

Paul Barach

List of Publications by Year in descending order

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Version: 2024-02-01

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	Implementing multidisciplinary tumor boards in oncology: a narrative review. <i>Future Oncology</i> , 2022, 18, 375-384.	2.4	12
2	How To Hospital: barriers to developing a patient "Hospital Survival Guide"™ to support information transfer during ward-rounds on the patient journey from admission to hospital to discharge. <i>BMJ Open Quality</i> , 2022, 11, e001556.	1.1	0
3	Perceptions of Practicing Physicians and Members of the Public on the Attributes of a "Good Doctor". <i>Healthcare (Switzerland)</i> , 2022, 10, 73.	2.0	12
4	Future direction for healthcare based on big data analytics. , 2022, , 277-287.		0
5	Anaesthesia and perioperative incident reporting systems: Opportunities and challenges. <i>Bailliere's Best Practice and Research in Clinical Anaesthesiology</i> , 2021, 35, 93-103.	4.0	6
6	COVID-19 and Medical Education: A Four-Part Model to Assess Risks, Benefits, and Institutional Obligations During a Global Pandemic. <i>Mayo Clinic Proceedings</i> , 2021, 96, 20-28.	3.0	9
7	Designing and integrating purposeful learning in gameplay: What will it take to ensure sustainable learning and effectiveness outcomes?. <i>Educational Technology Research and Development</i> , 2021, 69, 161-166.	2.8	3
8	Impact of electronic health records on predefined safety outcomes in patients admitted to hospital: a scoping review. <i>BMJ Open</i> , 2021, 11, e047446.	1.9	12
9	Supporting the Quadruple Aim Using Simulation and Human Factors During COVID-19 Care. <i>American Journal of Medical Quality</i> , 2021, 36, 73-83.	0.5	16
10	A Dynamic Risk Management Approach for Reducing Harm From Invasive Bedside Procedures Performed During Residency. <i>Academic Medicine</i> , 2021, 96, 1268-1275.	1.6	1
11	Non-pharmaceutical Interventions and the Infodemic on Twitter: Lessons Learned from Italy during the Covid-19 Pandemic. <i>Journal of Medical Systems</i> , 2021, 45, 50.	3.6	22
12	A Brazilian national preparedness survey of anesthesiologists during the coronavirus pandemic. <i>Brazilian Journal of Anesthesiology (Elsevier)</i> , 2021, 71, 184-187.	0.4	0
13	Population Health Strategies to Support Hospital and Intensive Care Unit Resiliency During the COVID-19 Pandemic: The Italian Experience. <i>Population Health Management</i> , 2021, 24, 174-181.	1.7	45
14	Facing Death: Attitudes toward Physician-Assisted End of Life among Physicians Working at a Tertiary-Care-Hospital in Israel. <i>International Journal of Environmental Research and Public Health</i> , 2021, 18, 6396.	2.6	5
15	The Art of Effective Handoff Communication Among Medical and Surgery Residents. <i>Journal of Cognitive Engineering and Decision Making</i> , 2021, 15, 66-82.	2.3	2
16	Remote Patient Monitoring: A Promising Digital Health Frontier. , 2021, , .		3
17	Express check-in: developing a personal health record for patients admitted to hospital with medical emergencies: a mixed-method feasibility study. <i>International Journal for Quality in Health Care</i> , 2021, 33, .	1.8	0
18	The High Stakes of Outsourcing in Health Care. <i>Mayo Clinic Proceedings</i> , 2021, 96, 2879-2890.	3.0	5

