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# **A multitude of voices and worlds: Towards a new model of the medical case report**

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## ABSTRACT

*Patient-centredness* is an umbrella term for trends in medical practice that have attempted to redefine the doctor-patient relationship. Two decades ago, the concept of *patient advocacy* was introduced to emphasise a more empowered role for the patient. This paper problematises the patient's perspective in medical case reports from professional medical journals. It attempts to determine how these concepts are realised at the level of specialist text by looking for their linguistic manifestations of the two above-mentioned notions of medical practice. Further, the paper proposes a more patient-oriented variety of case reports. In this way, it addresses the conceptualisation of the patient in the written context, something which has received comparably less attention than that of spoken discourse in medical settings studied with a view to improving the quality of physicians' encounters with patients. Medical texts may not consider communication in the doctor-patient dyad, but nonetheless they refer to patients, and how they do so is critical.

## **1. Introduction**

The ability to communicate effectively has always been a concern in medicine. Recently, medical practice has witnessed major changes and faced challenges which have found their reflection in studies of medical discourse. Some of this research examines discourse practices with reference to impressive technological advancement, specialisation of knowledge, progressing systematisation and withdrawal of management (e.g. Iedema 2006). Other studies address the issues of communication in multicultural settings (Roberts 2006). The aim of such research is not only to help clinicians in their work but also to improve the quality of their encounters

with patients. The need for cooperation between medical professionals and linguists originates from the pivotal role of language in medical activities. As Foucault (1973) observes, almost every aspect of patient management is accomplished by means of language, from an interview, through the description of the patient's condition, to instructing him/her. Language also plays a significant role in the *patient-centred* and *patient advocacy* approaches, alternative models of practicing medicine, where eliciting and communicating a patient's experience of illness and empowering the patient respectively take centre stage. Yet, although substantial literature regarding doctor-patient communication exists, the question arises as to whether written medical discourse can also adopt the patient's perspective. In this paper, the discursive construction of a patient's perspective in medical case reports will be examined. Firstly, the theoretical background will be presented, including the aforementioned two approaches, the description of the medical genre of the case report and its development, as well as the linguistic features that do not accord with the approach. Secondly, how medical authors textually acknowledge patients as experiencing individuals in the interactive variety-in accordance with the premises of the *patient-centred approach* and *patient advocacy*- will be presented. Finally, a model of a new type of case report will be presented based on an interactive case report. By way of discussion, an attempt will be made to show the need for, and rationale behind, patient-oriented professional texts.

## 2. The case report genre

Taavitsainen and Pahta (2000: 60) define the genre of the case report in the following way:

In its typical form, the case report records the course of a patient's disease from the onset of symptoms to the outcome, usually either recovery or death. The background and a commentary on the disease are also given, but their scope may vary. Often a limited review of the literature is added and the number of known cases stated.

Thematically, case reports address three types of issues: a new way of treating a disease, a new disease or a disease with an unusual manifestation (Hoffman 1999: 253). These strict requirements stem from the fact that the status of case reports has decreased significantly due to the standardisation

of medical education and studies (Hunter 1991: 93; cf. Section 3, below). Yet, they still perform a very important pedagogical function by informing medical academia about new cases (cf. Smith 2008: 1). What is more, they exemplify the specific clinical reasoning behind developing a case.

Case reports are “the briefest and simplest category of article” (Adams Smith 1984: 27) and usually consist of three parts: “a short Introduction, a more detailed Case Report body, and a brief Comment or Discussion section” (Rowley – Jolivet 2007: 185), although they are not unified compositions. This structure can be compared with the arrangement of a narrative as exemplified by Labov (1979), who divides narratives into Orientation, Complication, Evaluation and Result. Consequently, case reports start with the Introduction (Orientation), which orients readers to the patient whose case is described. This section, which may also include some demographic facts about the patient, such as sex, age and sometimes occupation or ethnic origin, briefly explains the reason for the presentation. What follows is the Case Report body (Complication). It is the most extensive part as it features not only descriptions of various diagnostic procedures, but also the very treatment. Lastly, the Comment or Discussion (Evaluation and Result), often a combination of the two, evaluates the actions performed by the physicians and discusses the outcomes and effectiveness of treatment. The section may also include implications for further assessment and treatment procedures. According to Calnan and Barabas (1973: 8), it is important that these types of information follow the same sequence in which they were given in the patient’s case notes.

The clinical case record freezes in time that episode in life called illness. It is a story in which patient and family are the main characters, with the doctor serving a dual purpose as both biographer and part of the plot. The content of this biography varies greatly, reflecting its main purposes: to recall observations, to inform others, to instruct students, to gain knowledge, to monitor performance, and to justify interventions. (Reiser 1991: 902)

As Reiser (1991) aptly describes, case reports are stories of patient’s diseases that document a medical case in order to inform and teach others.

