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Explorations: A Journal of Language and Literature

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Incommensurability of discourses in professional medical communication

Abstract. The present paper discusses the incommensurability of discourses in the context of professional medical communication. It will be shown how, though relating to the same medical aspect/reality, medical practitioners and patients avail themselves of different means of expression, stemming from two different perspectives from which they perceive it. This way, it is possible to talk about two discourses which can be found in written medical discourse, namely *patient-centered* and *objectifying discourse*. These will be exemplified on the basis of medical case reports (both standard and recently developed) derived from British and American journals aimed at health professionals. It will also be shown that though seemingly incommensurable, the two discourses may coexist depending on where medical authors wish to place communicative accents in their texts.

Key words. medical discourse, incommensurability, case report, patient-centered discourse, objectifying discourse

1. Introduction

Medical records, though authored by one or a group of medical professionals, very often include voices of different participants of management including the very patient, his/her family, auxiliary staff, which are then filtered through the doctor's lenses. As Irene McEwen (2009) observes, apart from the patient, information may also be supplied by family or friends (2009, 105). The editor of *Cases Journal*, one of electronic open-access journals of case reports, openly states that he "wants to accept not reject and to include patients as authors as much as possible" and that "case reports can eventually be submitted by anybody - patients, doctors, nurses, relatives, anybody" (Smith 2008b, 1; cf. Hunter et al. 1995). Therefore, although initially it is a number of different accounts, they come to be appropriated by means of and reworked into medical discourse of the doctor. Such "third-person ways of talking" contribute to the impersonal character of texts where *operations are done*, *procedures carried out* and *diseases treated*. As Arlene Katz and John Shotter (1996) claim, "[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" (921; cf. Charon 1992, 117; Poirier and Brauner 1988, 5). This paper discusses the incommensurability of two discourses that can be found in the descriptions of medical cases. It points to the reasons of this state of affairs, i.e. two models of medical practice that are reflected in professional discourse and their interaction, which is further illustrated with appropriate examples from medical case reports. First, the theoretical background will be discussed, including the aforementioned models and their interaction in medical texts as well the discourse of contemporary medical records in general. Next, the data to illustrate the problem will be described. Then, the analysis will follow in which two types of case reports will be exemplified to present the discourses. Finally, some concluding remarks will be given.

2. Models of medical practice

In order to understand better the incommensurability of two discourses in professional medical discourse in general, the *biomedical* and *patient-centered* models in medical practice will be discussed.

According to Charles Bazerman (1988), scientific discourses are shaped by given disciplines (1988, 47). It follows that the ways in which academics inform about their scientific activities are influenced by modes of reasoning, methodologies, objectives, etc. of a given area of study (cf. Atkinson 2001; Taavitsainen and Pahta 2000). In other words, how researchers argue in scientific papers and the theories and methods they choose depend on a particular model which is practiced at a particular moment in a particular discipline. Following this line of reasoning, features of medical texts might be conditioned by the nature of medicine both as an area of study and of practice.

As regards medical practice, the model which has been present since the 19th century is the *biomedical model*, which views illness as a direct consequence of the diseased body and patients as mere recipients of treatment (cf. Wade and Halligan 2004, 1398). It follows that subjective perception is treated as irrelevant and may even yield false results (cf. Yardley 1997, 4). The model is believed to be reductionist because it limits the understanding of disease only to its biological manifestations, thereby excluding social and psychological aspects. As Richard Baron (1985, 607) puts it, there is a "shift in focus from the human experience of illness to various technologic facts of disease“. Accordingly, in Western diagnostic procedures only the biological aspects of disease are taken into consideration (Monroe et al. 1992, 48; cf. Baron 1985, 607; Donnelly and Hines 1997, 1046). The *patient-centered model*, on the other hand, is based upon the premise that the diagnosis of a disease is incomplete without considering the combination of psychological and social aspects of the patient's life (Pereira and Smith 2006, 455; cf. Hunter 1991, 21; Quill 1983; Yardley 1997, 5). Such a holistic approach was in direct opposition to the reductionist *biomedical model,* which took only biological facts as pertinent in the treatment of a disease (cf. Engel 1988; Pellegrino 2001, 83). What this model is about can be explained with the help of Mattingly's (1998b) description of the character of therapists' job, i.e. learning the effect of a patient's ailment on his/her daily life (1998b, 74).