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19	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
20	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
21	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
22	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
23	Rethinking COVID-19 in children: Lessons learned from pediatric viral and inflammatory cardiovascular diseases. Progress in Pediatric Cardiology, 2020, 57, 101233.	0.4	6
24	Disruption of healthcare: Will the COVID pandemic worsen non-COVID outcomes and disease outbreaks?. Progress in Pediatric Cardiology, 2020, 59, 101254.	0.4	115
25	Using Evidence to Design Cancer Care Facilities. American Journal of Medical Quality, 2020, 35, 397-404.	0.5	7
26	Safety 3.0 and the End of the Superstar Clinician. , 2020, , 515-535.		2
27	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
28	COVID-19 and Healthcare Facilities: a Decalogue of Design Strategies for Resilient Hospitals. Acta Biomedica, 2020, 91, 50-60.	0.3	47
29	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
30	Toward a Learning System for ERAS: Embedding Implementation and Learning Evaluation. , 2020, , 361-372.		2
31	The Seoul Declaration: A Manifesto for Ethical Medical Technology. Minimally Invasive Therapy and Allied Technologies, 2019, 28, 69-72.	1.2	2
32	Differences in identification of patients' deterioration may hamper the success of clinical escalation protocols. QJM - Monthly Journal of the Association of Physicians, 2019, 112, 497-504.	0.5	3
33	Associations between work satisfaction, engagement and 7-day patient mortality: a cross-sectional survey. BMJ Open, 2019, 9, e031704.	1.9	12
34	Medication Safety in Anesthesia: Epidemiology, Causes, and Lessons Learned in Achieving Reliable Patient Outcomes. International Anesthesiology Clinics, 2019, 57, 78-95.	0.8	14
35	“Do You Know What I Know?” 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
36	Six Sigma in healthcare: a systematic review of the literature. International Journal of Quality and Reliability Management, 2018, 35, 1075-1092.	2.0	84

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37	Measuring and improving comprehensive pediatric cardiac care: Learning from continuous quality improvement methods and tools. <i>Progress in Pediatric Cardiology</i> , 2018, 48, 82-92.	0.4	10
38	When is early septal myectomy in children with hypertrophic cardiomyopathy justified?. <i>Translational Pediatrics</i> , 2018, 7, 362-366.	1.2	4
39	Quality improvement through public reporting: The surgeon scorecard "are we there yet?". <i>Journal of Hospital Administration</i> , 2018, 7, 27.	0.1	0
40	Content counts, but context makes the difference in developing expertise: a qualitative study of how residents learn end of shift handoffs. <i>BMC Medical Education</i> , 2018, 18, 249.	2.4	5
41	Lowering the P Value Threshold. <i>JAMA - Journal of the American Medical Association</i> , 2018, 320, 936.	7.4	2
42	Lowering the <i>P</i> Value Threshold. <i>JAMA - Journal of the American Medical Association</i> , 2018, 320, 935.	7.4	3
43	"Workin' on Our Night Moves" How Residents Prepare for Shift Handoffs. <i>Joint Commission Journal on Quality and Patient Safety</i> , 2018, 44, 485-493.	0.7	7
44	Towards a learning system for pediatric outcomes: Harvesting meaning from evidence. <i>Progress in Pediatric Cardiology</i> , 2018, 49, 20-26.	0.4	11
45	A dynamic risk management approach to reduce harm in hypertrophic cardiomyopathy. <i>Progress in Pediatric Cardiology</i> , 2018, 49, 12-17.	0.4	4
46	Simulation based medical education in graduate medical education training and assessment programs. <i>Progress in Pediatric Cardiology</i> , 2017, 44, 33-42.	0.4	32
47	A targeted noise reduction observational study for reducing noise in a neonatal intensive unit. <i>Journal of Perinatology</i> , 2017, 37, 1060-1064.	2.0	31
48	The danger of relying on the interpretation of p-values in single studies: Irreproducibility of results from clinical studies. <i>Progress in Pediatric Cardiology</i> , 2017, 44, 57-61.	0.4	4
49	Improving communication with families of patients undergoing pediatric cardiac surgery. <i>Progress in Pediatric Cardiology</i> , 2017, 45, 83-90.	0.4	19
50	Does Lowering Heart Rate Improve Outcomes in Children With Dilated Cardiomyopathy and Chronic Heart Failure?. <i>Journal of the American College of Cardiology</i> , 2017, 70, 1273-1275.	2.8	4
51	Healthcare system reliability analysis addressing uncertain and ambiguous data. , 2017, , .		4
52	Improving Learner Handovers in Medical Education. <i>Academic Medicine</i> , 2017, 92, 927-931.	1.6	36
53	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. <i>BMC Health Services Research</i> , 2017, 17, 334.	2.2	23
54	Building Surgical Expertise Through the Science of Continuous Learning and Training. , 2017, , 185-204.		4

