Medicine is and always has been a profession that relies heavily on narrative. Considering writing has been done about the psychiatric case study as literature, but the medical case report can also be approached from a literary perspective and studied with many of the same methodologies that one would apply to a literary genre. The work of the French theorician Jacques Derrida is especially applicable to medical discourse.

In *Of Grammatology*, Derrida states that words, either written or spoken, are an alteration of an actual presence, that is, the immediate event or experience that is being put into words. Language appropriates and inevitably alters reality by representing it and making it a reflection of the speaker’s (or writer’s) perspective. In this way, Derrida considers the use of language to be an activity of violence. The French word, with less of a physical connotation than the English cognate, serves to suggest the artificiality of language and the ways it can manipulate reality.*

This sense of violence can be seen in the creation of the medical report. At the moment of the medical event, the patient (in most cases) tells his or her “story” to a physician. The physician—for example, a physician in the emergency room—begins to manipulate that narrative by posing certain questions and organizing information to conform to the format of the medical report. If the patient is admitted to the hospital, the ER physician will probably present the “case” at morning report. A new physician, armed with the patient’s medical record, sees the patient and adds to that record. The “case” is then “presented” repeatedly at morning rounds or attending rounds—often in the absence of the patient. With each retelling, the presence of the patient is further abstracted.

The above description assumes the presence that is verbalized for the first time is the encounter of physician and patient. The presence, however, could also be seen as the experience that brings the patient-to-be, voluntarily or not, to the physician. Distinguishing between these two events, one centered in the consciousness of the patient and the other in the consciousness of the physician, raises an issue central to the theory and practice of medicine: Is the story being told in the medical report the story of the patient’s life or of the physician’s relationship with the patient’s illness? The tension between these two possibilities is a frequent factor in various ethical dilemmas.

Derrida remarks that when speech or writing replaces an actual presence, it becomes a “symbolic reappropriation” of reality that can “make one forget the vicariousness of its own function.” This raises particular challenges for medicine. The case report, by the very nature of its purposeful, carefully ordered creation, runs the danger of displacing (or replacing) in a reduced form the unorganized, overwhelming amount of information contained in the very presence of the patient. This reduction, in turn, can lead to the depersonalization of the patient. The common criticisms of physicians who refer to “the gall bladder in Room 204” clearly reflect an awareness of the dangers that threaten when words replace reality. Derrida indicates that this symbolic reappropriation is an attempt to organize, and hence “master” the present with words. In the medical report, that present can be either the patient or the patient’s illness. In this process, the details of the patient’s life that are chosen to be reported by the physician reflect the methods—and values—of medicine, which emphasize diagnosis and treatment and support a belief in the system and objectivity of medical science.

When this happens, the genre or text begins to control its writers. As Derrida observes:

> The writer writes in a language and in a logic whose proper system, laws and life his discourse by definition cannot dominate absolutely. He uses them only by letting himself, after a fashion and up to a point, be governed by the system.

In medicine, the “system” is the structure of the medical case report and the biomedical language of diagnosis and treatment. Although physicians must exercise their own imagination and judgment in the questions they ask patients, the tests they choose to run, and the details they finally organize and put into the medical records, their description of their observations and actions must ultimately be tailored to fit the medical “system.” Thus, physicians

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*Subsequent uses of Derrida’s terms will be italicized to indicate the special meanings Derrida applies to the terms.
sacrifice some aspects of the patient’s presence (and the physician’s own presence in terms of his or her own subjective response to the situation) to the “system” of the medical record.

Language, Narrative, and Medical Discourse in the Case Conference

This “symbolic reappropriation” and its consequences are played out week after week in case conferences in various medical venues. The weekly interdisciplinary conferences in geriatrics and gerontology at the University of Illinois, involving physicians, nurses, social workers, and others who provide consultation for physicians, reflect these considerations and provide an understanding of the dynamics of medical discourse. Each week, interns are assigned by their residents to present one of their patients at the conference. Though they are given no instructions for their presentation, they invariably “present” in the traditional format they have been taught since their second year of undergraduate medical education: chief complaint, history of present illness, past medical history, social history, review of systems, tests ordered and their results, assessment of problem, treatment, and outcome. The delivery is also predictable: face and voice become expressionless, speech is usually either gently deliberate or rapidly businesslike. The patient is seldom named. The intern, meanwhile, uses passive verbs to avoid first person direct references to him or herself. The intern is clearly reciting from the patient’s medical record, and the “genre” has dictated the language, structure, and even tone of the oral presentation.

