Hardeep Singh

List of Publications by Year in Descending Order

173 papers	5,909 citations	41 h-index	71 g-index
189 ext. papers	7,562 ext. citations	5.8 avg, IF	6.51 L-index

#	Paper	IF	Citations
173	Laboratory monitoring to reduce adverse drug-related events: a mixed methods study.. *Journal of Managed Care & Specialty Pharmacy*, **2022**, 28, 16-25	1.9	
172	Applying requisite imagination to safeguard electronic health record transitions.. *Journal of the American Medical Informatics Association: JAMIA*, **2022**,	8.6	1
171	Identifying opportunities for timely diagnosis of bladder and renal cancer via abnormal blood tests: a longitudinal linked data study.. *British Journal of General Practice*, **2022**, 72, e19-e25	1.6	0
170	Five strategies for clinicians to advance diagnostic excellence.. *BMJ, The*, **2022**, 376, e068044	5.9	4
169	Inviting patients to identify diagnostic concerns through structured evaluation of their online visit notes.. *Journal of the American Medical Informatics Association: JAMIA*, **2022**,	8.6	2
168	Missed Opportunities to Promptly Diagnose and Treat Adrenal Tumors.. *Journal of Surgical Research*, **2022**, 276, 174-181	2.5	0
167	Adherence to National Guidelines for Timeliness of Test Results Communication to Patients in the Veterans Affairs Health Care System.. *JAMA Network Open*, **2022**, 5, e228568	10.4	0
166	Reporting Outcomes of Pediatric Intensive Care Unit Patients to Referring Physicians via an Electronic Health Record-Based Feedback System.. *Applied Clinical Informatics*, **2022**, 13, 495-503	3.1	
165	Operational measurement of diagnostic safety: state of the science. *Diagnosis*, **2021**, 8, 51-65	4.2	11
164	Identifying trigger concepts to screen emergency department visits for diagnostic errors. *Diagnosis*, **2021**, 8, 340-346	4.2	1
163	Harnessing Event Report Data to Identify Diagnostic Error During the COVID-19 Pandemic. *Joint Commission Journal on Quality and Patient Safety*, **2021**, 48, 71-71	1.4	0
162	Factors Associated With Delay of Diagnosis of Hepatocellular Carcinoma in Patients With Cirrhosis. *Clinical Gastroenterology and Hepatology*, **2021**, 19, 1679-1687	6.9	6
161	Diagnostic Errors in Pediatric Critical Care: A Systematic Review. *Pediatric Critical Care Medicine*, **2021**, 22, 701-712	3	6
160	Why Test Results Are Still Getting "Lost" to Follow-up: a Qualitative Study of Implementation Gaps. *Journal of General Internal Medicine*, **2021**, 1	4	1
159	Incidence, origins and avoidable harm of missed opportunities in diagnosis: longitudinal patient record review in 21 English general practices. *BMJ Quality and Safety*, **2021**, 30, 977-985	5.4	4
158	Monitoring Diagnostic Safety Risks in Emergency Departments: Protocol for a Machine Learning Study. *JMIR Research Protocols*, **2021**, 10, e24642	2	1
157	Patient and clinician experiences of uncertainty in the diagnostic process: Current understanding and future directions. *Patient Education and Counseling*, **2021**, 104, 2606-2615	3.1	3

156	Validation of an electronic trigger to measure missed diagnosis of stroke in emergency departments. *Journal of the American Medical Informatics Association: JAMIA*, **2021**, 28, 2202-2211	8.6	2
155	Fighting a common enemy: a catalyst to close intractable safety gaps. *BMJ Quality and Safety*, **2021**, 30, 141-145	5.4	4
154	Building the evidence-base to reduce electronic health record-related clinician burden. *Journal of the American Medical Informatics Association: JAMIA*, **2021**, 28, 1057-1061	8.6	10
153	A Program to Provide Clinicians with Feedback on Their Diagnostic Performance in a Learning Health System. *Joint Commission Journal on Quality and Patient Safety*, **2021**, 47, 120-126	1.4	7
152	Referral communication for pediatric intensive care unit admission and the diagnosis of critically ill children: A pilot ethnography. *Journal of Critical Care*, **2021**, 63, 246-249	4	1
151	Prolonged Diagnostic Intervals as Marker of Missed Diagnostic Opportunities in Bladder and Kidney Cancer Patients with Alarm Features: A Longitudinal Linked Data Study. *Cancers*, **2021**, 13,	6.6	5
