

The Premature Closer



**Stay fast — without missing what
matters**



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Section 1 — You are a Premature Closer

You are a decisive clinician.

You are efficient, action-oriented, and comfortable making decisions under pressure.

That is a strength. But your biggest risk is this

You can lock onto a diagnosis too early.

In emergency medicine, speed matters. But speed without a checkpoint can create diagnostic risk.

You do not need to become slow.

You need to stay fast — while deliberately testing your first assumption.

Section 2 — Why This Matters

Premature closure happens when a clinician accepts an early diagnosis before the full picture is clear.

It often feels efficient in the moment.

The patient appears to fit a familiar pattern.

The first diagnosis seems likely.

The plan starts to form quickly.

But once the diagnosis is fixed, everything else can become filtered through that assumption.

You may:

- Lock onto a diagnosis early
- Filter new information through that first impression
- Move quickly to action
- Discount information that does not fit

The risk is not that you are careless.

The risk is that your decisiveness moves faster than your diagnostic checkpoint.

Section 3 — What Is Really Happening

Your decision-making is often driven by three forces.

Anchoring bias

The first impression sticks

Cognitive efficiency

Your brain prefers a fast, closed loop

Confidence under pressure

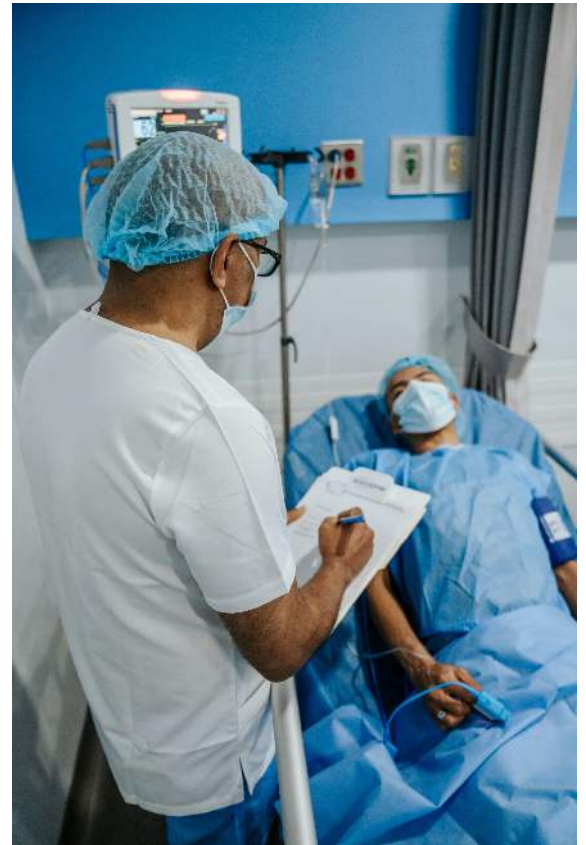
You trust your early judgement and move forward. Again this is not a flaw. It is a strength without an interruption point

The goal is not to remove your speed
The goal is to protect it

Section 4 — How This Shows Up on Shift

You may recognise this pattern:

- You form a diagnosis early and stick with it
- You feel confident in fast decisions
- You dismiss data that does not fit
- You realise later that you narrowed too quickly
- You act before actively testing alternatives



This is especially likely when the presentation feels familiar.

Chest pain.

Shortness of breath.

Collapse.

Abdominal pain.

Sepsis-like symptoms.

The more familiar the pattern feels, the easier it is to close too early.

Section 5 — The Hidden Cost

Left unchecked, premature closure can lead to:

- Missed or delayed diagnoses
- Overconfidence in early decisions
- Reduced diagnostic flexibility
- Failure to recognise deterioration
- Avoidable clinical error

The dangerous part is that premature closure often looks like competence at first.

You are moving quickly.

You are making decisions.

You are progressing the patient journey.

But if the original assumption is wrong, every step afterwards may reinforce the wrong pathway.

Section 6 — Reframe

Your goal is not to slow down unnecessarily.