In the following section, it will be shown how these models are reflected in contemporary medical discourse.

3. Discourse of contemporary medical case reports

As has been observed in section 2 above, scientific discourse is believed to be affected by particular models observed in given disciplines. Consequently, models of medical practice may affect the way in which medical professionals construct their academic texts. In this respect, written medical discourse in specialist context has recently come in for significant criticism for the portrayal of the patient, which is said to be affected by the *biomedical model*. This section will shed some light on this particular aspect.

Case reports are one of many medical genres and describe new diseases or diseases which are already known but which have unusual manifestations. Accounts of new conditions or diseases appear to be the first manifestations of medical communication. "[They] underpin 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 center" (Peh and Ng 2010, 10). A case commences the whole process of diagnosis and treatment through gathering information, its interpretation and presentation (Hunter 1991, 68). As Richard Smith (2008a, 1) notes, "every new condition - whether it is AIDS, SARS, or the next emergent disease - begins with a single case" (cf. McEwen 2009, 17). Every case may be a valuable source of new information or simply add some new perspective/aspect to the body of knowledge accumulated so far (Smith, 2008a, 1).

Much as the language of medical case reports 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 Lawrence McCullough (1989) points out, it abstracts from the subjective experience of being ill, and by doing that, it depersonalizes him/her (Monroe et al. 1992, 45). "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. Frank 1991; 1995; Hatem and Rider 2004, 1; Mishler 1984).

Furthermore, the central position of modern medical equipment, medical tests and the data they provide in textual representation may be the consequence of the attitudes and values developed by students in the course of medical studies. The activities and tasks assigned to students during hospital and clinical training are supposed to teach them how to handle difficult and stressful situations through emotional detachment and various depersonalizing techniques. In the context of written medical discourse, the passive voice is regarded as an example of such techniques. 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 Suzanne Poirier and Daniel 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" (6).

Another depersonalizing device is used when the results of the tests are given. These are reported either as "attributes" (Atkinson 1995, 107) of patients or the patients are even not referred to. 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. Atkinson 1997; Fowler 1996; Grice and Kramer-Dahl 1992, 73; Hunter 1991). The very word *case* merits some attention. It has been stated at the beginning that the *case* is the basic unit of medical thought. Yet, this basic unit may be understood differently. For doctors and nurses *cases* are patients who are managed for particular diseases (Radley and Chamberlain 2001, 323). *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"). Then *cases* are discursive constructs with their 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" (103; cf. 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" (103).

Lastly, the choice of verbs by means of which patients' accounts are presented as opposed to the ones used in referring to test results requires elaboration. While in the former case, patients are often reported as *denying* something or *complaining* about something, in the latter case, CT scans *confirm*, *show* and *present* particular results. This way, what is implied is that the patient's account is subjective and thus less reliable/valuable than the data rendered by machines (Monroe et al. 1992, 46-47; cf. Anspach 1988; Charon 1992, 116). 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 labeled as non-factive, contributing to the effect of uncertainty and unreliability. This way, the choice of verbs reflects the different status of the patient's account and test results as represented in medical discourse. According to William Monroe et al. (1992, 47), the effect of such discourse is implying that it is not the illness that causes trouble but the patient. Further, the authors recall a student who in a similar vein when asked to define a patient said that he is "some lab values on a chart" (49). This specific use of *factive* and *non-factive* verbs has also been confirmed by Helán's (2012) study of case reports.

