TRANSFORMATIONS
comparative study of social transformations

NOTES ON THE SOCIOLOGY
OF MEDICAL DISCOURSE:
THE LANGUAGE OF CASE PRESENTATION

RENEE R. ANSPACH

NOTES ON THE SOCIOLOGY OF MEDICAL DISCOURSE:

THE LANGUAGE OF CASE PRESENTATION
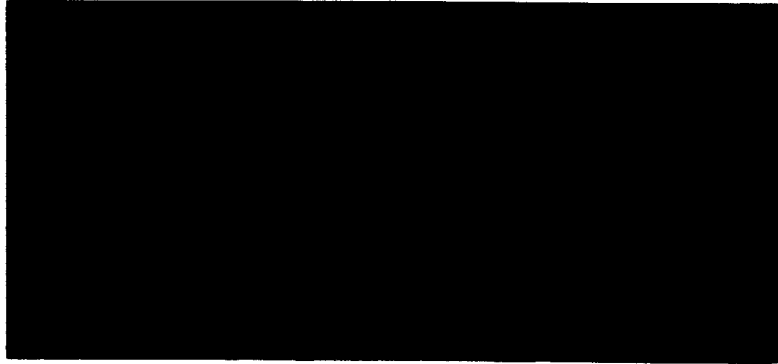
Renee R. Anspach
Department of Sociology
University of Michigan
Ann Arbor, MI 48109-1382

ABSTRACT

This paper examines a segment of medical social life that has not been well studied: formal presentations of case histories by interns, residents, and fellows. Because they are presented by physicians in training to their status superiors who are evaluating them, case presentations are exercises in self presentation which serve as a vehicle for professional socialization. This analysis of the language of case presentation is based on case presentations collected in two intensive care nurseries and an obstetrics and gynecology service. Four features of case presentation are identified: 1) the separation of biological processes from the person (depersonalization); 2) omission of the agent (e.g., use of the passive voice,); 3) treating medical technology as the agent; and 4) account markers, such as "states", "reports", and "denies", which emphasize the subjectivity of patient accounts.

The language of case presentation has signficant if unintended consequences for those who use it. First, some features of case presentation eliminate the element of judgment from medical decisions and mitigate responsibility for medical decision-making. Second, some are rhetorical devices which enhance the credibility of the findings that are presented. Third, the language of case presentation minimizes the import of the patient's history and subjective experience. Finally, case histories socialize those who present them to a culture or world view, which may contradict the explict tenets of medical education.

This paper examines a significant segment of medical social life: formal presentations of case histories by medical students, interns, and residents. Despite the fact that physicians-in-training spend much of their time presenting cases to their superiors (Mizrahi, 1984), little is known about the social and cultural significance of the case presentation[1]. The ostensible purpose of the case history is quite simple: imparting information about patients to peers, superiors, and consultants. However, basing my analysis on case presentations collected in two intensive care nurseries and an obstetrics and gynecology service, I argue that the case presentation does much more than that. It is an arena in which claims to knowledge are made and epistemological assumptions are displayed, a linguistic ritual in which physicians learn and enact fundamental beliefs and values of the medical world. By analyzing the language of this deceptively simple speech event, much can be learned about contemporary medical culture.

APPROACHES TO MEDICAL LANGUAGE

This analysis of case presentations combines the concerns of two traditions in medical sociology: the study of medical discourse and the study of professional socialization. I will briefly summarize the major findings of each approach in order to discuss how this analysis is informed by their concerns.

Over the past ten years, an extensive literature on doctor-patient interaction has emerged. This literature builds upon the findings of studies which suggest that practitioners restrict the flow of information to patients, often withholding critical facts about their diagnosis and treatment (Davis, 1963; Glaser and Strauss, 1965; Lipton and Svarstad, 1977; Korsch, et al, 1968; Korsch and Negrete, 1972; Waitzkin, 1985). Recently, more systematic and detailed studies, often informed by conversation analysis and discourse analysis, have emphasized the following issues. First, the medical interview is a socially structured speech exchange system, organized hierarchically into phases (Drass, 1983) and sequentially into provider-initiated questions, patient responses and an optional comment by the physician (Fisher, 1979; West, 1983; Mishler, 1985).

---

1 A notable exception is Arluke's (1980) discussion of the social control functions of roundsmanship.

Second, the interaction between patients and providers is asymmetrical (see Fisher, 1985).
Doctors control the medical interview tightly by initiating the topics of conversation (Fisher,
1979;), asking the questions (West, 1983), limiting patients' questions, and often deflecting
patients' concerns (Beckman and Frankel, 1984; Frankel, forthcoming; West, 1983). Third,
medical interaction is shaped by the context in which it takes place: cultural assumptions of
providers and patients, the logic of differential diagnosis, and the demands of bureaucratic
organizations combine to constrain doctor-patient communication (Cicourel, 1981; Drass, 1983;
Fisher, 1985). Finally, by subordinating the patient's concerns, beliefs, and life world to the
demands of medical discourse (Cicourel, 1983; Beckman and Frankel, 1984; Mishler, 1985), the
medical interview may become a form of repressive communication which seriously compromises
the quality of patient care.

This very extensive literature on medical discourse contains a significant omission. While
much has been written concerning how doctors talk to patients, very little has been written about
how doctors talk about patients. (Notable exceptions are studies of the written case record by
Cicourel (1983) and Beckman and Frankel 1984). This analytic focus on the medical interview
occurs despite the fact that the way in which physicians talk about patients is a potentially
valuable source of information about medical culture. Rarely do doctors directly reveal their
assumptions about patients when talking to them; it is in talking and writing to other doctors
about patients that cultural assumptions, beliefs, and values are more directly displayed. A
consequence of this omission is that, with few exceptions, much information about medical culture
is inferred indirectly or introduced into discussions of medical discourse in an ad hoc fashion.

By contrast, how doctors talk to each other, particularly about patients, is ananalytic focus of
the second medical sociological tradition: studies of professional socialization. This largely
ethnographic literature uses medical language, particularly slang, as a key to understanding the
subculture that develops among medical students and residents as a response to problems created
by their work environment (Becker et al, 1961; Coombs and Goldman, 1973; Mizrahi, 1987). This
unofficial,subterranean culture that flourishes among physicians in training includes a rich and

graphic slang which contains: reference to uninteresting work as "scut" (Becker, et al, 1961); employing "gallows humor" in the face of tragedy (Coombs and Goldman, 1973); and the use of highly pejorative terms to characterize those patients having low social worth (Sudnow, 1967), those with chronic or supposedly self-inflicted illness, those presenting complaints with a suspected psychogenic etiology, or those with dimished mental capacity, who are termed, respectively "gomers", "turkeys", "crocks", "gorks", or "brain stem preparations" (Becker, et al, 1961; Leiderman and Grisso, 1985; Mizrahi, 1984). Ethnographers of medical socialization have been fascinated by this typing of patients, since it flies in the face of the ostensible aim of medical training: to impart humanitarian values or a service orientation (Parsons, 1951). How sociologists assess the ultimate significance of this slang depends partly on their theoretical orientation--that is, whether medical training is seen as partly successful in instilling a collectivity orientation, as it is by functionalists (e.g., Fox, 1957; Bosk, 1979); or whether, alternatively, medical training entails a suspension or relinquishment of idealism, as conflict theorists contend (see, for example, Becker, et al, 1961; Light, 1980; Mizrahi, 1985). A more sanguine view holds that these terms are healthy psychosocial mechanisms designed to cope with the limits of medical knowledge or incurable illness which frustrates the active meliorism of the physician (e.g., Leiderman and Grisso, 1985). According to this view, medical slang need not represent a loss of humanitarian values, but may even be beneficial in developing "detached concern." (Fox and Lief, 1963; Fox, 1979). From a more critical perspective, medical slang displays a blunted capacity to care and a deeply dehumanizing orientation to patients which blames them for their illness, views them as potential learning material, and jeopardizes their care (Mizrahi, 1984; Scully,1980; Millman, 1977; Schwartz, 1987). These ethnographies of socialization, despite their sometimes differing conclusions, treat medical slang as a cultural artifact and analyze its deeper social and cultural significance.

While addressing the cultural meaning of medical language, studies of professional socialization are limited by their exclusive reliance upon ethnographic methods. Medical slang is often presented out of context and divorced from the actual occasions in which it is used and

applied. Moreover, these studies have been confined to slang words and humor, often glaring violations of the service ethic which are readily apparent to the field worker. Rarely do ethnographers address the more subtle assumptions embedded in routine talk of physicians. For these reasons, the ethnography of professional socialization would be enhanced by the more detailed approach of disourse analysis.

