1. Newman-Toker DE, Nassery N, Schaffer AC, Yu-Moe CW, Clemens GD, Wang Z, Zhu Y, Saber Tehrani AS, Fanai M, Hassoon A, Siegal D. Burden of serious harms from diagnostic error in the USA. *BMJ Qual Saf*. 2023 Jul 17.

2. Flemming DJ, White C, Fox E, Fanburg-Smith J, Cochran E. Diagnostic errors in musculoskeletal oncology and possible mitigation strategies. *Skeletal Radiol*. 2023 Mar;52(3):493-503.

3. Goyal A, Martin-Doyle W, Dalal AK. Diagnostic Errors in Hospitalized Patients. *JCOM*. 2023

4. Lam D, Dominguez F, Leonard J, Wiersma A, Grubenhoff JA. Use of e-triggers to identify diagnostic errors in the paediatric ED. *BMJ Qual Saf.* 2022.

5. Baylor College of Medicine. Safer Dx Checklist: 10 High-Priority Practices for Diagnostic Excellence. 2022; Houston, Texas. Available at: http://www.ihi.org/resources/Pages/Tools/safer-diagnostic-checklist.aspx

6. Jorg I, Wieler J, Elfgen C, Bolten K, Hutzli C, Talimi J, et al. Discrepancies Between Radiological and Histological Findings in Preoperative Core Needle (CNB) and Vacuum-Assisted (VAB) Breast Biopsies. *J Cancer Res Clin Oncol*. 2021;147(3):749-754.

7. Perry MF, Melvin JE, Kasick RT, Kersey KE, Scherzer DJ, Kamboj MK. The Diagnostic Error Index: A Quality Improvement Initiative to Identify and Measure Diagnostic Errors. *J Pediatr*. 2021; 232:257-263.

8. Marshall TL, Ipsaro AJ, Le M, Sump C, Darrell H, Mapes KG, et al. Increasing Physician Reporting of Diagnostic Learning Opportunities. *Pediatrics*. 2021;147(1): e20192400.

9. Fox MD, Bump GM, Butler GA, Chen LW, Buchert AR. Making Residents Part of the Safety Culture: Improving Error Reporting and Reducing Harms. *J Patient Saf*. 2021;17(5):e373-e378.

10. Estrada-Orozco K, Cruz FC, Cruz JB, Ruiz-Cardozo MA, Suarez-Chacon AM, Tribaldos JAC, et al. Hospital Adverse Event Reporting Systems: A Systematic Scoping Review of Qualitative and Quantitative Evidence. *J Patient Saf*. 2021;17(8): e1866-e1872.

11. Graber ML, Holmboe E, Stanley J, Danielson J, Schoenbaum S, Olson APJ. A call to action: next steps to advance diagnosis education in the health professions. *Diagnosis (Berl)*. 2021;9(2):166-175.

12. Rosen M, Ali KJ, Buckley BO, Goeschel C. Leadership To Improve Diagnosis: A Call to Action. *Rockville, MD: Agency for Healthcare Research and Quality*; June 2021.

13. Sampath B, Rakover J, Baldoza K, Mate K, Lenoci-Edwards J, Barker P. Whole System Quality: A Unified Approach to Building Responsive, Resilient Health Care Systems. IHI White Paper. *Boston: Institute for Healthcare Improvement*; 2021. Available at: http://www.ihi.org/resources/Pages/IHIWhitePapers/whole-systemquality.aspx

14. Singh H, Upadhyay DK, Torretti D. Developing Health Care Organizations That Pursue Learning and Exploration of Diagnostic Excellence: An Action Plan. *Acad Med*. 2020;95(8):1172-1178.

15. Mathews BK, Fredrickson M, Sebasky M, et al. Structured case reviews for organizational learning about diagnostic vulnerabilities: initial experiences from two medical centers. *Diagnosis (Berl)*. 2020;7(1):27-35.

16. Mahajan P, Pai CW, Cosby KS, Mollen CJ, Shaw KN, Chamberlain JM, et al. Identifying Trigger Concepts to Screen Emergency Department Visits for Diagnostic Errors. *Diagnosis*. 2020;8(3):340-346.

17. Singh H, Bradford A, Goeschel C. Operational measurement of diagnostic safety: state of the science. *Diagnosis (Berl).* 2020;8(1):51-65.

18. National Steering Committee for Patient Safety. Safer Together: A National Action Plan to Advance Patient Safety. *Boston, Massachusetts: Institute for Healthcare Improvement*; 2020. Available at: www.ihi.org/SafetyActionPlan

19. Delio J, Catalanotti JS, Marko K, Paul C, Taffel M, Ho G, et al. Text Mobile Application Used in Daily Workflow

Increases Adverse Event Reporting by Physicians. *Am J Med Qual.* 2020;35(5):374-379.

