INFORMATION TO USERS

This manuscript has been reproduced from the microfilm master. UMI films the text directly from the original or copy submitted. Thus, some thesis and dissertation copies are in typewriter face, while others may be from any type of computer printer.

The quality of this reproduction is dependent upon the quality of the copy submitted. Broken or indistinct print, colored or poor quality illustrations and photographs, print bleedthrough, substandard margins, and improper alignment can adversely affect reproduction.

In the unlikely event that the author did not send UMI a complete manuscript and there are missing pages, these will be noted. Also, if unauthorized copyright material had to be removed, a note will indicate the deletion.

Oversize materials (e.g., maps, drawings, charts) are reproduced by sectioning the original, beginning at the upper left-hand corner and continuing from left to right in equal sections with small overlaps. Each original is also photographed in one exposure and is included in reduced form at the back of the book.

Photographs included in the original manuscript have been reproduced xerographically in this copy. Higher quality 6" x 9" black and white photographic prints are available for any photographs or illustrations appearing in this copy for an additional charge. Contact UMI directly to order.

UMI®

Bell & Howell Information and Learning
300 North Zeeb Road, Ann Arbor, MI 48106-1346 USA
800-521-0600

GENRE AS INITIATION:

SOCIALIZING THE STUDENT PHYSICIAN

by

Lorelei Lingard

B.A., University of Western Ontario, 1991

M.A., Simon Fraser University, 1993

THESIS SUBMITTED IN PARTIAL FULFILLMENT OF

THE REQUIREMENTS FOR THE DEGREE OF

DOCTOR OF PHILOSOPHY

in the Department

of

English

SIMON FRASER UNIVERSITY

August 1998

ABSTRACT

This project presents a rhetorical analysis of the oral case presentation genre as it is taught and learned during the third-year student clerkship in Medicine at San Francisco General Hospital. Investigating the role of generic discourse in the initiation of novices into a professional community, this study participates in three areas of inquiry: the teaching and learning of genres, the transition between academic and professional communities, and the role of discourse in workplace initiation.

The oral case presentation is a professional genre used by physicians to speak amongst themselves about patient diagnosis and treatment; it presents the speaker's reasoning about the cause of a patient's illness as it argues towards diagnostic and treatment decisions. The oral presentation, however, is more than simply a mode of communication. It performs social actions essential to the smooth functioning of organizational medicine as it collects, selects, arranges, and thus constructs medical work, transferring such work across hospital contexts and facilitating the collective arbitration of medical decisions.

The primary method of instruction and evaluation during the hospital clerkship program for third-year medical students, the oral presentation performs a gate-keeping function at the threshold of this discourse community. As they adopt the orientations inscribed in its generic

practices, students, who must master this genre in order to complete their clerkships, are acculturated into the shared attitudes and interests of the medical profession. Through curriculum handouts and verbal feedback during work and attending rounds in the hospital, students' presentations are shaped to conform to community standards; and as their discourse is shaped, so are students' perceptions of what it means to practice medicine.

This study seeks to understand how the acquisition of a medical genre facilitates the acquisition of medical values. Using the New Rhetorical understanding of the suasive nature of language and form, it explores the oral presentation's patterns of naming, selecting, and organization, and shows how such patterns both reflect and reproduce biomedicine's traditional conceptions of the patient, the diagnostic process, and the treatment of disease. This analysis confirms a number of precepts of the new genre theory, including its basic premise that genres are more than formal structures -- they are also rhetorical strategies, ways of acting in the world.

Seen rhetorically, the teaching and learning of the oral presentation reveals itself as an ideological activity that cultivates community values in initiates and protects biomedicine's status quo. Comparing expert and novice approaches to the genre, this study uses the concepts of generic stability and innovation, audience and subject

position, and explicit instruction and tacit learning to explore the rhetoric of genre as a vehicle of initiation into the medical community. The analysis of students' presentations and instructors' feedback suggests that explicit genre instruction could both improve students' mastery of this genre and help ensure that its acquisition cultivates the values that medical educators intend to pass on. In its attention to the rhetoric of the case presentation genre, this exploration of medical students' transition to hospital discourse suggests the value of a rhetorical approach to communication and composition instruction in both academic and professional contexts.

ACKNOWLEDGEMENTS

Acknowledgements are difficult to write: what such a small space allows can never encompass all of the debts incurred by a research project such as this. I am grateful to the students and physicians at San Francisco General Hospital for offering their time and insights and to Rick Haber for challenging conversations, helpful ideas, and insider knowledge. Thanks also to Judy Segal, who helped me to see the complexity of medical discourse and the delicate balance required by rhetorical researchers. I have learned much from Janet Giltrow's uncanny ability to see solutions to methodological and political problems, and I am grateful for her open office door and unending stream of must-read "little books". And to Rick Coe, who has the imagination and the faith to see value in projects off the beaten path, who took the time to guide me not only through a degree but also into a community: thank you.

This project could not have come to fruition without many supportive relationships outside the dissertation's boundaries. I owe a great debt to Andrea Lebowitz, for offering freely her friendship and wisdom; to my mother, Margaret Robinson, for the unfailing belief that this day would come; and, finally, to Brent and Connor, whose love and understanding strengthen me, making everything possible.

Table of Contents

List of Tables

CHAPTER ONE
Disciplinary Context and Method of the Study

Qualitative Research in Professional Discourse: A Developing Discipline

This study of genre as initiation belongs to an evolving discipline of research into professional discourse. Over the past two decades, the scope of writing research has widened to include analysis of professional discourses. The shift in writing researchers' traditional gaze towards everyday writing practices has been heralded as the opening of "a new disciplinary frontier" (Segal et al. 1) and a "watershed" moment in the evolution of the discipline (Spilka, "Preface" viii).

In its focus on how professional discourse is produced and how that production is constitutive of writers' professional identities (and of a profession itself), much recent writing research reflects the New Rhetorical conception of language as constitutive rather than descriptive. Words, according to Kenneth Burke, act as "terministic screens" through which wordlings view their world, directing their attention to some aspects of a situation rather than others (*Language* 44). The words we select are a "reflection" of

certain attitudes -- and a "deflection" of others (45) -- and it is this power that Burke refers to when he argues that language is strategic, a "symbolic action" (44).[1] Burke's godterm is not Aristotle's "persuasion" but, rather, "identification," the notion of establishing shared ground in order to create consubstantiality between the rhetor and his/her audience (*Rhetoric* 55). This distinction directs our attention beyond a Classical understanding of the power of language to *persuade* and towards a theory of language's ability to *enact*.

This reorientation has contributed to a new relationship between rhetoric and composition studies, raising rhetoric from its nineteenth-century academic drudgery in English

---

[1] Burke attributes to I.A. Richards the idea that "the symbolic act is the dancing of an attitude" (*Philosophy* 8) but extends Richards' concept of attitudes as incipient, potential acts waiting for activating situations. This extension embraces both the notion that attitude can be "the *first step towards* an act" and the notion that "attitude can be the *substitute* for an act" (*Grammar* 236). Richard Coe explains that the crucial relation of attitude to act (and, "as synonyms such as standing, position, and posture suggest, [attitudes] ...crucial relation to substance") is an insight that "underlies the reframing of rhetoric that leads both Richards and Burke to the New Rhetoric" ("Burke's Act" 3). Importantly, the New Rhetorical perspective draws attention to two aspects of rhetorical action: rhetorical discourse which *influences* action and rhetoric *as* action. Both of these aspects are invoked in this research project.

departments-- what Richards called the "dreariest and least profitable part of the waste that is Freshman English" (3) -- to a partnership in composition's recent inquiry into the making of knowledge. Bruce Herzberg characterizes this inquiry's rhetorical nature as founded on the "social perspective" in communication, which he summarizes as the understanding that "the truth is not found but made; it is never unassailable; its genesis is to be investigated in the arguments that have established it, in the purposes it serves, in the power it confers" (48).

In a development continuous with and motivated by a Burkean view of language, genre theory has become a prominent figure in writing research, renewed as a strategy for understanding (not just classifying) discourse. Carolyn Miller's proposal that genres be defined by "the action they accomplish" reflects Burke's attention to "situation and motive" (Miller, "Genre" 24). Miller's work has inspired others' to lend their efforts to the reconception of genre as a rhetorical tool, and a rich scholarly debate has evolved about, for instance, genre as heuristic and/or tyrannical, genre as stabilized social strategy and/or site of dissent, and genre learning as tacit and/or explicit.

Across the landscape of genre theory researchers are establishing important points of reference, extending the discipline's analysis of text types into intertextual analyses of professional communication. Recent contributions in this area include Charles Bazerman's notion of "genre systems," which highlights the role of prior generic acts in a rhetorical situation ("Systems" 99), Janet Giltrow's depiction of genre's dependence on the background knowledge of a community of users (174-5), and Anne Freadman's articulation of the "ramified, intertextual memory" of generic "uptake" ("Uptake" 9). As genre theory becomes more intricate and developed, researchers increasingly appreciate its explanatory capacity for professional discourse; at the same time; as the theory is tried and tested in diverse sites, its principles are problematized, revised, enriched.

As the field of professional discourse research develops, there is increasing concern with its "method." As Rachel Spilka reports, researchers since Lee Odell and Dixie Goswami's 1985 anthology, *Writing in Nonacademic Settings*, have undertaken "qualitative studies aimed at exploring the relationship between social contexts and the composing process in workplace settings", studies varying in design, methodology

and analysis ("Preface vii). Spilka's anthology devotes substantial attention to "strengthening [the discipline's] research programs" and encourages an evaluation of "which research approaches it considers most valuable ... in strengthening the integrity of its scholarly inquiries" (ix-x). Essays in the final section of her volume reflect on the place of qualitative validity and reliability tests in writing research (Debs 243); the ends of rhetorical research (specificity and interpretation or generalizability) (Herndl, qtd. in Debs 244); the issues of the theory-practice binary (Sullivan and Porter 221) and method as heuristic praxis (Sullivan and Porter 225-6); the choice of single or multiple case studies, or single or extended observations (Debs 251); and the ethics of research and representation (Doheny-Farina 267).

Scholars' representations of their research methods suggest a number of methodological possibilities, ranging on a scale defined at one end by classic ethnographic practice and at the other by the traditional methods of literary criticism. The examples which follow do not exhaust this range but begin to demonstrate the valuable work that has been conducted from a variety of methodological stances. For instance, Catherine

Schryer, "called ... in as consultant" ("Sites" 106) to her research site, characterizes her study as "reflecting ... ethnographic methods" and recounts "80 interviews ... over 200 hours of participant observation ... over ten reader protocols ... [and] extensive document collection" (107). Schryer adopts Barney Glaser and Anselm Strauss' grounded theory technique for classifying data and turns to genre theory to explicate her findings. Reflecting a similar methodology, Anthony Paré introduces his study of social workers' disposition reports as "an extensive qualitative study" consisting of interviews, protocols "up to seven hours long," and document analysis (114). Paré's analysis of how the "rules of play" (123) in this discourse are represented in its recurring textual and contextual features also invokes the concept of genre to theorize the ideological import of discourse regulations.

Offering another approach, Francis Sullivan, a researcher-consultant providing services to the IRS, bases his study of the textualization of labour division on "interviews, observation of tax examiners at work, and collection of documents used by tax examiners to accomplish their work" (326). Sullivan performs a systemic analysis of "the features

of staging, semantic relations, and nominalizations" to create "a profile of each text's projection of tax examining as a field of activity" (329). Moving slightly away from the ethnographic influence, Amy Devitt's study of tax accountants takes as its sources of information "samples of texts, and interviews with accountants" ("Intertextuality" 337). Devitt invokes genre theory to produce an insightful account of the range and function of intertextuality in accountants' documents, and she seeks an understanding of "rhetorical situations" from the texts themselves and from interview responses. Similarly, Carol Berkenkotter and Doris Ravotas use written texts and interviews with writers as the basis of their study of the activity and ideology of classification in psychotherapists initial evaluations. Berkenkotter and Ravotas turn their analytical attention to the "microlevel linguistic practices" revealed though the therapist's use of nominalizations as they explore the construction of therapists' "credibility [and] billability" in these texts (271).

Another methodological approach is represented by Bazerman's study of the knowledge-making practices of three disciplines. Bazerman presents a textual analysis comparing

the features of a representative scholarly article from three distinct disciplines. By examining each text for its representation of topic, related literature, audience, and researcher/writer, Bazerman reveals how "knowledge-producing activities" are shaped by each discipline's linguistic and stylistic "resources and expectations" (*Shaping* 47). Adopting a method similar to Bazerman's in its focus on textual representations of a discourse community, Judy Segal's study of the rhetoric of medicine examines two hundred articles from a sample of four hundred and tests the claims of this "more empirical research" through "historical and theoretical research" ("Writing and Medicine" 86-7). Segal positions her approach within "(largely classical) rhetorical theory" (86) and "[maps] the rhetoric of medicine onto its practice" (88) as she explores textual features such as the appeal from ethos and the use of the passive voice.

This representation of methodological diversity reveals that one variation among professional writing studies is the extent to which they involve participatory field research. Many studies of professional writing are characterized by their desire to understand the process, not just the product, of professional writing. The interest in process sends many

researchers to the field to observe and inquire into the conditions of textual production. Theorizing this trend, Carl Herndl suggests that "careful ethnographic research might use techniques such as the discourse-based interview to explore an individual agent's relationship to the dominant discourse . . . [and] the degree to which individual agents understand the institutional and ideological construction of their discourse ("Teaching" 358).

Writing researchers' interest in both text and context shapes their representations of their work in published studies. For instance, authors adopt both the ethnographer's claim to authority by virtue of "being there" (the researcher's quotation of fieldnotes representing this form of 'credibility') and the literary critic's claim to authority by virtue of close textual analysis. But while indebted to methods from diverse disciplines, the field seems also wary of them. Steven Doheny-Farina represents the tempering of the anthropological stance with his reminder that "the goal of writing researchers should not be to limit nor extend their participatory role in field research. Their goal should be for their role to be consistent with the claims that their studies ultimately make" (258). And Segal et al. suggest the

importance of working "from the inside out", of creating relationships within the discourse community under study to "avoid the trap of cataloguing discourse practices and the social practices they constitute without paying attention to the deeper work they perform in the discipline" (22). Both sorts of cautionary advice suggest writing researchers' desire to make issues of method a matter of careful reflection, rather than naive importation.

While the studies summarized show a wide range of approaches, research appears to be gradually moving towards the increased quantifiability and generalizability of findings. The importation of a style of "writing-up" that includes tabulation and numerical representation of data and findings has proved nourishing for studies of professional writing, not the least because these new methods of representation have offered researchers transport to other scholarly venues, initiating conversations with (not just about) the practitioners they study.

In addition to the benefits, however, we have begun to acknowledge the tensions imported with these methods. As Aviva Freedman and Peter Medway argue, citing Herndl, "partly because of its reliance on the research methods and cultural

pluralism of anthropology, research into scientific and professional writing . . . 'lends itself to a mode of reporting that reproduces the dominant discourse of its research site'" (11). Herndl's criticism suggests that the anthropological task of description has the tendency to overshadow what Herzberg describes as the rhetorical task of critiquing "the ways that knowledge is created and the purposes for which it is used" (Herzberg 48).

As Doheny-Farina explains, qualitative and ethnographic approaches to studying discourse have "taken hold among writing researchers just when some are questioning the underlying assumptions of traditional ethnography", assumptions about objectivity, representation and generalizability (253). He goes on to suggest an "inherent tension" between the researcher's triumphant return from "the field" with claims to make and the nature of those claims as "constructed by our disciplinary biases and our methods" 254). Doheny-Farina's characterization of research as "a rhetorical act" complements Patricia Sullivan and James Porter's argument for approaching method as "praxis", a kind of conceptual "triangulation" that places theory and practice "in dialectical tension, which can then allow either to change"

(226). Sullivan and Porter (citing Miller) define praxis as "a middle ground between theory and practice . . . a higher form of practice, an 'informed or conscious practice'" (225). Understood as "praxis", method is not so much a *theory* of practice as a *means* or *instrument* of practice, that means subject to revision as the practice unfolds. Sullivan describes his research in this way, characterizing "work conducted under contract" as particularly incompatible with "method-driven" or "problem-driven" approaches. Instead, he adopts Sullivan and Porter's notion of "'praxis' in which the methodology functions 'in a middle ground between theory and practice, as a heuristic set of filters . . . for both theory and practice'" (cited in Sullivan 315) to define his approach to the IRS project.

Sullivan and Porter report that the methodology of praxis may not be so recent; however, the *acknowledgement* of such method is. They suggest that "in workplace studies methodologies are of necessity a *praxis*, though write-ups of such studies sometimes mask the heuristic nature of researcher's methods-in-practice." They warn, too, that "treating methodology as a set of antiseptically applied rules governing the collection of practice strips the knowledge-

making ('-ology') possibilities out of method" (228-9).

At the center of the method debate reflected in such arguments is the issue of the role of the researcher in studying professional discourse, and, by implication, the purpose of this research. Segal et al. problematize both concerns when they ask, "what is the rhetoric of our rhetorical work?" and "what can and should we do with what we learn when we study the discourse practices of professional communities?"(2) Troubled by an untheorized relationship between "rhetoric" and "reform" and equally dissatisfied with the goal of "neutral descriptions" (3), Segal et al. suggest instead that "rhetorical inquiry into professional language practices can be a form of critical pedagogy" (12). Importantly, though, they warn that such inquiry must proceed "slowly and respectfully", preferably "in collaboration" with insiders (21), and with constant vigilance against "the missionary's righteous zeal" (28).

Method of the Study

This brief description of the evolution of rhetorical research and its methodological concerns provides some disciplinary context for my own method. As Doheny-Farina

asserts, "our 'results' are not what is 'out there' in the field. Our results are, in a large part, what we, as researchers, bring to the research event" (254). With this in mind, the remainder of this chapter describes and rationalizes the research methods that guided my collection and analysis of data and my representation of the findings in this paper.

Consultancy Research: Doheny-Farina and Odell argue that the very act of inquiry constructs, to some degree, what the researcher will find. "Questions imply a set of expectations about the phenomena one is observing," expectations which not only guide but also limit the research possibilities (510). The large, theoretical questions that guided and constrained my research began years earlier, when I entered the doctoral program desiring to pursue my interest in how language and genre shape attitudes and actions, how saying/reading/writing something can make it so. In a graduate course on linguistic pragmatics I became interested in medical discourse as I examined the role of cohesion, presupposition and theme/rheme structure in the rhetoric of a guide to natural childbirth. The choice of text was not random: I was expecting my first child and experiencing the discourses of gestation, labor and

delivery as I visited my doctor, attended childbirth classes, and explored the literature on the subject. The construction of my pregnancy experience in medical discourse fascinated me, and medical discourse suggested itself as a fruitful site for my dissertation research into the rhetoric of genre.

The choice of research site for this project was also not random and perhaps reflects the roots of the researcher-consultant role not uncommon in rhetorical analyses of professional discourse. The project came about as a result of a conversation between old friends. Richard Haber, a professor of medicine, mentioned to Richard Coe, a professor of rhetoric, an interesting feature of the student clerkship under his supervision at San Francisco General Hospital. Haber wondered why some students had difficulty mastering the oral presentation genre required for communication on hospital rounds during their third-year clerkship in Internal Medicine. Although all students eventually developed sufficient mastery of the genre to pass the clerkship, many endured a stressful process of trial and error before "getting it", and Haber wondered if the learning process could be improved. Coe, hearing the puzzle, suggested that a rhetorical perspective might help in understanding the situation and, when Haber

expressed interest, asked me if I was interested in this context as a research site.

The researcher-consultant role that developed from this introduction to the site resembles Schryer's study of veterinary school genres and Sullivan's work with IRS tax examiners. The research-consultancy study develops the close ties with practitioners advocated by Segal et al. and, by definition, "[concentrates] on problems that the practitioners recognize as significant within their own frame of reference" (Segal et al. 23). Devised in collaboration with practitioner-informants, such studies are well-suited to returning findings to the studied community and contributing to its comprehension of and intervention in its writing processes (see Schryer, "A Consultancy Model"; Segal et al.).

Additionally, research-consultancy's close and sustained community contact requires that the researcher attempt to balance her research purposes with the community's, her interests with theirs. For example, Sullivan reports that his IRS collaborators' "institutional committment to the elimination of error" (316) determined to some degree both his literacy program's activity and its language, with IRS management insisting on a literacy "test" and the use of terms

such as "deficiencies" (316). The situation Sullivan describes has important implications for consultancy research since, as Doheny-Farina suggests, the expectations of diverse communities exert different demands on the researcher (266-7). One wonders how Sullivan's reporting of his findings to his IRS collaborators compares with the account in a journal for writing researchers and how the potential conflicts in the researcher-consultant's role affect data collection, hypothesis formation, and the representation of findings.

In this study of students' oral presentations during the third-year clerkship, Haber and I have enjoyed an ongoing dialogue throughout design, collection and analysis phases. This dialogue has been both challenging and constraining. For instance, my adoption of current critiques of medicine's objectification and infantilisation of the patient (see, e.g., Good and Good; Segal) and its selective attention to pathophysiological aspects of the "illness experience" (Kleinman) was often challenged by Haber's insider perspective on such issues. This is not to say that Haber denied the validity of most critiques but rather that he could suggest how such apparently "dysfunctional" aspects of biomedicine served certain functions within biomedical contexts. As a

newcomer to both the scholarly critique of medicine and its daily activities, I have often felt swayed by both perspectives during this project, and I have struggled for the necessary reflective distance from each that such a project requires. Balancing my research goals with Haber's more practical aims proved difficult at times, and can put the researcher/consultant into a delicate position in relation to the community which has kindly invited her in.

When objective distance and theoretical reflection are attained, however, the "perspective by incongruity" of the outsider's gaze can reveal aspects of a situation not seen from within (Burke, *Perspectives* 94). By "wrenching" terms and metaphors loose of their customary settings, the outsider/researcher can "link hitherto unlinked words" and interpret situations anew (*Perpectives* 94-5).

In some ways I suspect that Haber's practitioner's perspective has complicated my rhetorical analysis of medical discourse; in others, it may have constrained it. Adding Haber's clinical lens to my rhetorical one still achieves a partial vision at best, and this study may at times reflect how sometimes conflicting motivations (a rhetorician trying to remain critical, a physician trying to control the impulse

towards self-protection) directed its attention.

Notwithstanding the complexity of such interdisciplinary cooperation, Haber's insider's perspective on medical discourse has served as one measurement of the adequacy of my interpretations and conclusions (Creswell 167-8; Segal et al. 22). Of course, as Doheny-Farina warns, such "satisfying [of] the natives" does not "balance the distortions that [researchers] bring to events as a result of our discipline-specific agendas" (261). Internal validity, he argues, is a "myth" (260), a "screen", "one of several means of interpretation" (261). As a member of the community under study, the informant is himself subject to bias and must be viewed both as an informant/collaborator and as part of the context of the study. Thus, writing research is not purified of its disciplinary bias by "field" consultancy or collaboration: it becomes, rather, an act of balancing bias -- that imported from outside the field of observation and that acquired from relations within it.

The Impact of Theory on the Research Questions: Formative aspects of this study were Haber's first depiction of the research situation and my role as a rhetorician invited to

consider the following questions: "What is the nature of this problem?" and "What might be done about it?". Knowing that I was going to study discourse -- and a particular, recurrent form of discourse in the oral presentation -- I entered the research site with a theoretical perspective based in new conceptions of genre. My understanding of this theory and my knowledge of other researcher-consultant studies informed the questions and hypotheses that accompanied me to the site.

Miller's definition of genre as not "the substance or the form of discourse" but "the action it is used to accomplish" ("Genre" 24) suggested to me that the oral presentation genre that students were learning in the clerkship performed a function in this education context, likely a function of initiation. Anthony Paré and Graham Smart's description of a "profile of regularities" in the four areas of "texts, the composing processes involved in creating these texts, the reading practices used to interpret them, and the social roles performed by writers and readers" (147) suggested further that the initiation enacted through acquisition of this medical genre would turn out to be a social phenomenon with overlapping activities performed by multiple participants in shared contexts. I hypothesized that learning the oral

presentation's textual rules of play (to invoke Paré) likely performed an acculturation into the community's professional rules of play.

Similarly, Coe's discussion of the rhetoric of genre directed my attention to the persuasive nature of the oral presentation form: "forms influence writers and speakers -- in effect persuade them, as they articulate their intuitions and shape their materials -- to make particular selections, create particular emphases, generate particular substance, adopt particular personae" ("The Rhetoric" 182). This conception of genre, based in the New Rhetorical understanding of forms as "strategies for responding to rhetorical situations and adapting to contexts of situation" (Coe, "The Rhetoric" 186) emphasizes the ideological aspects of discourse, as evidenced by Miller's claim that "when we learn a genre . . . we learn . . . what ends we may have" ("Genre" 38). How genres are learned and what it means (socially, rhetorically, ideologically) to learn them has been a focus of genre theory because of its close relationship with writing pedagogy. Coe's distinction between "the formal tyranny of standard structures and the heuristic processes through which generic form guides the creation and comprehension of substance" (182)

suggests the gatekeeping function of generic discourse. Paré's articulation of the duality of discourse rules which "determine what *can* and *cannot* be discussed, as well as what *might* and *must* be discussed" (112) echoes the emphasis on *regulation*.

My perspective upon entering the clerkship setting was also influenced by Freedman's articulation of the debate among North American and Australian genre theorists about how best to impart generic knowledge to students. In her critique of the Sydney School's project to help disadvantaged students master genres of privilege in order to gain access to social power, Freedman agrees with Allan Luke that "power is utterly sociologically contingent . . . there are no genres of power" (cited in Freedman 192). Furthermore, she questions the very possibility and the efficacy of explicating generic features for students (193). Freedman's claims that explicit teaching is not necessary and, in fact, may mislead genre newcomers (195-99) also shaped my initial impressions of the clerkship learning situation, as I wondered, "By what process do students acquire the oral presentation genre?"

These notions of what it means to acquire formal discourse patterns, acquired from my acquaintance with genre

theory, shaped my first encounters with the oral case presentation by suggesting what I might turn my attention to in this study of medical students learning to deliver oral presentations[2].

My training in New Rhetorical theory also influenced my earliest research questions. Knowing little about this genre upon entering the site, as a rhetorician I asked "What are the audiences, purposes and contexts of the oral presentation?" Informed by Burke's theory of language as symbolic action, I also entered the site asking "How is the language of the presentation rhetorical, and what attitudes does it enact?" This question was further shaped by the reading that I began before embarking on the research, such as Howard Stein's *American Medicine as Culture* and Melvin Konner's *Becoming A Doctor*. Stein's sociological account of the initiation rites of the clerkship, especially the "pimping" and "hazing" during

---

[2] Being invited to study discourse has other, less often articulated implications for this sort of rhetorical research. As Doheny-Farina warns, paraphrasing North, "we go into an organization looking for writing and we damn well better find it!" (266) There is no way around this research reality (which I extend to oral as well as written discourse) but through it, with the explicit recognition that our attention is focused in this direction and we do not, therefore, enter research sites free of bias.

teaching rounds (the barrage of questions students face and their psychological terrorizing by superiors), probably influenced my interest in the nature of resident and attending physicians' responses to student presentations. Konner's anthropological and autobiographical account of the shifts in perspectives he experienced during his medical education tended to substantiate the New Rhetorical theory that adopting new terministic screens involves adopting new attitudes and influenced my sense of what sorts of shifts to watch for.

The Research Situation: The observational component of the study consisted of two on-site visits. The first, in October/November 1996, involved more than 160 hours of observation over 18 days at the beginning of the clerkship. The second visit, in January 1998, involved another 20 hours of observation in the first week of the clerkship and interviews with students and resident and attending physicians.

The 1996 observation was scheduled to offer access to some critical combinations of clerkship contexts and interactions. I accompanied students throughout their shifts

at varying times of the day and night, keeping their schedule in order to experience as nearly as possible this early initiation process. I witnessed numerous presentations performed by four students on two observed medical teams during the first two weeks of the clerkship. Chapter Two presents a narrative account of the physical, temporal and social maps of the setting that I produced during these weeks of observation. Remaining on-site with students for extended lengths of time also provided the opportunity to witness the intensive "learning curve" of the first two weeks of the clerkship, after which as Haber reported, "if they haven't got it [the presentation skill], they're probably in trouble."

While intensive observation over a brief time period has advantages for this project, it also limits the findings. Generalizability is difficult without observations of multiple clerkships to increase the number of students closely observed and without repeated observations of the same clerkship to facilitate valid comparisons (e.g., observing the October clerkship over two or more years). While the January 1998 observation allowed me to witness more oral presentations and student/teacher interactions, comparisons with October 1996 observations are difficult because of the different time of

year: the January students had completed an additional clerkship, which influenced their performance. For this reason, when January 1998 observations are referred to in this study, I provide a discussion of the influence of contextual features on comparisons.

Another potential difficulty with short-term observations is the influence of "observer effect" (Goetz and LeCompte, qtd. in Doheny-Farina and Odell 515). Data gathered over short periods of time risk being skewed, as participants may be influenced by the researcher's presence, whereas extended observation can render the researcher's presence customary and offer the opportunity to compare early data with data gathered later in a project. I endeavoured to reduce the chances of being misled by observer effect and to increase the credibility of my findings by "talking with a variety of participants in a variety of situations" and "confirming conclusions by drawing on multiple sources of data" (Doheny-Farina and Odell 515). These additional sources of data include interview and questionnaire responses, curriculum documents, and studies in medical discourse performed by other researchers (e.g., Good and Good; Hunter; Atkinson; Anspach; Segal; Pomerantz, Ende & Erickson; Kleinman; Waitzkin).

Role of the Researcher: As I conducted this research, I assumed at various times three different roles. I endeavoured from the beginning of the observations to be a participant-observer[3], to accompany the third-year students and interact with them and other members of the medical team only to establish myself as an acceptable presence (answering their questions, engaging in casual conversation) and to clarify data (asking people about a presentation or situation I had observed in order to discover their perspectives). Students in particular wanted to know who I was ("Are you a doctor?") and what I wanted to observe them for ("Are you looking for mistakes?"). Generally apprehensive because of the

---

[3] As a participant-observer from a background in language and rhetoric, I am influenced by the discipline-specific direction of my gaze. That is to say, while a sociologically-minded observer might have entered the scene with questions about gender, class or ethnicity, my observations focus on language use. Thus my questions and my data might involve sociological factors but do not take them as their main concern. The categories that have guided my observations (audience, purpose, occasion, attitude, motive, form, process, etc.) shape the angle of my "perspective by incongruity." As Burke explains, this approach involves pulling out words that belong to one category and applying them to a different category in order to re-envision a situation. In addition to the perspective of the rhetorician, I am also influenced by my own experiences as a patient encountering the medical institution, although physician/patient encounters are not the focus of this study.

clerkship's high-stakes situation, third-year students seemed less concerned about me when they discovered I was not a member of the medical community and would not be contributing to their clerkship evaluation form. I did not tell them (until post-observation debriefing) that I was investigating their language practices or, more specifically, their oral presentations. I simply told them, as did the "Information Sheet for Subjects" that accompanied their "Informed Consent Forms", that I was interested in how they adjusted to the clerkship. (The January, 1998 group, on the other hand, knew of my focus on the oral presentation because they were being interviewed and observed during the same week.)

Interestingly, a potential drawback of my participant-observer role was my close collaboration with Haber. Because a requirement for human research at UCSF is that a faculty member be a principal investigator, Haber was identified as part of this project on all documents given to subjects at its outset. Thus, "ally" perception (Doheny-Farina and Odell 513), also referred to as "over-rapport" (Miller, qtd. in Hammersly and Atkinson 111), poses a threat of "observer effect", as Haber is one of those who evaluate students' clerkship performance. I tried to protect against observer

effect by concealing from subjects the focus of our research (the acquisition of oral presentation skills) and by defining myself clearly as a non-medical person. And although it is only speculation and cannot be confirmed, students seemed much more preoccupied with the resident and attending physicians' presence than with mine, so that the danger of observer effect in students seemed less likely than in other team members.[4]

While my predominant role in the October 1996 study was as a participant-observer, the nature of the site sometimes shifted me towards the role of complete observer. The pace and intensity of the medical work at times necessitated that my observations be as passive as possible, and with some subjects (particularly residents) any gestures towards interaction were clearly irritating and unwanted. On the other hand, once the subjects realized I was not a medical professional, some showed a desire to have me participate more than I might have liked. I had the feeling that I was being "tested" (and they were being entertained), as one medical

---

[4] Residents, for example, are also evaluated by Haber and may therefore have altered their teaching/feedback styles in my presence. This may help explain why I witnessed little resembling the "hazing" and "pimping" that Stein vividly describes (201-9).

team on my first day observing them insisted that I don a face mask and accompany them on some very gruesome bedside visits.

A third research role that I adopted was that of the observer-as-participant (Gold, qtd. in Doheny-Farina and Odell 514) during constructed situations such as the formal discourse-based interviews in January 1998. Here, more unavoidably than elsewhere, I am constructing the research site as I observe it: Doheny-Farina characterizes such instruments as "[creating] conflict" (265) in interviewees in order to stimulate their thinking in a direction fruitful to the research. In my analysis and representation of findings from these interviews I am, I hope, approaching Doheny-Farina's goal of ethical self-consciousness by articulating the processes by which such data were solicited and the theory informing those solicitations.

Reflecting on my role as a rhetorical researcher, I see with the clarity of hindsight some of the signs of what Segal et al. have called "the missionary's righteous zeal" (28). My "corrective" slant as I have worked to summarize and comprehend my findings may have been partly shaped by the initial focus on students' presentation *problems*, a perspective imported from Haber's experience. I suspect,

though, that it was also due to the nature of rhetorical inquiry which "seeks to know how discursive systems work in order to improve the ways in which people learn those systems and even . . . to improve the systems themselves" (Segal et al. 7). Chastened by the prospect of inadvertently becoming one of "those rhetorical researchers . . . who study fragments of a 'community's' conversation over a period of time and conjure up a publication that purports to explain authoritatively that community's discourse or teach the community how to improve their rhetorical practices" (Segal et al. 4-5), I have endeavoured to locate this study somewhere between the descriptive accounts of classic ethnography and the corrective claims of missionary rhetoric (Segal et al. 21). I present the results of this study as an exploration of how medical students learn one of the discursive practices of their profession and a contribution to the theorized understanding of situated generic practice and its role in initiation processes.

Carrying Out the Study: Clerkship observations involved accompanying third-year students during all activities while on shift in the hospital. I followed two medical teams on

alternating days, thus regularly observing the activities of four students. The social network of the medical team is outlined in Table 1.1.

Table 1.1: Status and Role of Medical Team Members

	Status	Role
Attending Physician	*UCSF faculty member and practicing Internal Medicine Physician	*Responsible for overseeing the medical care of all patients admitted by the team *Responsible for the instruction and evaluation of all team members
Resident Physician	*Physician two or three years past graduation from medical school	*Responsible for daily decisions of patient care for all patients admitted by the team (although attending may be consulted in critical or complicated cases) *Supervises the admission of all new patients *Responsible for his/her own patients (those not delegated to interns and students) *Responsible for guiding interns' and students' medical decisions
Intern	*Physician who graduated the previous year	*Responsible for his/her own patients (supervised loosely by residents) *Responsible also for the patients of 3rd year students
4th year student	*Student in the final year of medical school	*Responsible for fewer patients than intern but usually has more independence from supervision than 3rd year student
3rd year student	*Student in the first year of clinical medicine	* Responsible for one or two patients at a time, "sharing" them with an intern. Both interview, examine and care for patients but intern makes care decisions and shows student how to do basic procedures.

In a usual day, I would observe clerkship activities and witness the presentation genre manifesting itself in the following adjacent contexts:

Pre-rounds (7:30am): Bedside visits with patients before work rounds, to catch up on overnight developments and check for recent laboratory data to include in presentation.

Work rounds (8:00-9:30am): Hallway presentations to medical team (excluding the attending) and group bedside visits to patients. Order of presentations usually is by date of admission (new admissions first) and by location (all patients in one Ward presented before moving on to another Ward or floor). Each team member will usually present at least one patient.

Breakfast (9:30am): The medical team concludes work rounds (or interrupts them, if running late and desiring to eat before breakfast service ends) with breakfast together in the cafeteria. Here, the presentation form is still recognizable in the more casual conversation among team members. Also in this setting, residents may offer advice to students about the presentations just finished, or those to come in attending rounds.

Patient work: Between work and attending rounds, any treatments or testing plans decided upon during work rounds begin. This may involve ordering tests, doing procedures (drawing blood,inserting intravenus line, etc.), requesting consultations, finding old charts, scheduling meetings with family members, etc. Much of this work takes place "on the run", so observations were spontaneous and sporadic.

Attending rounds (10:30-11:30am): Presentations in the attending's office or other formal location. Usually students present first, then anyone else with new patients, followed by follow-up presentations on ongoing patients. Sometimes attending physicians come prepared with a teaching agenda ("Let's talk about acids today"); alternatively, Socratic teaching exchanges may follow from the details of a particular case (see Irby "Three Exemplary Models" and "How

Attending Physicians Make Instructional Decisions").

Lunch Conference (12:00pm): Speakers present cases, often as a puzzle to be solved by the audience, or the conference may address a contemporary medical issue in, for example, patient management or diagnostic testing. In one sort of lunch conference, "Morbidity and Mortality Rounds" ("Death Rounds"), the purpose of the presentation may be more complex (see Arluke). Students rarely speak out at these occasions; most dialogue is between presenters and residents.

Afternoon and Evening Admissions: Two teams are on call each day. The "short-call" team alternates admissions to the Department of Medicine from the Emergency Department with the "long-call" team until early evening when the "long-call" team takes over all admissions until the next morning at 8am when the shift changes. I followed two teams, so over two weeks I observed a team on call each day except three. During the afternoons and evenings I would accompany students as they did admissions; when no admissions arrived, I talked with them, observed them with their ongoing patients, or accompanied them on scheduled student seminars (such as a trip through the hospital lab, or the rotating schedule of student presentations to the Director and other third-year students). Waiting with them in the waiting/reading/computer room which served as the hub of the medicine department, I was able to overhear countless mini-presentations over the phone, as this was a favored place to send (and respond to) pager messages.

Across these contexts I was able to observe the presentations of students and other medical team members. Interns provided useful presenting models (for students and for me), and the exchanges between residents and attendings offered a glimpse of the presentation at its most manicured and efficient. Even observing the exchanges between medical staff and nursing

staff provided intriguing opportunities for rhetorical speculation, and this kind of professional medical discourse deserves its own comprehensive study.

Data Collection: In total, I observed and made notes on 73 oral presentations by various speakers in a variety of situations. Although I witnessed probably twice that number, I was not always in a situation where note-taking was possible. Occasions when note-taking was not feasible included many resident presentations, which unfolded so quickly and densely that I often could not record them, casual cafeteria conversations when notepads were pocketed and jotting seemed obtrusive and inappropriate[5], or phone consultation requests when the presentation's reception was

---

[5] Robert Emerson, Rachel Fretz and Linda Shaw warn that "fieldworkers must constantly rely on interactional skills and tact to judge whether or not taking jottings in the moment is appropriate" and take care that "open jottings not . . . strain relations with those who notice the writing" (23). For the team, breakfast seemed "off the record time", and jokes were often made at the expense of absent patients, hospital staff, and attending physicians in this context. As Martyn Hammersly and Paul Atkinson point out, such non-recording moments are valuable, because "pure sociability should not be underestimated as a means of building trust" (89). "Breakfast rounds" afforded an opportunity for me to be less "strange" to the team, joining them in lamenting the food or wiping the sleep from my eyes.

inaccessible to me. Because of these limitations on data collection, I have confined the data presented here to the presentations for which I have observation notes, although my interpretations are, of course, influenced by the wider scope of activities I witnessed. Most notetaking occurred during presentations by third-year students on work and attending rounds, but interns' presentations offered interesting models for comparison. Tables 1.2 (Oct. 1996) and 1.3 (Jan. 1998) categorize the observed presentations by speaker and context. Report of no presentations in a particular context only signifies that I did not record observations in these instances. For example, residents regularly present cases in attending rounds but I rarely recorded observations of them. Similarly, a vast amount of non-rounds team talk occurs during a shift, but much of this I did not witness or could not overhear, and some of what I did hear was difficult to record in notes, as in the example of cafeteria conversation. "N/A", not applicable, indicates contexts in which the class of speaker would not normally present cases.

