Paul Barach

List of Publications by Year in descending order

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213 papers	7,659 citations	71102 41 h-index	60623 81 g-index
235 all docs	235 docs citations	235 times ranked	6472 citing authors

#	Article	IF	Citations
1	Reporting and preventing medical mishaps: lessons from non-medical near miss reporting systems. BMJ: British Medical Journal, 2000, 320, 759-763.	2.3	893
2	Clarifying Adverse Drug Events: A Clinician's Guide to Terminology, Documentation, and Reporting. Annals of Internal Medicine, 2004, 140, 795.	3.9	523
3	Five System Barriers to Achieving Ultrasafe Health Care. Annals of Internal Medicine, 2005, 142, 756.	3.9	483
4	Improving Patient Handovers From Hospital to Primary Care. Annals of Internal Medicine, 2012, 157, 417.	3.9	285
5	When Do Supervising Physicians Decide to Entrust Residents With Unsupervised Tasks?. Academic Medicine, 2010, 85, 1408-1417.	1.6	243
6	Wrong-Side/Wrong-Site, Wrong-Procedure, and Wrong-Patient Adverse Events. Archives of Surgery, 2006, 141, 931.	2.2	235
7	The Role of Teamwork in the Professional Education of Physicians: Current Status and Assessment Recommendations. Joint Commission Journal on Quality and Patient Safety, 2005, 31, 185-202.	0.7	172
8	A systematic review of hospital accreditation: the challenges of measuring complex intervention effects. BMC Health Services Research, 2015, 15, 280.	2.2	158
9	Errors and the Burden of Errors: Attitudes, Perceptions, and the Culture of Safety in Pediatric Cardiac Surgical Teams. Annals of Thoracic Surgery, 2008, 85, 1374-1381.	1.3	139
10	Are patients discharged with care? A qualitative study of perceptions and experiences of patients, family members and care providers. BMJ Quality and Safety, 2012, 21, i39-i49.	3.7	136
11	A prospective observational study of human factors, adverse events, and patient outcomes in surgery for pediatric cardiac disease. Journal of Thoracic and Cardiovascular Surgery, 2008, 136, 1422-1428.	0.8	133
12	Interventions to improve patient safety in transitional care â€“ a review of the evidence. Work, 2012, 41, 2915-2924.	1.1	126
13	Improving patient discharge and reducing hospital readmissions by using Intervention Mapping. BMC Health Services Research, 2014, 14, 389.	2.2	123
14	Evaluating policy and service interventions: framework to guide selection and interpretation of study end points. BMJ: British Medical Journal, 2010, 341, c4413-c4413.	2.3	116
15	Disruption of healthcare: Will the COVID pandemic worsen non-COVID outcomes and disease outbreaks?. Progress in Pediatric Cardiology, 2020, 59, 101254.	0.4	115
16	Postoperative patient complaints: a prospective interview study of 12,276 patients. Journal of Clinical Anesthesia, 2010, 22, 13-21.	1.6	102
17	Understanding the complexity of redesigning care around the clinical microsystem. Quality and Safety in Health Care, 2006, 15, i10-i16.	2.5	101
18	Postoperative Visual Loss. Anesthesiology, 2001, 95, 575-577.	2.5	93

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19	Integrating patient safety into the clinical microsystem. Quality and Safety in Health Care, 2004, 13, ii34-ii38.	2.5	84
20	A prospective study of paediatric cardiac surgical microsystems: assessing the relationships between non-routine events, teamwork and patient outcomes. BMJ Quality and Safety, 2011, 20, 599-603.	3.7	84
21	Six Sigma in healthcare: a systematic review of the literature. International Journal of Quality and Reliability Management, 2018, 35, 1075-1092.	2.0	84
22	How do supervising physicians decide to entrust residents with unsupervised tasks? A qualitative analysis. Journal of Hospital Medicine, 2014, 9, 169-175.	1.4	82
23	Relationships between Exterior Views and Nurse Stress: An Exploratory Examination. Herd, 2008, 1, 27-38.	1.5	80
