Discourses in Co(n)text

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The Many Faces of Specialised Discourse

Edited by

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and Anna Szczepaniak-Kozak

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PREFACE

In order to function effectively in professional contexts, one has to communicate with others (Schnurr 2013, 1). For example, in the medical context, 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 (Foucault 1963/2003). The major theme of the present work is specialised discourse. In their definitions of specialised and professional discourses both Gotti and Gunnarsson respectively stress that it is a discourse which has a particular form and is used by specialists in a particular context (Gunnarsson 2009, 5; Gotti 2008, 15–16). The features of this discourse stem from its contextual grounding in professional practices and the functions it performs. What is more, it is not a static entity but it is constantly modified, which reflects how disciplines and professions in which this discourse is utilised evolve (Gunnarsson 2009).

Professional discourses of various occupational groups have recently attracted keen interest within the framework of the analysis of specialised and professional discourse (Gotti and Giannoni 2006; Gotti and Salager-Meyer 2006; Gotti 2008; Gunnarsson 2009; Schnurr 2013). On the one hand, the popularity of this research avenue stems from the myriad of different genres found in specialised discourse and, on the other hand, from its potential to tap into the intricacies of the construction of particular professional realms and their implications for both communication training and language pedagogy. However, the importance of communication in professional contexts has resulted not only in the increased attention of applied linguists to this particular area but also in the contributions of other disciplines. In their undertakings, specialised discourse analysts have drawn on theories from neighbouring disciplines such as sociology, psychology, ethics and philosophy. This interdisciplinary cooperation has frequently proved effective in revealing not only how professional identities are reflected and enacted in language (Garzone and Archibald 2010), but also how discourses portray various areas of our lives (Eubanks 2000). Specialised discourse analysis may in turn inform other disciplines, such as English for Specific Purposes (Loiacono et al. 2012), translation/interpreting studies (Grego 2010), culture/communication studies (e.g., Angelelli 2004; Wodak and Koller 2008), etc. This contribution may be examined from two angles. On the one hand, from the

micro-perspective, formal text features may be analysed, i.e., lexical and syntactic ones (Vihla 1999; Smith 2003; Connor and Upton 2010) as well as the generic structure (Bhatia and Gotti 2006), which helps researchers to learn more about the technicalities of specific professional texts. From the macro-perspective, a closer reading of the texts may help to identify different discourses with which specialised texts are saturated, revealing the positioning of participants in communication (Garzone and Sarangi 2008), foregrounding and backgrounding particular information (Campbell 2000) as well as shaping certain conceptualisations (e.g., Van Rijn-Van Tongeren 1997). Moreover, results of the studies from both perspectives may be relevant for applied linguists.

The book features submissions addressing the area of specialised/professional discourse analysis from the two aforementioned angles—the studies of formal aspects of texts and the studies of discourses in their specific professional contexts. Moreover, in the articles, specialised discourse will be approached from linguistic, literary and cultural perspectives as well as from that of applied linguistics. In this way, specialised discourse will be viewed from both the frog's and the bird's eye view, which helps the authors of the contributions to demonstrate aspects of specialised/professional discourses, determined by their contextual groundings, such as evolution, user-needs and rationale behind their use.

The book is divided into three parts: professional discourse, discourse of the media, arts and literature and, finally, discourse in academic settings. The first part begins with three articles concerning medical discourse.

The opening article of the monograph authored by Magdalena Zabielska focuses on a group of genres which are used in case reporting in medicine, both from the micro-perspective, i.e., the language used, and from the macro-perspective, i.e., the contextual factors guiding their evolution. It also shows how the studies of medical discourse may draw on other disciplines and, in turn, how linguistic analyses may inform medical practice.

While the first chapter concerns written discourse, Ashley Bennink's chapter deals with doctor-patient communication in the context of medical interviews involving Latino speakers. Applying the accommodation theory, the author demonstrates how the interactants adapt or fail to adapt their speech to each other and points to some factors that may influence this adaptation, such as linguistic competence, health status and affective state in this particular speech event. Still in the context of medicine, Agnieszka Dudzik's chapter, on the other hand, approaches professional

medical discourse from a pedagogical perspective and argues for the incorporation of intercultural competence in English for Medical Purposes programs to enhance learners' occupation-specific communication skills by emphasising implications for streamlining patients' communication and thus, quality of healthcare. Finally, Gabriella Klein's contribution focuses on the bureaucratic form as a genre whose creators and users are on two opposite poles, i.e., institutional clerks and lay people, including non-native speakers. The author discusses both the formal aspects of bureaucratic forms and the communicational implications of these features for their users. This is done in the context of the challenge of simplification of bureaucratese of Italian forms.

The second part of the volume contains chapters addressing a broad variety of topics regarding discourse of the media, arts and literature. Katarzyna Mołek-Kozakowska's chapter demonstrates the use of presupposition and nominalisation as devices enabling writers to frame and compress information. However, she also draws attention to their potential to manipulate information through presenting particular opinions as facts and distorting the character of events. Karolina Sznycer's chapter addresses the field of sport and shows how tennis players construct their professional identifies through resisting and choosing particular categories during post-match conferences. To study this particular aspect, the author uses two ethnomethodological approaches of membership categorisation analysis and discursive psychology. The discursive practices presented in Emilia Wąsikiewicz-Firlej's chapter are of a different character. She concentrates on discourse about women in women's magazines. Analysing a corpus of 600 adverts randomly selected from seven Polish magazines for women, she shows how they utilise typical visual representations of gender and their relations in order to promote particular products.