The next section will give an account of the history of medical case reports, i.e. how the compelling narratives about the incredible were transformed into concise and conventionalised accounts based on scientifically verifiable facts.

### 3. The case report in historical perspective

Peh and Ng (2010: 10) observe that “[r]eporting a rare or unusual case is probably the oldest form of medical communication”. Accounts of oncological cases written on papyrus come from Ancient Egypt around 1600 B.C. (Dib et al. 2008: 1) and they are considered the first records of breast cancer. The practice of recording cases of diseases also reaches back to Hippocrates’s (ca. 460 BC – ca. 370 BC) medical writings (Hunter 1991: 93; cf. Nowell-Smith 1995: 3). Hippocratic case reports were highly focused on the subject of study and the author revealed no emotional involvement. On the other hand, Galenic (AD 129 – 200) case reports were characterised by verbosity and a greater focus on the patient’s point of view. Another stage in the development of the genre were the so-called *consillia*. These were texts in which doctors established diagnoses for diseases in particular cases and decided on treatment (Agrimi – Crisciani 1994: 19). Such texts began to be collected, forming repositories of cases which functioned as a source of medical knowledge. They also laid the foundations for contemporary forms of case-recording (Alderotti 1937 [1997]). The form and content of case reports from the Middle Ages were heavily influenced by the philosophical movement of scholasticism. In medical texts, scholasticism was marked by direct references to authors- to ensure the quality of information- as well as by prescriptive phrases (Taavitsainen – Pahta 1998). The aim of these means of expression was to “emphasise the reliability and correctness of the information and the necessity of having confidence in knowledge that was handed down as axioms” (Taavitsainen et al. 2002: 258). According to Gotti and Salager-Meyer (2006: 9), it was not until the early fifteenth century that medicine rejected the unquestionable status of the ancestors’ teachings as the ultimate authority (cf. French 2003: 9). “In a well-known dichotomy, science that relies on authorities is contrasted to empirical investigation and rationalistic views” (Taavitsainen et al. 2002: 253). With these words, Taavitsainen et al. (2002: 253, 256) point to the growing importance of observation in the second half of the sixteenth century. The seventeenth and eighteenth centuries saw more preoccupation with patients’ accounts in case reports. What was also characteristic of that period was the propensity of the authors to write about curious medical phenomena to pique readers’ interest. However, the discourse about diseases changed with the growing importance of pathological anatomy at the turn of the nineteenth century. This was coupled with the growing role of observation and the development of technology which offered more and more accurate images of the human

body and recordings of its functions (cf. Hurwitz 2006). New diagnostic devices made the body “transparent” and allowed accurate assessment while medical sciences directed where the medical gaze should be focused (Foucault 1973). What is more, developing medical knowledge and modern equipment determined what counted as reliable data, which diminished the role of patients’ accounts while the very patients came to be treated as “quantifiable material” (Gunnarsson 2009: 61). Yet, with the development of medical practice the status of case reports decreased significantly. Firstly, the introduction of modern diagnostic equipment and procedures rendered case reports less credible due to the subjectivity of the material presented there. Essentially, they are physicians’ accounts based on their observation and interpretation of signs of a disease, where the “author is much more that of the practitioner than that of a knowledge builder or holder” (Salager-Meyer 2001: 77). Secondly, the growing importance of the genre of the research article in medicine, which is often based on larger populations and statistical analyses, devalued the case report as a valid source of information (Atkinson 1992). However, despite the “fall from favour” (Vandenbroucke 2001: 333; cf. Fye 1987) that this genre has witnessed, functions of case reports such as increasing the knowledge of the medical community about rare cases and serving pedagogical purposes in medical training cannot be questioned (Vandenbroucke 2001; cf. Hunter 1991: 93; Taavitsainen – Pahta 2000: 61; Salager-Meyer 2001). Case reports are regularly published in major general medical journals such as *The Lancet*, *The Journal of American Medical Association*, *The New England Journal of Medicine* and *The British Medical Journal*, though their structures may differ. Separate online journals that exclusively publish case reports such as *Ground Rounds*, *Case Reports in Medicine*, *Journal of Medical Case Reports*, *BMJ Case reports* or discipline specific *Radiology Case Reports*, *Journal of Radiology Case Reports* and *Journal of Surgical Case Reports* also exist. One of the most recent developments of the genre is the so-called *interactive* case report, which used to be published by the *British Medical Journal*<sup>1</sup>. This form appeared as a series of case reports devoted to one particular topic, published in subsequent issues, starting with *case presentation*, through *case progress* to *case outcome*. The first part is similar to a regular case report presenting a given case, additionally including a call for readers’ responses/comments and/or questions to be answered. The progression of the

