

Eric J Thomas

List of Publications by Year in descending order

Source: <https://exaly.com/author-pdf/9782091/publications.pdf>

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43
papers

5,499
citations

331259

21
h-index

264894

42
g-index

45
all docs

45
docs citations

45
times ranked

4746
citing authors

#	ARTICLE	IF	CITATIONS
1	Error, stress, and teamwork in medicine and aviation: cross sectional surveys. <i>BMJ: British Medical Journal</i> , 2000, 320, 745-749.	2.4	1,289
2	The Safety Attitudes Questionnaire: psychometric properties, benchmarking data, and emerging research. <i>BMC Health Services Research</i> , 2006, 6, 44.	0.9	1,245
3	Missed and Delayed Diagnoses in the Ambulatory Setting: A Study of Closed Malpractice Claims. <i>Annals of Internal Medicine</i> , 2006, 145, 488.	2.0	549
4	The frequency of diagnostic errors in outpatient care: estimations from three large observational studies involving US adult populations. <i>BMJ Quality and Safety</i> , 2014, 23, 727-731.	1.8	421
5	Measuring errors and adverse events in health care. <i>Journal of General Internal Medicine</i> , 2003, 18, 61-67.	1.3	374
6	Association of Telemedicine for Remote Monitoring of Intensive Care Patients With Mortality, Complications, and Length of Stay. <i>JAMA - Journal of the American Medical Association</i> , 2009, 302, 2671.	3.8	203
7	Burnout in the NICU setting and its relation to safety culture. <i>BMJ Quality and Safety</i> , 2014, 23, 806-813.	1.8	178
8	The effect of executive walk rounds on nurse safety climate attitudes: A randomized trial of clinical units. <i>BMC Health Services Research</i> , 2005, 5, 28.	0.9	174
9	Electronic health record-based surveillance of diagnostic errors in primary care. <i>BMJ Quality and Safety</i> , 2012, 21, 93-100.	1.8	108
10	Electronic health record-based triggers to detect potential delays in cancer diagnosis. <i>BMJ Quality and Safety</i> , 2014, 23, 8-16.	1.8	104
11	Speaking up about traditional and professionalism-related patient safety threats: a national survey of interns and residents. <i>BMJ Quality and Safety</i> , 2017, 26, 869-880.	1.8	93
12	Clinical decision support alert appropriateness: a review and proposal for improvement. <i>Ochsner Journal</i> , 2014, 14, 195-202.	0.5	79
13	Application of electronic trigger tools to identify targets for improving diagnostic safety. <i>BMJ Quality and Safety</i> , 2019, 28, 151-159.	1.8	78
14	Exposure to Leadership WalkRounds in neonatal intensive care units is associated with a better patient safety culture and less caregiver burnout. <i>BMJ Quality and Safety</i> , 2014, 23, 814-822.	1.8	74
15	“Speaking up” about patient safety concerns and unprofessional behaviour among residents: validation of two scales. <i>BMJ Quality and Safety</i> , 2015, 24, 671-680.	1.8	65
16	Baby-MONITOR: A Composite Indicator of NICU Quality. <i>Pediatrics</i> , 2014, 134, 74-82.	1.0	64
17	Accuracy of the Safer Dx Instrument to Identify Diagnostic Errors in Primary Care. <i>Journal of General Internal Medicine</i> , 2016, 31, 602-608.	1.3	45
18	Structuring Patient And Family Involvement In Medical Error Event Disclosure And Analysis. <i>Health Affairs</i> , 2014, 33, 46-52.	2.5	44