Both Małgorzata Godlewska's and Elizabeth Woodward-Smith's chapters address the literary discourse of monologues. Małgorzata Godlewska focuses on the text *Ghost* by Eva Figes, which is regarded as an attempt to create an innovative expressive form. The analysed text concerns the memories of a Holocaust survivor which are studied by the author from the perspective of trauma studies. This allows her to decipher particular mental processes of the protagonists and to demonstrate how they are realised at the level of the text. Elizabeth Woodward-Smith, on the other hand, focuses on humorous monologues which are performed for entertainment purposes. Drawing on a corpus of audio-visual recordings of the exponential public figures, she studies both linguistic and paralinguistic features and emphasises that, though performed by only one person, the genre is highly interactive as it contains various discourses,

and bases on the relationship with the audience and its reaction to what is and what is not said. She also emphasises the didactic potential of comic monologues. Finally, Alan Floyd Moore addresses the issue of the applicability of the term *communication* in the context of video games. He suggests that the process of *localisation*, i.e., adapting particular games to different cultural contexts, may be seen as a form of communication with their users. He also demonstrates the potential of video games to influence their users through the presentation of certain stereotyped behaviours.

The third and final part of this volume contains studies of discourse in academic settings. Ewa Data-Bukowska tackles the issue of writer-reader interaction (Hyland 1998, 442) in research articles representing Translation Studies (TS) in Poland. She is particularly interested in the conventions (if any) of textual metadiscourse which may be distinguished in the scholarly communication in Polish TS—whether the IMRAD (Introduction, Method, Results, Discussion or Conclusion) macrostructure of research articles is preserved and how the texts guide the reader through their content. Pilar Mur-Dueñas and colleagues explore current practices of Spanish scholars when wanting to publish their research outcomes internationally in English. Similarly to other chapters (Woodward-Smith's and Klein's), it has important pedagogical implications with regard to the progressive consolidation of English as a *lingua franca* in different disciplinary contexts. Verónica Pérez Gómez, on the other hand, concentrates on higher education discourses and their marketisation, a process that has become more widespread recently. On the basis of the analysis of a corpus of universities' mission statements, guides designed for students and the prospectuses for certain programmes, she focuses on the self-representation of Galician universities as corporate identities and of students as customers of those universities. Additionally, she delves into how these two aspects shape the universities' policies regarding international students. In particular, she examines the linguistic choices made in those documents. Anna Szczepaniak-Kozak touches upon the importance of pragmatics in the business/academic context. She observes that it is in the process of acculturation that native speakers develop the ability to respond appropriately in different contexts. However, this is not the case when foreign language learners are considered. To illustrate this difference, she draws on data from a longitudinal research on EFL acquisitional pragmatics. Lastly, Hadrian Lankiewicz's chapter addresses educational linguistics, a growing field of studies which promotes teaching in a way that is both personally relevant and based on a variety of ways. Lankiewicz argues that it prevents SLE from turning into "a rule-based mechanical operation of arbitrary symbol". The author thoroughly

discusses the concept as well as its advantages, and complements his discussion with a discourse analysis of classroom interaction.

Each of the papers are of great interest and importance in their own rights, but the value of this volume lies in its holistic view on specialised/professional discourse, i.e., examining both their co-texts and contexts, on the one hand, and practical applicability of discourse analyses and the potential to create connections with other disciplines on the other. Also, the expertise of the contributors who are experienced scholars affiliated to leading universities in Poland, Spain, Italy, and representing different research backgrounds ensures the high quality of the publication.

The Editors
Magdalena Zabielska
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Bibliography

Angelelli, Claudia V. 2004. *Medical Interpreting and Cross-cultural Communication*. Cambridge: Cambridge University Press.

Bhatia, Vijay K., and Maurizio Gotti, eds. 2006. *Explorations in Specialised Genres*. Bern: Peter Lang.

Campbell, Constantine R. 2000. *Verbal Aspect, the Indicative Mood, and Narrative: Soundings in the Greek of the New Testament*. Bern: Peter Lang.

Connor, Ullam, and Thomas A. Upton, eds. 2010. *Discourse in the Professions: Perspectives from Corpus Linguistics*. Amsterdam: John Benjamins.

Eubanks, Philip. 2000. *A War of Words in the Discourse of Trade: The Rhetorical Constitution of Metaphor.* SUI Press.

Foucault, Michel. 1963/2003. *The Birth of the Clinic. An Archaeology of Medical Perception*. 3rd edition. London: Routledge.

Garzone, Guliana, and Srikant Sarangi, eds. 2008. *Discourse, Ideology and Specialised Communication.* Peter Lang: Bern.

Garzone, Guliana, and James Archibald, eds. 2010. *Discourse, Identities and Roles in Specialised Communication*. Bern: Peter Lang.

Gotti, Maurizio. 2008. *Investigating Specialised Discourse*. Bern: Peter Lang.

Gotti, Maurizio, and Davide S. Giannoni, eds. 2006. *New Trends in Specialised Discourse Analysis*. Bern: Peter Lang.