Table 1.2: October 1996 Presentations Observed (Total: 45)

	Work Rounds	Attending Rounds	Lunch Conference	Student Seminar	Non-rounds Team Talk	Outside of Department	Total
3rd-year Student	15	10	n/a	1	1	0	27
4th-year Student	4	1	n/a	n/a	0	0	5
Intern	7	0	n/a	n/a	0	1 in radiology	8
Resident Physician	0	1	0	n/a	0	0	1
Visiting Speaker	n/a	n/a	4	n/a	n/a	n/a	4

Table 1.3: January 1998 Presentations Observed (Total: 28)

	Work Rounds	Attending Rounds	Clinic*	Outside of Department	Total
3rd-year Student	4	3	n/a	0	7
4th-year Student	2	1	n/a	0	3
Podiatry Student	1	1	n/a	0	2
Intern	9	2	0	2	13
Resident	0	2	1	0	3

*I witnessed only one presentation in the Outpatient Clinic in the hospital, as I was meeting an attending physician there who allowed me to observe the exchange between the resident and attending preceptor during a patient visit (see Pomerantz, Ende, Erickson for a consideration of these teaching exchanges).

As Aaron Cicourel points out, it is often possible to obtain only a limited number of cases for study in discourse

analysis projects focusing on specific groups and topics. Faced with this situation, I have tried to ensure the representative nature of the database and the quality of my analysis by consulting an expert within the particular area (Cicourel, "Theoretical and Methodological Implications" 65). In this role, Haber has provided a sense of which presentations are "commonplace" and which are unique, aiding my selection of representative anecdotes for analysis in this study.[6]

I began the 1996 observations with the intention of accompanying students in all of their clerkship activities and did so for the first 10 days. I was, however, uncomfortable with the experience of observing patient interviews and physical examinations in the Emergency Department setting. This was probably due in part to the fact that, unlike the medical students, I had not been socialized to view as acceptable the invasion of personal privacy and physical space. But in addition, observer effect seemed particularly

---

[6] Haber's experience as Director of Clerkships positions him to comment reliably on the nature of student presentations and the recurrence of various difficulties in the acculturation process. Further inquiry into this genre might compare his sense of what is "commonplace" in this initiation process with other physicians'.

high in this context, not only because students were made more nervous by my presence during these first, formative doctoring experiences (and reported this sentiment to me), but also because patients would include me in the discursive exchange, presuming perhaps that I was another physician because of my seemingly evaluative role (though I had none of the usual physician trappings of stethescope, white lab coat, or the green outfit worn on "long-call"). Introducing myself to patients as a "researcher" did not solve this problem, and so I decided to discontinue this aspect of my observations.

As the 1996 observations progressed, I became increasingly interested in the role of physician feedback and commentary in this process of genre acquisition. This interest resulted in the collection of curriculum documents as a site where I could perform more precise linguistic and rhetorical analysis of the teaching discourse that surrounds the oral presentation. First, I chose to study the two documents received by all students in the SFGH Medicine clerkship: "The Compleat Write-up" and "The Student Clerkship Evaluation Form." The first, a guide to composing the written patient record handed in (by third-year students only) to attending physicians 72 hours after a patient's admission, is

authored by Haber and has been used in the Internal Medicine Clerkship at SFGH for many years. Haber instructs students to use it as a general guideline for their oral presentations as well as their write-ups. The "Student Clerkship Evaluation Form" (SCEF) used at SFGH is taken from the *Core Medicine Clerkship Curriculum Guide* compiled by Allan Goroll and Gail Morrison for the Society of General Internal Medicine and the Clerkship Directors in Internal Medicine. The SCEF uses standardized categories and ranking characteristics and represents the Internal Medicine community's agreed upon criteria for judging student performance.

Seeking to increase this sample, I made a request to the UCSF Medical School for documents used to teach the oral presentation. I received in response two documents, one ("Oral Presentations") a single-authored text distributed to the students preceptored by the author (Molly Cooke), the other ("The Oral Presentation" by Craig Keenan) created as part of a jointly- authored (Keenan and Go) "Tips to Survive the Wards" package distributed to UCSF second-year students before they embark on their clerkships. These four documents, variously authored and representing different contexts of instruction, embody and enact the values that faculty (and the

students who receive them) regard as central to the clerkship learning experience. Moreover, their resemblance to both the instructive feedback observed on rounds and attendings' responses to interview inquiries about their introductory advice to students suggests that these documents are not atypical of the teaching discourse surrounding the oral presentation. Furthermore, informant-checking confirms that they conform to the general expectations for such documents.

As I performed preliminary analyses on the data gathered in 1996, I realized the need for a triangulation exercise to test the hypotheses forming from the analysis and provide more precise information about the process of learning this new genre. In January 1998, during the first week of the Medicine clerkship, I interviewed 8 third-year students, 6 attending physicians and 4 residents. To ensure reliability, the interviews followed written protocols developed specifically for student and physician groups.

From students I wanted to elicit information about how they had learned about this genre. For this purpose I used open-ended questions such as, "What did you learn about the oral presentation in your preceptor instruction?" I also wanted to explore how students decided on the composition of

their oral presentations and what their awareness was of the contextual influences on their presentations during rounds. In designing interview questions for these purposes, I adapted Lee Odell, Dixie Goswami and Anne Herrington's discourse-based interview procedure for exploring nonacademic writers' tacit knowledge.[7] Their procedure, designed for use with written documents and their authors, involves selecting significant topics in the composing process for discussion, composing alternatives to discuss with writers, and asking writers to compose aloud (228-234). In my adaptation of this method, I selected from students' presentation "write-ups" a sample of the history component that represented many of the difficult composition decisions students must make when designing these opening segments of their presentations. Haber and I reshaped the sample slightly to foreground these decision-making moments, and I presented it to students as an unorganized transcript, asking them to "compose aloud" by indicating how

---

[7] As Mary-Beth Debs reports, analysis of interviewee accounts has been viewed by some researchers as problematic. "Traditional research considers self-reporting unreliable" because respondents may offer information selectively and researchers may influence responses with cues or misunderstand. Supporters of the discourse-based interview, however, argue that it "admits ambiguity" and "the subjectivity of the researcher" (248).

they would select and arrange this material for an admitting presentation.

Based on my analysis of presentation data from the 1996 observations, I selected two "significant topics" to guide the interview after this point: the decision of whether to put material in the History of the Present Illness or the Past Medical History and the positioning of Social and Family History material in the presentation. In my questions, I focused on places in the composition process where the student had made content choices and asked if s/he would be willing to substitute any of the alternatives for the original choice (e.g., "Would you feel comfortable presenting this material if I moved [data] out of the PMH and into the HPI?). This method, as Doheny-Farina explains, is "designed to pose choices, oppositions or impediments to the participants in order to stimulate their thinking", "to get a glimpse of what they 'know without saying' or seemingly do without conscious thought" (265).

While the "topics" were predetermined and I planned, for example, to ask students if they would agree to move "Social History" (SH) data from that category to the "History of the Present Illness" section, the interview could still be quite

flexible since the specific SH data I chose was based on response to the sample, allowing the interviewee to communicate and elaborate on the meanings s/he attributed to the issue at hand. During this process, interviewees were asked to define any terms they invoked that had shown themselves to be value-laden or problematic in earlier observations (Doheny-Farina and Odell 524). Terms that arose often in interviews (as in curriculum documents and observation notes) were "relevance" or its synonym, "pertinence", and when interviewees invoked such concepts I would ask them to complete the following sentence: "Something is relevant [pertinent] if . . .."

Expert users of this genre (residents and attendings) were interviewed about its rhetorical features and their socio-cultural meanings in the hospital context. These interviewees were asked both open-ended questions (e.g., "What do you tell your students about the oral presentation?") and discourse-based questions about the organized version of the sample shown to student interviewees (e.g., "Would you make any changes in this student's oral presentation?"). Experts were also questioned about the meaning and possible contexts of representative presentation feedback which had been

selected as recurrent in the observation notes.

This dissertation reports findings from a completed phase of a larger, ongoing study. Questionnaires are being implemented as this larger study of genre acquisition develops. I refer occasionally to data from end-of-clerkship questionnaire responses by the January 1998 group of students. When such preliminary questionnaire data appear, I use them not to generalize about students' learning process but, rather, to suggest intriguing relationships between what students report at the beginning of the clerkship and what they report upon its conclusion. Such suggestions are speculative and require a wider administration of the instrument before arguments based on this data can be mounted.

Recording Data: An unfortunate limitation of this study is the small amount of audio-taped data. Because of the relative difficulty in securing permission to do human research that involves violation of patient privacy, Haber and I proposed a study that observed, but did not tape record doctor/patient exchanges and the presentation of that material on rounds.[8]

---

[8] Another reason we did not record oral presentations on rounds was Haber's concern that audio-taping would increase

Tape-recorded data include student presentations to the Director and other students (1996), many discussions between Haber and me, and all student, resident, and attending physician interviews from January 1998.

Since oral presentations on rounds were not recorded, my notes had to be precise enough to allow me to recapture individual presentations after the fact. I wrote fieldnotes during rounds, admissions, bedside visits, and other occasions. Following Hammersly and Atkinson's advice that notetaking should be "congruent with the social setting under scrutiny" (177), I adopted the community's style of notetaking on small, coloured recipe cards attached with a metal ring. This allowed my note-taking to resemble the note-taking being done by other team members and, I hope, made me less obtrusive (an ethnographic goal articulated by Emerson, Fretz and Shaw 22).[9]

---

students' anxiety about this (already difficult) experience and distort the findings. And, unlike the doctor-patient interview (audiotaped and/or videotaped in Debra Roter's collaborative investigations) which occurs in a fixed setting, the range and mobility of oral presentation contexts constrain the use of hidden recording devices.

[9] I found, as did Olesen and Whittaker, that a good method was to write when others wrote and listen with they did (qtd. in Hammersly and Atkinson 177), and I adopted this

For the most part, my notes represent various oral presentations. I followed standard ethnographic procedure (Hammersly and Atkinson; Doheny-Farina and Odell) and distinguished in my notes among observing (my recording of events), theorizing (my thoughts on what I was observing), and research planning (my reminders to myself to ask a question or consider other research strategies). Without the medical knowledge required to reproduce accurately the specialized vocabulary, equations, and pathophysiological arguments that make up much of an oral presentation, I decided early in the observations to focus my attention on rhetorical aspects of the communication and record what I could of its medical content. Often after observing I requested aid in filling in medical details such as terminology that seemed important to particular rhetorical issues. What remain are, I must acknowledge, fieldnotes of a very narrow sort, reflecting what my understanding allowed and encouraged me to emphasize.

Atkinson recognizes that notes such as these, "a mixture

---

approach whenever feasible. And though I did not attempt to disguise myself as a member of the medical community, devices such as my adopted note-taking style and the use of a pager were attempts at "impression management" (Hammersly and Atkinson 87).

of summary, indirect and direct speech", are "clearly far from ideal." Nevertheless, as he points out, such notes allow "a different line of approach, which is more concerned with the narrative form" (*Sociological Readings* 117). While I would characterize students' presentations and their reception as a rhetorical as well as a narrative form of discourse, I agree with Atkinson's opinion that emphasis on these larger-scale events can complement smaller-scale linguistic analysis of conversations and texts, as the former "draws attention to the complex [rhetorical!] relationship between 'events', their organization into a 'story', and the performance of that narrative to an audience" (*Sociological Readings* 117).

Data Analysis: As I reviewed my observation notes, compiled process notes and began the analysis of curriculum documents acquired from the Clerkship Director, I generated categories that represented trends in the data. The categories arise from my application of Glaser and Strauss' grounded theory technique of data analysis, wherein the researcher analyses data by creating "emergent" categories from the material gathered (37). These categories undergo a "constant comparative" process of evaluation and revision as data are

sorted and the researcher works to generate "theory that is integrated, consistent, plausible, [and] close to the data" (Glaser and Strauss 103). The process of forming categories and separating the data into them performs the classic "de-" and "re-contextualization" common to analysis of qualitative data (Atkinson, *Sociological Readings* 123). The terminology for these categories was abstracted from the data. For example, the terms "order" and "management" were recurrent in my observation notes and helped the early categorization of references to these issues in the data (Atkinson, *Sociological Readings* 113).

As accounts of ethnographic research admit, "although one tries to analyze data chronologically and systematically, the analysis process will be partially recursive and intuitive" (Doheny-Farina and Odell 526). For example, as data clusters demanded more specific arrangements to accommodate the array of instances and details, the category of "order" was subdivided into two, related categories: organization and selection, the two aspects of taxis/dispositio -- that is, the Classical rhetorical concept of "arrangement." "Organization" came to represent the way presentation sections were understood and arranged, while "selection" began to focus on

the issues of level of detail, promotion and demotion of material, and the principle of relevance. Soon, "relevance" graduated to a sort of meta-category that overlapped and informed issues of organization, selection and argumentation. Chapter Four charts the role of relevance as a governing principle in presentation composition and as a pedagogical theme.

As one method of analysis, I have employed the Burkean strategy of creating an index of terms from the curriculum documents. Burke's strategy, useful for charting the textualization of implicit social values and tensions, involves locating "pivotal terms" that appear at "crucial moments" in a text or dominate its narrative (Coe, "Burke's Words" 3). From the index, clusters of associated terms and agons of oppositional or transformational terms are arranged. Clusters allow the analyst to trace relationships among ideas and values, while agons suggest dialectical contraries, moments when the text defines its meaning by opposition. I employ this method of rhetorical analysis for its ability to reveal the embedded "structure of motivation" in these curriculum documents (Burke, *Philosophy* 18). In particular, the analysis of dialectical terms offers insight into how

medicine defines itself and what values and assumptions direct its attention. Such analysis of oppositions may also highlight what Schryer calls "the destabilizing features" ("Sites" 108) of a text or genre, those features in which social tension and dissent are closest to the surface.

In addition to this Burkean analysis, linguistic pragmatic study offers further insight into an indexed term rife with social tension ("relevance") and suggests how rhetorical motivation[10] is inscribed in the grammatical features of two curriculum documents.

The analysis and representation of study findings have benefitted from Haber's input and insight. In person and by telephone, we engaged in conversations about the data as it was being gathered, organized, and interpreted; furthermore, Haber read and responded to early drafts of chapters two, three, and five early in 1998.

---

[10] The notion of "motive" is commonly used to refer to individual motives that are contained within the agent of an action. Burke, however, extends the concept to include a wider sense of how and why actions are motivated. His Pentad offers an heuristic for examining motives by ratio, such as the scenic-act ratio (where the act is motivated by its scene) and the agency-act ratio (where the act is motivated by the available means) (*Grammar* 3-20).

The Representative Anecdote: Burke's notion of "representative anecdote" is largely intuitive: he directs us to seek "some anecdote *summational* in character, some anecdote *wherein human relations grandly converge*" (*Grammar* 324). Describing the matter and circumference of such an anecdote, he suggests that it "must be supple and complex enough to be representative of the subject-matter it is designed to calculate. It must have scope. Yet it must also possess simplicity, in that it is broadly a reduction of the subject-matter" (*Grammar* 60). Unwilling to rely solely on the interloper's sense of "intuition" about the clerkship that I gained during my observations, I decided to supplement Burke's intuitive selection process with a more analytic approach. Table 1.4 represents the method by which I categorized "events" in order to determine "the subject matter" of presentation interruptions and, thus, which of the witnessed events might serve as sufficiently representative.

To chart the nature of instructive feedback during third-year students' presentations, I analysed the data for instances of residents' and attendings' interruptions. These data could have been represented in a number of ways. One alternative would have been to chart the interruptions

according to the structural point at which the student was stopped: e.g., during the Chief Complaint, during the Review of Systems, or during the Laboratory Results. However, when I analysed the data using this method, I found that it did not always satisfactorily emphasize my perception of the instructor's *motive* for interruption. Yet another approach is demonstrated by Anita Pomerantz, Jack Ende and Frederick Erickson, who present their findings as "four interactional strategies that preceptors use" to coax appropriate answers during intern questioning (153). In order to explore rhetorically the pattern of feedback during presentations, I categorised comments according to rhetorical "topics": that is, what aspect of oral presentation structure and strategy did the interruption point to?

It may seem from the tabulation in Table 1.4 that students are not interrupted as often as accounts of clinical education have suggested (e.g., Stein; Konner). My system for charting interruptions does not represent the "barrage of questions about [students'] knowledge of medical facts, differential diagnoses, treatment plans, medication levels, outcomes, [and] contingency plans" (Stein 201) that may characterize the Socratic exchanges of attending rounds.

These Socratic exchanges are often used to impart medical knowledge, while the initial interruption that prompts them may be seen to suggest a rhetorical/generic feature of interest. Thus, I have chosen to count only the interruption that introduces such exchanges and not each question that follows, as a way of distinguishing rhetorical issues in presentation structure and strategy from issues relating to biomedical knowledge.[11]

The categories in Table 1.4 and those that structure the analysis of curriculum documents later in the study developed as patterns surfaced in students' presentations and supervisors' feedback. As much as possible, these categories are "abstracted from the language of the research site"

---

[11] This distinction is, to some extent, artificial: generic and pathophysiological commentary are related, of course. For instance, a student interrupted for failure to assert a diagnosis and articulate a plan ("Statement of Diagnosis and Plan") may suffer from a lack of pathophysiological knowledge that makes her reluctant to "put [her] money down on a diagnosis" (Fieldnotes). Perhaps problems in the presentation's rhetoric, such as the failure to conclude satisfactorily with a diagnosis and plan, signal to the listener possible problems in its biomedical content. Alan Hull et al.'s recounting of the finding of "a tendency for students who have good communication skills to be assessed as having better clinical problem-solving ability and knowledge skills" (Dawson-Saunders and Paiva, qtd. in Hull et al. 520) suggests a connection (real or assumed) between rhetorical and medical sophistication that deserves further study.

(Glaser and Strauss 107), thus abstractions such as "Management of Patient." Let me explain more precisely these entitlements:

Duration of Material evolved as a category in order to distinguish feedback whose purpose was to end the presentation. These include instances of nonverbal feedback where the resident left the presentation "circle" in the hallway and headed for the patient's bedside, and comments such as "That's enough: save the rest for attendings [rounds]." The category evolved when it appeared that these were not exactly comments about "selection" or "statement of diagnosis and plan", nor could their motivation (why precisely must the presentation end now?) be easily ascertained.

Organization of Material includes comments about order, such as presenting "Review of Systems" data by system according to a set order. It also includes comments related to the sections of the presentation ("Chief Complaint", "History of Presenting Illness", etc.), their boundaries and their relative order. I have had to make interpretive decisions about whether some interruptions are instances of "Organization" or "Selection" (in terms of selection of data for particular sections of the presentation). In these instances, I have been guided by the wording of the feedback, so that references to "order" are categorized in "Organization" even while they may also provide guidance for selection.

Selection of Material includes interruptions related to the issue of relevance, as well as references to the need for more or less detail in the presentation.

Construction of Argument for Audience and Occasion includes references to the persuasive aspects of the presentation, such as the notion of "building a case" and "arguing for what you think is going on." While such feedback can be seen also to refer to "Organization" and "Statement of Diagnosis and Plan", I have created this category to account for the interruptions that invoke notions of audience and purpose.

Management of Patient includes references to patient admission, treatment, and discharge. These elements are often included in the "Assessment/Plan" section of the presentation and are related to the patient's trajectory of care.

Use of Hospital Resources is related to "Management of Patient" and "Construction of Argument" but isolates instances where students are given feedback on how to access and wield hospital resources such as ordering tests and requesting consultations. Here, for example, students may be coached in how to structure their presentations to request a consultation, or they may be interrupted because they have asserted a test that the presentation has not "argued" towards (that is, has not prepared the listener to expect).

Statement of Diagnosis and Plan, while related to "Management and Argument", focuses on instances where students are interrupted because their presentations resist conclusion. These are most often pointed questions such as "So where's your money on this one?", "What's your plan, Stan?" or "Well, what's she got?"

The categorization of presentation feedback represented in Table 1.4 informed my determination of which observed events might constitute representative anecdotes of the student oral presentation situation. The anecdotes in ensuing chapters of this study were selected to provide examples of recurring presentation problems and repeated feedback commentary, and to offer a set of illustrations to ground the theoretical discussions of genre acquisition in this professional setting.

Table 1.4 (A & B):
Rhetorically Motivated Interruptions in Third-year Student Presentations by Residents (R) and Attendings (A) (from October 1996 clerkship)

	Duration of Material	Organization of Material	Selection of Material
# of interruptions	4 (R) 1 (A)	1 (R) 2 (A)	3 (R) 4 (A)
Total	5	3	7
Relative Frequency (as %)	13%	8%	18.5%

	Construction of Argument	Management of Patient	Use of Hospital Resources	Statement of Diagnosis and Plan
# of interruptions	2 (R) 3 (A)	4 (R) 2 (A)	2 (R) 2 (A)	4 (R) 4 (A)
Total	5	6	4	8
Relative Frequency (as %)	13%	16%	10.5%	21%

The tables quantify the interruptions and their relative frequency as a means of illustrating how often rhetorical motives sparked supervisory feedback and which of these motives seemed more prevalent. The presentation anecdotes I have selected from my observation notes are not "special": indeed, as Atkinson has argued of the representative fragment, "its value lies precisely in the fact that -- by comparison with other encounters recorded and observed -- it presents no

remarkable features at all" ("Rhetoric as a Skill" 117). There is, however, an important distinction between the sociological notion of "representative" and Burke's rhetorical notion. While Atkinson's discussion reveals an understanding of a "representative" event as typical, common, or ordinary, Burke's sense of the ideal representative anecdote is prototypical. He seeks an instance wider in scope than simply "the average", one that is able to illustrate the range of experience encountered in a given situation.

Anecdotes were analysed and chosen according to their "topic" using the system illustrated in Table 1.4, and I relied on informant-checking and comparison with sociological descriptions of teaching rounds to confirm their nature as prototypical events in the clerkship process. They are particularly illustrative examples of the student presentation "event" and contribute to the "thick description" of this workplace discourse, offering the reader a sense of the students' experience of acquisition and a record of daily teaching interactions.

In conclusion, I should acknowledge the fate of patients in this representation of the research, for they appear only as "patient data", robbed of their personalities and

characters, reduced to the "materials" that physicians glean from them and carry off to their professional discursive gatherings. I am not unaware of this extreme objectification of the patient (and of the relation of such "use" of patients to medicine's own objectifying tendencies.) However, as this is neither a study of patients' illness stories, nor an analysis of patient-physician exchanges, patients receive attention here only as the "topic" of physicians' discourse.

CHAPTER TWO

Acquiring the Oral Presentation Genre: The Genre, The Issues, The Context

In the tradition of research into situated generic practices, this project explores the relationship between generic forms of discourse and social contexts of situation and culture.[12] It applies New Rhetorical theory and reconceptions of genre to an aspect of medical education, examining the acquisition of a generic discourse form as an acculturation into a professional community. In its focus on the threshold of community and the situated practices of gatekeeping and gaining access, this project reports on students' formative encounters with a central medical genre -- the oral case presentation -- and traces the role of generic form as a vehicle for reflecting and reproducing community values.

---

[12] This important distinction among contextual frames originates with Bronislaw Malinowski. Malinowski defines "context of situation" as "the situation in which words are uttered" (306) and context of culture as "the general conditions under which a language is spoken" (306), those "geographical, social and economic conditions" that must be referenced in any discussion of "the meaning of a word" (309). Coe represents both these contexts as framing the rhetorical situation of an utterance, that is, its audience, purpose and occasion ("Eco-Engineering").

The Genre: The Oral Case Presentation

The oral case presentation is a method of discourse used by medical professionals to communicate the salient details of patient cases to one another during the course of medical care. Like its written counterparts, found in encrypted form in patient charts and in extended form in patient files, the oral case presentation presents selected details of the patient's case.

The differences between the oral and written versions of this genre are rhetorical as well as structural. The chart, a form of notation rather than argument, reports daily details to be read by physicians and nurses, requests for procedures (directed towards nursing staff), and occasionally copies of relevant articles for perusal by team members. The patient file is a longer and more detailed record of the patient's encounter with the medical institution, consisting of written reports that serve an archival purpose and may be consulted (usually by physicians) on subsequent hospital admissions.

The oral presentation differs from these written versions of the genre in its audience, occasion, and purpose. The presentation is conducted by physicians for physicians; it occurs primarily on hospital rounds (of varying degrees of

formality); and it communicates the presenter's argument about what ails the patient and how the team can address this ailment. The presentation constructs a differential diagnosis in early stages of the patient's management and articulates the evolving problem/plan lists throughout the patient's course of treatment. Its existence is testimony to the organizational nature of medicine, what Atkinson calls "the collective and dispersed character of clinical work" (*Medical Talk* 53). It is an interprofessional form of communication which facilitates the collection, construction, transportation and presentation of medical data to varying audiences during the trajectory of a patient's care in the hospital.

As is common with institutional genres, the structural features of the oral presentation are standardized and, despite important variations among users and contexts, constitute shared knowledge among users of the genre. The presentation is divided into sections, which appear in a standard order that reflects the process of forming a diagnosis, moving from the information gathered from the patient's account during the interview and examination to the laboratory tests ordered and the results achieved. At UCSF, teaching physicians, both in their written instructions and in

their oral feedback on student presentations, appear to agree on the order of presentation elements shown in Table 2.1:

Table 2.1: Order of Presentation Elements
Identification/Patient Profile (ID/PP) & Chief Complaint (CC)
History of the Present Illness (HPI)
Medications & Allergies (OMP)
Past Medical History (PMH)
Social History (SH)
Family History (FH)
Review of Systems (ROS)
Physical Examination (PE)
Laboratory Findings (LAB)
Assessment: Problem/Plan List

In an article exploring "The Case Presentation as a Teaching Tool", J. Brose presents a descriptive list quite similar to the format in Table 2.1. His definitions of each category's contents are useful for an understanding of how the presentation shapes patient data:

> **General statement**: Patient's age, sex, and occupation;
> **Chief complaint**: What brought the patient to the hospital or physician's office, stated in one sentence;
> **History of present illness**: Positive and negative historical findings (character, duration of complaint, evolution of illness) presented in chronologic order;
> **Other medical history**: Previous

> medications, surgery, and psychiatric illnesses, as well as earlier occupations, travel, and life-style factors not mentioned in the present illness history;
> **Family history**: Important negative -- and positive -- findings;
> **Personal and social history**: Any information concerning lifestyle behaviors not previously mentioned;
> **Review of systems**: Short evaluation of any pertinent findings not involving the chief complaint; avoid long lists of negative findings ; acceptable to say, "no other significant findings";
> **Physical examination**: Begins with patient's appearance and general assessment of severity of illness and vital signs, as well as pertinent positive and negative physical findings;
> **Summary of findings**: Brief review of most significant historical and physical findings;
> **Laboratory, imaging, electrocardiogram, special tests**: Pertinent laboratory data given, without listing *every* test value, except in those formal presentations in which all laboratory data are presented;
> **Diagnostic impression**: Problems listed with the most important ones noted first;
> **Differential diagnosis**: A group of possible diagnoses in order of most likely to least likely;
> **Management plan**: Therapies, medications, surgery, further investigations, consultations.
>
> (377)

Brose's descriptions imply that a great amount of data is packed into an oral presentation. This is true; however, another equally vital feature of presentations is their

brevity. As David Irby reports in his study of how attending physicians conduct teaching (attending) rounds, oral presentations in this context may range "from less than a minute to 92 minutes" ("How Attending" 633). Such variations Irby attributes to "the complexity of individual cases and to their educational value" (633).

In my observations, attending rounds presentations are generally about 7-20 minutes long, while work rounds presentations are more condensed, usually lasting 3-7 minutes. However, the identity of either the speaker or the patient can influence these norms. More novice speakers such as third-year students are often granted more time to present (i.e., less manicured presentations are more readily forgiven students than interns), and patients with whom the team is familiar require less background information (unless a newcomer is rounding with the team, a fairly regular occurrence because the hospital rotation schedules of interns, residents, and students are not in synch with one another). The follow-up presentation about a continuing patient is often contracted to an updated problem/plan list and can last less than a minute, although the discussion of the patient that often ensues can extend this time of discursive attention to

the case. Public presentations during lunch conferences (another, more formal type of presentation) are considerably more drawn out than presentations to the team on rounds, with multiple presenters (from, for example, radiology and pathology) joining the key speaker to offer a collective perspective of a patient's case.

As I have suggested in Chapter One, presentations occur in adjacent contexts throughout the teaching hospital and the form's structural influences are visible in even the most casual exchanges between physicians in the elevator or over breakfast. Atkinson acknowledges that "the case presentation is a very pervasive type of narrative performance in medical (and other) settings" ("The Ethnography" 119). His use of the term "narrative" to describe the case presentation reveals a tension between the concept of presentation as "story" (organized on the principle of *chronos*) and the concept of presentation as "argument," a building of a case (according to the principle of *logos*).

Although the presentation is often referred to as a 'narrative' or a 'story' by both researchers (e.g., Atkinson, Hunter) and medical practitioners (e.g., Cooke, Keenan, Haber), it is more accurately understood as an exposition in

its logical arrangement of material. The naming of the presentation as "narrative" is telling, however, for it reveals a conflation of *chronos* and *logos* that deflects attention away from the differences between "telling a story" and "building a case" (see Cooke's, Keenan's, and Haber's usage of these phrases). In fact, curriculum documents will call for "accurate chronology" while advising a strategy of "promotion" and "demotion" that is based on cause-to-effect logic, not, strictly, *chronos*. The conflation of *chronos* and *logos* evident in references to the presentation as a story or narrative suggests that those who assume it are emphasizing the similarities between a case and a story and downplaying the differences between these two forms of discourse, differences of motive and action.

"Case talk", as Atkinson calls it, occurs across diverse contexts, with a variety of purposes and audiences: it ranges from "the most fleeting and informal sharing of information, through daily working rounds, teaching rounds, weekly mortality and morbidity reviews, 'conferences', and 'grand rounds'" ("The Ethnography" 119). The presentation is so pervasive because it provides a vehicle for not only the exchange of information but also the production of

information. As Atkinson asserts,

> medical *work* involves not only the 'direct' diagnosis and management of individual patients, but also the transformation of such work into accounts of it. The construction of the 'case' is discursive work which is fundamental to the tasks of sharing, communicating, informing, debating and monitoring between members of the medical profession. ("The Ethnography" 122)

As it functions across the medical community, the case presentation form reflects what Schryer has characterized as genre's "inherently ideological" nature: it "[embodies] unexamined or tacit ways of performing some social action" ("Sites" 108). In the teaching hospital, such social actions will often participate in more than one organizational domain. In order to suggest the varied motivations that underly the presentation's patterns in the teaching hospital, these domains might be entitled:

> 1) *practical*, regarding patient diagnosis and treatment;
>
> 2) *pedagogical*, regarding student education and enculturation; and
>
> 3) *professional*, regarding member relationships and positions within the medical hierarchy.

These domains, though I will describe them separately, are inter-related and mutually constituting. Their combination

provides the required site for students' "legitimate peripheral participation" in the student clerkship: as Jean Lave and Etienne Wenger explain, "newcomers participate in a community of practitioners as well as in productive activity" (110). Participation across these domains, through relations with patients, relations with what Lave and Wenger call "masters" and other "apprentices", and relations with a variety of practitioners across the community's social strata, contributes to the student clerk's identity transformation into "a different person with respect to the possibilities enabled by these systems of relations" (Lave and Wenger 53).

In the practical domain of patient diagnosis and treatment, the purpose of the case presentation is to provide for personnel a methodical organization of the data gathered during the medical interview and physical examination of the patient. In Western healthcare systems, the case presentation records the intersection of the individual patient and the medical system, a complicated conglomerate of physicians, medical facilities, support staff (nurses, lab technicians, etc.), insurance carriers, and government and legal representatives. Cicourel points out that, through the case, "the patient's folk cognitive perspective and language use"

are interpreted and integrated into "existing procedural and declarative knowledge employed by the physician" ("Reproduction" 94).

In the practical domain, the case presentation performs "signification" by the coding of patient experience into the symbolic order of biomedicine: the genre thus, as Miller contends about genres generally, "embodies an aspect of cultural rationality" ("Genre" 39). In this regard, presentation discourse resembles bureaucratic and administrative discourse generally in its categorizing capacity. Anthony Giddens relates such categorizations to the nature of modern social life, characterized by

> profound processes of the reorganisation of time and space, coupled to the expansion of disembedding mechanisms -- mechanisms which prise social relations free from the hold of specific locales, recombining them across wide time-space distances. The reorganisation of time and space, plus the disembedding mechanisms, radicalise and globalise pre-established institutional traits of modernity; and they act to transform the content and nature of day-to-day social life. (*Modernity* 2)

The reorganisation Giddens describes is an aspect of cultural rationalization: categories provide a system for ensuring that like entities are dealt with similarly (Coe, personal

communication August, 1997). As Susanne Langer has said, "the recognition of structure gives the mind its ability to find meaning" (qtd. in Coe, *Process* 119). When the case presentation has categorized the patient's story, pried it free of its specific locale in the patient's "lifeworld" (Mischler, qtd. in Atkinson, *Medical Talk* 129) and reorganised it in terms of biomedical time and space, the physician knows what to do with the patient and has procedures to follow for dealing with the presenting condition.

This categorization is a rhetorical as well as a scientific exercise and brings to mind both Coe's question, "To what extent do the 'available means of persuasion' persuade the rhetor?" ("The Rhetoric" 186) and Burke's assertion that "we spontaneously, intuitively, even unconsciously persuade ourselves" through our choice of terms (cited in Coe, "The Rhetoric" 181). As entitlements, different categories lend different emphases and create different effects in medical discourse. Categories such as "History of the Present Illness" and "Past Medical History" direct the presenter's attention to chronology and to the act of separating past from present, persuading their users at a most basic level.

In the case presentation, data from the medical interview and physical exam are selected, entitled, ordered, inter-related, and emphasized according to medicine's two controlling goals: the identification and the treatment of disease syndromes. For physicians, the task of knowing is "one of rejecting information, sorting through detail, knowing what to ignore, and applying general rules while retaining skepticism" (Hunter 44). As Kathryn Montgomery Hunter and Stein have argued, this signification of the illness experience renders it "legitimate" by subjecting the patient/narrator to the physician's dominance as authority of the practical domain. Each manipulation of patient data constitutes a site where rhetorical strategies are at work, naming structures in a way that contains an attitude towards them.

In addition to its practical role of organizing patient data towards diagnosis and treatment, the case presentation also functions as a pedagogical method in the teaching hospital. "After the clinical observation of patients, the presentation of cases is the principal teaching method in clinical medicine" (Hunter 57). The case presentation does not teach *everything* (e.g., patient interview and physical

examination skills are learned by following established questions and practicing on both real and mock patients), but it does teach a meta-skill that pervades all clinical activities, including the interview and exam. This meta-skill is clinical reasoning.

Clinical reasoning is a process of hypothesizing and problem-solving, organizing patient data according to a knowledge base of analogous cases. In Irby's 1992 study, attending physicians described the process as that of "holistic pattern-recognition", of "trying to fit the picture of previous patients with these problems" ("How Attending" 633). The process of writing and delivering case presentations is seen to be the best way to acquire the skill of clinical reasoning because it "aids the learner's development of illness scripts and builds stronger connections among medical concepts" (Irby, "What Clinical Teachers" 340).

In the vast arena of medicine, the necessary "cognitive flexibility" is acquired by

> case-based presentations which treat a content domain as a landscape that is explored by "criss-crossing" it in many directions, by re-examining each case "site" in the varying contexts of different neighboring cases. (Spiro, qtd. in Irby, "What Clinical Teachers" 340)

Presentation discourse facilitates this "criss-crossing" for the novice physician and provides a site for feedback, for the guided refinement of individual cases and their comparison with analogous cases.

While the community recognizes the importance of case-based learning, members do not agree that case-based *teaching* is performed satisfactorily. Irby claims that "teaching in response to case presentations . . . is often done poorly" and summarizes the discipline's recent critique of attending physicians' teaching as "(1) containing lengthy case presentations that are repetitions of work rounds, (2) failing to actively involve and meet the diverse needs of team members, and (3) providing little learning" ("Three Exemplary Models" 947). While medical studies such as Irby's report largely on the teaching of pathophysiological content through cases, my study of student presentations considers how the case genre functions to initiate students into the community's rhetorical contexts and to acculturate them to its values and goals. These two approaches are complementary; what this rhetorical study adds is explicit consideration of some of the political implications of case-based pedagogy and the role of

genre in professional socialization.

As rhetoric and genre theory tell us, language has the power to shape attitudes and influence potential actions. This perspective enables an understanding of the case presentation's dual role on the threshold of the medical community: like a revolving door, it is both a method of gatekeeping -- constraining communicative utterances and sifting out speakers in conflict with community values and goals -- and a method of gaining access -- generating communication that will succeed in the community and announce the neophyte speaker as kindred.

The gatekeeping function of the presentation is especially clear in the preliminary days of the student clerkship. Since a governing factor in hospital medicine is cost and therefore efficient care, case presentations need to prioritize and select patient data. Only "presenting" conditions -- those that are acute or have recently become so, such as an asthmatic emergency -- will be treated by the medical team; indirectly related chronic conditions may deserve notice and the scheduling of a follow-up appointment in the outpatient clinic, but not the expenditure of hospital resources. Thus, not everything learned in the physical exam

and the patient history will impact on the management of the presenting complaint. The strict order and length requirements of the oral presentation constrain students' tendency to inclusiveness and enforce data selection through the principle of relevance (considered more fully in Chapter Four) to create the "highly distilled summary" (Irby, "How Attending" 630) valued by the profession.

The inclusive tendency is neither incidental nor undesirable. In fact, it is fostered in medical school as a method of learning and demonstrating knowledge of clinical pathology. But, while the vast knowledge implied by inclusiveness is retained in the professional setting of the hospital, the habit of communication of all of this knowledge must be unlearned. A resident explains:

> in medical school we do these things called CPC's which is the clinical pathologic conference ...it's always ...some disease that you know is totally rare, that you never see, it's never like pneumonia or something like that ... and the reason they present those is because they are trying to get people to have this broad differential and to be able to come up with those Zebra diagnoses when it's warranted and so that's how they teach us in first and second year to develop differentials. (Interviews)

She articulates further that learning this way is useful so

that students learn to include all possible causes in their minds when forming a diagnosis so that when the exotic ("Zebra") case appears, they will be able to come up with the diagnosis. Additionally, she asserts that while students should not present the inclusive differential, they should be "writing out [the] presentation in the beginning thinking broadly because this is [the] first exposure to a patient and figuring out what really is wrong with people." Thus, the oral presentation needs to be based on a broad differential but not reproduce that diffuse diagnostic process.

In addition to structuring students' knowledge of and attitudes towards disease, the case presentation also performs a regulatory function within the established medical community. In this capacity it acts rather like an official language, which Pierre Bourdieu characterizes as a legislative and communicative code that is

> recognized (more or less completely) throughout the whole jurisdiction of a certain political authority, [which] helps in turn to reinforce the authority which is the source of its dominance. It does this by ensuring among all members of the 'linguistic community' . . . the minimum of communication which is the precondition for economic production and even for symbolic domination. (45)

Professional membership is regulated and evaluated by reference to an established set of community standards and values which are reflected in the presentation genre. In this respect, the case presentation is a critical genre for initiates to master, because it influences not only their entrance into this professional community but also their sustained success in it.

Research into the Oral Presentation: Disciplinary Inquiries

As this introductory description of its formal features and institutional contexts suggests, the oral presentation is a genre central to the activities of medicine that does double duty as an educational tool. As such, it has received attention from a variety of disciplinary perspectives. Analyses of medical discourse from sociology (e.g., Atkinson; Waitzkin), anthropology (e.g., Good & Good; Stein), psycho-anthropology (Kleinman), and medical humanities (e.g., Hunter) offer a rich array of perspectives that this rhetorical study of genre draws upon to sketch the contexts of situation in which the oral presentation functions.

While most of these studies do not call themselves "rhetorical" (with the exception of some of Atkinson's work),

they do concern themselves with the action of medical discourse -- with what it accomplishes in the community, the motivations that fuel it, and the consequences of its action for patients and physicians themselves. Where the present study builds on these is in its emphasis on the rhetoric of a particular generic form -- that is, in its disciplinary attention to the rules of composing and delivering oral presentations -- and on the acquisition of these rules by novices. The findings of projects from other disciplines represent theorized positions in the landscape of medical discourse studies, positions that this study uses both as points of reference and as points of contrast for its particular exploration of the rhetoric of the presentation genre.

