One scale too far?

I have spent the past week accompanying a relative into, through, and out of hospital (twice, since the problem recurred). This has given me ample opportunity to become familiar with contemporary admission procedure and the lengthening menu of tests and checklists used to diagnose and monitor the acutely-ill patient.

On one occasion, I found my relative, whose presenting complaint did not affect the bowels, studying a pictorial chart labelled the Bristol Stool Scale. Any excreta produced were to be categorised on a fluidity scale from 'Type 1: separate hard lumps, like nuts' through to 'Type 7: watery, no solid pieces'. Sausage-shaped variants should be sub-categorised according to the degree of lumpiness and cracks on the surface. Notes accompanying the scale explained that Types 1 and 2 indicate a tendency to constipation while Types 5, 6, and 7 suggest diarrhoea.

According to its Wikipedia page, the Bristol Stool Scale was developed by a gastroenterologist who correlated the macroscopic appearance of the human stool with transit time in the gut, thereby establishing the foundations for a science broadly akin to phrenology but (arguably) more evidence based.

I can immediately think of numerous medical conditions for which such a scale, used by trained staff — and indeed, trained patients — with robust quality control, may add value and avoid the need for more invasive tests. I can also see why T-shirts and mugs bearing the 7-point scale, complete with illustrative schematic examples, may appeal to those with a scatological bent in humour.

What I could not initially fathom is why every patient placed temporarily on the holding ward adjacent to the A&E department (known in some hospitals as the Breach Avoidance Unit) was issued with a copy of it along with a clutch of similar scales designed to quantify and classify the minutiae of their physiological, psychological, and emotional state.

But then I remembered the inexorable tendency towards rationalism that is occurring in clinical care. In the olden days, nurses monitored (and doctors got out of bed for) a handful of quantitative variables:

temperature, pulse, respiratory rate, blood pressure, fluid intake, fluid output. The remainder of the acute illness experience was an unclassifiable and idiosyncratic mess involving (pick any that apply) deep pain, green puke, blue lips, clammy forehead, collywobbles, inner yearnings, free-floating anxiety, and déjà vu.

The nurse's skill was not merely to mop your brow and empty your bedpan, but to connect intersubjectively with the totality of your acute illness experience in a way that answered the question 'How and to what degree is this patient sick — and what are their care needs and priorities?'

This question, which I acknowledge is heavily dependent on the experience and judgement of the clinician (indeed, that is precisely my point), has been steadily replaced by a sheaf of 'validated' instruments designed to prompt (and make auditable and transparent) a comprehensive assessment of the patient. The reductionist myth that has spawned this expanding toolkit is that by first quantifying and classifying each aspect of illness and then plotting all the scores on a dashboard, it will be possible to get an accurate handle on how sick the patient is and what needs to be done next.

Here's a hypothesis that is surely worth testing: the more time nurses and doctors spend mechanically administering these instruments to acutely-ill patients, the less time they are engaging mindfully with what is really going on. I do believe I feel a multicentre trial with qualitative process evaluation coming on.

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DOI: 10.3399/bjgp13X667268

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