Gotti, Maurizio, and Françoise Salager-Meyer, eds. 2006. *Advances in Medical Discourse Analysis—Oral and Written Contexts*. Bern: Peter Lang.

Grego, Kim. 2010. *Specialised Translation. Theoretical Issues, Operational Perspectives*. Milan: Polimetrica.

Gunnarsson, Britt-Louise. 2009. *Professional Discourse*. London: Continuum.

Loiacono, Anna, Iamartino, Giovanni, and Kim S. Grego, eds. 2011. *Teaching Medical English*. Milan: Polimetrica.

Schnurr, Stephanie. 2013. *Exploring Professional Communication. Language in Action.* Oxon: Routledge.

Smith, Carlota S. 2003. *Modes of Discourse: The Local Structure of Texts.* Cambridge: Cambridge University Press.

Van Rijn-Van Tongeren, Geraldine W. 1997. *Metaphors in Medical Texts*. Amsterdam: Rodopi.

Vihla, Minna. 1999. *Medical Writing: Modality in Focus*. Amsterdam: Rodopi

Wodak, Ruth, and Veronika Koller, eds. 2008. *Handbook of Communication in the Public Sphere.* Berlin: Mouton de Gruyter.

PART I:

PROFESSIONAL DISCOURSE

CHAPTER ONE

PATIENT-CENTRED CASE REPORTING: STATE OF THE ART

MAGDALENA ZABIELSKA

Abstract

A case is one of the basic concepts in medicine and sharing information about new cases of diseases belongs to the oldest forms of medical communication. In this chapter, the state of the art of research on the genres of medical case reporting is discussed. In detail, two perspectives are adopted. On the one hand, its definition as well as history are provided in order to demonstrate the evolution of the genres as a result of developing medicine and changing intellectual thought styles. Moreover, the case report, along with other case-related genres, is presented to point to its characteristic features, the most important one being that it is relatively patient-focused in that it reports a particular case of a disease in a given patient. This fact allows it to be studied within the patient-centred models of medical practice. Additionally, approaches from which researchers have studied it so far are demonstrated. These include: qualitative, quantitative and linguistic approaches as well as drawing on other disciplines such as literary studies, ethnography or ethics. Some problematic areas regarding the linguistic aspects of the genres are also pointed to. It has been shown that the genres of medical case reporting feature an effaced discourse in which cases are studied and diseases are managed, and thus abstracting from the patient. At this point, some solutions proposed by researchers to remedy this situation are demonstrated, addressing the issues of how patients are referred to and which information is given priority. Finally, recent developments of the genre of case reports are presented. These are new features which reflect the changes taking place in medical practice where medical knowledge is becoming increasingly accessible to a lay audience and open to perspectives other than that of a doctor. Thus, the chapter focuses on a group of genres of the specialised discourse of medicine, both from the micro-perspective,

i.e., the language used, as well as from the macro-perspective, i.e., the contextual factors guiding its evolution. It also shows how the study of medical discourse may draw on other disciplines and, in turn, how linguistic analyses may inform medical practice. Finally, the chapter points to the importance of patient reference in written medical discourse, as opposed to the oral one, which has attracted keen interest in broadly understood health communication research.

1. Case

A *case* is an essential element in medicine. According to Hunter (1991), "the case is the basic unit of thought and discourse" (1991, 51). A case commences the whole process of diagnosis and treatment through gathering information, its interpretation and presentation (Hunter 1991, 68). As Smith (2008a, 1) puts it, "every new condition—whether it is AIDS, SARS, or the next emergent disease—begins with a single case" (cf. McEwen 2009, 17). It frames the patient's account of a disease "in a short-story-like fashion" (Salager-Meyer 2001, 63) creating "mini medical tales" (Coker 2003, 907), very often shared by colleagues in various professional contexts (cf. Bignall and Horton 1995, 1), and retells it in the physician's discourse (Bleakley et al. 2011, 202). In other words, a case makes it possible to apply the biomedical lenses to the subjective account of a patient (Hunter 1992, 163), combining the paradigmatic or logico-scientific, and the narrative (Bruner 1986). Moreover, although originally appearing as a chart, it may take a number of forms, from a case presentation conveyed to fellow physicians, through the transcription from a pathological conference to a written case report/study (Hunter 1992, 164).

The very word *case* merits some attention. As stated above, the case is the basic unit of medical thought. Yet, this basic unit may be understood in many different ways. For doctors and nurses cases are patients who are managed for particular diseases (Radley and Chamberlain 2001, 323; Bleakley et al. 2011, 201). Cases may also be interpreted as instances of particular diseases identified in patients, which are defined by doctors upon the discovery of a new pathology ("cases are found"). In this understanding, cases are discursive constructs with their specific reasoning and structure ("cases are objects", which emerge out of case reports). This leads the authors to conclude that "cases are conventions" created by medical practitioners (Radley and Chamberlain 2001, 326). In one of the guides to medical writing, McEwen (2009) explains further that the case is "the patient's condition, including the therapeutic and personal

consequences of that condition" (2009, 103; Wodak 1996, 26). The word may also suggest identifying the patient with "a clinical problem rather than a human being who has an essential role in decision making and outcomes" (McEwen 2009, 103).