Undoubtedly the largest concentration of research into medical discourse has been conducted by the social sciences, but it is only recently that these disciplines have turned their attention to the discursive exchanges *among* physicians. Atkinson, a prominent scholar in the sociology of medicine and author of seminal ethnographic studies of medical education, explains that medical sociology defined its territory by "[discriminating] between the realm of the *natural* and the

world of the *social*" and formulating "oppositions that constitute the conceptual armature of the discipline . . .: disease/illness; biology/culture; signs/symptoms; professional/lay; medical/social" (*Medical Talk* 22-23). Fueled by such oppositions that defined both that which was within their disciplinary territory and that which was without, studies of medical sociology turned their attention toward illness, that is, the lay-person's understanding of medicine, to "illness behavior" and "the sick role", and treated the physician's world of science as "given" (*Medical Talk* 24). "The net effect," he explains, is an awkward asymmetry in the classic sociological formulations: lay medical understanding is self-evidently appropriate subject matter for sociological analysis, while professional medical understanding somehow escapes scrutiny" (29). Atkinson also suggests that anthropology falls short of a critical analysis of professional medical discourse, flawed by its construction of biomedicine (medicine which is predicated largely on a mechanistic model of disease processes) as a unified and homogeneous culture (29).

Atkinson attributes to such disciplinary orientations the predominance of research into the medical encounter between

physician and patient. The focus on the illness "career" of the patient combined with the tendency to perceive biomedicine as unified, "a *cultural* system," shapes what Atkinson characterizes as researchers' "obsessive focus on doctor-patient dyads" (33). Such studies appear to assume that the doctor-patient interview represents biomedicine, to the extent, Atkinson complains, that sociological studies have traditionally not looked to complicate the depiction of medical practice and physicians that the clinical encounter offers.

Notwithstanding such blindspots, these studies have produced rich and subtle analyses of the ideological nature of the medical encounter, including discussions of the power relations conveyed and confirmed through medical questioning in Howard Waitzkin's articulation from a sociological perspective of a critical theory of medical discourse; the community functions served by translating the patient's story into a medical format in Hunter's critical analysis of doctor's "narratives"; the distortions created by such translations in Arthur Kleinman's psycho-anthropological study of illness narratives; and the impact of patient age, race, and sex on the interview process and its outcome in medical

researcher Debra Roter's psychometric studies of physicians' interview skills. This research is important: it contributes to the reconception and reconfiguration of the encounter between patients and their physicians, and directs attention to the vast reaches of biomedical ideology within Western culture.

What the exclusive focus on physician-patient discourse misses, however, are what Atkinson describes as "the back regions" -- exchanges among physicians that transform medical information into medical work (*Medical Talk* 34). He criticizes the present corpus of sociological and anthropological literature for "[telling] us far too little about how medical science is produced and reproduced, how it is shared and transmitted, how it is legitimated in practice" (34).

There are notable exceptions to this trend, exceptions which Atkinson acknowledges and uses to situate his own studies of medical discourse. Studies of the case presentation as a form of professional discourse include Hunter's account of its role in the accomplishment of daily medical work and the grounding of medical knowledge in "narrative knowledge" (65), by which she seems to mean

discursive knowledge. Drawing on her ethnographic observations of medical discourse in a teaching hospital, Hunter, a professor in the medical humanities, explores the "literary phenomena" (xiv) evident in physicians' stories and analyses the role of narrative in the teaching and learning of medicine.

Hunter's analysis illustrates the implicit rhetorical trend in many studies of medical discourse. While many researchers do not theorize their findings from an explicitly rhetorical perspective, their studies do offer insight into the rhetorical action of medical discourse, its audiences, purposes, occasions, and contexts of situation. For instance, Arnold Arluke offers a sociological analysis of the deflecting features of oral presentations during "Morbidity and Mortality Rounds". Focusing on the discursive enactment of medical attitudes and interests, his study suggests the motivatedness of the medical accounts that present themselves as objective, factual reports of patient data.

Researchers have also investigated the case presentation as a site of knowledge production and transmission. Renée Anspach explores the values embedded in grammatical features such as the passive voice and verbal account markers,

considering how "the case presentation serves as an instrument for professional socialization" (372). The structural and grammatical features of the presentation, Anspach argues, "both reflect and create a world view" (372), and he questions the functionality of such transmitted values for medical education.

Also interested in the educational aspects of presentation discourse, Anita Pomerantz, Jack Ende, and Frederick Erickson demonstrate how attending physicians use particular questioning strategies to elicit appropriate responses and diagnostic strategies from interns during case presentations in the outpatient clinic. The authors offer an "ideological" explanation for these teaching strategies, suggesting that the discursive exchange surrounding the presentation provides a means for "educators [to] get novices to discover for themselves precisely what the professionals hold should be discovered" (163). Trained to share the biomedical orientation, students learn to "see" what other physicians see.

In his sociological study of how "common sense reasoning" is learned by novices' presentation of cases to senior members of the medical community, Cicourel considers both the

encounter between training fellows (residents) and patients, and the subsequent encounters between training fellows and their attending physicians. Analysing data gathered in observations and recordings of these latter encounters, he argues that the act of re-presenting patient data immediately to a senior physician teaches the resident that medical decisions are "constrained and facilitated by interactional and bureaucratic regularities and practices" ("Reproduction" 110).

Atkinson too, has examined the role of the case presentation as a site of knowledge production and professional socialization. In an ethnographic study of bedside teaching methods in the Medicine department of a Scottish teaching hospital, he exposes the discursive strategies "whereby students are coached to recognize and describe the manifestation of disease" ("Discourse" 179). This coaching, enacted through the presentation, establishes "a potent set of norms, expectations and frameworks of understanding": through it, "the medical student is incorporated into the discourse of contemporary medicine" ("Discourse" 180) via the "joint display of clinical reasoning" orchestrated in the "shared talk at the bedside"

(186). In a later study, Atkinson expands on this notion to articulate what he characterizes (adapting Mishler's term for analysing physician/patient exchanges) as a diverse set of "voices" within presentation talk (*Medical Talk* 150), that diversity reflecting the various audiences, purposes, and occasions of presentation exchanges.

Medical educators, too, have developed a robust literature debating the circumstances of case-based instruction (e.g., Elliot and Hickam; Irby "How Attending", "Three Exemplary Models", "Clinical Teachers"). Recent debates about the presentation *form* were sparked largely by Lawrence Weed's 1969 publication, *Medical Records, Medical Education, and Patient Care: The Problem-Oriented Record as a Basic Tool*. In an attempt to give more prominence to the patient's voice in the medical record, Weed suggested that what he called "subjective" data -- gathered from the patient's perspective -- deserve more emphasis and attention in medical accounts. Hoping to reform the tradition of presentations that effectively ignored the patient's personhood and his/her experience of illness and medical intervention in illness, Weed argued for the adoption of the now standard Subjective, Objective, Assessment, Plan (SOAP)

form of organizing patient data. Such a formula, he thought, would place the patient's experience in the foreground and would help the writer/presenter to better organize her thoughts toward the goal of diagnosis by arranging details by problem.

Weed's early argument suggests the medical community's awareness that 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" (Donnelly 1045). This understanding of the constitutive nature of generic language has caused arguments to arise which question the standard approaches to case histories and presentations. For instance, Donnelly has suggested adjustments which address the SOAP form's tendency (notwithstanding Weed's intention) to privilege the physician's *objective* data and minimize the patient's *subjective* account. His proposed shift from "Subjective/Objective" to "History/Observations" (1048) accommodates a growing trend to validate the patient's illness experience and reduce medicine's dehumanizing tendencies. He suggests further that the presenter "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" (1047). Donnelly explains that such shifts help physicians to "avoid rhetorical devices that thoughtlessly enhance the credibility of medical data and cast doubt on what the patient says" (1047).

Scholars within the medical community also debate the genre's instructional duties and argue about how to best capitalize on its role in teaching clinical reasoning. For instance, J. Brose argues for the use of two forms of presentation -- 'traditional' and 'chunked' -- in small and large teaching groups respectively. The 'traditional' format is that described in this study of SFGH rounds, where the student presenter "bears almost sole responsibility for interpreting the data" (Brose 377). It is also the form commonly used for communication among physicians.

For larger groups, Brose prefers the 'chunked' approach, in which two physicians (one acting as presenter and the other as "expert clinician") recreate the diagnostic reasoning process with and for an audience. Brose explains that each piece of information should be "presented in the sequence in which it became available to the managing physician" and that after each chunk the "experienced clinician -- unacquainted

with the case -- orally 'thinks through the problem'" (378). According to Brose, this approach "minimizes the potential for embarrassing" speakers and offers a better method of teaching clinical problem-solving skills than the traditional approach, which "does not permit interns and residents to work through the problem in the same way as the managing physician did" (377-8). At SFGH, this chunked approach is used for Grand Rounds (which all members of the medical team attend), except that the audience may sometimes fill the role of "expert clinician", responding to a facilitator's questions.

In response to Brose's article, B. Russell and C. Penney have argued that a reorganization of the "traditional" case presentation can enhance students' learning and promote clinical reasoning skills without dissolving the traditional presentation format. They suggest a shift in the traditional order of elements, moving the differential diagnosis after summary findings but before laboratory tests (see Brose's categories, this Chapter). This will, they contend, not only "enhance this method as a learning tool, but it will facilitate the development of a more logical approach to a particular diagnosis and treatment plan" (967). They also support these changes as facilitating "a justifiable rationale

for the ordering of various tests and studies in this age of cost containment and managed healthcare" (967-8). The exchange between Brose and Russell & Penney begins to suggest the contested nature of the presentation form and the purposes for which it may be harnessed in medical education.

Rita Charon, another medical practitioner taking a critical look a presentation discourse, recognizes the ideological nature of medical genres. She asserts that "our genres limit us in significant ways" and "insist on a particular stance toward the material" (10). The educational power of such discursive forms needs explicit recognition, Charon insists, since "by teaching our students how to tell this type of story, we teach them deep lessons about the realms of living that are included and excluded from patient care" (10).

The research findings of medical sociologists and anthropologists, the scholarly debates among medical practitioner-educators, and the growing accounts of the rhetorical nature of medical discourse provide important points of reference for this study of the role of case presentations in socializing the novice physician. The clerkship neatly fits Lave and Wenger's concept of a "learning

curriculum" (97) wherein the novice's legitimate peripheral participation (largely accomplished through the engagement in discursive tasks such as patient interviewing and case presentation) involves both "the development of knowledgeably skilled identities in practice and . . . the reproduction and transformation of communities of practice" (55).

As Lave and Wenger report, citing Jordan, "learning to become a legitimate participant in a community involves learning how to talk (and be silent) in the manner of full participants" (105). The oral presentation's central role in the clerkship curriculum demonstrates vividly their claim that "for newcomers then the purpose is not to learn *from* talk as a substitute for legitimate peripheral participation; it is to learn *to* talk as a key to legitimate peripheral participation" (109). In learning to talk, as Lave and Wenger so pointedly put it, the novice physician acquires a feel for -- and a place in -- the "long-term, living relations between persons and their place and participation in communities of practice" (53).

The clerkship fits Lave and Wenger's refined notion of apprenticeship because it involves students in "both absorbing and being absorbed in . . . the culture of practice"; "it

offers exemplars (which are grounds and motivation for learning activity), including masters, finished products and more advanced apprentices in the process of becoming full practitioners" (95). In this way, as the notion of legitimate peripheral participation illustrates, "identity, knowing, and social membership entail one another" (53). The oral presentation genre performs a pivotal role in the novice physician's guided participation in medical practice, structuring knowledge, reproducing culture, and shaping identity.

SFGH's Student Clerkship in Internal Medicine

In preparation for exploring the acquisition of this genre, the remainder of this chapter introduces my research journey into the world of the student clerkship and charts some of the changing contexts, audiences, and purposes of the student presentation. My narrative mapping of these rhetorical frames sketches the hospital setting of this research investigation[13] and considers how social, physical and

---

[13] The hospital itself is more than just a geographical location in which students study. That is, it is an instance of a type but also a particular, local instance. Each hospital is a different culture and as students travel to

temporal elements shape the audience and rhetorical purpose of the patient case presentation.[14]

The Teaching Hospital: My directions said, "#47 bus to Potrero. New gray slab building. Walk across lawn, past old hospital (red brick), cross the driveway. Entrance on the right, go to the second set of elevators. Gone too far if you're in Emergency. 5th floor, blue door: 'Department of Medicine'." The bus had taken me through the financial section of San Francisco and into a lower income, largely residential quarter. San Francisco General Hospital is a county hospital, offering the surrounding population of

---

different hospitals to fulfill various clerkship requirements, they must adapt to the local culture of individual institutions as well as individual departments within them. From his own internship experiences, Konner deduces from "hospital-by-hospital differences in procedures and [the] arbitrary idiosyncrasies of some of them . . . [that] local traditions were obviously important" (216) if one desired to successfully signal community membership.

[14] A survey of the rhetorical geography of the teaching hospital reveals a landscape governed by two central, sometimes conflicting goals: patient care and student instruction. As the "Medicine 110" handout pointedly asserts, "Patient care comes before education. Through this order of priorities will come your most important learning" (1). This dual purpose shapes hospital activity and contributes to the complicated rhetorical conditions at this threshold of the medical community.

largely uninsured citizens "humane care of the highest quality" (Haber, "Orientation"). The type of hospital--county rather than private--and the economics of its patient base are governing contextual influences, a wide rhetorical context of situation shaping the process, form, and substance of patient case presentations.

On this day, after communicating by phone and email for months as we planned this observation visit, I was to meet Dr. RichardHaber. My period of observation began with the last day of the previous clerkship, so that I could meet students already acculturated to the internal medicine service and witness the fluent confidence of patient case presentations honed during eight weeks of practice.

On this Saturday morning, work rounds were already in progress when Haber and I finished our introductions. On the wards we found the team Haber was supervising (i.e., he was their attending physician) and I was introduced as an observer researching "how you guys survive this place" (Fieldnotes). As I listened to the update and discussion of patient cases, I could already tell who the resident must be from his relationship with the attending. "Real" questions (as distinguished from rhetorical, teaching questions) were often

addressed to him, and even when they were not, his was the answer requested when others had tried their reasoning and failed. I could not, however, pick out who was an intern (first-year graduate from medical school) and who was a third- or fourth-year student, not at least by the demeanor of the individuals. Most wore the physician's white coat (on sale in the campus bookstore) over street clothes, each carried a stethoscope, and each consulted a stack of coloured "recipe" cards held together with a metal ring and crammed with minute scribblings of patient data. Even their pagers seemed to sing in continuous sequence.[15]

To varying degrees, each speaker seemed confident and self-assured. Presentations were concise and fluid: diagnoses were bantered about and rule-outs listed with certainty; acronyms were sprinkled liberally throughout the discourse; problem lists and assessment plans were declared; disposition issues were dealt with matter-of-factly. Each presentation was delivered as if the speaker were the patient's primary

---

[15] One student in this group was obviously a peripheral member. Rarely offering responses to questions not directed to him or opinions during debates about others' patients, this student turned out to be from podiatry, a "lesser" specialty.

physician.[16]

Later that day I explored the fifth floor, domain of the Internal Medicine Department. There were four wards here, as well as an intensive care unit and a cardiac intensive care unit. Patients were also admitted to wards on the fourth floor and to "jail", a restricted ward upstairs for patients either transferred from penal facilities or awaiting transfer to them. Nursing stations provided a central hub in each ward, and patients' names were posted on the wall above the station along with the name of the admitting resident or intern. The offices of the department of medicine were in the centre of the fifth floor. Here a tiny common area housed a computer lab, a library of medical journals, a photocopier, conference tables and two ever-ringing phones. Interns, residents, and attendings gathered here -- but especially students, usually to pore over journals and conduct phone

---

[16] As it turned out, one of these impressively authoritative presentations was delivered by a fourth-year student who had as her morning's work the undesirable duties of informing a patient that her HIV test had come back positive and securing the testing of her young daughter. She seemed to approach this difficult conversation with a calm sense of responsibility: "She's my patient--[the resident] said he'd do it for me, but it's my job" (Fieldnotes).

consultations. Down the hall in a seminar room, everyone gathered almost daily for a free lunch and medical presentation of a particularly interesting case or a contemporary hospital issue such as the management of the city's tuberculosis outbreaks.

The Student Clerkship: On Monday morning, the new eight-week clerkship rotation began. Third-year UCSF students begin their clerkship year in July, so this November session was the third placement for these students.[17] Three of the four students whose clerkship I followed closely had come from the Surgery clerkship, where they said they had been treated as "students--not given any real responsibility and only allowed to sometimes stitch up--always just watching" (Fieldnotes).

---

[17] The entire third-year class begins the clerkship rotation in July, assigned in groups of about eight to various hospital departments such as surgery, psychiatry, and internal medicine. Therefore, the order in which students progress through the departments varies: some may begin with surgery, some with internal medicine, etc. It is not unlikely that this order affects their evolving presentation styles and perhaps predisposes them (if only temporarily) to certain "styles" of medical practice. It is equally possible that moving between particular clerkships (e.g., from surgery to psychiatry, to choose two extreme examples) presents especially intense genre difficulties, as the oral presentation requirements differ between such philosophically diverse departments.

Here, in Internal Medicine, they would be "involved clinically: for the first time these students [would be] part of a medical team" (Haber, interview). As Haber explained, for students "there is a lot riding on this clerkship. . . . It has a mystique about it, and students need to do well here" (Haber, interview). The evaluation from this clerkship would help determine future internship and residency placements. And as he told students, this is "the first, maybe only clerkship where you'll actually treat patients on a team and be looked at as doctors by the patient" ("Orientation").

In their orientation talk, the eight students were told that they needed to achieve two goals in this clerkship. First, they needed to learn "how to function in the clinical setting", and for this reason they would work on the in-patient service (i.e., with patients admitted to hospital) rather than in the out-patient clinic because "things happen fast here, the patient's sicker, so you can observe changes faster" ("Orientation"). Second, students would have to learn how to obtain data through the patient history and exam, add that data to the laboratory results, and determine a differential diagnosis. The director emphasized that they must "concentrate on the differential diagnosis and the path

of disease" rather than on treatment or procedures such as drawing blood and starting intravenous lines. And, he pointed out, the primary method of practice and instruction in the diagnostic process and the path of disease would be their oral and written case presentations. (See "Medicine 110" handout -- Appendix A -- for a written version of this orientation talk.)

At the end of the orientation, students were informed of assigned teams, given team work schedules for the internship period, and told to "find your resident." A long pause ensued, while students checked schedules to see where they needed to be next. "Okay everybody, go--find your resident", the director repeated. "Page them!" he finally added, gesturing to the phone. One student moved to the phone, dialed, punched in his own pager number, and hung up. Others repeated this, as it turns out, ritual action[18], and pagers

---

[18] I use ritual as a term meaning more than simply repeated action. Charting the use of the term in cultural anthropology, through Malinowski's suggestion of ritual's role "as a means of alleviating anxiety" (1121) and Durkheim's "essential argument that ritual and religion more generally are key to constructing and maintaining social solidarity" (1121), Elizabeth Evans defines rituals as repeated, structured phenomena that "assert connections, thereby asserting explanation, meaning, and comprehensibility" (1122). Furthermore, "rituals may assert authority, making ritual a key element of the construction of power and the institutionalization of inequality, or in masking such

began to sound in the room.

This exercise struck me as odd, given what the director had told me about students entering this clerkship. They would, he predicted, "look and act jetlagged"; they would be anxiously "trying to figure out what's expected, their place -- which is different on each team they're a part of" (Haber interview). He knew from experience that they were "going to be very reluctant to be aggressive . . . they won't volunteer much information without being asked, and even when they're asked some will freeze up--some won't but a lot will" (Haber, interview). Furthermore, I began to realize as the days passed that this reluctance characterized their patient presentations: without complete data (a rarity in acute

---

patterns under a veneer of patriotism, nationalism, and the ritual enactment of the community" (1122). The pager activity is ritualistic because it embodies the community values of action and prestige: in medical issues, it is always appropriate to interrupt. Thus, the potential social problem of infringing on someone's time without proper respect for politeness (you cannot ask, "may I page you", in most instances where an immediate page is necessary) is resolved *as long as* the page involves a medical issue. I learned this lesson quickly, as *my* pages were not always received with the same acceptance as pages from fellow medical practitioners. In this, the paging action gives order and guidance: unwritten guidelines seem to outline what one can -- and cannot -- page someone for, and who can page. Doctors give their pager numbers to other doctors -- rarely, if ever, to patients.

medicine), students hesitated to begin the Assessment/Plan section of the presentation, resisting the form's inevitable pull towards a differential diagnosis. Continually residents and attendings would resort to forcing the diagnosis with a question like, "So what do you think she's got?"

The "find your resident" exercise that concluded the orientation meeting seemed to bring students immediately into the medical realm of acting with certitude while not in possession of complete data.[19] It forced them to act, to make a preliminary move, to assert their presence in the face of doubts: Where are we supposed to meet the residents? How do we find them? Is it acceptable to page them? Should we maybe wait till they call for us? The social action of this orientation exercise began to acculturate the students: it communicated that "aggressiveness is good -- and necessary -- here" ("Orientation" 3) in the culture of biomedicine. And while this was not the first clerkship experience for these students, it was the first in a new clerkship community, and students' hesitation suggests their sense of the distinct

---

[19] Haber reported that this was not his conscious intention, yet he agreed that certainly the exercise could be seen to serve this socializing function.

culture of each new hospital department.

Medical sociologists (e.g., Stein, Konner, Good and Good) understand such initiation exercises as part of the acculturation into what Segal has called biomedicine's "interventionist" perspective ("Writing" 88). Konner asserts that the first lesson of clinical interaction is that

> the doctor is not entitled to be reluctant. However awkward the situation, however discouraging or confusing or ugly the disease, however apparently withdrawn the patient, the doctor must step across the barrier in interpersonal space that everyone else must properly respect. (24)

The orientation exercise which opened the clerkship in Internal Medicine cultivates -- and thus regenerates -- the assertiveness valued by this community of physicians.

The Medical Team: Patient care on the wards is delivered by medical teams and a support staff of nurses, social workers, technicians, and other hospital personnel. Each medical team generally consists of a resident physician (two or three years out of medical school), two interns (graduates of the previous year), a fourth-year student, and two third-year students. The medical team is a hierarchical body; however,

responsibilities overlap in ways that complicate the issue of audience for students presenting to the team (see Table 1.1 for a representation of team responsibilities).

The attending physician, a member of the university faculty and a practicing physician, is officially responsible for all of the patients on the service and for the medical actions of all members of his team. However, he may not see the patients personally each day because attending rounds are usually held in an office or common room on the wards. Attending physicians will often drop in on patients in the afternoon to read the chart write-ups and examine particularly puzzling cases, and they may join work rounds on weekends or post-call mornings to save time when the workload is high. Generally, though, the attending's first encounter with a new patient's case and his first indication of daily changes in the case is during the case presentation on attending rounds.

For the presentation format this means two strategies: summary and selection. On the one hand, the attending needs an overview, a general sense of the whole; on the other hand, he doesn't need to know everything. Many details are not relevant to the present care of the chief complaint or to the attending's level of involvement in the patient's care.

The attending's role and the frequency and circumstances of his involvement with individual patients dictate what he needs from the patient case presentation during attending rounds. But in addition, this is a formal teaching and testing situation. Using a Socratic teaching method, the attending interrupts at intervals during the case presentation, rendering explicit students' thinking processes and quizzing them on disease mechanisms (see Atkinson, "Discourse" 181). Irby describes this teaching activity as made up of a combination of "illness scripts and curriculum scripts" which contain stored clinical and instructional information. He finds that attendings employ a range of "routinized teaching activities" in rounds, including "standardized formats for rounds, consistent ways of allocating time and structuring discussions, use of canned presentations[20], and use of generic questioning strategies" ("How Attending" 636).

As the attending is evaluating the resident as well, attending rounds also offer students the opportunity to see

---

[20] "Canned" presentations are standard, positive and negative paradigm cases that are used to demonstrate by analogy the diagnostic particulars of the case at hand.

the residents formally present cases. Through this modelling, students witness the rhetorical refinements of the form and learn from the subtle adjustments evident in the resident's presentations.

The resident is not only a model for the student clerks but also, on work rounds, the supervisor and primary audience. As her involvement with patients is much greater than the attending's, her requirements for the oral presentation are quite different. The resident physician is in her second or third year out of medical school and is directly responsible for the care of patients and for the on-site teaching of clerks and interns. While residents may often work afternoons seeing outpatients in "Clinic", they spend most of their time on the wards, taking patient histories, completing physical examinations, performing procedures and ordering tests. They oversee admissions, examine with varying degrees of thoroughness all patients on the service, and monitor the work of caring for those patients because everyone else on the team is, to varying degrees, a beginner. As an audience, then, a resident almost always knows more about the case than the presenter; this complication of roles presents a possible explanation for what I observed as residents' tendency towards

impatience and irritation.

Residents are responsible for the patients of all other members of the team. Interns, in their first year of doctoring, also have responsibility for their own patients and a sort of referral responsibility for the patients assigned to students. This is, in part, simply the necessity of dividing up responsibility and designating a chain of seniority; it creates, though, a complicated array of primary, secondary, and tertiary audiences for student case presentations. For the student may expect that the resident has seen the patient being presented, perhaps even since the student made her last visit to the patient, but she cannot be certain about what details the resident already knows. Because the intern also monitors the progress of the student's patient and has the seniority to perform procedures that students will usually only observe, students will often defer to an intern's knowledge or allow the intern to fill in the gaps in the uncertain assessment/plan section of the case presentation.

As a result of the nature of audience in these contexts, there may be a perceived lack of exigency in the *medical* situation of the student case presentation, although, of course, the exigency of the "test" is always a factor in the

pedagogical situation. The other members of the team already know much of the data being presented and probably have already formulated their own problem/plan lists. Indeed, many mornings on work rounds, the intern has already decided about and ordered tests that the student presenter is still considering. Thus, in terms of information communication and patient care, the student presentation on work rounds is a formality. On attending rounds, the need for patient information is an actual part of the rhetorical exigency of the situation, but by this point in the day any straightforward decisions about patient care arising from work rounds have already been made and acted upon.

The student case presentation, while it may be a formality in terms of the teaching hospital's goal of patient care, is integral to the achievement of the teaching hospital's second goal of student instruction and acculturation. The presentation on rounds may not directly contribute to patient care but, as Haber explains, as an heuristic it ensures that students "get a system that helps avoid overlooking something" and "develop a certain reasoning process that a) helps narrow the differential diagnosis, b) helps with rule-outs, and c) dictates tests and treatment"

(Fieldnotes). In Burke's terms, it engenders consubstantiality, ensuring the regeneration of the medical community's shared worldview through the established patterns of diagnostic reasoning.

On the Wards -- Call Schedules and Stages of Care: Students on this clerkship admit one patient per "call" day and will be responsible for the patient history, physical exam, chart write-ups, and case presentations on rounds. The call schedule involves a 24-hour shift every fourth day ("long call") where the team remains in hospital through the night, processing all admissions to Internal Medicine from Emergency. "Short call", also every fourth day, necessitates staying at the hospital and alternating admissions with the "long-call" team until the early evening.

The call schedule has significant impact on the presentation form. For example, case presentations delivered on post-long call work rounds are highly time-constrained[21]:

---

[21] Time constraints are an issue to some degree in all presentation contexts and perform an important role in student acculturation to the hospital setting. In fact, Stein describes "the experience of time" as a "metacurriculum within medicine" (186). In Irby's study, case presentations and discussions ranged "from 6 seconds to 92 minutes per case":

the number of patients in the team's care may have doubled throughout the night, yet work rounds must be completed in approximately the same two hours as the morning before and case test and treatment decisions enacted as soon as possible. The increase in patient numbers affects not only the team's time but also its resources. Because of this, the content of case presentations is influenced as well as the length. Follow-up presentations, on patients who have been on the ward for a day or more, become more concise, offering a minimum of background and progressing quickly to the remaining problems and plans for their management.

As a strategy for accommodating presentation content to the context of post-call rounds, interns solicit summary and selection guidance from the resident/audience. They will ask questions such as, "Do you want the rest of these labs?" allowing the resident to tailor the presentation to her needs. In the post-call context, interns have learned that offering less is better than offering more. In one such instance an

---

one physician allowed a mean time of "13 minutes for new admissions and 4 minutes for reviews of ongoing patients" ("How Attending" 633). These time constraints force students to select and priorize from the mass of data they gather during the patient interview and physical exam.

intern asserts during the lab results section, "I've got a whole lot of lytes here -- here's the pertinent positives"; quite happily the resident responds, "Can you give them all to me please?" (Fieldnotes). She would rather ask for more, than wish for less.

In the absence of direct instruction about what is required to please the resident audience, student clerks learn to mimic the interns' rhetorical strategies as a method of improving their presentations. Lave and Wenger refer to this common apprenticeship phenomenon as "the importance of near peers in the circulation of knowledgeable skill" (57). For example, one clerk employs the strategy of audience questioning to aid him in minimizing his post long-call presentation of an ongoing patient, asking "Do you want all his other labs too?" (Fieldnotes). This strategy is pro-active: it solicits direct guidance from the resident before s/he gets frustrated with unwanted details. However, in an instance where mimicking this intern strategy means making an assertion like "here are the pertinent lytes", the fear of exposing ignorance combined with student uncertainty about determining relevance may render such instructional modelling less effective. Such a strategy requires students

to declare, assertively, which data are pertinent. Because of their uncertainty about determining relevance, students are, therefore, likely to be reluctant to adopt this particular presentation technique in spite of its advantages for pleasing the resident audience.

Interns model the adaptation of the presentation to another contextual influence: the patient's condition and care status. In terms of its influence on the presentation, a patient's care status on the hospital ward is categorized in three stages: a new admission, an ongoing patient (not newly admitted, not being discharged imminently), and a patient approaching discharge. The presentation of a new case necessitates more introductory detail, reference to the admitting physical exam, review of systems, and history-taking interview. This content, however, is also informed by the presentation's placement in the call schedule and the number of patients on the service. Interns model the adjustments required for a follow-up case presentation, minimizing Patient Profile, History of the Present Illness, Physical Examination and other background information and moving directly to new lab results, evolutions in the Chief Complaint over the past hours, the effect of applied treatments, and the consequent

changes to the Problem/Plan list. Demonstrating the highly esteemed ability to summarize information in follow-up presentations, one such presentation on post-long call work rounds consists of reference to the patient's chief complaint ("remember she came in with . . .") and then the following summary: "Plan for her today is to continue her IV Septra to control her [infection], wait on the labs done this morning and then see about talking to her about home support" (Fieldnotes). This summary weaves together references to medicines, present treatment strategies, and laboratory tests and implies a problem/plan list to listeners familiar with her condition and probable diagnoses. Its acceptance by the resident reveals the intern's knowledge of what rhetorical corners to cut.

When a patient is ready for discharge, the final presentations shift in form and content. In short, the presentation becomes a justification of the medical "disposition"[22] argument: what the patient's

---

[22] Disposition (i.e., "dispositio") is also, interestingly, a rhetorical term for the arrangement of the parts of an argument or discussion. The Oxford English Dictionary offers other uses of the term that seem not unrelated to its medical use with reference to the discharge of patients from hospital. Disposition is "the action of disposing of, putting away,

medical/psychological/social status is and, consequently, where s/he will be discharged to -- home, substance-abuse-program center, hotel, chronic-care facility, family-member's home, jail, etc. But the student presenter may not be certain that discharge is appropriate: s/he may have reservations and will probably not have had the opportunity to discuss the situation with the resident before rounds.

Interns have an effective strategy for dealing with this situation. They preface the presentation with a statement of a tentative discharge decision and, if the resident does not interrupt to argue otherwise, then they have established a rationale for various shortcuts in structure and content that would otherwise be questionable and open to criticism. In one such presentation, the intern opens with the assertion that "Mrs. X looks ready to leave us this morning" and commences a brief statement of the patient's expected change to portable medicines, improvements in her percentage of "room air" intake (i.e., her relative independence from artificial oxygen

---

getting rid of", as well as "the action of setting in order, or condition of being set in order" and the "physical constitution, nature, aptitude, tendency, or inclination" (493). Each of these meanings is reflected in the medical use of the term.

sources), and the assurance that her "exam [is] unchanged today." These statements provide the rationalisation for the opening discharge decisions. While presentations of patients in the earlier two stages of hospital care culminate in the critical "Problem/Plan List" of clinical diagnosis, this presentation, prefaced by the discharge decision, can eliminate this heretofore essential feature of the case.

Students seem to have difficulty mimicking this particular strategy, perhaps because making discharge decisions comes slowly to them. In my observations, one of the lessons of the hospital clerkship was learning the boundaries of acute care. One student, presenting an ongoing patient case, introduces a "new problem" in his morning update: "the patient complains of a sore throat" (Fieldnotes). But the resident wants the patient discharged: her presenting vasculitus condition has stabilized and he does not see the sore throat necessitating further hospital care. "She can have it checked by her primary [physician]," he states. The student, though, is reluctant to let this new problem go so easily: he asks if "we shouldn't test for . . .?" and continues the final section of the presentation, listing four problems, but the resident shakes his head before the student

begins his "Plan List"--he has decided.

In another case on the same team, the resident signals with his thumb to the presenting student, communicating that this patient is "outta here" today. While the student notices and acknowledges the discharge signal by nodding and saying "Oh, okay, so she'll be discharged", he continues to work through the presentation. He considers "her exam . . ." and "her issues today . . .," then suggests a test that the resident brushes off with a wave of his hand. The failure to re-organize the presentation according to the situational signals offered by the resident can mean three things: first, that the student disagrees with the resident; second, that he has not yet learned to accurately interpret contextual signals in terms of messages about formal presentation revisions; and third, that he has not yet realized the boundaries of acute hospital care. Disagreement, while possible, is not likely to be overtly signalled -- student clerks feel very strongly the authority and superior experience of the resident heading their team. The interpretation of situational signals is a rhetorical lesson, the understanding of acute care goals a lesson in hospital management. For the medical team cannot cure everything on the ward: these high-cost resources are for

diagnosing and stabilizing patients, who can then receive longer-term care in the outpatient clinic or from their primary physician. The new clerks' reluctance to assert diagnostic and treatmant plans with incomplete data seems to parallel their reluctance to discharge with questions left unanswered and new problems pending.

Interns' presentations to residents and residents' presentations to attending physicians provide models which student clerks can and do use as a means of determining how to present cases successfully in the context of the teaching hospital. Students seem to derive from these models a sense of the influence of rhetorical contexts on the form of the case presentation. And as they adapt the form, students also, consequently, adapt their perception of patients, their conditions, their management. As Konner reports

> there is more to [the process of modelling] than meets the eye, more, that is, than learning hands-on procedures that cannot be taught any other way. The physician's attitudes, mind-set, moral stance, and the hour-by-hour decisions about how to use one's time -- all these and many other subtle matters, even including how and what and how much to feel, are observed by the student and imitated assiduously. (363)

Konner's description of the modelling function of clerkship

teams echoes Lave and Wenger's understanding that "learning involves the construction of identities"; thus, learning "implies becoming a different person" (53). It is "never simply a process of transfer or assimilation: learning, transformation, and change are always implicated in one another" (57; see also 116).

The clerkship activities of presenting cases to an audience and being the audience for others' presentations effectively immerse students in the discursive exchanges that construct and report medical work (see Atkinson, *Medical Talk* 93). These clerkship activities and the opportunities they offer for both observing and engaging in medical talk and medical work, facilitate the "intentionality" of learning that Giddens' characterizes as "an ongoing flow of reflective moments of monitoring in the context of engagement in a tacit practice" (qtd. in Lave and Wenger 54). The acquisition of genre, then, is an essential part of the novice physician's legitimate peripheral participation and contributes to the construction of professional identity accomplished through the clerkship experience.

CHAPTER THREE
Generic Strategies and the Creation of Consubstantiality

> [L]anguage and genre, in constructing the disciplinary discourse, construct the discipline itself. (Segal, "Writing" 93)

> Human social activities . . . are recursive. That is to say, they are not brought into being by social actors but continually recreated by them via the very means whereby they express themselves *as* actors. In and through their activities agents reproduce the conditions that make these activities possible.
> (Giddens, *Constitution* 2)

Acquiring Genre, Acquiring Culture

The discursive exchanges of the medical community offer members various strategies for encompassing medical situations. Viewed from a New Rhetorical perspective, "these strategies size up the situations, name their structure and outstanding ingredients, and name them in a way that contains an attitude towards them (Burke, *The Philosophy* 1). The patient case presentation acts as such a strategy, naming the ingredients of the biomedical encounter: patient, physician, symptom, sign, laboratory value, differential diagnosis, treatment plan.

This genre's strategic value recalls Miller's proposal

that the way to understand what genres *are* is to focus on what they *do*, for whom, and in what situations. Defining genre as "typified rhetorical action" ("Genre" 24), Miller invites us to consider not only the forms of genres but also their contexts and their functions; similarly, Coe depicts generic structures as "*pre-pared* ways of responding . . . [which] embody our social memory of standard strategies for responding to types of situations we encounter repeatedly" ("The Rhetoric" 183). Genre theorists' agreement that genres are both formal structures and social strategies (see, e.g., Miller "Genre"; Devittt "Generalizing"; Coe " The Rhetoric") suggests an important implication for teaching and learning discourse: for as novice members in a community acquire generic ways of reporting information, they acquire modes of "social and ideological action" (Schryer, "Sites" 107).

By ideological action I refer in this chapter to actions/ideas that are, as Burke explains, "framed and propounded for an ulterior purpose" (*Rhetoric* 88). Burke refines this notion by characterizing ideology as "but a kind of rhetoric (since the ideas are so related that they have in them, either explicitly or implicitly, inducements to some social and political choices rather than others)" (88). To

draw a finer distinction that may be useful for this study, a rhetorical act (ideas included in this term) persuades by identification of the rhetor's ways with the audience's (*Rhetoric* 55), while an ideological act is a type of rhetorical act that persuades towards the end of maintaining the interests of a dominant group by invoking in other groups identification with these interests. The difference between ideology and other sorts of rhetoric is, then, one of motive: ideology encourages identification for the purpose of concealing -- and thus perpetuating -- social contradiction.

Genre acquisition, then, may be a double-edged sword. Genres provide the novice "keys to understanding how to participate in the actions of a community" (Miller, "Genre" 39); the categories and conventions of form offer her "rhetorical means for mediating private intentions and social exigency" (Miller, "Genre" 37). But as Miller reveals, invoking Burke, "motives are distinctly linguistic products" ("Genre" 31). Thus, in learning a genre, the novice learns "a method of achieving [her] own ends," but she also learns, "more importantly, what ends [she] may have" (Miller, "Genre" 38).

A genre's textual features not only *represent* its

rhetorical and ideological features: text and context mutually *constitute* one another, (re)generating a discourse community. Segal's analysis of medical journal writing reveals this generative interplay between text and context whereby "the collective constructs its character from the work of its members as the members construct their character from the work of the collective" ("Writing" 90). Such constructions extend beyond the creation of texts: as Segal argues, the individual and the collective in cooperation assert and renew the community's existing paradigm (Segal, "Strategies" 528).

As Coe and Freedman assert, invoking Bill Green and Alison Lee, Frances Christie, and Pam Gilbert, "genres are neither value-free nor neutral" (3). The constraints that the oral presentation places on students' communication serve social and ideological needs in the medical community: learning to present appropriately involves learning the "values and beliefs [that] are instantiated within this set of practices" (Coe and Freedman 4). This understanding parallels Lave and Wenger's neo-Marxist characterization of learning[23],

---

[23] A variety of Marxisms and neo-Marxism have arisen in critical discourse, most sharing an interest in the historical forces that shape and reflect material conditions and the means by which individuals and class groups achieve control of

in which the acquisition of new discourses contributes to "the historical production, transformation, and change of persons" (51). Learning, they argue, "implies becoming a different person with respect to the possibilities enabled by . . . [the] systems of relations [which] arise out of and are reproduced and developed within social communities" (Lave and Wenger 53). Such learning is more than the accumulation of knowledge and skills: it is "a construction of identities" (Lave and Wenger 53).

Motivation: A Burkean Analysis of Pivotal Terms

The rhetorical lens of genre theory allows us to see that the curriculum of the case presentation is an exercise in communion. As a method of appreciating this symbolic action, this chapter presents a Burkean concordance of pivotal terms from selected case curriculum literature, charts some important clusters and dialectical oppositions of these terms, and examines how they help develop consubstantiality in

---

material conditions. In characterizing Lave and Wenger's approach as neo-Marxist, I echo their self-alignment with "a long Marxist tradition in the social sciences" that theorizes "social practice, praxis, activity, and the development of human knowing through participation in an ongoing social world" (50).

medical initiates.