At the completion of the presentation, the case is opened for questions or discussion. Many questions are medical, and the collective expertise of the geriatric assessment team conducting the conference is offered in a fairly traditional medical style. Many questions, however, pertain to the patient’s social history, which the intern has usually limited to the patient’s marital status, occupation, family size and situation, and smoking and drinking habits. These few pieces of information are seldom incorporated into an understanding of the patient’s situation.

Other participants in the conference often weave these fragments of the patients’ lives into the medical events reported to introduce such topics as level of functioning before hospitalization, plans following the patient’s release, family situations and dynamics, the patient’s mood and state of mind, the intern’s feelings and state of mind, and the ethical, legal, economic, and historical issues surrounding the case.

Under such questioning a change sometimes occurs in both the content and the tone of the presentation. At one weekly meeting, for example, an intern reported in the usual monotonous voice of a patient who had been admitted, quickly and easily diagnosed, and treated. Originally cared for by a daughter who worked at home and was eager to resume taking care of him, he would be dismissed that afternoon to her care. Although he was frailer than before his latest illness and would require more care, this did not bother his daughter. “So—a real success story!” exclaimed one physician in the audience. Response from the professionals involved with the patient, however, was lackluster: “Why?”

Intern, resident, and social worker began talking about their separate conversations with the patient’s daughter, and all of them expressed doubts about her ability to care for her father. The discussion ranged from Hispanic cultural mores to the daughter’s economic, mental, physical, and emotional status. This information was presented in an anecdotal style, a more informal form of storytelling that permits “I” to speak and act. The intern began to use language such as “I spoke to his daughter yesterday...She said...But I wondered if she could...because...” In providing information that was more personal to both patient and physician, the intern could no longer use passive verbs but had to become a visible, active part of the story. His narrative changed from a stylized chronology to personal anecdotes of patients, families, and physicians living with and talking to each other.

In this case, not all the patient’s problems could be solved with hospital treatment alone, but the format of the original story was not designed to reveal either the broader situation or the intern’s doubts about the “success” of his work. A narrative format that does not provide the opportunity to integrate a patient’s social history with the other sections of his or her story does not encourage a holistic approach to patient care. 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. A genre that purports to answer questions rather than ask them limits the physician’s understanding not only of the patient but of other issues of medical relevance.

A second case demonstrates these limitations even more dramatically. An intern presented the conference with a seventy-year-old “cantankerous” man who, wheelchair bound, had been cared for by his common-law wife for the past fifteen years. Due to numerous medical complications, he was now on a respirator, and would not live much longer. The intern’s presentation consisted almost entirely of the tests performed on the patient each day for the past week and their results. A physician opened the discussion with a deliberately provocative question: “So what is it about this patient that everybody loves him so much that they’re heaping all this attention on him?” “Oh, no one really likes him. He’s cantankerous,” the intern repeated. Then she quietly added, “Just me.”

The questions softened, and the intern’s voice became increasingly conversational and personal. She related that she was the only professional her patient had trusted during his long hospitalization. Only she shared his concern about the Do-Not-Resuscitate (DNR) order indicating that he should receive no chest compression or electrical shock in the event of cardiac arrest. The original order had been taken off his chart when attempts were begun to “wean” him from the respirator. He wanted that order to be reinstated should he be either successfully “weaned” from or forced to remain on the respirator. She feared that when she left the floor
in two days, no one would recognize and act upon his wish. "Have you told him you're leaving the service tomorrow?"-"No."-"Don't you think that you should prepare him for this?" The group then considered how she could talk to her patient. They reviewed the hospital policy on DNR with her and arrived at a plan to honor her patient's wishes.

There are issues here that obviously go beyond language, to both the roots of medical training and the day-to-day practice of medicine. The structure and language of the medical report in this instance, however, played an important role in masking the ethical and human issues of the case for both patient and physician. Not until the intern was drawn from the strictures of the medical genre was she able to describe the dilemma that was of most concern to her patient. Even more significantly, although the problem was clearly troubling her, she did not raise it; it was not the "stuff" of a case report.

It should be noted at this point that the medical report has never been seen as capturing the totality of a patient's being. Although some physicians do see beyond the text, many believe in the "objectivity" of the case record and medicine itself and go on to convey this attitude to their students. One of the problems here is the equation of the "objective" with the "impersonal." Every medical decision (although some will be less controversial than others) is still a choice, made by a human being and can never be totally objective. Presenting the "story" of these accumulated choices in a narrative style that effaces the narrator and abstracts the person who is the patient, however, lends an air of anonymity, authority, and absoluteness to the events. This tone may artificially "absolve" any feelings of doubt the physician may have, but it also discourages self-reflection. The language and form of the medical case report can thus allow a physician to be unaware of her or his own feelings or values. Finally, the structure of this medical genre can prevent certain important questions, such as questions of medical ethics, from being asked—or even recognized.