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55	Information Technology Infrastructure, Management, and Implementation: The Rise of the Emergent Clinical Information System and the Chief Medical Information Officer. , 2017, , 247-262.		4
56	Redesigning Hospital Alarms for Reliable and Safe Care. , 2017, , 263-275.		1
57	Failure to Rescue and Failure to Perceive Patients in Crisis. , 2017, , 635-648.		4
58	Capturing, Reporting, and Learning from Adverse Events. , 2017, , 683-694.		3
59	Tools and Strategies for Continuous Quality Improvement and Patient Safety. , 2017, , 121-132.		1
60	How Regulators Assess and Accredite Safety and Quality in Surgical Services. , 2017, , 755-783.		1
61	Surgical Safety in Developing Countries: Middle East, North Africa, and Gulf Countries. , 2017, , 859-867.		0
62	How Not to Run an Incident Investigation. , 2017, , 695-714.		0
63	The Science of Delivering Safe and Reliable Anesthesia Care. , 2017, , 327-347.		2
64	Safer Medication Administration Through Design and Ergonomics. , 2017, , 461-478.		0
65	Diagnostic Error in Surgery and Surgical Services. , 2017, , 397-412.		0
66	PERSONALIZED MEDICINE AS AN UPDATED MODEL OF NATIONAL HEALTH-CARE SYSTEM.PART 1. STRATEGIC ASPECTS OF INFRASTRUCTURE. Rossiyskiy Vestnik Perinatologii I Peditrii, 2017, 62, 7-14.	0.3	5
67	Readmitting Children with Heart Failure: the Importance of Communication, Coordination, and Continuity of Care. Journal of Pediatrics, 2016, 177, 13-16.	1.8	7
68	Designing high-reliability healthcare teams. , 2016, , .		4
69	A qualitative study of patient experiences of decentralized acute healthcare services. Scandinavian Journal of Primary Health Care, 2016, 34, 317-324.	1.5	17
70	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
71	Improving Pediatric Cardiac Care with Continuous Quality Improvement Methods and Tools. , 2015, , 39-50.		4
72	A systematic review of hospital accreditation: the challenges of measuring complex intervention effects. BMC Health Services Research, 2015, 15, 280.	2.2	158

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73	Design of Cardiac Surgery Operating Rooms and the Impact of the Built Environment. , 2015, , 411-424.		4
74	Leadership, Surgeon Well-Being, and Other Non-technical Aspects of Pediatric Cardiac Surgery. , 2015, , 293-306.		2
75	Improving patient discharge and reducing hospital readmissions by using Intervention Mapping. BMC Health Services Research, 2014, 14, 389.	2.2	123
76	Why has the safety and quality movement been slow to improve care?. International Journal of Clinical Practice, 2014, 68, 932-935.	1.7	30
77	Hospital Alarms and Patient Safety. JAMA - Journal of the American Medical Association, 2014, 312, 651.	7.4	3
78	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
79	Expertise in medicine: using the expert performance approach to improve simulation training. Medical Education, 2014, 48, 115-123.	2.1	61
80	Improving Clinical Performance Using Rehearsal or Warm-up. Academic Medicine, 2014, 89, 1416-1422.	1.6	24
81	Injury Prevention. Pediatric Clinics of North America, 2013, 60, 1241-1253.	1.8	21
82	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
83	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
84	Organizational Culture. Medical Care, 2013, 51, 90-98.	2.4	63
85	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
86	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
87	The Handover Toolbox: a knowledge exchange and training platform for improving patient care. BMJ Quality and Safety, 2012, 21, i114-i120.	3.7	29
88	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
89	Handover training: does one size fit all? The merits of mass customisation. BMJ Quality and Safety, 2012, 21, i84-i88.	3.7	19
90	Mapping and assessing clinical handover training interventions. BMJ Quality and Safety, 2012, 21, i50-i57.	3.7	31