A Burkean analysis of the rhetoric of words as "terministic screens", magnifiers and blinkers that shape our views of our worlds, provides a system for charting the textualization of implicit social values and tensions. Its words are a community's most basic form of self-definition. Before any arguments have been formulated, the medical community's shared terms reflect what it finds worth naming and what it disregards, what it values and the oppositions within which it understands those values. Analysis of such "naming" involves locating "pivotal terms" that appear at "crucial moments" or in high frequency in a text and dominate its narrative (Coe, "Burke's Words" 3).[24] From the index,

---

[24] While Burke's analysis of "naming" is the method I will employ in this chapter, it is worth noting that the issue of naming has been approached from other perspectives. An important example is M.A.K. Halliday and James Martin's analysis of science nominals and of the sciences' tendency to "technicalize" words by turning them into nouns (3-7). Using grammatical analyses of science texts, Halliday explores the power of such nominalizations to reconstrue processes as "an edifice of things" (14), to depict "a reality of a particular kind -- one that is fixed and determinate, in which objects predominate and processes serve merely to define and classify them" (17). Halliday's analysis approaches an ideological critique, as it recognizes the contradiction between the static world construed by science nominals and the direction of physical sciences which have moved "from object to process, from determinate to probabilistic, from stability to flow"

clusters of associated terms and agons of oppositional or transformational terms are arranged. Clusters allow the analyst to trace relationships among ideas and values, while agons suggest dialectical contraries, moments when the text defines its meaning by implied or stated oppositions. I employ this method of rhetorical analysis for its ability to reveal the embedded "structure of motivation" (Burke, *Philosophy* 18) in these curriculum documents. Burke suggests that we can uncover the "implicit equations" in a work by examining interrelationships (associations, oppositions, transformations) among terms. These interrelationships, he argues, reveal the author's motives (*Philosophy* 20). We can discover motivation by attention to "the structural way in which [the author] puts events and values together when he writes" (20).[25]

---

(17). Furthermore, he suggests that the "technicality" of scientific discourse "has become increasingly anti-democratic . . . set[ting] apart those who understand it and shield[ing] them from those who do not" (18).

[25] Motivation, Burke explains in *The Grammar*, is "a constraint upon the will" (104), shaping language into patterns. Thus, "motivational clusters" in the structure of texts contain "an implicit set of evaluations", assumptions as to what kinds of acts are appropriate in the situations presented (108). A community, he suggests, may share "tribal or collective motives" (93) which provide a "symbolic" or

The history sections are often considered the heart of the presentation. Graham Bradley reports that, in most cases, "what the patient has to say about his illness -- the history -- contributes most to the diagnosis" (61). At the same time, he emphasizes that thoroughness in gathering this information is not as important to correct diagnosis-forming as "interpreting and judging information" (60). The patient's history is, then, a highly valued and high-stakes part of the student's oral presentation. This chapter indexes and analyses the "History" sections of these curriculum documents (Identification & Chief Complaint, History of the Presenting Illness, Past Medical History, Social History and Family History), where students are offered instruction in how to compose these opening segments of the oral presentation.

Following Burke, my analysis of associated and dialectical terms explores how these authors define the history presentation to initiates and what values and assumptions direct their attention, motivate their discourse. Such analysis of terministic interrelationships may also highlight what Schryer calls "the destabilizing features"

"spiritual" ground of social cohesion (94).

("Sites" 108) of a text or genre, those features in which social tension and dissent are closest to the surface.

The following analysis reports on the rhetoric of naming in the 'history instructions' of four curriculum documents from UCSF's medical program. These samples offer a representation of some of the written teaching discourse that supports students' acquisition of the oral presentation genre. Two of these documents are received by all students during the SFGH Medicine clerkship. "The Compleat Write-up", authored by Haber in his capacity as Director of Clerkships in Medicine, guides students' composition of the written patient record which is handed in for evaluation to attending physicians 72 hours after a patient's admission. Haber instructs students to use this document as a general guideline for their oral presentations as well as their write-ups, and his instructions for the history of the presenting illness provide particular guidance in the appropriate use of patient data for this purpose. The second clerkship document, the "Student Clerkship Evaluation Form" (SCEF), uses communally agreed upon categories and ranking characteristics, and provides the internal medicine community with shared criteria for judging student performance.

As I have explained earlier, the other two documents included in this analysis are preparatory handouts given to students before they begin their clerkships. The first of these, Molly Cooke's "Oral Presentations", provides a general introduction to the context and purpose of oral presentation, and partial information about data selection, organization and delivery. The other, "The Oral Presentation", is Craig Keenan's handout, created as part of a jointly authored (Keenan and Go) "Tips to Survive the Wards" package distributed to UCSF second-year students before they embark on their clerkships. Keenan provides tips for presentation delivery followed by a section-by-section outline of what material to include and emphasize in the oral presentation on rounds.

The following analysis concentrates on high frequency and high intensity terms from selected portions of these four documents. For Haber's and Keenan's handouts, I have closely analysed only the sections referring to the presentation of History material (CC/ID, HPI, PMH, SH, FH), for the SCEF I have considered only the section referring directly to oral presentation skills, and for Cooke's handout I have analysed the whole document, since it is brief and not organized by

presentation sections. Appendix B presents indexed copies of these sections to illustrate the frequency and distribution of the terms I have interpreted as pivotal references to the preferred presentation form and content.

The indexed terms suggest a number of associational relationships that reveal important themes running through these documents. This is one strength of Burkean analysis: it allows one to re-view texts and suggests entitlements perhaps different from those provided by the authors. While Keenan and Haber use presentation section headings to divide and entitle their narrative blocks, and Cooke uses the subtitles "Important", "Content" and "Delivery", my indexing of terms draws attention to other useful entitlements of this material. Though more and other groupings and entitlements are possible, Tables 3.1, 3.2, and 3.3 present the three thematic clusters most relevant to this chapter's focus under the headings, "Selection Strategies" (the sorting and judging of patient data), "Organization Strategies" (the arrangement and emphasis of selected patient data), and "Professional Context Issues" (the nature of the rhetorical situation housing the presentation activity). Terms are accompanied by a bracket reference to the sentence(s) in which they occur.

Learning "Selection Strategies"

Each of the curriculum documents emphasized the notion of selectivity in relation to patient data. That is, not all data can be presented orally (although more will appear in the written record), and therefore students must learn the criteria for selection. Table 3.1 records the pivotal terms from each document that invoke the activity of selection.

Table 3.1: "Selection" Clusters in Curriculum Documents

Keenan	Haber	Cooke	SCEF
limit (S18, 72)	include (S11, 23, 23, 24, 31)	discount "old" (S11)	primary problems (S6, 10)
pertinent (S18, 44, 44, 62, 67)	pertinent (S15)	emphasize "now" (S11)	key events (S7, 10)
relevant (S34)	relevant (S18, 20, 23, 24, 26)	omit (S12)	focused (S9, 12)
associated (S42)	bear ... on (S15)	important (S12)	diagnostic info. (S5, 8, 11)
important* (S18, 24, 29, 36, 46, 47, 54, 56, 65)	related (S28)	concentrated (S10)	
crucial (S57)	acute (S15, 19)	edited (S10)	
significant (S67)	significant (S20, 26, 32, 32)		
major (S33)	reasonable question (S21)		

*The documents contain other references to "important" which refer to the presentation itself rather than the data being selected. E.g., "It [the presentation] is an important skill to perfect" (Keenan S6). I have not recorded these uses of "important" in this Table.

In their function as rules and resources for structuring presentations, these terms suggest appropriate responses to exigencies in the rhetorical situation of the student presentation. Terms such as "edit" and "limit", while they are not arguments, are perhaps more rhetorical than arguments because, as namings, they have "without the <u>form</u>, the <u>force</u> of an assumption" (*Rhetoric* 98). As Coe argues, "they embody

attitudes that prejudicially lean us toward certain conclusions" ("Burke's Words" 6). Examined as "camouflaged presumptions" ("Burke's Words" 6), these terms reveal implicit arguments about the clinical situation. As tacit assertions that particular aspects of this situation should be focused on and others deflected, these pivotal terms are concise summaries offering the analyst access to the "gist" of clinical practice.

A close look at these "Selection" clusters suggests the exigencies from which these terms spring, the institutional motivations that undergird them, and the social action that they direct. All three of these rhetorical issues -- exigency, motivation, social action -- bring us to the framework of oral presentation: the differential diagnosis. The differential diagnostic process, guided by the goal of uncovering the likely causes of patient symptoms and connecting those causes to the epidemiology of disease, controls the presentation. The diagnosis follows the principles of mechanistic thinking, seeking the cause of a set of determinants. Not all patient data will contribute to the quest for a pathophysiological cause, and these curriculum documents offer advice (such as Keenan's direction to select

data "relevant to the illness or the complaint for which [the patient is] seeking help" (S34)) that directs students' attention to some data and deflects it from others.

Keenan makes a number of references to the quality of the desired data: for instance, they must be "pertinent"(S18), such as "pertinent positives and pertinent negatives" (S44), they should be "associated" (S42) to the chief complaint, and "more important illnesses" (S56) should be listed first while "less important data" should be "just [outlined]" (S17). Cooke's advice both characterizes the desired data and emphasizes the actions required for appropriate selection: the presenter needs to "[discount] 'old' information" (S11) and presentations need to be "edited and concentrated" (S10). "Concentrated" might suggest itself as a principle of organization, except that in this discourse its dialectically opposed term would seem to be "diluted", which implies the inclusion of inappropriate data. Data not sufficiently pertinent presumably 'dilute' a presentation by weakening the cumulative pull towards a particular diagnosis: one attending physician referred to such data as "clutter" or "red herrings" and scolded students for distracting him with such details that did not connect to a "reasonable" diagnosis (Fieldnotes).

Haber's depiction of the ideal presentation as one which "[leaves] no reasonable question unanswered at its end"(S21) echoes this attending's requirements. Selection is a process of reasoning, a process which Jerome Kassirer and Richard Kopelman characterize as a form of pattern recognition, of problem-solving by forming "semantically meaningful 'chunks', gathering data relevant to a perceived specific solution of the problem, and applying familiar, 'prepackaged' actions" (4). Thus, the "unreasonable question" in dialectical opposition to Haber's "reasonable question" would be one that is outside the set of semantically meaningful 'chunks' that serve the genre's purpose(s) in relation to a particular patient's situation. Understood dialectically, the "reason" invoked by Haber and other attendings is not (as it might first appear) reason as a universal, objective principle (in opposition to its absence) but, rather, reason as defined by a discipline's interests and intentions.

The issue of 'relevance' pervades the selection clusters. Of particular interest to the present analysis is that notions of relevance (and its quasi-synonyms, 'pertinence', 'significance', and 'importance') are regularly invoked by

these authors without reference to any context. So, while Haber offers the contextualization "relevant not only *to the Chief Complaint* but *to caring for the patient while hospicalized* [sic]" (S18, emphasis mine) and Keenan qualifies "relevant *to the illness or the complaint* for which [the patient is] seeking help" (S34, emphasis mine), Cooke can advise promoting information "too important to leave out" (S12) without suggesting how to determine "importance." Keenan, similarly, tends to end sentences with the uncontextualized conditional, such as "if significant" (S67), "if pertinent" (S71), and "if particularly relevant to the case" (S75). This pattern of question-begging (Pertinent to what? Significant for what?) erases context, making issues of relevance and significance appear universal, unbiased, when they are actually tied to local and institutional contexts and informed by disciplinary attitudes and interests. The ambiguity nurtured by question-begging is functional: by erasing contexts and interests, the process of selecting data is purged of the appearance of bias.

'Revelance' and 'reason' are ideological notions for the medical discipline: they are "half-truths", both reflecting and concealing the social contradictions of the

physician/patient relationship in order to maintain these contradictions. For instance, the dialectic 'relevant/irrelevant' both *represents* the hierarchical tension between physician and patient, objectivity and subjectivity, disease and suffering, and *justifies* this hierarchy. Objective data about disease (articulated by physicians) are relevant, subjective data about suffering (articulated by patients) are less so. The mere invocation of relevance conjures up this hierarchy, the belief that relevant data further medical practice justifies this hierarchy, and the demand for "relevant data" by superiors reinforces it. The value of 'relevance' and the method of cause-effect reasoning support disciplinary interests by determining what clinicians attend to in their patient encounters -- that which is objective, related to biological entities rather than contextual meanings. This directing of medical attention reinforces the low value accorded to the patient's subjective experience in diagnostic reasoning, (re)producing the ideological subject position of physicians with its interests and its power. Agon analysis of these terms helps to reveal dialectical oppositions embedded in curriculum documents, oppositions which reflect the medical community's attitudes

and interests and define the circumference of its activity.

Learning "Organization Strategies"

A consideration of associations and oppositions suggests that the message communicated through these curriculum documents is one of priorization. The system of priorization that culminates in a diagnosis extends beyond the selection process to include the organization of selected material into an appropriate format for presentation. Table 3.2 presents the "Organization" clusters from the four curriculum documents.

Table 3.2: "Organization" Clusters in Curriculum Documents

Keenan	Haber	Cooke	SCEF
story (S27, 28, 29, 31)	focus point (S 21)	building the case (S13)	delineation (S6, 10)
path (S28) (vs.) wandering (S29)	summary (S24, 27)	formulation (S13)	chronology (S3, 10) chronicle (S9)
conclusion(S29, 30)	list(ed) (S26, 29, 29, 33)	diagnoses (S14)	
diagnosis (S28)			
structure (S31)	numbering (S32)	a position (S7)	
chronological (S37) time-line (S43)	patient's own words (S9) (vs.) astray (S10)	focused and directed (S16)	
list (S54, 56, 74)	problem-oriented organization (S32)	promote (S12)	
detail (S54, 60)			
preliminary thoughts (S36)			
begin (S33)			
up front (S34)			
distinct blocks (S48)			
preference* (S8, S34, S59)			

*Later in this chapter we will consider this notion of "preference" as it is related to differences in organization strategies and the meanings of those differences.

These clusters reveal some important associations in this discourse about creating a presentation. Keenan reports that

the presentation has a "structure" (S31), that it is in fact the physician's "story" about the patient's presentation to the hospital (S27, 28, 29, 31); however, this story, with its "path to the diagnosis" (S28) is not "biased." The "conclusion" (S29), Keenan assures, simply keeps the presenter from "wandering" (29). His claims echo the decontextualized notion of selection: leaving out data, he asserts, only creates "bias" if the data left out are "important" (S29). The "path" Keenan refers to is the linear path of causality which threads through the presentation, knitting it into the necessary final product: a diagnosis of the pathophysiological cause of the patient's condition.

In his recent textbook intended to encourage medical students to acknowledge and analyse medical uncertainty, Bradley explores the limitations of this "scientific approach . . . based on Newtonian principles" (xii) when applied to the diagnosis and management of disease. "Modern medicine is based on the concept of cause and effect" (xiii) he tells students: this approach, he explains, depends upon "a conceptual framework of anatomy, physiology and pathology in which the idea of cause . . . [plays] an essential role" (47). The linear, mechanistic causality that Bradley depicts

underlying medical problem-solving provides a framework for understanding the SCEF's esteem for "delineation" (S6, 10) and "chronology" (S3, 10), Keenan's encouragements to shape the path according to a "time-line" (S43) and Cooke's direction to "[build] a case" (S13), to "[focus] and [direct]" (S16) the material towards the diagnostic goal.

As Alvan Feinstein explains, diagnostic thinking "goes chronologically backward to decide about pathogenesis and etiology" and "goes chronologically forward to predict prognosis and to choose therapy" (73). He likens the "pathologic diagnostic challenge" to a sort of "intellectual entertainment . . . as the clinician-detective tries to 'find the killer' in a 'who-dunit' mystery that will shortly be 'solved' by the pathologist" (79)[26]. This metaphor is

---

[26] In daily presentations this entertainment atmosphere surfaces regularly. In the differential diagnostic process of rule-outs, the "who-dunit" tone permeates the discourse. While attention is always first directed towards "the usual suspects" and students are warned "not to assume zebras when they hear hoofbeats" (Fieldnotes), the more exotic findings ("zebras") seem to entertain and please the medical audience. An attending physician, commenting on students' suggested diagnoses, agrees that "a stroke is possible--less satisfying as a diagnosis though" (Fieldnotes). In another case he exclaims "it would be so elegant if it *was* morantic endocarditis!" (Fieldnotes). Another attending physician responds to a student's "zebra" diagnosis with the advice that "you need lots of supporting evidence to suspect meningitis .

revealing of the motivational structures underlying the presentation and the methods employed in it. The focus here is on the disease rather than the person affected, in much the same way that a criminal investigation is focused on the criminal rather than the victim. And, like a criminal, disease becomes the enemy to be tracked down and eradicated. (Cf. Hunter's comparative discussion of medical "stories" and Sherlock Holmesian reasoning.)

Hunter's distinction between the patient's "story" and the physician's "metastory" suggests the implications of such foundational metaphors as the 'detective' thriller. Cast as a 'thriller', the metastory does not reflect the patient's subjective account of illness; rather, it may depersonalize the patient who becomes a "case" to be solved (Hunter 135) and may invite what Hunter calls "reification" (136), the reduction of the patient to "the bladder infection on [ward] 5D" (Fieldnotes). Hunter suggests that the motive for reification is emotional protection for doctors, the cultivation of a professional distance between themselves and the suffering of their patients. The detective metaphor, in

---

. . just like you can't convict someone of murder with one piece of evidence" (Fieldnotes).

its foregrounding of the condition as a puzzle to be solved, may cooperate in this demarcation of professional space.

Like Keenan, Feinstein also invokes the metaphor of the path, referring to the "clinician's pathway to an anatomic diagnosis" (80). This pathway, he explains, consists of observation of evidence and first-order classifications of evidence followed by "a sequential series of deductions . . . and finally reaching the ultimate inference that constitutes the anatomic diagnosis" (81).

This path is more than mere skeletal structure for the presentation: it defines not only what may be said but also what may be known. This influence extends into the relations between physicians and patients, as well as into the bureaucratic relationship between doctors and the healthcare system. The influence of generic structure on meaning -- and how that influence is ideological -- is an important aspect of genre research. In their study, Berkenkotter and Ravotas have traced the ideological influence of DSM IV classification systems on psychotherapists' organization and interpretation of patient data in initial evaluations. Their argument that the goal of "translating" the patient's story into a "billable" diagnosis (and the achievement of this goal via

"diagnostic categorization") suggests that the structure imposed by DSM IV categories defines the patient's "clinical picture": what the patient 'has' is dictated by the possible categories. Thus, what can be said and 'known' about a patient, in terms of the official patient record, is constrained by the "assumptions implicit in the classification systems" (272). As Berkenkotter and Ravotas argue, invoking Giddens, the use of "inference-generating categories" is "structurally constitutive" (272): it facilitates the "translating [of] the images and concerns of one world into those of another and then [the] disciplining and maintaining [of] that translation in order to maintain a powerful network" (Star, qtd. in Berkenkotter and Ravotas 272).

Medicine's diagnostic logic and the organization it imposes on case presentations performs similar ideological 'work' as it defines what can be said and known about patients. Before exploring medicine's system of logic, an outline of what is intended by "causal logic" is necessary to frame this discussion.

While "causality" is often used to mean "cause-to-effect" logic, there are in fact different types of causal reasoning. Coe articulates the following types of causal explanation:

cause-to-effect causality which may be linear or cyclical, singular or multiple, and contextual causality which involves many *levels* of explanation (*Process* 353). He explains that "because it is the type of reasoning that gave rise to machines and that best explains their internal workings, mechanical cause-to-effect reasoning predominates in industrial societies" (*Process* 350-363). Cause-to-effect reasoning creates "causal chains" (353) and can accurately explain linear process: however, in complex situations, Coe explains, cause-to-effect reasoning may oversimplify and distort.

Different situations call for different sorts of causal reasoning. As Anthony Wilden asserts,

> somewhere between the low order of systems complexity of the energy relationship involved when two billiard balls strike each other, and the very high order of informational complexity when men, nations, and ideas collide, we pass from the realm of closed systems to that of open systems, from the 'inorganic' to the 'organic'. (357)

Wilden's distinction between closed and open systems offers a framework for understanding both the origins of different causal models and their appropriate applications. A closed system, he explains, is "not in an essential relation of

feedback to an environment" (357). Thus, it "is explicable in energy terms" (358). Wilden's cause-to-effect example of one billiard ball striking another after a stroke with a billiard cue represents a closed system which is accurately explained in Newtonian terms of the transfer of energy from one object to another (*Process* 360).

If, however, the billiard cue strikes a person rather than a ball, a causal analysis based on Newtonian physical energy analogies will be insufficient and potentially distorting, for "human 'reactions' cannot be explained adequately by analogy to physical motion" (*Process* 360). The nature of the human response is shaped, Coe explains, by contextual information such as the influence of situation, memory and analogy on the individual's interpretation of the event (*Process* 360-1). Contextual causality is required to understand the effect/response as a result of the transfer of meaning rather than of energy.

This transfer of meaning may be highly complicated, and contextual causal analysis reveals that an effect is "determined in several ways, is 'overdetermined'" (Freud, qtd. in Wilden 37). According to Wilden, all open systems, that is, those "involving or simulating life or mind . . . [and]

necessarily in communication with another 'system' or 'environment'" (36), are overdetermined. By "overdetermined" he means that there is more than one adequate way of explaining a symptom or effect, for the open system is not ruled by cause-to-effect but by possibility and constraint (35).

Wilden is talking about more than simply multiple causality, which Coe explained as a type of cause-to-effect logic. Wilden argues that

> certainly there are 'results' and 'consequences' in open systems (and it seems that we cannot do without a terminology of 'because') -- but the lineal, closed-system constructs lying behind the term 'causality' are completely inadequate to deal with the fact that in the feedback relations of open systems, CAUSES CAUSE CAUSES TO CAUSE CAUSES (39, emphasis in original).

In open systems, information and relations (not entities) are the ingredients of causality and, as Wilden insists, "RELATIONS BETWEEN RELATIONS CANNOT BE TALKED ABOUT in the analytic logic of lineal [cause-to-effect] causality and unidimensional sequence" (40, emphasis in original).

Medical diagnostic logic directs attention towards such a lineal, unidimensional sequence of cause and effect based on

Newtonian physical energy analogies: it is, Waitzkin argues, "limited and exclusionary" in that "contextual concerns that do not lend themselves to the technical lexicon of diagnostic possibilities tend to gravitate toward the margins of medical talk" (55). Kassirer and Kopelman's definition of "causal models" helps explain this exclusion: they are, he asserts, "dependent exclusively on fundamental knowledge about physiologic function and dysfunction" and "specific to disease entities and independent of the patient population" (29). This "independence" renders contextual issues largely unnecessary for the diagnosis achieved via causal reasoning.

Segal demonstrates the ideological impact of the causal model Kassirer and Kopelman describe, with the case of

> a patient whose chronic headaches disappeared in the course of his treatment for gastric ulcers. Readers of the case study are urged to agree it is "serendipity" that the restricted diet treatment for the ulcer removed the dietary triggers for the headaches. The article mentions, but fails to note the significance of, the fact that the patient's ulcers had been caused by his ingestion of thousands of aspirin tablets for his headaches. The "patient" is implicitly viewed as the locus of two disease processes rather than as a whole person whose health was undermined by the treatment for one of his symptoms and restored by the treatment for another.

("Writing" 83)

Segal presents this case as an illustration of the influence of representation on reality: this patient's "diagnosis" is determined -- indeed, overdetermined -- by the linear mode of causality employed by his physician. In deflecting attention away from the "whole person" situated within overlapping (and possibly conflicting) contexts and towards a single, identifiable causal chain, the lens of mechanistic causality performs the ideological function of "[perpetuating] an interventionist approach to health care and a fragmented view of patients" (Segal, "Writing" 83).[27]

The learning of such cause-to-effect forms of organization also performs an ideological function. The question of how to organize data in the oral presentation caused students great difficulty in our discourse-based interviews, and their responses suggest not only structural but also social and ideological struggles. When I showed

---

[27] Chaim Perelman, examining "chain" argumentation from a rhetorical perspective, argues that this metaphor allows the subordination of one activity to another, so that the subordinated activity may be presented as "means", "making it possible to treat what gains adherence most readily as an end" (276). Thus, the linearity of the chain metaphor likely distorts the "relations between relations" that may adhere in situations such as the one Segal reports.

students an unorganized passage of patient data and asked, "Would it matter if I moved this information about the patient's depression [which had been placed in Social History] into the History of the Present Illness?" , one student, after long hesitation, responded that "Well, you could, I mean I think I'd want to but you might get in trouble. That's not where it's meant to go."

The student's response that "that's not where it's meant to go" suggests that depression is not close enough to the chief complaint in the chain of cause-to-effect causality to warrant such promotion. At the same time, the claim that "I'd want to" hints at the student's recognition that this information does impact on the patient's condition and should be taken seriously. That he recognizes potential conflict between cause-to-effect and contextual causality and between the diagnostic philosophies that such causal explanations represent, and he assesses alternatives and their meanings in his decision-making, suggests that this student is aware of alternative strategies in this situation. The student's concern with "[getting] in trouble" for the decision to promote the information demonstrates his rhetorical awareness of the influence of audience: as my observations attest, some

practitioners might not mind the promotion, others might react strongly. Beneath his statement runs an implicit ideological undercurrent: to promote psycho-social data such as depression is to risk offending the community's traditional sense of data hierarchy.

How does the student acquire such ideological sensibilities? He receives countless reinforcements of the idea of the relative importance of patient data in medical school curricula which are heavily weighted towards pathophysiology, biology, and anatomy; in the healthcare community's hierarchies of pay and prestige; and in public lore about the relative "status" of disease (consider, for example, the relative medical validation of -- and the shame associated with -- two conditions such as heart disease and depression).

In addition to these cultural reinforcements, the presentation *form* communicates the profession's traditional data hierarchy. As Miller has argued, "when we learn a genre . . . we learn . . . what ends we may have" ("Genre" 38). In the presentation format, psycho-social factors "belong" in the family and social history sections, and despite an increase in the medical community's attention to these factors, the

traditional form helps to maintain the traditionally low status of these data. Here is an instance of what Burke calls the "ways in which we spontaneously, intuitively, even unconsciously persuade ourselves" (qtd. in Coe, "The Rhetoric" 181). As Coe explains,

> the social availability and efficacy of particular forms influence writers and speakers -- in effect persuade them, as they articulate their intuitions and shape their materials -- to make particular selections, create particular emphases, generate particular substance, adopt particular personae. ("The Rhetoric" 181)

The organization strategies implicit in the presentation are rhetorical -- and ideological: as students shape their materials (patient data), promoting, delineating, focusing, this organizing shapes their perception of the data and of the patient from whom they came.

Arluke offers a particularly vivid example of the ideological nature of such "shaping" in his analysis of case presentations during Morbidity and Mortality Rounds. On these regular group rounds, residents present selected cases of patients who have died on the medical service. Such a situation, Arluke hypothesizes, might suggest a review of the way deceased patients have been handled by the profession.

But, as he finds in his analysis, these presentations are carefully shaped to "[focus] on the clinical course of patients, [so that] death becomes a natural end to the review process" (122). Rather than providing a context for analysing error and assessing professional competence, the presentation "becomes an 'academic exercise' in assembling case histories out of disparate pieces of clinical evidence and impressions, invariably impressing those present [with the presenter's] skills in conveying a 'feel' for the case" (122). The ultimate goal is the symbolic resolution of the social contradiction threatened by an instance of 'medical failure': the presentation is conducted to "imply that had anyone else managed the case, the patient's death would still not have been avoidable" (122). Thus, any possible error is brushed aside, and competence is never directly questioned. Arluke finds that the death, the medical failure, recedes into the background: "the clinical complexity of the case" is what receives emphasis (122).

As Arluke's study suggests, presentations are assembled in ways that satisfy medical motives and reinforce the community's mandate. This mandate, the community's dominant view of its self and its interests, is reflected in

dialectical oppositions embedded in the "Organization" clusters presently under analysis. Keenan opposes the notion of "path" (S28) (implicitly linear and 'scientific' as the associated terms reveal) with "wandering" (S29), suggesting a distinction not between *types* of organization (say, linear and recursive) but between organization and its absence.[28] There is, pointedly, only one correct "path" to be followed in these 'stories': "delineation"'s dialectical partner is "disorganiz[ation]" (S1), as evidenced by the alternative offered in the SCEF's lowest ranking for oral presentations. This usage of wandering recalls the Latin etymology of the term "error", which means "the action of roaming or wandering; hence a devious or winding course" (*OED* 277).

In his critique of medical reasoning, Bradley recasts this dialectic in an innovative way, suggesting the limits of

---

[28] The abstraction "organization" used as a measure for a community's discursive practices is not unique to medicine. Other discursive groups such as the disciplinary community of academic English also represent their language practices to themselves (and, perhaps especially, to novice members) with such abstract, absolute distinctions as "organized" and "unorganized." This may be a result of the difficulty expert genre users have rendering tacit discourse knowledge explicit -- they resort to abstractions to represent (however distortedly) their implicit consciousness of how things are "done" discursively in the community. Chapter Five addresses this problem in more detail.

causal theory, which he argues has limited validity for complex, non-linear systems such as human beings, by opposition to chaos theory, which he recommends as "a useful way of exploring the complex interaction between disease and treatment with a view to defining the limits imposed on achieving a predictable response" (46-7). Paired with chaos theory, causality (and by this Bradley seems to means cause-to-effect logic) is revealed as one organizational framework with particular strengths and weaknesses, historically connected to a situated way of perceiving the world based, Bradley argues, on Newtonian principles and the constructed view of the world as "certain and predictable" (xi). Thus contrasted, the ways in which cause-to-effect reasoning serves (and limits, according to Bradley) biomedicine are revealed.[29]

---

[29] Cause-to-effect reasoning may be, as Bradley has argued, the basis of modern medicine, but medicine also employs another common method of logic in diagnosis: probabilistic reasoning. Kassirer and Kopelman explain that, unlike causal models which are "specific to disease entitities and independent of the patient population" (29), "probabilistic models are dependent on the specific population from which the patient is drawn" (29). Probability reasoning follows patterns of disease prevalence in demographic groups. Thus, the presentation opens with the patient's "Identification" in terms of demographic membership (age, race, sex, occupation, etc.) But, while probabilistic reasoning would appear to be related to contextual causality, it does not address "feedback relations"; that is, probabilistic reasoning maintains a focus

Since cause-to-effect models are, as Kassirer and Kopelman define them, dependent on physiologic function and independent of the patient's lived experience (*Learning* 29), the discipline may proceed (to paraphrase Stein) rationally, dispassionately, and objectively. It may maintain its beliefs that disease is best understood pathologically (that is, acontextually, without reference to the relationship between the body's biological system and its social environment) and that an intervention in the mechanistic cause-to-effect chain will 'cure' the patient (Stein xiv).

Another set of dialectical terms within the "Organization" cluster offers further insight into the attitudes and interests that motivate these texts. Haber opposes "the patient's own words" with going "astray" (S9), suggesting that premature translation of the patient's subjective experience may in fact bias the presentation against the reality of that experience. Haber's suggestion seems to stand on its head the common opposition between the patient's 'story' -- flawed by subjectivity and inclusive of

---

on entities as the elements of causality, adding demographic characteristics to those entities but not attempting to appreciate the meaning of relations between relations that demographics opens up.

endless, irrelevant details -- and the physician's 'account' which applies scientific reasoning to transcend that subjectivity and render the mass of information into a logical diagnosis.

In Keenan's depiction, for example, the patient's story arrives unformed and is given structure by the biomedical perspective. Haber's reconstitution of the dialectical pair[30] demonstrates provocatively Burke's point that, while we understand dialectical terms by contrast, particular oppositions themselves are not essential. Contrasted differently, terms are differently emphasized, they embody different presumptions and newly direct our attention (see Coe, "Burke's Words" 13-14; Burke, *Rhetoric* 184)). Just as Bradley's dialectical pairing of causal and chaos theory offers another perspective on the notion of "cause" as an organizing principle and diagnostic model, Haber's opposition redefines the 'standard' understanding (and use) of the patient's story in medicine. Such evolving dialectics suggest the fluctuating nature of disciplines and genres, as new

---

[30] Haber's re-pairing has a history: as early as 1969 Weed (*Medical Records*) had argued for greater reference in presentations and written records to the patient's terms for describing his state.

orientations bubble beneath an apparently smooth surface.

Learning about "Professional Context"

The third cluster of pivotal terms in these instructional documents represents the recurrence of professional context issues and allows further insight into the situatedness of all the terms considered so far. For these instructions guide students to produce texts for particular uses and effects. In references to the recurring situation(s) that evoke this genre, these terms suggest what Coe and Freedman have called "the functional relation" (2) between the form and its context of professionals convening to discuss a patient's case.[31] I have excluded from the index references to patients and their conditions, in order to focus attention on the extra-medical motives structuring case presentation; that is, motives not

---

[31] My entitling of this cluster as "Professional Context" reveals my focus on the genre's function as a method of interprofessional communication. There are, of course, many references to patients in these documents, representing what we might call the "practical" context of the presentation: a patient has been admitted to the hospital and the medical team must treat him. For instance, Keenan refers to "patients" and their "complaints", "pain", and "symptoms" throughout his instructions. An analyst interested in the presentation's re-visioning of patient experience might create 'patient' clusters and agons to chart this transformation.

directly related to patient care. Patients and their conditions are *what* physicians talk about, but it is not this "topic" that dictates *how* physicians conduct these exchanges, or even always *why*. The exigencies that evoke this genre are also professional and institutional: particular data are chosen and arranged according to the attitudes and interests of an audience of physicians. Reflecting my interest in this professional rhetorical context, Table 3.3 records terms in Keenan's and Cooke's texts that invoke inter-professional relations. These clusters were not prominently echoed in either Haber's document or the SCEF sections under analysis for this chapter, so they are not represented in the Table.

Table 3.3: "Professional Context" Clusters in Curriculum Documents

Keenan	Cooke
colleagues (S2)	get advice, transfer responsibility, and supervise (S2)
professional life (S3)	faculty (S9)
	practice of medicine* (S1)
impression (S4)	asset (S3) advantage (S3)
present ourselves (S5)	assess (S5)
internal medicine (S10)	image (S4) 'look' (S5)
audience (S21, 26)	junior/senior physician (S8)
listener (S28, 30, 36)	listener (S14)

* It may be useful in this consideration of the professional medical community to distinguish between two meanings of "practice" at work in medical literature: the noun, *practice*, which may be capitalized to signal the professional institution and the verb *to practice*, which denotes the physician's relationship to the disease. In the nominal sense of the term, new physicians learn "the practice of medicine" or are said to be "brought into Practice" when they join established medical offices; in the verbal sense, medicine "is practiced" on patients by doctors.

Molly Cooke's instructions for "The Oral Presentation" begin by situating the form within the professional community, in relation to "the practice". Her handout begins: "

Important: The oral presentation is an essential skill in the

practice of medicine. We get advice, transfer responsibility and supervise using the form" (S1,2). The primary communicative site of these statements is the social relations between -- and the hierarchy of -- physicians[32]. In fact, these three verb phrases represent the three directions in which communication can flow in any hierarchical system. The request for advice usually involves a communicative flow upwards, from a more novice physician to a physician that the sender of the message perceives to be superior in knowledge, experience, or power. The activity of "transfer" may suggest a lateral motion, with "responsibility" moving between departments or between physicians of similar rank. And, most evident in the situation of the case presentation as a teaching device, the activity of "supervision" involves an evaluative gaze, and the use of the form to send messages from

---

[32] When the integrity of this site is threatened -- for example, when attendings move teaching rounds to the bedside -- students in particular may be dismayed. Wang-Chang et al. report that students prefer not to present at the bedside (qtd. in Elliot and Hickam 506), while 15% of D. L. Elliot and D. H. Hickam's student interviewees "found the bedside an overall negative experience" (506). (Elliot and Hickam do not report on students who may have found the experience negative but to a lesser degree.) When we consider bedside presentations rhetorically, as creating a highly conflicted audience for student presentations, their dismay is understandable.

expert to initiate, or from one expert to another outside her domain of expertise (e.g., from radiologist to resident physician in internal medicine).

This professional domain of the presentation, its function as a method of regulating community membership and structuring hierarchical relationships, frames what I have termed the practical domain of patient care. Cooke's introduction mentions the patient twice[33], both references that situate the patient within a context of professional exchange. Good presentation skills, she tells students, are "an advantage for your patients" (S3). This advantage appears twofold. Within the diagnostic logical process itself, these skills may improve a physician's understanding of the patient's condition. In a wider professional scope, though, the skills may also increase her ability to get advice regarding, transfer responsibility for and supervise the

---

[33] The patient's appearance in Keenan's introduction is meaningfully postponed. There is no mention of the patient (either as subject or as object of the presentation) until the first sentence in paragraph four. Here, the description of the presentation as "as story of the patient's illness" is qualified by the advice that the physician must give "some structure to the story", supporting Kleinman's and Hunter's arguments about the "re-storying" that the presentation enacts on the passive patient.

patient's treatment. These effects are related, yet distinct. The first involves individual logic and data management: as Cooke argues, "you can't present well until you have a position on what the patient's problem is" (S7). The second "advantage for the patient" (S3) involves not thought processes but "the image each practitioner projects when she presents" (S4).

This professional image determines to a large extent the individual physician's ability to successfully wield hospital resources (nurses, laboratory, specialty departments, etc.) on behalf of the patient. As Haber reported, the specialty consultation requested will almost certainly arrive whether the requesting presentation is good or bad, but a good presentation may get the consulting physician to come more readily -- and more happily. Haber's anecdote recalls Irby's contention that the presentation represents a physician's professional "competence" -- her credibility -- and may help to determine the degree of respect she garners from her colleagues ("How Attending" 633).

In its capacity of regulating access to hospital resources and professional power, the case presentation is an

ideological[34] structure of signification which is "separable only analytically either from domination and [sic] from legitimation" (Giddens, *Constitution* 33). Giddens' argument about the mobilization of two distinct types of resource -- allocative and authoritative -- helps to illustrate how the presentation form works ideologically to enable domination and legitimation in "the practice of medicine" (i.e., the diagnosis and treatment of patients) and in "the Practice" (i.e., the professional hierarchy of healthcare institutions). This function of the genre reverberates throughout the clusters represented in Table 3.3 in Keenan's references to "impressions" and self-presentation (S4, 5) and Cooke's emphasis on the "image" and "look" (S4, 5) constructed through the presentation's performance.

The self-presentation enacted by the presentation of a patient enables the mobilization of "[a]llocative resources" which Giddens describes as "capabilities -- or, more accurately, . . . forms of transformative capacity -- generating command over objects, goods, or material phenomena"

---

[34] Giddens' use of "ideology" complements my earlier discussion of the term. For Giddens, ideology refers "to those asymmetries of domination which connect signification to the legitimation of sectional interests" (*Constitution* 33).

(*Constitution* 33). Here, one of the resources being mobilized is the patient. We can resolve the potential difficulty of categorizing patients as allocative resources with Giddens' argument that although, like raw materials and land, they have an undeniable time-space presence, "their 'materiality' does not affect the fact that such phenomena become resources . . . when incorporated within processes of structuration" (33). Like hospital beds, laboratory tests, and pharmaceuticals, patients[35] are the goods of medicine, passed among specialties and relegated to the passive state of material.

The "professional context" clusters also suggest that the case presentation, performed appropriately, enables the mobilization of what Giddens calls "authoritative resources." "Authoritative resources refer to types of transformative capacity generating command over persons or actors"[36]

---

[35] The etymology and presumptions of the term "patient" are relevant here. Descended from the Latin stem of "patiens", the present participle of "pati" (to undergo, to suffer), the "patient" is one who undergoes action (*Random House* 1421). The term designates a passive entity acted on by doctors. Compare, for example, the social work term "client", which presumes other potentially problematic relations by invoking consumerism but does escape the pure passivity of "patient" (see Paré; Segal, "Writing" Endnote 6).

[36] I have not described the treatment of patients as the mobilization of authoritative resources because, in the

(*Constitution* 33). As it contributes to professional image, the presentation can influence the speaker's ability to generate command over other members of the medical community, to "get advice, transfer responsibility, and supervise" (Cooke) on behalf of the patient.