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<sup>1</sup> The project was eventually discontinued by the *British Medical Journal* due to the fact that in the era of Web 2.0, sending comments to the editor of the journal became obsolete and it was very time-consuming. However, it cannot be denied that it proved to be a valuable venture.

treatment, as well as possible readers' responses, is the topic of the second part. The third one presents the outcomes of the treatment and discusses the prognosis and implications for further investigations. Apart from the inclusion of the readers' responses and comments supplied in the course of treatment, interactive case reports contain the patient's account, which appears in the third part. Therefore, this type of case report is a series of smaller narratives constructed by doctors, readers and patients. It is also dynamic in that the plot develops over a series of texts. In other words, interactive case reports enable the medical community and other readers to "[s]har[e] communication issues from different perspectives, enriched by a valuable patient contribution" (Peile 2003: 1136). This is acknowledged by the *British Medical Journal*, which can be seen in the following quote:

The fact that real patients take part is, we feel, one of the strengths of interactive case reports. We encourage questions that are patient centred rather than simply clinical, asking what the doctor should say to the patient and sometimes prompting discussion on ethics issues. Taking part and helping others to learn from personal experience takes generosity and courage on the part of patients and, to some extent, their doctors.

The editors emphasise the innovative nature of the format, which, at the same time, is challenging for both doctors and patients, as it presents new perspectives in medical practice (Siotia et al. 2005: 1068). Helán (2012) points to another variety of journals publishing case reports (not interactive) including the patient's perspective. Journals such as *Journal of Medical Case Reports* and *Cases Journals* feature occasional examples of case reports with the patient's narrative, either as a separate section (*Patient's perspective* section) or as part of the *Case Presentation* section, in which the patient's words are embedded. The editor of *Cases Journal* openly states that it is a journal that "wants to accept not reject and to include patients as authors as much as possible" and where "case reports can eventually be submitted by anybody—patients, doctors, nurses, relatives, anybody" (Smith 2008: 1).

#### **4. Patient-centredness and patient advocacy**

The innovative devices of the nineteenth century, such as the ophthalmoscope, which visualised the human body and bodily functions, immediately caused concern over the diminishing patient's role as a source

of information. The subsequent introduction of equipment that was able to test smaller and smaller parts of the body with greater and greater precision widened the gap, between a patient and his/her body on the one hand, and between a patient and a physician on the other. Eventually formulated was the *biomedical model of medicine*, which views illness as a direct consequence of the diseased body and patients as mere recipients of treatment (cf. Wade – Halligan 2004: 1398). It follows that subjective perception is treated as irrelevant and may even yield false results (cf. Yardley 1997: 4). The model is believed to be reductionist because it limits the understanding of disease to only its biological manifestations, thereby excluding potentially vital social and psychological aspects. Accordingly, in Western diagnostic procedures only the biological aspects of disease are taken into consideration (Monroe et al. 1992: 48). Yet, as Armstrong observes (1984: 739), such a one-dimensional perception of the patient changed in the 1950s. Apart from the bodily sphere where diseases manifest themselves, the social sphere and its influence upon the patient's health also came to be acknowledged. The author of this "boldest attempt" (Armstrong 2002: 66) was Balint (1956) who maintained that localising bodily manifestations was not enough to diagnose a patient. He claimed that what was missing was the elicitation of information about symptoms which then had to be placed against the background of the patient's experience (Balint 1956). Consequently, observation began to be accompanied by patients' interviews which were to "illuminate the dark spaces of the mind and social relationships" (Armstrong 1984: 739). While diagnosing, physicians examined patients' bodies to discern any signs of a disease and listened to the patients' accounts of symptoms. This way, although the Cartesian dualism of mind and body was not altogether eliminated, the mind component was granted significance in the assessment of the patient's condition. The separation of signs and symptoms as part of the *biomedical model* was also seen in a new light. While a sign was still associated with a lesion, a symptom received new meaning as it was linked to the patient's identity. "The patient was beginning to have a voice- and an existence- independent of pathological lesion" (Armstrong 2002: 65). Such a change in perception paved the way not only for the acknowledgement of the role of the patient's account but also for a subsequent improvement in the quality of doctor-patient communication (cf. Armstrong 2002: 67-70). What is more, it led to further formulations which, although in various forms, shared the underlying criticism of the *biomedical model* and advocated openness to the patient's experience. These various formulations can be subsumed under the umbrella term *patient-centredness*. For example, the *biopsychological model* (Engel 1977) is based upon the premise that the diagnosis of a disease is



incomplete without considering the combination of psychological and social aspects of the patient's life (Pereira – Smith 2006: 455; cf. Hunter 1991: 21; Yardley 1997: 5). Such a holistic approach was in direct opposition to the reductionist *biomedical model*, which took only biological facts as pertinent in the treatment of a disease (cf. Pellegrino 2001: 83; cf. Engel 1988). What this model is about can be explained with the help of Mattingly's (1998b) description of the character of the therapist's job, i.e. learning the effect of one's ailment on his/her daily life (1998b: 74).

