Eric J Thomas

List of Publications by Year
in descending order

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	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. BMJ Quality and Safety, 2023, 32, 644-654.	1.8	12
2	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. BMJ Quality and Safety, 2022, 31, 526-540.	1.8	17
3	Human Factors and Ergonomics in Healthcare: Industry Demands and a Path Forward. Human Factors, 2022, 64, 250-258.	2.1	11
4	Research to improve diagnosis: time to study the real world. BMJ Quality and Safety, 2022, 31, 255-258.	1.8	3
5	Preface: Special Issue on Human Factors in Healthcare. Human Factors, 2022, 64, 5-5.	2.1	1
6	Replicating and publishing research in different countries and different settings: advice for authors. BMJ Quality and Safety, 2022, 31, 627-630.	1.8	2
7	Long-Term Impacts Faced by Patients and Families After Harmful Healthcare Events. Journal of Patient Safety, 2021, 17, e1145-e1151.	0.7	24
8	Pediatric Traineesâ€™ Speaking Up About Unprofessional Behavior and Traditional Patient Safety Threats. Academic Pediatrics, 2021, 21, 352-357.	1.0	3
9	The Correlation Between Neonatal Intensive Care Unit Safety Culture and Quality of Care. Journal of Patient Safety, 2020, 16, e310-e316.	0.7	21
10	Introduction from the new editors-in-chief. BMJ Quality and Safety, 2020, 29, 873-874.	1.8	0
11	Association of open communication and the emotional and behavioural impact of medical error on patients and families: state-wide cross-sectional survey. BMJ Quality and Safety, 2020, 29, 883-894.	1.8	23
12	Development of a framework to describe patient and family harm from disrespect and promote improvements in quality and safety: a scoping review. International Journal for Quality in Health Care, 2019, 31, 657-668.	0.9	10
13	Application of electronic trigger tools to identify targets for improving diagnostic safety. BMJ Quality and Safety, 2019, 28, 151-159.	1.8	78
14	Can Communication-And-Resolution Programs Achieve Their Potential? Five Key Questions. Health Affairs, 2018, 37, 1845-1852.	2.5	22
15	Use of Home Blood Pressure Results for Assessing the Quality of Care for Hypertension. JAMA - Journal of the American Medical Association, 2018, 320, 1753.	3.8	6
16	Creating a comprehensive, unit-based approach to detecting and preventing harm in the neonatal intensive care unit. Journal of Patient Safety and Risk Management, 2018, 23, 167-175.	0.4	5
17	Teamwork in the NICU Setting and Its Association with Health Careâ€“Associated Infections in Very Low-Birth-Weight Infants. American Journal of Perinatology, 2017, 34, 1032-1040.	0.6	26
18	Speaking up about traditional and professionalism-related patient safety threats: a national survey of interns and residents. BMJ Quality and Safety, 2017, 26, 869-880.	1.8	93

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19	Video Laryngoscopy vs. Direct Laryngoscopy in Teaching Neonatal Endotracheal Intubation: A Simulation-Based Study. Cureus, 2017, 9, e962.	0.2	5
20	Improving Communication and Resolution Following Adverse Events Using a Patientâ€Created Simulation Exercise. Health Services Research, 2016, 51, 2537-2549.	1.0	6
21	Patients as Partners in Learning from Unexpected Events. Health Services Research, 2016, 51, 2600-2614.	1.0	28
22	Resolving Malpractice Claims after Tort Reform: Experience in a Selfâ€Insured Texas Public Academic Health System. Health Services Research, 2016, 51, 2615-2633.	1.0	8
23	Comparing NICU teamwork and safety climate across two commonly used survey instruments. BMJ Quality and Safety, 2016, 25, 954-961.	1.8	23
24	Accuracy of the Safer Dx Instrument to Identify Diagnostic Errors in Primary Care. Journal of General Internal Medicine, 2016, 31, 602-608.	1.3	45
25	Surgical resident education in patient safety: where can we improve?. Journal of Surgical Research, 2015, 199, 308-313.	0.8	16
26	â€˜Speaking upâ€™ about patient safety concerns and unprofessional behaviour among residents: validation of two scales. BMJ Quality and Safety, 2015, 24, 671-680.	1.8	65
27	Structuring Patient And Family Involvement In Medical Error Event Disclosure And Analysis. Health Affairs, 2014, 33, 46-52.	2.5	44
28	Electronic health record-based triggers to detect potential delays in cancer diagnosis. BMJ Quality and Safety, 2014, 23, 8-16.	1.8	104
29	Burnout in the NICU setting and its relation to safety culture. BMJ Quality and Safety, 2014, 23, 806-813.	1.8	178
30	Exposure to Leadership WalkRounds in neonatal intensive care units is associated with a better patient safety culture and less caregiver burnout. BMJ Quality and Safety, 2014, 23, 814-822.	1.8	74
31	The frequency of diagnostic errors in outpatient care: estimations from three large observational studies involving US adult populations. BMJ Quality and Safety, 2014, 23, 727-731.	1.8	421
32	Baby-MONITOR: A Composite Indicator of NICU Quality. Pediatrics, 2014, 134, 74-82.	1.0	64
33	Clinical decision support alert appropriateness: a review and proposal for improvement. Ochsner Journal, 2014, 14, 195-202.	0.5	79
34	Online Narratives and Peer Support for Colorectal Cancer Screening. American Journal of Preventive Medicine, 2013, 45, 98-107.	1.6	20
35	Electronic health record-based surveillance of diagnostic errors in primary care. BMJ Quality and Safety, 2012, 21, 93-100.	1.8	108
36	Diagnostic Adverse Events: On to Chapter 2. Archives of Internal Medicine, 2010, 170, 1021.	4.3	7

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37	Association of Telemedicine for Remote Monitoring of Intensive Care Patients With Mortality, Complications, and Length of Stay. JAMA - Journal of the American Medical Association, 2009, 302, 2671.	3.8	203
38	Missed and Delayed Diagnoses in the Ambulatory Setting: A Study of Closed Malpractice Claims. Annals of Internal Medicine, 2006, 145, 488.	2.0	549
39	The Safety Attitudes Questionnaire: psychometric properties, benchmarking data, and emerging research. BMC Health Services Research, 2006, 6, 44.	0.9	1,245
40	The effect of executive walk rounds on nurse safety climate attitudes: A randomized trial of clinical units. BMC Health Services Research, 2005, 5, 28.	0.9	174
41	Measuring errors and adverse events in health care. Journal of General Internal Medicine, 2003, 18, 61-67.	1.3	374
42	Error, stress, and teamwork in medicine and aviation: cross sectional surveys. BMJ: British Medical Journal, 2000, 320, 745-749.	2.4	1,289
43	Communication regarding adverse neonatal birth events: Experiences of parents and clinicians. Journal of Patient Safety and Risk Management, 0, , 251604352110177.	0.4	2