The present analysis of case presentations is informed by both approaches to medical language. As a study of medical discourse, it attempts a detailed analysis of language as it is actually used. Like ethnographers of professional socialization, I emphasize the cultural significance of this language. The approach used here might be termed "symbolic sociolinguistics". The emphasis is less on the social structure of the case presentation (the hierarchical and sequential organization of speech exchange), and more on the symbolic content of language. I attempt an interpretive analysis of the connotative, cultural meanings of the language of case presentation--meanings which are taken for granted and may not always be readily apparent to those who use it.

Learning to present a case history is an important part of the training of medical students, interns, and residents. Because case histories are presented by subordinates before their superiors, sometimes in front of large audiences, presenting a case skillfully assumes considerable importance in the eyes of physicians in training. The case presentation, then, is a speech event which serves both to impart information and as a vehicle for professional socialization, and herein lies its sociological import. As I will suggest, case presentations, as highly conventionalized linguistic rituals, employ a stylized vocabulary and syntax, which reveals tacit and subtle assumptions, beliefs and values concerning patients, medical knowledge, and medical practice to which physicians in training are covertly socialized. The case presentation, then, provides an opportunity to study an important aspect of professional socialization and is a window to the medical world view.

METHODS

This analysis of case presentations is based on data collected in three settings. I first observed case presentations as part of a 16-month field study of life-and-death decisions in two newborn intensive care units. Twelve months were spent in the 20-bed intensive care nursery of Randolph Hospital (pseud.), which serves as a referral center for a region which spans fully half the state. Owing to the diverse nature of this region, the clientele was heterogeneous from a demographic and socioeconomic standpoint. Because Randolph Hospital is an elite institution, part of a major medical school, competition for its pediatric residency program is rather intense. Four months of field work were also undertaken in the 40-50 bed nursery of the hospital I call General, an acute care hospital for the indigent having a largely Hispanic clientele. Although both Randolph and General are teaching hospitals, closely affiliated with major medical schools, the settings contrast sharply with respect to their size, relative prestige, and the demographic composition of their patient populations. In both settings, my observations focused on the pediatric interns and residents and the neonatology fellows who rotated through the nursery and presented cases to attending neonatologists.

In order to compare case presentations in neonatal intensive care to presentations concerning adult patients, I then conducted three months of field work in the obstetrical and gynecology department the hospital I call Bennett, a teaching hospital having a demographically and socioeconomically heterogeneous clientele. About 300 infants are delivered each month in the inpatient obstetrics and gynecology ward, which accommodates about 90 obstetrics and 20 gynecology patients. Interns and residents complete rotations in labor and delivery, the gynecology clinic, gynecological oncology, and an affiliated hospital. I observed cases presented by the eight residents and three interns to full-time attending physicians, perinatologists, and part-time clinical faculty.

In all three settings, participant observation and interviews provided information about the daily life and organizational context of case presentations. I also conducted informant interviews with residents in Bennett Hospital concerning strategies of presenting cases. However, the major

method of data collection was non-participant observation of a total of 50 cases presented by interns, residents, and fellows in daily rounds, consultations, formal conferences, and Morbidity and Mortality conferences. In Bennett Hospital, my observations focussed primarily on formal presentations in weekly "statistical conferences" and the very formal didactic presentations at breakfast conferences. A total of 15 case presentations were tape recorded, nine from obstetrics, six from neonatology; the others were transcribed in short hand, and attempts were made to approximate a verbatim transcript. In addition, nine written histories in hand-outs and patients' case records were examined. I also obtained and examined 200 admitting, operative, and discharge summaries from Bennett Hospital, and subjected a random sample of 100 to detailed analysis. These field notes, transcripts, and written summaries were coded and content analyzed to reveal the features of case presentations that will be discussed. In order to provide a comparative framework, I analyzed a total of 14 journalistic medical articles, from Time and Newsweek from September, 1987 through February, 1988. These journalistic accounts, selected because they were comparable in content to case presentations, make it possible to determine whether the features of case presentations that will be discussed are also used in other occupations.

THE CASE PRESENTATION AS A SPEECH EVENT

Occasions

Over the course of his or her career, virtually every resident must present a formal case history. In fact, so important is case presentation to the work routine of housestaff, that one researcher notes that "interns spend most of their time keeping charts and presenting cases to senior staff" (Mizrahi, 1984: 243). Formal case histories are presented on certain occasions which include: 1) formal conferences (e.g. mortality review, chief of services rounds, statistical rounds, and didactic conferences); 2) daily rounds, when a new patient is admitted to the nursery or when a new attending physician takes charge of the nursery; 3) occasions when a specialist is consulted; 4) written summaries distributed in conferences; and 5) at certain points in the case record (e.g., on-service notes, off-service notes, when residents begin and end rotations, and admission, operative, and discharge summaries). Case presentations vary on a continuum of formality,

ranging from relatively informal presentations on daily rounds to formal presentations in large conferences, attended by the senior staff of a department. Although fellows , who are between residents and faculty in the medical hierarchy, occasionally present cases, as a general rule, they are presented by the intern or resident assigned to the particular case.

Format

Although the specific features of the history vary according to the purpose of the occasion, the case history, whether presented in written or verbal form, tends to follow an almost ritualized format, characterized by the frequent use of certain words, phrases, and syntactic forms and a characteristic organization. Histories presented in rounds generally begin with a sentence introducing the patient and the presenting problem. This is followed by a history of the patient's problem and its management, followed by a list and summary of the present problems in each organ system, presented in order of importance. Because social aspects of the case are always presented only after medical problems have been discussed, if at all, the semantic structure of the case presentation attests to the relatively low priority accorded to social issues in the reward structure of residency programs (Frader and Bosk, 1981).

Evaluation

Case presentations provide attendings (faculty) with an opportunity to evaluate house officers' competency--their mastery of the details of the case, clinical judgment, medical management, and conscientiousness. Interns and residents are aware that case presentations are a significant component of the evaluation process, and for this reason, presenting skills are part of that elusive quality called "roundsmanship" (sic.) (for a detailed discussion of roundsmanship, see Arluke, 1978). As one resident noted, when asked about the importance of presentations:

> Competency or surgical skills carry some weight (in attendings' evaluations); the ability to get along with team members carries even more weight; and the most important is the case presentation.

Although the salience of this evaluative component varies according to the occasion, this evaluative element is a background feature of most case presentations. Even the written case record serves as an informal social control mechanism, which provides physicians the opportunity

to evaluate their colleagues (Mizrahi, 1984)--to say nothing of opening the door to community scrutiny in the case of malpractice suits. At the Bennett Obstetrical and Gynecology Service, the evaluative element looms large, particularly in the weekly statistical conferences, in which residents present cases before 15 or 20 senior staff.

At any point, attendings can interrupt the resident's presentation to ask questions about the details about the particular case, its clinical management, or general issues of pathophysiology or medical/surgical techniques. Attendings employ a version of the Socratic method, in which the first question invites further questions, until a "correct" answer is received and no further questions are deemed necessary. As Bosk notes, this questioning process follows Sacks' chain rule for question-answer sequences in which the floor belongs to the questioner (Bosk, 1979: 95), and, once the process has begun, the presenter has lost control of the interaction. Any omission of details relevant to the case (e.g., laboratory values), oversights, or displays of ignorance on the part of the resident are occasions for this questioning process to begin:

> During a presentation, a Bennett resident was discussing tocalyzing a preterm labor (administering a drug for the purpose of stopping uterine contractions). An attending asked, "How much ritadine was given?" The resident replied, "Per protocol". The resident, in referring to the nurses' protocol, had displayed his ignorance of the details of the case and implied that he left the details of case management to the nurses. The attending, detecting this thinly-disguised ignorance, then asked, "Well, exactly how _many_ miliequivalents were given?", forcing the resident to respond that he didn't know, thereby admitting his ignorance.

Attendings' questions, then, are questions in the second sense of the word, designed to call a resident's competency into question rather than to request information. Residents refer to this questioning process as "pimping" and distinguish between "benign pimping" (helpful and constructive questions, usually by the senior resident) and "malignant pimping" (questioning, usually on the part of the attending, for the purpose of humiliating a resident). Residents are aware that once a resident falters in rounds, s/he will be suspected of incompetence and targeted for future questioning:

> Take Melvin, for instance. He really wasn't so dumb but he got raked over the coals all the time because he just didn't know how to present cases well so that it really sounded like he really knew what he was talking about. They go for the jugular. They'll pick on someone that they don't think knows what's going on, and

they they get labelled and then picked on, and, once labelled that's pretty much it--unless they invent the Salk vaccine or something.

Case Presentation As Self Presentation

Because of this evaluative element, as Arluke (1978) also notes, case presentations become self presentations. Beginning in medical school and throughout their training, physicians develop a set of skills and strategies, designed to display competence and avoid questions from the attendings. Among the most basic of these skills are "dressing professionally" and mastering "the correct medical terminology" and the semantic organization of the case presentation. One of the "rules" by which a successful presentation is judged appears to be: "be concise", and "be relevant"--i.e., a history should contain all and only those points deemed to be important, with a minimum of wasted verbeage. Interns were instructed by senior residents in the nursery to omit a detailed chronology of the history and to move from detailed account of the delivery, resuscitation, and the infant's first few hours of life to an ennumeration of the patient's problems in relevant organ systems--that is, to present an analytic summary rather than a chronological account.