Yet another concept that is of interest here is *patient advocacy*, which was introduced to emphasise a more empowered role for the patient. Although the notion concerns certain aspects of health education going back to the early 1900s (Norris et al. 2008: xvii), the term *advocacy* has appeared in nursing literature only in the last two decades (Hewitt 2002; Mallik 1997). The concept has yet to develop as a fully-fledged area of research, yet it is possible to point to its main aims: "patient-centred care, safer medical systems and greater patient involvement in healthcare delivery and design" (Gilkey et al. 2008: 11). It can be referred to as "the navigator, both in its aim to help and guide patients to make well-informed decisions about their health for the best outcomes, and its quest to create more effective systems and policies" (Norris et al. 2008: xv). Whereas *patient-centredness* seems more holistic and focuses primarily on patients' "wellbeing" in the social and personal dimension, *patient advocacy* "very broadly (...) include[s] interventions targeting individual empowerment" (Gilkey et al. 2008: 13). Again with reference to Mattingly's (1998b) account, it is "not only what is wrong and how to fix it but also how to engage the patient in that fixing process" (1998b: 74).

## 5. Mishler's *voices* in medical discourse

The issue of doctor-patient communication has become a subject of study for linguists who have offered their help in establishing rapport between the parties (e.g. Heritage – Maynard 2007). One of the classical approaches to this issue is Mishler's (1984) conception of two voices in doctor-patient communication. Following Habermas's (1984: 1) theory of Communicative Action, Mishler (1984) identified two voices in the discourse of doctor-patient interviews – the *voice of the lifeworld* and the *voice of medicine*. While the former refers to the patient's account of the experience of illness, the latter is the doctor's perspective. In such an approach, physicians are regarded as "applied bioscientists", "collectors and analysers of technical information

elicited from patients”, while patients are “passive object[s] responding to the stimuli of a physician’s queries” (Mishler 1984: 10). In his study of doctor-patient communication, Mishler (1984) pointed to the dominant position of the *voice of medicine*. In Mishler’s own words, the *voice of medicine* can be compared to “the technical-scientific standpoint of the biomedical model” which interrupts the *voice of the lifeworld*, “the concerns of everyday life” (Mishler 1984: 6). He showed that these two voices are not of the same status, in that the former dominates and disregards the latter, which testifies to the multi-faceted nature of the patient’s experience. However, in their re-examination of Mishler’s (1984) conception, Barry et al. (2001), proposed a more fine-grained classification of the voices on the basis of a collection of different interviews (patient-doctor, doctor-doctor, consultations). It is a more detailed alternative to the previous dichotomous division. Firstly, there is Strictly Medicine when the patient and the doctor use the *voice of medicine*. Secondly, there is Mutual Lifeworld, which is a situation when the patient talks about the way he experiences the illness and the doctor acknowledges that. There are also Lifeworld Ignored, when the doctor responds with the *voice of medicine* as a response to the extended employment of the *voice of the lifeworld*, and Lifeworld Blocked, when there are “glimpses” of the Lifeworld, but there is no appropriate reaction (Barry et al. 2001: 493-499). As the authors claim, this finer differentiation was supposed to help doctors to engage more fully in patient-centred communication. In the present work, the classification of voices and lifeworlds will be applied to the analysis of written medical discourse, i.e. interactive case reports. In other words, what will be analysed will not be doctor-patient exchanges but medical specialist texts, which are also a platform for the interaction of different contributions.

For the purposes of the analysis, a modified classification will be put forward, namely Strictly Medicine, Lifeworld Transferred, Partial Lifeworld, and Lifeworld, which will be discussed in Subsection 7.3, below. The fact that the classification is patient-oriented stems from the very character of the analysed material, which dictates the categories to be distinguished.

