

Lingua Medica

The Language of Medical Case Histories

Questionable language pervades case histories, the professional accounts of illness and medical care constructed by students and practitioners of medicine every day in teaching hospitals. In the archetypal configuration taught to medical students, the case history begins with the patient's chief complaint and concludes with an interim or final summary of diagnoses, course, and care. I use the term *case history* generically to refer to both the medical record and its numerous offspring, such as oral case presentations and published case reports. However, I give greatest attention to the written record. As the official, permanent account of professional medical care, the medical record not only shapes the style and focus of its various progeny but also determines what students take seriously in an antecedent activity, the medical interview (1).

Case histories matter. These narratives are the way in which physicians at every level of training communicate to each other their understanding of particular patients and their medical problems, what has been done about the problems, and what is being done about them. Moreover, as Weed (2) first pointed out many years ago and as Anspach (3) and Good (1) showed recently, case histories are not mere storage-and-retrieval devices. They are formative institutions that shape as well as reflect the thought, the talk, and the actions of trainees and their teachers. Moreover, Weed's conviction that reform of the medical record is central to the improvement of medical education, patient care, and clinical research continues in recent proposals to make the patient's personal situation or perspective an integral part of the written record (4-6).

Seven Language Maladies

Unfortunately, whatever their merits, case presentations and write-ups in teaching hospitals often include the following problematic language practices.

1. Introducing the sick person solely as a biological specimen (for example, as "a 37-year-old, gravida II, para I black female"). Characterizing the patient in this way paves the way for a case history

that describes the patient's sickness primarily, or even exclusively, in terms of disordered biology.

2. Translating the patient's "chief complaint" into biomedical language (for example, by recording "angina pectoris" rather than some of the words that the patient actually used to describe his or her chest pain or concerns). This practice banishes the voice of the patient from the one place specifically reserved for it even in traditional, disease-oriented case histories. Such translations risk not only premature, incorrect diagnosis but also loss of important information—exactly why the patient sought medical care at this time, from his or her point of view.

3. Using rhetorical devices that repetitively and nonreflectively enhance the credibility of physicians and laboratory data and cast doubt on the reliability of the patient's testimony. In these histories, the patient "says," "reports," "states," "claims," or "denies." The first four verbs mark the patient's testimony as a subjective account rather than fact (3). "Denies" suggests that a negative response to an interviewer's query may be untruthful. In contrast, physicians "note," "observe," or "find." Technology-derived information rates even higher, especially when clinicians say or write, "The EKG (or chest x-ray or biopsy) *shows* or *reveals*," a usage that implies that the information is a "scientific revelation" (3) independent of interpretation.

Another rhetorical device frequently used to give the observations of physicians an authoritative, objective status is the agentless passive (3). For example, saying "The spleen was palpable," rather than "I (or Dr. Jones) palpated the spleen." Use of the agentless passive is similar to another rhetorical device: the presentation of the entire case history from the point of view of an omniscient, anonymous narrator. For historical works, this mode of discourse provides a comforting "illusion of pure reference" (7). However, presenting the text of a medical case history as a nonproblematic "view from a depersonalized nowhere" (8) obscures not only the narrator's role in gathering, interpreting, and ordering the evidence used to compose the history but also the fact that all clinical knowledge—from the initial history to autopsy results—is uncertain, tentative, incomplete, and subject to change.

4. Converting the patient's story of illness, his or her human experience of being sick, disabled, or simply worried, into a history of present illness focused solely on the onset and course of biological dysfunction. This may be the most serious medical language malady, and what is lost in so complete a translation has been well described by such authors as Charon (9, 10), Kleinman (11), and Toombs (12, 13). The exclusion of such matters as the patient's understanding of his or her condition and its effect on his or her life from the history of present illness loudly signals their insignificance in medical care and relegates such important realities as the patient's misunderstandings, fears, and suffering to an informal, off-the-record assessment and response.

5. Categorizing what the patient says as "subjective" and what the physician learns from physical examination and laboratory studies as "objective." "Subjective" and "objective" can be used ontologically, as I believe Weed (2) intended when he made these terms part of the problem-oriented medical record, to distinguish between two categories of reality (subjective mental states and processes as opposed to objective physical and biological phenomena). Unfortunately, the distinction is more commonly understood epistemically, especially in a science-using activity, to mark "different degrees of independence of claims from the vagaries of special values, personal prejudices, points of view, and emotions" (14). Inevitably, then, categorizing what the patient says as "subjective" stigmatizes the patient's testimony as untrustworthy. On the other hand, calling physical findings and laboratory studies "objective data" gives an air of infallibility to the quite fallible observations of physician and laboratory.