More senior residents attend to the issue of a confident style. One resident, when asked about presentation strategies, emphasized the importance of a smooth presentation, avoiding the pauses and hesitations which would display uncertainty and provide a conversational slot for questions from the attendings:

> Roundsmanship is salesmanship. You gotta put on an air so that you will convince the attendings that you know about the case, and that you're smarter than they are. You've gotta display an air of confidence. (How do you do that?) You show confidence by the way you talk. (How do you talk?). You don't stop between sentences, you don't hesitate. They don't wnat to see you flipping through the chart. If you make a mistake in the hemoglobin value, don't say it was a mistake....If you have to say 'I don't know', don't apologize for it, or say it unconfidently. You can say, 'I don't know', but it has to be done in the right way, like nobody else would know either, not like you should've known. Just keep up the flow so you don't get interrupted.

Errors of all kinds are occasions for intense questions by the attendings, and as Arluke (1978) also notes, skillful presenters employ strategies which anticipate and deftly deflect these questions. In the case of minor errors, these include "covering" to avoid displays of ignorance, presenting justifications for choosing a questionable course of action, and excusing or mitigating

responsibility by blaming another department or a physician in the community. (In fact, cases involving errors by outside physicians are frequently selected for presentation):

If the attending asks you, 'What is the hemoglobin?', don't say, 'I don't remember'. That's the worst thing you can say--it's blood in the water. If you know it's normal, but you can't remember the value, give a normal value....You have to anticipate the questions. If you are asked, 'Why wasn't that done?', you can say, 'We considered that, but...' For instance, in the case of an elective caesarian hysterectomy (a controversial procedure), where blood was transfused, you can anticipate you'll be asked about the caesarian hysterectomy and about the blood transfusions, and you're likely to get raked over the coals. So you bring it up by deflecting or defusing the attending's questions. You say, 'This patient received three units of blood. We felt the hematological indices didn't warrant transfusions, but anesthesiology disagreed. This way the attending will get sidetracked (because a discussion of another department's competency would ensue).

Attempts to cover up a major error in medical management, however, represent instances of what Bosk (1979) calls "normative errors", likely to arouse suspicions about the presenter's moral character. Even in such cases, residents, much like the attendings discussed by Bosk, are able to transform a mistake into a moral virtue by a candid admission:

> If the case of the little stuff, you can blame the mistake on someone else, and, if not you can try to cover it up. If you overlook the little details, you can get away with it, as long as it is confidently presented. If it's a major mistake, the worst thing is to cover it up--that's the worst thing you can do. If you're caught trying to cover up, then they'll look upon you as someone who will cover up the next time, and it will follow you around. The way you treat a major mistake can transform you from a villain to a hero by simply stating, 'In retrospect, we wish we had done it this way.' Then you're a hero--you've showed you've learned from your mistake. They'll admire you and everyone will become your champion. You'll get questioned far less and you won't get pimped by the other attendings. They'll say, 'that's OK, it happens to all of us.'

This discussion is intended to convey the climate surrounding the case presentation: the importance case presentations assume in the training of residents; the extent to which case presentations contain an evaluative element; and the fact that case presentations are simultaneously self presentations. Case presentations, then, are rituals for the display of

credibility--a background issue that informs some of the linguistic practices which will be discussed in the following section.

<u>FEATURES OF CASE PRESENTATIONS</u>

In the highly interpretive analysis of case presentations that follows, I will focus on epistemological assumptions and rhetorical features by which claims to knowledge are made and conveyed. I will emphasize four aspects of case presentations, which I have called: 1) the separation of biological processes from the person (de-personalization); 2) omission of the agent (e.g., use of the passive voice); 3) treating medical technology as the agent; and 4) account markers, such as "states", "reports", and "denies", which emphasize the subjectivity of the patient's accounts. Table 1 presents the frequencies with which these features were used in the larger corpus of materials. These features of case presentations are variable, but, as the table suggests, some are employed so frequently as to be considered conventions of the language of case presentation. While it would be useful to compare the frequency with which these features are used in case presentations to the frequency with which they are used in ordinary speech, unfortunately no study of the use of these features in the vernacular exists. However, as the table shows, most of these features are found more frequently in ordinary speech than they are in a study of the passive voice in English novels (Estival and Myhill, 19) and in journalism, in which the author's goal is to create a heightened sense of agency.

Table 1 about here

At the conclusion of this paper, I have presented segments of five case histories. These case presentations were selected according to two criteria: the frequency with which the features of case presentation are used, and the extent to which they represent oral and written presentations in neonatology and obstetrics. The first is a summary, written by a neonatology fellow for the Morbidity and Mortality Conference which followed the death of Robin Simpson, an

infant with serious chronic lung disease of unknown etiology, who died rather unexpectedly. The next two are the initial portions of tape recorded transcripts of histories in two ethics conferences concerning an infant who had a very unusual brain lesion (Roberta Zapata). One was presented by a fellow and the other by a resident approximately six weeks later. The fourth is an excerpt from a presentation in "statistical rounds" by a resident in obstetrics and gynecology. This case, which concerns a woman with cervical cancer, involved serious medical mismanagement by an outside community physician. The final case is the history portion of the written admission summary presented by a resident concerning a patient admitted for obsetrical care. A detailed analysis of these case presentations provides the basis for the discussion of the four features of medical language that follows.

De-personalization

The case history presented in the Morbidity and Mortality Conference which followed Robin Simpson's death begins with the statement: "Baby Girl Simpson was the 1044-gram product of a 27 week gestation". Outside observers of medical settings have commented that physicians sometimes employ an impersonal vocabulary when referring to their patients (Lakoff, 1975:65; Emerson, 1970:73-100). A clear example of this phenomenon is reference to patients in case presentations. Robin Simpson is identified as a member of a class of baby girls having a particular weight and gestational age. A typical introduction in obsetrics is presented on line 66, "The patient is a 21 year old Gravida III, Para I, AbI black female at 32 weeks gestation." This introduction lists the patient's age, previous pregnancies, live births, and abortions, her race and weeks of pregnancy. Throughout the presentations, neonatology patients are identified as "the infant" or "the baby" (lines 4, 23, 25, 35), or "s/he" (lines 6-10, 13, 15). (Note that the second presenter is mistaken about Roberta's gender). Obstetrics and gynecology patients are identified as "the patient" (38, 60, 66, 69, 81) or "she" (45, 46, 47, 67, 69, 71, 72, 74, 77, 79). These references invite the audience to see infants or patients, rather than individuals; except for in the written summary, never are patients referred to by their proper names.2 I will not comment in

---

2 Unlike in psychiatry, this omission of names is not intended to protect the confidentiality of the patient, whose name is noted in the written summary.

detail about this phenomenon of no-naming (for a discussion of this issue, see Frader and Bosk,

1981). Nor will I comment extensively on what, from an outsider's perspective, may appear to be

the rather impersonal and mechanistic connotative imagery of "expiration date" and "product".

When I speak of de-personalization, I am referring not merely to the use of an impersonal

vocabulary, but rather to a more subtle set of assumptions. For to refer to a baby as a "product"

of a "gestation", seems to emphasize that it is the gestation, a biological process, rather than the

parents, who have produced the baby. Similar formulations are found in all three histories, for

example: "the pregnancy was complicated by..."(1), "SROM (spontaneous rupture of membranes)

occurred"(2), "the bruit (murmur) has decreased significantly..." (16), "the vagina and the cervix

were noted to be clear,"" the cervix was described..." (51), each of these inviting the question "to

whom?" or "whose?" These formulations draw attention to the subject of the sentence: a disease

or organ, rather than to the patient. Of course, the physicians know that the parents have babies

and that persons become ill, but the use of this language seems to suggest that biological processes

can be separated from the persons who experience them. The language I have just described is not

confined to physicians, for in ordinary language we speak of a person "having a disease", thereby

separating the disease from the subject, and this may reflect deeply rooted cultural conceptions of

the duality between mind and body. The most egregious examples of de-personalization occur in

the everyday talk of physicians (and also nurses), when they refer to patients as "the + disease"

(e.g., "the trisomy in room 311"). On surgical wards, and, less frequently in the intensive care

nursery, practitioners sometimes refer to patients as "the + procedure", (e.g., "the tonsilectomy in

214"). Whether or not these forms of de-personalization may impel practitioners to adopt certain

attitudes toward their patients may be debated. However, by using these designations,

practitioners leave themselves open to the criticism made by many consumers: that doctors "treat

diseases rather than patients."

