

Laura Zwaan

List of Publications by Year in descending order

Source: <https://exaly.com/author-pdf/9067448/publications.pdf>

Version: 2024-02-01

40
papers

1,324
citations

430442

18
h-index

360668

35
g-index

41
all docs

41
docs citations

41
times ranked

1392
citing authors

#	ARTICLE	IF	CITATIONS
1	The size of an attentional window modulates attentional capture by color singletons. <i>Psychonomic Bulletin and Review</i> , 2007, 14, 934-938.	1.4	153
2	Patient Record Review of the Incidence, Consequences, and Causes of Diagnostic Adverse Events. <i>Archives of Internal Medicine</i> , 2010, 170, 1015.	4.3	136
3	The challenges in defining and measuring diagnostic error. <i>Diagnosis</i> , 2015, 2, 97-103.	1.2	123
4	Is bias in the eye of the beholder? A vignette study to assess recognition of cognitive biases in clinical case workups. <i>BMJ Quality and Safety</i> , 2017, 26, 104-110.	1.8	96
5	To what extent are adverse events found in patient records reported by patients and healthcare professionals via complaints, claims and incident reports?. <i>BMC Health Services Research</i> , 2011, 11, 49.	0.9	82
6	Relating Faults in Diagnostic Reasoning With Diagnostic Errors and Patient Harm. <i>Academic Medicine</i> , 2012, 87, 149-156.	0.8	75
7	Relationship between non-technical skills and technical performance during cardiopulmonary resuscitation: does stress have an influence?. <i>Emergency Medicine Journal</i> , 2017, 34, 728-733.	0.4	73
8	Diagnostic error increases mortality and length of hospital stay in patients presenting through the emergency room. <i>Scandinavian Journal of Trauma, Resuscitation and Emergency Medicine</i> , 2019, 27, 54.	1.1	66
9	Advancing the research agenda for diagnostic error reduction. <i>BMJ Quality and Safety</i> , 2013, 22, ii52-ii57.	1.8	43
10	Does inappropriate selectivity in information use relate to diagnostic errors and patient harm? The diagnosis of patients with dyspnea. <i>Social Science and Medicine</i> , 2013, 91, 32-38.	1.8	38
11	Immunising physicians against availability bias in diagnostic reasoning: a randomised controlled experiment. <i>BMJ Quality and Safety</i> , 2020, 29, 550-559.	1.8	37
12	Analysis of unintended events in hospitals: inter-rater reliability of constructing causal trees and classifying root causes. <i>International Journal for Quality in Health Care</i> , 2009, 21, 292-300.	0.9	33
13	Diagnostic errors by medical students: results of a prospective qualitative study. <i>BMC Medical Education</i> , 2017, 17, 191.	1.0	32
14	Differences between pulmonologists, thoracic surgeons and radiation oncologists in deciding on the treatment of stage I non-small cell lung cancer: A binary choice experiment. <i>Radiotherapy and Oncology</i> , 2015, 115, 361-366.	0.3	29
15	Debiasing versus knowledge retrieval checklists to reduce diagnostic error in ECG interpretation. <i>Advances in Health Sciences Education</i> , 2019, 24, 427-440.	1.7	27
16	Bridging the gap between uncertainty, confidence and diagnostic accuracy: calibration is key. <i>BMJ Quality and Safety</i> , 2019, 28, 352-355.	1.8	27
17	Unit-based incident reporting and root cause analysis: variation at three hospital unit types. <i>BMJ Open</i> , 2016, 6, e011277.	0.8	24
18	Design of a study on suboptimal cognitive acts in the diagnostic process, the effect on patient outcomes and the influence of workload, fatigue and experience of physician. <i>BMC Health Services Research</i> , 2009, 9, 65.	0.9	19