4. Incommensurability of discourses

To explicate the nature of the incommensurability of two discourses which can be associated with *biomedical* and *patient-centered models* respectively (Atkinson 1995; Hunter 1991; Rawlison 1982), Paul Atkinson (1995) refers to the notion of *voice* (originally developed by Torode 1984) to denote different worldviews orienting speakers towards reality in particular ways. In this context, Mishler's (1984) distinction between the *voice of medicine* and the *voice of the lifeworld* seems relevant. While the latter refers to the patient's account of the experience of illness, the former is the doctor's perspective. In such an approach, physicians are regarded as "applied bioscientists", "collectors and analyzers of technical information elicited from patients", while patients are "passive object[s] responding to the stimuli of a physician's queries" (Mishler 1984, 10). In his study of doctor-patient communication, Elliot Mishler (1984) points to the dominant position of the *voice of medicine*. In Mishler's (1984) own words, the *voice of medicine* can be compared to "the technical-scientific standpoint of the biomedical model" which interrupts the *voice of the lifeworld*, "the concerns of everyday life" (6). Atkinson (1995) refers to the former voice as "decontextulized" (1995, 129) and it seems to be a keyword, as what is focal in this viewpoint is a disease viewed as free from its milieu (cf. Mishler 1984, 192). Atkinson (1995) also offers other sets of opposites, namely *personal experience* and *text-book science* or the *voice of science* and the *voice of experience*.[1] Although Atkinson (1995) uses Mishler's (1984) voices in the context of interactions in the doctor-patient dyads, such a distinction seems to be universal in medical discourse in general, referring to texts and modes of behavior as well. Kathryn Montgomery Hunter's (1991) book also includes a subsection devoted to the issue of incommensurability of discourses. The title *One illness, two stories* illustrates well the yawning gap between patient's and doctor's discourses, which can be extended to the *voices of the lifeworld/science* and *patient-*

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[1] As there are different voices, so are discourses. Fleck (1979) distinguishes *journal science, textbook science, vademecum science* and *popular science* whose modes of mediation depend on the audience to whom the knowledge is addressed.

centered/biomedical models respectively. The patient's account is, according to Hunter (1991), a personal story of an experienced ailment. Consequently, illness is described here from the perspective of its influence on the patient's life. The other discourse, i.e. from the doctor's perspective, is significantly different. It is the patient's account seen through the biomedical lenses which depersonalize his/her experience and select only necessary information pertinent to the diagnosis. What is more, the account is phrased in a specialized vocabulary. This way, the patient's perspective becomes "distorted and flattened" (Hunter 1991, 13; cf. Condrau 2007, 529; Kleinman 1988).

All in all, although describing the same medical fact, the two discourses originate from two different underlying worldviews and have different aims. The patient's account is the story about illness, out of which a doctor constructs the story about disease. Yet, as Hunter (1991) observes, the patient's story is neither changed for the other nor translated. "Neither [of them] can be comprehended or satisfactorily reduced to other's terms" (Hunter 1991, 124). "[T]he subjective experiential story and the outsider's objective, scientific interpretation" (Hunter 1991, 124) cannot be united because "medical language (...) [,] an abstract discourse about organs (...) is not about patients and their experience of illness" (McCullough 1989, 103). Unfortunately, according to Hunter (1991), "[t]his difference, critical to the care of the patient, is seldom acknowledged in medicine" (14), which, in turn, perpetuates the taken-for-grantedness of the *biomedical model*. For Mary Rawlison (1982), however, it is not the incommensurability of the discourses but the fact that medicine uses "scientific language concerning itself only with observable and measurable physical findings (...) inadequate to its own practice" (83). This language deals only with the body and abstracts away from any contextualization of its primary subject. Consequently, medicine focuses on biological processes and pathological lesions but does not place them against the background of those whose bodies are affected (Rawlison 1982, 83). This view is also shared by McCullough

(1989, 124), who notes that patients and physicians avail themselves of two different languages, of illness and disease respectively, and that neither party can employ the language of the other.