According to Charon (1992, 120), the aims of recording cases are the following:

- make a record of the patient's account,
- give an account of his/her history,
- record the results of examination and tests,
- show the writer's expertise,
- confirm doctor's initial diagnosis,
- justify the choice of regimen.

Moreover, from the perspective of medical practice, this recording "underpins the basic observation and descriptive learning skills that all medical students acquire during their clinical clerkships and which most doctors use throughout their careers, particularly in the setting of a teaching hospital or academic medical centre" (Peh and Ng 2010, 10; Treasure 1995, 279). In Sobel's (2000, 85) words: "The medical case history is a powerful, proven tool for clearing through the mud and muck of a suffering person's illness story and plucking from it the pit of the problem. Its purpose is to answer the question: "What recognised disease (or what named 'problem') does this patient have?"".

There are a few genres which, though performing different functions, share the feature of dealing with medical cases.

2. Case-related genres

Case-related genres differ from one another with respect to the context of their use. These include: case presentation, case history, case record and case report. Although the final genre is the focus of this chapter, reference will be made to different case-related genres, depending on the focus of different studies or historical accounts.

Case presentation

Case presentations are highly conventionalised oral descriptions of patients and their diseases, which are performed by clinicians and medical students in clinical settings (cf. Atkinson 1995). Although different from case reports in that they are delivered orally, case presentations bear

significant resemblance to their written counterparts both in the form and content (Anspach 1988; Hunter 1991; Atkinson 1995, 90ff.).

Case history

Following Fleischman (2001, 477), "it includes information on how the patient's condition was noticed and diagnosed, how the condition has been treated, and how the patient responded to treatment. Psychosocial aspects of the case are presented (if at all) only after the medical problems have been discussed". "The medical case history inscribes a patient's story of illness within a framework of pathophysiologic processes, contextualises current symptoms in a broader health history, interprets data from the physical exam and laboratory studies, and narrates a diagnostic process" (Goyal 2013). Rylance (2006) observes that "case histories are not mere chronicles; they are diagnostic instruments and, as such, are one of the key ways in which medical knowledge is transmitted". This function, however, may be applied not only to a medical history but also to other case-related genres.

Case record

"contain[s] both subjective and objective information about the patient's condition, as well as a plan for treatment and any follow-up which is necessary" (Van Naerssen 1985, 44). Berg and Bowker (1997) refer to it both as "a memory of the patient" and an "anatomical geography". The former is comprised of a detailed chronological account of different ailments, and associated diagnostic and treatment procedures along with administrative practices (doctors responsible, hospitals visited, etc.). The latter, on the other hand, are the results of different diagnostic tests targeting particular body parts, fluids, etc. For Strauss and colleagues (1985, 8), a case record is an "'illness trajectory': the course of the illness, the total organisation of work done over that period, and the impact of that work on those involved".

Case report

Peh and Ng define a case report in the following way:

> A case report is a description of a single case with unique features. This includes a previously-unreported clinical condition, previously-unreported observation of a recognised disease, unique use of imaging or diagnostic test to reveal a disease, previously-unreported treatment in a recognised disease, or previously-unreported complication of a procedure. Case reports should be short and focused, with a limited number of figures and

> references. The structure of a case report usually comprises a short unstructured (or no) abstract, brief (or no) introduction, succinct but comprehensive report of the case, and to-the-point discussion (Peh and Ng 2010, 10; cf. Monk 1995).

It needs to be noted that the structure of the genre varies for different journals, yet they all follow the problem-solution pattern (i.e., situation, problem, solution and evaluation). There may be also a series of related cases (Pique-Angordans and Posteguillo 2006, 655). From a different perspective, Leder (1990) identifies four types of texts that can be found in medical genres referring to patients, i.e., "the-person-as-patient": *experiential*, *narrative*, *physical* and *instrumental*. These types can be found in the genre of the case report, too. Following this division, the presenting complaint may be referred to as the *experiential* text whereas the patient's history as the *narrative*. The next section, which is actually a constituent of the Case Report body, i.e., Examination/tests, can be related to the *physical* text where reading the patient's body and deciphering diagnostic data are described. The Treatment section may be treated as the *instrumental* text. Leder's classification (1990), however, does not provide any counterpart for the Discussion/Conclusion section.

A word of comment needs to be given regarding the genres identified. Firstly, whereas a medical record is a set of documents, a medical history is only a fragment of medical documentation, e.g., of a record. Case reports, on the other hand, are fully-fledged publications consisting of constituent parts (Abstract, Introduction, Methods, Results, etc.). Parts of other genres may also be labelled as case reports. Secondly, in the case of the above-given examples, the term *macro-genre* (Martin 1994; 1995) may be used, which refers to genres "which combine familial elemental genres" (Martin 2000, 16). In this context, as case presentations, records, histories and reports deal with cases and their structure is similar, they may be referred to as the subgenres of the micro-genre of case reporting.