Omission of the agent (e.g., use of the passive voice)

Case presentations not only fail to mention the patient's personal identity, but they also omit

the physician, nurses, or other medical agents who perform procedures or make observations, as

Table 1 suggests. A common example of a form that omits the agent is the "existential" , "there was no mention of bleeding pattern..." (41).

The canonical form which omits the agent is the "agentless passive". The presenters frequently use the agentless passive voice and they do this in two contexts. First, they use the passive voice when reporting on treatments and procedures, for example: "The infant was transferred..." (4), "she was treated with high FiO2's (respirator settings) ..."(6), "she was extubated" (taken off the respirator) (7), "he was transferred here" (13), and "was put on phenobarb"(30), "the patient was admitted to...the hospital" (54), and "was referred to the _____ Cancer Center"(61). In this case the presenters are not omitting reference to the patient on whom the procedures were done, but rather omitting the persons who performed the procedures. This has the effect of emphasizing what was done rather than who did the procedure or why a decision was made to engage in a given course of action.

This becomes particularly significant when the decisions are controversial, problematic, or questionable. For example, in two sentences in the summary concerning Robin Simpson, the use of the passive voice obscures the fact that the actions that were performed resulted from rather problematic and highly significant decisions (and in venturing this interpretation, I am going outside the text to interviews and discussions that I observed). For example, "she was extubated" (7) refers to a life-and-death decision, discussed later in the same conference, in which Robin Simpson was weaned from the respirator and was expected to die. Consider, also, the statement "No betamethasone was given" (3). Betamethasone is a steroid administered in several large university centers to mothers undergoing prematurely ruptured membranes for the purpose of maturing the baby's lungs. In a subsequent interview a resident who had been present when Robin Simpson was admitted to the Randolph nursery suggested that the failure of physicians at St. Mary's, a small community hospital, to administer betamethasone, may have contributed to the severity of Robin's illness. Since betamethasone is commonly given in the Randolph nursery, I am assuming that the fellow alludes to the failure to give betamethasone in an effort to make sense of Robin's illness, and that other participants in the conference understand this implication.

It is, of course, impossible to discern the fellow's intention in using the passive voice. However, it seems to me that by divorcing the action from the person who performed the action, the passive voice has the effect of muting an allusion to an unfortunate decision about medical management. (Compare this with "The doctors at St. Mary's did not give betamethasone"). The fourth case concerns a serious error in medical management on the part of a community physician, a type of case frequently chosen for presentation in rounds. A woman had come to her gynecologist complaining of vaginal bleeding. The physician, noting the enlarged uterus, simply assumed that the patient had fibroid tumors and scheduled her for a total hysterectomy. The gynecologist failed to perform a pap smear during the examination, and, therefore, he did not know that, in addition to fibroids, the patient also had cervical cancer. Consequently, the physician inadvertently cut into the tumor during surgery, which may have seriously compromised the patient's prognosis. As the resident, when interviewed afterword, confirmed, the case was chosen to deflect attendings' questions by emphasizing the error of an outside doctor, while at the same time symbolically affirming superior management at the teaching hospital and the ability of the resident to learn from the error. The presentation is constructed as a morality play, a drama beginning with allusions to the errors (40, 52), the denouement in which revelations from the pathology report are disclosed (58), and the moral lesson at the end (62). Note the resident's language to describe the errors: "No further details were noted in the history" (40) and "No pap smear was performed at the time of this initial visit" (52). By placing the negative at the beginning of the sentence, the resident draws the listener's attention to the errors. Although it is clearly understood that the error was committed by an outside doctor, the passive voice softens the accusation by leaving this implicit and deflecting attention from the perpretrator. (Compare this to the active voice in ordinary conversation, "The doctor didn't perform a pap smear"--a formulation, which, according to the resident in describing the case to me, "would not have been subtle.")

There is yet another context in which the fellow and residents use the agentless passive voice, and that is when they refer to observations and make claims to knowledge:, e.g., "both babies were noted to have respiratory problems on examination" (10), "the baby was noted to have

congestive heart failure"(23), "she was found on physical exam ..."(47); and "the vagina and the cervix were noted to be clear" (50). The use of the passive voice is an extremely common, though not invariant feature of medical discourse, and when one compares this use of the passive voice with its alternative ("they noted that the baby had temporal bruits"), I believe that something can be learned about the epistemological assumptions of the case presentation. For to delete mention of the person who made the observation seems to suggest that the observer is irrelevant to what is being observed or "noted", or that anyone would have "noted" the same "thing". In other words, using the passive voice while omitting the observer seems to imbue what is being observed with an unequivocal, authoritative factual status.

Technology as Agent

Physicians do occasionally use the active voice. For example, in the second, third and fourth case histories, the fellow and the residents make the following statements:

"Ausculation of the head revealed a very large bruit, and angiography showed a very large arterio-venous malformation in the head..." (11,12)

"follow-up CT-scans have showed the amount of blood flow to be very minimal"(17)

"the arteriogram showed that this AVM was fed...(26, 27)

"the e.e.g. showed...an abnormal..."(31)

"The path report revealed endometrial curretings..."(56)

These formulations seem to carry the process of objectification one step further than the use of the passive voice, for not only do the physicians fail to mention the person or persons who have performed the diagnostic procedures, but, they also omit mention of the often complex processes by which angiograms and CT-scans are interpreted. Moreover, these forms actually treat medical technology as though it were the agent. (Again compare these claims with others which seem somewhat less objectified: "Dr.   evaluated...",13, "they...did an EMI scan (CT-scan)",25.) Moreover, using the terms "revealed", and "showed", seems to suggest that the information obtained by using the stethoscope, angiogram, or brain scan, was obtained by a process of scientific revelation, rather than equivocal interpretation. Having had the opportunity to observe radiology rounds, I was impressed by the considerable amount of negotiation and debate

which takes place as the participants come to "see" evidence of lesions on X-rays. While physicians undoubtedly would acknowledge that this interpretation does indeed take place, they tend to attribute varying interpretations to the vagaries of "observer error" or "opinion", rather than viewing the process of interpretation as an intrinsic feature of the way in which data obtained via measurement instruments are produced. The use of such formulations as "auscultation revealed" or "angiography showed" supports a view of knowledge in which instruments, rather than people, create the "data".

<u>Account markers</u>

If physicians imbue the physical examination and diagnostic technology with unquestioned objectivity, they treat the patients' reports with an ethnomethodological skepticism--that is, as subjective accounts with tenuous links to reality. When presenting a clinical history obtained from a patient, the physician has two choices. One is to present events and symptoms reported by the patient as facts, as physical findings and laboratory results are presented. This is occasionally done, as it in the last clinical history: "she takes prenatal vitamins daily" (79) , "the patient has a male child with sickle cell trait"(81), and "she has had no surgeries (74)." Alternatively, and more commonly, the history is treated as a subjective narrative, consisting of statements and reports. For example,the patient "reports" she was seen in the emergency room," (70), "states" that she has been having uterine contractions (67), that there is fetal movement (7), and that she has a history of sickle cell trait (72). "States" and "reports" are markers which signal that we have left the realm of fact and entered the realm of the subjective account. (Note that this information is attributed to the patient, which implies that the physician's knowledge has been obtained via hearsay (Prince, Frader, and Bosk, 1982:91)).

Another frequently used account marker, "denies", actually calls the patient's account into question or casts doubt on the validity of the history. While it is sometimes used whenever the patient provides a negative answer to the physician's question,"denies" is used most frequently in three contexts. First, it is almost always used in the context of deviant habits likely to compromise the health of the patient or the unborn child, e.g., "She denies tobacco, alcohol, coffee,

or tea" (78-79). (Compare this with the alternative, "She does not use tobacco, alcohol, etc..."). In this case, "denies" suggests that the patient may not be telling the truth or may be concealing deviant behavior, and casts doubt on the patient's credibility as a historian. Second, "denies" is used frequently in connection with allergies, as on line 75: "She denies any allergies." Another frequently used phrase is, "She has no known allergies." In this case, I suspect that "denies" has a self-protective function, however unintentional. In the event that the patient were to have an allergic reaction to a drug administered during treatment, the responsibility would rest with the patient's faulty account, rather than with the physician. "Denies" is used in one other context: when a patient reports a symptom which usually belongs to a larger constellation of symptoms, but does not report the others s/he would be likely to have, e.g., "She denies any dysuria, frequency or urgency."(77)

Physicians "note", "observe", or "find" ; patients "state", "report", "claim", "complain of", "admit" or "deny". The first verbs connote objective reality--i.e., only concrete entities can be noted or observed; the second verbs connote subjective perceptions. As Table 2 suggests, physicians are inclined to present information obtained from the physician as though it were factual, while treating information obtained from the patient as accounts.