To summarize, according to the authors dealing with the incommensurability of discourses, medical discourse (be it the *biomedical model*, the *voice of science*, etc.) fails to acknowledge the fact that the aim of medicine is not to center exclusively around identifying and treating bodily dysfunctions but instead to view them against the background of a person and his/her experience. The focus of modern medicine should fall on the entirety of patient as opposed to his/her fragmented body. In other words, when examining their bodies and biological processes, patients should be viewed not as objects of science but its subjects whose illness needs to be understood (cf. Pellegrino 2001, 31).

Due to the fact that the discourse of biomedicine comes as a natural choice, its reflections can also be found in medical texts. In this context, Hunter (1991) distinguishes between impersonalization and reification in the approach to the patient. By impersonalization Hunter (1991) understands a symbolical transformation of a patient into a medical narrative. It is a story that contains information about disease manifestations in a given patient and subsequent treatment which in medical community "comes to *be* [original emphasis] a patient" (Hunter 1991, 135). However, patients tend to be discursively equaled with a disease and there are several causes of such a state of affairs. Firstly, the incommensurability of the discourses appears to be part and parcel of Western medicine (Hunter 1991, 134). The *biomedical model* adopted there is conducive to the view of diseases as entities and focuses solely on their manifestations in patients as opposed to the patients' experience of illness. Secondly, it is claimed that in emergency, what counts is a disease or a condition to be treated and not the patient's experience. Thirdly, such objectification is supposed to help physicians to distance themselves emotionally from their task. As a result, treating disease and not the patient's suffering reduces the emotional load accompanying patient management: “The person who becomes a case of bowel cancer is a problem in therapeutics to be addressed, but a person who has become the bowel cancer itself is a fait accompli. Bowel cancer is a congeries of qualities and events with a known course requiring physical attention but no investment of self” (Hunter 1991, 137). Yet, if modern medicine treats pathological changes exclusively, then it is only a step away from identifying patients with these changes. “Without a saving recognition of the reality and persistence of the patient experience and its incommensurability with its medical interpretation, the diagnosis replaces the case history as an representation of a patient” (Hunter 1991, 136). Therefore, turning the patient’s account into a medical text about his/her disease exemplifies “abstraction”, which is typical of medicine. What should not be allowed, however, is treating patients as disease entities (Hunter 1991, 136; Mead and Bower 2000, 1089). Unfortunately, as will be demonstrated in the next section, the language of modern medicine reflects the *biomedical model*. It is what the biomedical mode of reasoning forces on medical discourse and what the *patient-centered model* strives to change.

5. Analysis

5.1. Data and methods

The present study consists of 2 stages – the analysis of standard and the so-called interactive case reports. In the first stage, the examples come from the corpus of 56 case reports taken from four international medical journals aimed at health professionals – *The Lancet* (15), *The Journal of American Medical Association* (13), *The New England Journal of Medicine* (16), and *The British Medical Journal* (12), published between 1995 and 2008 and devoted to a variety of medical fields. They are also thematically varied. The rationale behind the choice of the genre of case report was the fact that this text-type does not present general medical knowledge or detailed results of clinical research, but it discusses particular patients suffering from particular diseases. In other words, case reports give the account of diagnosis and treatment but always in the real context referring to a given person.

In the other stage, patient-centered discourse will be demonstrated as exemplified in interactive case reports which feature the 1st person narration of the patient. It is one of the recent developments of the genre and used to be published by *The British Medical Journal*. This form usually appears as a series of case reports devoted to one particular topic, published in subsequent issues, starting with *case presentation*, through *case progress* to *case outcome*. The first part resembles a regular case report presenting a given case, additionally including the call for reader's responses and comments. The progression of the treatment as well as possible readers' reactions are the topic of the second part. The third one presents the outcomes of the treatment, and discusses the prognosis and implications for further investigations. The material for this stage of analysis comprises 8 interactive case reports derived from *The British Medical Journal* (BMJ), which is the only journal known to the author which used to publish this variety of case reports. The reports were published in 2003, 2004 and 2006.