24	What is Operative Morbidity? Defining Complications in a Surgical Registry Database. Annals of Thoracic Surgery, 2007, 84, 1416-1421.	1.3	74
25	â€œIt's like two worlds apartâ€• an analysis of vulnerable patient handover practices at discharge from hospital. BMJ Quality and Safety, 2012, 21, i67-i75.	3.7	68
26	Organizational Culture. Medical Care, 2013, 51, 90-98.	2.4	63
27	The collaborative communication model for patient handover at the interface between high-acuity and low-acuity care. BMJ Quality and Safety, 2012, 21, i58-i66.	3.7	61
28	Expertise in medicine: using the expert performance approach to improve simulation training. Medical Education, 2014, 48, 115-123.	2.1	61
29	Hand-hygiene practices in the operating theatre: an observational study. British Journal of Anaesthesia, 2011, 107, 553-558.	3.4	58
30	Microsystems in Health Care: Part 6. Designing Patient Safety into the Microsystem. Joint Commission Journal on Quality and Safety, 2003, 29, 401-408.	1.3	57
31	High Reliability Organizations and Surgical Microsystems: Re-engineering Surgical Care. Surgical Clinics of North America, 2012, 92, 1-14.	1.5	57
32	Searching for the missing pieces between the hospital and primary care: mapping the patient process during care transitions. BMJ Quality and Safety, 2012, 21, i97-i105.	3.7	55
33	Designing a Patient Safety Undergraduate Medical Curriculum: The Telluride Interdisciplinary Roundtable Experience. Teaching and Learning in Medicine, 2009, 21, 52-58.	2.1	54
34	Beliefs and experiences can influence patient participation in handover between primary and secondary careâ€”a qualitative study of patient perspectives. BMJ Quality and Safety, 2012, 21, i76-i83.	3.7	53
35	The key actor: a qualitative study of patient participation in the handover process in Europe. BMJ Quality and Safety, 2012, 21, i89-i96.	3.7	52
36	A human factors approach to understanding patient safety during pediatric cardiac surgery. Progress in Pediatric Cardiology, 2005, 20, 13-20.	0.4	47

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37	COVID-19 and Healthcare Facilities: a Decalogue of Design Strategies for Resilient Hospitals. Acta Biomedica, 2020, 91, 50-60.	0.3	47
38	How the NHS can improve safety and learning. BMJ: British Medical Journal, 2000, 320, 1683-1684.	2.3	46
39	Managing alarm fatigue in cardiac care. Progress in Pediatric Cardiology, 2012, 33, 85-90.	0.4	46
40	Examining Links Between Signâ€Out Reporting During Shift Changeovers and Patient Management Risks. Risk Analysis, 2008, 28, 969-981.	2.7	45
41	Population Health Strategies to Support Hospital and Intensive Care Unit Resiliency During the COVID-19 Pandemic: The Italian Experience. Population Health Management, 2021, 24, 174-181.	1.7	45
42	Making Sense of Root Cause Analysis Investigations of Surgery-Related Adverse Events. Surgical Clinics of North America, 2012, 92, 101-115.	1.5	44
43	Clinical sensemaking: a systematic approach to reduce the impact of normalised deviance in the medical profession. Journal of the Royal Society of Medicine, 2013, 106, 387-390.	2.0	42
44	Creating Effective Leadership for Improving Patient Safety. Quality Management in Health Care, 2002, 11, 69-78.	0.8	40
45	Pulmonary complications associated with the treatment of patients with congenital cardiac disease: consensus definitions from the Multi-Societal Database Committee for Pediatric and Congenital Heart Disease. Cardiology in the Young, 2008, 18, 215-221.	0.8	40
46	Assessing and improving teamwork in cardiac surgery. BMJ Quality and Safety, 2010, 19, e29-e29.	3.7	40
47	Housestaff and Medical Student Attitudes Toward Medical Errors and Adverse Events. Joint Commission Journal on Quality and Patient Safety, 2007, 33, 493-501.	0.7	39
48	The European HANDOVER Project: a multi-nation program to improve transitions at the primary careâ€"inpatient interface: TableÂ1. BMJ Quality and Safety, 2012, 21, i1-i6.	3.7	39