20. Singh H, Upadhyay DK, Torretti D. Developing Health Care Organizations That Pursue Learning and Exploration of Diagnostic Excellence: An Action Plan. *Acad Med.* 2020;95(8):1172-1178

21. Brown A. Communication and Leadership in Healthcare Quality Governance. *J Health Organ Manag.* 2020;34(2):144-161

22. Priebe M, Markin R. Review of Anatomic Pathology and Diagnostic Radiology Quality Assurance Tools to Reduce Diagnostic Discordance in Cancer. *ACTA Scientific Cancer Biol.* 2019;3(9):4-11.

23. Doshi AM, Huang C, Melamud K, Shanbhogue K, Slywotsky C, Taffel M, et al. Utility of an Automated Radiology-Pathology Feedback Tool. *J Am Coll Radiol.* 2019;16(9 pt. A):1211-1217.

24. Park M, Giap T. Patient and Family Engagement as a Potential Approach for Improving Patient Safety: A Systematic Review. *J Adv Nurs.* 2019;76(1):62-80.

25. Graber ML, Grice GR, Ling LJ, Conway JM, Olson A. Pharmacy Education Needs to Address Diagnostic Safety. *Am J Pharm Educ.* 2019;83(6):7442.

26. McKean EL, Snyderman CH. Leadership Driving Safety and Quality. *Otolaryng Clin N Am.* 2019;52(1):11-22.

27. Whitehead NS, Williams L, Meleth S, Kennedy S, Epner P, Singh H, et al. Interventions to Improve Follow-Up of Laboratory Test Results Pending at Discharge: A Systematic Review. *J Hosp Med.* 2018;13(9):631-636.

28. Gupta A, Harrod M, Quinn M, Manojlovich M, Fowler KE, Singh H, et al. Mind the Overlap: How System Problems Contribute to Cognitive Failure and Diagnostic Errors. *Diagnosis.* 2018;5(3):151-156.

29. Sharma AE, Rivandeneira NA, Barr-Walker J, Stern RJ, Johnson AK, Sarkar U. Patient Engagement in Health Care Safety: An Overview of Mixed-Quality Evidence. *Health Affairs.* 2018;37(11):1813-1820.

30. Muse ED, Godino JG, Netting JF, Alexander JF, Moran HJ, Topol EJ. From Second to Hundredth Opinion in Medicine: A Global Consultation Platform for Physicians. *NPJ Digit Med.* 2018; 1:55.

31. Guide to Patient and Family Engagement in Hospital Quality and Safety. *Agency for Healthcare Research and Quality*. 2017. Available at: https://www.ahrq.gov/patient-safety/patients-families/engagingfamilies/index.html

32. Smith A, Hatoun J, Moses J. Increasing Trainee Reporting of Adverse Events with Monthly Trainee-Directed Review of Adverse Events. *Acad Pediatr.* 2017;17(8):902-906.

33. Graber ML, Rusz D, Jones ML, et al. The new diagnostic team. *Diagnosis (Berl).* 2017;4(4):225-238.

34. Considine J. Nurses, Diagnosis and Diagnostic Error. *Diagnosis.* 2017;4(4):197-199.

35. Gleason KT, Davidson PM, Tanner EK, Baptiste D, Rushton C, Day J, et al. Defining the Critical Role of Nurses in Diagnostic Error Prevention: A Conceptual Framework and a Call to Action. *Diagnosis.* 2017;4(4):201-210.

36. Kammer JE, Hautz WE, Herzog SM, Kunina-Habenicht O, Kurvers RHJM. The Potential of Collective Intelligence in Emergency Medicine: Pooling Medical Students' Independent Decisions Improves Diagnostic Performance. *Med Decis Making.* 2017;37(6):715-724.

37. Berghout MA, Fabbricotti IN, Buljac-Samardzic MB, Hilders CGJM. Medical Leaders or Masters? A Systematic Review of Medical Leadership In Hospital Settings. *PLoS One.* 2017;12(9):e0184522.

38. Laposata M, Cohen MB. It's Our Turn: Implications for Pathology from the Institute of Medicine's Report on Diagnostic Error. *Arch Pathol Lab Med.* 2016;40(6):505-507.

39. Thomas DB, Newman-Toker DE. Diagnosis is a Team Sport – Partnering with Allied Health Professionals to Reduce Diagnostic Errors: A Case Study on the Role of a Vestibular Therapist in Diagnosing Dizziness. *Diagnosis.* 2016;3(2):49-59.

40. Singh H, Graber ML. Improving Diagnosis in Health Care – The Next Imperative for Patient Safety. *N Engl J Med.* 2015;373(26):2493-2495.

41. Committee on Diagnostic Error in Health Care; Board on Health Care Services; Institute of Medicine; The National Academies of Sciences, Engineering, and Medicine. Improving Diagnosis in Health Care. Balogh EP, Miller BT, Ball JR, editors. *Washington (DC): National Academies Press (US)*; 2015 Dec 29.

