

# Allen Kachalia

## List of Publications by Year in descending order

Source: <https://exaly.com/author-pdf/11236953/publications.pdf>

Version: 2024-02-01

60  
papers

3,177  
citations

361045

20  
h-index

189595

50  
g-index

60  
all docs

60  
docs citations

60  
times ranked

2624  
citing authors

#	ARTICLE	IF	CITATIONS
1	Lessons Learned From Rapid Deployment of 100% Mortality Review for Patients With COVID-19 Across a Health System. <i>American Journal of Medical Quality</i> , 2022, 37, 422-428.	0.2	1
2	Apology laws and malpractice liability: what have we learned?. <i>BMJ Quality and Safety</i> , 2021, 30, 64-67.	1.8	5
3	Rescuing Failure to Rescue—Patient Safety Indicator 04 on the Brink of Obsolescence. <i>JAMA Surgery</i> , 2021, 156, 115.	2.2	12
4	Operational Recommendations for Scarce Resource Allocation in a Public Health Crisis. <i>Chest</i> , 2021, 159, 1076-1083.	0.4	26
5	Building an Ambulatory Safety Program at an Academic Health System. <i>Journal of Patient Safety</i> , 2021, 17, e84-e90.	0.7	0
6	Covid-19 has made clear why all physicians need to know about the business of healthcare. <i>Journal of Patient Safety and Risk Management</i> , 2021, 26, 51-55.	0.4	0
7	The Medical Liability Environment: Is It Really Any Worse for Hospitalists?. <i>Journal of Hospital Medicine</i> , 2021, 16, 446.	0.7	0
8	Closing the Loop with Ambulatory Staff on Safety Reports. <i>Joint Commission Journal on Quality and Patient Safety</i> , 2020, 46, 44-50.	0.4	0
9	Development of a Web-Based Nonoperative Small Bowel Obstruction Treatment Pathway App. <i>Applied Clinical Informatics</i> , 2020, 11, 535-543.	0.8	0
10	Ensuring successful implementation of communication-and-resolution programmes. <i>BMJ Quality and Safety</i> , 2020, 29, 895-904.	1.8	11
11	Health equity and distributive justice considerations in critical care resource allocation. <i>Lancet Respiratory Medicine</i> , 2020, 8, 758-760.	5.2	18
12	To improve quality, keep your eyes on the road. <i>BMJ Quality and Safety</i> , 2020, 29, 943-946.	1.8	3
13	Reflections on implementing a hospital-wide provider-based electronic inpatient mortality review system: lessons learnt. <i>BMJ Quality and Safety</i> , 2020, 29, 304-312.	1.8	12
14	Body of Evidence. <i>Journal of Patient Safety</i> , 2020, Publish Ahead of Print, 576-582.	0.7	2
15	The Role of Transparency in Patient Safety Improvement. , 2019, , 244-259.		0
16	Improving Patient Experience in Radiology: Impact of a Multifaceted Intervention on National Ranking. <i>Radiology</i> , 2019, 291, 102-109.	3.6	13
17	Classifying Safety Events Related to Diagnostic Imaging From a Safety Reporting System Using a Human Factors Framework. <i>Journal of the American College of Radiology</i> , 2019, 16, 282-288.	0.9	15
18	Early Performance Trends After the Public Posting of Ambulatory Patient Satisfaction Reviews. <i>Journal of Patient Experience</i> , 2019, 6, 329-332.	0.4	2

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19	Quality measurement for <i>Clostridium difficile</i> infection: turning lemons into lemonade. <i>BMJ Quality and Safety</i> , 2018, 27, 414-416.	1.8	3
20	Malpractice claims related to diagnostic errors in the hospital. <i>BMJ Quality and Safety</i> , 2018, 27, 53-60.	1.8	46
21	Effects Of A Communication-And-Resolution Program On Hospitalsâ€™ Malpractice Claims And Costs. <i>Health Affairs</i> , 2018, 37, 1836-1844.	2.5	32
22	Addressing the Lack of Competition in Generic Drugs to Improve Healthcare Quality and Safety. <i>Journal of General Internal Medicine</i> , 2018, 33, 2005-2007.	1.3	3
23	Assessing information sources to elucidate diagnostic process errors in radiologic imaging â€” a human factors framework. <i>Journal of the American Medical Informatics Association: JAMIA</i> , 2018, 25, 1507-1515.	2.2	8
24	Perception of Resources Spent on Defensive Medicine and History of Being Sued Among Hospitalists: Results from a National Survey. <i>Journal of Hospital Medicine</i> , 2018, 13, 26-29.	0.7	10
25	Financial incentives and mortality: taking pay for performance a step too far. <i>BMJ Quality and Safety</i> , 2017, 26, 164-168.	1.8	6
26	Association of Unsolicited Patient Observations With the Quality of a Surgeonâ€™s Care. <i>JAMA Surgery</i> , 2017, 152, 530.	2.2	0
27	Physician and Patient Views on Public Physician Rating Websites: A Cross-Sectional Study. <i>Journal of General Internal Medicine</i> , 2017, 32, 626-631.	1.3	83
28	Rates and Characteristics of Paid Malpractice Claims Among US Physicians by Specialty, 1992-2014. <i>JAMA Internal Medicine</i> , 2017, 177, 710.	2.6	153
29	Medical Liability â€” Prospects for Federal Reform. <i>New England Journal of Medicine</i> , 2017, 376, 1806-1808.	13.9	12
30	Outcomes In Two Massachusetts Hospital Systems Give Reason For Optimism About Communication-And-Resolution Programs. <i>Health Affairs</i> , 2017, 36, 1795-1803.	2.5	25
31	Annals for Hospitalists Inpatient Notes - Mistakes in the Hospitalâ€™ Communicating, Apologizing, and Beyond. <i>Annals of Internal Medicine</i> , 2016, 165, HO2.	2.0	0
32	Implementation of a Comprehensive Post-Discharge Venous Thromboembolism Prophylaxis Program for Abdominal and Pelvic Surgery Patients. <i>Journal of the American College of Surgeons</i> , 2016, 223, 804-813.	0.2	21
33	Creating a Fellowship Curriculum in Patient Safety and Quality. <i>American Journal of Medical Quality</i> , 2016, 31, 27-30.	0.2	4
34	Design and Implementation of the Harvard Fellowship in Patient Safety and Quality. <i>American Journal of Medical Quality</i> , 2016, 31, 22-26.	0.2	3
35	Legal and Policy Interventions to Improve Patient Safety. <i>Circulation</i> , 2016, 133, 661-671.	1.6	18
36	Medical Liability and Reporting Malpractice Paymentsâ€™Reply. <i>JAMA - Journal of the American Medical Association</i> , 2015, 313, 1058.	3.8	2