49	Conducting a multicentre and multinational qualitative study on patient transitions. BMJ Quality and Safety, 2012, 21, i22-i28.	3.7	39
50	Improving Medical Care: The Use of Simulation Technology. Simulation and Gaming, 2001, 32, 164-174.	1.9	38
51	Patient safety and health policy: a history and review. Hematology/Oncology Clinics of North America, 2002, 16, 1463-1482.	2.2	36
52	Disclosing Adverse Events to Patients. Joint Commission Journal on Quality and Patient Safety, 2005, 31, 5-12.	0.7	36
53	Improving Learner Handovers in Medical Education. Academic Medicine, 2017, 92, 927-931.	1.6	36
54	Patient Safety and the Reliability of Health Care Systems. Annals of Internal Medicine, 2003, 138, 997.	3.9	35

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55	Stakeholder perspectives on handovers between hospital staff and general practitioners: an evaluation through the microsystems lens. BMJ Quality and Safety, 2012, 21, i106-i113.	3.7	35
56	Simulation based medical education in graduate medical education training and assessment programs. Progress in Pediatric Cardiology, 2017, 44, 33-42.	0.4	32
57	Mapping and assessing clinical handover training interventions. BMJ Quality and Safety, 2012, 21, i50-i57.	3.7	31
58	A targeted noise reduction observational study for reducing noise in a neonatal intensive unit. Journal of Perinatology, 2017, 37, 1060-1064.	2.0	31
59	Evaluation of a predevelopment service delivery intervention: an application to improve clinical handovers. BMJ Quality and Safety, 2012, 21, i29-i38.	3.7	30
60	Why has the safety and quality movement been slow to improve care?. International Journal of Clinical Practice, 2014, 68, 932-935.	1.7	30
61	Raised speed limits, case fatality and road deaths: a six year follow-up using ARIMA models. Injury Prevention, 2007, 13, 156-161.	2.4	29
62	The Handover Toolbox: a knowledge exchange and training platform for improving patient care. BMJ Quality and Safety, 2012, 21, i114-i120.	3.7	29
63	Emergency Preparedness and Response in Israel During the Gulf War. Annals of Emergency Medicine, 1998, 32, 224-233.	0.6	28
64	Training Teams for the Perioperative Environment: A Research Agenda. Surgical Innovation, 2006, 13, 170-178.	0.9	28
65	Incident reporting: science or protoscience? Ten years later. Quality and Safety in Health Care, 2002, 11, 144-145.	2.5	27
66	A New Paradigm for the Design of Audible Alarms that Convey Urgency Information. Journal of Clinical Monitoring and Computing, 2007, 21, 353-363.	1.6	27
67	Assessing the Impact of Patient-Facing Mobile Health Technology on Patient Outcomes: Retrospective Observational Cohort Study. JMIR MHealth and UHealth, 2020, 8, e19333.	3.7	27
68	Flexibility during the COVID-19 Pandemic Response: Healthcare Facility Assessment Tools for Resilient Evaluation. International Journal of Environmental Research and Public Health, 2021, 18, 11478.	2.6	27
69	Healthcare Assessment and Performance: Using Simulation. Simulation and Gaming, 2001, 32, 147-155.	1.9	26
70	Cardiac complications associated with the treatment of patients with congenital cardiac disease: consensus definitions from the Multi-Societal Database Committee for Pediatric and Congenital Heart Disease. Cardiology in the Young, 2008, 18, 196-201.	0.8	26
71	Patient-centered handovers between hospital and primary health care: An assessment of medical records. International Journal of Medical Informatics, 2015, 84, 355-362.	3.3	26
72	Patient Safety Curriculum. Academic Medicine, 2000, 75, 551-552.	1.6	25

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73	The End of the Beginning. Journal of Legal Medicine, 2003, 24, 7-27.	0.5	24
74	Quality improvement methods to study and improve the process and outcomes of pediatric cardiac care. Progress in Pediatric Cardiology, 2011, 32, 147-153.	0.4	24
75	Improving Clinical Performance Using Rehearsal or Warm-up. Academic Medicine, 2014, 89, 1416-1422.	1.6	24