## 6. Features of written medical discourse

A substantial number of studies of spoken language have been undertaken, possibly with the assumption that written communication excludes patients, and, therefore, is of a different nature. It therefore seems important to establish whether written medical communication may also be *patient-centred* in its

own sense since certain patterns of linguistic strategies are evident in written medical discourse as well. So far, researchers have devoted their attention to the impersonal character of medical discourse, pointing for instance to the passive voice, whose notorious use allows for such bizarre situations as when there is no reference either to patients or to the very physicians and the only active participant in a description is “the chest tube bubbling” (Kenny – Beagan 2004: 1074). Another depersonalising device is used when the results of the tests are given. These are reported either as “attributes” (Atkinson 1995: 107) of patients (e.g. *her 24h urinary free cortisol* or *her pulse*) or in other ways where the patients are not even referred to (e.g. *muscular pain* or *weakness*). Some authors of medical texts also tend to refer to patients as *cases*. In medical texts, the word *case* is used to denote an individual occurrence of a particular disease, but there are studies which document using the word to refer to patients, especially in spoken discourse (cf. Hunter 1991; Grice – Kramer-Dahl 1992: 73; Fowler 1996; Atkinson 1997). This suggests treating the patient as “the object of some disease entity” (Mead – Bower 2000: 1089) or reducing them to the disease they suffer from. It may also lead to other naming practices of this kind used among health professionals (cf. Anspach 1988). As Fowler (1996) rightly observes, the impersonality of the word *case* or other objectifying terms referring to patients does not seem to be suitable for speaking or writing about such subjects as ailing patients and their experience. From such a perspective, each patient “lose[s] his or her individuality, and (...) [is] subsumed in an aggregate of people”, for instance in “the pseudo-locative phrase ‘in the majority of cases’” (Fowler 1996: 128-129). Even in one of the guides to medical writing it is stated explicitly that “a case is a particular instance [while] (...) a patient is a person” (Matthews – Matthews 2008: 135) and that these two cannot be used interchangeably. Finally, the last feature of medical discourse that is supposed to reduce the emotional load is that of acronyms. Here, the whole meaning that the name of a disease encodes is reduced to a set of letters which may seem neutral in value to patients and physicians, for example *TB*, *MS* or *HIV* (Kirmayer 1988: 61).

As medical texts are written by already established members of the profession, they may be treated by young medics as examples to follow. The texts not only acquaint novices with particular attitudes and values, but also promote discipline-specific modes of writing. Therefore, it seems of interest to study the discursive construction of the patient persona. Following the premises of the *patient-centred approach* (cf. Section 4, above), it may be assumed that these texts should also acknowledge the patient’s role in treatment and give expression to their experience of being ill. The linguistic

reflections of these aspects have therefore been sought for in the texts of interest. As will be demonstrated, a patient's experience of their illness can be made visible in interactive case reports in a twofold manner. On the one hand, the patient's own 1<sup>st</sup> person account which features lay perception and vocabulary may be included. On the other, the doctor's text may refer to the patient's experience and ensure the textual presence of the treated.

## 7. Analysis

The following analysis consists of two parts. Firstly, the issue of how interactive case reports adopt the patient's perspective will be presented, demonstrating their unique character and suitability as a basis for a new model of the genre. Secondly, different voices found in the texts will be identified with the help of Barry et al.'s (2001) re-examination of Mishler's (1984) *voice of the lifeworld* and *voice of medicine*. This, in turn, is meant to prove the multi-layered narrative character of the reports at hand. The analysis will be preceded by a description of the data and followed by a discussion. Finally, a proposal for a new model will be put forward.

### 7.1 Data and methods

The material for this analysis comprises eight interactive case reports (with a total of 11,625 words, excluding tables, graphs, photograph captions and some other information not contained in the text) taken from the *British Medical Journal*, which is the only journal known to the author to have published this variety of case reports. These are also the only interactive case reports available from the BMJ archives. The reports were published in 2003, 2004 and 2006, and are thematically varied and devoted to a variety of medical fields. Each of the articles is a series of reports including Case Presentation, Case Progression and Case Outcome components (cf. Section 3 above for a detailed description of this type of case reports).

In the first stage of the analysis, each article was perused in order to find any words that referred to the patients. Next, the examples containing references to the patients were isolated by means of *WordSmith 5* and examined qualitatively. The results show that what is characteristic of this variety is that it contains patients' accounts in the 1<sup>st</sup> person. Apart from that, in the texts authored by the doctors, the patients' experience of illness is acknowledged and they have a textual presence.

## 7.2 The patient-centred character of medical case reports

### 7.2.1 1<sup>st</sup> person accounts and exact words

Regular case reports feature primarily the doctor's perspective and the references to the patient are made mainly in the 3<sup>rd</sup> person. The result is that the patient's voice is filtered by the doctor-writer, which is different from the patients speaking about themselves without any intermediaries<sup>2</sup>. Interactive case reports, on the other hand, introduce the patient's perspective in the form of 1<sup>st</sup> person narration, which is termed by Hawkins (1993) as *pathography*. This seems to be in accordance with the *patient advocacy* concept, which emphasises the patient's empowerment. As the analysis shows, at the level of the text, this empowering of the patient is realised through giving the floor to the patient, who voices his/her concerns and perceptions. The unique character of such an element is exemplified by the lay vocabulary that patients use to describe their experience of illness.