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37	Evaluating inpatient mortality: a new electronic review process that gathers information from front-line providers. <i>BMJ Quality and Safety</i> , 2015, 24, 31-37.	1.8	20
38	Challenges to implementing expanded team models: lessons from a centralised nurse-led cholesterol-lowering programme. <i>BMJ Quality and Safety</i> , 2014, 23, 338-345.	1.8	3
39	Greatest Impact Of Safe Harbor Rule May Be To Improve Patient Safety, Not Reduce Liability Claims Paid By Physicians. <i>Health Affairs</i> , 2014, 33, 59-66.	2.5	20
40	The Medical Liability Climate and Prospects for Reform. <i>JAMA - Journal of the American Medical Association</i> , 2014, 312, 2146.	3.8	75
41	Disclosing medical errors: The view from the USA. <i>Journal of the Royal College of Surgeons of Edinburgh</i> , 2014, 12, 64-67.	0.8	21
42	Liability impact of the hospitalist model of care. <i>Journal of Hospital Medicine</i> , 2014, 9, 750-755.	0.7	11
43	Increasing pneumococcal vaccination for immunosuppressed patients: A cluster quality improvement trial. <i>Arthritis and Rheumatism</i> , 2013, 65, 39-47.	6.7	52
44	Breast Cancer Screening. <i>JAMA - Journal of the American Medical Association</i> , 2013, 309, 2555.	3.8	16
45	Meaningful measurement: developing a measurement system to improve blood pressure control in patients with chronic kidney disease. <i>Journal of the American Medical Informatics Association: JAMIA</i> , 2013, 20, e97-e101.	2.2	9
46	Improving Patient Safety through Transparency. <i>New England Journal of Medicine</i> , 2013, 369, 1677-1679.	13.9	56
47	Defensive Medicine—“Legally Necessary but Ethically Wrong?”. <i>JAMA Internal Medicine</i> , 2013, 173, 1056.	2.6	21
48	The Medical Liability System: Essential Information for the Hospitalist. <i>Hospital Medicine Clinics</i> , 2012, 1, e276-e287.	0.2	0
49	Cognitive Errors and Logistical Breakdowns Contributing to Missed and Delayed Diagnoses of Breast and Colorectal Cancers: A Process Analysis of Closed Malpractice Claims. <i>Journal of General Internal Medicine</i> , 2012, 27, 1416-1423.	1.3	31
50	New Directions in Medical Liability Reform. <i>New England Journal of Medicine</i> , 2011, 364, 1564-1572.	13.9	97
51	Building a Departmental Quality Program: A Patient-Based and Provider-Led Approach. <i>Academic Medicine</i> , 2011, 86, 314-320.	0.8	11
52	Routinely measuring and reporting pneumococcal vaccination among immunosuppressed rheumatology outpatients: the first step in improving quality. <i>Rheumatology</i> , 2011, 50, 366-372.	0.9	32
53	Liability Claims and Costs Before and After Implementation of a Medical Error Disclosure Program. <i>Annals of Internal Medicine</i> , 2010, 153, 213.	2.0	302
54	Missed and Delayed Diagnoses in the Emergency Department: A Study of Closed Malpractice Claims From 4 Liability Insurers. <i>Annals of Emergency Medicine</i> , 2007, 49, 196-205.	0.3	401

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55	Claims, Errors, and Compensation Payments in Medical Malpractice Litigation. <i>New England Journal of Medicine</i> , 2006, 354, 2024-2033.	13.9	722
56	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
57	The Incorporation of Patient Safety into Board Certification Examinations. <i>Academic Medicine</i> , 2006, 81, 317-325.	0.8	21
58	Physician Responses to the Malpractice Crisis: From Defense to Offense. <i>Journal of Law, Medicine and Ethics</i> , 2005, 33, 416-428.	0.4	20
59	Professional Liability Issues in Graduate Medical Education. <i>JAMA - Journal of the American Medical Association</i> , 2004, 292, 1051.	3.8	68
60	Does Full Disclosure of Medical Errors Affect Malpractice Liability? The Jury Is Still Out. <i>Joint Commission Journal on Quality and Safety</i> , 2003, 29, 503-511.	1.3	70