150	Advancing Diagnostic Safety Research: Results of a Systematic Research Priority Setting Exercise. *Journal of General Internal Medicine*, **2021**, 36, 2943-2951	4	7
149	Use of patient complaints to identify diagnosis-related safety concerns: a mixed-method evaluation. *BMJ Quality and Safety*, **2021**, 30, 996-1001	5.4	4
148	Artificial Intelligence Techniques That May Be Applied to Primary Care Data to Facilitate Earlier Diagnosis of Cancer: Systematic Review. *Journal of Medical Internet Research*, **2021**, 23, e23483	7.6	9
147	Diagnosis Documentation of Critically Ill Children at Admission to a PICU. *Pediatric Critical Care Medicine*, **2021**,	3	2
146	Improving diagnostic performance through feedback: the Diagnosis Learning Cycle. *BMJ Quality and Safety*, **2021**, 30, 1002-1009	5.4	3
145	Policies to Promote Shared Responsibility for Safer Electronic Health Records. *JAMA - Journal of the American Medical Association*, **2021**, 326, 1477-1478	27.4	1
144	COVID-19 and the Need for a National Health Information Technology Infrastructure. *JAMA - Journal of the American Medical Association*, **2020**, 323, 2373-2374	27.4	38
143	Factors Associated With Potentially Missed Diagnosis of Appendicitis in the Emergency Department. *JAMA Network Open*, **2020**, 3, e200612	10.4	21
142	Imaging activity possibly signalling missed diagnostic opportunities in bladder and kidney cancer: A longitudinal data-linkage study using primary care electronic health records. *Cancer Epidemiology*, **2020**, 66, 101703	2.8	8
141	Reducing the Risk of Diagnostic Error in the COVID-19 Era. *Journal of Hospital Medicine*, **2020**, 15, 363-366	2.7	23
140	Reducing the Risk of Diagnostic Error in the COVID-19 Era. *Journal of Hospital Medicine*, **2020**, 15, 363-366	2.7	22
139	Detection and Remediation of Misidentification Errors in Radiology Examination Ordering. *Applied Clinical Informatics*, **2020**, 11, 79-87	3.1	0

138	Patient Perspectives on the Usefulness of an Artificial Intelligence-Assisted Symptom Checker: Cross-Sectional Survey Study. *Journal of Medical Internet Research*, **2020**, 22, e14679	7.6	31
137	A Sociotechnical Framework for Safety-Related Electronic Health Record Research Reporting: The SAFER Reporting Framework. *Annals of Internal Medicine*, **2020**, 172, S92-S100	8	14
136	Contributing Factors for Pediatric Ambulatory Diagnostic Process Errors: Project RedDE. *Pediatric Quality & Safety*, **2020**, 5, e299	1	0
135	Application of Human Factors Methods to Understand Missed Follow-up of Abnormal Test Results. *Applied Clinical Informatics*, **2020**, 11, 692-698	3.1	2
134	Developing Health Care Organizations That Pursue Learning and Exploration of Diagnostic Excellence: An Action Plan. *Academic Medicine*, **2020**, 95, 1172-1178	3.9	7
133	Influence of doctor-patient conversations on behaviours of patients presenting to primary care with new or persistent symptoms: a video observation study. *BMJ Quality and Safety*, **2020**, 29, 198-208	5.4	11
132	How can we partner with electronic health record vendors on the complex journey to safer health care?. *Journal of Healthcare Risk Management: the Journal of the American Society for Healthcare Risk Management*, **2020**, 40, 34-43	0.9	3
131	Variation in surgical management of primary hyperparathyroidism in the US Department of Veterans Affairs healthcare system: A 15-year observational study. *Surgery*, **2020**, 168, 838-844	3.6	1
130	Assessment of Health Information Technology-Related Outpatient Diagnostic Delays in the US Veterans Affairs Health Care System: A Qualitative Study of Aggregated Root Cause Analysis Data. *JAMA Network Open*, **2020**, 3, e206752	10.4	7
129	Essential activities for electronic health record safety: A qualitative study. *Health Informatics Journal*, **2020**, 26, 3140-3151	3	4
128	A Roadmap to Advance Patient Safety in Ambulatory Care. *JAMA - Journal of the American Medical Association*, **2020**, 324, 2481-2482	27.4	2