Table 2 about here

It is significant that medical training teaches physicians to distinguish between subjective symptoms, apparent only to the patient, and objective signs, apparent to the expert. Moreover, according to the Weed (SOAP) System for recording progress notes, any medical information provided by the patient should be classified as "subjective", while observations by the physician or laboratory studies should be classified as "objective".

The one exception to this rule is the rare occasion in which the presenter calls another physician's account into question. This is precisely what happens in the fourth case history, which

is structured around mismanagement by the community doctor who failed to perform the pap smear. The resident explicitly emphasizes the rather cursory history taken by the community gynecologist, which does not include several pertinent facts:

> No further details were noted in the history. There was no mention of bleeding pattern, frequency duration, female dyspareunia (pain on intercourse), or dysmenorrhea or coital bleeding....In the family history that that was obtained, her mother was deceased of gastric carcinoma at age 64.(lines 40-45)

Since a major theme of this history is the physician's cursory examination, which did not include a pap smear, it is not surprising that the resident uses an account marker when relating the physician's physical findings: "The vagina and cervix were noted to be clear, and the cervix was described as "closed." The account marker, "described" has the effect of casting doubt on the accuracy of the physician's observations or report and is in keeping with the overall emphasis on a lack of thoroughness. It is significant that in the handwritten notes that the resident used in this history and gave to me, the phrase, "the cervix was noted to be closed" was crossed out and replaced by "described as". As is the case when used with patients, account markers call attention to the subjective nature of the narrative.

SO WHAT?...SOCIAL CONSEQUENCES OF THE LANGUAGE OF CASE PRESENTATION

Before discussing the implications of the language of case presentation, some caveats should be mentioned. In venturing into the realm of connotative meaning, I am aware that I am treading on perilous ground. For the interpretations I have presented are my interpretations of the language of case presentation. Many other alternative interpretations can be made and I will briefly mention two of them. First, some might suggest that the features of case histories are "merely" instances of "co-occurrence phenomena". Sociolinguists have observed that certain words and phrases tend to "go together", and tend to be used in certain social situations. Thus formulations such as "this patient is the product of a gestation" and "auscultation revealed..." are parts of a style within an "occupational register". When presenting a case history, the resident may simply slip into this style rather automatically. To be sure, the practices I have just discussed represent instances of linguistic co-occurence, and may be used without regard for whatever deeper meanings the observer may attribute to them. But I am asking a very different

set of questions: namely what assumptions seem to be embodied in this style, what are the possible sociological consequences of this particular form of co-occurrence? To be sure, the welfare administrator who writes a memo might automatically slip into "bureaucratese", but what does this occupational register tell us about the assumptive world of the bureaucrat?

Secondly, my interpretation of the language of case presentation is an "outsider's interpretation". When questioned about their use of the formulations I have discussed, some physicians agreed with my interpretations, while others responded that this style within what linguists call an "occupational register" exists merely for the purpose of imparting information as briefly and concisely as is possible (for a discussion of this issue, see Ervin-Tripp, 1971). However, the characteristic formulations of case presentations may not always be the most parsimonious ones. (Compare "the baby was noted to have congestive heart failure" on line 25, with "they noted that the baby had temporal bruits" on line 26--an equally succinct formulation). Although brevity is an important emphasis in resident culture, the fact that the residents and fellows sometimes use alternative, and equally brief formulations suggests that more may be at issue in the use of the language of case presentation than the requirement for the brief transmission of information. Moreover, to claim that linguistic forms exist merely for the transmission of information is to subscribe to a rather narrow view of language. Ordinary language philosophers argue that words not only transmit information, but accomplish actions and produce certain effects on those who hear them. Although transmitting information is clearly a manifest function of case presentations, the discursive practices I have described may have other consequences which are less obvious:

Mitigation of Responsibility

Sociolinguists who have discussed the passive voice note that it is a responsibility mitigating device. The discursive practices I have identified in the previous section minimize responsibility in two ways. First, by suggesting that the observer is irrelevant to what is "observed", "noted", or "found", using the passive voice minimizes the physician's role in producing findings or observations. A similar point can be made about third practice

("auscultation revealed..."), which locates responsibility for producing the data in diagnostic technology rather than the physician's observations and interpretations.

Secondly, the passive voice minimizes the physician's role in medical decision-making. When used in reporting on treatments and procedures, the passive voice calls attention to the action and deflects attention from the actors or the decisions which led to the action. This becomes particularly significant when the passive voice is used to report problematic decisions, such as life-and-death decisions, obscuring both the decision makers and the controversy surrounding those decisions. Even on those occasions when they call attention to mistakes in medical management or clinical judgment, by using the passive voice, physicians blunt the accusation by emphasizing the error rather than the perpetrator. In short, by eliminating both the actor and the element of judgment from medical decision-making, the passive voice places physicians, their knowledge, and their decisions beyond the pale of linguistic scrutiny.

One might ask whether these practices arise out of a structural imperative in the medical profession to protect itself from scrutiny. This is precisely what the professional dominance perspective would suggest (Freidson, 1970). For example, Millman's (1977) study of Mortality Review in three community hospitals depicts these conferences as rituals designed to neutralize medical mistakes. Writing from a neo-functionalist perspective, Bosk (1979) takes a different view of Mortality Review in a university-based teaching hospital. According to Bosk, attendings do acknowledge their mistakes, but turn their contrite admissions into displays of authority. This study provides data from a third context: cases presented by housestaff who are being evaluated by their superiors. Like the physicians described by Millman, these physicians cover and deflect blame from minor errors. Like those described by Bosk, housestaff openly admit major errors--if only to escape moral censure and to benefit from their candor--and they openly discuss mistakes of community doctors--if only to deflect criticism and demonstrate the superior management of teaching hospitals. In each instance, the intent is the same: to protect their credibility from challenge by the attendings. Because it mitigates responsibility for clinical decisions, the passive voice, while perhaps not used intentionally and strategically for this purpose, clearly serves this aim.

Oral presentations are private affairs open only to physicians. In the written case record, however, the ambit of evaluation widens. The case record is not only open to evaluation by other physicians but can potentially become a public record in malpractice suits. Given the salience of malpractice in medical culture, the rise of so-called "defensive medicine", and the demand for documentation and the use of diagnostic technology, a language which treats findings as unproblematic and minimizes the responsibility of physicians for decision-making, has the effect of protecting those who use it from public scrutiny.

Passive Persuasion: the Literary Rhetoric of Medical Discourse

The practices I have just mentioned are by no means the exclusive province of physicians. Quite the contrary--some are commonly found in academic prose. For instance, one need look no farther than the two previous sentences for examples of parallel devices: the presentation of practices apart from the persons who engage in them, and the use of the passive voice (found--by whom?). And, regardless of my intention in using these devices, they do seem to cloak the claims that are made in the garb of objectivity. In an analysis of the academic prose in a well-known paper on alcoholism, Gusfield (1977) suggests that science has a "literary rhetoric". If one accepts this interpretation of academic prose, then it might be possible that medicine, too, has its "literary rhetoric". Some of the devices I have just mentioned have the effect of convincing the listener or reader of the unequivocal "truth" of the "findings". By suggesting that observers are irrelevant to what is observed and that measurement instruments create the data, the language of case presentation approaches rhetoric or the art of persuasion.

Writing from the perspective of ordinary language philosophy, Austin (1975) suggests that every linguistic utterance has three dimensions: a locutionary or referential dimension (it imparts information), an illocutionary dimension (it accomplishes an action) and a perlocutionary dimension (it produces certain effects on the hearer, including convincing and persuading). Some of the practices I have described as part of the language of case presentation may be used by physicians to convince the audience of the credibility of their claims to knowledge, and, hence may belong to

the "perlocutionary" realm (which is another way of saying that there may be a literary rhetoric of medical discourse). For two reasons, I suspect that, at least on certain occasions, the language of case presentation may be used precisely because of its persuasive power. First, case histories are presented by medical students, interns, residents and fellows to status superiors--attending physicians--who are evaluating them. Case presentations, as physicians acknowledge, are self presentations, displays of credibility. By adopting a mode of presentation in which observations and diagnostic findings are endowed with unequivocal certainty, these younger physicians may be exploiting the persuasive power of words at the very moments when they may feel most uncertain. Second, I observed a very interesting instance of "style switching", in which a resident, when criticized by his attending physician for failing to conduct certain diagnostic tests, immediately switched from the active voice into the language of case presentation ("this infant was the...product of a...gestation...was noted", etc.) Case presentations are not only rituals affirming the value of scientific observation and diagnostic technology, but perlocutary acts, affirming the speaker's credibility as well. For this reason, the epistemology of the case presentation serves the social psychology of self presentation.