- (1) Elisabeth first became unwell during the evening of her 2nd birthday. Her parents noticed that she was "*grizzly and off her food.*" (I3, 2003)
- (2) "*Once you turn yellow,*" he thought, "*it's cancer, and once you're opened up, the cancer takes over your whole body.*" (I1, 2004)
- (3) I never really thought I was ill, but *the palms of my hands and the soles of my feet were driving me round the twist. I could have used a wire brush on them. It was so deep down I was making myself bleed, but I was scared.* (...) (I1, 2004)
- (4) Even though the medication didn't work in the end, I don't regret doing the trial. *It was helpful that someone took an interest in how I was feeling.* (I2, 2004)

As can be seen in the examples above, the descriptions offered by the patients refer to both mental (1) and physical (2-3) experiences. Additionally, in (4), the patient refers directly to the way she was approached by doctors. The inclusion of the patient's perspective seems a complimentary element that introduces how things are experienced and understood by the other party. This way, "the patient emerge[s] very differently when recounted as an agent in a personal story" (Mattingly 1998a: 274).

<sup>2</sup> Cf. Coker (2003) on how the patient is constructed in Egyptian medical records and the different voices employed therein.

### 7.2.2 Other patient-centred elements

Apart from the novel element presented above, interactive case reports include the already known elements from regular case reports, i.e.: acknowledgement of the patient's experience of illness (5-6) and their textual visibility (7):

- (5) Ruth *experienced* adverse effects from azathioprine and risks more while she continues taking steroids. *The aims, risks, and benefits of treatment need to be discussed with her, because her views will ultimately determine whether she takes prescribed drugs.* (I2, 2004)
- (6) Vitamin B-6 was also ineffective in *alleviating our patient's three other most important symptoms of dizziness, daily activities, and general wellbeing.* *We believe an n of 1 trial is a useful means of helping patients decide on which treatment to take in situations where evidence is poor or equivocal.* (I2, 2004)
- (7) What of *Mrs Reynolds*, the subject of the case report? *Her case is not entirely typical since her sickness started later in pregnancy than is usual at 8 weeks and because she had not had this problem in previous pregnancies. Her history suggests that social or psychological factors were absent. She did not benefit from prochlorperazine, but it is important that antiemetics are taken regularly rather than on an as required basis and this should be clarified with her.* It is also important to consider whether *she* was vomiting up the drugs. In this situation suppositories can be helpful. *Her condition seems to have progressed and was affecting her ability to function. However, she had no evidence of dehydration (absence of postural hypotension) and no ketonuria, features present when vomiting has progressed to hyperemesis.* (I4, 2004)

In examples (5-6) reference is made to a patient's experience of illness through the use of specific verbs (*experience* in (5) and *alleviate* in (6)) as well as a noun referring to a particular ailment- *dizziness* in (6). What is also addressed in (5) is the process of decision making with direct reference to a patient's involvement (her views) and well-being (risks and benefits). (7) is a longer excerpt from a text which evidences the patient's visibility, achieved through the use of both personal and possessive pronouns. Additionally, similarly to regular case reports, the author's voice can be observed here as well (cf. *we* in (6) above). These, together with direct references to patients, contribute to a more patient-oriented text, and not one in which *diseases are treated and procedures are carried out.*

### 7.3 From *Strictly Medicine* to *Lifeworld* – the many worlds in interactive case reports

In this section, the application of a modified classification of different voices in medical case reports will be presented, namely *Strictly Medicine*, *Lifeworld Transferred*, *Partial Lifeworld*, and *Lifeworld*. The reason that the classification is patient-oriented is because the material analysed, i.e. interactive case reports are, as has already been demonstrated, more patient-centred, which dictates the categories to be distinguished.

The following analysis will show how the above-presented voices manifest themselves at the level of the text.

#### 7.3.1 *Lifeworld*

Examples (3-4) above both reveal the *Lifeworld*, as these are patients' 1<sup>st</sup> person narrations, and not indirect accounts given by doctors. It is the patient's voice, and thus the individual experience of illness, which adds another perspective in this narrative.

#### 7.3.2 *Partial Lifeworld*

*Partial Lifeworld* refers to those fragments, which, though written from the 3<sup>rd</sup> person perspective, include selected phrases or quotes from the patient- cf. examples (1-2) above. As Poirier et al. (1992) observe, in western medical case reports it is ultimately the doctor who chooses what to include; nevertheless, the patient's perspective is introduced. These quotes are unique for this genre in the sense that they do not belong to professional medical discourse and if included in regular case reports, they would be rendered in 3<sup>rd</sup> person, more objective discourse. What is more, they are absent in standard case reports, which do not have such a section at all.