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19	Treatment recommendations by clinicians in stage I non-small cell lung cancer: A study of factors that influence the likelihood of accounting for the patient's preference. <i>Patient Education and Counseling</i> , 2016, 99, 1808-1813.	1.0	19
20	Radiology education: a radiology curriculum for all medical students?. <i>Diagnosis</i> , 2017, 4, 185-189.	1.2	19
21	<i>Annals</i> for Hospitalists Inpatient Notes - Reducing Diagnostic Error? A New Horizon of Opportunities for Hospital Medicine. <i>Annals of Internal Medicine</i> , 2016, 165, HO2.	2.0	16
22	Advancing Diagnostic Safety Research: Results of a Systematic Research Priority Setting Exercise. <i>Journal of General Internal Medicine</i> , 2021, 36, 2943-2951.	1.3	16
23	Improving diagnostic performance through feedback: the Diagnosis Learning Cycle. <i>BMJ Quality and Safety</i> , 2021, 30, 1002-1009.	1.8	16
24	Think Twice: Effects on Diagnostic Accuracy of Returning to the Case to Reflect Upon the Initial Diagnosis. <i>Academic Medicine</i> , 2020, 95, 1223-1229.	0.8	15
25	Evidence supporting dual-process theory of medical diagnosis: a functional near-infrared spectroscopy study. <i>Medical Education</i> , 2019, 53, 143-152.	1.1	14
26	Diagnostic error in hospitals: finding forests not just the big trees. <i>BMJ Quality and Safety</i> , 2020, 29, 961-964.	1.8	14
27	Education in Clinical Reasoning: An Experimental Study on Strategies to Foster Novice Medical Students' Engagement in Learning Activities. <i>Health Professions Education</i> , 2018, 4, 86-96.	1.4	13
28	Specific Disease Knowledge as Predictor of Susceptibility to Availability Bias in Diagnostic Reasoning: a Randomized Controlled Experiment. <i>Journal of General Internal Medicine</i> , 2021, 36, 640-646.	1.3	9
29	The Nature and Causes of Unintended Events Reported at 10 Internal Medicine Departments. <i>Journal of Patient Safety</i> , 2011, 7, 224-231.	0.7	8
30	Inducing System-1-type diagnostic reasoning in second-year medical students within 15% minutes. <i>Medical Teacher</i> , 2018, 40, 1030-1035.	1.0	8
31	The reliability and usability of the Anesthesiologists' Non-Technical Skills (ANTS) system in simulation research. <i>Advances in Simulation</i> , 2016, 1, 18.	1.0	7
32	Improving medical residents' self-assessment of their diagnostic accuracy: does feedback help?. <i>Advances in Health Sciences Education</i> , 2022, 27, 189-200.	1.7	7
33	Can We Teach Reflective Reasoning in General-Practice Training Through Example-Based Learning and Learning by Doing?. <i>Health Professions Education</i> , 2020, 6, 506-515.	1.4	6
34	Promotion of knowledge transfer and retention in year 2 medical students using an online training exercise. <i>Advances in Health Sciences Education</i> , 2021, 26, 1059-1074.	1.7	6
35	Application of an evidence-based decision rule to patients with suspected pulmonary embolism. <i>Journal of Evaluation in Clinical Practice</i> , 2013, 19, 682-688.	0.9	5
36	The critical step to reduce diagnostic errors in medicine: addressing the limitations of human information processing. <i>Diagnosis</i> , 2014, 1, 139-141.	1.2	4

#	ARTICLE	IF	CITATIONS
37	What Can We Learn From In-Depth Analysis of Human Errors Resulting in Diagnostic Errors in the Emergency Department: An Analysis of Serious Adverse Event Reports. Journal of Patient Safety, 2022, Publish Ahead of Print, .	0.7	3
38	When Measuring Is More Important than Measurement: The Importance of Measuring Diagnostic Errors in Health Care. Journal of Pediatrics, 2021, 232, 14-16.	0.9	2
39	Incorporating artificial intelligence in medical diagnosis: A case for an invisible and (un)disruptive approach. Journal of Evaluation in Clinical Practice, 2024, 30, 3-8.	0.9	2
40	The Oral Case Presentation. Journal of General Internal Medicine, 2023, 38, 1076-1076.	1.3	0