76	Design of cardiovascular operating rooms for tomorrow's technology and clinical practice â€" Part 2. Progress in Pediatric Cardiology, 2012, 33, 57-65.	0.4	23
77	Crisis checklists for in-hospital emergencies: expert consensus, simulation testing and recommendations for a template determined by a multi-institutional and multi-disciplinary learning collaborative. BMC Health Services Research, 2017, 17, 334.	2.2	23
78	The July Effect: Fertile Ground for Systems Improvement. Annals of Internal Medicine, 2011, 155, 331.	3.9	22
79	Non-pharmaceutical Interventions and the Infodemic on Twitter: Lessons Learned from Italy during the Covid-19 Pandemic. Journal of Medical Systems, 2021, 45, 50.	3.6	22
80	Raised Speed Limits, Speed Spillover, Case-Fatality Rates, and Road Deaths in Israel: A 5-Year Follow-Up. American Journal of Public Health, 2004, 94, 568-574.	2.7	21
81	Assessment of technical competency in pediatric cardiac surgery. Progress in Pediatric Cardiology, 2012, 33, 15-20.	0.4	21
82	Injury Prevention. Pediatric Clinics of North America, 2013, 60, 1241-1253.	1.8	21
83	Delivering safe health care. BMJ: British Medical Journal, 2001, 323, 585-586.	2.3	20
84	Anaesthetic complications associated with the treatment of patients with congenital cardiac disease: consensus definitions from the Multi-Societal Database Committee for Pediatric and Congenital Heart Disease. Cardiology in the Young, 2008, 18, 271-281.	0.8	20
85	Balancing clinical team perceptions of the workplace: Applying â€˜work domain analysisâ€™ to pediatric cardiac care. Progress in Pediatric Cardiology, 2012, 33, 25-32.	0.4	20
86	Handover training: does one size fit all? The merits of mass customisation. BMJ Quality and Safety, 2012, 21, i84-i88.	3.7	19
87	Improving communication with families of patients undergoing pediatric cardiac surgery. Progress in Pediatric Cardiology, 2017, 45, 83-90.	0.4	19
88	Patterns in medication incidents: A 10-yr experience of a cross-national anaesthesia incident reporting system. British Journal of Anaesthesia, 2020, 124, 197-205.	3.4	19
89	Microsimulators in Medical Education: An Overview. Simulation and Gaming, 2001, 32, 250-262.	1.9	18
90	Emergency Preparedness for Biological and Chemical Incidents: A Survey of Anesthesiology Residency Programs in the United States. Anesthesia and Analgesia, 2005, 101, 1135-1140.	2.2	18

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91	A qualitative study of patient experiences of decentralized acute healthcare services. Scandinavian Journal of Primary Health Care, 2016, 34, 317-324.	1.5	17
92	A team-based risk modification programme to make health care safer. Theoretical Issues in Ergonomics Science, 2007, 8, 481-494.	1.8	16
93	Patient care handovers: what will it take to ensure quality and safety during times of transition?. Medical Journal of Australia, 2009, 190, S110-2.	1.7	16
94	Leadership, surgeon well-being and non-technical competencies of pediatric cardiac surgery. Progress in Pediatric Cardiology, 2011, 32, 129-133.	0.4	16
95	Supporting the Quadruple Aim Using Simulation and Human Factors During COVID-19 Care. American Journal of Medical Quality, 2021, 36, 73-83.	0.5	16
96	Emergency Preparedness and Response in Israel During the Gulf War. Annals of Emergency Medicine, 1997, 30, 513-521.	0.6	15
97	Residents' hours of work. BMJ: British Medical Journal, 2002, 325, 1184-1185.	2.3	15
98	Cranial Electrotherapy Stimulation: A Safe Neuromedical Treatment for Anxiety, Depression, or Insomnia. Southern Medical Journal, 2004, 97, 1269-1270.	0.7	15
99	Death and injury from motor vehicle crashes: a public health failure, not an achievement. Injury Prevention, 2001, 7, 176-178.	2.4	14
100	Medication Safety in Anesthesia: Epidemiology, Causes, and Lessons Learned in Achieving Reliable Patient Outcomes. International Anesthesiology Clinics, 2019, 57, 78-95.	0.8	14