3. Historical background

Peh and Ng (2010) observe that "[r]eporting a rare or unusual case is probably the oldest form of medical communication" (2010, 10). 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 reaches back also to Hippocrates' (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 more focused on the patient's point of view. Another stage in the development of the genre were the so-called *consillia,* which appeared in the thirteenth century. Following the structure of legal documentation, these were texts in which diagnoses for diseases in particular cases were established and treatment decided (Agrimi and Crisciani 1994, 19). A more detailed account of a particular disease and treatment could be further found in the so-called *practica* (Taavitsainen 2006, 691). Such texts began to be collected, forming repositories of exemplary cases, or they were embedded in longer treaties, which functioned as a source of medical knowledge. Ultimately, they became one of the major genres (Taavitsainen and Pahta) and lay the foundations for contemporary forms of case-recording (Alderotti 1937). In the fourteenth and fifteenth centuries, case reports appeared not only in collections or in treaties but also in remedy books, in the latter case to show that a particular regimen was effective (Taavitsainen 2006, 691). The reports contained non-literary histories of illness, which lay at the heart of medical teaching and research (Taavitsainen 2011, 255). "Accounts of illustrative and typical cases" (Gotti 2006, 680) appeared further in medical instructive handbooks, which, along with translated treaties and guidebooks to health, constituted early printed works of the sixteenth century (cf. Bennett 1969). The seventeenth and eighteenth centuries saw even more preoccupation with patients' accounts in case reports, in comparison to Hippocrates' and Galen's. What was also characteristic of that period was the propensity of the authors to write about curious medical phenomena to pique readers' interest. This could be observed in the titles of the texts of that time, e.g., "Dr Barnes' account of the knife-eater's last illness", "Attempt at suicide by swallowing a key" or "Dr Pickell's case of a woman who discharges insects from the stomach" (Smith 1860, 587). The eighteenth century was also the time when hospitals began to keep patients' records (Siegler 2010, 672). However, the discourse about diseases changed with growing importance of pathological anatomy at the turn of the nineteenth century. This was coupled with the increasing role of observation and the developing 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. What is more, developing medical knowledge and modern equipment determined what counted as reliable data, which diminished the role of patients' accounts (cf. Rylance 2006) while the very patients became to be

treated as "quantifiable material" (Gunnarsson 2009, 61). This change is well captured by Sacks (1986), who observes that "[t]he tradition of richly human clinical tales reached a high point in the nineteenth century, and then declined, with the advent of an impersonal neurological science" (1986, xiv). In a similar vein, Siegler (2010), in her article on the evolution of the case record genre, observes that it changed its character from a retrospective narrative to a real-time record in a compact chart form, "address[ing] only the technical side of care" (Burnum 1989, 482). It is also interesting to note that the nineteenth century was the time when recording cases began to be regularly practiced (Rylance 2006). Hunter (1992) points to particular developments in the history of the case as a basic medical concept which contributed to its impersonal status. Firstly, it was the introduction of statistics into medicine by Feinstein in 1967, which was supposed to make it more objective. This particular development allows the author to refer to contemporary medical texts as "case-derived statistics (…) as the basis of medical persuasion" (Atkinson 1992, 363). Secondly, reporting cases gained a new character when the problem-solution pattern by Weed (1969) was adopted. He also applied the well-known SOAP (Subjective-Objective-Assessment-Prognosis) structure. 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 their interpretation of signs of a disease (cf. Rose and Corn 1984). Secondly, also the growing importance of the genre of the research article in medicine, which is often based on statistical analyses, devalued the case report as a valid source of information (Atkinson 1992). Additionally, it needs to be pointed out that, as Taavitsainen (2014) observes, although case studies have been constantly present in the English medical writing, this presence has been changing its character, "from core to periphery". Case studies emerged as descriptions of typical manifestations of diseases, however, they gradually turned into descriptions of rare instances of medical conditions (Taavitsainen 2014).

> Case studies have acquired an unmerited reputation as being anecdotal, unscientific and intrinsically inferior to group studies. The subsequent disregarding of individual patients as the focus of investigation has led to the neglect of an extremely useful clinical research method, and has probably impaired the pace of therapeutic innovation (Charlton and Walston 1998, 147).

As a result, between 1971 and 1991, the publication of case reports in three major general professional medical journals—*Journal of the American Medical Association*, *New England Journal of Medicine* and *Lancet*—decreased from 42% to 8% (McDermott et al. 1995). Similar results were obtained for the *Lancet* journal between 1965 and 1995 (Pique-Angordans and Posteguillo 2006, 655). However, despite the "fall from favour" (Vandenbroucke 2001, 333) this genre has witnessed, being often referred to as "low profile" (Salager-Meyer and Alcaraz Ariza 2013, 295), or "delegated to the lowest rung of the evidenced-based ladder" (Tomaszewski 2006, 139), the functions of case reports such as increasing the knowledge of the medical community about rare cases (cf. Rylance 2006) and serving pedagogical purposes in medical training cannot be questioned (Vandenbroucke 2001; cf. Hunter 1991, 93; Monk 1995; Iles 1998; Taavitsainen and Pahta 2000, 61; Pique-Angordans and Posteguillo 2006, 655; Tomaszewski 2006; Benson 2008; Jamjoom et al. 2009), especially as a starting point in publishing research in medicine (Iles 1998). As Harvey and Koteyko (2012) put it, "[t]he patient record (…) given its transformational power [has the] (…) ability to translate the flesh and blood patient into a written, fictional case" (2012, 96). Charlton and Walston (1998) are also the proponents of the genre arguing that

> [i]ndividual case studies deserve fresh consideration by researchers, since they are a clinician-friendly method with a unique potential for incorporation into routine practice (1998, 154; Morgan 1985; Salager-Meyer and Alcaraz Ariza 2013, 291).