In the following discussion of the results, first, the identified *patient-centered* and *objectifying discourses* from the perspective of the doctor will be shown on the basis of standard case reports. Next, the interactive variety will be demonstrated featuring *patient-centered discourses* as authored by the doctor and the patient.

5.2. Patient-centered discourse

As there is a mode of practicing medicine which encourages patient's active participation in the process of diagnosis and treatment and takes into consideration his/her experience of illness, so there is a *patient-centered discourse* which reflects the model linguistically. The acknowledgement of the patient's presence in medical texts is achieved in two ways, namely by foregrounding them as well as recognizing them as experiencing individuals.

Firstly, the qualitative analysis of the selected sentences has shown that patients come to the fore when they are presented as active participants in the process of diagnosis and treatment. Such a mode of writing is possible when their volitional actions are described:

(1) *At that time, the patient reported difficulty in concentrating, memory loss, and occasional loose stools.* NEJM5
(2) *A 64-year-old woman presented to the emergency department with a stiff painful jaw.* LA14
(3) *He was treated with broadspectrum antibacterial agents (i.e., vancomycin, ceftriaxone, and metronidazole) and antivirals (i.e., acyclovir and foscarnet).* JA2

Sentences (2) and (1) portray patients as visiting the health unit and reporting their health problems respectively. The patients function here as Agents of the sentences, i.e. the instigators of the actions denoted by the verbs. It can be said that participants in a given sentence can be compared to actors in a little drama (cf. Aarts 1997, 80). The roles they play are hierarchically ranked and the Agent is the most prominent participant. What is more, being the Agents of the sentences, patient references hold the most prominent sentential position, namely the Subject position, which makes them the referents of the rest of sentence. As a result, their significance in terms of semantics and syntax foregrounds them in the texts. Nevertheless, even if a patient is described as undergoing treatment, which means that he/she is not the Agent, it is still possible to foreground him/her in a sentence. This can be done by keeping him/her in the Subject position (cf. 4 and 5 below) or using the passive voice (cf. 3 above).

(4) *He underwent tracheostomy and was ventilated mechanically for the next few days*. B5
(5) *The patient deteriorated rapidly with swinging pyrexia of 41°C and died 2 weeks later, in September, 2003*. LA3

As a result of the meaning of the verbs in (4), (5) and (3), the patients take the thematic role of Patient. Nevertheless, their position is still central, as they are those to whom the sentences refer in the context of particular treatment (4 and 3) and condition (5). This effect is possible thanks to the location of patient references in the Subject positions, as in (4) and (5). In the case of (3), where the patient, due to the meaning of the verb, cannot be the Agent and is not in the Subject position in the active voice, the passive voice can be used. This option enables Patients to be the sentential topics while the Agents, in this case physicians who perform the procedures described, are textually absent. Consequently, although patients' status in examples (3), (4) and (5) is different from, for example, (1) or (2) above, the readers' attention is still drawn to the patients as being managed or experiencing changes of their conditions and not exclusively to treatment or diseases.

By contrast, the second element of the *patient-centered discourse,* i.e. the presentation of the patient's experience of illness, is a categorical choice. Such information is either present, i.e. thought as relevant, or not. The following examples demonstrate these references in their particular sentential co-texts.

(6) *Although the man complained of a headache for the next 24 hours, he recovered completely.* JA6
(7) *She developed pain and massive inflammation at the injection site, was told she was allergic to the toxoid and should not have further tetanus immunizations.* LA14
(8) *Having sustained two fractures from simple falls, my patient was understandably worried about further fractures.* B3
(9) *He had incapacitating leg pains and increasing difficulty walking.* LA7
(10) *He immediately felt rectal pain; four hours later he developed dysuria, frequency, and frank hematuria.* B12
(11) *He developed acute pelvic discomfort at the time of injection, followed by urgency, dysuria, fever, and aching in the left testis.* B12

As the examples above demonstrate, the authors of medical case reports under study acknowledge the way patients react to illness in a two-fold manner. It can be presented either as an "isolatable entity" (Blois 1984) associated and, therefore, mentioned with a particular condition (cf. 7, 9 and 11 above) or described as a state that can be experienced (cf. 6, 8 and 10 above). In the former case, the means of expression are nouns which allow to list symptoms, while in the latter case, the verbs which denote particular experience, and adjectives which describe the state in which the patient finds himself/herself.