101	Creatine Phosphate Kinase Elevations Signaling Muscle Damage following Exposures to Anticholinesterases: 2 Sentinel Patients. Archives of Environmental Health, 2003, 58, 167-171.	0.4	13
102	Trauma Team Performance. , 2007, , 101-113.		13
103	The Role of Qualitative Methods in Designing Health Care Organizations. Environment and Behavior, 2008, 40, 191-204.	4.7	12
104	Associations between work satisfaction, engagement and 7-day patient mortality: a cross-sectional survey. BMJ Open, 2019, 9, e031704.	1.9	12
105	Impact of electronic health records on predefined safety outcomes in patients admitted to hospital: a scoping review. BMJ Open, 2021, 11, e047446.	1.9	12
106	Hospital work environments affect the patient safety climate: A longitudinal follow-up using a logistic regression analysis model. PLoS ONE, 2021, 16, e0258471.	2.5	12
107	Implementing multidisciplinary tumor boards in oncology: a narrative review. Future Oncology, 2022, 18, 375-384.	2.4	12
108	Perceptions of Practicing Physicians and Members of the Public on the Attributes of a â€œGood Doctorâ€• Healthcare (Switzerland), 2022, 10, 73.	2.0	12

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109	Extending the boundaries of the Declaration of Helsinki: a case study of an unethical experiment in a non-medical setting. Journal of Medical Ethics, 2001, 27, 126-129.	1.8	11
110	Towards a learning system for pediatric outcomes: Harvesting meaning from evidence. Progress in Pediatric Cardiology, 2018, 49, 20-26.	0.4	11
111	Revisiting safe airway management and patient care by anaesthetists during the COVID-19 pandemic. British Journal of Anaesthesia, 2020, 125, 863-867.	3.4	11
112	Assessing and Improving Medical Competency: Using Strategic Management Simulations. Simulation and Gaming, 2001, 32, 156-163.	1.9	10
113	Measuring and improving comprehensive pediatric cardiac care: Learning from continuous quality improvement methods and tools. Progress in Pediatric Cardiology, 2018, 48, 82-92.	0.4	10
114	â€œDo You Know What I Know?â€• How Communication Norms and Recipient Design Shape the Content and Effectiveness of Patient Handoffs. Journal of General Internal Medicine, 2019, 34, 264-271.	2.6	10
115	Personal Watercraft-Related Injuries. JAMA - Journal of the American Medical Association, 1998, 279, 433-a-434.	7.4	10
116	Design of cardiovascular operating rooms for tomorrow's technology and clinical practice â€” Part one. Progress in Pediatric Cardiology, 2011, 32, 121-128.	0.4	9
117	Improving cardiac care quality and safety through partnerships with patients and their families. Progress in Pediatric Cardiology, 2012, 33, 73-79.	0.4	9
118	What can artefact analysis tell us about patient transitions between the hospital and primary care? Lessons from the HANDOVER project. European Journal of General Practice, 2013, 19, 185-193.	2.0	9
119	COVID-19 and Medical Education: A Four-Part Model to Assess Risks, Benefits, and Institutional Obligations During a Global Pandemic. Mayo Clinic Proceedings, 2021, 96, 20-28.	3.0	9
120	PERIOPERATIVE ANESTHETIC MANAGEMENT OF PATIENTS WITH CARDIAC TRAUMA. Anesthesiology Clinics, 1999, 17, 197-209.	1.4	8
121	Preventable Deaths From Medical Errors. JAMA - Journal of the American Medical Association, 2001, 286, 2813.	7.4	8
122	The role and influence of public reporting of pediatric cardiac care outcome data. Progress in Pediatric Cardiology, 2012, 33, 99-101.	0.4	8
123	Designing Safe Intensive Care Units of the Future. , 2009, , 525-541.		8
124	National preparedness survey of pediatric intensive care units with simulation centers during the coronavirus pandemic. World Journal of Critical Care Medicine, 2020, 9, 74-87.	1.8	8
125	Implantable Defibrillators, Pacemakers, and Electronic Antitheft Devices. New England Journal of Medicine, 1999, 340, 1117-1119.	27.0	7