#	ARTICLE	IF	CITATIONS
19	Patients as Partners in Learning from Unexpected Events. <i>Health Services Research</i> , 2016, 51, 2600-2614.	1.0	28
20	Teamwork in the NICU Setting and Its Association with Health Care-Associated Infections in Very Low-Birth-Weight Infants. <i>American Journal of Perinatology</i> , 2017, 34, 1032-1040.	0.6	26
21	Long-Term Impacts Faced by Patients and Families After Harmful Healthcare Events. <i>Journal of Patient Safety</i> , 2021, 17, e1145-e1151.	0.7	24
22	Comparing NICU teamwork and safety climate across two commonly used survey instruments. <i>BMJ Quality and Safety</i> , 2016, 25, 954-961.	1.8	23
23	Association of open communication and the emotional and behavioural impact of medical error on patients and families: state-wide cross-sectional survey. <i>BMJ Quality and Safety</i> , 2020, 29, 883-894.	1.8	23
24	Can Communication-And-Resolution Programs Achieve Their Potential? Five Key Questions. <i>Health Affairs</i> , 2018, 37, 1845-1852.	2.5	22
25	The Correlation Between Neonatal Intensive Care Unit Safety Culture and Quality of Care. <i>Journal of Patient Safety</i> , 2020, 16, e310-e316.	0.7	21
26	Online Narratives and Peer Support for Colorectal Cancer Screening. <i>American Journal of Preventive Medicine</i> , 2013, 45, 98-107.	1.6	20
27	Filling a gap in safety metrics: development of a patient-centred framework to identify and categorise patient-reported breakdowns related to the diagnostic process in ambulatory care. <i>BMJ Quality and Safety</i> , 2022, 31, 526-540.	1.8	17
28	Surgical resident education in patient safety: where can we improve?. <i>Journal of Surgical Research</i> , 2015, 199, 308-313.	0.8	16
29	Diagnostic error experiences of patients and families with limited English-language health literacy or disadvantaged socioeconomic position in a cross-sectional US population-based survey. <i>BMJ Quality and Safety</i> , 2023, 32, 644-654.	1.8	12
30	Human Factors and Ergonomics in Healthcare: Industry Demands and a Path Forward. <i>Human Factors</i> , 2022, 64, 250-258.	2.1	11
31	Development of a framework to describe patient and family harm from disrespect and promote improvements in quality and safety: a scoping review. <i>International Journal for Quality in Health Care</i> , 2019, 31, 657-668.	0.9	10
32	Resolving Malpractice Claims after Tort Reform: Experience in a Self-Insured Texas Public Academic Health System. <i>Health Services Research</i> , 2016, 51, 2615-2633.	1.0	8
33	Diagnostic Adverse Events: On to Chapter 2. <i>Archives of Internal Medicine</i> , 2010, 170, 1021.	4.3	7
34	Improving Communication and Resolution Following Adverse Events Using a Patient-Created Simulation Exercise. <i>Health Services Research</i> , 2016, 51, 2537-2549.	1.0	6
35	Use of Home Blood Pressure Results for Assessing the Quality of Care for Hypertension. <i>JAMA - Journal of the American Medical Association</i> , 2018, 320, 1753.	3.8	6
36	Creating a comprehensive, unit-based approach to detecting and preventing harm in the neonatal intensive care unit. <i>Journal of Patient Safety and Risk Management</i> , 2018, 23, 167-175.	0.4	5

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37	Video Laryngoscopy vs. Direct Laryngoscopy in Teaching Neonatal Endotracheal Intubation: A Simulation-Based Study. <i>Cureus</i> , 2017, 9, e962.	0.2	5
38	Pediatric Trainees™ Speaking Up About Unprofessional Behavior and Traditional Patient Safety Threats. <i>Academic Pediatrics</i> , 2021, 21, 352-357.	1.0	3
39	Research to improve diagnosis: time to study the real world. <i>BMJ Quality and Safety</i> , 2022, 31, 255-258.	1.8	3
40	Communication regarding adverse neonatal birth events: Experiences of parents and clinicians. <i>Journal of Patient Safety and Risk Management</i> , 0, , 251604352110177.	0.4	2
41	Replicating and publishing research in different countries and different settings: advice for authors. <i>BMJ Quality and Safety</i> , 2022, 31, 627-630.	1.8	2
42	Preface: Special Issue on Human Factors in Healthcare. <i>Human Factors</i> , 2022, 64, 5-5.	2.1	1
43	Introduction from the new editors-in-chief. <i>BMJ Quality and Safety</i> , 2020, 29, 873-874.	1.8	0