#### 7.3.3 *Lifeworld Transferred*

Apart from the novel element of the *patient's perspective* section presented above, a substantial part of interactive case reports consists of a doctor's account, which is part and parcel of regular case reports. In this form of discourse, the patient's perspective is filtered through the doctor's lens, and therefore this voice is termed as *Lifeworld Transferred*. These examples are different from the *Lifeworld* and the *Partial Lifeworld* in that here it is not 1<sup>st</sup> person narration or chosen quotes from the patient, but the patient's individual experience of illness (cf. 5 above), as well as their perception,

understanding of and attitude towards their condition (cf. 8 below) transformed into medical meta-language.

- (8) Ruth was reassured but advised that it would be sensible to increase her calcium intake to 1500 mg a day. *She found this difficult to achieve* and so was started on an oral calcium and vitamin D supplement. She was also advised to take as much weight bearing exercise as possible. (I6, 2003)
- (9) Five weeks ago (...) we presented the case of Ms Reynolds, a 25 year old woman who presented to her general practitioner when *eight weeks pregnant complaining of nausea and vomiting with light headedness*. (I2, 2004)
- (10) A 19 year old university student was admitted to our hospital *with history of high grade swinging temperature up to 39°C. She had had a sore throat, which lasted for a few days, accompanied by fever, rigors, and myalgia*. (I7, 2006)

In standard case reports, examples of *Lifeworld Transferred* can also be found, usually at the beginning of the report, which informs about the patient who comes or is brought to the doctor with a specific ailment. In examples (9) and (10), some of the complaints that the patient presented are briefly recounted. It might well have been the case that the patient conveyed this information in a more elaborate and subjective manner, which was then translated into 'objective' medical discourse. Such an approach enumerates diseases as entities thus reducing the patient's experience of illness to a single label which stands for a group of particular symptoms. Example (8) explicitly refers to the patient's attitude towards the case at hand.

### 7.3.4 *Strictly Medicine*

- (11) Results from the blood tests taken on admission (including creatine kinase, creatine kinase MB isoenzyme, and troponin T as serum markers of acute myocardial ischaemia) were within the normal range. Liver and renal function tests also gave normal results. He had high concentrations of C reactive protein (171 mg/l, normal < 10 mg/l), fibrinogen (6.24 g/l, normal < 3.9 g/l), and D dimer (5.31 mg/l, normal < 0.5 mg/l). His full blood count was normal except for a raised white blood cell count ( $15.1 \times 10^9/l$ , normal <  $10 \times 10^9/l$ ). (I5, 2003)



- (12) *Chest radiography showed* right sided posterobasal shadowing, which was reported as being indicative of pulmonary embolism or the start of pneumonia. “Non-significant enlargement of the heart and of the aortic arch” was also noted. There were no signs of cardiac decompensation (figure). (I5, 2003)
- (13) Vitamin B-6 in the form of pyridoxal-5-phosphate acts as an important coenzyme in the transamination of amino acids, with deficiency leading to polyneuropathy and convulsions. Vitamin B-6 has an important role in protein metabolism and transporting many amino acids across cell membranes. The mode of action in alleviating nausea in pregnancy is not known. No clear relation *has been found* between indicators of vitamin B-6 status and nausea and vomiting. (I5, 2003)

In stark contrast to the previous categories, subsumed under the category *Strictly Medicine*, are examples in which diagnostic or treatment procedures are described without reference to the patients. Here rather than to patients themselves, the readers’ attention is drawn to so-called “medical techniques and therapeutics” (Ashcroft 2000: 288). Mattingly (1998a: 274) refers to this mode of writing as “chart talk” which emphasise[s] diagnosis and pathology”. Linguistically, it is achieved through impersonal constructions (cf. 11 above), the passive voice (cf. 13 above), or so-called “abstract rhetors” (Halloran 1984: 74), where medical equipment or procedures are presented as showing or revealing particular results (cf. 12 above). This linguistic technique is referred to by Anspach (1988) as “technology as the agent”. In regular case reports, such examples appear most frequently in the examination section, which gives an account of the patient’s current condition, i.e. what the doctor observes as well as the results of medical tests (Murawska, forthcoming). Additionally, in (13), the focus falls on various medical aspects, which are the reference points of the sentences.