The Surrender of Subjectivity

If information produced by means of diagnostic technology is valued in the language of case presentation, information obtained from the patient is devalued. Technology "reveals" and "shows"; the physician "notes" or "observes"; and the patient "reports" and "denies". The language of case presentation reflects a clear epistemological hierarchy in which diagnostic technology is valued most highly, followed in descending order by the physician's observations and, finally, the patient's account. The case presentation concerning mismanagement is not only a symbolic affirmation of the superior management of the resident in a teaching hospital, but a ritual affirming the value of diagnostic technology over the physical examination and the patient's history.

This hierarchy reflects an historical transformation that has been described by Reiser (1978). In the early 19th century, physicians diagnosed and treated patients in their homes or by mail, and the major source of data was the patient's subjective narrative, accepted at face value. As the locale of diagnosis moved to the hospital and laboratory, medical practice turned away from a reliance on the patient's account toward the physician's clinical perceptions (observation, palpation, and percussion) which in turn gave way to a reliance on sophisticated diagnostic technology. Reiser suggests that each juncture in this epistemological evolution was accompanied by an increasing alienation in the doctor-patient relationship. The new diagnostic armamentarium entailed changes in the physician's role, wherein history taking assumed less importance in medical practice. Patients in turn were compelled to surrender their subjective experience of illness to the authority of the expert.

There is another sense in which the language of case presentation reflects a culture which objectifies patients and devalues their subjective experience. The discursive practices which I have called "de-personalization" refer to patients rather than people. In fact, the subject of sentences--and the real object of medical intervention--is not the patient, but diseases and organs (this phenomenon appears to exist in other settings, described by Donnely,1986, and Frader and Bosk, 1981). The ability to "see" diseases, tissues, and organs as entities apart from patients, also a recent historical development, is what Foucault (1975) calls "the clinical men-tality".3 In its most extreme form, the language of case presentation treats the patient as the passive receptacle for the disease rather than as a suffering subject.

Socialization to a World View

Because they are presented before superordinates, the case presentation serves as an instrument for professional socialization. Since case presentations are self presentations, interns and residents learn a set of strategies designed to display and protect their own credibility in the eyes of their superiors. While the skills of presentation are conscious and strategic, many of the

---

3 Foucault's use of the term "clinical mentality" differs from Freidson's (1970) use of the term to describe an insular, defensive posture on the part of the physician.

deeper assumptions of case presentations are tacit and taken for granted, and for this reason, much of the learning is unintentional and implicit. In fact, many of the values and assumptions in the language of case presentation contradict the explicit tenets of medical education. Thus, although medical students are taught to attach more weight to the patient's history than to the physical examination or laboratory findings, the language of case presentation devalues patient accounts. By using this language, physicians learn a scale of values which emphasizes science, technology, teaching, and learning to the expense of interaction with patients.

Whether used intentionally or unwittingly, the language of case presentation does contain certain assumptions about the nature of medical knowledge. The practices I have persons, observations can be separated from those who make them, and the knowledge obtained from measurement instruments has a validity independent of the persons who use and interpret this diagnostic technology. Inasmuch as the presenting a case history is an important part of medical training, those who use the language of case presentation may be impelled to adopt an unquestioning faith in the superior scientific status of measurable information and to minimize the import of the patient's history and subjective experience. In a restatement of the Whorf hypothesis[4], one linguist comments that "language uses us as much as we use language" (Lakoff, 1975: 3). This discussion suggests that the medical students, residents and fellows who present case histories may come to be used by the very words they choose.

---

4 According to the Whorf hypothesis, language structures, rather than merely reflects, perceptions of reality.

EXAMPLES OF CASE PRESENTATIONS

A. WRITTEN SUMMARY FROM MORBIDITY AND MORTALITY CONFERENCE
Simpson, Baby Girl
Birthdate: 5/13/78
Expiration Date: 12/9/78

Baby Girl Simpson was the 1044-gram product of a 27 week gestation. The pregnancy was complicated by the mother falling 2 weeks prior to delivery. SROM occured on 5/9/78 and the infant was delivered by repeat C-section on 5/13/78 at St. Mary's. No betamethasone was given before delivery. Apgars were 4 and 8. The infant was transferred to Randolph in room air. The infant developed chronic lung disease after being intubated at about 24 hours of age for increasing respiratory distress. She was treated with high F^iO_2's and a course of steroids as well. She was extubated and at the time she expired, she required an F^iO_2 of 1.0 by hood. She was on chronic diuretics and potassium supplement and had problems with hyperkalemia. She expired on 12/9/78.

B. NURSERY ETHICS ROUNDS, Fellow:
both babies were noted to have respiratory problems on examination and auscultation of the head revealed a very large bruit and angiography showed a very large arterio-venous malformation in the head... ah he was transferred here and Dr. S evaluated and decided to introduce the wires and then within 48 hours there was another baby diagnosed as having the same problem. He was transferred here and his physician had the wires inserted into the malformation. Ah post op, the bruit has decreased significantly in the first baby and follow up ct scans have showed the amount of blood flow to be very minimal at this time. The second baby is due to go through a CT-scan in the very near future, but has had a lot of other neurological problems, and it has also been much more difficult to control the second one's congestive failure post op.

C. NURSERY ETHICS ROUNDS, ROBERTA Z. Res:
the mother was 44 years old, gravida 10, para 8. At about 24 hours of age, the baby was noted to have congestive heart failure and was transferred to (hospital). At about 48 hours of age they noted that the baby had temporal bruits, did an emi scan and found a very large vein of galen malformation. The arteriogram showed that this avm was fed by both the anterior cerebral arteries, both posterior arteries and the ver tebrals and the (hospital) neurosurgeons thought the baby to be inoperable, so the baby was transferred here. The baby had some right sided seizures as of 24 hours of age, the baby was put on phenobarb. The e.e.g. done at that time--this was still at (hospital)--showed an abnormal--it was abnormal in that this was a space occupying lesion, but there were no other abnormalities. Since then the baby has been on and off phenobarb, but has still been on maintenance phenobarb most of the time. The baby was transferred here and on the fourth of December had wires placed in the malformation in the hopes of inducing a thrombosis and closing off the malformation.

D. OB-GYN ROUNDS
The patient is a 43 year old Taiwanese female Gravida6,Para-3,Ab-3 initially seen by her gynecologist for about a six-week history of vaginal bleeding. No further details were noted in the history. There was no mention of bleeding pattern, frequency, duration, female dyspareunia, discharge, or dysmenorhea or coital bleeding. Her past medical history included no hypertension, diabetes mellitus, and blood dyscrasias. In the family history that was obtained, her mother was deceased of gastric carcinoma at age 64, but it was othewise

non-contributory. She had no previous surgeries. She had been in the U.S. for about five years from Taiwan, and had no pelvic exam during this time. She was found on physical exam to be a well developed, well-nourished, slender Asian female with no acute distress; 5'0", 113 pounds; the blood pressure was 130/70; pulse 80, respirations, 18. The physical exam was unremarkable. The vagina and cervix were noted to be clear, and the cervix was described as "closed." The uterus was a 10 to 12-week size and the adenexa were clear. No pap smear was performed at the time of this initial visit. The hematocrit was 12.9 and the hemoglobin was 36.9. The patient was immediately admitted to the hospital and underwent a D and C, total hysterectomy-left salpingo-oopharectomy with a pre-operative diagnosis of menomenorrhagic fibroid uterus. The path report of the specimin revealed endometrial curretings-secretory endometrium, the uterus was 180 grams with adenomyosis and a left corpus luteum cyst. Of particular note was the incidental finding of infiltrating squamous cell carcinoma involving the surgical margins that had been cut through. Two weeks later, the patient wsa referred to the _____ Cancer Center for further evaluation and treatment....This case was presented to demonstrate the need for systematic evaluation of vaginal bleeding. This patient's prognosis may have been compromised by cutting through the cervical tumor.

E. HISTORY (OB)   DATE OF ADMISSION: 11/07/84

The patient is a 21 year old Gravida III, Para I, Ab I black female at 32 weeks gestation, by her dates. She states that she has been having uterine contractions every thirty minutes, beginning two days prior to admission. The patient has a history of vaginal bleedintg on 10/23, at which time she reports she was seen in the _____ Emergency Room and sent home. Additionally, she does state that there is fetal movement. She denies any rupture of membranes. She states that she has a known history of sickle cell trait.

PAST MEDICAL HISTORY: Positive only for spontaneous abortion in 1980, at 12 weeks gestation. She has had no other surgeries. She denies any trauma. She denies any allergies.

REVIEW OF SYSTEMS: Remarkable only for headaches in the morning. She denies any dysuria, frequency, or urgency. She denies any vaginal discharge or significant breast tenderness. HABITS: She denies tobacco, alcohol, coffee, or tea. MEDICATIONS: She takes pre-natal vitamins daily.

FAMILY HISTORY: Positive for a mother with sickle cell anemia. It is unknown whether she is still living. The patient also has a male child with sickle cell trait. Family history is, otherwise, non-contributory.