**Ethics in the Case Conference**

Ethical issues have not traditionally been allotted a place in the language of the standard medical case report, prompting some medical ethicists such as Albert Jonsen, Mark Siegler, and William Winslade to advocate special ethics rounds to present the patient in a format designed toward making an ethical decision. Others would argue against such an approach, agreeing more with Erich Loewy that physicians are wrong to view and teach ethics "as though it were separate from the technical considerations of medicine. Ethics is and has always been as much a part of the practice of medicine as an understanding of pathophysiology." By not identifying ethics per se as the key issue of the conference ethical issues can arise as part of the fabric of the patient's care. And, because the interns have become so indoctrinated to the impersonality of the medical report, many of them are not aware of the ethical dimensions of a patient's care or their own uncertainties about a patient's treatment. Couched within a medical conference, discussions can emerge about issues that have not yet caused disagreement between patient and physician but may still linger as vague doubts in the minds of physicians or other members of the health care team.

Two questions are involved here. One is the variety of ethical issues to be discussed within the setting of the medical case report. The other, already demonstrated, is the way in which language has masked these issues or prevented them from being recognized. K. Danner Clouser has distinguished three dimensions of ethics as they appear in medicine. One dimension reflects traditional, often culturally and historically bound codes of ethics that prescribe the nature of the physician-patient relationship. A second dimension encompasses such bioethical issues as resuscitation or informed consent, which arise "as a natural response to new dilemmas, increased knowledge, and threatened rights" in medicine. Finally, both these medical and bioethical concerns are reflections of the broader, philosophical framework, the set of "basic moral rule(s)" by which a group or institution operates and from which the rules of medical or bioethics are derived.

The geriatric case conferences discussed here raise all these kinds of issues. Conference participants see their patients' illnesses as frequently chronic, usually involving several medical problems that are delicately balanced systemically, and inseparable from the patient's past and present life. They have come to define medicine in a way that is more holistic than the traditional disease orientation.

In addition to the narrative element of this process discussed above, the timing and selection of the presentations can contribute to this process. Patients to be presented are often not "interesting cases" in terms of diagnostic or therapeutic interventions in the usual sense. They are usually presented late in the course of their hospitalization, at a time when they are no longer the subject of much medical discussion by the house staff. By then, though, interactions of a more personal nature may have taken place between patients and house staff, including an opportunity to meet family and friends and gain an appreciation of the patient's life outside the hospital. Such a situation not only offers the opportunity for nonmedical anecdotes to arise, but also provides the intern with information often not considered by many physicians.

Many concerns of the geriatric team demand that the physician establish a relationship with the patient that seeks beyond—both before and after—the patient's hospitalization. One point often painfully clear in the conference, for example, is how pitifully little is known about the "life" of the patient in whom a diagnosis such as dementia is made. Such topics as what the patient was capable of doing in terms of "activities of daily living" (ADLs) or even the types of conversation the patient could engage in before hospitalization are often not considered within the purview of house staff. Without this knowledge, assessments of the time course or the nature of declining mental status, which are prerequisites to diagnosing dementia of the Alzheimer's type, cannot be made in a
meaningful fashion. Similarly, the need for nursing home placement, usually a life sentence for the patient, may be made with precious little information about family support, involvement, or even wishes.

A view of the physician as one who takes a patient's whole life and wishes into account before making decisions about diagnosis, treatment, or disposition—and learns about that life through direct interaction with the patient and his or her family—is an essential part of the "medical ethics" (keeping with Danner Clouser's definitions) of this geriatric team. Such a view reflects the team's broader ethic of a more interactive, reciprocal relationship between physician and patient, a placing of human priorities alongside medical ones, and a holistic approach to medical practice.

Similarly, team members frequently challenge accusations of noncompliance made when patients do not do well and require frequent hospital admissions. Pointing out possible alternate explanations such as extended time intervals between clinic appointments or the natural progression of some diseases can help suggest other ways of thinking about the medical "fact" of a particular condition to express respect for the patient and can prevent a hasty, unfair appraisal of a frustrating situation.