127	An Exploration of Barriers, Facilitators, and Suggestions for Improving Electronic Health Record Inbox-Related Usability: A Qualitative Analysis. *JAMA Network Open*, **2019**, 2, e1912638	10.4	15
126	Missed Diagnosis of New-Onset Systolic Heart Failure at First Presentation in Children with No Known Heart Disease. *Journal of Pediatrics*, **2019**, 208, 258-264.e3	3.6	8
125	A Decade of Health Information Technology Usability Challenges and the Path Forward. *JAMA - Journal of the American Medical Association*, **2019**, 321, 743-744	27.4	47
124	Evaluating diagnostic strategies for early detection of cancer: the CanTest framework. *BMC Cancer*, **2019**, 19, 586	4.8	21
123	Barriers and facilitators impacting reliability of the electronic health record-facilitated total testing process. *International Journal of Medical Informatics*, **2019**, 127, 102-108	5.3	7
122	The Path to Diagnostic Excellence Includes Feedback to Calibrate How Clinicians Think. *JAMA - Journal of the American Medical Association*, **2019**, 321, 737-738	27.4	31
121	Follow-up of Abnormal Estimated GFR Results Within a Large Integrated Health Care Delivery System: A Mixed-Methods Study. *American Journal of Kidney Diseases*, **2019**, 74, 589-600	7.4	6

120	Practicing CliniciansTRecommendations to Reduce Burden from the Electronic Health Record Inbox: a Mixed-Methods Study. *Journal of General Internal Medicine*, **2019**, 34, 1825-1832	4	11
119	Recommendations for using the Revised Safer Dx Instrument to help measure and improve diagnostic safety. *Diagnosis*, **2019**, 6, 315-323	4.2	18
118	Analysis of Human Performance Deficiencies Associated With Surgical Adverse Events. *JAMA Network Open*, **2019**, 2, e198067	10.4	36
117	Letter to the Editor. *Journal of General Internal Medicine*, **2019**, 34, 1960	4	
116	Isolating red flags to enhance diagnosis (I-RED): An experimental vignette study. *International Journal for Quality in Health Care*, **2019**, 31, G97-G102	1.9	
115	Increasing Recognition and Diagnosis of Adolescent Depression: Project RedDE: A Cluster Randomized Trial. *Pediatric Quality & Safety*, **2019**, 4, e217	1	4
114	Cluster Randomized Trial Reducing Missed Elevated Blood Pressure in Pediatric Primary Care: Project RedDE. *Pediatric Quality & Safety*, **2019**, 4, e187	1	4
113	Project RedDE: Cluster Randomized Trial to Reduce Missed or Delayed Abnormal Laboratory Value Actions. *Pediatric Quality & Safety*, **2019**, 4, e218	1	1
112	Application of electronic trigger tools to identify targets for improving diagnostic safety. *BMJ Quality and Safety*, **2019**, 28, 151-159	5.4	35
111	Measures to Improve Diagnostic Safety in Clinical Practice. *Journal of Patient Safety*, **2019**, 15, 311-316	1.9	24
110	Electronic health record reviews to measure diagnostic uncertainty in primary care. *Journal of Evaluation in Clinical Practice*, **2018**, 24, 545-551	2.5	11
109	Patient perspectives on how physicians communicate diagnostic uncertainty: An experimental vignette study. *International Journal for Quality in Health Care*, **2018**, 30, 2-8	1.9	40
108	Tracking Progress in Improving Diagnosis: A Framework for Defining Undesirable Diagnostic Events. *Journal of General Internal Medicine*, **2018**, 33, 1187-1191	4	14
107	Electronic Triggers to Identify Delays in Follow-Up of Mammography: Harnessing the Power of Big Data in Health Care. *Journal of the American College of Radiology*, **2018**, 15, 287-295	3.5	15
106	Associations between diagnostic activity and measures of patient experience in primary care: a cross-sectional ecological study of English general practices. *British Journal of General Practice*, **2018**, 68, e9-e17	1.6	9
105	Adherence to recommended electronic health record safety practices across eight health care organizations. *Journal of the American Medical Informatics Association: JAMIA*, **2018**, 25, 913-918	8.6	7
104	Improving the safety of health information technology requires shared responsibility: It is time we all step up. *Healthcare*, **2018**, 6, 7-12	1.8	43