REFERENCES

Arluke, Arnold, 1978. "Roundsmanship: Inherent Control on a Medical Teaching Ward". Social Science and Medicine 14A: 297-302.

Austin, J.L., 1975. How to Do Things With Words. Cambridge: Harvard University Press.

Becker, Howard S., Blanche Geer, Everett C. Hughes, and Anselm S. Strauss, 1957. Boys in White. Chicago: University of Chicago Press.

Beckman, Howard B. and Richard M. Frankel, 1984. "Effect of Patient Behavior on Collection of Data." Annals of Internal Medicine 102: 520-528.

Bosk, Charles, 1979. Forgive and Remember. Chicago: University of Chicago Press.

Cicourel, Aaron V., 1981. "Notes on the Integration of Micro and Macro Levels of Analysis." Pp. 1-40 in Advances in Social Theory and Methodololgy: Toward an Integration of Macro-and Micro Sociologies, edited by Karin Knorr-Cetina and Aaron Cicourel. London: Routeledge and Kegan Paul.

Cicourel, Aaron V., 1983. "Language and the Structure of Belief in Medical Communication." Pp. 221-240 in The Social Organization of Doctor-Patient Communication, edited by Sue Fisher and Alexandra Dundas Todd. Washington, D.C.: Center for Applied Linguistics.

Coombs, Robert H. and Lawrence J. Goldman, 1973. "Maintenance and Discontinuity of Coping Mechanisms in an Intensive Care Unit." Social Problems 20: 342-355.

Davis, Fred, 1963. Passage Through Crisis. Indianapolis: Bobbs-Merrill.

Donnely, William J. 1986. "Medical Language as Symptom: Doctor Talk in Teaching Hospitals". Perspectives in Biology and Medicine, 30.

Drass, Kris A, 1981. The Social Organization of Mid-Level Provider-Patient Encounters. Unpublished Ph.D. dissertation, Indiana University.

Ervin-Tripp, Susan, 1971. "Sociolinguistics." Pp. 15-91 in Advances in the Sociology of Language, Volume I, edited by Joshua Fishman. The Hague: Mouton.

Fisher, Sue Carole, 1979. The Negotiation of Treatment Decisions in Doctor/Patient Communication and Their Impact on Identity of Women Patients. Doctoral dissertation, University of California, San Diego.

Fisher, Sue, and Stephen B. Groce, 1985. "Doctor-Patient Negotiation of Cultural Assumptions." Sociology of Health and Illness 7: 72-85.

Foucault, Michel, 1975. The Birth of the Clinic. New York: Vintage.

Fox, Renee C., 1957. "Training for Uncertainty." Pp. 207-241 in The Student Physician, edited by Robert K. Merton, George G. Reader, and Patricia L. Kendall. Cambridge: Harvard University Press.

Fox, Renee,C., 1979."The Human Condition of Health Professionals." Lecture, University of New Hampshire.

Fox, Renee C. and Harold I. Lief, 1963. "Training for Detached Concern in Medical Students." Pp. 12-35 in The Psychological Basis of Medical Practice, edited by Harold Lief, Victor F. Lief, and Nina R. Lief. New York: Harper and Row.

Frader, Joel E. and Charles L. Bosk, 1981. "Parent Talk at Intensive Care Rounds." Social Science and Medicine, 15E: 267-274.

Frankel, Richard M., forthcoming. "Talking in Interviews: A Dispreference for Patient-Initiated Questions in Physician-Patient Encounters." in Interactional Competence, edited by George Psathas and Richard Frankel. New York: Irvington.

Freidson, Eliot, 1970. Profession of Medicine. Chicago: Aldine.

Glaser, Barney, and Anselm Strauss, 1965. Awareness of Dying. Chicago: Aldine.

Gusfield, Joseph, 1976. "The Literary Rhetoric of Science: Comedy and Pathos in Drinking Driver Research." American Sociological Review 41: 16-34.

Korsch, B.M., E.K. Gozzi, and V. Francis, 1968. "Gaps in Doctor-Patient Communication: Doctor-Patient Interaction and Patient Satisfaction." Pediatrics 42: 855-871.

Korsch, B.M. and V.F. Negrete, 1972. "Doctor-Patient Communication." Scientific American 227: 66-74.

Lakoff, Robin, 1975. Language and Woman's Place. New York: Harper Colophon.

Leiderman, Deborah B. and Jean-Anne Grisso, 1985. "The Gomer Phenomenon." Journal of Health and Social Behavior 26: 222-231.

Light, Donald, 1980. Becoming Psychiatrists: the Professional Transformation of Self. New York: W.W. Norton.

Lipton, Helene L. and Bonnie Svarstad, 1977. "Sources of Variation in Clinicians' Communication to Parents About Mental Retardation." American Journal of Mental Deficiency 82: 155-161.

Millman, Marcia, 1977. The Unkindest Cut. New York: Morrow.

Mishler, Eliot, 1985. The Discourse of Medicine. New York: Ablex.

Mizrahi, Terry, 1984. "Coping with Patients: Subcultural Adjustments to the Conditions of Work Among Internists-in-Training." Social Problems 32: 156-165.

Mizrahi, Terry, 1987. "Getting Rid of Patients: Contradictions in the Socialisation of Internists to the Doctor-Patient Relationship." Sociology of Health and Illness 7: 214-235.

Parsons, Talcott, 1951. The Social System. New York: Free Press.

Prince, Ellen F., Joel Frader and Charles Bosk, 1982. "On Hedging in Physician-Physician Discourse". in Linguistics and the Professions: Proceedings of the Second Annual Delaward Symposium on Language Studies, edited by Robert J. Di Pietro, Norwood (N.J.) Ablex.

Reiser, Stanley, 1978. Medicine and the Reign of Technology. Cambridge: Cambridge University Press.

Schwartz, Howard D., 1987. <u>Dominant Issues in Medical Sociology</u> (2nd Edition). New York: Random House.

Scully, Diana, 1980. <u>Men Who Control Women's Health: the Miseducation of Obstetrician-Gynecologists.</u> Boston: Houghton Mifflin.

Sudnow, David, 1967. <u>Passing On</u>. Englewood Cliffs: Prentice-Hall.

Waitzkin, Howard, 1985. "Information Giving in Medical Care." <u>Journal of Health and Social Behavior</u> 26: 81-101.

West, Candace, 1983. "Ask Me No Questions...An Analysis of Queries and Replies in Physician-Patient Dialogues." Pp. 75-106 in <u>The Social Organization of Doctor-Patient Communication</u>, edited by Sue Fisher and Alexandra Dundas Todd. Washington, D.C.: Center for Applied Linguistics.

TABLE 1. Frequency of Types of Information

	Depersonalization	Personalization	De-Personalized[1] References	Personalized[2] References	Reports on Treatments, Procedures, and Actions Which Omit Medical Agent	Reports on Treatments, Procedures, and Actions Which Mention Medical Agent	Claims to Knowledge Which Omit Medical Agent	Claims to Knowledge Which Mention Medical Agent	Omission of the Agent; Other Context — Forms Which Omit Medical Agent	Forms Which Mention Medical Agent	All Contexts, Alternate — Forms Which Omit Medical Agent	Forms Which Mention Medical Agent	(Agentless) Passive Voice	Active Voice	Percent Passive	Technology as Agent	Alternatives	Account Markers Used	Account Markers Not Used
Obstetrics, Written	3271	92	870	2	1687	29	697	10	28	229	2412	268	2029	389	83.91	23	105	129	2247
Obstetrics, Oral	102	4	92	0	58	3	153	5	0	4	211	12	64	51	55.65	21	55	11	161
Neonatology, Written	160	66	135	4	85	16	178	5	0	10	263	31	101	156	39.30	5	49	N/A	N/A
Neonatology, Oral	103	58	129	1	30	35	107	36	0	30	137	101	26	161	13.90	9	8	N/A	N/A
Total	3636	220	1226	7	1860[3]	83[4]	1135[5]	56[6]	28[8]	273[9]	3023	412	2220	757	74.57	58	217[10]	140[11]	2408
Number of Presenters Using More Than 60% of Forms	18	3	16	5	15	6	17	4	1	20	1 S	2	14	7		4	17	0	21
Comparisons Estival and Myhill (19—)													206	1940	9.60 %				
Journalism	69	186	78	49	97	101	193	120	33	56	1	277	116	390	22.92 %	4	3	66	291
Number of Authors Using 60% of Forms	2	5	3	4	0	5	4	0	2	5	1	4	1	6	1 →	1 →	0 →	7	

[1] De-personalized references are those instances in which the patient is not referred to by name, but as the/this patient, woman, gravida, para, infant, twins, parents, child or by pronouns which refer to the above.

[2] Personalized references are those in which the patient or family is referred to by name.