Pivotal terms in Keenan's document also reflect the presentation's function as a means of mobilizing authoritative

---

traditional biomedical paradigm, patients are not "actors". As I have argued, in terms of Giddens' scheme, the traditional patient fits (perhaps unfortunately but not less logically) in the category of "goods, objects, or material phenomena". This may begin to explain the difficulty encountered by physicians in recent attempts to encourage patient compliance in treatment regimens. Treatment programs that encourage the patient to be "an active participant in her healthcare" may be contradictory, asking for patient action that is passive, that simply accepts and follows prescribed procedures. "Compliance" is a particular sort of "acting": the term means "the acting in accordance with, or the yielding to a desire, request, condition, direction" (*OED* 728). In the trend of encouraging patients to be active participants, biomedicine addresses patients as both allocative and authoritative resources; when this paradox is revealed, noncompliance (as action that transcends the double bind of "active passivity") is perhaps not such a surprising result. In fact, Segal's rhetorical analysis of the issue of patient compliance presents the "problem" as "trapped in the paradigm which invented it" ("Patient Compliance" 91). Calling attention to the "distance, reification, and asymmetry" of the physician-patient relationship (92), Segal argues that the physician-patient "rhetorical transaction" carried out in this context lacks the shared sub-stance of language and values that are necessary conditions for rhetoric (96-7). (Non)compliance, in Segal's account, is a highly complex issue, made up of rhetorical, social and structural factors (96).

resources. He states that the oral presentation "is an essential way to present information to and ask questions of your colleagues regarding a certain case" (S2), echoing Cooke's claim that the presentation helps the physician "get advice." Describing the presentation as "crucial" and "essential", he warns students that from their presentations colleagues will form "an impression of [their] clinical skills" (S4): "if you present well, people think you are a good clinician and if you present poorly, they may think you are a bad clinician (though often they are wrong)" (S4). Keenan's notion of the audience's perceptions of the presenter parallel Cooke's sense of the professional "image" projected through the presentation.

In his study of attending physicians, Irby explains that the case presentation carries such professional currency because it demonstrates the speaker's clinical reasoning, and "imbedded in the clinical reasoning process is the question of the physician's personal competence to diagnose and manage a particular case" ("How Attending" 633). Inadvertently, Irby hits on the essence of genre theory which is that discursive structures serve social purposes; they inscribe and enact community motives. Thus it is not surprising that, in

clerkship evaluation forms, clinical reasoning and communication skills are often conflated, supporting Keenan's claim that a poor presentation suggests poor clinical ability. For example, in its "Record Keeping" section, the SCEF characterizes a superior written record as not only being "conscientious and accurate in recording findings" but also including an "excellent formulation of patient's difficulties including differential diagnosis and treatment plan." The latter "formulation" depends on clinical reasoning skills, which make possible certain appropriate medical actions in the treatment plan.

Medical educators Hull et al., in their study of the student-evaluation system in the required medicine clerkship at the Case Western Reserve University School of Medicine, found that "there is a tendency for students who have good communication skills to be assessed as having better clinical problem-solving ability and knowledge skills" (520). The conflation is potentially problematic for two reasons. On the one hand, students with weak clinical reasoning skills may be undetected if they are good "communicators" and those skills may, consequently, not be improved. On the other hand, students with strong reasoning skills may be targeted as weak

clinical problem-solvers when in fact it is their rhetorical problem-solving that needs improvement. Hull et al. call for "additional measures of clinical performance that can differentiate these skills" (521).

The implication that one can present poorly but think clearly appears to separate knowledge from discourse, but clearly the two are conjoined. Our discourse is not superficial: it constitutes our knowledge, of our world and our selves. But discourse as image is critical in this (and other) professional contexts. In the clerkship students will have to adequately reproduce the structure of the oral presentation in order to generate command over the authoritative resources represented by the advice, aid, and support of other members of the medical community.

Beneath A Smooth Surface: Genre and the Heterogenous Community

What has this Burkean rhetorical analysis revealed as the "structural motivation" of these curriculum documents? The creation of consubstantiality with the discipline's shared attitudes and interests arises as a primary intention, emphasized by the "context" clusters' representation of the

genre's professional value: what Bourdieu would call its "symbolic power." In his discussion of the production and reproduction of legitimate language, Bourdieu invokes Durkheim's theory of consensus wherein the teaching of the same fixed language to children inclines them "quite naturally to see and feel things in the same way" (49). As students learn to be "organized, thorough, knowledgeable" (Cooke) via the fixed discourse of the case presentation, they are adapting their minds to the biomedical logic of differential diagnosis, learning to see and feel like doctors. And as Giddens' explains, "structure is both the medium and the outcome of the reproduction of practices" (*Central Problems* 5). Use of the presentation's legitimate language and its accepted logic helps to ensure students' professional success, and the "common consciousness" (Bourdieu 52) advertised by the genre sustains the biomedical paradigm through the duality of structure.[37]

---

[37] This paradigm has been described by Segal as a triadic set of values, "atomism, interventionism, and paternalism" ("Writing" 87-8), which underlie, respectively, medicine's fragmentation of the patient (Young, Anderson cited in Segal 87), its primary mode of response to the patient's state (Stewart and Roter, cited in Segal 88), and its traditional model of physician/patient relations (Stewart and Roter, cited in Segal 87). Similarly, Howard Berliner's neo-

Approaching medical narrative as a binding force in medical culture, Hunter presents a related view of the role of language. She asserts that the case presentation serves the purpose of ensuring "fundamental uniformity" (52) in physicians' narratives, "[proclaiming] the observer's careful attention and reliability: other observers with the same training, they assert, would observe and report just the same thing" (162). The presentation genre not only reports patient data: it also reflects biomedical epistemology, the belief that medical "data" are "out there", objectively observable and reportable as fact.

Marxist discussion of "medical modes of production" describes "scientific medicine" with reference to its traits of "invasive manipulations", a "largely passive" patient role, and the assumption that illness is "generated by specific elements such as bacteria" and "can be empirically observed" (162). While such generalizations are useful for illustrating widely shared interests and attitudes in biomedicine, they are best understood within the framework of the discipline's inherent diversity. As Stein reminds us, while these generalizable characteristics reflect "medicine's official, or formal worldview", it nevertheless "interacts in actual clinical supervision and decisionmaking with countless unofficial, or informal worldviews that are intrinsic and extrinsic to medicine" (16). Stein argues that the medical model coexists with other models such as "the 'explanatory models' approach advanced by Arthur Kleinman (1980); the 'disease/illness' distinction formulated by Leon Eisenberg (1977) . . .; [and] the 'biopsychosocial model' propounded by George Engel" (16).

This Burkean cluster and agon analysis of curriculum documents seems to confirm medical discourse's re-creation of "common consciousness" and "fundamental uniformity." Certainly the four texts emphasize similar themes, however incompletely stated, such as 'relevance' and 'linearity', which are intimately connected to the shared attitudes and interests of clinical practitioners. These guidelines create consubstantiality in novices because, as Giddens points out, "rules relate on the one hand to the constitution of *meaning*, and on the other hand to the *sanctioning* of modes of social conduct" (*Constitution* 18). As students draw on the "rules" suggested by pivotal terms in UCSF documents, they are engaging and enacting the duality of structure, reproducing the biomedical paradigm as they shape patient presentations according to its generic structures.

As recent reconsiderations of the concept of "discourse community" suggest, however, the nature of 'community' is only partly realized by attention to 'unity'. Paré challenges the homogenous notion of "discourse community", presenting an argument for recognizing the actual heterogeneity and "tensions between individual vision and community expectations" (113). Miller, too, rejects "vague, comforting,

sentimental" notions of community ("Rhetorical Community" 72). She envisions, instead, community as rhetorical, "fundamentally heterogeneous and contentious", a site of "agreement and dissent" and "shared understandings and novelty" (74). The tension of dissent, of conflicting worldviews that members carry in from other communities in which they dwell, suggests the need to consider carefully the ways that discourse communities shift according to their membership at a given time, just as genres evolve according to their users' needs and the uses they put them to.

Stability and constraint are only one side of genre's potential. As Schryer argues, genres are only "stabilized-for-now" ("Records" 200): they shape their users, but their very use also (re)shapes the genre (Schryer, "Sites" 107-8). So, while genres are by definition repeated and recognizable strategies, they "come from somewhere and are transforming into something else" ("Sites" 108). The ends genres are used for and the situations of this use affect generic form and content. As a community's membership and its mandate shifts over time and space, how recurring situations are "construed" (Miller, "Genre" 29) also shifts, and genres may show evidence of strain and instability as individual (and sufficiently

influential) users adapt them to evolving ends.

Following the November 1996 observations, my analysis of pivotal terms in UCSF curricular documents began to suggest such an instance of generic instability. As I examined the "Organization" cluster, the notion of order arose repeatedly. Connected to issues of delineation, chronology and causality, this concept dominates both Keenan's and Haber's accounts of the history presentation -- but to strikingly different ends.

Order of Elements: The HPI/PMH Question

The order of elements in the oral presentation generally follows a linear pattern established by chronology. According to Cooke, the content of the presentation "emphasizes how the patient is **now** (CC, HPI, PE, lab and assessment) and discounts 'old' information (OMP, PMH, FH and SH)" (P2, S4: emphasis in original). Information from the past is not considered essential to understanding the patient's symptoms now: it is "discounted" in the hospital context of acute care. Recent information (usually recounted in the "History of the Present Illness") is presented according to the real order of events

in time.[38]

Generally, as I have asserted earlier, teaching physicians at the University of California at San Francisco seem to agree on a standard order of presentation elements (see Table 2.1). The presentation categories are hierarchical in terms of both temporality and relevance, two intimately related issues in the linear logic of diagnosis. "Old" information gets relegated to the lower categories of the presentation, or is deleted altogether. According to Cooke, "the ROS (Review of Systems) is typically omitted entirely; information from ROS which is too important to leave out is 'promoted' to another section of the presentation" (P2, S5). This concept of "promotion"[39] is an important one for the rhetorical activities of selecting and ordering patient data; much of the supervisory feedback that students receive on their oral presentation regards the promotion and demotion of

---

[38] Hunter makes the point that the medical narrative, while it may purport to present an accurate chronology, actually begins "*in medias res*", at the point of the patient's entry into the medical world rather than at the point of the onset of symptoms (54).

[39] It is also an intriguing -- and revealing -- metaphor. For to promote something (or someone) implies a movement out of and above their natural state. Thus, even in promoting material to a place of higher prominence, the physician confirms that it usually belongs somewhere else.

various presentation elements. However, rarely are these rhetorical activities placed in any context for student presenters: for instance, Cooke does not explain why the ROS can be omitted entirely from the case in oral delivery.

These activities of promotion and demotion relate directly to the linear logic of the differential, and supervisory advice about order reveals one of the potential weaknesses of this logic. In my observation of supervisory feedback from attending and resident physicians and in my analysis of curriculum documents, the most contentious category in the presentation is the HPI: the History of the Presenting Illness. It would seem that the decision about what patient data to promote to the HPI and what to demote to the category of Past Medical History (PMH) is a highly complicated one -- and one about which few physicians entirely agree. Apparently, the "line" of direct cause and effect in biomedicine's linear logic threatens to wander, and decisions about relevance are an attempt to fit an open biological system into a closed form. As evidence of the difficulty establishing a temporal line of relevance and causality, Table 3.4 presents Keenan's and Haber's guidelines for selecting and arranging the patient's 'history' information.

Table 3.4: Comparison of Organization Systems

Keenan (Document)	Haber (Document)
CC: "tell the patents' major past medical problems up front especially if they are relevant to the illness or complaint for which they are seeking help"	CC: "in patient's own words" "a premature diagnosis in the CC instead of a symptom or sign can lead you astray"
HPI: "...is done best by giving a chronological description of the events/symptoms/etc that lead up to the patient seeking medical assistance at this time" "be sure to cover...all of the qualities of a symptom" "it is important to include associated symptoms as well" include "important review of symptoms items" but "you do not have to included [sic] these if they bear no importance to the case" "pertinent negative history of illness should be included in the HPI" "If the patient has separate complaints, you can present them in distinct blocks"	HPI: "the HPI must contain all the information, including symptomatology and known past laboratory date and treatment, relevant not only to the CC but to caring for the patient while hospicalized [sic]" "when a person is through reading your HPI, he/she should have no further questions regarding the patient's acute problem(s), or chronic problem(s) that would affect hospital management" "relevant positives and negatives from ROS, FH, PMH and SH ...should be included in the HPI" "significant medical problems...even if not directly relevant to the CC...should be listed in the HPI" "summary of past hospitalizations...should be included in the HPI if relevant" "any medications and allergies to medications should appear in the HPI even if not directly related to the CC"
PMH: "Remember that medical history items that are crucial to the HPI can be discussed in the HPI...it depends on your personal preference"	PMH: "see HPI"
SH:"discuss occupation, living situation, social supports. How much to include depends upon how important it is to that patient's presentation and care plan"	SH: "see HPI"
FH: "mention specifics only if it is pertinent to the patient's illness...otherwise I say 'non-contributory"	FH: "see HPI"
ROS:"If a patient has a diffusely positive ROS...I will include much of it [in ROS] to avoid confusing HPI"	ROS: "see HPI"
PE:"always discuss the vital signs" "make a comment about the patient's general appearance" "at a minimum, one should discuss the chest, heart, and abdominal exam"	PE: "see HPI"

The central difference between these two approaches is Haber's promotion of material to the HPI: in his instructions,

anything that is relevant to the HPI, from family and social history to medications and past medical events, belongs in this category. Furthermore, even items "not directly related" or "not directly relevant" to the chief complaint deserve promotion if they could affect the hospital management of the patient. In regards to the written presentation, Haber asserts that "when a person is through reading your HPI, he/she should have no further questions regarding the patient's acute problem(s), or chronic problem(s) that would affect hospital management" ("Compleat" 7). He relates this written structure to the oral presentation, advising that "the CC and the HPI then become the focus point for a concise oral presentation of the case, again leaving no reasonable question unanswered at its end" ("Compleat" 7).

Haber desires to leave no reasonable question unanswered because often oral presentations follow a "positives only approach" popular for its economy (Fieldnotes). He advises students that "if you're going to do just the positives . . . use phrases like 'the physical exam is unremarkable except for'" (Fieldnotes). Furthermore, he instructs them that "if you're going to do this sort of presentation, you can't leave things out--'cause then people will stop trusting you", and he

says that "if you've done the presentation right ... your response to questions will be 'no, I would have told you that' or "no, there's not [epigastric pain]'" (Fieldnotes). In contrast, Keenan assures students that listeners "can ask for more specific information about details--this is okay" and "its [sic] okay for people to ask questions at the end." While Haber might agree that listeners' questions are common, his notion of "trust" suggests that some material must necessarily be included in the presentation and readers' need for it anticipated by the speaker.

This difference in the structure of the presentation is often depicted as a matter of personal style. Keenan refers often to what we might call stylistic divergences in the structure of the case, calling attention to "my personal bias" and "a personal preference", and discussing what "some people will want" and "what some would discuss" in contrast to what "I am a proponent of." His use of the first-person pronoun to mark his individual preferences ("I like to tell", "I usually just", "I then list", "I will often tell") further highlights the issue of individual style. But he suggests the influence of context of situation with the introductory warning, "Remember that this method is that of an internal medicine doc

(me), and specifics may need to be changed for other specialties (especially pediatrics and obstetrics)." Apparently his "personal preference" is not simply personal; it is also a rhetorical preference, addressing exigencies of a particular rhetorical context--internal medicine. What is it about the contexts of pediatrics and OB that require shifts in the form, and what shifts are these, exactly? Keenan offers no guidance in this, and his suggestion of personal idiosyncracy may mislead students about the reciprocity of context and form, deflecting their attention from the fact that professional exigency -- not personal preference -- shapes these differences.

As the discussion of Keenan's messages suggests, "personal preference" is an insufficient explanation for physicians' different approaches to presenting cases. In fact, such differences suggest that medicine's causal diagnostic logic -- and its accompanying fragmentation and delineation of the patient's story -- is a site of ideological struggle in this community.

What is at stake in the differences between Keenan's and Haber's organizational strategies is the essence of summative logic, the premise that 1+1=2. The History of the Present

Illness is the locus of the differential diagnosis: it is the site where linear causality begins to be determined. As medical lore has it (communicated often to students in my observations), "if you've taken a good history, it'll give you your diagnosis." Haber's presentation system promotes to the HPI patient data from sections usually representing more distant chronological spheres. This en masse promotion implies a resistance to the linear logic of cause and effect for it widens the diagnostic focus on physical cause to include contextual meaning, to the interpretation of a symptom as information within and about a context.

In Haber's presentation, the inclusion of multiple aspects of patient data creates a cluster of contextual conditions surrounding the present illness, conditions which range from the biological and pharmaceutical to the social and psychological. What this does, though Haber would not likely articulate his system's symbolic action in these terms, is expand the traditional definition of "relevance" in the diagnostic process. The expansion challenges the ideology of fragmentation, of treating conditions rather than persons and moves towards treating the patient (to use Wilden's terms) as an open rather than a closed system, a system "in an essential

relation of feedback to an environment" (35). In this regard it is an application, Haber explains, of the "biopsychosocial" model of medicine, which, Engel argues, "includes the patient as well as the illness" and tries to determine not only what ails the patient but also the patient's perception of his state (Engel 133).

When giving his third-year students feedback, Haber clarifies their confusion about what to put in the HPI by explaining: "The CC is what's wrong now . . . the HPI is how what's wrong now is related to the past" (Fieldnotes). This approach explicitly overlaps present and past. Even "Past Medical History" is brought forward in this style of presentation, promoted to a factor in the history of the *Present* illness in a move that challenges traditional biomedicine's largely chronological conception of past and present. By their inclusion in the HPI section, Meds, PMH, FH, and SH graduate from their status as "old" information that ought to be "discarded" (Cooke) and gain new respectability in terms of their diagnostic relevance.

In fact, Haber argues that "old" and "new" are inappropriate terms for categorizing patient data. He prefers the opposition "active/inactive" to characterize the relevance

of data. "Old" data that are still "active" (as is the case in chronic conditions) deserve attention. This shift in terminology directs attention away from chronology (a feature of cause-to-effect causality) and towards an understanding of the contextual causality of illness. Rather than diagnostic chains or "trails" (Bradley 61), Haber's method of organization suggests diagnostic clusters, nodes of overlapping bio-psycho-social activity.

Whether or not Haber's position is representative of a trend in clinical medicine (or even in clinical medicine at this particular institution) is an important question and one that requires further investigation.[40] Students and other attending physicians interviewed often commented on the

---

[40] In a research study of this "consultancy" sort, it may appear suspicious that I have found in my collaborator/informant's style evidence of a generic evolution that appears to respond in some ways to current calls for medical reform. That others, too, acknowledge Haber's distinctive presentation style assures me that I am not simply projecting because of our working relationship. Certainly, though, I alone am responsible for my interpretation of features such as the renovation of the HPI as a socio-rhetorical advance in the form. It is, in fact, unlikely that Haber would articulate his "preferences" in the terms I have used. Later in the analysis I will consider possible explanations for Haber's innovation, ranging from his senior status in his institution to the local "culture" of the hospital wards he supervises.

particular expectations that Haber required for oral presentations, suggesting that this was his "style" or "preference." And Keenan's document makes a related reference to presentation "style" in his discussion of the Impression/Plan section that closes the presentation. He explains that how the plan is arranged "depends on what kind of person you are -- a "lumper" of data into a few problems or a "splitter" of data into multiple small problems." By Keenan's criteria, Haber would be a "lumper" but, as I have argued previously, the "personal style" argument has little value for understanding the rhetorical and ideological motivations that assuredly underly such differences.[41]

Medical Culture and the Formation of Motives

These motivations are related to what medicine conceives of as its goals and how it defines its professional mandate. According to Hunter, Western biomedicine has traditionally developed towards the achievement of two goals: the

---

[41] Interestingly, I witnessed few residents or interns attempting to manipulate the generic features of the presentation. It may be that, lower in the hospital hierarchy and employed in temporary positions, residents and interns are less likely to challenge generic traditions.

identification and relief of disease syndromes and the explanation of the phenomena of illness (3). Goals, in turn, shape biomedical values. In medical school, for instance, "from the first tutorial, diagnosis is the assumed goal" (Good and Good 90). The entitlement of the patient's condition as a biomedical diagnosis demonstrates the crux of Burke's conception of language as symbolic action (Burke, *Language* 300). The act of diagnosis is the objective act of naming the disease. And this is a social action with consequences for both the attitudes of the diagnoser and her relational and contextual communion with the patient. The logic of diagnosis is linear, as Feinstein's chronological explanation shows; it is concerned with the ailment rather than the sufferer.

The diagnostic goal shapes the value-system of the discipline. Medical students absorb biomedicine's values as the patient shifts in their perception from a person experiencing illness (and its accompanying subjective meanings) to "the site of a problem to be identified and solved" (Good and Good 90). Byron Good and Mary Jo DelVecchio Good assert that this shift illustrates a central paradox in Western biomedicine: "students experience a culturally distinctive configuration of contradications as they attempt

to maintain qualities of 'caring' while encountering the world of medical science" (91).

Articulating this paradox through two central symbols -- "competence" and "caring" -- the researchers argue that the consistent salience of this theme illustrates a cultural tension woven throughout biomedicine:

> "Competence" is associated with the language of the basic sciences, with "value-free" facts and knowledge, skills, techniques, and "doing" or action (cf. M. Good 1985). "Caring" . . . is expressed in the language of values, of relationships, attitudes, compassion, and empathy, the nontechnical or . . . "personal" aspects of medicine.
>
> (91)

In their consideration of this tension, medical sociologists argue that competence weighs more heavily in the Western medical paradigm, often to the detriment of the caring factor. In Good and Good's description, caring is importantly defined as not-action. Stewart and Roter assert that "the traditional method is strictly objective: it diagnoses diseases. It does not aim, in any systematic way, to understand the meaning of the illness for the patient or to place it in the context of his life story or culture" (cited in Segal, "Writing" 88). As Laurence Kirmayer argues in his analysis of the values

inherent in "biomedicine's rhetoric of scientific rationality" (57), the traditional method is structured within a Cartesian framework, where "body" and "soul" are dichotomized and medicine takes as its province the body (59). The Cartesian opposition allows the exclusion of the subjectivity of the patient--his emotions, his relationships, his understandings of his condition.

This opposition may be a medical defense mechanism intended to distance the practitioner from human sorrow and the psycho-social consequences of illness (see Kirmayer 63). Additionally, it is a consequence of the problem-solving model of medical treatment which depicts disease as the enemy (Hunter 136), shifting attention from the patient as sufferer to the patient as site of disease.

Good and Good argue that this objectification of the patient and the ensuing focus on bodily parts and processes -- which Segal refers to as medicine's "atomism" ("Writing" 87) -- can be traced in medical education to the socializing experience of morbid anatomy class. The atomistic quality of the dissection experience depersonalizes the cadaver, first symbolic patient of the medical student, into a "machine." Students' developing image of the machine-like qualities of

the body includes

> perceptions of its having compartments and parts, of these being defined functionally, of human similarities and differences being essentially bodily, and of the sheer physicality of the human person.
>
> (Good and Good 96)

As a primary feature of medical education, morbid anatomy may be a factor in biomedicine's atomism, its tendency to fragment and focus on part rather than whole. This tendency lends itself neatly to binary perspectives: as the patient splits into body and soul, objective analysis of signs detaches from subjective accounts of symptoms and cure for disease parts company with care for illness. Furthermore, the oppositions perpetuate themselves in the definitions of professional healthcare roles -- doctors cure, nurses care -- and even within community ranks: internists care, surgeons cut (Haber, personal communication January, 1998).

Good and Good report that gross anatomy cultivates in medical students the ability to "'think anatomically' in a way that is central to the medical gaze" (96). Michel Foucault attributes the evolution of this modern medical gaze in part to scientific advances in microscopic technology at the turn of the 18th century. The new ability of the doctor to

describe "what for centuries had remained below the threshold of the visible and the expressible" forged a new alliance "between words and things, enabling one *to see* and *to say*" (*Birth of the Clinic* xii). This contributes to the medical development of the "sovereign power of the empirical gaze that turns . . . darkness into light" (xiii). In the shift from the 18th century physician's inquiry, "What is the matter with you?", to the 19th century medical question, "Where does it hurt?", Foucault recognizes the redistribution of "the whole relationship of signifier to signified, at every level of medical experience" (xix).

The understanding of language as symbolic action may help us to understand that the shift in expression described by Foucault is not a change in language alone but a radical shift in the motive and purpose of the medical inquiry. Foucault explores such epistemological shifts in his analysis of the "episteme" which he defines as

> something like a world-view, a slice of history common to all branches of knowledge, which imposes on each one the same norms and postulates, a general stage of reason, a certain structure of thought that the men [sic] of a particular period cannot escape. (*The Archaeology* 191)

The archaeological project that Foucault undertakes attempts to "show how the establishment of a science, and perhaps its transition to formalization, have come about in a discursive formation" (*The Archaeology* 190). As such a project, his study of medicine tries to unearth "the processes of epistemologization" that have formalized it by analysing, in part, the discursive structures through which it reflects and enacts its mandate. In this regard, Foucault's analysis of the episteme is not unlike this rhetorical analysis of language as symbolic action.

The rhetorical action of the question, "What is the matter with you?" is to take the patient as an organic being, a subject whose balance is somehow upset and who experiences this condition in relation to their daily "matters": work, relationships, emotions. In addition, this question can be seen to solicit the patient's *self*-diagnosis, asking him to name "what" is the matter. In contrast, the symbolic action of "Where does it hurt?" is atomistic and objectifying, a taking of the part for the whole. It seeks the sign (which will be read by the physician), not the patient's reading of the sign; thus, it requires the patient to point to the offending site on his body but not to interpret or suggest

what "matter" might be signalled by the symptom. The implications of treating this shift in language as a shift in symbolic action are weighty indeed. If we follow Burke and define language more by its purpose than by its content, we are directed to study the relational and contextual aspects of this shift in medical discourse, and to understand it as "the entitling of complex nonverbal situations" (*Language* 361). Entitling sums up a situation, suggests motive and purpose and directs attention to certain aspects while deflecting it from others.

The linguistic shift that Foucault notes directs medical attention to the site of disease processes, and this has serious consequences for how medicine defines its activity. Good and Good suggest the consequence of this orientation in medical education experiences such as the gross anatomy lab, which "teach implicitly that the appropriate response to the medicalized body is an active one: "Let's figure out how it works and let's fix it'" (97). As Segal argues, such attitudes embody medicine's "interventionism" ("Writing" 87), which Good and Good attribute to the discipline's "reconstruction of the person as an object of the medical gaze, an object identified as a case, a cadaver, or a patient"

(97) rather than as a complex social organism embedded in a lifestyle and governed by a personal disposition.

The biomedical orientations that Foucault situates historically and Good and Good trace in medical education are, as Deborah Gordon argues, the consequence of "social choices rather than natural inevitability" (20). Stanley Reiser offers further evidence of the social nature of biomedical evolutions in his study of medical technology. For example, he reports that the development of the binaural stethoscope in the mid-nineteenth century and its widespread adoption by physicians in the 1890's increased the accuracy of auscultation, the diagnosis of chest disease by studying the character of sounds in the damaged tissue. As a result, a model of disease produced from this study of sounds "largely replaced the model constructed from the patients' subjective impressions and the physicians' own visual observations of the patient" (43). Furthermore, the physician's abandonment of such subjective signs of illness was increased because "the auscultatory process required the physician to isolate himself in a world of sounds, inaudible to the patient" (43). This tendency to withdraw from the patient could be intensified with the development and social acceptance of other

technologies such as the X-ray, since the physician who possessed an X-ray film could study the patient without requiring his physical presence (68).

As Reiser reports, society's embracing of technology has influenced the physician's conceptions of both disease and the role of medicine in response to disease. Technology engenders the rise of the specialist and the hospital as central forces in medical care, and thus shapes the decline of the general practitioner and an increase in medical atomism. The influence of technology throughout the twentieth century is not restricted to the practices of doctors; it has also shaped patients' conceptions of disease and medical treatment. Edward Tenner recognizes that "the new instruments revolutionized the ways doctors saw, heard, and thought -- and in turn changed the attitude of patients toward their physicians as well as their own bodies" (32). Technology -- and the social choice to adopt and even glorify it -- is what distinguishes patient expectations from 150 years ago when they vaguely hoped that medicine would restore the balance of their humors: "now they want not only a precise diagnosis of their condition but an equally precise remedy for it" (34).

Motivation and the Meanings of Generic Instability

These selected sociological and anthropological accounts of medical culture offer a sense of the social choices and ideological motivations that have shaped biomedicine's development. The medical gaze 'dissects' the patient body (pun intended), selecting parts for the whole and defining problems in ways that suit the discipline's traditionally interventionist end of a "cure." As Waitzkin argues, medicine's acontextual approach (nurtured by its preference for causal reasoning) "tends to exclude basic social change as a meaningful alternative" to such physiological interventions (61). Medical technology, in Reiser's account, intensifies this tendency to understand disease selectively, physiologically.

Seen within this framework, Haber's changes to the traditional order and organization of presentation material suggest an attitudinal as well as a structural innovation. His innovation, further, reflects Gordon's point about the role of "social choice" in the evolution of biomedicine and her claim that the "reductionism by which modern medicine is frequently characterized is more theoretical than actual" (19). Generic diversity, implied by the differences between

Keenan's and Haber's presentation strategies, supports the notion that biomedicine may demonstrate broad trends, but within these trends exist currents of difference, dissent and innovation. These currents reflect the heterogeneity Paré, Miller and others have defined as an essential part of discourse community. In the presentation, strategies of promotion and demotion, of lumping and splitting can vary *as long as* the genre retains its functionality for the context, suggesting that a level of controlled diversity exists within biomedicine's traditionally linear model.

The context requiring functionality in the clerkship oral presentation is acute-care medicine. Hospitals deal largely with acute conditions, and longer-term, primary care is left to the family physician. Because it does not threaten the hospital goal of diagnosis and stabilization of acute conditions, Haber's innovation has survival value. For while his diagnostic clusters suggest wider spheres of influence, his focus remains on the patient's "care while in the hospital" (S15, 26) and issues related to "hospital management" (S19, 28). His diagnostic gaze begins with a wider angle of vision, redefining the range of what is relevant to these goals, but narrows appropriately to focus on

the acute condition and its hospital management.

The contrast of Haber's and Keenan's guidelines, particularly their different systems for the position and promotion of material relating to the *History of the Present Illness*, demonstrates that this genre is not static. While it functions to create consubstantiality and common consciousness in novices, it does not perform a simple replication of the biomedical structure -- it also provides a site for resistance and change. This tension between constraint and creativity is the dynamism of genre; it is why Mikhail Bakhtin characterizes genres as sites of tension between unifying, "centripetal" forces and stratifying, "centrifugal" forces (*Dialogic Imagination*).

Giddens offers a further theorization of the communicative act suspended between centripetal and centrifugal social forces through his concept of "the duality of structure" (*Constitution* 16). Giddens attempts to transcend the dualisms of individual/society, or subject/object, by offering an argument that social life is essentially recursive:

> Structure is both the medium and the

> outcome of the reproduction of practices. Structure enters simultaneously into the constitution of the agent and social practices, and 'exists' in the generating moments of this constitution. (*Central Problems* 5)

Giddens helps us capture the dynamic nature of genre, for his structuration theory does not intend simple replication but allows for agency, for change and evolution within structure.

Bazerman has documented such generic evolution in his study of the history of the experimental report. Establishing a parallel between the developments in a genre and the evolution of a scientific community, Bazerman finds that "the emerging form of experimental report offered a way to . . . satisfy the objections and desires of the growing scientific community" (*Shaping* 79). And he characterizes this emergence as continual and context-based, responsive to the community's formulation of evolving objections and desires (79).

Haber's case presentation instructions suggest a similar instance of generic emergence in response to evolutions in the medical community. As patients and physicians formulate objections and desires in relation

to the biomedical status quo, the social and logical tensions subsumed in pivotal terms such as "relevance" and "limit" demand reconciliation. As Carol Berkenkotter and Thomas Huckin argue, genres are more than simply encapsulations of appropriate responses to recurring situations:

> As the world changes, both in material conditions and in actors' collective and individual perceptions of it, the types produced by typification must themselves undergo constant incremental change. . . . Genres, therefore, are always sites of contention between stability and change. They are inherently dynamic, constantly (if gradually) changing over time in response to the sociocognitive needs of individual users. (6)

If the case presentation is evolving, new genre theory would then have us ask: in response to what exigencies and whose sociocognitive needs? In order to answer these questions, a critical understanding of the rhetorical concept of exigency is necessary. Alan Brinton, building on Lloyd Bitzer's definition of "The Rhetorical Situation" defines situation as consisting of three elements: an exigency, an audience, and

constraints. In his discussion of exigence, he employs Bitzer's definition of exigence as consisting of a factual and an interest component (244). The factual component, according to Bitzer, is the "objective" aspects of the situation about which any rhetors would agree. The interest component of the exigence is the relation of these objective facts to some interest. So, as Brinton concludes, "the factual component *is* the exigence (or defect), although it may be exigent (or defective) only relative to an interest. . . . So exigence is a constituent of the situation, but it is exigent only relative to an external term" (246).

Seeking to redress the essentialism that Brinton's "factual/interest" distinction risks, Miller has approached the issue of situational exigence from the point of view that "because human action is based on and guided by meaning, not by material causes, at the centre of action is a process of interpretation" (29). In our interpretation of our material surroundings, Miller argues, we determine situations by the invocation of "types": thus, what recurs, according to Miller, is not an actual situation but our construal of a type of

situation ("Genre" 29).

This distinction may help explain the variations among physicians' presentation responses to the situation of diagnosing and treating a patient. One might argue that doctors agree on the following events: a patient has come under medical care; the patient is experiencing particular symptoms; the practitioner's duty is to explain and respond to the patient's distress; the practitioner must communicate to her peers as part of the construction of this explanation and response. However, the variety of responses may be explained by the act of typification, which we might see as a matter of perspective or orientation (which Burke reminds us is a matter of attitude and incipient action).

In the HPI section of the presentation, practitioners may typify the events by focusing on clinical pathophysiology — the bodily sources of disease. Surgeons are considered the extreme example of this traditional orientation, not only by the public but also by other medical communities such as internists. At another extreme, practitioners of alternative medicines, such as herbalists, might respond by seeking psycho-

social causes such as work-related stress and typify the events in those terms. As Brinton insists (and this part of his argument I think remains useful), both responses are rhetorical, and their uniqueness can be explained by the understanding that "the seeming is part of the exigence" (245); that is, what the "defect" *seems to be* to the rhetor shapes "what the defect is." This rhetorical perspective parallels neatly Stein's claim that, in medicine, "[h]ow a problem is treated is an extension of how that problem is understood" (10); furthermore, this perspective reveals that the "understanding" of the problem depends as much on the physician's orientation as on the problem itself.

The comparison of Keenan's and Haber's approaches to the presentation indicates that, even within medical communities (here, Internal Medicine), the way that a situation is understood may be quite different. My interviews with student clerks, resident physicians, and attending physicians illustrate a wide range of approaches to the selection of HPI data. When I asked them to evaluate a student's data selections for the HPI and the PMH (Appendix C), residents and attendings

offered the following assertions:

> **Attending**: HPI should be only the immediate causes for their visit today -- what brings them here *now*.
>
> **Resident**: The student has mixed a lot of the different portions of the History into the HPI and also in the PMH ... there's no clear breakdown where one is HPI and one is PMH and it goes back and forth into PMH.
>
> **Resident**: I don't necessarily want to hear the history as the illness because I'm basically trying to keep everything quick and snappy and this is sort of diverging...this isn't really his present illness, this is kind of how he's puttering along and really what I want to think of is present illness. I want to figure out what are the events that brought him into the hospital right now. I'll pick up how he does normally in the PMH.
>
> **Resident**: Eight year smoking history quit one year ago is not...some people would put that in HPI, you know they think that's legitimate...I actually put that in the past.

These excerpts suggest the range of appropriate distribution of data between the HPI and the PMH, and a range of typifications of the presentation situation. Some physicians might name the exigence, "Articulate what brought the patient in today", while others might express it as "Articulate all of the patient's active problems, including what brought him in today." As Keenan's and

Haber's guidelines demonstrate, this difference can have an enormous impact on the shape of the presentation.

The difference between students and physicians is even more significant, as students are confronted with two competing typified situations: the communication of data and the passing of a 'test'. As a result, students may be likely to name the exigence, "Show what you know", in contrast to physicians who typify the situation according to the medical team's need for information and thus name the presentation's purpose as "Communicate" (Interviews). As Miller asserts, "to comprehend an exigence is to have a motive" ("Genre" 30). In their defining of the "material circumstance" of the presentation as different "situation types" (Miller, "Genre" 31), students and supervising physicians adopt different motives, which may partly explain students' struggles to present in ways that satisfy their supervising physicians. The two groups do not necessarily share "a need to mean" (Freedman 201).

If rules governing order are also, as Giddens' claimed about rules generally, rules "sanctioning social conduct" (*Constitution* 18), then Keenan's and Haber's

diverse rules signal more than structural tensions: they signal competing attitudes towards the social conduct of physicians. These attitudes might be "titled", respectively, "Treat the presenting illness" and "Treat the patient." And once attitudes are understood rhetorically, it becomes clear that the issue is not what physicians say in presentations, or how they say it: the issue at stake is what physicians *do*, as the presentation's principles of organization shape clinical thought and clinical action.

In his introduction, Stein draws attention to the relationship between clinical thought and action. He explains that "[d]ifferent treatment procedures derive from different kinds of assumptions and explanations" of medical problems (10). He goes on to assert that "problems, medical ones included, are often unconsciously designed so that they cannot be solved except at the partial, symbolic level. People often formulate and address certain problems in order to avert others" (11). Medicine's attention to physiological aspects of patient distress (the disease) does not accidentally overlook the psycho-social aspects (the illness) but, rather,

purposefully averts them.

Part of what sets biomedicine apart from its near relatives (e.g., nursing, psychology) and aligns it with the gentrified branches of its family (sciences such as chemistry and biology) is its focus on quantifiable data, the *signs* (objective) rather than the *symptoms* (subjective) of pathology. The hierarchies in this family tree are protected by medicine's articulation of medical problems, the priorities it sets for itself, the aspects of patient care that it happily leaves to the social work or psychiatric consultation and those that it guards closely. Explorations of these professional relationships further our understanding of both *what* is deflected from attention in biomedicine's pivotal terms and *why*.

To illustrate this point, consider physicians' interview responses to my inquiry about what students need to improve in their presentations. These responses indicate a variety of structural "habits", and physicians' explanations of these habits illustrate the underlying attitudes which inform -- and are formed by -- the rules governing order. For example, one attending

physician comments that,

> students have to organize in a sequence that answers the biggest question first. ... if you have someone who comes in with chest pain, you want to present the information that addresses the most pressing question first. You wouldn't want to diddle around about odd little peripheral things that might or might not be related ... the first thing you want to talk about is how likely it is this person is dying of a heart attack.

On one level, this approach is perfectly reasonable: knowing that the patient has just argued with his wife will not enable the practitioner to stabilize his present condition. As Paré reminds us, "regulations are not inherently harmful. . . . Not all rules that block discourse are necessarily bad, nor are those that encourage discourse automatically good" (120). The attending's rule about getting right to "the biggest question" is functional in this context of acute-care medicine, for although the domestic argument represents a contributing circumstance to the patient's present condition, it has minimal "rule-out" value in terms of the differential diagnosis that occurs to the physician upon encountering such a case. Additionally, though, the

regulation inscribes the boundaries of medical work: internal medicine physicians are not social workers or psychiatrists, and they do not include marital counselling among their professional duties.[42]

Another strong indicator of ideology at work in discursive regulations comes from students' responses to interview questions about order, such as the query, "Would it matter if I moved this [data to HPI]?" While strongly influenced by their sense of what the rules are — "It doesn't go there, it's one of the Social questions" — students also realize that messing up the order is more than a structural technicality. The sanctions of ideology, controlling community responses which might be out of step with biomedicine's paradigm of values, lie

---

[42] Waitzkin articulates the ideological function of such diagnostic strategies as that offered by this attending, arguing that the boundaries of medical work, which define aspects of social context as a "given" exterior to the province of the medical gaze, cause medicine "to exclude basic social change as a meaningful alternative" for patients (61). By directing attention to medical solutions for disease (and discouraging pursuance of "how the patient's social circumstances might relate to the difficulties for which he or she is seeking medical attention" (54)), the boundaries of medical work encourage the status quo "by rendering social change unthinkable" (61). This, he argues, may be medicine's "main contribution to social control" (61).

behind the student's sense that "you could [move the data], but you might get in trouble." This "trouble" is presumably more than a curt reminder from the attending that there is a correct order: it is the risk of sanction for illustrating a lack of consubstantiality with the values inherent in the hierarchy of order, values that inform physicians' self-definition of their trade.