103	Defining and Measuring Diagnostic Uncertainty in Medicine: A Systematic Review. *Journal of General Internal Medicine*, **2018**, 33, 103-115	4	98

102	Beyond Dr. Google: the evidence on consumer-facing digital tools for diagnosis. *Diagnosis*, **2018**, 5, 95-105	4.2	29
101	Methods for Patient-Centered Interface Design of Test Result Display in Online Portals. *EGEMS (Washington, DC)*, **2018**, 6, 15	2.2	10
100	Challenges in Communication from Referring Clinicians to Pathologists in the Electronic Health Record Era. *Journal of Pathology Informatics*, **2018**, 9, 8	4.4	1
99	Diagnostic evaluation of patients presenting with hematuria: An electronic health record-based study. *Urologic Oncology: Seminars and Original Investigations*, **2018**, 36, 88.e19-88.e25	2.8	5
98	Development and Validation of Trigger Algorithms to Identify Delays in Diagnostic Evaluation of Gastroenterological Cancer. *Clinical Gastroenterology and Hepatology*, **2018**, 16, 90-98	6.9	12
97	Diagnostic Errors in Primary Care Pediatrics: Project RedDE. *Academic Pediatrics*, **2018**, 18, 220-227	2.7	15
96	General Internists in Pursuit of Diagnostic Excellence. *Journal of General Internal Medicine*, **2018**, 33, 2026	4	
95	Diagnostic Decision-Making in the Emergency Department. *Pediatric Clinics of North America*, **2018**, 65, 1097-1105	3.6	11
94	Learning From PatientsTExperiences Related To Diagnostic Errors Is Essential For Progress In Patient Safety. *Health Affairs*, **2018**, 37, 1821-1827	7	28
93	Payment Innovations To Improve Diagnostic Accuracy And Reduce Diagnostic Error. *Health Affairs*, **2018**, 37, 1828-1835	7	5
92	Two Decades Since To Err Is Human: An Assessment Of Progress And Emerging Priorities In Patient Safety. *Health Affairs*, **2018**, 37, 1736-1743	7	111
91	Evaluating a mobile application for improving clinical laboratory test ordering and diagnosis. *Journal of the American Medical Informatics Association: JAMIA*, **2018**, 25, 841-847	8.6	10
90	The global burden of diagnostic errors in primary care. *BMJ Quality and Safety*, **2017**, 26, 484-494	5.4	123
89	Finding Diagnostic Errors in Children Admitted to the PICU. *Pediatric Critical Care Medicine*, **2017**, 18, 265-271	3	27
88	Electronic Detection of Delayed Test Result Follow-Up in Patients with Hypothyroidism. *Journal of General Internal Medicine*, **2017**, 32, 753-759	4	5
87	Safety huddles to proactively identify and address electronic health record safety. *Journal of the American Medical Informatics Association: JAMIA*, **2017**, 24, 261-267	8.6	24
86	Application of Electronic Algorithms to Improve Diagnostic Evaluation for Bladder Cancer. *Applied Clinical Informatics*, **2017**, 8, 279-290	3.1	12
85	Assigning responsibility to close the loop on radiology test results. *Diagnosis*, **2017**, 4, 173-177	4.2	9

84	Toward More Proactive Approaches to Safety in the Electronic Health Record Era. *Joint Commission Journal on Quality and Patient Safety*, **2017**, 43, 540-547	1.4	11
83	Errors in Diagnosis of Spinal Epidural Abscesses in the Era of Electronic Health Records. *American Journal of Medicine*, **2017**, 130, 975-981	2.4	29
82	Patient portals and health apps: Pitfalls, promises, and what one might learn from the other. *Healthcare*, **2017**, 5, 81-85	1.8	76
81	Electronic Health Record Alert-Related Workload as a Predictor of Burnout in Primary Care Providers. *Applied Clinical Informatics*, **2017**, 8, 686-697	3.1	78
80	Electronic Health Records Quantify Previously Existing Phenomenon-Physicians Spend Hours Coordinating Care-Reply. *JAMA Internal Medicine*, **2016**, 176, 1235-6	11.5	
79	Virtual Patient Simulation: A Method to Study Diagnostic Process as an Emergent Aspect of Information Sampling Behavior. *Proceedings of the Human Factors and Ergonomics Society*, **2016**, 60, 533-537	0.4	
78	Communicating Findings of Delayed Diagnostic Evaluation to Primary Care Providers. *Journal of the American Board of Family Medicine*, **2016**, 29, 469-73	1.6	6
77	A Socio-Technical Approach to Preventing, Mitigating, and Recovering from Ransomware Attacks. *Applied Clinical Informatics*, **2016**, 7, 624-32	3.1	50
