

The Intuitive Sprinter



**Stay fast - without missing what
matters**



Dr James Wallace

You are The Intuitive Sprinter

How to Balance Clinical Instinct with Structured Thinking

As a clinician, you may find that you often recognise patterns quickly.

You can walk into a clinical situation and form an impression within seconds.

You notice the unwell patient.
You sense when something is wrong.
You often move quickly from assessment to action.

That is a strength.

In emergency medicine, intuition matters. Pattern recognition is part of how experienced clinicians work safely and efficiently.

But intuition has a risk.

It can feel right before it has been tested.

In my experience working in emergency medicine, fast instinctive thinking is often useful, but it needs a structure around it. The problem is not that your instinct is wrong. The problem is relying on it before checking whether it fits the full clinical picture.

The key is not to suppress intuition.

The key is to test it quickly.

Section 1: Understanding the Intuitive Sprinter

As an Intuitive Sprinter, you may move rapidly from first impression to action.

You are often:

- Fast to recognise patterns
- Comfortable acting under pressure
- Confident in your clinical instincts
- Able to make decisions with limited information
- Good at spotting when a patient “just looks wrong”

These are valuable clinical traits.

But under pressure, the risk is that you may:

- Trust your first impression too strongly
- Skip over contradictory information
- Act before fully checking the physiology
- Struggle to explain your reasoning to others
- Miss slower, less obvious diagnoses

This is not a knowledge problem.

It is a **checking problem**.



Your instinct may be useful.

But it must be tested.



Section 2.

Practical Steps to Check Your Instinct

Here's how you can keep the speed of your intuition while making it safer.

1. Name Your First Impression

Do not hide your instinct.

Name it clearly.



Say:

“My first impression is sepsis.”

“My instinct is this patient is high-risk.”

“This looks like an asthma exacerbation.”

Naming your instinct makes it visible.

Once visible, it can be tested.

2. Ask: "What Would Prove Me Wrong?"

Before acting fully on your first impression, ask:

What would make this diagnosis unsafe or incomplete?

This prevents your instinct becoming a fixed conclusion.

It also forces you to look for missing or contradictory features.

3. Separate Pattern Recognition from Decision - Making

Pattern recognition gives you a starting point.

It should not always be the endpoint.

Your instinct may tell you where to begin, but your decision should still be checked against:

- Physiology
- Worst-case risk
- Contradictions
- Response to treatment

This is how you keep speed without becoming careless.

4. Explain your Reasoning Out Loud

If you cannot explain your reasoning, the decision may not be fully formed.

Try saying:

“I think this is likely pneumonia because of the fever, cough and focal chest signs, but I am checking for sepsis and PE because of the tachycardia.”

This keeps the instinct useful but controlled.

It also improves team communication.

5. Build in a Reassessment Point

Fast decisions are safer when they are paired with planned reassessment.

Ask:

When will I check whether I was right?

This may be:

- After treatment
- After observations are repeated
- After blood gas results
- After imaging
- After senior review

A fast first decision needs a deliberate second look.



Section 3: A Quick Win – Apply to a Clinical Case

Case Study: The Child with "Simple Gastroenteritis"

You are asked to assess a 6-year-old child in the emergency department.

They present with:

- Abdominal pain
- Vomiting
- Reduced oral intake
- Temperature 37.9°C
- Heart rate 142
- Respiratory rate 24
- Capillary refill time 3 seconds
- No diarrhoea yet

The child is quiet, lying still, and reluctant to move.

The parent says:

"I think it's probably a stomach bug."

Your immediate instinct might be:

"This is likely viral gastroenteritis."

That may be correct.

But this is also a classic Intuitive Sprinter risk point.

The pattern sounds familiar.

Vomiting in children is common.

The parent has already suggested a diagnosis.

The presentation appears to fit.

Before you act entirely on instinct, apply the RADIAL framework.

RADIAL Framework

R — Recognise instability

Stable vs unstable?

A — ABCDE prioritisation

What kills first?

D — Define worst-case risk

What can't be missed?

I — Identify contradictions

What doesn't fit?

A — Act & escalate

What needs action now?

L — Loop reassess

What has changed?



R - Recognise Instability

The child is not peri-arrest, but there are concerning physiological signals.

The heart rate is raised.

Capillary refill is prolonged.

The child is quiet and lying still.

Oral intake is reduced.

These are not reassuring features.

In children, deterioration can be subtle until it becomes sudden.

Clinical step:

Do not let the “gastroenteritis” label override your assessment of physiology.

Key question:

Is this child genuinely stable, or am I being reassured by a familiar story?

A - ABCDE Prioritisation

Even if gastroenteritis is possible, you still start with ABCDE.

Clinical priorities:

- Assess airway and work of breathing
- Check oxygen saturations
- Assess circulation carefully
- Review capillary refill, pulse volume and peripheral temperature
- Check conscious level and behaviour
- Check glucose
- Assess hydration status

This protects against treating the story before assessing the child.

Clinical step:

Use ABCDE to identify whether this is a child who can safely wait or needs urgent senior review.

You do not need to investigate every possibility immediately.

But you do need to decide what cannot be missed.

Clinical step:

Ask targeted high-risk questions:

- Where exactly is the pain?
- Is the child walking normally?
- Any polyuria, polydipsia or weight loss?
- Any bilious vomiting?
- Any rash or limb pain?
- Any urinary symptoms?
- Any safeguarding concerns?

This keeps instinct grounded in risk.

D - Define Worst-Case Risk

In this case, worst-case risks include:

- Sepsis
- Appendicitis
- Diabetic ketoacidosis
- Testicular torsion if male
- Bowel obstruction or intussusception
- Non-accidental injury depending on context

I - Identify Contradictions

Now ask:

What does not fit simple gastroenteritis?

Possible contradictions:

- No diarrhoea
- Localised abdominal pain
- Reluctance to move
- Persistent tachycardia
- Prolonged capillary refill
- Drowsiness, irritability or unusual quietness
- Pain out of proportion
- Bilious vomiting

In this case, the child lying still and reluctant to move is a red flag.

Clinical step:

Do not dismiss abnormal behaviour or physiology because vomiting seems common.

Use contradictions to test your first impression.

A - Act & Escalate

The next safe action depends on risk.

Possible actions:

- Give analgesia early
- Check blood glucose
- Obtain senior paediatric or ED review
- Consider urine dip
- Consider blood gas if DKA or sepsis is possible
- Consider IV access and fluids if clinically dehydrated or shocked
- Follow local sepsis or abdominal pain pathway if indicated
- Keep the child nil by mouth if surgical pathology is possible

Clinical step:

Do not close the case as gastroenteritis until the child has been properly risk assessed.

Let physiology, behaviour and red flags decide the next action.

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L - Loop & Reassess

After initial assessment and treatment, reassess.

Has the heart rate improved?

Has capillary refill normalised?

Is the child more interactive?

Has the abdominal pain localised?

Can the child walk, hop or move comfortably?

Have new symptoms appeared?

If the child remains tachycardic, quiet, poorly perfused, or reluctant to move, restart the loop.

Clinical step:

A diagnosis of gastroenteritis should become safer over time, not simply be accepted at the beginning.

Key Learning

By using RADIAL, you did not ignore your instinct.

You tested it.

You moved from:

“This is probably gastroenteritis.”

To:

“This may be gastroenteritis, but I have checked physiology, red flags and contradictions before closing the case.”

That is the core skill for the Intuitive Sprinter.





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 your instinct feels obvious, pause.

Do not ignore it. Do not blindly trust it.

Run the loop.