The fragmentation implicit in the presentation's conventions of order and organization recalls Kleinman's concern about the effect of medicine's atomism on patients with chronic conditions. The fragmentation and hierarchy of the presentation form enact an ideological stance when used to organize patient data: it may, in Coe's words, "*unconsciously* persuade" ("The Rhetoric" 181) students about the relative importance of data. The form asserts that the bodily sources of disease are the legitimate province of medicine, that social contexts are less important. While it does not disallow the formulation of social questions, it positions them low on the list of answers to be sought. Of course, this is acute care: *right now* an asthmatic patient admitted for shortness of breath needs help breathing, not analysing

his motivation for smoking and the habit's present status. But the suasive power of the form is almost tangible, inscribing in users the ends for which it may be used.

The presentation's structural and ideological tensions may be further understood with reference to the meta-exigency in the larger context of healthcare. By "meta-exigency" I intend the new and encompassing rhetorical exigency created by the rise of chronic illness as contemporary medicine's foremost adversary, replacing epidemics and acute infection. Arthur Kleinman reports that "chronic pain is a major public health concern in North American society" (56), caused, according to Tenner, by stunning improvements in medical technology that prolong life, creating the conditions for chronic illness to thrive (69; see also Hunter 170). Tenner asserts that the relatively recent phenomenon of chronic illness is causing chaos in western biomedicine because it runs counter to the strengths of medical technology. He quotes the director of a major New York hospital as acknowledging that, "in a setting for acute medical treatment, 'chronic disease is an accusation'"

and "staff members are demoralized when 'nothing can be done'" (51).[43]

In explanation of this crisis, Kleinman argues that health practitioners are crippled by their socialized tendency to "[reconfigure] the patient's and family's illness problems as narrow technical issues, disease problems" (5). Accordingly, when "the healer . . . interprets the health problem within a particular nomenclature and taxonomy, a disease nosology, that creates a new diagnostic entity, an "it" -- the disease" (5). He continues:

> In the practitioner's act of recasting illness as disease, something essential to the experience of chronic illness is lost; it is not legitimated as a subject for clinical concern, nor does it receive an intervention. . . . Hence, at the heart of clinical care for the chronically ill--those who cannot be cured but must continue to live with

---

[43] In an interesting clash of perspectives, this medical attitude that "nothing can be done" is in stark contrast to the attitudes of people living with chronic conditions, who may be more interested in what can be done to *manage* their symptoms than in the fact that it is incurable (Coe, personal communication July 1998). Notwithstanding the argumentative purpose behind Kleinman's opposition between acute and chronic, curable/incurable is an artificial dichotomy, as a metaphor such as "management" suggests.

> illness--there is a potential (and, in many cases, actual) source of conflict. (6)

As the beginning of a solution to this struggle between traditional biomedical logic and chronic illness, Kleinman suggests a movement away from thinking of disease entities as having "natural histories and precise outcomes" and towards a wider understanding of the conditions and contexts of chronic illness.

> The interpretation of symptoms in the longitudinal course of illness is the interpretation of a changing system of meanings which are embodied in lived experience and which can be understood through the acquisition of what amounts to an ethnographic appreciation of their context of relationships, the nature of their referents, and the history of how they are experienced. (17-18)

Kleinman's outline of his method for a "meaning-centered model" of patient care proposes features which are suggested by Haber's revisionist case presentation format. Haber's promotion of material to the HPI, creating a cluster of inter-related conditions and contexts, seems to approach Kleinman's instruction to "come up with a rough appreciation of the patient's local social system and the recursive influence of his illness

on that context and of the context on the illness" (234). And while it is not my purpose here to locate or evaluate potential revisionary models of patient care, the similarity between Haber's presentation guidelines and Kleinman's model supports the contention that this genre can -- and may -- evolve in this direction.

Medicine's discourse, its namings, entitlements and metaphors, is socially constitutive because its words direct physicians' attention, signalling what they should acknowledge and, conversely, what they should overlook. In the Burkean conception of words as terministic screens and titles, "how we name shapes our attitudes, constitutes our motives, influences our actions" (Coe, "Burke's Words" 6). Implicit in the words and ways with words that the medical community privileges are "preferences about what to select, what to deflect, how to interpret, what to make emblematic, and what to put under erasure" (Coe, "Burke's Words" 9).

As they name aspects of biomedical experience, the terministic screens considered in this chapter help make up medicine's shared orientation, its substance. And substance, as Burke tells us, is "an *act*; and a way of

life is an *acting-together*; and in acting together, men [sic] have common sensations, concepts, images, ideas, attitudes that make them *consubstantial*" (*Rhetoric* 21, emphasis in original). Terministic screens create consubstantiality in a community for which they provide shared perspectives on the world, because when members share words for things, they also share attitudes towards them and potential actions in relation to them. Discourse, thus, forms a community's sub-stance, its shared ground (Burke, *Grammar* 23).

CHAPTER FOUR
Teaching and Learning The Principle of Relevance

The semantic analysis in Chapter Three explored the substantive principle of medical relevance as a governing feature of oral presentation discourse. Essentially, relevant data are those which are necessary to a differential diagnosis and subsequent treatment decisions, in relation to a particular stage of the hospital process (e.g., admission or disposition). The contrast between Keenan's and Haber's approaches suggested that some expert presenters focus more narrowly on the chief complaint while others adopt a broader perspective that incorporates contextual issues while still focusing, finally, on the acute care goals. The study of clerkship documents suggested, however, that the diversity and the motivations of the principle of relevance are inadequately explained by teaching physicians. Ideologically, this inadequate instruction may be functional in that it protects the status quo, maintaining community attitudes and assumptions.

Using linguistic pragmatic analysis of curriculum documents and clerkship instruction, this fourth chapter

presents a rhetorical explanation of the inadequate instruction in medical relevance.[44] It explores the rhetorical action of presupposition, that is, of begging the 'relevance' question in a context of initiation. Moreover, in articulating the rhetorical aspects of determining relevance, it offers an argument about the ideological nature of such question-begging.

The Principle of Relevance in Medical Discourse

From the initial encounter with the patient, the history taking, the physician selects the aspects of the illness story that biomedicine has privileged as relevant[45], using interruption to curtail and redirect the

---

[44] To avoid confusion in this chapter which discusses both the medical principle of relevance and the linguistic pragmatic principle of relevance, I will clearly signal the instances in which I am referring to the latter. Other references to relevance (and particularly, any unmodified invocations of the term) involve the medical principle.

[45] I am referring, throughout the first three sections of this chapter (until I propose a definition of my own), to the traditional notion of relevance represented in Chapter Three by Keenan's presentation instructions and the features of reductionist causal reasoning. Haber's method of presentation suggests what I have called an "expanded" notion of relevance that can be seen to reflect the contemporary concern for a more 'open system' approach to the patient that weaves contextual with cause-to-effect causality and considers both

patient's subjective narration of illness (Cicourel, "Reproduction" 93-96). Organizing the data gathered during the history interview into a presentation requires further selection and summary. One SFGH attending physician, interrupting a student presentation on attending rounds, instructs her to "isolate each symptom complex [in the Chief Complaint] and give appropriate information about that ... leave background to the history but indicate, for example, 'he has x in regards to this symptom but I'll discuss that in the history" (Fieldnotes).

In a different feedback situation, the same physician explains the rhetorical exigency which motivates this formal structure:

> A good HPI requires the ability to just run through the chart. The HPI is focused — just what brought them into the hospital. Don't run history (non-pertinents) into Chief Complaint, because when the attending is rounding on everyone after not being here all night on call, he wants to quickly be able to assess from the chart *what* brought them into the hospital *now*. In acute hospital medicine, we just focus on why the

---

pathophysiological and pyscho-social aspects of disease.

person's here. (Fieldnotes)

The attending explains that such selectivity enables the hospital to function within its mandate to provide treatment for acute conditions. His explanation suggests that the medical community may not consciously and purposefully construct objectified, fragmented conceptions of the patient, divorced from her emotional being, her social roles, her past life experiences; however, in the rhetorical situation of the teaching hospital, getting the day's work done may predispose physicians to this approach. Of course, as discussed in Chapter Three, the definition of medical work both shapes and is shaped by such generic strategies. Knowing how -- and for whom -- the genre is a functional strategy allows a keener insight into its rhetorical action.

The UCSF documents analysed in this study make repeated reference to these selection and summary procedures. For instance, Cooke emphasizes the need for an "edited and concentrated" (S10) presentation which is executed in a "concise, focused and directed" (S16) delivery. Her directions draw attention to the *limiting*

of patient data by a process of 'editing' and 'concentration', probably the most difficult aspect of the case presentation for new student clerks. When asked by what process they decide to omit data from their oral presentations, two clerks agreed that "You don't know for sure what to leave out and what to put in" (Fieldnotes). An intern offered this writer-centred analysis of the philosophy of selection: "I remember from being a student, you know all this info and you want to show you did it all, you know all this stuff -- but nobody cares. You have to learn to budget your information" (Fieldnotes). The principle that guides this budgeting is "relevance", a central tenet of diagnostic reasoning.

Haber's and Keenan's instructions demonstrate the importance of relevance in the selection process as a cluster of collocates repeatedly foregrounds this principle in their texts. Tables 4.1 and 4.2 represent, in clusters organized by key term, the pervasiveness of the principle in these presentation instructions.

Table 4.1
Collocative Clusters in Keenan's "Oral Presentations"
(History Sections)

Relevance	Pertinence	Importance	Others
"tell the patients' major past medical problems [in CC], especially if they are **relevant** to the illness" (S34) "include other family members only if particularly **relevant** to the case" (S74)	"the **pertinent** data" (S18) "always include **pertinent** positives and **pertinent** negatives with regards to other symptoms that may be related to the CC" (S44) "**pertinent** negative history of illness" (S61) "sometimes travel history and animal exposures are included [in SH], if **pertinent**" (S70) "be sure to include occupational exposures [in SH] if **pertinent**" (S65) "mention specifics [of FH] only if it is **pertinent**" (S72)	"just outline less **important** data" (S18) "[do not] leave out **important** data" (S29) "Very **important** information" (S36) "**important** to include associated symptoms" (S42) "some **important** review of symptoms items" (S45) "bear no **importance** to the case" (46) "how to decide their **importance**" (S46) "do not mention the dose of the medication unless it is **important** to the HPI" (S51) "a specific item is **important**" (S53) "list more **important** illnesses first" (S55) "depends how **important** it is to the patient's presentation and care plan" (S64)	"PMH items that are **crucial** to the HPI" (S56) "also include sexual history in [SH] if **significant**" (S66)

Table 4.2
Collocative Clusters in Haber's "The Compleat Write-up" (History Sections)

Relevance	Pertinence	Significance
"all the information ...relevant not only to the CC but to caring for the patient while hospicalized" (S18) "it assumes you know what the relevant information is" (S20) "Relevant positives and negatives from the ROS, FH, PMH, and SH ... should be included" (S23) "summary of past hospitalizations...if relevant" (S24) "even if they are not directly relevant" (S26)	"all information pertinent to his/her care while in the hospital" (S15)	"know which past and present illnesses are significant for each Chief Complaint" (S20) "significant medical problems affect a patient's care" (S26) "multiple significant medical problems" (S32)

The collocations represented in Tables 4.1 and 4.2 suggest the extent to which notions of relevance provide a rationale for data selection in these written instructions. But because neither author clearly articulates what he intends "relevance" or "pertinence" to imply in individual statements, the important differences in their notions of relevance (illustrated in Chapter Three) are not communicated in their use of these terms.

The dense interweaving of references to relevance and its

sibling terms in such instructions has the effect of blurring the meaning of these words. Often the terms are used synonymously, as when Keenan requests that students "Limit [themselves] to the **pertinent** data and just outline **less important** data" (S18). Sometimes, though, vaque distinctions arise, as when Haber explains that "since **significant** medical problems affect a patient's care in the hospital, even if they are not **directly relevant** to the CC they should be listed in the HPI" (S26). These terms appear in such abundance that students are not likely to miss the presence of an important diagnostic notion at work here, but the indistinct meanings of these concepts and their fluctuating relations to one another create a sense of a central but ill-defined premise underlying these instructions.

Not surprisingly given its popularity in curriculum documents, relevance is a concept much bandied about in oral teaching discourse on rounds. Residents repeatedly request "only what's warranted", they remind students to avoid "[telling] everything you learned about [the patient]," and sometimes, frustrated, they interrupt with inquiries such as "how is this [information] relevant to getting him to his baseline?" (Fieldnotes). The issue of relevance also surfaced

in all student and physician interviews, with reference to a variety of issues ranging from how students decide what material to include in an oral presentation (Question B1, Appendix D) to what residents and attendings perceive as the key weaknesses in student case presentations (Question A2, Appendix C).

Interviews suggest that both students and teaching physicians recognize the importance of and the problems associated with learning the principle of relevance. Furthermore, end of clerkship questionnaires suggest that the skill of determining relevance remains problematic well into the clerkship training. Students observed in January 1998 (students in their fourth of six third-year clerkships) indicated on questionnaires that relevance remained a problematic issue for them. In response to the question, "What do you find to be the most difficult aspects of preparing and delivering an oral presentation?", six of eight students made reference to relevance: "knowing what to include ... anticipating what will be important to your audience ... trying to be complete"; "when there are subordinate, unrelated issues that I think deserve mentioning"; "not going off on tangents"; "be[ing] concise and brief yet complete"; "knowing

what is relevant/irrelevant." Similarly, five of the eight mentioned the issue of determining relevance when asked to recall an oral presentation that went poorly. They attributed their error to "[going] overboard on pertinent negatives"; "the filtering and selecting of those pieces that convey the 'story' that I'm trying to tell"; "includ[ing] too much 'irrelevant' stuff"; being "too general and tangential"; and "being overinclusive."

The prevalence and difficulty of this central principle suggests that what relevance means and how it is taught and learned are important elements in understanding both how students learn to present cases and the values acquired in this learning process. Chapter Three's consideration of the dialectics implied by the term and its analysis of Keenan's and Haber's diverse strategies for prioritizing data, suggest further that the principle of relevance may be applied differently, for different purposes, by different physicians.

As Freedman reports, citing Herrington's and McCarthy's investigations of genre acquisition, such specialized genre knowledge is commonly acquired without explicit instruction (196). (Chapter Five will address more fully the tension between tacit learning and explicit instruction in the

clerkship setting.) Yet, notwithstanding theorists' general agreement that genre knowledge can (and often does) develop tacitly, one might logically expect that the guidance medical students receive about relevance -- a critical and complex aspect of medical discourse -- would be explicit and context-sensitive.

Teaching and Learning Relevance: Assumed Familiarity as a Pedagogical Strategy

While UCSF students and teachers agree on both the importance of learning to determine relevance and the difficulty of this skill, rarely is the activity of determining relevance 'unpacked' and explicitly articulated for students.[46] On the contrary, much of what constitutes

---

[46] On a few occasions, a resident or attending would offer a more detailed than usual articulation of relevance. Some of these were what I would call "hindsight" explanations: faced with a student who is carefully implementing yesterday's feedback, the teaching physician may recognize this and redirect with "I told you to leave out the family info yesterday because we were pressed for time and worried about his [worsening symptom], but now let's have it" (Fieldnotes). Other articulations of the principle were reported but not witnessed. For instance, one attending reported that she offers explicit treatment of the relevance issue in introductory advice to her new student clerks: "I tell them about the different sorts of presentations they'll have to give, and how to know what you'd better not bother the specialty consult with, or what to make sure you tell radiology . . ." (Interviews).

relevance is left unsaid in presentation instruction, through the pragmatic strategies of presupposition and conversational implicature.

Presupposition: Presupposed expressions survive the negation of the proposition's main verb (Green). For example, in the sentence, "The patient's pain is manageable", the existence of the patient and the existence of his/her pain survive negation while the issue of manageability does not ("The patient's pain is not manageable"). In this example, "patient" and "pain" are thus said to be presupposed. Presupposition offers some discursive items the status of "a given", rendering them relatively impermeable to inquiry or dissent by the hearer(s).

Keenan's document uses this pragmatic feature to presuppose, among other items, the existence of the patient (e.g., S27, 34, 37, 39, 44), the patient's problems or complaints (e.g., S27, 34, 37, 44, 53), his own presentation method (S7), and the notion of relevance (S18). Each of these presuppositions is intriguing, not the least the presupposition of patient illness which Atkinson notes in his study of bedside teaching ("Reproduction" 97) and which Friedson calls the "bias towards illness" (qtd. in Atkinson

97) that characterizes medical decisions. Transferred from the acute care context of the clerkship to other medical contexts such as primary care (where the patient may not always have a "complaint" in this traditional, biomedical sense), such presuppositions may cause problems. For the purposes of this chapter, however, I will focus on the presupposition of relevance, since Keenan employs the strategy in his introductory reference to the principle and sets the tone for the general lack of explanation that characterizes his instructions.

The first reference to the principle of relevance in Keenan's document (S18) uses presupposition to construct the principle as already known to the addressees of the document, second-year medical students:

(S18) Limit yourself to the pertinent data and just outline less important data (if you include it at all) to save time and keep your listener awake.

The presuppositional content of Keenan's statement, "Limit yourself to the pertinent data", is that there are data and some of them are pertinent. That there are data is a general presupposition that draws on the reader's common knowledge of the world. But the premodifying element of the noun phrase, "the pertinent data", is a local presupposition that sends the

student to access her knowledge of this particular biomedical world and the diagnostic logic that determines which data are pertinent and which are not (Clark 9-59). In this initial reference to the principle of relevance, the definite determiner "the" indexes the referent as constructed by Keenan as already known to the students.

Haber's document similarly presupposes students' understanding of relevance in the following statements:[47]

(S18) "Therefore, the HPI must contain all **the information**, including symptomatology and known past laboratory date and treatment, **relevant** not only to the Chief Complaint but to caring for the patient while hospicalized [sic]."

(S20) "This is obviously difficult because it assumes you know what **the relevant information** is ... for each Chief Complaint."

In both statements, that there is "information" is a general presupposition accompanied by the local presupposition in the modifier "relevant." Again, the definite determiner "the" indexes the principle of relevance as already known to the student audience.

---

[47] Haber's use of presupposition extends to include, among other items, "the patient" (e.g., S3, 5, 15, 19), the patient's illness/problems/Chief Complaint (e.g., S15, 18, 19), and the division of the presentation into segments (e.g., S10, 11, 15, 17, 21).

The presupposition of relevance by attending physicians may be in part related to the nature of their own relevance knowledge. As experts, these physicians will rarely access the principle in a conscious manner: it has become what Freedman, invoking Ellis, calls "implicit knowledge" which is "unconscious and procedural", which they can "enact" but not articulate (204). In interviews, when physicians invoked the concept of relevance in their response to a question, they were asked to complete this sentence: "Something is relevant if . . .." The responses varied: "... if it bears on the chief complaint", "... if it is related to why they're here", "if it helps us understand what's wrong with [the patient]." Though most shared an emphasis on the goal of diagnosis (discovering "what's wrong" or "why they're here"), as definitions they were quite general, or tautological ("related to" creates a cyclical definition), suggesting that these expert presenters were unable to explicitly outline the generic formula of relevance that informed their own, closely manicured presentations.[48]

---

[48] Students' responses to the "Something is relevant if ...?" question, not surprisingly, often echoed their supervisors in their vagueness. One student responded, "if, um, when assembled with other pieces of data it makes a

One physician was more forthcoming, offering the following metaphor that he uses with his students to explain issues of priority and relevance:

> I give the analogy of telling a story. They may tell me "this is a story about a young woman with a red cape on her way to Grandmother's house." And then they have to give me the history and physical exam, but I should know that they're thinking about Little Red Riding Hood. They might tell me, "and of course this person did not come in with a frog", so I know they're not telling me about the Toad Princess; "there was no slipper attendant to the person", so okay, I'm ruling out Cinderella . . . and then they will come out and say "a wolf accompanied her", or whatever. (Interviews)

Would this metaphoric explanation help students understand the biomedical principle of relevance? Let's unravel the analogy. It suggests that presentations have main characters just as fairytales do and that knowing the characters of a story is information both necessary *and sufficient* for situating that story among all other stories and for being able to predict how it ends. In this regard it offers a model

---

picture." When asked in the context of a particular case, however, a few offered highly detailed explanations of relevance. This may suggest that students who have tacit knowledge of relevance are, like their instructors, unable to render that knowledge explicit in an abstracted definition.

of how pragmatic relevance functions rhetorically in a text's reception. But the analogy also serves to sustain the presupposition of biomedical relevance. For if I do not know the Toad Princess story, then the lack of a frog [sic] is not clearly a pertinent negative for me, because it does not help me rule out the particular Toad Princess story in my differential diagnosis of "what story is this?" And how do I know that "no slipper attendant" is relevant if "Cinderella" is not part of my fairytale database? Because many students are familiar with these stories, this attending physician's analogy might momentarily soothe their fears about relevance. But the analogy assumes a parallel familiarity with medical "stories" which students do not enjoy in the third-year clerkships.

This parallel familiarity is true for seasoned physicians: as Elstein, Shulman and Sprafka conclude, "when [physicians] encounter a patient's problem within their domain of expertise, they make their diagnosis in an automatic, nonanalytic manner" (qtd. in Irby, "How Attending" 631) which Schmidt et al. characterize as "the rapid retrieval and matching of patient or illness scripts derived from prior experience" (qtd. in Irby 631). Physicians diagnose by

pattern recognition (Bradley), so they do not articulate the principle of relevance because they do not consciously apply this implicit knowledge. For students, the illness scripts that allow for pattern recognition are not yet part of their medical lore, so that the attending physician's fairytale analogy continues the presupposition of relevance *even while* modelling how it works to help listeners make sense of communication.

The assumption of familiarity makes it difficult for students to assert to their attendings and residents that relevance is not common knowledge, for to admit ignorance in this regard is to suggest that you are not fit for membership in the community that apparently shares this knowledge. Initiates to a community, desirous of entrance, will likely accept the facade of consubstantiality rather than risk advertising their consubstantial lack, even though Haber's orientation handout concludes with the "truism" that "feeling stupid or inadequate at some time (especially) during the first part of your 3rd year Medicine Clerkship is not only NOT abnormal (note the multiple negative), but almost the rule" (Appendix A).

Implicature: The presuppositions of relevance in Keenan's and Haber's documents are emphatic and suggestive but they are not especially abundant. Yet the atmosphere of assumed familiarity persists in discussions of relevance in these instructions, as the authors invoke the principle without articulating how to apply it in particular instances. Appendix E reproduces the sixteen such references to relevance in Keenan's instructions (up to the end of the "Family History" section) and the five references in Haber's document (up to the end of the "History of the Present Illness" section, which includes Haber's directions for the PMH, SH, and FH materials). The linguistic pragmatic concepts of relevance (Sperber and Wilson) and conversational implicature (Grice) offer a means of exploring how the addressed audience of students makes sense of such messages and the logical process by which they infer the unsaid material necessary for these instructions to successfully communicate.

H.P. Grice argues that "in conversing (indeed, in behaving rationally), human beings follow a behavioral dictum" (qtd. in Green 88). His theory is an attempt to explain how listeners make sense of an utterance by assuming that the communicator is trying to meet certain general standards

summed up by "the Cooperative Principle."[49] The crux of Grice's notion as interpreted by Dan Sperber and Dierdre Wilson is the idea "that the very act of communicating creates expectations which it then exploits" (37). This idea helps explain how explicit and implicit meanings can co-exist in an utterance and how listeners supply assumptions and conclusions, called inferences, to preserve their presumption that the cooperative principle is being adhered to (Sperber and Wilson 34-5).

While Sperber and Wilson recognize the value of the Gricean approach to implicature, they argue that it is insufficient to explain how a listener chooses a particular interpretation from the range of potential implicatures that inhere in an utterance in context (37). In their exploration of this question of interpretation and inference, they argue that "human cognition is relevance-oriented" (46); that is, that "the train of human thoughts is steered by the search for

---

[49] Grice outlines four conversational maxims, covering the "Quantity", "Quality", "Relation" and "Manner" of an utterance. As Georgia Green explains, "as long as participants in a mutual enterprise such as a conversation each assume that the other is adhering to the Cooperative Principle, meanings that are conveyed without being said follow as inferences from the fact that some particular maxim appears to be being violated" (88).

maximal relevance" (147). In essence, Sperber and Wilson reduce Grice's maxims to "a single well-defined maxim of relevance" (Chap 1, Note 26) and assert that

> a rational communicator, who intends to make the presumption of relevance manifest to the addressee must expect the processing of the stimulus to confirm it. . . . To recognise the communicator's informative intention, the addressee must discover for which set [of assumptions] the communicator had reason to think that it would confirm the presumption of relevance. (165)

They continue, explaining that the listener's task is to construct hypotheses about what assumptions are being made manifest and to choose the one that best confirms the relevance of the communicator's message (165). The listener's process of selecting a hypothesis is influenced, Sperber and Wilson claim, by "the cognitive environment", "the initial context", and "the stimulus", factors which make some hypotheses more accessible than others, requiring less processing effort, and, thus, according to the authors, more likely to be relevant (167).

Sperber and Wilson's relevance theory differs from the Gricean approach to communication in that they posit a lesser

degree of cooperation than is required by the maxims (161). Grice assumes that people know the maxims and use them to interpret messages, while Sperber and Wilson's principle of relevance need not be "known" or "followed" and, they argue, could not be violated even if communicators wanted to (162).

Sperber and Wilson's theory may explain the pedagogical effect of the dense occurrence and scarce detail of clerkship references to biomedical relevance. Students, interns, and physicians alike acknowledge that the determination of relevance is both a critical skill and a difficult acquisition for initiates. Yet some curriculum documents assume in the student audience an apparently undue level of familiarity with the practical applications of the principle. If we approach Keenan's document as an instance of ostensive-inferential communication, which Sperber and Wilson characterize as having "the informative intention, to make manifest to [the] audience a set of assumptions. . . and . . . the communicative intention, to make [the] informative intention mutually manifest" (163), then we must decipher the inferences that the audience would make in their identification of this set of assumptions.

Consider the following examples from Keenan's guidelines

for the social and family history[50] sections of the presentation:

> (S66) I also include sexual history in this portion of my oral presentation, **if significant**.
>
> (S70) Sometimes travel history and animal exposures are included here, **if pertinent**.
>
> (S72) I personally tend to mention specifics **only if it is pertinent** to the patient's illness, but otherwise I say "non-contributory."
>
> (S74) I include other family members **only if particularly relevant** to the case.

Each of the data selections advised by the speaker depends upon the ability to determine "significance", "pertinence", and "relevance" and thus shape the patient's illness story from the biomedical perspective. In these examples, Keenan tells the reader that relevance is the determining principle for selecting social and family history data but does not tell her how the principle is to be applied. How, for instance, does one determine which family members, and which data about those members, are "relevant to the case"? As Sperber and

---

[50] Chapter Five will present the case of a student struggling to determine what social and family history is relevant to the case presentation on work rounds. For now, suffice it to say that this is a part of the presentation where students in my observation tended to select data with difficulty.

Wilson explain, a reader trying to ascertain the intentions behind such communication must find a rational interpretation for it. The reader will assume that it is relevant that Keenan did not explain how to apply the principle and will set out to construct an inferable interpretation or implicature of the utterance that confirms this assumption.

According to Sperber and Wilson's theory of relevance, student readers of Keenan's instructions, faced with the frequent references to relevance with insufficient explanation of how to determine it, will seek to construct the inferences necessary to make it relevant for Keenan to be offering such limited guidance. And, in the competitive context of medical education, where the pace of knowledge acquisition is furious and students dread being caught without the answer (see, e.g., Stein 51), what they may infer from the absence of what they perceive to be a necessary articulation of the principle and its application is either that they *ought to already know* these answers which they find themselves requiring or that they are supposed to find out for themselves. That is, the implicature made manifest to the reader by Keenan's failure to explain how to apply the principle of relevance may be *assumed familiarity.*

While the grammatical action of Keenan's sentences is to construct medical relevance as already known to his audience, thus implying assumed familiarity, the rhetorical action of the document may not always be assumed familiarity per se. That is, Keenan (and other teaching physicians) readily assent that students do not know how to determine relevance. Thus, the use of implicature in this case does not necessarily signal such an assumption on Keenan's part; rather, it acts to construct a particular subject position for the student audience, to *invoke* an audience familiar with the principle while *addressing* one unfamiliar with it. Green and Lee argue that this construction (and the potential adoption) of subject positions forms an essential component of school "literacy" and contributes to "the role of writing and reading practices in subject-production" (219).

A term from rhetorical theory describes the rhetorical action of Keenan's implicature, which is a form of question-begging. Burke explains question-begging via Bentham, charaterising it as "a basic rhetorical device" through which the speaker/writer "begins by positing the very thing that is to be proved", thus creating "an opportunity to *establish this very assumption in the mind of his hearer*" (*Rhetoric* 94).

Keenan begs two questions for which his audience does not have answers: "What is relevance?" and "How do we determine it?" By so doing, he implies that either they ought to already have these answers or that these are things they must learn on their own. Either way, he sets up a teaching situation in which the responsibility for articulating the answers is transferred from the instructor to the student.

Sperber and Wilson's theory suggests that, in making manifest the implicature of assumed familiarity, Keenan must (at some level of consciousness) realize that the students will try to interpret his behavior as cooperating with his duty to teach them what they still need to know. Doing so, students will (again, at some level of consciousness) conclude that it is significant that he did not explain more. Two logical (and not mutually exclusive) reasons for Keenan to not explain more are that (a) determining relevance can or should only be learned by the process of experience *and/or* (b) it should already be understood (i.e., the paradox that, once in the process, your actions will be valid only if you already know).

Given the general acknowledgement of the difficulty of acquiring "clinical judgement" -- the ability to determine

relevance and select and focus patient care appropriately -- it is evident that Keenan and Haber are invoking an audience familiar with the principle, not addressing one (see Ede and Lunsford). Both recognize the difficulty that relevance decisions present for student clerks. Haber acknowledges that "this is obviously difficult because it assumes you know what the relevant information is (i.e., know the complete differential diagnoses and know which past and present illness(es) are significant) for each Chief Complaint" (S20). Students do not usually have all of this information before they present, partly as a result of time constraints on their medical journal research and partly because they struggle to select relevant material from the research as they do from the patient history.

Similarly, while Keenan's outline of the HPI instructs students that "it is important to include associated symptoms as well" (S42) and to "always include pertinent positives and pertinent negatives with regards to other symptoms that may be related to the chief complaint" (S44), he acknowledges that "how to decide their importance comes with experience" (S46). His concession reveals one explanation for the inadequate explanation of medical relevance: for the expert presenter,

the knowledge of how to determine relevance is tacit, unarticulated in his own mind because it is implicit knowledge. He cannot explain it and (conveniently) declares it unexplainable.

Tacit knowledge is one possible explanation for the inadequate instruction in relevance. The other explanation under consideration in this argument is that the invocation of familiarity where it does not exist is a conscious pedagogical strategy, a method of constructing preferred subject positions for students to occupy.

Sperber and Wilson's theory of relevance draws attention to both the explicit and the implicit content of communication, and in this distinction may lie the role of implicature in presentation instruction. Consider the following situation observed on attending rounds. During a long presentation early in a patient's hospital stay, a student pauses before offering the laboratory results and asks:

(Q) "You just want pertinent labs, or should I run through it all?" (Fieldnotes).

Because laboratory tests are ordered to facilitate the rule-out process, all the lab data will be pertinent if tests

relevant to an appropriate differential diagnosis were performed. A particular finding might render others redundant (e.g., a positive result on a test that has a minimal margin of error and indicates only one diagnosis in the differential), but all are potentially pertinent.

The student's question implies uncertainty about what might constitute pertinence in this case, and it is an indirect way of soliciting guidance for his selection process. This is as close as most clerks come to admitting ignorance in this situation, because the assumed familiarity enveloping the issue of relevance essentially disallows it. The attending makes a joke out of the question, replying,

(A)"Anything drawn inadvertently, I don't want to know about" (Fieldnotes).

The joke about "inadvertent" drawing of bodily samples for testing is a reference to the inability to determine relevance implied in the student's question. If the proper tests were ordered, all data should be relevant; thus, the student's query casts his test-ordering skills in doubt.

An indirect answer such as the one this attending offers must expect to achieve some additional contextual effects not available to direct answers in order to reward the additional

effort needed on the part of the listener to process the indirect response, supply its premises, and deduce the implicated conclusion (Sperber and Wilson 196-7). What Sperber and Wilson mean is that, if the entire relevance of the attending's response (A) is (A2) "I just want you to report the pertinent labs", then he could have spared the student some unnecessary processing time by just saying so. The attending's response as it stands (A) does not seem to answer the question: rather than guiding the selection of lab data, it suggests that the student may have performed unnecessary tests on the patient.

This response (A), which sparks laughter from the team, could be interpreted two ways. It could be a shared recognition of how problematic the determination of relevance is for novices:

(A3) "I understand that you may have trouble determining which tests are relevant."

Or it may be a sarcastic way of saying,

(A4) "Why did you [draw the blood, order the spinal tap, do the biopsy] if it's not relevant to the case?"

Tests are ordered to rule in or out the most probable diagnoses suggested by the patient interview and examination. There is, then, for each case a number of tests that could be

ordered, but only some of them are relevant to the rule-out process and only in certain configurations. It is not often appropriate, for example, to order tests to rule-out a "Zebra" (exotic) diagnosis before tests have been ordered to rule-out more common conditions. If the student has ordered appropriate tests (that is, if they were ordered according to the logic of an appropriate differential diagnosis), then both the positive and the negative laboratory results will be pertinent to this rule-out process -- there will be no non-pertinent lab data.

As Sperber and Wilson realize, "the surplus of information given in an indirect answer must achieve some relevance in its own right" (197); that is, the surplus information must have some value for the hearer. The sympathetic response (A3) could imply recognition of the student's difficult position and acceptance of his uncertainty. The sarcastic response (A4) could imply the inappropriateness of such a question in a community of professionals for whom medical relevance is a presupposed, unquestionable principle. From the attending's apparent shift in subject from lab results to performing tests, the student (who in this case was apparently not soothed by the indirect

answer and took a defensive stance in relation to it) might infer that (a) if you ordered pertinent tests it will all be pertinent, and (b) if you can't tell what is pertinent lab data, how do I know you even performed the pertinent tests?

The additional information supplied by the sarcastic response suggests the paradox of the "learn by experience" credo. Students will hone the skill of determining relevance by what Lave and Wenger call "legitimate peripheral participation", the learner's gradually integrated activity in and with the community of practice (33). But, as Renee Fox's groundbreaking sociological study of "uncertainty" in medical education suggests, "students [are] often expected to see before they know how to look or what to look for . . . [to have] the ability to 'see what you ought to see', 'feel what you ought to feel', and 'hear what you're supposed to hear'" (qtd. in Atkinson, *Medical Talk* 111). Such expectations are conveyed by the implicature, which invokes an audience that already knows, thus inviting students to accept this subject position. For in order to participate (even peripherally, with limited responsibility and engagement) in almost any of the clerkship tasks (such as admitting, presenting, ordering tests and treatments), students will need to know *already* how

relevance works.

Medical Initiation as Symbolic Violence

While a lack of explicit genre instruction is recognized as normal and viable in professional communities (Freedman 196), the ideological functionality of this lack is rarely investigated (see Coe, "The Rhetoric" Note 4). Rather than accepting it as normative, this section of the chapter seeks to explain ideologically the seeming evasion of opportunities for direct instruction in the medical clerkship.

The implicature surrounding the principle of relevance may act, in this medical context, as a form of intimidation in Bourdieu's sense of "a symbolic violence which is not aware of what it is (to the extent that it implies no *act of intimidation*)" and which "can only be exerted on a person predisposed (in his habitus) to feel it" (51). "Habitus" is a key concept in Bourdieu's approach to language as symbolic power and one which can help us explore the issue of agency for medical students learning the presentation form. As he explains,

> the habitus is a set of *dispositions* which incline agents to act and react in certain ways. The

> dispositions generate practices, perceptions and attitudes which are 'regular' without being consciously co-ordinated or governed by any 'rule'. (12)

Bourdieu further theorizes that these dispositions are inculcated "through a myriad of mundane processes of training and learning"; they are structured "in the sense that they unavoidably reflect the social conditions within which they were acquired"; they are durable, "ingrained in the body . . . operating in a way that is pre-conscious"; and finally they are generative and transposable, "capable of generating a multiplicity of practices and perceptions in fields other than those in which they were originally acquired" (12-13).

Medical students share a common habitus: many descend from medical families and have had cultivated in them the goal of a medical career. As Stein explains, medical education alone does not achieve the transformation of lay person into physician. Powerful screening tools pre-select candidates from common social and economic backgrounds, with shared intellectual abilities and attitudes. "Scores on nationally standardized examinations, interviews with medical schools' admissions committee members, and previous academic preparation in 'premed' college curricula" signal potential

"medical school candidates whose characteristics are most congruent with those of the admitting medical institution and its clinical cultural ethos" (179-80).

Stein identifies what he calls a "reciprocal selection process" wherein students' early family environment, their childhood experiences and "unconscious structure", shape their "self-selection for [the] healer role" in entrance into the premedical curriculum (180). Because of the continuity between the applicant's social conditions, mental structure and "character" fit (180), the socialization process has begun well before the recruitment to medical school. Professional preparation in school, internship and residency depend upon this established, congenial habitus to successfully engender identification with the biomedical role and its community values.

The habitus of the medical student inclines her to act in ways that complement her structured dispositions and maximize her achievement of professional goals. The extreme example of the congenial habitus is the student descended from a family of physicians, such as the soon-to-be third-generation Ear/Nose/Throat physician I followed closely during my November 1996 observations. Such students are intimately

familiar with core medical values such as the expectation that the physician will make medicine his first priority, an expectation that dictates aspects of daily life such as the perception and use of time and the cultivating of relationships. Similarly, the student whose acceptance of mechanistic logic has been shaped by a highschool science education and the likely valuation of such logic by the parents encouraging her pursuit of a medical degree is predisposed to embrace and thrive within the diagnostic reasoning processes required by the profession.

In terms of the presupposition and assumed familiarity of relevance, the inclinations embedded in the habitus hold multiple significance. Consider the following statement from Haber's instructions for writing up the HPI:

> This is obviously difficult because it assumes you know what the relevant information is (i.e., know the complete differential diagnoses and know which past and present illness(es) are significant) for each Chief Complaint. (S20)

This statement comes at a critical point in the instructions, after discussing the selection of data for an audience that "should have no further questions regarding the patient's acute problem(s), or chronic problem(s) that would affect

hospital management" (S19). While S20 admits the difficulty of selecting and prioritizing data, it nevertheless presupposes that "there are data" and "some data are relevant." Like the presupposition of relevant data in Keenan's document (and the implicature that extends from his preliminary presupposition), this statement invokes in the student reader a level of familiarity with the principle of relevance that the speaker knows does not likely exist. But this assumption of mutual knowledge in the subordinate clause is belied by the main clause's claim that "this is obviously difficult."

Viewed through the lens of linguistic pragmatics, these inconstancies in the way that curriculum documents inscribe their student reader might make us wonder whether readers would not resist such assumptions, insist on clarification, demand the tools to analyse and question what they are being told. But their shared habitus inclines them to be an agreeable audience; indeed, Gillian Brown and George Yule define pragmatic presupposition as "assumptions the speaker makes about what the hearer is likely to accept without challenge" (29). These students do not resist their instruction, even when their success depends upon

understanding it and they do not.

Students are inclined to accept without challenge that biomedical relevance is a part of the medical community's common consciousness because their habitus, established by class conditions and reinforced by their medical school training, assures them both that the prioritizing of patient data is a reasonable activity and that the diagnostic logic that guides this prioritization is sound. And, as the community's esteem for clinical judgement predicated on personal experience suggests (Atkinson, "Discourse" 89), if students are inclined to believe that tacit knowingness is more valuable than directly delivered/acquired knowledge, the evasive instructional routine of presentations is likely to be supported.

If the understanding of relevance is in fact *not* common ground among the participating teachers and the medical students in these learning situations, then the assumption of familiarity through presupposition or implicature may be understood as an act of intimidation in Bourdieu's sense. In the case of Keenan's provision of information about determining relevance, students will be inclined to accept the subject position constructed for them by 'assumed familiarity'

rather than risk exposing themselves as non-members in a community whose borders are in part defined by mutual knowledge.