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91	The key actor: a qualitative study of patient participation in the handover process in Europe. <i>BMJ Quality and Safety</i> , 2012, 21, i89-i96.	3.7	52
92	“It's like two worlds apart”: an analysis of vulnerable patient handover practices at discharge from hospital. <i>BMJ Quality and Safety</i> , 2012, 21, i67-i75.	3.7	68
93	Beliefs and experiences can influence patient participation in handover between primary and secondary care—a qualitative study of patient perspectives. <i>BMJ Quality and Safety</i> , 2012, 21, i76-i83.	3.7	53
94	Conducting a multicentre and multinational qualitative study on patient transitions. <i>BMJ Quality and Safety</i> , 2012, 21, i22-i28.	3.7	39
95	Evaluation of a predevelopment service delivery intervention: an application to improve clinical handovers. <i>BMJ Quality and Safety</i> , 2012, 21, i29-i38.	3.7	30
96	Stakeholder perspectives on handovers between hospital staff and general practitioners: an evaluation through the microsystems lens. <i>BMJ Quality and Safety</i> , 2012, 21, i106-i113.	3.7	35
97	Searching for the missing pieces between the hospital and primary care: mapping the patient process during care transitions. <i>BMJ Quality and Safety</i> , 2012, 21, i97-i105.	3.7	55
98	Improving Patient Handovers From Hospital to Primary Care. <i>Annals of Internal Medicine</i> , 2012, 157, 417.	3.9	285
99	Interventions to improve patient safety in transitional care—a review of the evidence. <i>Work</i> , 2012, 41, 2915-2924.	1.1	126
100	High Reliability Organizations and Surgical Microsystems: Re-engineering Surgical Care. <i>Surgical Clinics of North America</i> , 2012, 92, 1-14.	1.5	57
101	Making Sense of Root Cause Analysis Investigations of Surgery-Related Adverse Events. <i>Surgical Clinics of North America</i> , 2012, 92, 101-115.	1.5	44
102	Assessment of technical competency in pediatric cardiac surgery. <i>Progress in Pediatric Cardiology</i> , 2012, 33, 15-20.	0.4	21
103	Balancing clinical team perceptions of the workplace: Applying “work domain analysis”™ to pediatric cardiac care. <i>Progress in Pediatric Cardiology</i> , 2012, 33, 25-32.	0.4	20
104	Design of cardiovascular operating rooms for tomorrow's technology and clinical practice—Part 2. <i>Progress in Pediatric Cardiology</i> , 2012, 33, 57-65.	0.4	23
105	Improving cardiac care quality and safety through partnerships with patients and their families. <i>Progress in Pediatric Cardiology</i> , 2012, 33, 73-79.	0.4	9
106	Sustainable cardiac services—From the catheterization laboratory to the operating room and beyond. <i>Progress in Pediatric Cardiology</i> , 2012, 33, 81-84.	0.4	1
107	Managing alarm fatigue in cardiac care. <i>Progress in Pediatric Cardiology</i> , 2012, 33, 85-90.	0.4	46
108	The role and influence of public reporting of pediatric cardiac care outcome data. <i>Progress in Pediatric Cardiology</i> , 2012, 33, 99-101.	0.4	8