This is well illustrated by Pattison and colleagues (1999) in the following anecdote:

> Case studies function as the salvation of ethics teaching and discourse in the modern academy. If principles and practices are discussed in abstract terms, seminar groups and lecture audiences furrow their brows and look puzzled, and, not infrequently, bored. All this changes when a case study is introduced. Suddenly, people are interested and engaged. They identify with the individuals and their positions in the situation described. They start speaking and sharing their own experiences and views. A dead space becomes alive with animated conversation and debate as they become actively involved in deliberation and dialogue. There is nothing like a good case study for arousing interest, gaining attention, ensuring engagement, enabling participation, unleashing the tongues of the shy and reticent and racking out the range of possible views, opinions and interpretations that can apply to any particular ethical issue or situation. Case studies introduce context, persons, emotions and realism into what can otherwise be abstract

> and sterile theoretical debate that, at its worst, can seem to be irrelevant wit-sharpening and logic chopping for its own sake (1999, 42).

Morgan (1985, 353) is of the same opinion: "A good case report begets awareness, jogs the memory and adds to understanding". Therefore, it can be concluded that every case may a valuable source of new information or simply add some new perspective/aspect to the body of knowledge accumulated so far (Monk 1995; Treasure 1995, 279; McCarthy and Reilly 2000; Rylance 2006; Smith 2008a, 1; Jamjoom et al. 2009; Salager-Meyer and Alcaraz Ariza 2013).

4. Literature on case reporting

Studies of medical case reporting, though relatively less numerous than other medical genres, have touched upon various aspects. On the one hand, there is a body of literature documenting the development of case genres against their historical background, taking into consideration changing intellectual trends. In such studies, the presentation of patients and their diseases is scrutinised, yet without formal linguistic analysis (e.g., Reiser 1991; Nowell-Smith 1995; Hurwitz 2006; Rylance 2006). Hurwitz's (2006) study also takes a literary perspective, whereas Francis and Kramer-Dahl (2004) compare lexicogrammatical choices employed in a case report in neuropsychology and in a literary text. The latter, however, is a fully fledged linguistic analysis, adopting the SFL framework. Some of the studies refer to contemporary case reports and their functions from a pedagogical angle, arguing either for or against the genre (Morgan 1986; Fye 1987; Bignall and Horton 1995; Treasure 1995; Vandenbroucke 2001). A separate group of research comprises diachronic explorations, such as Taavitsainen and Pahta's study (2000). It differs from the above-cited studies in that it includes a formal analysis of textual references to patients in the description of diagnosis and treatment, and discusses the effect they produce. A diachronic perspective is also adopted by Salager-Meyer and Alcaraz Ariza (2013) in their study of titling and authorship. One of the most comprehensive and exhaustive resources concerning case reporting and its varieties in medical discourse is Hunter's *Doctors' stories. The narrative structure of medical knowledge* (1991). Yet, although detailed in its description of the functions, structure and conventions of writing of the genre, the work fails to offer actual linguistic examples. Berkenkotter (2008) studies extensively the significance and use of case reports in psychiatry using a multimodal research approach.

Yet another body of literature is quantitative investigations into specific semantic and grammatical features and their functions (Rowley-Jolivet 2007; Méndez-Cendón 2009). Moreover, contemporary analyses of academic discourse focus extensively on metadiscourse, which has been the case in the studies of case reports as well (Adams Smith 1984; Salager-Meyer 2001). Finally, there are studies of related genres such as case histories (Charon 1992; Nowell-Smith 1995; Donnelly 1996; Donnelly and Hines 1997; Sobel 2000; Rylance 2006; Goyal 2013) and case records/notes belonging to hospital documentation (e.g., Feinstein 1973; Van Naerssen 1985; Burnum 1989; Donnelly 1992; Grice and Kramer-Dahl 1992; Sarangi and Brookes-Howell 2006; Siegler 2010) or case presentations during hospital rounds (e.g., Anspach 1988; Lingard et al. 2003). Additionally, there are studies investigating the construction of a medical case from a cultural perspective (Coker 2003). The present author knows also of only one PhD dissertation that focuses exclusively on case reports. Helán's (2012) work is a meticulous study of the genre with special attention to its pedagogical implications, additionally complemented by the comparison with the nineteenth century case reports. Yet, the very discussion of the patient's portrayal is only one of the elements presented.

Fleischman (2001, 478) offers another classification of research of case-based genres, i.e., those analysing the language used therein and aiming at reforming it, and those dealing with the process of transformation of the patient's account into a medical record (cf. Mishler 1984; Anspach 1988; Donnelly 1988; Kleinman 1988; Hunter 1991; Charon 1992; Poirier et al. 1992; Smith 1996; Donnelly 1997). Studies which seem the closest related to the present work are those regarding patient presentation, yet without a historical perspective (cf. historical analyses above) and discussing it with reference to contemporary medical models. However, these studies, similarly to the historical analyses above, lack linguistic examination and deal with patient imaging in general terms (Charon 1992; Hunter 1992; Monroe et al. 1992; Donnelly and Hines 1997).