126	Complications from Supervised Mask Use in Post-operative Surgical Patients during the Gulf War. Prehospital and Disaster Medicine, 1999, 14, 75-76.	1.3	7

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127	Readmitting Children with Heart Failure: the Importance of Communication, Coordination, and Continuity of Care. Journal of Pediatrics, 2016, 177, 13-16.	1.8	7
128	â€œWorkin' on Our Night Movesâ€• How Residents Prepare for Shift Handoffs. Joint Commission Journal on Quality and Patient Safety, 2018, 44, 485-493.	0.7	7
129	Using Evidence to Design Cancer Care Facilities. American Journal of Medical Quality, 2020, 35, 397-404.	0.5	7
130	On Teams, Organizations, and Safety: Of Courseâ€¦. Joint Commission Journal on Quality and Patient Safety, 2006, 32, 112-113.	0.7	6
131	Addressing barriers for change in clinical practice. , 0, , 142-151.		6
132	Rethinking COVID-19 in children: Lessons learned from pediatric viral and inflammatory cardiovascular diseases. Progress in Pediatric Cardiology, 2020, 57, 101233.	0.4	6
133	Anaesthesia and perioperative incident reporting systems: Opportunities and challenges. Bailliere's Best Practice and Research in Clinical Anaesthesiology, 2021, 35, 93-103.	4.0	6
134	Blood Transfusions in Critical Care. New England Journal of Medicine, 1999, 341, 123-124.	27.0	5
135	Adverse event disclosure: benefits and drawbacks for patients and clinicians. , 2007, , 76-90.		5
136	Reducing variation in adverse events during the academic year. BMJ: British Medical Journal, 2009, 339, b3949-b3949.	2.3	5
137	Where to now for paediatric cardiac surgery?. ANZ Journal of Surgery, 2011, 81, 659-660.	0.7	5
138	Content counts, but context makes the difference in developing expertise: a qualitative study of how residents learn end of shift handoffs. BMC Medical Education, 2018, 18, 249.	2.4	5
139	Facing Death: Attitudes toward Physician-Assisted End of Life among Physicians Working at a Tertiary-Care-Hospital in Israel. International Journal of Environmental Research and Public Health, 2021, 18, 6396.	2.6	5
140	The High Stakes of Outsourcing in Health Care. Mayo Clinic Proceedings, 2021, 96, 2879-2890.	3.0	5
141	Potential Chromosome 12 Locus for Late-Onset Familial Alzheimer Disease. JAMA - Journal of the American Medical Association, 1998, 279, 433-433.	7.4	5
142	Management of the Critically Ill Patient in the Hyperbaric Chamber. International Anesthesiology Clinics, 2000, 38, 153-166.	0.8	5
143	PERSONALIZED MEDICINE AS AN UPDATED MODEL OF NATIONAL HEALTH-CARE SYSTEM.PART 1. STRATEGIC ASPECTS OF INFRASTRUCTURE. Rossiyskiy Vestnik Perinatologii I Pediatrii, 2017, 62, 7-14.	0.3	5
144	Clarifying Terminology for Adverse Drug Events. Annals of Internal Medicine, 2005, 142, 77.	3.9	4

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145	COMMENTARY. Quality and Safety in Health Care, 2005, 14, 60-61.	2.5	4
146	Improving Pediatric Cardiac Care with Continuous Quality Improvement Methods and Tools. , 2015, , 39-50.		4
147	Designing high-reliability healthcare teams. , 2016, , .		4
148	The danger of relying on the interpretation of p-values in single studies: Irreproducibility of results from clinical studies. Progress in Pediatric Cardiology, 2017, 44, 57-61.	0.4	4
149	Does Lowering Heart Rate Improve Outcomes in Children With DilatedÂCardiomyopathy and ChronicÂHeart Failure?. Journal of the American College of Cardiology, 2017, 70, 1273-1275.	2.8	4
150	Healthcare system reliability analysis addressing uncertain and ambiguous data. , 2017, , .		4
151	When is early septal myectomy in children with hypertrophic cardiomyopathy justified?. Translational Pediatrics, 2018, 7, 362-366.	1.2	4
152	A dynamic risk management approach to reduce harm in hypertrophic cardiomyopathy. Progress in Pediatric Cardiology, 2018, 49, 12-17.	0.4	4