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109	Designing a Safe and Reliable Sedation Service: Adopting a Safety Culture. , 2012, , 429-444.		3
110	Addressing the Barriers and Political Pressures to Safety. International Journal of Reliable and Quality E-Healthcare, 2012, 1, 55-64.	1.1	2
111	The July Effect: Fertile Ground for Systems Improvement. Annals of Internal Medicine, 2011, 155, 331.	3.9	22
112	Where to now for paediatric cardiac surgery?. ANZ Journal of Surgery, 2011, 81, 659-660.	0.7	5
113	Design of cardiovascular operating rooms for tomorrow's technology and clinical practice " Part one. Progress in Pediatric Cardiology, 2011, 32, 121-128.	0.4	9
114	Leadership, surgeon well-being and non-technical competencies of pediatric cardiac surgery. Progress in Pediatric Cardiology, 2011, 32, 129-133.	0.4	16
115	Improving communication and reliability of patient handovers in pediatric cardiac care. Progress in Pediatric Cardiology, 2011, 32, 135-139.	0.4	3
116	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
117	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
118	Hand-hygiene practices in the operating theatre: an observational study. British Journal of Anaesthesia, 2011, 107, 553-558.	3.4	58
119	When Do Supervising Physicians Decide to Entrust Residents With Unsupervised Tasks?. Academic Medicine, 2010, 85, 1408-1417.	1.6	243
120	Assessing and improving teamwork in cardiac surgery. BMJ Quality and Safety, 2010, 19, e29-e29.	3.7	40
121	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
122	Postoperative patient complaints: a prospective interview study of 12,276 patients. Journal of Clinical Anesthesia, 2010, 22, 13-21.	1.6	102
123	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
124	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
125	Designing a Patient Safety Undergraduate Medical Curriculum: The Telluride Interdisciplinary Roundtable Experience. Teaching and Learning in Medicine, 2009, 21, 52-58.	2.1	54
126	Reducing variation in adverse events during the academic year. BMJ: British Medical Journal, 2009, 339, b3949-b3949.	2.3	5

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127	Designing Safe Intensive Care Units of the Future. , 2009, , 525-541.		8
128	Examining Links Between Signâ€Out Reporting During Shift Changeovers and Patient Management Risks. Risk Analysis, 2008, 28, 969-981.	2.7	45
129	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
130	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
131	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
132	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
133	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
134	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
135	Relationships between Exterior Views and Nurse Stress: An Exploratory Examination. Herd, 2008, 1, 27-38.	1.5	80
136	The Role of Qualitative Methods in Designing Health Care Organizations. Environment and Behavior, 2008, 40, 191-204.	4.7	12
137	A team-based risk modification programme to make health care safer. Theoretical Issues in Ergonomics Science, 2007, 8, 481-494.	1.8	16
138	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
139	Wrong-Site Surgeries Are Preventableâ€”Reply. Archives of Surgery, 2007, 142, 1112.	2.2	0
140	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
141	Adverse event disclosure: benefits and drawbacks for patients and clinicians. , 2007, , 76-90.		5
142	What is Operative Morbidity? Defining Complications in a Surgical Registry Database. Annals of Thoracic Surgery, 2007, 84, 1416-1421.	1.3	74
143	Latency: An important consideration in gulf war syndrome. NeuroToxicology, 2007, 28, 1043-1044.	3.0	2
144	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

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145	Trauma Team Performance. , 2007, , 101-113.		13
146	On Teams, Organizations, and Safety: Of Course. Joint Commission Journal on Quality and Patient Safety, 2006, 32, 112-113.	0.7	6
147	Wrong-Side/Wrong-Site, Wrong-Procedure, and Wrong-Patient Adverse Events. Archives of Surgery, 2006, 141, 931.	2.2	235
148	Training Teams for the Perioperative Environment: A Research Agenda. Surgical Innovation, 2006, 13, 170-178.	0.9	28
149	Understanding the complexity of redesigning care around the clinical microsystem. Quality and Safety in Health Care, 2006, 15, ii10-ii16.	2.5	101
150	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
151	Disclosing Adverse Events to Patients. Joint Commission Journal on Quality and Patient Safety, 2005, 31, 5-12.	0.7	36
152	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
153	Five System Barriers to Achieving Ultrasafe Health Care. Annals of Internal Medicine, 2005, 142, 756.	3.9	483
154	A human factors approach to understanding patient safety during pediatric cardiac surgery. Progress in Pediatric Cardiology, 2005, 20, 13-20.	0.4	47
155	Clarifying Terminology for Adverse Drug Events. Annals of Internal Medicine, 2005, 142, 77.	3.9	4
156	COMMENTARY. Quality and Safety in Health Care, 2005, 14, 60-61.	2.5	4
157	Integrating patient safety into the clinical microsystem. Quality and Safety in Health Care, 2004, 13, ii34-ii38.	2.5	84
158	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
159	Current Concepts in Treatment of Agents of Mass Destruction. Refresher Courses in Anesthesiology, 2004, 32, 19-28.	0.1	0
160	Clarifying Adverse Drug Events: A Clinician's Guide to Terminology, Documentation, and Reporting. Annals of Internal Medicine, 2004, 140, 795.	3.9	523
161	Cranial Electrotherapy Stimulation: A Safe Neuromedical Treatment for Anxiety, Depression, or Insomnia. Southern Medical Journal, 2004, 97, 1269-1270.	0.7	15
162	The End of the Beginning. Journal of Legal Medicine, 2003, 24, 7-27.	0.5	24