The sentences (7-11) above describe patient's discomfort. The verbs: *complain, feel, ache* and the adjectives: *worried* on the one hand, and nouns: *pain, discomfort, difficulty* on the other, denote the experience of particular reactions and states or refer to them as abstracted elements of a disease respectively. Yet, regardless of whether listed or described as an experience, all these manifestations of how patients feel are mentioned in the co-texts where patients are referred to as whole persons (in contrast to their body-parts only), and where they are the subjects of the sentences, i.e. the point of reference.

All in all, such a mode of writing as the one described above is clearly in line with the broadly understood *patient-centeredness* in medicine. Firstly, the focus falls on the whole person of a patient, which is achieved by the use of personal pronouns or nouns referring to people and not to the parts of their bodies/aspects of condition/treatment, and by placing the words indexing the patients in the Subject position. The latter is possible both in active and passive sentences, depending on the semantic features of verbs. As a result, regardless of the patient's status as Agents or Patients, they are the topics of the sentences. Secondly, the patient's experience of illness is presented, which, though filtered through the author's/physician's lenses, clearly acknowledges the psychological (patient's feelings) and social (patient's inability to perform certain activities) aspects of illness. Consequently, rather than presenting them as entities separated from an experiencer, conditions, symptoms, or reactions are literally *felt* by the patient and hence incorporated into the patient's experience. It follows that the *patient-centered discourse* focuses on the whole person and recognizes other than biological aspects of ailment. The result is a narrated story of illness which is contextualized in an experiencing individual, something regarded by Steven Miles and Kathryn Montgomery Hunter (1990) as of primary importance in medical cases ("circumstance and historical setting") and something that is not possible in the *biomedical model*. Furthermore, it has been pointed out that the presence or absence of the examples of the *patient-centered discourse* is not always conditioned by the aims of a particular section, but may also be the author's choice.

5.3. Objectifying discourse

It has been said in section 2 above that *biomedical model* is reductionist, because it focuses solely on the biological manifestations of diseases and treatment procedures and not on the patient's experience of illness. The discourse which corresponds to this model is the *objectifying discourse*, which objectifies patients in three respects. Firstly, patients' mental/somatic experience is given without reference to the experiencers. Secondly, the texts separate patients from their bodies, either writing solely about the affected/treated body-parts or abstracting from their owners. Thirdly, also medical procedures are either foregrounded or dealt with without mentioning those who undergo them.

For one thing, as has already been stated (cf. section 5.2 above), the textual presence of the patient's experience of illness is one of the characteristic features of the *patient-centered discourse*. Examples (1-11) above clearly portray this experience as contextualized in particular patients who are referred to as whole persons. In contrast, mentioning pain or any other sensations without reference to an experiencer may not be treated as the *patient-centered discourse*.

(12) *We started a magnesium infusion to maintain ionized magnesium levels of 1·5–2·0 mmol/L, as* ***muscle spasms*** *were consistently worse once the serum magnesium fell below 1·5 mmol/L.* LA14

(13) *The development of* ***pelvic pain*** *at the time of injection and urinary symptoms within a few hours was highly suggestive of a misplaced injection into the prostatic or periprostatic tissue.* B12

The above-given sentences enumerate two bodily reactions – *muscle spasms* and *pelvic pain* – and abstract them from their experiencers. Instead, the focus falls here on the treatment procedure while patients' bodily responses are described as accompanying biological conditions. Such instances treat the patients themselves and their reactions or symptoms separately and, consequently, do not acknowledge patients' suffering or any other discomfort stemming from the abnormal condition. As a result, the reactions and symptoms seem to have value in themselves without the need of contextualizing them in patients.