153	Design of Cardiac Surgery Operating Rooms and the Impact of the Built Environment. , 2015, , 411-424.		4
154	Building Surgical Expertise Through the Science of Continuous Learning and Training. , 2017, , 185-204.		4
155	Information Technology Infrastructure, Management, and Implementation: The Rise of the Emergent Clinical Information System and the Chief Medical Information Officer. , 2017, , 247-262.		4
156	Failure to Rescue and Failure to Perceive Patients in Crisis. , 2017, , 635-648.		4
157	What is the role of healthcare managers in delivering safe care?. Quality and Safety in Health Care, 2003, 12, 161-162.	2.5	3
158	Improving communication and reliability of patient handovers in pediatric cardiac care. Progress in Pediatric Cardiology, 2011, 32, 135-139.	0.4	3
159	Hospital Alarms and Patient Safety. JAMA - Journal of the American Medical Association, 2014, 312, 651.	7.4	3
160	Lowering the P Value Threshold. JAMA - Journal of the American Medical Association, 2018, 320, 935.	7.4	3
161	Differences in identification of patientsâ€™ deterioration may hamper the success of clinical escalation protocols. QJM - Monthly Journal of the Association of Physicians, 2019, 112, 497-504.	0.5	3
162	Designing and integrating purposeful learning in gameplay: What will it take to ensure sustainable learning and effectiveness outcomes?. Educational Technology Research and Development, 2021, 69, 161-166.	2.8	3

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163	Remote Patient Monitoring: A Promising Digital Health Frontier. , 2021, , .		3
164	Designing a Safe and Reliable Sedation Service: Adopting a Safety Culture. , 2012, , 429-444.		3
165	Capturing, Reporting, and Learning from Adverse Events. , 2017, , 683-694.		3
166	The Sleep of Long-Haul Truck Drivers. New England Journal of Medicine, 1998, 338, 389-391.	27.0	2
167	Room I, 10/17/2000 2: 00 PM - 4: 00 PM (PS) Statewide Survey of Massachusetts Physician Attitudes Towards Policy and Workplace Issues of Patient SafetyÂ. Anesthesiology, 2000, 93, A-1188.	2.5	2
168	Quality and Safety in Health Care: a time of transition. Quality and Safety in Health Care, 2002, 11, 1-1.	2.5	2
169	Latency: An important consideration in gulf war syndrome. NeuroToxicology, 2007, 28, 1043-1044.	3.0	2
170	Principles and Practice of Disaster Medicine: What Every Anesthesiologist Should Know About Responding to Medical Disasters. Advances in Anesthesia, 2008, 26, 175-199.	0.9	2
171	Lowering the P Value Threshold. JAMA - Journal of the American Medical Association, 2018, 320, 936.	7.4	2
172	The Seoul Declaration: A Manifesto for Ethical Medical Technology. Minimally Invasive Therapy and Allied Technologies, 2019, 28, 69-72.	1.2	2
173	The Art of Effective Handoff Communication Among Medical and Surgery Residents. Journal of Cognitive Engineering and Decision Making, 2021, 15, 66-82.	2.3	2
174	Patient Safety Education and Curriculum Design. , 0, , 238-253.		2
175	Safety 3.0 and the End of the Superstar Clinician. , 2020, , 515-535.		2
176	Enhancing patient safety: beginning the dialogue in health services research. Journal of Health Services Research and Policy, 2001, 6, 67-69.	1.7	2
177	Multifactorial Etiology of Postoperative Vision Loss. Anesthesiology, 2002, 96, 1532-1532.	2.5	2
178	Addressing the Barriers and Political Pressures to Safety. International Journal of Reliable and Quality E-Healthcare, 2012, 1, 55-64.	1.1	2
179	Leadership, Surgeon Well-Being, and Other Non-technical Aspects of Pediatric Cardiac Surgery. , 2015, , 293-306.		2
180	The Science of Delivering Safe and Reliable Anesthesia Care. , 2017, , 327-347.		2

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181	Toward a Learning System for ERAS: Embedding Implementation and Learning Evaluation. , 2020, , 361-372.		2
182	Injury Prevention. New England Journal of Medicine, 1998, 338, 132-133.	27.0	1