5. Problematic aspects of the discourse of case reporting

Much as the language of case reporting renders scientific facts accurately, it does not refer to other aspects of the patient's disease, which has been the source of criticism (Schwartz and Wiggins 1985). As McCullough (1989) pointed out, it abstracts from the subjective experience of being ill, and by doing that, it depersonalises him/her

(Monroe et al. 1992, 1). "The message is clear, disease counts; the human experience of illness does not" (Donnelly 1986, 88). In other words, in the "medical case report (...) the protagonist is the illness, not the ill subjects, whose voice is silenced (or so at least they feel)" (Rimmon-Kenan 2002, 11; cf. Mishler 1984; Frank 1991; 1995; Sinclair 2000, 117; Hatem and Rider 2004, 1). "As such he was designated a passive and uncritical role in the consultative relationship, his main function being to endure and to wait" (Jewson 1976, 235), or, in Francis and Kramer-Dahl's (2004) perspective, "plays a role of Goal, or 'done to'" (2004, 173). Kumagai (2008) offers another perspective on this issue. He claims that the way patients are portrayed in standard medical case reports is "two-dimensional" and does not focus on the patient as an experiencing individual and his/her suffering. In other words, "[i]ndividual patients portrayed in paper-based cases do not allow for true interpersonal interactions, and, because of the medically based language in which the cases are often written, they may actually dehumanise the patient and minimise observers' appreciation of the patients' suffering" (2008, 655; cf. Pattison et al. 1999; Kenny and Beagan 2004). According to Charon (2005), "[t]he focus is usually shifted from the suffering patient to the disease that needs to be treated, as we knew enough about the body by virtue of reducing it to its parts that we did not need to hear out its inhabitant" (Charon 2005, 262).

In detail, for example, what can be frequently observed in professional medical discourse is the central position of modern medical equipment, medical tests and the data they provide (cf. Rylance 2006). The patient "is faceless and characterless, crowded out of the situation—and the text—by batteries of tests" (Francis and Kramer-Dahl 2004, 175). It may be the consequence of the attitudes and values developed by students in the course of medical studies and is so because the activities and tasks assigned to them during hospital and clinical training are supposed to teach them how to handle difficult and stressful situations through emotional detachment and various depersonalising techniques.

In the context of written medical discourse, the Passive Voice is regarded as an example of such techniques (cf. Cornelis 1997, 3–4). Yet, as the researchers observe, the notorious use of this linguistic resource allows for such bizarre situations 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 and Beagan 2004, 1074). As Poirier and Brauner (1988) observe, "a written and oral style that does not use 'I' or active verb forms with which to discuss a patient discourages a sense of medicine as a personal, active, and interactive enterprise" (1988,

6). Instead, the 3rd person narration is used, which seems to be another problem. In Katz and Shotter's (1996, 921) words, "[f]or in the voice of the third person (…) there is no story, no narrator, no person, no patient, no physician; just a writing about a patient as an abstract generalisation". Such third-person ways of talking contribute to the impersonal character of case reports where the author "appropriates his[/her] patient's responses through 'indirect' speech'" (Francis and Kramer-Dahl 2004, 181) and where operations are *done*, procedures *carried out* and diseases *treated*. Katz and Shotter (1996) observe that "[i]f we privilege the medical voice alone, then what the patient says is located in the body, selectively translated into medical language, and the rest set aside" (1996, 921; cf. Poirier and Brauner 1988, 5; Charon 1992, 117; Harvey and Koteyko 2012, 96). Also Harvey and Koteyko (2012, 103) note that "(…) the impersonal agentless nature of the passive voice makes it suitable for use in the case history, in which biological processes overshadow personal agency".

How this linguistic resource is utilised is demonstrated by Warshaw (1989) on the basis of medical records of women treated due to physical abuse. She shows that in this particular case, the preference for passivity hides the person responsible and additionally textually removes the victim too. As Harvey and Koteyko (2012, 105) observe, "[t]he entire event of physical abuse is thus reduced to and represented by body parts—an exchange between fist and eye, with the latter removed from the individual attached to it", for example: "'was hit on the upper lip', 'blow to head by stick with nail in it', 'hit on left wrist by a jack hammer'" (Warshaw 1989, 512). As a result, the description fails to render, as Warshaw (1989) puts it, "the animate connection" that links the victim to the injuries he/she sustained and the circumstances in which it happened.

Another depersonalising device is used when the results of the tests are given. These are reported either as "attributes" (Atkinson 1995, 107; cf. Francis and Kramer-Dahl 2004, 176) of patients or patients are not even referred to. Alternatively, authors may "itemise" (Rylance 2006) symptoms or diseases treating them as things, "depreciating [at the same time] the patient's individuality" (Rylance 2006). A similar depersonalising effect may be achieved when nominalisation is used. Generally, this process involves changing parts of speech into nouns, which as well makes it possible not to include agents (i.e., doctors) and patients (Cohen et al. 2008, 5).

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 and Kramer-Dahl 1992, 73; Fowler 1996; Atkinson 1997).

Lastly, the choice of verbs by means of which patients' accounts are presented as opposed to the ones used in referring to tests results requires elaboration. While in the first case, patients are often reported as *denying* something or *complaining* about something, CT scans and analyses *confirm*, *show* and *present* particular information. This way, what is implied is that the patient's account is subjective and thus less reliable/valuable than the data rendered by machines (Anspach 1988; Monroe et al. 1992, 46–47; Donnelly and Hines 1997, 1045). The verbs in the other group are referred to as *factive*, as they create the impression that the information is objective and credible whereas those from the first group are labelled *non-factive* and contribute to the effect of uncertainty and unreliability. This way, the choice of verbs reflects the different status of the patient's account and of tests results as represented in medical discourse. According to Monroe et al. (1992, 47), the effect of such a discourse is implying that it is not the illness that causes trouble but the patient.