76	Accuracy of the Safer Dx Instrument to Identify Diagnostic Errors in Primary Care. *Journal of General Internal Medicine*, **2016**, 31, 602-8	4	30
75	Patient-Reported Attributions for Missed Colonoscopy Appointments in Two Large Healthcare Systems. *Digestive Diseases and Sciences*, **2016**, 61, 1853-61	4	20
74	The Burden of Inbox Notifications in Commercial Electronic Health Records. *JAMA Internal Medicine* , **2016**, 176, 559-60	11.5	68
73	Online public reactions to frequency of diagnostic errors in US outpatient care. *Diagnosis*, **2016**, 3, 17-22	4.2	2
72	Analysis of PrescribersTNotes in Electronic Prescriptions in Ambulatory Practice. *JAMA Internal Medicine*, **2016**, 176, 463-70	11.5	19
71	Using voluntary reports from physicians to learn from diagnostic errors in emergency medicine. *Emergency Medicine Journal*, **2016**, 33, 245-52	1.5	31
70	Diagnostic errors related to acute abdominal pain in the emergency department. *Emergency Medicine Journal*, **2016**, 33, 253-9	1.5	38
69	Crowdsourcing Diagnosis for Patients With Undiagnosed Illnesses: An Evaluation of CrowdMed. *Journal of Medical Internet Research*, **2016**, 18, e12	7.6	29
68	Workarounds and Test Results Follow-up in Electronic Health Record-Based Primary Care. *Applied Clinical Informatics*, **2016**, 7, 543-59	3.1	25
67	Measuring and improving patient safety through health information technology: The Health IT Safety Framework. *BMJ Quality and Safety*, **2016**, 25, 226-32	5.4	84

66	Primary care pediatriciansTinterest in diagnostic error reduction. *Diagnosis*, **2016**, 3, 65-69	4.2	13
65	Web Exclusives. Annals for Hospitalists Inpatient Notes - Reducing Diagnostic Error-A New Horizon of Opportunities for Hospital Medicine. *Annals of Internal Medicine*, **2016**, 165, HO2-HO4	8	10
64	Computerized Triggers of Big Data to Detect Delays in Follow-up of Chest Imaging Results. *Chest*, **2016**, 150, 613-20	5.3	24
63	Challenges in patient safety improvement research in the era of electronic health records. *Healthcare*, **2016**, 4, 285-290	1.8	16
62	Advancing the science of measurement of diagnostic errors in healthcare: the Safer Dx framework. *BMJ Quality and Safety*, **2015**, 24, 103-10	5.4	88
61	Releasing test results directly to patients: A multisite survey of physician perspectives. *Patient Education and Counseling*, **2015**, 98, 788-96	3.1	20
60	Evaluation of outcomes from a national patient-initiated second-opinion program. *American Journal of Medicine*, **2015**, 128, 1138.e25-33	2.4	31
59	Patient safety counterpoint: systems approaches and multidisciplinary strategies at the centerpiece of error prevention. *Clinical Gastroenterology and Hepatology*, **2015**, 13, 824-6	6.9	2
58	Lack of timely follow-up of abnormal imaging results and radiologistsTrecommendations. *Journal of the American College of Radiology*, **2015**, 12, 385-9	3.5	18
57	The challenges in defining and measuring diagnostic error. *Diagnosis*, **2015**, 2, 97-103	4.2	81
56	Electronic Trigger-Based Intervention to Reduce Delays in Diagnostic Evaluation for Cancer: A Cluster Randomized Controlled Trial. *Journal of Clinical Oncology*, **2015**, 33, 3560-7	2.2	55
55	Development and Validation of Electronic Health Record-based Triggers to Detect Delays in Follow-up of Abnormal Lung Imaging Findings. *Radiology*, **2015**, 277, 81-7	20.5	26
54	Improving Diagnosis in Health Care--The Next Imperative for Patient Safety. *New England Journal of Medicine*, **2015**, 373, 2493-5	59.2	88
53	Missed diagnostic opportunities and English general practice: a study to determine their incidence, confounding and contributing factors and potential impact on patients through retrospective review of electronic medical records. *Implementation Science*, **2015**, 10, 105	8.4	8
52	Measuring diagnostic safety of inpatients: time to set sail in uncharted waters. *Diagnosis*, **2015**, 2, 1-2	4.2	5