The second group of examples includes sentences in which it is the patient's body-parts that take center stage:

(14) *One month later* ***the spleen*** *was no longer palpable; at six months, the size of the spleen was normal (13 cm) on ultrasonography.* NEJM2
(15) *The left side of* ***the chest*** *was not explored.* NEJM10

What these sentences concern is the condition of the body-part (organ, etc.) itself (14) or its treatment (15) and not the patient whom this surgery concerns. These examples, i.e. where parts stand for wholes – patients, represent a metonymic type of reference. Here body-parts which are treated or whose condition is assessed seem to exist individually in the text. Their separation is an assumed feature, firstly, by virtue of the specificity of the genre that describes diseases in particular patients, and, secondly, of the local character of treatment. It follows that even if the patient is not mentioned, every time patient-related issues are dealt with, readers know who they are reading about. What is more, admittedly, when a disease is described, reference will be made more frequently to the treated body-parts than to the whole persons. Consequently, the patient becomes objectified as he/she is reduced to his/her body on which medical procedures are performed.

Thirdly, there are also sentences which, again, abstract from the patient but this time while describing various medical procedures – from tests to surgery. Regardless of whether they concern the whole patient or his/her body-part, patients may be textually absent.

(16) *Physical examination confirmed the previous findings and did not* ***show*** *any warning signs or indications of progressive involvement.* B10

(17) *On the evening of admission, transplantation of a cadaveric kidney into the left iliac fossa was performed without incident, except that endarterectomy of the left common iliac artery was necessary before creation of the anastomosis; (...)* NEJM13

Admittedly, the sentences describe medical procedures and tests by means of which information concerning patient's health is obtained. Therefore, specific diagnostic devices are presented as *showing* results (16) whereas the operation is the primary topic of sentence (17). Yet, the textual absence of patient references contributes to the instructive character of these examples, which seem to be informing how to perform a given procedure rather than describing patient management.

5.4. Patient's perspective

As has been demonstrated in sections 5.2 and 5.3 above, regular case reports feature primarily the doctor's perspective and the references to the patient are made in the 3rd person. This means that the patient's voice is filtered by the doctor-writer, which is different from the patient speaking about him/herself without any intermediaries.[2] Interactive case reports, on the other hand, introduce the patient's perspective in the form of the 1st person narration, which is termed by Anne Hawkins (1993) as *pathography*. As the analysis shows, at the level of the text, this narration is realized through giving the floor to the patient, who voices his/her concerns and perceptions. The unique feature of the aspect at hand is for example lay vocabulary that patients use to describe their experience of illness.

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[2] Cf. Elizabeth Coker (2003) on how the patient is constructed in Egyptian medical records and what different voices are employed therein.

(18) *Elisabeth first became unwell during the evening of her 2nd birthday. Her parents noticed that she was "**grizzly and off her food.**"* BMJ3

(19) *"**Once you turn yellow,**" he thought, "it's cancer, and once **you're opened up, the cancer takes over your whole body.**"* BMJ1

(20) *I never really thought I was ill, but **the palms of my hands and the soles of my feet were driving me round the twist. I could have used a wire brush on them. It was so deep down I was making myself bleed, but I was scared.** (...)* BMJ1

(21) *Even though the medication didn't work in the end, I don't regret doing the trial. **It was helpful that someone took an interest in how I was feeling.*** BMJ2

As it can be seen in the above-given examples, the descriptions provided by the patients refer to both mental (18) and physical (19-20) experiences. In (21), additionally, the patient directly refers to the way he/she was approached by doctors. The inclusion of the patient's perspective seems a complimentary element introducing how things are experienced and understood by the other party. This way, "the patient emerge[s] very differently when recounted as an agent in a personal story" (Mattingly 1998a, 274). What is interesting, at the beginning of the report, similar information is delivered by the doctor, but the medium of expression is entirely different.