It is to:

stay fast — while deliberately testing your first assumption

That is the skill.

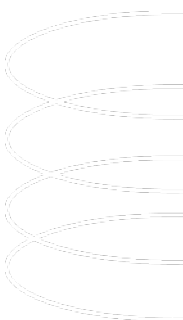
Not indecision.

Not overthinking.

Not defensive medicine.

Just a short, deliberate pause before the diagnosis becomes fixed.

The Premature Closer



Section 7— Immediate Wins

1. The Disconfirming Evidence Rule

Before committing, ask: What does not fit this diagnosis?

Then actively look for it.

This prevents you from only collecting evidence that supports your first impression.

2. The Second Diagnosis Pause

Before finalising your working diagnosis, force yourself to name one realistic alternative.

Even if you still choose the first diagnosis, this keeps your thinking open.

Ask: What else could this be?

3. The Investigative Pause

As you move onto complete the consultation you should take time to look through the investigations

This does not need to take minutes

It is a short diagnostic interruption point, where you look at results that confirm your alternative diagnoses, not deny, but confirm

The aim is not to delay action.

The aim is to prevent fixation on that first diagnosis

Section 8 — A Quick Win: The Clinical Pause in Practice

A 54-year-old man presents with central chest pain.

- ECG: non-specific changes
- Observations: stable
- Pain: improving
- He looks reasonably comfortable

Your immediate thought is:

“This is probably musculoskeletal or low-risk chest pain.”

That may be correct.

But this is also a classic premature closure point.

The presentation feels familiar.

The patient appears stable.

The pain is improving.

The first diagnosis is tempting.

Before you close the case, run a brief RADIAL check.



R — Recognise instability

A — ABCDE prioritisation

D — Define worst-case risk

I — Identify contradictions

A — Act & escalate

L — Loop and reassess

Section 9 — Apply RADIAL to Prevent Premature Closure

R -Recognise Instability

Ask:

Is this patient physiologically safe right now?



Clinical steps:

- Review the full set of observations
- Look specifically at heart rate, blood pressure, respiratory rate and oxygen saturations
- Assess whether the patient looks unwell despite “normal” numbers
- Check for subtle signs of shock, respiratory compromise or distress

In this case:

The patient appears stable, but chest pain can evolve. Stability at one point in time does not prove low risk.

Clinical takeaway:

Do not let “currently stable” become “safe to close.”

A - ABCDE Prioritisation

Ask:

What will kill this patient first if I do nothing?

Clinical steps:

- Confirm airway is patent
- Check breathing and oxygenation
- Assess circulation and perfusion
- Establish IV access if clinically appropriate
- Place the patient on cardiac monitoring if risk remains
- Treat immediate physiological problems before diagnostic debate

In this case:

There is no obvious airway or breathing compromise, but the presentation still requires cardiovascular risk assessment.

Clinical takeaway:

ABCDE prevents you from jumping straight to diagnosis before physiology is secure.

D - Define Worst-Case Risk

Ask:

What is the most dangerous plausible diagnosis?

Clinical considerations:

- Acute coronary syndrome
- Pulmonary embolism
- Aortic dissection
- Significant arrhythmia
- Myocarditis or pericarditis depending on history

Clinical steps:

- Take a focused high-risk history
- Ask about exertional pain, radiation, diaphoresis, syncope and previous cardiac disease
- Review cardiovascular risk factors
- Repeat or review ECG carefully
- Use an appropriate troponin pathway
- Consider whether the story truly supports safe discharge

