# Human Error and Cognitive Bias in Clinical Decisions Training Course

1 – 5 March 2027
Abu Dhabi

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## Overview

Human Error and Cognitive Bias in Clinical Decisions Training Course is a one-week advanced course for clinical leaders, patient safety teams, quality managers, medical educators, senior clinicians, and governance functions who leave with a Clinical Decision Safety Improvement Plan. Participants examine diagnostic reasoning, cognitive load, decision environments, teamwork, communication, incident learning, and system safeguards without assigning blame or teaching diagnosis. Agile Leaders Training Center presents human error and cognitive bias as a clinical decision safety discipline.

## Who Should Attend

- Teams responsible for clinical decision safety and governance
- Functions responsible for patient safety and quality improvement
- Personnel responsible for clinical education, simulation, and feedback
- Leaders responsible for incident review and organizational learning
- Clinicians responsible for team decisions, handoffs, and escalation

The course assumes participants influence clinical practice, safety, education, or governance and leaves out diagnosis instruction, treatment decisions, blame attribution, and specialty certification.

## Departments and Industries

The course supports departments and industries that manage clinical decision quality and learning from error.

- Clinical governance and patient safety departments
- Healthcare quality and risk management functions
- Medical education and simulation centers
- Hospital, primary care, and ambulatory service teams
- Academic health and professional development organizations

## Learning Objectives

By the end of this course, participants will be able to:

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- Analyze human and system contributors to clinical decision error
- Apply structured checks to cognitive traps and uncertainty
- Evaluate cognitive load, interruptions, and decision environments
- Use teamwork and communication safeguards in clinical reasoning
- Build psychologically safe incident-learning and feedback practices
- Prioritize system safeguards through an improvement plan

## Course Agenda

### Day 1: Human Error and Decision Systems

- Human-and-System Contributor Mapping Canvas
- Clinical Decision Process and Information Flow Map
- Error-Producing Condition Assessment Matrix
- Just-Culture Learning Question Set
- Decision Safety Boundary and Scope Charter

### Day 2: Cognitive Bias and Reasoning Checks

- Dual-Process Reasoning Comparison Map
- Anchoring, Availability, and Framing Bias Signal Card
- Premature Closure and Confirmation Checkpoint
- Alternative-Hypothesis Generation Worksheet
- Diagnostic Timeout and Reflective Pause Checklist

### Day 3: Decision Environment and Team Safeguards

- Cognitive Load and Interruption Risk Assessment
- Handoff Framing and Information Integrity Checklist
- Team Challenge and Escalation Conversation Guide
- Decision-Support Dependency and Override Map
- Uncertainty Communication and Follow-Up Plan

### Day 4: Incident Learning and Improvement Design

- Bias-Aware Clinical Case Review Method
- Hindsight and Outcome Bias Review Guardrail
- Psychological Safety Debriefing Protocol
- Decision Feedback and Calibration Loop
- System Safeguard Prioritization Matrix

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## Day 5: Clinical Decision Safety Practice

- Suggested Exercise: Contributor and Decision-Flow Review
- Suggested Exercise: Cognitive Trap and Alternative Analysis
- Suggested Exercise: Team Communication Safeguard Simulation
- Suggested Exercise: Incident Learning and Feedback Design
- Capstone Exercise: Clinical Decision Safety Improvement Plan

## Practical Exercises

The course uses suggested activities with fictional hospital, primary care, ambulatory, and education scenarios.

- Suggested activity: map human, workflow, technology, and communication contributors in a clinical decision scenario.
- Suggested activity: test anchoring and premature closure checks through a structured reasoning simulation.
- Suggested activity: practice uncertainty communication, team challenge, escalation, and feedback in a handoff case.
- Suggested activity: conduct a bias-aware review and prioritize system safeguards without assigning blame.

## FAQs

### Who suits human error and cognitive bias in clinical decisions training, and what does it assume?

Human error and cognitive bias training suits clinical leaders, safety and quality teams, educators, senior clinicians, and governance functions. It assumes responsibility for practice, learning, or oversight and excludes diagnosis instruction, treatment decisions, and blame attribution.

### How does cognitive bias in clinical decisions training differ from clinical diagnosis training?

Cognitive bias in clinical decisions training examines reasoning processes, decision conditions, communication, feedback, and safeguards, while clinical diagnosis training teaches specialty knowledge and diagnostic assessment for patient care.

### Which cognitive biases can affect clinical decision-making?

Cognitive biases affecting clinical decisions can include anchoring, availability, framing, confirmation, premature closure, hindsight, outcome bias, and overconfidence, often interacting with cognitive load and system conditions.

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## How can teams reduce human error in clinical decisions?

Teams can reduce error-producing conditions through structured information gathering, alternative consideration, reflective pauses, clear handoffs, challenge and escalation practices, follow-up, feedback, and system safeguards matched to local risks.

## How should clinical teams learn from decision errors without blame?

Clinical teams can learn through psychologically safe reviews that examine available information, context, workflow, technology, communication, reasoning, and system conditions while guarding against hindsight and outcome bias.

## Conclusion

Participants leave with a Clinical Decision Safety Improvement Plan containing contributor maps, reasoning checks, communication safeguards, feedback loops, and prioritized system controls. The plan shifts reviews from individual blame toward structured learning. It supports safer decision environments, clearer team challenge, and measurable improvement actions.