

Kaveh G Shojania

List of Publications by Year in descending order

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Version: 2024-02-01

48
papers

2,839
citations

394421

19
h-index

223800

46
g-index

49
all docs

49
docs citations

49
times ranked

3998
citing authors

#	ARTICLE	IF	CITATIONS
1	Changes in Rates of Autopsy-Detected Diagnostic Errors Over Time. JAMA - Journal of the American Medical Association, 2003, 289, 2849.	7.4	564
2	The effects of on-screen, point of care computer reminders on processes and outcomes of care. The Cochrane Library, 2021, 2021, CD001096.	2.8	323
3	Quality Improvement Strategies for Hypertension Management. Medical Care, 2006, 44, 646-657.	2.4	279
4	Effect of point-of-care computer reminders on physician behaviour: a systematic review. Cmaj, 2010, 182, E216-E225.	2.0	276
5	Interventions to Reduce Unnecessary Antibiotic Prescribing. Medical Care, 2008, 46, 847-862.	2.4	200
6	Computerised clinical decision support systems and absolute improvements in care: meta-analysis of controlled clinical trials. BMJ, The, 2020, 370, m3216.	6.0	188
7	Safe but Sound. JAMA - Journal of the American Medical Association, 2002, 288, 508.	7.4	187
8	Trends in adverse events over time: why are we not improving?. BMJ Quality and Safety, 2013, 22, 273-277.	3.7	109
9	Education as a low-value improvement intervention: often necessary but rarely sufficient. BMJ Quality and Safety, 2020, 29, 353-357.	3.7	79
10	Estimating deaths due to medical error: the ongoing controversy and why it matters: TableÂ1. BMJ Quality and Safety, 2017, 26, bmjqs-2016-006144.	3.7	61
11	Continuing Medical Education and Quality Improvement: A Match Made in Heaven?. Annals of Internal Medicine, 2012, 156, 305.	3.9	57
12	Vulnerability of the medical product supply chain: the wake-up call of COVID-19. BMJ Quality and Safety, 2021, 30, 331-335.	3.7	50
13	Multiple Interacting Factors Influence Adherence, and Outcomes Associated with Surgical Safety Checklists: A Qualitative Study. PLoS ONE, 2014, 9, e108585.	2.5	41
14	â€Bad applesâ€™: time to redefine as a type of systems problem?. BMJ Quality and Safety, 2013, 22, 528-531.	3.7	37
15	Application of a trigger tool in near real time to inform quality improvement activities: a prospective study in a general medicine ward. BMJ Quality and Safety, 2015, 24, 272-281.	3.7	34
16	Identifying adverse events: reflections on an imperfect gold standard after 20 years of patient safety research. BMJ Quality and Safety, 2020, 29, 265-270.	3.7	30
17	Cost of contact: redesigning healthcare in the age of COVID. BMJ Quality and Safety, 2021, 30, 236-239.	3.7	29
18	Simpson's paradox: how performance measurement can fail even with perfect risk adjustment. BMJ Quality and Safety, 2014, 23, 701-705.	3.7	23