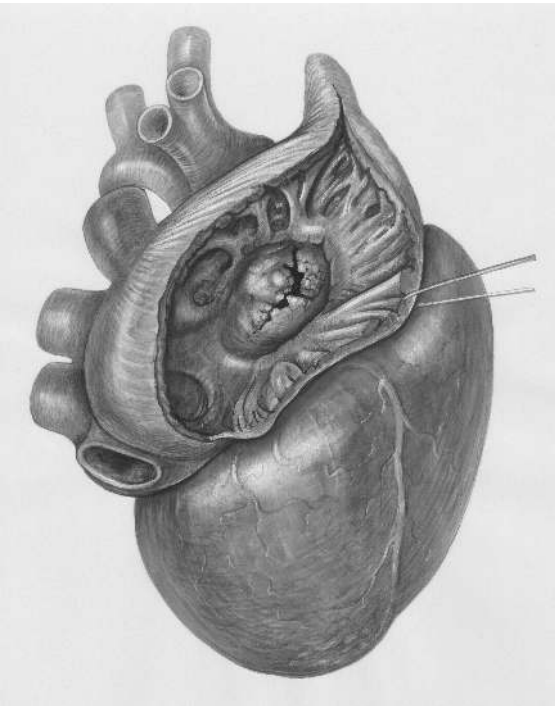


In this case:

The pain improving does not exclude acute coronary syndrome.

Clinical takeaway:

Worst-case thinking protects against false reassurance.



I - Identify Contradictions

Ask:

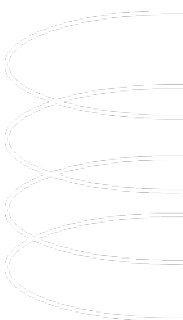
What does not fit the diagnosis I am about to choose?

Clinical steps:

- Challenge the initial label of “musculoskeletal” or “low-risk”
- Look for features that contradict the early diagnosis
- Revisit the history if something feels incomplete
- Re-examine if symptoms persist or evolve
- Pay attention to subtle ECG abnormalities
- Ask whether the patient’s age and risk profile fit your initial conclusion

In this case:

A 54-year-old man with central chest pain and non-specific ECG changes deserves deliberate diagnostic caution.



Clinical takeaway:

This is the anti-premature-closure step. You are looking for what does not fit.

A - Act & Escalate

Ask:

What action will make this patient safer right now?

Clinical steps:

- Treat as potential cardiac chest pain until appropriately risk stratified
- Provide analgesia where needed
- Follow local chest pain / ACS pathway
- Repeat ECG if pain changes or persists
- Escalate for senior review if uncertainty remains
- Avoid premature discharge based only on early improvement

In this case:

The safer action is not necessarily aggressive treatment. The safer action is appropriate investigation, monitoring and reassessment before closure.

Clinical takeaway:

Action should be based on risk, not premature certainty.

L - Loop and Reassess

Ask:

Has anything changed?

Clinical steps:

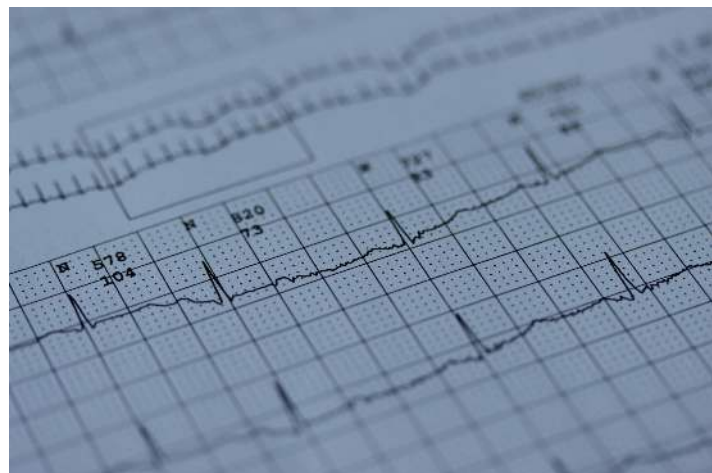
- Repeat observations
- Repeat ECG if symptoms evolve
- Reassess pain, appearance and clinical trajectory
- Review investigation results in context
- Revisit the working diagnosis before disposition
- Ask again: "Does this still fit?"

In this case:

If the pain returns, ECG changes evolve, troponin rises, or the story becomes more concerning, the original low-risk label must be abandoned.

Clinical takeaway:

The loop keeps the diagnosis open until the patient is genuinely safe.



Section 10 — The Key Shift

The difference is not doing more.