This symbolic violence is possible as a result both of the common habitus of medical students and of the nature of the clerkship experience, which Stein characterizes as "professionalization through terror" (51). He explains that "the dread of helplessness and uncertainty helps seal the identification with the aggressor and with it the professional attitude" (51). Assuming familiarity with what cannot possibily be yet known may be a successful tactic in a pedagogy built on the premise that "there will be a prodigious amount to know, that [students] must know it all, that they cannot possibly know it all" (Stein 184). This paradox is part of a pedagogical strategy which Stein articulates as "the inculcation and exploitation of vulnerability" in order to "[ensure] conformism to group norms" (184). To adopt Burke's terminology, the presupposition of relevance may be one of "the varying tactics of purification" ("Fact" 172) applied to such social tensions in a community's discourse.

The Ecology of Relevance

Underlying the principle of relevance is a selective, partial way of knowing that reflects (as Chapter Four argued) biomedicine's self-definition, its shared attitudes and interests. Mary Douglas argues that an institution "[gains] legitimacy by distinctive grounding in nature and in reason": she postulates that "it affords to its members a set of analogies with which to explore the world and with which to justify the naturalness and reasonableness of the instituted rules" (112). Douglas echoes Thomas Kuhn's notion of a dominant paradigm ("Postscript") with her assertation that, with such shared analogies in place,

> any institution then starts to control the memory of its members; it causes them to forget experiences incompatible with its righteous image, and it brings to their minds events which sustain the view of nature that is complementary to itself. It provides the categories of their thought, sets the terms for self-knowledge, and fixes identities. (112)

With reference to just such selective processes, Gregory Bateson argues that problems, or "pathologies" as he would call them, arise when part of a whole is "selected in any systematic manner" and taken as the whole by extrapolation (144). He warns of the dangers of the crosscutting of circuitry, arguing that if a totality (mind, body, ecological

system) is an integrated network and if the content of consciousness is only a sampling of different parts and localities in this network, then "inevitably, the conscious view of the network as a whole is a monstrous denial of the *integration* of that whole" (145). "Relevance" is a dramatic instance of Bateson's point, since, for medical practitioners, it is the eulogistic term for this institutional selectivity.

Bateson illustrates his theory of consciousness by analogy to the biomedical view of the human body, "a complex cybernetically integrated system" which appears as arcs of circuits above the surface rather than as circuits of circuits. "Relevance" is a method of selecting parts of this whole system in a systematic manner which must create "a distortion of the truth of some larger whole" (144). Such distortions Burke (following Veblen) describes as the result of "trained incapacity" whereby the foci of a discipline can function also as blindnesses (*Permanence* 7). In 1967, Bateson characterized biomedicine's efforts as

> focused . . . upon those short trains of causality which they could manipulate, by means of drugs or other intervention, to correct more or less specific and identifiable states or symptoms. Whenever they discovered an effective "cure" for something, research in that area ceased

> and attention was directed elsewhere.[51] (145)

As a method of systematic selection of part for the whole, the principle of relevance contributes to the maintenance of what Bateson might call biomedicine's "pathology of epistemology." For in its position of presupposed privilege, relevance does not get questioned overtly in the discourse of the oral presentation. And although students will gather, across the time and space of the clerkship, an index of the varied performances of determining relevance, they may be misled by its apparent unity and self-evidence as a principle in presentation instructions.

As a pivotal term in biomedical education, relevance is a

---

[51] Bateson offers the example that "we can now prevent polio, but nobody knows much more about the systemic aspects of that fascinating disease. Research on it has ceased or is, at best, confined to improving the vaccines" (145). Evidence has arisen to support his theory that a selective, partial biomedical consciousness is dangerous ecologically. Tenner reports that the treatment of the acute condition of polio has a chronic consequence, "post-polio muscular atrophy." This condition is predicted to eventually affect as many as a quarter of the 250,000 to 300,000 survivors of the 1950's American polio epidemic. Apparently, there was more to be discovered about polio than simply its 'cause' and its 'cure', and intervention in the visible portion of the 'circuit' set off a ripple effect across circuits of circuits that the "train of causality" could not predict or accommodate. Bradley's references to chaos theory come to mind here, as an alternative logic applicable in such situations.

"question-begging appellative" (Burke, *Rhetoric* 92) when the speaker does not define the term operationally *to something*. Coe (invoking Aristotle) provides a distinction between two types of definition, essential and operational (*Process* 320). The definition of relevant material as information about the Chief Complaint or material related to the patient's hospital stay tells students what relevance *is* (essence) but not explicitly what it *does* (function) (see *Process* 320). An operational definition would include concrete details about how and when and why a presenter makes particular determinations of relevance.

When, for instance, Keenan advises students to include "important review of systems items [in the HPI]" (S45), he begs the crucial question, "How does one know if a particular review of systems item is 'important' or 'relevant'?" The connotations of the term "relevance" (e.g., its apparent generalizability, its self-evidence) beg questions central to biomedical education, not the least of which are "What is the operational definition of relevance?" And "How does one apply the principle actually to particular data, particular patients, and particular contexts?"

Ideology Under Erasure: Defining Relevance

Throughout this chapter, a number of partial, occluded definitions of relevance have suggested themselves in physicians' feedback on students presentations, in their interview responses, and in their written instructions. Compiling them and comparing them with the features of relevance suggested in the findings of four studies of medical discourse may enable an articulation of both *what* assumed familiarity and question-begging have put under erasure in the presentation curriculum -- and *why*.

In the references to relevance in UCSF curriculum documents and attendings' comments on presentations and interview responses, a number of partial explanations of the principle appear. Relevant data may be:

* "just what brought them into the hospital...why the person's here" (attending feedback)
* "key patient problems" (SCEF)
* "[aspects of] the Chief Complaint" (Haber)
* "[issues of] caring for the patient while hospicalized [sic]" (Haber)
* "[what] helps us understand what's wrong with [the patient]" (Interviews)
* what contributes to "the complete differential diagnoses" (Haber)
* what leads to "the patient seeking medical assistance at this time" (Keenan)

When written and verbal instructions qualify the terms

"relevance", "pertinence", "significance" and "importance", they often make reference to the argumentation of the presentation, its "building" of a case towards institutional goals. In the patient case presentation, the problems to be solved vary during the hospital stay, but the governing questions are, generally: "what is causing the condition that brings the patient in *now*?" and "what can we do to improve the condition towards the goal of discharge?" In the teaching hospital, the patient case presentation argues towards the three goals of diagnosis, treatment, and discharge. These are overlapping phases of hospital medical practice and the business metaphor of "management" weaves issues of reimbursement throughout them.

The business metaphor is revealing of medicine's professional mandate, its perceptions of itself. As Burke points out, "metaphor is a device for seeing something <u>in terms of</u> something else" (*Grammar* 503): as such, metaphors are, as Coe suggests, "heuristic and persuasive" ("Metaphor" 3). As terministic screens, metaphors are symbolic action: motivated, functional, constitutive of orientations. The management metaphor for medicine directs attention to patients as clients purchasing the product of 'science', to suffering

and healing as quantifiable commodities, and to physicians as service 'providers'. This reconstitution shifts attention to the bottom line: by casting the elements of medicine as financially quantifiable, the management metaphor creates the notion that they *ought to be* quantified.

The power of casting such an 'argument' metaphorically is that, as Coe argues, such root metaphors "are comparable to the semiotic concept of myth", with the status of "utterances that constitute common sense, the norm, general opinion" ("Metaphor" 6). Kleinman points to financial issues, "the ubiquitous bottom line in a capitalist society" (53), as one of the factors which influence a) how problems are defined in patient presentations; b) how the diagnostic logic proceeds in selecting data and establishing "rule-outs"; c) and which treatments are selected. Stein reports that this aspect of clinical reality has been referred to as "the industrialization of medicine" (Kormos, Stephens cited in Stein 24), the "McDonaldization" of medicine (Ritzer and Walczak cited in Stein 24) and the "minimalism" of biomedicine as a reflection of contemporary culture where accountability reigns (Stein 24). The management metaphor is being criticized currently (see Stein, Kleinman) as inadequate to

the wider purposes of medicine and as responsible in part for leading to attitudes and actions that do not achieve the purpose of care for human suffering.

Once each of the three goals is achieved, the case presentation shifts to focus on the next. The process, however, is teleological rather than linear: treatment, discharge and reimbursement are ever-present in the physician's mind and shape the earliest differential diagnosis and the rule-out process of tests and treatments that follows in its wake.

A pattern of reference to the presenting complaint (the ailment that brought the patient to the hospital) and its diagnosis and treatment surfaces when various mentions of relevance are gathered together from instructive discourse. So relevance might be defined in relation to the goals of diagnosis and treatment: relevant data are pieces of information that help explain the causes of and address the patient's chief complaint.

This preliminary definition, however, fails to capture the essential difficulty of relevance decisions for novices, which is (as I have stated earlier) the issue of *what to leave out* in the rendering of patient data into a "concentrated"

presentation. As Atkinson reports, a successful medical "story" "will convey enough information as to satisfy a requirement for 'newsworthiness', but not so much as to overload the hearer with information that will become treated as 'irrelevant'" (*Medical Talk* 97). Selecting that which is 'newsworthy' and editing that which can be left unsaid, those "things which the hearer may take as read, or . . . background features that are entirely familiar to the hearer, and hence devoid of interest or relevance" (Atkinson, *Medical Talk* 98), are fundamentally difficult tasks for novices, particularly if they do not share what Schutz refers to as their listeners' "zones of relevance" (qtd. in Atkinson 97).

Atkinson's statements suggest that this is in part an issue of pragmatic background knowledge, of students not being sure about what they can assume rather than articulate in their presentations. Giltrow, in her account of the role of background knowledge in reports of sentencing for violent crime, explains background knowledge as "a factor in a text's *coherence*", "a resource shared by the producers and receivers of utterances" that allows a community of language users to "develop ways of leaving things unsaid, these unsaid things marking a condition of mutual understanding" (155).

Furthermore (and central to an analysis of how novices learn such shared resources), Giltrow asserts that, in a community which has such a developed system for leaving things unsaid, "to actually say what is usually assumed may sound mistaken" (155).

Medical students, caught in a high-stakes (life and death) apprenticeship situation, are loathe to leave any data out of their presentations, reluctant to estimate the background knowledge of their audience, perhaps because of their own, still developing, background knowledge indices. As Giltrow finds in her experience with novice writers in the university setting, "learning the reticence appropriate to a genre can be hard", and novices will "[say] too much . . . as if their readers didn't know things which they in fact did know very well and didn't want to be told" (174). Because I did not share the community's background knowledge, it was difficult for me to recognize instances in which students violated their audience's expectations of reticence. Therefore, in order to explore this feature of presentation discourse and consider its implications for relevance decisions in student presentations, I will rely on an anecdote presented in Atkinson's study of haematologists.

Atkinson offers a vivid example of how background knowledge functions in what gets said (i.e., that which is selected as relevant for reporting) in a haematology presentation and what gets left unsaid (*Medical Talk* 100):

> The narrative presents the results of the bone marrow biopsy and the immediate consequences. Immediately, chemotherapy has been initiated, using a standard combination of powerful agents. It is notable that the narrative has reached a denouement of sorts: the puzzle has been partially resolved. It is equally notable, of course, that in this context, and on this particular occasion, the narrator does not find it necessary to state precisely what the diagnosis is. The narrative itself builds towards the unstated diagnosis, which is confirmed in the recitation of the combination chemotheraphy. The latter is not justifed or marked in any special way. The signs that have been recounted by the medical student in rehearsing the case are sufficiently pathognomic for the actual disease label to go unspoken. (100)

As Atkinson recognizes, it is important that "the most salient issue -- what is wrong with this particular patient -- is precisely what remains unsaid" (100). The speaker is able to leave this crucially relevant piece of data out of the report because it is mutually understood by members of the medical community who recognize the diagnostic import of the signs, tests, results, and treatment plans reported in

this presentation.[52] Including it, in fact, would undermine the sophistication of the account.

As this example illustrates, background knowledge is one method of discriminating between what must be selected for presentation and what "goes without saying." The issue of background knowledge draws our attention to the importance of audience in discriminating between what are relevant data and must be presented, what are relevant data but may be left unsaid, and what are not relevant data and must be edited out of the presentation. The role of audience in these decisions suggests that a patient-centred (substantive) definition of relevance -- the definition of relevant data as those which

---

[52] As an outside observer, I often encountered background knowledge at work in the discourse of the physicians I followed on rounds. I was regularly "left hanging" by the recounting of particular cases or anecdotes when others' curiousity had clearly been sated. Once, intrigued by a lunch conference presentation of a young girl who had been bitten while camping and was in danger of having her limb amputated, I asked my neighbor "did they have to amputate?", when the presentation had ended without articulating (to my outsider ears) this critical information. "Oh, no", my neighbor replied, surprised, and explained that the test results confirmed a second diagnosis that would not involve such invasive treatment. For those who had the knowledge of the medical world to consult in their interpretation of the utterance, this highly relevant data was not missing: it was so clearly inferrable that offering it would have spoiled the "style" of the presentation.

help explain and address the Chief Complaint -- is not sufficient. Relevant data are also those details which:

*you provide so that "your listener [can] include this in their preliminary thoughts as you present" (Keenan)
*help the listener understand "what diagnoses you consider most likely" (Cooke)
*will "keep your listener awake" (Keenan)
*make up the medical "story of the patient's illness" (Keenan)
*a "consultant" or listener "should have no further questions" about (Haber)
*"keep your listener on the right track" (attending)

These statements suggest that relevance is related not only to the diagnosis itself but also to the communication of a diagnostic argument or "story" to a medical audience and, thus, to the organizational structure of medical work (Atkinson, *Medical Talk* 49-59). In relation to this goal of communication then, relevant data are details that help your listener process the case, that "[lead] [the] listener down a path to the diagnosis you have come to" (Keenan) so that the collective arbitration of this diagnosis may ensue.

As Atkinson claims, "within the spoken case narrative, . . . are inscribed socially and locally interpreted assumptions concerning the relevance of its contents" (*Medical Talk* 97). As my dual definition of the concept suggests, successful determinations of relevance depend on a

sense of the presentation's audience and its purpose, an aspect of the principle referred to only obliquely in teaching physicians' mentions of the "listener", "the audience", "the consultant", or the "colleagues" to whom the presentation is directed. Atkinson points out that ,

> in medical settings, the exercise of diagnostic decision-making may be the focus of interaction between house staff and their superiors, between teachers and their students, between medical and nursing professions, between clinicians and laboratory staff, between primary care teams and consulting specialists. (*Medical Talk* 52)

As a collective activity reflecting the organizational nature of medical practice (particularly in the hospital setting), diagnosis "may be assembled out of a plethora of decisions that are the outcomes of work in diverse settings" (Atkinson, *Medical Talk* 52). "Clinical decision-making", Atkinson notes, "is not the outcome of individual minds, operating in a social vacuum. It is not disinterested, therefore, and is as susceptible to shaping by social influences as any other knowledge" (54). Decisions about relevance, then, are rhetorical as well as biomedical, embedded in situations across multiple hospital sites and responsive to various medical audiences and purposes.

The findings of four analyses of medical discourse offer anecdotal evidence of how rhetorical factors influence the determination of relevance in oral presentations. Atkinson's discourse study of evidentials in oral presentations by haematology residents suggests that the rhetorical situation of presentations determines both the data presented and the attitude professed towards these data. In an oral presentation excerpt analysed by Atkinson, the resident recounts information not only about the patient's presenting illness and the medical actions taken in relation to that illness but also about the institutional situations in which medical work was undertaken, where, when, and by whom. For instance, the resident reports that the patient

> was seen at that time by Keith ah Chamberlain and ah they were concerned that there might be some sort of hypercoagulable state ah and they arranged for outpatient followup at which time he had an antithrombin three level which was done which was normal and then he was lost to followup. (0.4) Um The patient was discharged on coumarin and was being followed in vascular clinic um (0.2) In August of eighty four the coumarin was discontinued an' he was placed on aspirin and p(resantin) [sic] and reading their notes there was a suggestion that this caused a deterioration in the leg in the sense that it became more edematous an' perhaps the pulses in the leg were less

> palpable (0.4) Um it was sort of a gradual finding an' when he came in for his clinic appointment in um (0.8) September the feeling was that something was definitely going on in the leg. ("Rhetoric as a Skill" 123)

Given the professed medical preference for a closely manicured presentation of "facts", one might wonder that details of the physician's name, follow-up appointments, and "feelings" could be perceived as relevant by this resident's audience. But Atkinson explains that the inclusion of such material and the use of evidentials to convey the speaker's attitude towards these details, is acceptable because it has "the effect of encoding credibility within a medical division of labour" ("Rhetoric" 126).

Because the diagnostic process (even in a single hospital admission -- and Atkinson's example of multiple admissions further complicates things) is a collective one, deciding on relevant material for presentation necessary involves evaluating and judging the data collected from various sites of medical work. As Atkinson explains, in this collectivity,

> action and knowledge do not dovetail smoothly together to produce a seamless web of decision-making and action.

> Different specialists define their work and their interests in quite contrasting ways, and hence may define the clinical problem or problems they are addressing quite differently. (*Medical Talk* 56)

The consequence of such differences across medical subpopulations is that "the degree of trust put on a given piece of data in the patient's chart, or a piece of advice, or differential diagnosis, would depend very much on whose observation or opinion it was" and what specialty the individual belonged to (as some -- such as pathology -- are granted more prestige and reliability than others) (*Medical Talk* 57).

We might say, then, that these "professional" references to the sites and agents of medical work consitute relevant data because they form what Atkinson calls "a rhetoric of competence and credence" ("Rhetoric" 128) that enables collective medical decision-making to function smoothly. Atkinson's suggestion that "the [medical] narrative itself is no mere chronicle of events and facts . . . [that] it includes threads of responsibility, culpability and judgement" (*Medical Talk* 121) illustrates the importance of a rhetorical definition of relevance, since the bases for determining the relevance of data apparently extend beyond

the patient-centred goal of diagnosis and towards physician-centred goals of distributing professional responsibility, estimating professional competence and negotiating professional relationships.

Arluke's sociological study of the presentation of cases on Morbidity and Mortality Rounds supports an expansion of the definition of relevance to include these inter-professional factors. Testing his hypothesis that the presentation of "failed" cases (those which ended in the patient's death) might offer a context for the medical community to self-evaluate and explore its professional assumptions and practices, Arluke finds instead that "death rounds" presentations protect against just such self-evaluation by selecting as relevant patient data that direct attention to the course of the disease rather than to the issue of 'failed' medicine. For example, the resident in Arluke's study

> uses test results sparingly, but selectively, creating a rising crescendo of medical events that ends dramatically with the patient's death, 'even though we did everything we could for the patient'. The image created by the presentation is of a patient who has been 'run through' all the usual procedures, thereby demonstrating that the medical staff has

> done its job, sufficiently for all practical purposes . . . death could not have been avoided. (112)

What is relevant material for presentation in this context is, clearly, somewhat different than what is relevant for the student presentation on work rounds. Arluke suggests that what motivates the determination of relevant material for presentation on death rounds is the goal of "effectively [diffusing] the importance of death" and redirecting attention to "the clinical complexity of the case" (122). His example demonstrates vividly the motivatedness of relevance, strengthening the premise (put forward in Chapter Three) that this is not an objective, "scientific" principle despite the lack of contextual, procedural explication in UCSF teaching discourse which sustains this impression.

The contingent nature of relevance is also suggested by the findings of two analyses of the language used to "argue" the case presentation, one authored by a practicing physician (Donnelly) and the other by a medical sociologist (Anspach). While neither Donnelly nor Anspach address the issue of relevance explicitly, their exploration of the presentations' discursive features further our understanding of what constitutes relevant data in oral presentations and what

motivates its determination.

Both Donnelly and Anspach find that "objective" data (data gathered by medical means) further the argument towards diagnosis and are included in presentations; "subjective" data (patient testimony), when included, are uniquely characterized to mark their lesser "quality." Donnelly finds that physicians use "rhetorical devices that repetitively and nonreflectively enhance the credibility of physicians and laboratory data and cast doubt on the reliability of patient testimony" (1045). While physicians "note", "observe", or "find" and technology "shows" or "reveals" -- all "scientific revelations independent of interpretation" (Donnelly 1045), the patient "says", "reports", "states", "claims" or "denies." Anspach argues that such "account markers" "signal that we have left the realm of fact and have entered the realm of the subjective account" (368). Both authors draw particular attention to the marker "denies", as especially revealing of the status of patient data in the case argument. Donnelly suggests that the term implies that a negative response to an interviewer's query may be untruthful"[53]

---

[53] Donnelly explains the function of this usage as, partly, "the way in which a junior member of a medical team assures

(Donnelly 1045); Anspach notes the term's use in relation to "deviant habits" such as smoking or drug use (368) and suggests that it may have a "self-protective function" for physicians (368).

Additionally, both studies comment on the use of the agentless passive (also noted by Segal "Writing") to give physicians' observations an objective status, as in the claim "The spleen was palpable" rather than "I [or Dr. Jones] palpated the spleen" (Donnelly 1045). These and other features suggest that patient data are "marked" grammatically to signal relative levels of relevance in a presentation, so that inclusion of material is revealed as a insufficient factor in the speaker's communication (or the listener's interpretation) of relevance decisions. Atkinson ("Rhetoric"; *Medical Talk*) finds that such account marking

---

his or her superiors that he or she has in fact asked the patient about potentially related symptoms or habits" (1047). But the usage has permeated the discourse and is used indiscriminately by all team members (though a few attendings demonstrated vehement resistance to this linguistic habit -- one commented to me that "It sounds like you took [the patient] outside and beat him but he still wouldn't admit to the symptom you were looking for"). Donnelly concludes that its student function does not provide "a compelling reason to continue a practice that casts the physician as prosecutor and the patient as defendant" (1047).

serves to similarly code professional sources of data, so that even relevant biomedical information (that selected for presentation from medical sources) is conveyed as originating in different sources, "has different weight attached to it, and may be regarded as more or less warranted" (*Medical Talk* 127). "Relevance" is revealed by such findings as Atkinson's, Donnelly's and Anspach's to be highly complex, contextually situated, and subtly coded in presentation discourse.

Gathered together from primary and secondary sources of medical discourse, this assortment of relevance "sightings" begins to suggest what is ellided by the question-begging and assumed familiarity surrounding the issue in medical instruction. In their failure to secure the principle of relevance to presentation contexts or to articulate its application, Keenan's directions to "include sexual history ..., if significant" and Haber's instructions to include "summary of past hospitalizations ... if relevant" imply that such relevance decisions are self-evident, free of contextual influence, determined strictly by the logical process of finding a cause that explains the patient's present state (what Atkinson calls, citing Bursztajn et al., "the

reductionist or mechanistic" paradigm (112)).

That this implicature is false is demonstrated by the different applications of the principle by physicians such as Keenan and Haber, by the different forms of reasoning used by novice and expert clinicians to determine relevance, and by the professional motivations underlying applications of the principle in contexts such as Morbidity and Mortality rounds. By not articulating in their written and verbal instructions the relationship between relevance decisions and rhetorical situations and contexts, teaching physicians (perhaps inadvertantly) communicate to novice presenters the dominance and value of objective, cause-to-effect reasoning.

We might approach such invocations of relevance as illustrative of Burke's contention that "by basing one's statement on a censorial assumption without labelling it as such [--relevance is an objective principle and is always already known--], the speaker has an opportunity to *establish this very assumption* in the mind of his hearer" (*Rhetoric* 94, original emphasis). Establishing this assumption helps to define the position of the physician, and once observers

> agree to look from a particular perspective, [they] should be able to make approximately the same observations.

> If we have shared interests/purposes, if we develop shared terms and methods--in short, a shared orientation--we can have shared perceptions, interpretations, and attitudes; we can then agree on what is obvious, what is common sense, and what should be done in particular situations. (Coe, "Burke's Act" 7)

This shared orientation is an important rhetorical feature of "the politics of cohesion within the medical profession" (Segal, "Writing" 89) since, as Segal and Starr agree, the authority of physicians is not individual authority but located within the profession itself, a "collective authority embodied in individuals" (Segal, "Writing" 89).

The assumption of familiarity with relevance may be understood as a rhetorical tactic for defining and consolidating the medical community's position as observer of medical conditions in patients. Since, as Einstein asserted, everything is relative to the position of the observer (qtd. in Coe, "Burke's Act" 7), the collective scientific ethos to which clinical medicine subscribes is protected when medical observers share an "orientation." And yet, as many examples show, within this medical orientation co-exist a number of approaches to relevance which are shaped by the rhetorical situation and the motives of the speaker in relation to that

situation. As Atkinson finds, the socially organized discursive exchanges that house and shape determinations of relevance "fracture the spatial and temporal frames implied by most decision-making models" (*Medical Talk* 58).

Students need to understand the flexibility of relevance and its relation to diverse social contexts in order to both reason appropriately across a variety of medical situations and communicate that reasoning effectively to diverse medical audiences. This flexibility is demonstrated in the following list of factors that articulates the rhetorical operations of relevance in the teaching hospital. The relevance of data is determined with reference to:

*the background knowledge of the audience

* the organization of medical work, including
a) the assigning of responsibility,
b) the determination of credibility, and
c) the negotiation of relationships

*the occasion of the presentation (e.g., attending rounds, death rounds)

*the tasks for which the audience will use the information (e.g., the attending will use it to formally evaluate the student, whereas a specialty consultation audience will not).

Awareness of the combination of medical and rhetorical features that form the principle of relevance may better

equip student presenters to successfully meet the expectations of their professional audiences.

CHAPTER FIVE
Some Pedagogical and Political Implications of Genre Acquisition

Genre Acquisition, Explicit Instruction, and Tacit Learning

Throughout this study, my focus has been on how the novice physician learns the generic features of presentation discourse and how this learning is a form of socialization, acculturating the student to the shared attitudes and interests of the medical community. In this final chapter, I will explore the issue of genre acquisition through the lens of two representative student presentations, considering three central pedagogical questions that continue to fascinate genre researchers. These questions are: "How are genres learned?" "How can they best be taught?" and, to invoke Coe's pivotal query ("The Rhetoric" Note 6), "Are students of a genre *empowered by* or *subjected to* the generic strategies that are passed on to them?"

Before introducing two extended representative anecdotes from hospital rounds, let me summarize the current debate about teaching and learning genres. With the reconceptualization of genres as "typified rhetorical actions based in recurrent situations" (Miller, "Genre" 24) and the

concurrent approach to structural regularities as "socially recognized, repeated strateg[ies] for achieving similar goals in situations socially perceived as being similar" (Bazerman, *Shaping* 62), genre theorists and writing instructors have come to be concerned with how genres are learned and how to teach them. This concern is not just about effective classroom instruction. As Miller points out, "for the student, genres serve as keys to understanding how to participate in the actions of a community" ("Genre" 39). Similarly, Coe directs our attention to "the political and ethical implications of the rhetorical situation constructed, persona embodied, audience invoked and context of situation assumed by a particular genre" ("The Rhetoric" 186). Because of its socio-political dimension, genre studies is regarded by Freedman and Medway as allowing instructors "to see [their] work in the teaching of writing as contributing to an emancipatory *social* agenda" ("Locating" 2).

With such a mandate, it is no wonder that the debate about teaching and learning genres has been, at times, impassioned. Of most relevance to this study is Freedman's argument against explicit genre instruction, in which she

presents a counterstatement to the Sydney School's programme of social emancipation through explicit instruction in 'privileged' genres.

Freedman summarizes the Sydney School's "politically motivated project of genre education" (191) as an intervention with economically and culturally disadvantaged students. This intervention is designed to teach students the privileged genres of society (believed to be predominantly the scientific and social scientific genres) so that they can "gain access to the corridors of power" (191). Leaving the political premises of the argument in the hands of Luke's critique[54], Freedman embarks on an "[interrogation

---

[54] Luke argues that the genre-based model of literacy pedagogy lacks "a rigorous sociological analysis" that could inform teachers and teacher educators about "what kinds of textual performances and knowledges are 'empowering' for particular clientele, and, more significantly, of how the transmission of these performances and knowledge fits a larger educational project of political and economic change" (309). The genre-based pedagogy, he explains (citing Lee), "may lend itself to an uncritical reproduction of discipline" (314). In his argument, Luke is distinguishing between two notions of empowerment: the power associated with being able to successfully wield a genre that gains one entrance to an elite discourse community and the power associated with being able to question and change that community's status quo. Drawing on Bourdieu's theory of linguistic capital, Luke argues that "what is needed is a pedagogy which goes far beyond the transmission of genres, and offers social and cultural strategies for analysing and engaging with the conversion of

of] the educational assumptions of the Sydney School movement: that explicit teaching of genre can in fact lead to its acquisition" (193). Her central queries -- Is explicit teaching necessary? Possible? Useful? If so, when and by whom? -- and their negative counterparts -- Can explicit teaching be harmful? If so, when and by whom? (193) -- provide a useful critical vantage point from which to explore medical clerkship instruction in oral presentations. Freedman's claims -- that explicit teaching is largely unnecessary (195-6), rarely possible (197-8), potentially harmful (199), and, if to be employed with any success, necessarily secured to the contexts of generic practice (205) -- can be measured against the student clerkship in order to explore the theorized tension between tacit learning and explicit teaching.

An explanation is required for my implicit assertion that feedback on rounds can be considered "explicit teaching" in Freedman's sense. Freedman likely intends the term to refer to the sort of classroom instruction in procedural genre rules that Business or Engineering students encounter

---

capital in various cultural fields" (332).

in their required communications courses. Clerkship instruction differs from this model in its situation (it occurs inside the workplace) and its content (its step-by-step explicitness is variable). Medical students highly value feedback instruction, moreso than the written material examined in Chapters Three and Four, and, while written documents are not required for presentation instruction in the clerkship, verbal feedback is. Rounds feedback is, therefore, the most predominant and valued method of teaching presentation skills. For many attending and resident physicians, the sort of feedback examined in this chapter is considered the ideal form of presentation instruction and is *intended* as explicit guidance in how to compose and deliver cases orally.

The clerkship setting presents a complicated interface between the explicit instruction of the schoolroom and the implicit learning of the workplace. I refer to clerkship feedback as "explicit instruction" in order to connect to Freedman's discussion and to suggest how the clerkship situation complicates both the explicit teaching/implicit learning opposition and Freedman's suggested resolution.

Explicit Genre Instruction on Rounds

Students learn the "form" of the oral patient presentation in the first and second years of medical school. This instruction is distributed in a preceptor system where students are assigned in small groups to teaching faculty who, ideally, offer feedback on the presentation of mock cases.[55] Additionally, classes in disease processes often follow a "presentation" format for the lecture, presenting a mock case as a puzzle to be solved by the class.

During the third- and fourth-year clerkships, students must adapt the form learned in school to the exigencies of the hospital setting. Most do not do so easily. Whether the presentation is for morning rounds on the hospital floor or for attending rounds in a physician's office, whether morning

---

[55] My interview subjects did not uniformly confirm that this system *actually* functions in this way, which may only suggest that they do not *percieve* their instruction in this way. Most claimed that the oral presentation instruction in their preceptor arrangements had been sporadic and minimal. One admitted, "I don't actually, really I don't think I remember any definite kind of experience"; another characterized the instruction as "not much at all" (Interviews). Many referred to the amalgamation of instruction in interview techniques and presentation techniques, some consequences of which this chapter will consider in detail.

rounds involve 6 patients or 16, whether the patient is in critical condition in the Intensive Care Unit or resting comfortably on the regular unit -- such factors should influence the nature of the presentation. Yet student clerks struggle to relinquish the rigid presentation *form* acquired in school in spite of its inappropriateness to these shifting situations. A gap exists between their formalized understanding of the presentation and its required flexibility.

This chapter asks, Is this gap bridged by the "explicit" presentation instruction offered by residents and attendings on rounds? Or is this instruction "harmful" in Freedman's sense of explicit teaching that "[prevents] ... students from enacting what they know tacitly" (199)? And if this instruction were more explicit, could the gap be more effectively bridged? Two anecdotes selected from my observations of morning rounds will provide the basis of this chapter's exploration of the gap between structural and strategic understandings of the presentation and the impact of explicit feedback on students' ability to wield the genre effectively in the community of practice. I have chosen these particular anecdotes because they illustrate the

clerkship process of genre acquisition, which involves a cycle of trial-error-response-trial-error-response.

The first of these anecdotes is about John, a third-year student in his second day of the Medicine clerkship. His first case presentation was on a post-"long call" morning. The team had processed six new admissions since the previous day, bringing their total number of patients to fifteen. All of these patients needed to be presented and visited on work rounds and the "work" of their care started before attending rounds at 10am. In this anecdote, the contextual pressure of time shaped both the purpose of John's presentation and the expectations of his audience.

We came to John's patient about halfway through rounds, and we were running late. John's presentation began:

> Mr. Lee is a 47-year-old Samoan man with a 10-year history of "asthma" and a 6-year history of obstructive sleep apnea, who was brought to the Emergency Department with extreme shortness of breath and somnolence.

This characterization of the patient and his chief complaint was appropriately concise and satisfied the team's need to picture this person (not all members would have seen him) and priorize his problems. But the next

section of John's presentation (the HPI) was diffusely detailed: he included who found Mr. Lee in his short of breath state, what they tried to do to rouse him, and how this chronic difficulty breathing had restricted his daily activity.

The resident was shifting, checking his pager, rolling his eyes. Sometimes in this situation he would walk into the patient's room mid-sentence, leaving the student to scurry in after him. But today he interrupted: "We can formally present him at attending [rounds] -- just give a 'bullet' on him. Tell us why he came in, what's key in his history -- you know." The student apologized, embarrassed, and began to read his notes more quickly. He offered information such as the patient's last employment two years ago as a "shipyard worker", his living arrangements with sisters in the city, his multiple medications and dosage amounts.

In effect, John responded to the request for a shorter presentation not by editing information but by simply talking faster, trying to present the same amount of detail in a shorter time -- the oral equivalent of narrowing the margins instead of editing the paper. At

some level he recognized that he was being asked to priorize and select data, but he told me afterwards that he was not sure *what* to select or *how to know what's more important* (Fieldnotes). Unable to modify his sense of relevance to accommodate the resident's demands, he resorted to speed-reading rather than risk leaving out critical information.

Most students respond inappropriately to instructions about the case presentation because they have misinterpreted the rhetorical motive behind the resident's requests. When the resident interrupts to redirect for "pertinent positives only -- I'll ask for the negatives if I want them", or interjects with the pointed question, "So what do you think she's got?", students often interpret this as an aspect of the resident's mood or style. John reported to me after his presentation, "I had no business going on so long -- he [the resident] wasn't into it." He has learned to speed up, but he is not sure *why* he should except that maybe the resident wants to get home.

The point, however, was not that the resident had been on shift all night but what he had been doing while

on shift. He had already seen the patient that morning, knew all the recent statistics, and needed to get to the pressing issue of how his care would be managed today. This was the intended rhetorical information about audience, purpose and occasion contained in the request for "Just a bullet." However, the constraints of the work rounds situation and the tacit nature of the resident's genre knowledge shaped this rhetorical advice into a cryptic "one-liner."

At attending rounds later that morning, John implemented his newfound knowledge about conciseness. John's editing included deleting the introductory sentence that summarizes the patient's social profile, excluding most of the medical history, skipping the physical exam report altogether, and moving straight into the Problem/Plan list. But the attending interrupted him: "Back up! I want to hear the history, I need to know what's going on here!" (Fieldnotes).

John's revision was unsuccessful because he had not adjusted his sense of situation to account for the change in audience, purpose, and occasion. The attending, unlike the resident, had not seen these patients that day: he had

just arrived at the hospital. In order to supervise the care of the new patients, he needed a full report on their case. And in order to evaluate John's progress in this case, he needed the student to represent his clinical reasoning through his presentation. But neither of these exigencies were articulated, and John left attending rounds looking frustrated.

In many ways, John's clerkship experience appears to offer the sort of contextualized, authentic genre instruction that genre theorists such as Freedman advocate. Freedman advises that "the teaching [of genre] must always be done either in the context of, or in very close proximity to, authentic tasks involving the relevant discourse" (205; see also Hunt 247). The argument for learning genre by authentic experience is a key component of Freedman's hypothesis that explicit learning is unnecessary. Such experience nourishes the implicit, procedural genre knowledge that cannot, Freedman argues, be effectively formulated by teachers (or accessed by learners) as "rules."

As an apprenticeship in which students participate in

guided yet authentic ways in the practice of medicine, the student clerkship provides a context for realizing the social action of the oral presentation. That is, it appears to embody what Freedman recommends -- situated, implicit learning. And yet, despite fulfilling these qualifications for successful genre instruction, aspects of John's story call to mind some of the dangers of explicit teaching that Freedman outlines.

Some of these dangers rest with the nature of the instruction and the instructor's relation to the genre. Freedman insists that, in order for genre instruction to be at all successful (and she limits the conditions under which such instruction might have a positive impact on students), the teachers "must be in possession of accurate formulations of the genre elicited" (206). And these accurate formulations must be conscious -- that is, teachers must be able to articulate them. The resident and attending physician ought to be in possession of such "accurate formulations" of the oral presentation; they are, after all, experts in this discourse. But, as we considered in Chapter Four, much of their knowledge may well be tacit: thus, the explicit instructions that they

provide to student presenters may reflect but not articulate this wealth of tacit, experiential knowledge about how presentations work.

Student presenters receive kernels of wisdom which have often been unmoored from the situations and experiences that they represent. "Just the positives", they're told. Or, "Do the ROS [review of systems] in order." And, "Keep the past out of the HPI -- don't mix things up" (Fieldnotes). Something in the present situation summons these comments to the instructor's mind, but such quips betray neither past rhetorical origins nor present rhetorical intentions.

At a mid-point in this study, as I analysed the material gathered during the 1996 observations, I hypothesized that part of the difficulty with genre instruction in this site was the *intent* of the instruction. From the feedback quips offered on rounds, it appeared as though supervising physicians were offering advice about structure and form, advice which was encouraging students to develop an acontextual appreciation of the presentation genre. However, upon

interviewing residents and attendings in 1998, I began to realize that these abbreviated instructions were motivated as often as not by rhetorical issues and were meant to communicate the influence of contextual factors on the genre. Whether one offers "positives" alone or negatives also may be related to the audience of the presentation and its purpose and occasion. Review of systems material is presented in a particular order to facilitate the audience's memory and cumulative reasoning; bringing the "past" into the HPI in acute-care medical practice is, as I have argued earlier, as much an ideological issue as a structural one.

Because interview responses demonstrated physicians' unequivocally rhetorical sense of the oral presentation, I began to investigate the explicit genre instruction offered on rounds as an instance of the problematic translation of tacit knowledge. Investigating what feedback was intended to accomplish, how it was interpreted by students, and the consequences of slippage between the intent and the interpretation, I began to sense particular difficulties with the nature of explicit genre instruction in the clerkship situation.

In their study of how students learn a discipline's generic conventions of background knowledge, Janet Giltrow and Michelle Valiquette provide insight into the problems that can arise when experts try to articulate their genre knowledge to novices. Invoking Giddens, they explain that an expert's knowledge consists of

> both "practical consciousness" -- implicit in daily practice, including individuals' monitoring of their own and others' conduct -- and "discursive consciousness" -- what they would *say* if asked for the reasons for what they are doing. The relations between these domains of knowledge is somewhat oblique and not unproblematic . . . much tacit knowledge is not directly accessible to discursive consciousness . . . [and] practical consciousness is not exhaustively constituted by propositional beliefs. (48)

When an expert summons practical knowledge to discursive consciousness she may not achieve full "disclosure"; as Giltrow and Valiquette argue, "discursive consciousness can suppress or even distort elements of practical consciousness" (48).

Giltrow and Valiquette's description of the relationship between practical and discursive knowledge echoes Freedman's opposition between implicit and explicit

knowledge, and directs attention to the (implicit) importance -- and the problematics -- of "articulation" in Freedman's argument. Freedman's Restricted Hypothesis concedes that explicit teaching

> is unnecessary, but is at least possible by those teachers who are in possession of accurate formulations of the genre elicited. Such explication may be useful, but only for students with the appropriate learning style, and at the appropriate level of development, and only during the process of composing, broadly conceived. At the same time, explicit teaching may be dangerous, if the instructor is an outsider or alternatively is an insider with inaccurate representations of the genre . . . . (206)

Not only must the teacher be in possession of "accurate" formulations, she must also be in possession of accurate *articulated* formulations, an attribute which Giltrow and Valiquette's study reveals as distinct and perhaps less likely.

