Eric J Thomas

List of Publications by Year
in descending order

43 papers	5,499 citations	331538 21 h-index	265120 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. BMJ: British Medical Journal, 2000, 320, 745-749.	2.4	1,289
2	The Safety Attitudes Questionnaire: psychometric properties, benchmarking data, and emerging research. BMC Health Services Research, 2006, 6, 44.	0.9	1,245
3	Missed and Delayed Diagnoses in the Ambulatory Setting: A Study of Closed Malpractice Claims. Annals of Internal Medicine, 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. BMJ Quality and Safety, 2014, 23, 727-731.	1.8	421
5	Measuring errors and adverse events in health care. Journal of General Internal Medicine, 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. JAMA - Journal of the American Medical Association, 2009, 302, 2671.	3.8	203
7	Burnout in the NICU setting and its relation to safety culture. BMJ Quality and Safety, 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. BMC Health Services Research, 2005, 5, 28.	0.9	174
9	Electronic health record-based surveillance of diagnostic errors in primary care. BMJ Quality and Safety, 2012, 21, 93-100.	1.8	108
10	Electronic health record-based triggers to detect potential delays in cancer diagnosis. BMJ Quality and Safety, 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. BMJ Quality and Safety, 2017, 26, 869-880.	1.8	93
12	Clinical decision support alert appropriateness: a review and proposal for improvement. Ochsner Journal, 2014, 14, 195-202.	0.5	79
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	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
15	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
16	Baby-MONITOR: A Composite Indicator of NICU Quality. Pediatrics, 2014, 134, 74-82.	1.0	64
17	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
18	Structuring Patient And Family Involvement In Medical Error Event Disclosure And Analysis. Health Affairs, 2014, 33, 46-52.	2.5	44

#	Article	IF	Citations
19	Patients as Partners in Learning from Unexpected Events. Health Services Research, 2016, 51, 2600-2614.	1.0	28
20	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
21	Long-Term Impacts Faced by Patients and Families After Harmful Healthcare Events. Journal of Patient Safety, 2021, 17, e1145-e1151.	0.7	24
22	Comparing NICU teamwork and safety climate across two commonly used survey instruments. BMJ Quality and Safety, 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. BMJ Quality and Safety, 2020, 29, 883-894.	1.8	23
24	Can Communication-And-Resolution Programs Achieve Their Potential? Five Key Questions. Health Affairs, 2018, 37, 1845-1852.	2.5	22
25	The Correlation Between Neonatal Intensive Care Unit Safety Culture and Quality of Care. Journal of Patient Safety, 2020, 16, e310-e316.	0.7	21
26	Online Narratives and Peer Support for Colorectal Cancer Screening. American Journal of Preventive Medicine, 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. BMJ Quality and Safety, 2022, 31, 526-540.	1.8	17
28	Surgical resident education in patient safety: where can we improve?. Journal of Surgical Research, 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. BMJ Quality and Safety, 2023, 32, 644-654.	1.8	12
30	Human Factors and Ergonomics in Healthcare: Industry Demands and a Path Forward. Human Factors, 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. International Journal for Quality in Health Care, 2019, 31, 657-668.	0.9	10
32	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
33	Diagnostic Adverse Events: On to Chapter 2. Archives of Internal Medicine, 2010, 170, 1021.	4.3	7
34	Improving Communication and Resolution Following Adverse Events Using a Patientâ€Created Simulation Exercise. Health Services Research, 2016, 51, 2537-2549.	1.0	6
35	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
36	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

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