Bioethical issues that arise in the case conference often revolve around appropriate use of the available technology both in relation to diagnostic workup and therapeutic interventions. Such doubts clearly exist in the minds of the house staff but are usually voiced only informally, if at all, among house officers. Diagnostic dilemmas include the question of how far to work up problems that are not acutely affecting a patient with an obviously limited expected lifespan. The question that frequently follows from that is who should make the decision—the patient, the patient's family, or the physician. Therapeutic dilemmas include appropriate use of technology such as coronary artery bypass, heart valve replacement, and even chronic dialysis in patients with multisystem failure in whom only certain systems can be helped or in whom the quality of their lives does not warrant the morbidity involved with its extension by these means. The possibility of withholding less intense therapy (antibiotics, for example) from patients with an obviously poor "quality of life" is often an uncomfortable subject for all those who are trained to treat disease whenever possible. When the subject is raised in the geriatrics conference, house officers are usually amazed that the consideration would even be seriously entertained, although in their hearts they know that they are fighting a losing battle. It is like a chess game in which the winner is obvious, but which nevertheless must be played out in the traditional manner before it is declared over.

The use of a medical case conference format with an often unremarkable case in mid- or completed hospitalization presented to a diverse audience makes it possible to raise ethical issues spontaneously in a nonthreatening manner. By seeing ethics as an integral part of patient care, ethics itself does not become fragmented from daily care or considerations. In acknowledging the human dimensions of both patients and physicians, a patient's whole life and an active involvement of the physician with patient, family, and other health professionals must be considered. Furthermore, it permits expressions of doubt or anxiety. All of the "stories" generated by these concerns can lead to discussions of the everyday practice of humane medicine and the more dramatic confrontation with the bioethical issues of modern medical care.

**The Scientific and the Human**

As it currently stands, the history, physical examination, assessment, and plan format commonly used by house officers do not provide the sorts of information that are needed to really know the patient. Progress notes written in a problem-oriented fashion help to highlight new problems as they arise in the course of hospitalization, but many of the important issues discussed in the weekly conferences are not viewed as problems and thus are rarely listed in that context on the chart. A conference ranging beyond the patient's chart allows consideration of those issues that fall outside the realm of the traditional genre. The format of the conference allows its participants to raise doubts and broach vital subjects that are not usually dealt with in most medical case conferences. Ethical issues of all the types described by Danner Clouser achieve a new importance with this approach. Furthermore, the conference integrates different aspects of health care in a way that allows for the communication of any information or ideas relevant to the patients or the people caring for them.

The geriatric assessment team at the University of Illinois Hospital is usually not directly involved in the care of the patients presented or the supervision of the house staff who present their cases. This situation allows, perhaps, greater freedom of expression among the participants, but it also limits the direction and outcome of many of the discussions. The team sees its role as provocative rather than normative. Are the interns who leave the interdisciplinary conference on geriatrics and gerontology more aware of the ethical, medical ethical, or bioethical elements of their "stories"—or are they still too controlled by the traditional genre? How many times must an intern's story be challenged, new words demanded, before the genre can change to allow for a greater personal presence of both patient and physician, allow questions of human values to become an integral part of the case report?

The power, from long tradition, of medical language and the genres it has fashioned is formidable. Changing that language is a major undertaking. The geriatric assessment team, however, has begun working from within that structure and language to attempt to integrate the medical and human elements of health care. Their experience suggests application to other medical settings. Perhaps an open-ended narrative summary should be included in the medical record and presentations to give house officers an outlet to synthesize data, feelings, and unanswered questions concerning patients. Physicians conducting rounds or presentations...
could make a point of including questions, such as "How do you feel about the outcome of this patient's hospitalization?" that would force the presenter to make a value judgment. Conducting conferences at various stages of patients' hospitalization might prompt similar opportunities to raise questions of medical ethics. Including health professionals besides physicians as a regular part of rounds and reports could introduce other considerations into those case presentations.

All of these suggestions challenge the language and structure of traditional medical genres. They recognize that language not only reflects but in turn can affect how physicians are taught to think about patients. There is a need in current medical genres to introduce a language that will do (to return to Derrida's terms) as little violence as possible to the presence of both patient and physician. Only through this synthesis of the scientific and the human can physicians truly understand their patients and deliver optimal health care.

References
4. Derrida, Of Grammatology.
5. Derrida, Of Grammatology.

Bad Axioms in Genetic Engineering
by C. Keith Boone

Genetic engineering's potential for manipulating the "human" and its capacity for arousing fear and recrimination have promoted the use of "bad axioms" in analysis of the ethical issues raised by new technological capabilities. Our task is to consign these formulations, as axioms, to history, and to discern the truth they contain in non-axiomatic form.

Bad Axioms...