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163	What is the role of healthcare managers in delivering safe care?. Quality and Safety in Health Care, 2003, 12, 161-162.	2.5	3
164	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
165	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
166	Patient Safety and the Reliability of Health Care Systems. Annals of Internal Medicine, 2003, 138, 997.	3.9	35
167	Quality and Safety in Health Care: a time of transition. Quality and Safety in Health Care, 2002, 11, 1-1.	2.5	2
168	Incident reporting: science or protoscience? Ten years later. Quality and Safety in Health Care, 2002, 11, 144-145.	2.5	27
169	Creating Effective Leadership for Improving Patient Safety. Quality Management in Health Care, 2002, 11, 69-78.	0.8	40
170	Patient safety and health policy: a history and review. Hematology/Oncology Clinics of North America, 2002, 16, 1463-1482.	2.2	36
171	Residents' hours of work. BMJ: British Medical Journal, 2002, 325, 1184-1185.	2.3	15
172	Microsystems Simulation: Designing and Evaluating an Approach to Patient Safety and Systems Thinking. Anesthesiology, 2002, 96, A1108.	2.5	1
173	Response to bioterrorism. BMJ: British Medical Journal, 2002, 324, 362a-362.	2.3	0
174	Multifactorial Etiology of Postoperative Vision Loss. Anesthesiology, 2002, 96, 1532-1532.	2.5	2
175	Delivering safe health care. BMJ: British Medical Journal, 2001, 323, 585-586.	2.3	20
176	Preventable Deaths From Medical Errors. JAMA - Journal of the American Medical Association, 2001, 286, 2813.	7.4	8
177	Improving Medical Care: The Use of Simulation Technology. Simulation and Gaming, 2001, 32, 164-174.	1.9	38
178	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
179	Assessing and Improving Medical Competency: Using Strategic Management Simulations. Simulation and Gaming, 2001, 32, 156-163.	1.9	10
180	Microsimulators in Medical Education: An Overview. Simulation and Gaming, 2001, 32, 250-262.	1.9	18

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181	Healthcare Assessment and Performance: Using Simulation. Simulation and Gaming, 2001, 32, 147-155.	1.9	26
182	Death and injury from motor vehicle crashes: a public health failure, not an achievement. Injury Prevention, 2001, 7, 176-178.	2.4	14
183	Postoperative Visual Loss. Anesthesiology, 2001, 95, 575-577.	2.5	93
184	Enhancing patient safety: beginning the dialogue in health services research. Journal of Health Services Research and Policy, 2001, 6, 67-69.	1.7	2
185	Enhancing Patient Safety and Reducing Medical Error. , 2001, , .		0
186	Preventable Deaths From Medical Errors. JAMA - Journal of the American Medical Association, 2001, 286, 2813-a-2814.	7.4	1
187	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 Safety. Anesthesiology, 2000, 93, A-1188.	2.5	2
188	Simulation in anaesthesia. Minimally Invasive Therapy and Allied Technologies, 2000, 9, 321-324.	1.2	0
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