51	Graphical display of diagnostic test results in electronic health records: a comparison of 8 systems. *Journal of the American Medical Informatics Association: JAMIA*, **2015**, 22, 900-4	8.6	37
50	Patient safety goals for the proposed Federal Health Information Technology Safety Center. *Journal of the American Medical Informatics Association: JAMIA*, **2015**, 22, 472-8	8.6	19
49	Setting the record straight on measuring diagnostic errors. Reply to: Bad assumptions on primary care diagnostic errorsTby Dr Richard Young. *BMJ Quality and Safety*, **2015**, 24, 345-8	5.4	4

48	A vision for using online portals for surveillance of patient-centered communication in cancer care. *Patient Experience Journal*, **2015**, 2, 125-131	2.7	2
47	The patient portal and abnormal test results: An exploratory study of patient experiences. *Patient Experience Journal*, **2015**, 2, 148-154	2.7	29
46	Emergency physiciansTviews of direct notification of laboratory and radiology results to patients using the Internet: a multisite survey. *Journal of Medical Internet Research*, **2015**, 17, e60	7.6	24
45	The frequency of diagnostic errors in outpatient care: estimations from three large observational studies involving US adult populations. *BMJ Quality and Safety*, **2014**, 23, 727-31	5.4	265
44	Contingency planning for electronic health record-based care continuity: a survey of recommended practices. *International Journal of Medical Informatics*, **2014**, 83, 797-804	5.3	37
43	Breakdowns in communication of radiological findings: an ethical and medico-legal conundrum. *Diagnosis*, **2014**, 1, 263-268	4.2	11
42	Electronic health record-based triggers to detect potential delays in cancer diagnosis. *BMJ Quality and Safety*, **2014**, 23, 8-16	5.4	75
41	How context affects electronic health record-based test result follow-up: a mixed-methods evaluation. *BMJ Open*, **2014**, 4, e005985	3	26
40	Ebola US Patient Zero: lessons on misdiagnosis and effective use of electronic health records. *Diagnosis*, **2014**, 1, 283-287	4.2	38
39	Patient access to medical records and healthcare outcomes: a systematic review. *Journal of the American Medical Informatics Association: JAMIA*, **2014**, 21, 737-41	8.6	81
38	An analysis of electronic health record-related patient safety concerns. *Journal of the American Medical Informatics Association: JAMIA*, **2014**, 21, 1053-9	8.6	114
37	Exploring new avenues to assess the sharp end of patient safety: an analysis of nationally aggregated peer review data. *BMJ Quality and Safety*, **2014**, 23, 1023-30	5.4	12
36	Resilient Practices in Maintaining Safety of Health Information Technologies. *Journal of Cognitive Engineering and Decision Making*, **2014**, 8, 265-282	2.5	13
35	Developing checklists to prevent diagnostic error in Emergency Room settings. *Diagnosis*, **2014**, 1, 223-231	4.2	29
34	Patient-initiated second opinions: systematic review of characteristics and impact on diagnosis, treatment, and satisfaction. *Mayo Clinic Proceedings*, **2014**, 89, 687-96	6.4	50
33	The SAFER guides: empowering organizations to improve the safety and effectiveness of electronic health records. *American Journal of Managed Care*, **2014**, 20, 418-23	2.1	39
32	Safety Assurance Factors for Electronic Health Record Resilience (SAFER): study protocol. *BMC Medical Informatics and Decision Making*, **2013**, 13, 46	3.6	24
31	Types and origins of diagnostic errors in primary care settings. *JAMA Internal Medicine*, **2013**, 173, 418-25	11.5	276

30	Primary care practitionersTviews on test result management in EHR-enabled health systems: a national survey. *Journal of the American Medical Informatics Association: JAMIA*, **2013**, 20, 727-35	8.6	61
29	Advancing the research agenda for diagnostic error reduction. *BMJ Quality and Safety*, **2013**, 22 Suppl 2, ii52-ii57	5.4	36
28	PhysiciansTdiagnostic accuracy, confidence, and resource requests: a vignette study. *JAMA Internal Medicine*, **2013**, 173, 1952-8	11.5	132
27	Toward electronic medical record alerts that consume less physician time--reply. *JAMA Internal Medicine*, **2013**, 173, 1756	11.5	2