6. Pathologizing the patient's thoughts or feelings (for example, by calling a poor understanding of a medical condition "denial" or labeling mere sadness "depression"). This practice suggests that the speaker is at a loss for words to accurately describe such human experiences as bewilderment or sorrow.

7. Failing to elicit and record important changes in the patient's perspective (for example, not recording new understandings reached with a terminally ill patient about the goals of medical care, cardiopulmonary resuscitation, or intensive care). Failing to determine the medical goals and preferences of a seriously ill patient in a timely, proactive manner can result in unwanted interventions at the end of life (15).

Discussion

Although not all of the seven practices that I have described are the deadliest of sins, their aggregate effect is to derogate, obscure, or simply

ignore the person of the patient and much of his or her experience of sickness, disability, and medical care. These practices are not new: Most of them were part of the medicine that I learned in the late 1940s and early 1950s. Categorizing clinical information as either subjective or objective "data" came later, in 1969, ironically in the service of Weed's intent to give the patient's voice a more prominent place in the medical record (2).

Why, then, do these practices continue despite extensive criticism (3, 16, 17-19)? Largely because of two deeply held but seldom articulated or examined beliefs: First, sickness is fundamentally, even exclusively, a matter of disordered biology (1); second, if human illness is primarily biological, it follows that physicians should adopt, as much as possible, the (supposed) point of view and methods of natural scientists, an approach that tends to value objective, measurable manifestations of disease and its treatment and limit interest in the patient's subjective experience to symptoms of biological dysfunction that are useful for diagnosis or tracking the course of known disease. To make matters worse, such language practices as those discussed in points 3 and 5 blithely suggest that a scientific way of looking at the world provides an unmediated, direct knowledge of reality, "the way things actually are." Failure to acknowledge the pervasive roles of interpretation and language in the acquisition and representation of clinical knowledge can begin by thinking of a conventional, biomedically oriented history of present illness as "just the facts" rather than the result of a complex interpretive process that transforms a story of disordered experience into a narrative of disordered biology.

(In passing, it is important to acknowledge that transforming the patient's story of his or her one-of-a-kind experience of illness into a one-like-some-others history of disordered biological function does have value. Because this type of narrative is generalizable, it has diagnostic and predictive powers. However, the fact that to be generalizable a narrative of biological disorder must necessarily exclude the patient's unique experience of sickness seems to have reinforced the notion that the personal and social realities of sickness are "matters separate from the real object of medical practice" [1].)

Just as important, many of the dubious language practices used in conventional 20th-century medical case histories harm students and practitioners of medicine as well as patients. Such practices are at odds with an accurate understanding of the probabilistic, observer-mediated nature of all clinical knowledge; the physician's need to work with patients as partners, not adversaries; and the professional obligation to attend adequately to patients' suffering. Clearly, such practices impede the growth

and development of "patient-centered" (20) medicine.

Moreover, the language of medical case histories may be hazardous to the user's general linguistic health. Given what medical language claims for itself and the central role that it plays in the socialization of medical students (1, 3), it is hardly surprising that it becomes the student's first language for matters of health and disease. What may not be so apparent is that this language uses its users as much as its users use it. It constrains what its users are permitted to say not just in case presentations and the pages of the medical record but in the day-to-day conversations of students, residents, and attending physicians. On rounds or in case conferences, only the most senior physician present is really free to break the frame imposed by the language's biomedical point of view. Nonmedical ways of thinking or talking about illness and disability can become something like a second, foreign language, for which special instruction must be provided. Coulehan and Block (21) warn medical students that "premedical education and medical school can sterilize your vocabulary" and provide a glossary of everyday words that describe a range of such feelings as joy, anger, and sadness. Tracy's observations about the power of language could have been written for those same medical students (22):

Language is not an instrument that I can pick up and put down at will; it is always already there, surrounding and invading all I experience, understand, judge, decide, and act upon. I belong to my language far more than it belongs to me, and through that language I find myself participating in this particular history and society.

Remedies

To correct the seven language maladies that I have identified, I suggest that medical students and physicians do use the following in their oral case presentations and case write-ups.