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19	Temporal trends in patient safety in the Netherlands: reductions in preventable adverse events or the end of adverse events as a useful metric?. <i>BMJ Quality and Safety</i> , 2015, 24, 541-544.	3.7	21
20	Putting out fires: a qualitative study exploring the use of patient complaints to drive improvement at three academic hospitals. <i>BMJ Quality and Safety</i> , 2019, 28, 894-900.	3.7	20
21	Physician Characteristics Associated With Ordering 4 Low-Value Screening Tests in Primary Care. <i>JAMA Network Open</i> , 2018, 1, e183506.	5.9	18
22	Experiential Learning in Project-Based Quality Improvement Education: Questioning Assumptions and Identifying Future Directions. <i>Academic Medicine</i> , 2020, 95, 1745-1754.	1.6	17
23	Follow-up of Incidental High-Risk Pulmonary Nodules on Computed Tomography Pulmonary Angiography at Care Transitions. <i>Journal of Hospital Medicine</i> , 2019, 14, 349-352.	1.4	17
24	Evidence-based medicine: A cornerstone for clinical care but not for quality improvement. <i>Journal of Evaluation in Clinical Practice</i> , 2019, 25, 363-368.	1.8	16
25	Expanding the scope of Critical Care Rapid Response Teams: a feasible approach to identify adverse events. A prospective observational cohort. <i>BMJ Quality and Safety</i> , 2015, 24, 764-768.	3.7	13
26	Striving for high reliability in healthcare: a qualitative study of the implementation of a hospital safety programme. <i>BMJ Quality and Safety</i> , 2022, 31, 867-877.	3.7	13
27	Looking back on the history of patient safety: an opportunity to reflect and ponder future challenges. <i>BMJ Quality and Safety</i> , 2022, 31, 148-152.	3.7	12
28	Addressing the identity crisis in healthcare: positive patient identification technology reduces wrong patient events. <i>Transfusion</i> , 2019, 59, 899-902.	1.6	11
29	Are increases in emergency use and hospitalisation always a bad thing? Reflections on unintended consequences and apparent backfires. <i>BMJ Quality and Safety</i> , 2019, 28, 687-692.	3.7	11
30	Impact of stated barriers on proposed warfarin prescription for atrial fibrillation: a survey of Canadian physicians. <i>Thrombosis Journal</i> , 2014, 12, 13.	2.1	10
31	Estimating preventable hospital deaths: the authors reply. <i>BMJ Quality and Safety</i> , 2017, 26, 694-694.	3.7	10
32	The data of diagnostic error: big, large and small. <i>BMJ Quality and Safety</i> , 2018, 27, 499-501.	3.7	10
33	Use of Rheum to Improve Quality Improvement in Outpatient Rheumatology. <i>Journal of Rheumatology</i> , 2017, 44, 1304-1310.	2.0	9
34	Choosing quality problems wisely: identifying improvements worth developing and sustaining. <i>BMJ Quality and Safety</i> , 2020, 29, 1.12-2.	3.7	9
35	A Novel Collaborative Care Program to Augment Nursing Home Care During and After the COVID-19 Pandemic. <i>Journal of the American Medical Directors Association</i> , 2022, 23, 304-307.e3.	2.5	8
36	What problems in health care quality should we target as the world burns around us?. <i>Cmaj</i> , 2022, 194, E311-E312.	2.0	8

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37	Ethnography as a methodological descriptor: the editors' reply. <i>BMJ Quality and Safety</i> , 2016, 25, 555-556.	3.7	6
38	Medication non-adherence: an overlooked target for quality improvement interventions. <i>BMJ Quality and Safety</i> , 2020, 29, 271-273.	3.7	6
39	Beyond CLABSI and CAUTI: broadening our vision of patient safety. <i>BMJ Quality and Safety</i> , 2020, 29, 361-364.	3.7	6
40	Inpatient bedspacing: could a common response to hospital crowding cause increased patient mortality?. <i>BMJ Quality and Safety</i> , 2018, 27, 1-3.	3.7	5
41	Modelling resource requirements and physician staffing to provide virtual urgent medical care for residents of long-term care homes: a cross-sectional study. <i>CMAJ Open</i> , 2020, 8, E514-E521.	2.4	5
42	Implementation of a central-line bundle: a qualitative study of three clinical units. <i>Implementation Science Communications</i> , 2021, 2, 105.	2.2	4
43	Point-of-care decision support for reducing inappropriate test use: easier said than done. <i>BMJ Quality and Safety</i> , 2016, 25, 6-8.	3.7	2
44	Media Dissemination of the Montreal Cognitive Assessment After President Donald Trump's Medical Evaluation. <i>JAMA Neurology</i> , 2018, 75, 1286.	9.0	2
45	Rigor in Quality Improvement Studies and the Role of Time-Series Methodologies. <i>JAMA Internal Medicine</i> , 2018, 178, 724.	5.1	1
46	An Association Between Cardiologist Billing Patterns, Health Care Use, and Outcomes in Cardiac Patients. <i>CJC Open</i> , 2021, 3, 758-768.	1.5	1
47	Incident Reporting Systems: What Will It Take to Make Them Less Frustrating and Achieve Anything Useful?. <i>Joint Commission Journal on Quality and Patient Safety</i> , 2021, 47, 755-758.	0.7	1
48	Identifying vendors in studies of electronic health records: the editor replies. <i>BMJ Quality and Safety</i> , 2018, 27, e1-e1.	3.7	0