26	Origins of diagnostic error--reply. *JAMA Internal Medicine*, **2013**, 173, 1926-7	11.5	1
25	Reviving the Autopsy as a Diagnostic ErrorReduction Tool. *Laboratory Medicine*, **2013**, 44, 186-190	1.6	5
24	Information overload and missed test results in electronic health record-based settings. *JAMA Internal Medicine*, **2013**, 173, 702-4	11.5	130
23	Guideline adherence for diagnosis of liver cancer in veterans.. *Journal of Clinical Oncology*, **2013**, 31, 89-89	2.2	2
22	Electronic health record-based messages to primary care providers: valuable information or just noise?. *Archives of Internal Medicine*, **2012**, 172, 283-5		32
21	System-related interventions to reduce diagnostic errors: a narrative review. *BMJ Quality and Safety*, **2012**, 21, 160-70	5.4	83
20	Notifications received by primary care practitioners in electronic health records: a taxonomy and time analysis. *American Journal of Medicine*, **2012**, 125, 209.e1-7	2.4	80
19	Exploring situational awareness in diagnostic errors in primary care. *BMJ Quality and Safety*, **2012**, 21, 30-8	5.4	65
18	Electronic health record-based surveillance of diagnostic errors in primary care. *BMJ Quality and Safety*, **2012**, 21, 93-100	5.4	71
17	Cognitive interventions to reduce diagnostic error: a narrative review. *BMJ Quality and Safety*, **2012**, 21, 535-57	5.4	274
16	Postreferral colonoscopy delays in diagnosis of colorectal cancer: a mixed-methods analysis. *Quality Management in Health Care*, **2012**, 21, 252-61	1	16
15	Follow-up actions on electronic referral communication in a multispecialty outpatient setting. *Journal of General Internal Medicine*, **2011**, 26, 64-9	4	47
14	Should patients get direct access to their laboratory test results? An answer with many questions. *JAMA - Journal of the American Medical Association*, **2011**, 306, 2502-3	27.4	27
13	Reducing diagnostic error through medical home-based primary care reform. *JAMA - Journal of the American Medical Association*, **2010**, 304, 463-4	27.4	31

12	Characteristics and predictors of missed opportunities in lung cancer diagnosis: an electronic health record-based study. *Journal of Clinical Oncology*, **2010**, 28, 3307-15	2.2	82
11	Underdiagnosis of Lynch syndrome involves more than family history criteria. *Clinical Gastroenterology and Hepatology*, **2010**, 8, 523-9	6.9	55
10	Notification of abnormal lab test results in an electronic medical record: do any safety concerns remain?. *American Journal of Medicine*, **2010**, 123, 238-44	2.4	116
9	A new sociotechnical model for studying health information technology in complex adaptive healthcare systems. *Quality and Safety in Health Care*, **2010**, 19 Suppl 3, i68-74		357
8	Eight recommendations for policies for communicating abnormal test results. *Joint Commission Journal on Quality and Patient Safety*, **2010**, 36, 226-32	1.4	54
7	Missed opportunities to initiate endoscopic evaluation for colorectal cancer diagnosis. *American Journal of Gastroenterology*, **2009**, 104, 2543-54	0.7	86
6	Timely follow-up of abnormal diagnostic imaging test results in an outpatient setting: are electronic medical records achieving their potential?. *Archives of Internal Medicine*, **2009**, 169, 1578-86		141
5	Improving follow-up of abnormal cancer screens using electronic health records: trust but verify test result communication. *BMC Medical Informatics and Decision Making*, **2009**, 9, 49	3.6	42
4	Older patientsTenthusiasm to use electronic mail to communicate with their physicians: cross-sectional survey. *Journal of Medical Internet Research*, **2009**, 11, e18	7.6	46
3	Communication outcomes of critical imaging results in a computerized notification system. *Journal of the American Medical Informatics Association: JAMIA*, **2007**, 14, 459-66	8.6	118
2	Identifying diagnostic errors in primary care using an electronic screening algorithm. *Archives of Internal Medicine*, **2007**, 167, 302-8		74
1	Postradiation squamous cell cancer of the breast. *Cancer Investigation*, **2000**, 18, 343-6	2.1	11