1. Always introduce the patient as a person (for example, Mr. John Jones, a 55-year-old self-employed architect who lives with his architect wife in their Westchester home and studio). In the remainder of the case history, often refer to Mr. Jones as Mr. Jones rather than anonymously as "the patient."

2. Record the patient's chief complaint in the patient's own words. Better yet, speak of it as "chief concern" rather than a "chief complaint." Even if "complaint" is understood to mean "a bodily ailment" (23) rather than a dissatisfaction or a grievance, "concern" is a better word because it is less likely than a lay characterization of an ailment to be translated into biomedical language. Moreover, a verbatim statement of the patient's chief concern

can presage more detailed attention to the patient's voice in the history of present illness and throughout the course of medical care.

3. Avoid rhetorical devices that thoughtlessly enhance the credibility of medical data and cast doubt on what the patient says. Unless there is some reason to doubt the patient's truthfulness, relate his or her description of the illness matter-of-factly. When conveying pertinent negatives, avoid the witless, repetitive use of "the patient denies." Instead, simply say, for example, "The cough was not accompanied by chest pain, production of sputum, fever, or chills." or "No chest pain, sputum, etc." (I realize that the usage "the patient denies" can be the way in which a junior member of a medical team assures his or her superiors that he or she has in fact asked the patient about potentially related symptoms or habits, but this is hardly a compelling reason to continue a practice that casts the physician as prosecutor and the patient as defendant.) Relate some of the case history in the first person singular, making it clear that the speaker or writer is reporting what he or she personally heard, saw, or felt.

4. Compose a two-perspective history of present illness (6), one that describes both the *illness* and the *disease*, as these two terms are used by Kleinman (11) to refer to two different views of the total biological, personal, and social reality of an instance of sickness. It is clear that the ill or disabled person's view of his or her condition differs fundamentally from a biomedical view of the condition. The difference is not simply a matter of lay belief as opposed to expert knowledge of the injury, disease, or disability. Personal and biomedical points of view originate in two entirely different conceptual systems (12, 13). Calling each account a perspective reminds us that neither the illness nor the disease is the whole story, but a limited, complementary view of the total reality of the person's sickness and medical care. The biomedical perspective (or *disease*) is the conventional, chronologic account of the onset and course of symptoms of disease or disability, including information about previous diagnosis and treatment of a chronic or recurrent medical condition. This traditional, generalizable narrative of biological disorder has indispensable diagnostic and prognostic value. The patient's perspective (or *illness*) is a separate narrative that summarizes professionally relevant information about the patient's personal experience of illness, disability, and medical care. It describes such matters as the patient's understanding of the disease or disability (cause, diagnosis, prognosis, role in management); the impact of disease, disability, or medical care on the patient's life, work, and relationships, especially such important sufferings as pain, fear, and worry; the patient's personal goals and expectations of

medical care; and, if appropriate, the patient's preferences for end-of-life care and proxy decision making and whether the patient has executed a written advance directive for health care.

The patient's perspective need not be a lengthy narrative. My experience at Loyola University Stritch School of Medicine (6) confirmed Hunter's (24) view that forceful accounts can come in very small, strong packages. Four or five sentences can effectively begin to give attention to the patient's understanding, hopes, and concerns; this can continue in case discussions and in the medical record.

Stewart and colleagues (25) advocate a similar approach, simply using the terms *illness* and *disease* to identify the two subjects of the history of present illness. Their illness narrative addresses four aspects of the patient's experience: ideas about what is wrong; expectations of the physician; feelings, especially fears; and the effect of the illness on function.

5. Substitute the more inclusive, much less troublesome term *history* for *subjective* and the more accurate term *observations* for *objective* in SOAP (subjective, objective, assessment, and plan), the problem-oriented medical record's formula for addressing a problem. This change transforms SOAP into HOAP (history, observations, assessment, and plan) (18).

6. Consider that a patient's sadness or poor understanding of his or her condition may simply be a human situation that is more accurately described in nontechnical language than by a pathologic term, such as denial or depression.

7. Record as *history* or *patient perspective* in progress notes and summaries new or updated information about the patient's point of view. For example, at such critical times as the day of discharge from the hospital or the first postdischarge clinic visit, describe what the patient currently understands about his or her condition and its future management, not just what he or she has been told.

William J. Donnelly, MD

Edward Hines, Jr. Veterans Affairs Hospital
Hines, IL 60141

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Requests for Reprints: William J. Donnelly, MD, Medical Service (111), Edward Hines, Jr. VA Hospital, Hines, IL 60141.

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