2012, 35, 623-628.	1.4	4
83	Do Package Inserts Reflect Symptoms Experienced in Practice?. Drug Safety, 2012, 35, 623-628.	1.4	4
84	Evaluation of Patient Centered Medical Home Practice Transformation Initiatives. Medical Care, 2011, 49, 10-16.	1.1	74
85	Beyond the Prescription: Medication Monitoring and Adverse Drug Events in Older Adults. Journal of the American Geriatrics Society, 2011, 59, 1513-1520.	1.3	128
86	System Dynamics and Dysfunctionalities: Levers for Overcoming Emergency Department Overcrowding. Academic Emergency Medicine, 2011, 18, 1255-1261.	0.8	29
87	Deeper Problems in the Marketing of Drugs. Journal of General Internal Medicine, 2011, 26, 13-13.	1.3	0
88	Medical Error. JAMA - Journal of the American Medical Association, 2011, 305, 1890.	3.8	11
89	Principles of Conservative Prescribing. Archives of Internal Medicine, 2011, 171, 1433.	4.3	97
90	Estrogen Implants: Embodiments of Deeper Problems in the Marketing of Drugs. Journal of General Internal Medicine, 2010, 25, 893-895.	1.3	1

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91	Participation in an ambulatory eâ€pharmacovigilance system. Pharmacoepidemiology and Drug Safety, 2010, 19, 961-969.	0.9	25
92	Can Electronic Clinical Documentation Help Prevent Diagnostic Errors?. New England Journal of Medicine, 2010, 362, 1066-1069.	13.9	202
93	Promoting More Conservative Prescribing. JAMA - Journal of the American Medical Association, 2009, 301, 865.	3.8	41
94	Diagnostic Error in Medicine. Archives of Internal Medicine, 2009, 169, 1881.	4.3	477
95	Minimizing Diagnostic Error: The Importance of Follow-up and Feedback. American Journal of Medicine, 2008, 121, S38-S42.	0.6	109
96	Introduction to Special Theme Issue on Health Insurance in the United States. Medical Care, 2008, 46, 1003-1008.	1.1	0
97	One cheer for feedback. Annals of Emergency Medicine, 2005, 45, 24.	0.3	3
98	Standardized Pill Imprint Codes: A Pharma Fantasy. Journal of Medical Systems, 2004, 28, 1-7.	2.2	12
99	Decompensated heart failure: symptoms, patterns of onset, and contributing factors. American Journal of Medicine, 2003, 114, 625-630.	0.6	210
100	Linking Laboratory and Pharmacy. Archives of Internal Medicine, 2003, 163, 893.	4.3	122
101	Community health centers and the underserved: eliminating disparities or increasing despair. Journal of Public Health Policy, 2003, 24, 307-11.	1.0	1
102	An Unsuspecting American With No Medicare Coverage—Me!. Health Affairs, 2002, 21, 202-206.	2.5	2
103	Computerized prescriber order entry: Models and hurdles. American Journal of Health-System Pharmacy, 2002, 59, 1456-1460.	0.5	12
104	High rates of adverse effects and patient unawareness of withdrawn lipid-lowering drug combination in a public hospital clinic. Pharmacoepidemiology and Drug Safety, 2002, 11, 643-645.	0.9	11
105	Drug-Induced Hyperkalemia. Hospital Pharmacy, 2001, 36, 684-687.	0.4	3
106	Fatal distraction: Finance vs vigilance in our nation's hospitals. Journal of General Internal Medicine, 2000, 15, 269-270.	1.3	3
107	Prescribing potassium despite hyperkalemia: medication errors uncovered by linking laboratory and pharmacy information systems. American Journal of Medicine, 2000, 109, 494-497.	0.6	44
108	Electronic Point-of-Care Prescribing. Disease Management and Health Outcomes, 2000, 7, 297-304.	0.3	5

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109	Commentary: Diagnosis Tracking and Health Reform. American Journal of Medical Quality, 1994, 9, 149-152.	0.2	7
110	Consumer Interest and Health Reform: The Logic of Withdrawal from Managed Competition. Journal of Consumer Affairs, 1994, 28, 234-254.	1.2	1
111	Drug Formularies: Myths-In-Formation. Medical Care, 1990, 28, 928-942.	1.1	60
112	<scp>RaDonda</scp> Vaught, medication safety, and the profession of pharmacy: Steps to improve safety and ensure justice. JACCP Journal of the American College of Clinical Pharmacy, 0, , .	0.5	1