[3] This includes 1757 agentless passives (e.g., an ultrasound was done), 60 actives with a recipient subject (she had/received an ultrasound), 8 ambiguous without agent (attempts to obtain fetal heart tones were unsuccessful), 6 adverbials (the patient was in the lithotomy position), 4 passive actives (she had an ultrasound done), 2 agentive passives with treatment as agent (this was followed by progesterone), 1 active with the procedure as agent (the surgery removed . . . her disease).

[4] This includes 56 actives, 21 agentive passives (an ultrasound was done by Dr. H), 2 partial agentive passives (she was followed at the Cancer Center), 2 quasi-agentive declaratives (Her prenatal care was by Dr. H.), and 2 agentive actives (This 29 year old . . . underwent treatment by the emergency room doctor).

[5] This includes 265 agentless, 114 scores, 111 descriptive statements (she was afebrile), 77 existentials (there was . . .), 66 sponge and needle count were correct, 63 estimated blood loss was, 62 actives with a recipient subject, 46 technology as agent (auscultation revealed), 40 quasi-passives (patient is well-known), 42 consistent with, 28 appeared, seemed, felt (patient appears pale), 26 adverbials (she did well), 25 is (patient is), 24 Apgars, 21 scores and descriptive (electrolytes were within normal limits), 21 exam revealed, 14 organ revealed, 9 presented with, 8 palpable, visible, 6 agentive passives with non-human agent, 5 found to have, 4 results in, 4 improved, worsened, 4 developed, 3 it extrapositions (it extrapositions . . .), 3 required, 3 participles, 13 other actives with non-human agent (the surgery removed the disease), and 28 others.

[6] This includes 37 actives, 6 agentive passives, 5 partial agentive passives, 3 descriptive statements (they were in agreement), 2 it extrapositions, and 3 other.

[7] "Other contexts" pertain primarily to instances in which the patient or family is the agent.

[8] This includes 12 descriptives, 5 patient presented, 5 equivalences, 3 agentive passives and 3 existentials.

[9] This includes 205 actives, 46 intransitives with agentive subjects (the mother died), 11 prepositional verbs (complained of), 8 other intransitives (the infant died), and 3 agentive passives.

[10] These include, most commonly, scores, estimated blood loss, consistent with, and scores and descriptive statements. "Consistent with" was coded as an alternative to technology as agent, since it can designate uncertainty (Prince, Frader, and Bosk, 1982).

[11] Account markers include states, reports, claims, complains of, no known history of, no history was reported, admits, and denies.

[12] Although a total of 14 articles were examined, they were written by a total of seven authors, and anonymously authored articles were excluded from this calculation.

TABLE 2. PRESENTATION OF INFORMATION BY SOURCE OF INFORMATION

Source of Information

Presentation of Information	Information Obtained from Physician	Information Obtained from Patient	Total
As Fact (No Account Markers Used)	2009	399	2408
As Account (Account Markers Used)	19	131	151
Total	2028	530	2558

X^2 = 430.451
df = 1
p = .001

Explanation of Coding

1. De-personalized references are those instances in which the patient is not referred to by name, but as the/this patient, woman, gravida, para, infant, twins, parents, child or by pronouns which refer to the above.

2. Personalized references are those in which the patient or family is referred to by name.

3. This includes 1757 agentless passives (e.g., an untrasound was done), 60 actives with a recipient subject (she had/received an ultrasound), 8 ambiguous without agent (attempts to obtain fetal heart tones were unsuccessful), 6 adverbials (the patient was in the lithotomy position), 4 passive actives (she had an ultrasound done), 2 agentive passives with treatment as agent (this was followed by progesterone), 1 active with the procedure as agent (the surgery removed her disease).

4. This includes 56 actives, 21 agentive passives (an ultrasound was done by Dr. H), 2 partial agentive passives (she was followed at the Cancer Center), 2 quasi-agentive declaratives (Her prenatal care was by Dr. H.), and 2 agentive actives (This 29 year old underwent treatment by the emergency room doctor).

5. This includes 265 agentless passives, 114 scores, 111 descriptive statements (she was afebrile), 77 existentials (there was...), 66 sponge and needle count were correct, 63 estimated blood loss was, 62 actives with a recipient subject, 46 technology as agent (auscultation revealed), 40 quasi-passives (patient is well-known), 42 consistent with, 28 appeared, seemed, felt (patient appears pale), 26 adverbials (she did well), 25 is (patient is), 24 Apgars, 21 scores and descriptive (electrolytes were within normal limits), 21 exam revealed, 14 organ revealed, 9 presented with, 8 palpable, visible, 6 agentive passives with non-human agent, 5 found to have, 4 results in, 4 improved, worsened, 4 developed, 3 it extrapositions (it was felt that...), 3 required, 3 participles, 13 other actives with non-human agent (the surgery removed the disease), and 28 other.

6. This includes 37 actives, 6 agentive passives, 5 partial agentive passives, 3 descriptive statements (they were in agreement), 2 it extrapositions, and 3 other.

7. "Other contexts" pertain primarily to instances in which the patient or family is the agent.

8. This includes 12 descriptives, 5 patient presented, 5 equivalences, 3 agentive passives and 3 existentials.

9. This includes 205 actives, 46 intransitives with agentive subjects (the mother died), 11 prepositional verbs (complained of), 8 other intransitives (the infant died), and 3 agentive passives.

10. These include, most commonly, scores, estimated blood loss, consistent with, and scores and descriptive statements. "Consistent with" was coded as an alternative to technology as agent, since it can designate uncertainty (Prince, Frader, and Bosk, 1982).

11. Account markers include states, reports, claims, complains of, no known history of allergies, no history was reported, admits, and denies.

12. Although a total of 14 articles were examined, they were written by a total of seven authors, and anonymously authored articles were excluded from this calculation.

ACKNOWLEDGEMENTS

1   "Program in Comparative Study of Social Transformations," by William H.
        Sewell, Jr., Terrence J. McDonald, Sherry B. Ortner, and Jeffery M.
        Paige, May 1987, 15 pages. Also CRSO Working Paper #344.

2   "Labor History, Uneven Development, and the Autonomy of Politics: The
        Dockworkers of Nineteenth-Century Marseille," by William H. Sewell, Jr.,
        July 1987, 45 pages. Also CRSO Working Paper #346.

3   "Coffee, Copper, and Class Conflict in Central America and Chile: A
        Critique of Zeitlin's Civil Wars in Chile and Zeitlin and Ratcliff's
        Landlords and Capitalists," by Jeffery M. Paige, September 1987, 10
        pages. Also CRSO Working Paper #347.

4   "In Search of the Bourgeois Revolution: The Particularities of German
        History," by Geoffrey Eley, September 1987, 61 pages. Also CRSO Working
        Paper #350.

5   "The Burdens of Urban History: The Theory of the State in Recent
        American Social History," by Terrence McDonald, May 1988, 50 pages.
        Also CRSO Working Paper #355.

6   "History, Sociology, and Theories of Organization," by Mayer N. Zald,
        May 1988, 42 pages. Also CRSO Working Paper #357.

7   "Have Social Historians Lost the Civil War? Some Preliminary
        Demographic Speculations," by Maris A. Vinovskis, May 1988, 55 pages.
        Also CRSO Working Paper #358.

8   "Revolution and the Agrarian Bourgeoisie in Nicaragua," by Jeffery M.
        Paige, 42 pages. Also CRSO Working Paper #363.

9   "Nationalism and Class as Factors in the Revolution of 1917," by Ronald
        G. Suny, October 1988, 42 pages. Also CRSO Working Paper #365.

10 "The Original Caste: Power, History, and Hierarchy in South Asia," by Nicholas B. Dirks, October 1988, 30 pages. Also CRSO Working Paper #367.

11 "The Invention of Caste: Civil Society in Colonial India," by Nicholas B. Dirks, October 1988, 24 pages. Also CRSO Working Paper #368.

12 "Sociology as a Discipline: Quasi-Science and Quasi-Humanities," by Mayer Zald, October 1988, 43 pages. Also CRSO Working Paper #369.

13 "Constraints on Professional Power in Soviet-Type Society: Insights from the Solidarity Period in Poland," by Michael D. Kennedy and Konrad Sadkowski, November 1988, 37 pages. Also CRSO Working Paper #371.

14 "Evolutionary Changes in Chinese Culture," by Martin K. Whyte, November 1988, 20 pages. Also CRSO Working Paper #372.

15 "World Market, Class Conflict, and Rural Coercion in Post-Colonial Buenos Aires," by Karl Monsma, November 1988, 22 pages. Also CRSO Working Paper #373.

16 "Ritual and Resistance: Subversion as a Social Fact," by Nicholas B. Dirks, December 1988, 39 pages. Also CRSO Working Paper #375.

17 "Social Transformations of Gender in Andean South America: A Working Annotated Bibliography," by Janise Hurtig, December 1988, 24 pages. Also CRSO Working Paper #376.