Apart from the novel element presented above, interactive case reports include the already known elements from regular case reports, i.e.: the acknowledgement of the patient's experience of illness (22-23) and his/her textual visibility (24), both in the text constructed by the doctor:

(22) *Ruth **experienced** adverse effects from azathioprine and risks more while she continues taking steroids. **The aims, risks, and benefits of treatment need to be discussed with her, because her views will ultimately determine whether she takes prescribed drugs.*** BMJ2

(23) *Vitamin B-6 was also ineffective in **alleviating our patient's three other most important symptoms of dizziness, daily activities, and general wellbeing. We believe an n of 1 trial is a useful means of helping patients decide on which treatment to take in situations where evidence is poor or equivocal.*** BMJ2

(24) *What of **Mrs. Reynolds**, the subject of the case report? **Her** case is not entirely typical since **her** sickness started later in pregnancy than is usual at 8 weeks and because **she** had not had this problem in previous pregnancies. **Her** history suggests that social or psychological factors were absent. **She** did not benefit from prochlorperazine, but it is*

> *important that antiemetics are taken regularly rather than on an as required basis and this should be clarified with* **her***. It is also important to consider whether* **she** *was vomiting up the drugs. In this situation suppositories can be helpful.* **Her** *condition seems to have progressed and was affecting* **her** *ability to function. However,* **she** *had no evidence of dehydration (absence of postural hypotension) and no ketonuria, features present when vomiting has progressed to hyperemesis.* BMJ4

In examples (22-23), reference is made to the patient's experience of illness through the use of specific verbs (*experience* in 22 and *alleviate* in 23) as well as terms referring to a particular ailment – *dizziness* in (23). What is also addressed in (22) is the process of decision making with direct reference to patient's involvement (her views) and well-being (*risks and benefits*). (24) is a longer piece of text which exemplifies patient's visibility achieved through the use of both personal and possessive pronouns. Additionally, similarly to regular case reports, the author's voice can be observed here (cf. *we* in (23) above) as well, which, together with direct references to patients contribute to a more patient-oriented text, not the one in which *diseases are treated* and *procedures carried out*.

6. Conclusions

In the present paper, an attempt has been made to examine the problem of the incommensurability of discourses in written medical discourse aimed at health professionals. It has been shown that when referring to the same medical phenomenon/reality doctors and patients may use different discourses of different loci and linguistic resources. While doctors will focus rather on biological aspects of one's condition, translating symptoms into measurable features of an "anatomicopathologic fact (...) [,] taking illness from the universe of experience" (Baron 1985, 606), patients will rather concentrate on their experience of symptoms and how this change in their condition affects their daily activities. This has been illustrated with appropriate fragments from standard case reports and interactive ones, the latter demonstrating recent trends in this genre of making medical knowledge more accessible and opening it to wider audience. In the texts examined, examples of *patient-centered* and *objectifying discourses* were demonstrated. In regular reports, the discourses were authored solely by the doctor and, while the *patient-centered discourse* underscores patient’s agency and centers around his/her experience of illness, the *objectifying discourse* abstracts disease from the very patient, focusing on a treated body-part or a procedure. In the case of interactive case reports, two types of the *patient-centered discourse* were presented. The first one shifts the perspective from a medical professional to a treated person and allows the patient to choose the content and form. In this case, one may find lay vocabulary including metaphors and subjective perceptions. In the case of the *patient-centered discourse* authored by the doctor, similarly to standard case reports, reference is made to the patient‘s experience of illness but also patient’s textual visibility was identified in the form of frequent textual references to the treated. It has been added that these two discourses reflect linguistically two approaches to medical practice which differ in their conceptualization of disease and the role of the patient in the process of diagnosis and treatment. Though seemingly incommensurable, the discourses have been proven to coexist, with *patient-centered* and *objectifying discourses* from the perspective of the doctor and *patient-centered discourses* of doctors and patients in interactive case reports.

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