183	THE IMPACT OF THE YEAR 2000 ON PHYSICIANS. JAMA - Journal of the American Medical Association, 1999, 281, 862C.	7.4	1
184	Teaching Hospitals in Trouble: Finding Solutions. JAMA - Journal of the American Medical Association, 1999, 282, 1686.	7.4	1
185	Enhancing patient safety and reducing medical error The role of preventive medicine. American Journal of Preventive Medicine, 2000, 19, 202-205.	3.0	1
186	Sustainable cardiac servicesâ€"From the catheterization laboratory to the operating room and beyond. Progress in Pediatric Cardiology, 2012, 33, 81-84.	0.4	1
187	A Dynamic Risk Management Approach for Reducing Harm From Invasive Bedside Procedures Performed During Residency. Academic Medicine, 2021, 96, 1268-1275.	1.6	1
188	Teaching Hospitals in Trouble: Defining the Problem. JAMA - Journal of the American Medical Association, 1999, 282, 1592-b-1592.	7.4	1
189	Redesigning Hospital Alarms for Reliable and Safe Care. , 2017, , 263-275.		1
190	Tools and Strategies for Continuous Quality Improvement and Patient Safety. , 2017, , 121-132.		1
191	Microsystems Simulation: Designing and Evaluating an Approach to Patient Safety and Systems Thinking. Anesthesiology, 2002, 96, A1108.	2.5	1
192	Preventable Deaths From Medical Errors. JAMA - Journal of the American Medical Association, 2001, 286, 2813-a-2814.	7.4	1
193	How Regulators Assess and Accredit Safety and Quality in Surgical Services. , 2017, , 755-783.		1
194	Teams, Team Training, and the Role of Simulation in Trauma Training and Management. , 0, , 579-590.		0
195	Teaching Hospitals in Trouble: Defining the Problem. JAMA - Journal of the American Medical Association, 1999, 282, 1592A.	7.4	0
196	Simulation in anaesthesia. Minimally Invasive Therapy and Allied Technologies, 2000, 9, 321-324.	1.2	0
197	Current Concepts in Treatment of Agents of Mass Destruction. Refresher Courses in Anesthesiology, 2004, 32, 19-28.	0.1	0
198	Wrong-Site Surgeries Are Preventableâ€"Reply. Archives of Surgery, 2007, 142, 1112.	2.2	0

#	Article	IF	Citations
199	Trauma team training and simulation: creating safer outcomes. , 0, , 709-723.		0
200	Quality improvement through public reporting: The surgeon scorecard â€“ are we there yet?. Journal of Hospital Administration, 2018, 7, 27.	0.1	0
201	A Brazilian national preparedness survey of anesthesiologists during the coronavirus pandemic. Brazilian Journal of Anesthesiology (Elsevier), 2021, 71, 184-187.	0.4	0
202	Express check-in: developing a personal health record for patients admitted to hospital with medical emergencies: a mixed-method feasibility study. International Journal for Quality in Health Care, 2021, 33, .	1.8	0
203	ROAD DEATHS: A PUBLIC HEALTH FAILURE, NOT AN ACHIEVEMENT. Epidemiology, 2000, 11, S140.	2.7	0
204	Enhancing Patient Safety and Reducing Medical Error. , 2001, , .		0
205	Response to bioterrorism. BMJ: British Medical Journal, 2002, 324, 362a-362.	2.3	0
206	Evaluating Needle Sticks and Sharp Object Injuries in Developing Country: A Diagnostic Institute in Dominican Republic. International Journal of Infection Control, 2010, 6, .	0.2	0
207	THE IMPACT OF THE YEAR 2000 ON PHYSICIANS. JAMA - Journal of the American Medical Association, 1999, 281, 862-b-862.	7.4	0
208	Surgical Safety in Developing Countries: Middle East, North Africa, and Gulf Countries. , 2017, , 859-867.		0
209	How Not to Run an Incident Investigation. , 2017, , 695-714.		0
210	Safer Medication Administration Through Design and Ergonomics. , 2017, , 461-478.		0
211	Diagnostic Error in Surgery and Surgical Services. , 2017, , 397-412.		0
212	How To Hospital: barriers to developing a patient â€˜Hospital Survival Guideâ€™ to support information transfer during ward-rounds on the patient journey from admission to hospital to discharge. BMJ Open Quality, 2022, 11, e001556.	1.1	0
213	Future direction for healthcare based on big data analytics. , 2022, , 277-287.		0