To illustrate their point, Monroe and colleagues (1992) recall a student who, in a similar vein, when asked to define a patient, said that he is "some lab values on a chart" (1992, 49). Such an understanding has been confirmed in Helan's (2012) study of the genre at hand in general and in Zabielska's (2014) of patient imaging in medical case reports in particular. This suggests treating a patient as "the object of some disease entity" (Mead and Bower 2000, 1089) or reducing him/her to the disease he/she suffers. It may also lead to other naming practices of this kind used among health professionals (cf. Anspach 1988; Siegler 2010). This process is aptly summarised by Hurwitz (2000):

> The traditional medical view of the consultation is to see it as an opportunity to fashion a clinical case history. This particular narrative genre consists of a story that begins with a succession of events or experiences relating to the patient, which then becomes progressively abstracted from the patient's control and the context of its original telling. The extracted story progresses, transformed by a medicotechnical vocabulary not likely to be understood by the patient. The patient tends to lose control of the story as the case history develops and becomes a tale that only someone else can tell, taking on a life of its own in staff rounds, case conferences, and the medical literature. Meanwhile, the patient as the person from whom the story originally arose becomes increasingly incidental to it, maintaining within it only the anonymous presence of a ghost (2000, 2088).

Although the authors explicitly refer to the event of medical consultation, which then may be transformed by medical professionals into many different genres, the account of the process may also be applied to modern medical case reports, which commence with a few lines describing the reasons of the patient's presentation. Yet, the further the text progresses, from history and physical examination/tests, through treatment, to discussion, the patient, as a whole person, disappears, giving place to references to his/her body parts or only medical details.

6. Rationale behind studying case reporting

One may ask, however, why would medical professionals be patient-centred in written medical discourse? Two reasons may be adduced here. Firstly, 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 other sciences, the case reports examined here, as any other medical texts written for health professionals, are texts about human beings and in this way patients should be portrayed. In the case of case reports, the postulate appears even more valid as this genre treats about 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 the patient as an experiencing individual, whose suffering is to be alleviated, and not a case of a disease treated in a particular way. Secondly, the way patients are imaged in medical case reports seems to be of primary importance in the light of the fact that they perform a socialising function. They exemplify a certain pattern of clinical reasoning and presentation of information (Anspach 1988), and may reflect a particular image of how patients are positioned therein. Yet, if this mode of writing objectifies the patient, it requires linguistic attention. It is so, because these various texts are written by professionals who have already established their credentials as doctors and their texts may be treated as a paragon of 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 publications and be sensitised to the potential that language offers not only in communication *with* patients but also *about* patients. This reasoning is also shared by Donnelly (2002, 447), who points to the familiar phrase which actually is not true, that doctors *take* stories. In fact, doctors *create* stories and a

medical case report, objectified and disease-centred, is a variety of reality, but not its sole representation (Donnelly 1988, 824).

7. Solutions

7.1 General observations

As has been already discussed, there are a number of problematic areas regarding the way contemporary case reports portray patients. As a result, a number of solutions have been proposed, ranging from general observations, through single guidelines, to whole models to be implemented. These will be discussed below.

Firstly, though case-related genres are characterised by low narrativeness (in comparison, for instance, with patients' stories of illness, cf. Prince 1982) the narrative character of the genre needs to be emphasised as narrative as such is "central to the ways that physicians think about disease, make diagnoses and offer treatments that take into account patients' expectations and individual needs" (Goyal 2013). It "can help clinicians integrate biography and anecdote, life story and case history, with impersonal aspects of medical and scientific knowledge" (Hurwitz 2000, 2086), and improve the understanding of patients' accounts (Charon 2001). This goes in line with certain differentiations made by researchers: cure/care-oriented practice; identification (biomedical knowledge)/understanding (patient's experience) (Donnelly 1992); a two-fold account of pain/suffering (Donnelly 1996); a narrative, not a chronicle, as the most suitable form of conveying patient's experience of illness (Donnelly 1988, 824; cf. Rylance 2006), action (medical practice)/consciousness (emotions, states, etc.) (Bruner 1986); and disease/illness (Donnelly and Hines 1997, 1047; cf. Stewart et al. 1995). In the case of case reports, it is a story of all the stages of one's illness. Hunter (1991) describes the physician's task as being threefold: (a) to acknowledge the patient's subjective experience, (b) to formulate it as a medical version and then (c) to feed that back to the patient. According to Hudson Jones (1994), patients' *pathographies*, i.e., stories of illness, need to be acknowledged (1994, 197; Barr 2010, 683). What is more, it is of utmost importance for the experience to appear in the written form, which is more challenging than oral communication with the doctor (Donnelly 2002, 447). Then, if the narrative character of the text is appreciated, then it is possible for the doctor "to understand and affirm the life narrative of which it is a part" (Hunter 1991, 147). In order to access patient's experience of illness, a narrative has to be given, analysed and attended to,