It is thinking differently before committing.

Without a loop:

- The diagnosis closes early
- Alternative risks disappear
- Conflicting information is ignored
- Errors become obvious only later

With a loop:

- You remain fast
- Your thinking stays flexible
- Your decisions become safer

Premature closure is interrupted by one deliberate habit:

Pause before the diagnosis becomes fixed.

Section 11 — The Gap

Most clinicians know about bias. That is not the problem

The problem is that they do not interrupt bias in real time.

Under pressure, most clinicians:

- Default to speed
- Trust the first pattern
- Move quickly into action
- Lack a structured checkpoint system

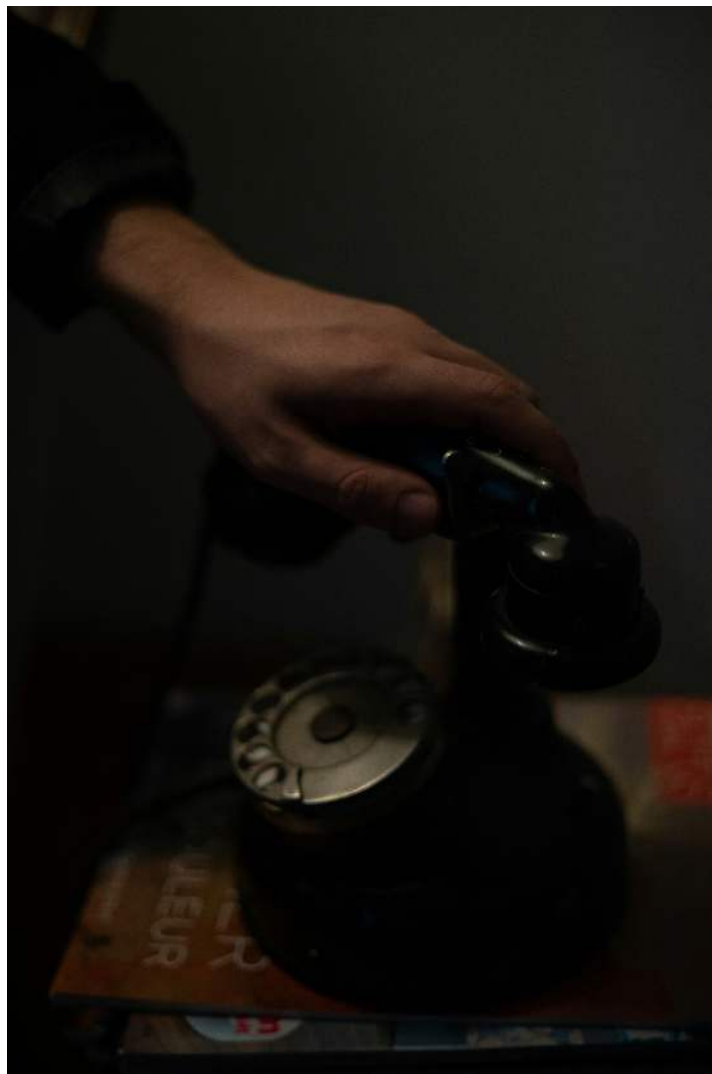
Knowing about premature closure is useful, having a process to prevent it is better

Section 12 — Transition to RADIAL

To fix this properly, you need a framework that helps you:

- Challenge your first assumption without becoming slow
- Identify contradictions before they become missed diagnoses
- Define worst-case risk early
- Act safely despite uncertainty
- Reassess before closing the case

That is exactly where the RADIAL Clinical Thinking Playbook comes into play.



The RADIAL Clinical Thinking Playbook

A structured clinical thinking loop for recognising risk, prioritising decisions, and acting safely under pressure.

Call to Action

The RADIAL Clinical Thinking Playbook is the next step.

It gives you a practical framework to recognise instability, prioritise risk, identify contradictions, act safely, and reassess as the situation evolves.

Final Line

When you feel confident early, pause.

Before you close the diagnosis:

Run the loop.