42. Dalal AK, Roy CL, Poon EG, Williams DH, Nolido N, Yoon C, et al. Impact of an Automated Email Notification System for Results of Tests Pending at Discharge: A Cluster-Randomized Controlled Trial. *J Am Med Inform Assoc.* 2014;21(3):473-480.

43. American Institutes for Research. Guide to Patient and Family Engagement: Environmental Scan Report. *Rockville, MD: Agency for Healthcare Research and Quality*; 2014 Oct. Available at: https://www.ahrq.gov/research/findings/final-reports/ptfamilyscan/index.html

44. Laposata M. Putting the Patient First – Using the Expertise of Laboratory Professionals to Produce Rapid and Accurate Diagnoses. *Lab Med.* 2014;45(1):4-5.

45. Donaldson SS. The Power of Partnerships: A Message for All Radiologists. *Radiology.* 2014;271(2):315-319.

46. Payne VL, Singh H, Meyer AND, Levy L, Harrison D, Graber ML. Patient-Initiated Second Opinions: Systematic Review of Characteristics and Impact on Diagnosis, Treatment, and Satisfaction. *Mayo Clin Proc.* 2014;89(5):687- 696.

47. Upadhyay DK, Sittig DF, Singh H. Ebola US Patient Zero: Lessons on Misdiagnosis and Effective Use of Electronic Health Records. *Diagnosis.* 2014;1(4):283-287.

48. Graber ML, Trowbridge R, Myers JS, Umscheid CA, Strull W, Kanter MH. The next organizational challenge: finding and addressing diagnostic error. *Jt Comm J Qual Patient Saf.* 2014;40(3):102-110.

49. Hardy K. Adding Value – Radiologists and Pathologists Stress Concordance Between Imaging and Lab. *Radiology Today.* 2013;14(8):20.

50. Committee on the Learning Health Care System in America; Institute of Medicine. Best Care at Lower Cost: The Path to Continuously Learning Health Care in America. Smith M, Saunders R, Stuckhardt L, McGinnis JM, editors. *Washington (DC): National Academies Press (US)*; 2013 May 10.

51. Singh H, Giardina TD, Meyer AN, Forjuoh SN, Reis MD, Thomas EJ. Types and origins of diagnostic errors in primary care settings. *JAMA Intern Med.* 2013;173(6):418-425.

52. Callen JL, Westbrook JI, Georgiou A, Li J. Failure to Follow-Up Test Results for Ambulatory Patients: A Systematic Review. *J Gen Intern Med.* 2012;27(10):1334-1348.

53. Sorace J, Aberle DR, Elimam D, Lawvere S, Tawfik O, Wallace WD. Integrating Pathology and Radiology Disciplines: An Emerging Opportunity? *BMC Med.* 2012; 10:100.

54. Murken DR, Ding M, Branstetter BF, Nichols L. Autopsy as a Quality Control Measure for Radiology and Vice Versa. *AJR Am J Roentgenol.* 2012;199(2):394-401.

55. Greene SM, Reid RJ, Larson EB. Implementing the Learning Health System: From Concept to Action. *Ann Intern Med.* 2012;157(3):207-210.

56. Lawton R, McEachan RRC, Giles SJ, Sirriyeh R, Watt IS, Wright J. Development of an Evidence-Based Framework of Factors Contributing to Patient Safety Incidents in Hospital Settings: A Systematic Review. *BMJ Qual Saf.* 2012;21(5):369-380.

57. Graber ML, Wachter RM, Cassel CK. Bringing diagnosis into the quality and safety equations. *JAMA.* 2012; 308(12):1211-1212.

58. Callen J, Georgiou A, Li J, Westbrook JI. The Safety Implications of Missed Test Results for Hospitalised Patients: A Systematic Review. *BMJ Qual Saf.* 2011;20(2):194-199.

59. Mihalik JE, Krupka L, Davenport R, Tucker L, Toevs C, Smith RS. The Rate of Imaging-Histologic Discordance of Benign Breast Disease: A Multidisciplinary Approach to the Management of Discordance at a Large

University-Based Hospital. *Am J Surg.* 2010;199(3):319-323.

60. Olsen L, Aisner D, McGinnis JM, editors. The Learning Healthcare System: Workshop Summary. *Washington DC: National Academies Press (US)*; 2007.

61. Kizer KW, Blum LN. Safe Practices for Better Health Care. Advances in Patient Safety: From Research to Implementation (Volume 4: Programs, Tools, and Products). *Rockville (MD): Agency for Healthcare Research and Quality (US)*; 2005 Feb.

62. Graber ML, Franklin N, Gordon R. Diagnostic error in internal medicine. *Arch Intern Med.* 2005;165(13):1493- 1499.

63. Roy CL, Poon EG, Karson AS, Ladak-Merchant Z, Johnson RE, Maviglia SM, et al. Patient Safety Concerns Arising from Test Results that Return After Hospital Discharge. *Ann Intern Med.* 2005;143(2):121-128.