## 8. Towards a new model of the medical case report

The new model of the medical case report proposed here is patient-centred, i.e. one that emphasises an individual’s experience of illness. The patient’s perspective would ideally be addressed in a two-fold manner. Firstly, it would be a model of a narrated story of the case from the doctor’s perspective but with the patient’s voice and would be co-constructed by both parties. This way it would go beyond the textual acknowledgement of the patient’s

experience and invite the patient to co-produce the account (Smith 2006; cf. Earp et al. 2008). At the level of the text, this would mean inclusion of the patient's perspective in a special section, which would follow the example of the interactive variety. At this point the narrative character of the genre would also be explored. Firstly, a case report tells a complete story of the patient's disease from the appearance of symptoms to recovery or death. Secondly, it is always a story of a particular patient(s), which offers the potential to mediate a unique experience of illness if it is given the textual floor. At the microstructural level, on the other hand, the focus would fall on how the author refers to the patient, i.e. his/her presentation as subject/object of medical procedures. Therefore, these guidelines will refer back to the thematic-rhematic structure of the text in the functional perspective (e.g. Halliday 1994).

## 9. Rationale behind patient-centred texts

It has been demonstrated above that certain linguistic choices allow authors to focus on the patient. One may ask, however, why should medical professionals be patient-centred in their written discourse? Two reasons may be adduced here. On the one hand, although written communication, especially among medical professionals, is not conceived of as being of direct relevance to the patient, it does matter how patients are written about. In comparison with texts of other sciences, the case reports examined here, as with any other medical texts written for health professionals, are texts about human beings and this is the way in which patients should be portrayed. With regard to case reports, this postulate appears even more valid as the genre is concerned with particular patients suffering from particular diseases, as opposed to, for instance, articles about innovative techniques of knee surgery. Although the texts carry a message communicated only to fellow medical researchers, it should be a message concerning a patient as an experiencing individual, whose suffering is to be alleviated, not a case of a disease treated in a particular way. Therefore, if these texts objectify patients in any way, they require linguistic attention. The production and reception of written specialised discourse is also one of medical practices. The texts are written by the professionals who have already established their credentials as doctors and their publications reflect a certain image of how patients are positioned therein. Therefore, these texts may also be read by novices and may be treated as examples of agreed medical style. Consequently, in their socialisation into medical culture, students ought to be made aware

of the image of patients that emerges from professional medical literature. On the other hand, with respect to the previously mentioned *interactive* case reports, following Mattingly (1998b: 1), the inclusion of a patient's experience of illness means "attention to human suffering" as "[t]he need to narrate the strange experience of illness is part of the very human need to be understood by others". In addition to this, another textual reflection of *patient-centredness* can be adduced, i.e. the adoption of a *patient-centred discourse*, which would fit well with the overall dynamic and polyphonic character of this genre. Also, given the uniqueness of case reports as medical texts, rather than including patients' comments, such reports could possibly be co-authored with patient and/or families and published in domains other than technical medical journals in order to inform the public about new doctor-patient partnerships and knowledge production practices.

## 10. Conclusion

The present paper has addressed the issue of constructing patients' presence in medical case reports. First, an attempt has been made to determine whether the concept of *patient-centredness*, which has been referred to so far in numerous studies of spoken medical discourse, can be considered with relation to written medical discourse. The materials that have been chosen for the study of the aforementioned issue are interactive case reports, a variety of the genre, which, by definition, convey an account of a particular patient suffering from a particular disease and thus not, for instance, a description of innovative surgical methods in which no direct references to patients may be present. What is more, the studied type of case report has been proven to be more patient-centred than the regular one. Firstly, it includes a *patient's perspective* section in which the patient is given the floor. Secondly, features of the doctor's discourse have also been shown to adopt the patient's perspective, i.e. it often acknowledges the patient's experience of their illness and marks their textual presence. Furthermore, the reports under scrutiny have been investigated for the variety of voices appearing in them on the basis of Barry et al.'s (2001) re-examination of Mishler's (1984) voices. It has been demonstrated that in the reports the following voices coexist: *Strictly Medicine*, *Lifeworld Transferred*, *Partial Lifeworld*, and *Lifeworld*. Finally, a model of a new patient-centred variety of case reports has been proposed which, drawing on the interactive variety, would emphasise the patient's experience of illness and, therefore, present the process of diagnosis and treatment in a holistic way. The proposed model could be viewed as an alternative

for both medical authors and journal editors. Moreover, its adoption may be beneficial both to doctors in the development of compassion towards patients, and to patients, who are able to become active participants in the process of diagnosis and treatment and are not perceived merely as diseased entities that should be managed. The paper has also discussed the possible need for such an approach to medical texts. It is believed that texts about new methods of treatment should still refer to patients as those who undergo this treatment, as opposed to body-parts which are treated. Moreover, inviting patients into specialist text emphasises the importance of the patients' narratives of their individual experiences of illness. Consequently, both medical students and doctors should be sensitised to the potential that language offers considerable insight, not only in communication *with* patients but also *about* patients.

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