In the clerkship site, even teachers who have insider and accurate knowledge of a genre may provide problematic instruction as a result of the tacit nature of their expert genre knowledge and the "distortions" and "suppressions" which may accompany translation of this

knowledge. That is, while residents' and attendings' tacit genre knowledge is accurate, their attempts to render that knowledge explicit in feedback may be, at worst, inaccurate and, at best, abstract and easily misinterpreted. As Giltrow and Valiquette's think-aloud protocols revealed, "in the transfer to discursive consciousness, practical know-how [loses] something" (50). In physicians' feedback, this "something" is the rhetorical nuances which as expert presenters they clearly understand but do not effectively articulate.

The medical clerkship suggests something else about the complexities of genre instruction. For although the clerkship provides an authentic context for genre learning, the very authenticity of the context may pose problems for instruction, as the priority of medical care leads to highly abbreviated instruction that is prone to "rules of thumb" and to condensed bits of advice that can be offered -- and swallowed -- quickly.

John's story suggests that when students receive directions about the form of their patient presentations, implicit in those directions is a sense of rhetorical

exigency, of contextual pressures. Feedback offers information about the audience's needs, the purpose of the presentation, and the importance of the occasion. But this rhetorical content of presentation feedback is cloaked and stifled, often packed into memorable "one-liners" that give little hint of their contextual origins or situational significance.

Students, not surprisingly, may overlook such rhetorical elements, perhaps as a result of their poor packaging and perhaps because students have perceived the evaluative component of the exigency without fully considering its communicative component. They interpret feedback as a signal of how well they are doing in terms of the resident's or attending's academic evaluation of their presentation, rather than interpreting it as a signal of how functional their communication is for the medical situation. Their difficulty recognizing and using the rhetorical information contained in feedback creates for students a frustrating cycle of trial and error in their early clerkship presentations that they perceive as a "rite of passage."

Genre as Structure, Genre as Strategy: The Gap

John's story is typical of students' difficulties in their early presentations, and represents the problems that may arise in the cycle of trial, error, feedback, interpretation, and application/re-trial. In many instances, the explicit genre feedback from residents is interpreted acontextually by students, creating a sort of slippage that plagues the first weeks of the clerkship experience. Some students more readily overcome it, while others struggle throughout their clerkships to revise in ways that satisfy their instructors.

As earlier chapters in this study have suggested, students may have little sense of how to select and arrange the abundance of medical data gleaned from each patient, and they look to the formal structure of the presentation to guide them. This is the origin of the "gap," the distance between seeing the presentation as a *form* and seeing it as a *genre*, a social strategy. It is no accident that students approach the presentation structurally; this is a learned perspective.

When I asked students to tell me how they had learned

to present, most referred back to their Clinical Medicine course which taught them how to interview and examine patients. In the patient interview and exam, students follow a set of questions: they inquire about the chief complaint, the history of the present illness, the past medical history, the social and family history, and so on through the review of body systems and the physical examination. Structurally, these forms (patient interview 'script', physical examination checklist, and oral presentation format) are, to varying degrees, similar. Rhetorically, they are not. The interview script and exam checklist facilitate particular sorts of physician/patient discourse, while the presentation format facilitates physician/physician discourse. But, having learned it in the interview and exam setting, students largely perceive the presentation form as yet another system for gathering medical data and storing them in a particular arrangement.

Difficulties arise when this schoolroom perception of the form as a gathering and storing mechanism is extended to the clerkship's oral presentation contexts. Consider the following example. When I presented students with an unorganized transcript of John's presentation of Mr. Lee

(Appendix D), asked them to arrange it as they would for an oral presentation, and then questioned their organization decisions by offering alternative positions for material, some students responded by telling me what the rules were about the order of elements in the presentation structure. One insisted, "That [moving information about depression from the Social History section into the History of the Present Illness section] would be wrong: it's social, it's one of the social questions" and pulled out of his pocket the long list of questions to demonstrate; another said, "Well, you could, I mean I think I'd want to, but you might get in trouble. That's not where it's meant to go."

When asked whether an element of the Past Medical History could be moved into the History of the Presenting Illness, many students admitted confusion about the reasons for deciding between the sections.[56] Some resorted

---

[56] For instance, consider the following response to my inquiry about whether I could move the information about "10-year history of progressive dyspnea with exertion that has progressed to hypoxia at rest" from PMH (where the student had initially put it when he organized Passage A) to HPI: "Geez, I might actually, well I don't really know ... no, right, no I don't know, that's what I'm trying to figure out, where would

to defining their selection in terms of section headings. One explained his choice to leave chronic elements in the PMH by arguing: "Well, it's 'Past' or it's 'Present', isn't it? His chronic venous stasis and non-healing ulcers are in the past -- I mean he's got them now but he had them already, so it's past, not present."

These explanations of content and organization demonstrate a structural, formalized understanding of the genre, generated by explicit instruction in the structural features of interviews and presentations and enforced by 'props' and 'models' such as the laminated pocket cards students may carry which outline the order of interview questions. Yet students' responses to my interview

---

I put it? I would ... well, I don't know if I would be, I wouldn't be really adamant [about not moving it to HPI] ...well, I'd say no, don't move it because I think it definitely bears on some of the same type of things that we're worried about with him. I guess my hesitation would be, like I'm not so sure how ... " (Interviews). Interestingly, while this student put the dyspnea and the hypoxia in the PMH when I interviewed him in the first week of the clerkship and then struggled to respond to my question about whether it could go in the HPI, in the questionnaire filled out in the last week of the clerkship he put the dyspnea in the PMH and the hypoxia in the HPI. In future research, it might be useful to have a way of asking students about such progressions in their organization strategies, in order to determine what informs such changes.

questions about the "goal" of the presentation were often rhetorical. On work rounds, many perceive the goal as communication about the patient's state and contributing to care decisions, whereas on attending rounds the evaluative goal is emphasized. So students may recognize a communicative goal, yet approach the content arhetorically. When asked about learning and delivering orals, they lapsed into reciting the patient interview and physical examination questions, suggesting that their drafting of the presentation is guided by the mechanisms used to gather and store patient data. The re-presentation of this material for communicative (rhetorical) purposes slides into the background.[57]

---

[57] In her discussion of such apparent conflicts in students' genre understanding, Freedman invokes the distinction between "learning" and "acquisition" and cites Ellis and Krashen's theory of "non-interface" between learners' "explicit knowledge" (which is "conscious and declarative" and "allows the learner to specify features and rules") and "implicit knowledge" (which is "unconscious and procedural") (204). Ellis and Krashen's hypothesis that these two types of knowledge do not interact may help to explain how students' responses can be sometimes rule-based and sometimes rhetorical. In my interviews, this difference seemed dependent at least in part on the phrasing of the question and whether students' attention was directed to the presentation's structural features or its performance.

In contrast to students' conflicted descriptions of the oral presentation, physicians' descriptions of the genre are clearly rhetorical. When asked to describe the presentation's primary purpose, all agreed that it is "communication among doctors." They describe it as "the way we talk to each other" and stress that a good presentation "tells a story: it's both an argument and a narrative" (Interview).

When asked whether there were any "golden rules" for giving presentations, all the physicians referred, not surprisingly, to the need for conciseness and focus. But they characterized this need rhetorically: "You need to tell your listeners everything they need to know to treat the patient and nothing more" (Interview). One attending, explaining to his students his expectations, summed it up this way: "You can't be too brief for me unless you don't tell me what I want to know -- above all, tell me what I want to know" (Fieldnotes).

Of course, students may struggle to determine what the attending "wants to know." In part, they lack the pathophysiological knowledge -- what Irby calls the "illness scripts" -- that would tell them which data are

relevant to diagnosis and treatment in a given case. As John Swales suggests, "the acquisition of genre skills depends on previous knowledge of the world, giving rise to *content schemata*, knowledge of prior texts, giving rise to *formal schemata*, and experience with appropriate tasks" (9-10, emphasis in original). Students' understanding of the presentation's formal schemata, unbalanced by both content schemata and what I will call *rhetorical schemata* (knowledge of audiences, purposes, and occasions) intensifies their difficulty. It directs their attention to structural features rather than communicative purpose, which Swales understands as "[driving] the language activities of the discourse community" (10).

Of students' tendency to focus on structure to the exclusion of rhetoric, one attending explained that,

> if you give them section headings, they'll always put something under them, even if all the information we need is really contained in the first two sections of the presentation. They'll fill the written form and then present from it. (Interviews)

Another says: "They forget about communication, who they're talking to and what that person needs and just

present masses of information till you can't see the forest for the trees" (Interviews). Swales attributes such misuse of generic forms to their being learned as "formulae" (16) and Freedman warns that the explicit teaching of forms *as forms* may "prevent students from enacting what they know tacitly" (199). What these students know tacitly is that this is how doctors talk to one another, how they construct and communicate medical information. On rounds, students experience and, at some level, understand the occasion and the "need to mean" to which the presentation responds (Freedman 201). However, in their determination to follow correctly all the structural rules of presentations, they lose sight of this bigger picture, hanging onto the formal schemata because they feel sure of these.

When I asked attendings what introductory advice they offered their new student clerks about the presentation, most identified the structure as important, reporting that the presentation "follows a very standardized, very rote prescription because that's a way in which people can sort this data as it comes towards them, so they know how to use it." The structural regulations have meaning for

physicians, however, not as structures per se but as socially recognized, recurring strategies for achieving the diagnostic and therapeutic goals of communication about patients.

Physicians see the genre as the basis of their expectations about how medical data will be passed among professionals, and when the form is violated they are not, as one student assumed, "frustrated because you did the order wrong" (Interview). Their frustration arises because, by changing the expected order of data, a student directs the audience's attention differently. This directing of the attention may suggest a different message to the listener, disorienting her by throwing her developing pattern recognitions into disarray. Physicians need to act on the information presented, and how it is presented affects the range of acts that they consider. Because of this, they approach the patient presentation not only as a form to follow but also as a strategy for getting things done in the hospital setting.[58]

---

[58] There was a noticeable difference in the level of rhetorical awareness between students observed at the start of their third clerkship (Oct./Nov. 1996) and those observed at

Teaching the presentation as a strategy is a difficult business in the clerkship context. Freedman's references to "pushed output" (Swain, cited in Freedman 201) and "scaffolding" (Bruner and Cazden, cited in Freedman 201) echo Lave and Wenger's legitimate peripheral participation theory, as she suggests that such instruction is achieved by "cooperative interaction over the work-in-progress, with the teacher probing and responding tactfully where necessary, and giving over more and more responsibility to the learner as the learning progresses" (Freedman 201-2). But, as I have explained, the nature of the clerkship context -- its frantic pace, high stakes, and competing purposes of medical practice and medical training -- constrains such instructive

---

the start of their fourth (Jan. 1998). The latter group, with the experience of more contexts, had a greater sense of the form as a strategy and of its required flexibility. One response to my interview question about whether the presentation changes in different circumstances was: "for instance in surgery you would stress past surgical history which I would never have written in psychiatry, versus in psychiatry you write past psychiatric history and you know, you deal more with the social aspects as well as the physiological aspects in your HPI . . . and neurology you stress certain parts ... like the neural exam, mental status, cranial nerves ... versus in surgery if they're alert and oriented that's all they want to know."

cooperation. Importantly, the examples to which Freedman refers occur in a classroom situation, where no such conflict of interests constrains the teacher's potential teaching strategies. In fact, one of the greatest challenges of classroom genre instruction is providing 'authentic' tasks to frame genre learning. In the clerkship, by contrast, the challenge is to make room for effective instruction in the crowded time and space of authentic tasks.[59]

Physicians generally believe that more medical knowledge -- familiarity with *content* -- will improve student presentations. One explained to me that "when they've seen more medicine, they'll know what goes where." This is certainly true: the more disease they encounter, the better equipped students will be to determine

---

[59] Of course, explicit instruction is not a necessary component of an apprenticeship. Lave and Wenger cite Jordan's study of Yucatec midwives as an instance where "apprenticehip happens as a way of, and in the course of, daily life. It may not be recognized as a teaching effort at all." In fact, novices grow into the profession and "absorb the essence of midwifery practice . . . [including] what kinds of stories" are told by the men and women who seek the midwife's aid and the "stories of difficult cases, miraculous outcomes, and the like" (68) that are told by expert midwives.

relevance. But more than just medical sophistication is required to present successfully. Rhetorical sophistication is necessary too.

The importance of rhetorical awareness is reflected in physicians' responses to my interview inquiry, "Are there any golden rules for giving presentations?" One resident replied,

> It's such a fluid- and patient- and time- and situation- dependent activity and skill that, other than always keeping in mind your audience and, you know, tailoring your presentation with that in mind, I don't think there's anything.

Another comments, more cynically but still rhetorically,

> The one golden rule that I think is [sic] to find out what the person you are presenting to wants before you go and present. That's the big golden rule because, otherwise, you are definitely going to make a mistake.

Interestingly, when I interviewed students in their first week of the clerkship, most offered "golden rules" such as, "Keep it short", "Don't add extraneous material", and "Be concise." But on the End of Clerkship Questionnaire (Appendix F) when asked what tips they would give new students about delivering successful

presentations, half of the same students made comments such as "Ask the attending/resident what info to include right from the start", "Ask attendings/residents what order and what length they would like"[60] and "Ask of the people you'll be presenting [sic] explicitly what they need/want/prefer to hear" (emphasis in original). While this small sample of students cannot offer generalizable conclusions, their responses suggest that, however well understood, the power of the audience is quickly realized. This shift suggests that the students recognize, to some degree at least, that an issue such as "extraneous

---

[60] This student, who recommends asking the audience "what order . . . they would like", asserts in response to Question 1, "What is the accepted order of sections in the oral presentation? Does it ever change?", that "order is essentially the same." What does this discrepancy mean? It would seem that on one level the student knows that the nature or needs of the audience can influence the discourse regulations about order; on another level, though, he retains his acontextual sense that rules are rules. The response to Question 1 by the group suggests a range of rhetorical consciousness after the 8-week clerkship rotation. Three students claim that the order can change and give contextual reasons such as "It changes after first presentation when often [sic] simply integrate all sections to problem list format" or "It changes when the whole team is familiar with patient on work rounds." Two students do not respond to the inquiry about change, two assert that it "does not change" and one warns, "Not a good idea."

material" may be judged by the listener.

As I have suggested, students sense the element of rhetorical savvy required to negotiate the presentation structure successfully. One clerk commented that,

> you know, the hardest thing about this is that there is this very rigorous form but the people who are really good at it don't use it -- they just converse. So there's this structure that we learn and that I'm using to present my patient but they want me to pop in and out of it--I guess to have all the details that following the structure implies, but then to play jazz with it, to ease in and out of it. But how do I know when it's okay to pop out? (Interview)

For this student, like many others, the "rules" about presenting are structural ones -- what to select for each section, what order the sections come in -- so it is not surprising that he cannot guess when it is acceptable to violate them. For physicians and for students more contextually aware, the "rules" are at least partly rhetorical; so that by considering the audience and purpose of different presentations, they can make decisions about which rules to bend in a given context.

This student's complaint draws attention to an important aspect of genres, which is the tension between

constraint and creativity inherent in them. As Bakhtin recognizes, a genre needs to be known intimately before its rules can be trespassed successfully ("Speech Genres" 80). Furthermore, such trespass is, according to Bakhtin, necessary if we are to control the genres we use rather than be controlled by them:

> the better our command of genres, the more freely we employ them, the more fully and clearly we reveal our own individuality in them (where this is possible and necessary), the more flexibly and precisely we reflect the unrepeatable situation of communication -- in a word, the more perfectly we implement our free speech plan (80).

Applied to the clerkship situation, where students rely heavily on masters and more senior apprentices as models for their own presentations, Bakhtin's point reveals a potential problem with genre acquisition by indwelling. For experts' presentations may offer misleading models to students if, as Swales suggests, experts' examples are "stylistically atypical" (129) because these speakers have already mastered the genre, asserted their credibility in

the community, and gained the right to "play jazz."[61]

Like the clerk who recognizes the "playing" that constitutes expert use of the presentation genre, medical students may sense (as do writing students in university contexts) the implicit value of originality. References to "personal preferences" abound in presentation discourse, and students recognize that their "style" contributes to how others perceive them.[62] But as the student's complaint -- "how do I know when it's okay to pop out?"-- reveals, successful (i.e., sanctioned) novelty is difficult for novice presenters to achieve.

As Freedman explains, appropriate "*novelty*" in novice discourse is governed by a "delicate and nuanced set of

---

[61] Bourdieu's discussion of "mastery" takes this point further, drawing attention to language as socio-political currency. He explains that "competence, which is acquired in a social context and through practice, is inseparable from the practical mastery of a usage of language and the practical mastery of situations in which this language is *socially acceptable*" (82). To be competent in the presentation genre, students will need to master the professional situations which give rise to it, as well as (indeed, as a part of) mastering the discourse itself. This sort of mastery, although Bourdieu does not use the term, is *rhetorical*.

[62] One student explained to me that he wanted to be a pediatrician and therefore made a conscious effort to include humor and "personality" in his presentations, "because that's what Peds docs are like" (Fieldnotes).

conventions" (198). Citing Kaufer and Geisler, she argues that these conventions constitute

> 'an insider's rhetoric' -- a set of *tacit beliefs* that *accrue* to one who actively tries (and mostly fails) in the role of knowledge maker . . . [The relevant] conventions are learned *only* in the effort to be new and in the feedback one receives for one's effort. (198, emphasis Freedman's)

According to this perspective, the trial and error system of clerkship presentations is a necessary requirement for genre acquisition. Particularly when instruction is cryptic and models are diverse and possibly atypical, students will need to learn the rhetorical schemata of this genre by trying, and failing, to respond to occasions, fulfill purposes, and satisfy audiences.

Kaufer and Geisler's depiction of *accrual* of tacit beliefs suggests a question not explicitly articulated in Freedman's discussion and one which is especially relevant when genre acquisition performs a gatekeeping function on the threshold of a professional community. We should also ask of the accrual of tacit generic conventions, "What tacit values accrue to the novice in this process?" and "Are these the values that medical educators intend to

pass on?" Such queries direct the attention to the ideological nature of the "accrual" process: the conventions learned through performance and feedback govern and transmit the shared values and interests of the community as well as its discursive resources.

Language as Symbolic Action

Understanding language as symbolic action allows us to see that being literate in a particular discourse means more than just shared discourse: it means shared values and shared goals. Thus, a misinterpretation of language can be a misinterpretation of values and of actions. The slippage between the intent of feedback instruction and its interpretation by students renders the clerkship's genre teaching not only inefficient but also politically problematic. For, as John's telescopic presentation on attending rounds suggests, students who perceive feedback arhetorically are likely to generalize from it and apply it arhetorically, across multiple contexts. A second representative anecdote facilitates an examination of how such generalizations can be said to have political implications.

Judy was another third-year student in her first week of the clerkship. She began her oral presentation by introducing "a 49 year-old man who presented to Emergency with the Chief Complaints of physical trauma to the head and alcohol withdrawal." Judy's presentation contained an abundance of social data. She reported that this man has been an alcoholic for many years. He is homosexual, and his physical trauma was inflicted by his partner during a domestic dispute. He is unemployed, and he lives with and is financially dependent on his partner. He has no family in the city; his family does not know that he is homosexual. The domestic abuse is a recurring aspect of his relationship (Fieldnotes).

The resident interrupted to give instruction:

> Just give me the social context stuff when it's warranted, when it's related to the presenting illness. I mean, all the social info is of course important for the patient, but in rounds it's not important except what's related to the chief complaint. Say something like, "social history, past history, family history are non-contributory except as I have already told you.(Fieldnotes)

Interestingly, while the student interpreted this feedback structurally as a rule about the treatment of social,

family, and past history data, she did seem to recognize the social action enacted by such formal structures. She understood that this formal revision carries directions about her medical relationship with this patient. As she told me in conversation after rounds, "Well yes, I mean if it's not going to affect how we manage their care right now on the ward, then it really doesn't belong in the presentation. It's not something we can change, the social part."

Judy's subsequent presentations on this patient focused on the treatment of the physical trauma and the alcohol withdrawal. Then, towards the end of the patient's hospital stay, her work rounds presentation of his case was interrupted. The resident wanted to know if she had thought about "disposition", that is, about the two issues of patient discharge: "how is the patient" and, therefore, "where is the patient going when s/he leaves here?" Judy's resident asked: "So is the guy going back home? There aren't many programs for abused men even in this town, are there? And his partner's been visiting him today -- what's our role here?" Judy was flustered. She had not come prepared to talk about social issues and

apparently had no response. I overheard her say to the other third-year student on the team as we moved down the hallway, "god, I wish he'd make up his mind."

When I interviewed physicians about the meaning of the comment, "Just give me the social context stuff when it's warranted, when it's related to the presenting illness," they all referred to contextual factors to explain it. Some agreed that this might sound questionable, "as though the social information isn't important in medicine," but they all suggested that if this comment was seen in context, it was appropriate. One attending physician explained that "the purpose of work rounds is to review what's happened right now and make a plan for that day, so a lot of the other information isn't really contributory to the decision process that's going on." A resident explained that

> a few things, like whether or not someone is homeless, and their other HIV risk factors such as habits and sexual preference, can be very important when you are trying to figure out what's wrong with a new patient. But much of the other social stuff doesn't contribute to our management of patients until their acute problems are stable and we start

> thinking about where we'll discharge them to, whether they'll be compliant with treatment regimens -- stuff that comes later.

In Judy's case, the student interpreted the feedback about social data as a formal "rule" about *whether* social data are allowed in the presentation--and *how much*, rather than as a comment on *when and why* social data are appropriate. Krashen, cited in Freedman, points to this very danger in the explicit transmission of abstracted "rules": such conscious learning, he warns, "can be misapplied by overanxious and insecure writers" (199). A danger of the commonly cryptic feedback offered by residents and attendings -- a consequence of time pressures and the conflict between patient care and student instruction in the teaching hospital -- is that students seeking "rules" to ease their presentation anxiety infer them quite readily from one-liners such as "Don't mix the past up with the present" or "Just the positives." And, having inferred such rules, they generalize from them. This tendency is not unique to medical students: Perl's study of basic writers at university found that such overgeneralization of rules was

not uncommon (qtd. in Freedman 206).

Judy's story suggests the political implications of such generalizations. For, having interpreted the message about social data acontextually, she then proceeded to apply it acontextually to other presentations at other points in the patient's treatment. Her generalization that social history is not important kept her from seeing that, although social issues were not central to the attempt to form an acute therapeutic plan for the patient, they would become the main issue of his "disposition" (with the consideration of issues such as where he will be discharged to and whether his compliance can be expected in treatment regimens). Even more seriously, there is the potential in this situation for Judy to make the false generalization that social data are *never* important in patient care.

Judy's case suggests vividly the implications of how the oral presentation genre is taught and learned. The resident leading Judy's team appears to be a caring, humane doctor. The attending physician stresses to his students the humanitarian philosophy of this county

hospital, famous for its AIDS Ward and its state-of-the-art treatment for an underprivileged, high-risk community. But in this case it seems that Judy's misinterpretation of feedback and her subsequent generalizations about the role of social data in medical treatment have worked against the passing on of these medical values. Judy relinquished responsibility for social issues entirely, not realizing that, although they were not central to the medical treatment of the patient, they would become the main issue of disposition. Her case suggests a tension between the values of "humanitarian care" that these medical educators *intend* to pass on and those enacted by the reception conditions of presentation feedback.

Genre and Subjectivity

When I asked students what it meant that their audiences differed in expectations about social data (for in my observations, this is one area of great variation), one student explained:

> some people just don't have an interest in people's social lives or what job they have it's just ... I

> don't know if it's because they don't have the time or if it's because they're just not interested ...so I think there's just that line between how medical you make things and how much of peoples' lives you bring in to it all.

While this response attributes such preferences to individual people and their time constraints or lack of interest, the distinction the student draws between "medical things" and "peoples' lives" is a dialectical one that suggests ideological undertones, a conflict running through the professional community.

The implicit value judgement internalized by this student tells her that it is not "medical" to be concerned about "peoples' lives," that this is extraneous to the duty of treating their physiological conditions. Yet actual presentations by interns, residents, and attendings vary in their inclusion of social data, influenced by rhetorical factors, such as the occasion of the presentation or what the presenter suspects is her listener's stand on the ideological issue of social data, and by individual preferences. Some attendings and residents do demonstrate closer attention to psycho-social

data in their own presentations and are more accepting of these details in others' presentations. That these are individual choices does not make them less ideological or less rhetorical; rather, it reveals that while there is a normative position of controlling attention to social data, individual physicians are finding ways to negotiate their relationship to this norm discursively.

What the student needs to know in order to successfully navigate the problem of social history is "the range of tolerance" of the presentation genre in instances such as this. Perhaps, as Green and Lee have found in their study of geography discourse, a student can depart from the conventional treatment of an issue in certain acceptable ways and still satisfy her audience's generic expectations (215). Green and Lee's research raises the issue of subject position in relation to genre, and their investigation of the rhetoric of school genres "is as much concerned with the formation of identities as the construction of texts" (208).

Preferring the term "subjectivity" over "socialisation" to describe the forming of individuals

into social subjects "through signifying practices" (218), Green and Lee seek

> to understand how subjects are positioned and position themselves in discursive-disciplinary fields, in and through their textual practice, and hence how specific social identities are constructed out of available cultural and semiotic resources. (219)

Using "the concept-metaphor of positioning," Green and Lee examine "the dynamic undecidability of the dialectical relationship between structure and agency" (219). Their study of student writing in Geography suggests the individual's ability to assume generic subject positions while maintaining personal integrity and satisfying alternative motives, even when those motives do not reflect the community's conventional interests.

Our earlier consideration of the HPI/PMH tension suggests one site where this "dynamic undecidability" is particularly close to the surface of presentation discourse, a site where a range of positions are visible in relation to medicine's traditional scientific rationality. The students I observed had not yet reached the stage of being able to manipulate the opportunity for

subject positioning offered by the causal tension surrounding HPI/PMH decisions, but they were beginning to recognize that more than structure was at stake in the manipulations of HPI and PMH in experts' presentations. Their very indecision about HPI/PMH choices and their fear that "you might get in trouble" for shifting the traditional order of material suggest their budding sense that agency is at stake here too.

Green and Lee understand such constraints in geography discourse from the perspective that

> to learn and succeed at Geography means learning how to take up an authoritative position within a particular scientific-rational discourse. It means to consent to (rather than to resist) the performance, display, and resultant (re)production of official curriculum versions of geographical facts and interpretations and their associated forms of textuality. It also necessarily means to suppress whatever does not fit into that category. (220)

According to Green and Lee, genres have inscribed in them subject positions that (re)produce a community's mandate and shared values. Students learning these genres will need to adopt the subject positions they offer in order to successfully negotiate the genres' gatekeeping functions.

However, in the writing of a particular geography student, Kathryn, Green and Lee find evidence of elbow room, space to manipulate the genre in order to achieve non-institutionalized goals.

The oral presentation offers such space as well. In fact, one of the benefits of the varied models that student clerks encounter during the clerkship is their representation of a range of subject positions in medical discourse. The social and family history portions of the presentation, as a site of dispute over medical presentations and the practice they construct, suggest additional opportunities for students to witness and experiment with subject positioning along "that line between how medical you make things and how much of peoples' lives you bring in to it all" (student interview). Comparison of the variations in the handling of social history data in a large corpus of presentations might allow a charting of the range of alternative formulations across a set of rhetorical contexts. Such a study might provide insight into how physicians "learn to adopt social motives as ways of satisfying private

intentions through rhetorical action" (Miller, "Genre" 36); additionally, such research might produce a set of cases students could consult for acceptable strategies of contestation within medicine's generic forms.

Seeing how other presenters handle generic issues such as the designation of data as "present" or "past" or the placement and emphasis of social history offers students a demonstration of the tolerance of the presentation genre, the balance between "[adopting] various positions within a discourse" (Green and Lee 221) and cultivating a subject position that is not disjunctive with personal beliefs and values. Green and Lee call this a "critical dimension to literacy" (221), the ability to, as Coe, Luke and others have described, master rather than be mastered by the genres we wield.

CONCLUSION
Review of Findings and Implications

The preceding chapters have presented anecdotes and analyses of the oral presentation genre in the third-year medicine clerkship. Applying New Rhetorical notions of language and contemporary conceptions of genre, this study has examined the acquisition of the oral presentation as an important feature of acculturation into the professional medical community. This conclusion reviews the major findings of the study and suggests their implications for our understanding of the rhetoric of genre, our research into workplace genres and professional socialization, and our theories about teaching and learning generic discourse.

Findings: Ideology, Rhetoric, and Relevance

The major findings of this study offer insight into: the nature of the oral case presentation as constitutive of medical attitudes and actions; the medical and rhetorical/operational features of the principle of relevance; the role of relevance as a pivotal term for

understanding and composing presentations; the particular innovations within the relevance principle that are supported by the presentation genre; and the characteristics and implications of clerkship instruction in determining relevance. Within each of these areas, my analysis has explored the ideological significance of how the oral presentation genre is conceived, composed, taught, and learned in the third-year clerkship program of a university teaching hospital.

The Social Action of Patient Presentation: The composing and reporting of a patient's case involves constructing a diagnostic argument by selecting and arranging data. While students are judged on their ability to present a faithful chronology of events (SCEF) and the presentation is often characterized as a "story" (implying organization by *chronos*), the case presents an argument ordered by *logos* -- the cause-to-effect explanation of pathophysiological events.

The oral presentation functions as a social strategy across three domains in the teaching hospital: the practical domain of patient diagnosis and treatment, the

pedagogical domain of student instruction and socialization, and the professional domain of physician hierarchies and relationships. Atkinson's argument that medical work is performed collectively (*Medical Talk*) points to the organizational nature of the presentation's social action, and to the inter-relationships among these three domains.

The presentation not only *communicates* patient diagnosis and treatment across hospital sites such as the wards, the laboratory, and the attending physician's office; it is also the discursive means of *constructing* the diagnosis and treatment as a variety of medical actors receive, assess, answer, and enact patient information from various sources in the hospital landscape (Atkinson, *Medical Talk*). Giddens' theory of the duality of structure applies neatly to the oral presentation, a genre that relates both "to the constitution of meaning" and "to the sanctioning of modes of social conduct" (*Constitution* 18). As students draw on the "rules" for presentations, they engage and enact the duality of structure, reproducing the medical community's shared values and

interests as they shape patient presentations according to its generic structures.

Defining Relevance: Drawing on sightings of the principle in curriculum documents, clerkship discussions, and studies of medical discourse, I have attempted to outline the medical and rhetorical factors that seem to define relevance. Medically, relevant data are what contribute to explaining and treating the patient's chief complaint during the phases of his hospital stay. Appropriate determinations of medical relevance are dependent on the presenter's sense of a sufficient and reasonable (i.e., includes all possibilities but priorizes "the usual suspects" rather than "zebras") differential diagnosis that accounts for the patient's symptoms.

The assembly of the differential depends upon pattern recognition: confronted with a set of symptoms, the student must access her memory of all diagnoses which could "match" some or all of the patient's symptoms. Of course, the novice lacks a complete set of patterns, which makes relevance determinations foreboding. The method of pattern recognition extends to the listener, who (if

sufficiently experienced) will seek patterns in the presentation that allow her to come to her own diagnostic conclusions.

More than just "medical" factors contribute to determinations of relevance, however, so that a more complete, operational definition of the principle is required. In terms of the social and organizational action of the presentation genre in the teaching hospital, the relevance of data is determined with reference to: the goals, levels of involvement, and background knowledge of the audience; the organization of medical work, including the assignment of responsibility, the determination of credibility, and the negotiation of relationships; and the local occasion of the presentation.

The Role of Relevance: The composition of a patient case presentation for oral delivery requires two primary activities: the *selection* and the *organization* of data gathered from the patient (in the history interview and physical exam) and from other medical professionals (such as laboratory technicians and physicians acting as

specialty consultants). Both selection and organization are governed by the principle of relevance, which is the pivotal term for understanding what patient data the presenter should include and exclude, and how to arrange material for emphasis and diagnostic logic.

Agon analysis reveals the ideological underbelly of the "scientific" principle of relevance; it exposes community interests beneath the ostensibly self-evident nature of terms such as "reasonable question" (Haber) and "relevant data" (Keenan). Understood dialectically, "reasonableness" and "relevance" can be approached not as universal, objective principles but as defined by the discipline's interests and motivations. As "camouflaged presumptions" (Coe, "Burke's Words" 6), they reveal implicit arguments about clinical medicine's self-definition.

Implicit in the principle of relevance is medicine's method of causal explanation, a paradigmatically acontextual, closed-system approach to patient diagnosis and treatment that directs attention towards a lineal, unidimensional sequence of cause and effect. Students learn strategies of "promotion" and "demotion" that, while

based on a linear sense of present and past that echoes chronology, serve to turn the patient's story into an logical account of the cause of the presenting illness.

The ideological impact of such reasoning is its deflection of attention away from what Wilden would call an "open system" conception of the patient, situated within overlapping and potentially conflicting contexts and in a relation of feedback with them. Through determinations of relevance the community defines medical problems in such a way that it can address them within its dominant paradigm.

Stein's claim that how physicians treat a problem is an extension of how they understand it (10), combined with the rhetorical notion that the understanding of a problem is relative to the position of the observer -- her orientation -- reveals the social action of relevance decisions. As Bradley argues, cause-to-effect diagnostic reasoning serves biomedicine by reinforcing the traditionally mechanistic approach to disease and allowing the discipline to proceed in its objective bodily interventions (see Segal, "Writing"; Stein; Kleinman).

Divergent Approaches to Relevance: The analysis of how particular physicians varied in their promotion and demotion of patient data suggests that the oral presentation genre, like genres generally, can sustain a certain degree of innovation, divergence, and dissent. Furthermore, the nature of Haber's innovation confirms the emerging nature of genre (see Bazerman *Shaping*; Schryer, "Sites"; Giltrow; Berkenkotter and Huckin) in response to the exigencies of its context of situation.

Haber's and Keenan's distinct applications of the principle of relevance seem to reveal attitudinal as well as structural differences, and confirm current redefinitions of "discourse community" as heterogeneous rather than unified (see Paré; Miller). Haber's promotion of material from Meds, PMH, FH and SH to the HPI appears to challenge the traditional, chronological conception of past and present (and the cause-to-effect approach that depends upon chronological, "billiard ball" notions). Moreover, his innovation expands the definition of relevant data, widening the medical gaze to accommodate a more contextual causal approach to illness. Because genre is social action, such generic divergences are not only

different ways of talking about patients but also different ways of acting medically in relation to them.

A Pedagogy of Assumed Familiary: While students and teaching physicians alike agree that determining relevance is a difficult and stressful task for novices, explicit, procedural instruction in this skill is rare. Rather, the relationship between relevance decisions and rhetorical situations and contexts is often left unstated in instructional discourse, creating the impression that relevance decisions are self-evident, untainted by contextual influence, and governed strictly by the scientific, objective search for a "cause."

Ideologically, this impression serves to beg the questions of how physicians actually determine relevance and why physicians from various departments select different material as relevant. Begging these questions, and deflecting attention from them, encourages the assumption in students that relevance is, in fact, self-evident and free of contextual influence, thus protecting and reproducing the discipline's collective authority

derived from medical "objectivity" -- the presentation as a reporting of facts rather than a particular (and, therefore, subjective) interpretation of events (see Hunter; Segal, "Writing").

The lack of procedural explanation of relevance has another effect. In both the advice in written handouts and the feedback offered on rounds, students are invited to take up the subject position of someone who already knows what relevance is and how to determine it. Constructed by presupposition and conversational implicature, this subject position is, in my observations, never refused by student presenters, who prefer to withhold their questions rather than advertise their consubstantial lack.

Bourdieu's notion of "habitus" suggests that students are predisposed to identify with community values such as the preference for cause-to-effect logic and experiential over instructed knowledge. Similarly, Stein's depiction of the power relations inherent in the organization of the medical team and the vulnerable position of the student presenter helps to explain why students do not challenge the subject position constructed for them by assumed

familiarity.

Seeking the pedagogical motivations that underly such inadequate instruction leads to two potential, and not mutually exclusive, explanations. The first possibility is that expert presenters, unable to easily render explicit their tacit knowledge about how relevance is determined, conveniently project the belief that such knowledge is unteachable and a) should already be known by students or b) can only be learned by experience. Another explanation involves the pedagogical strategy of constructing subject positions for the audience in order to motivate their acquisition of particular knowledge or beliefs (see Green and Lee). Assuming familiarity with what is not known may be a powerful tactic in a medical pedagogy built on the premises that the knowledge required is immense, that students cannot possibly know it all, and that they must know it all to succeed (Stein 184).

Implications: Workplace Initiations and the Rhetoric of Genre

The findings of this analysis of how students acquire the oral case presentation genre suggest implications both

for medical education and for genre theory. These implications revolve around three issues currently under debate in discussions of genre. The first is Green and Lee's distinction between constructing readers and constructing subject positions, which relates to our developing understanding of what Bakhtin calls genre's "addressivity" ("Speech Genres" 95). The second is the debate surrounding explicit teaching and tacit learning. Is tacit learning natural and preferable, rendering explicit teaching unnecessary and potentially intrusive as Freedman argues? Or, as Coe wonders, is explicit teaching effective and politically empowering in certain circumstances? The third involves the logical step between the unconscious persuasion of perspective (Burke; Coe) and the doublebind[63] of genre knowledge which, as Coe

---

[63] A doublebind is more than a mere contradiction because it cannot be resolved by a choice. According to Bateson, a doublebind involves a genuine paradox: it is a situation that involves two equally correct but equally insufficient alternatives, each of which seems to be invalidated by the other. Genre acquisition creates such a doublebind because, in order to graduate from their status as novices and gain power in the medical community, one of the skills students must master is the oral presentation of patients. However, once they have mastered the genre they may have also succumbed to its attitudes (see Luke), embraced its orientation as their own, thus neutralizing their power to assert alternative

and Luke point out, may empower the user in the sense that she gains entrance to a discourse community but simultaneously neutralize her ability to effect change within the genre's context of situation.

Distinguishing Readers and Subject Positions: In the essay "Anyone for Tennis?", Freadman's game metaphor drew attention to an aspect of genre that, while implicitly recognized in theorists' citations of Bakhtin's notion of "addressivity", had been largely untheorized: a genre necessitates at least two utterances in some sort of

---

attitudes and effect change. Paradoxically, in order to gain one kind of power, students must give up power of another sort. In the context of initiation, the doublebind is particularly intense because the tertiary injunction ("Master this genre/Adopt this orientation or you will not gain entrance to this community") is foregrounded. As Coe explains, the individual faced with a paradox has three options: she "may illogically deny the paradox and make a dogmatic choice, oscillate between the two contradictory positions within the paradox, or communicate *about* the paradox (thereby transcending it)" ("Logic" 491). As my analyses of presupposition and implicature have suggested, communication *about* the acquisition process is constrained by the construction of a subject position that already understands the genre's features. Transcendance of the generic doublebind may be particularly unlikely in this setting where such features are not articulated as propositions and are not, therefore, available for discussion and dissent.

dialogical relation -- the "rules" of genre are "rules of play" ("Anyone for Tennis?" 46). A key implication of Freadman's approach is that

> one of the things a text will do is play its partner, whether or not that partner is present. It order to do so, it must *represent* its partner . . . [and] texts may, and frequently do, play several games -- and thus, several partners -- at once (46).

This notion of a text "representing" its partner(s) -- its projected and appropriate response(s) -- relates to Green and Lee's discussion of the subject positions that school genres construct for students, and how students might negotiate those subject positions. Green and Lee endeavour to understand subject positioning in relation to the textual practice of "discursive-disciplinary fields", relating the construction of identities to the "available cultural and semiotic resources" (219). Discussing the case of school geography, their theory implies that when students learn a genre they encounter the subject positions (what Burke might call the "orientations") appropriate to that genre's context of situation. Problematizing this connection between reader and subject

position, Green and Lee inquire into the contradictions endured by female students who may find the available subject positions personally untenable (in terms of their implicit values and interests), but necessary for success in school.

The notion of subject position offers genre theorists a more precise way of articulating the relationship between a generic utterance and its "audience." The term "audience" is ambiguous, particularly in its potential conflation of the audience addressed by the utterance and the audience it invokes. Lisa Ede and Andrea Lunsford have distinguished these two types of audience for composition theorists as, respectively, the actual audience and the audience constructed by a text. Green and Lee's concept of "subject position" offers a similar vocabulary for genre theorists to distinguish between the readers addressed by a genre and the subject positions it constructs.

Recall the anecdote of the student who asks whether the attending wants just the pertinent labs or all of them and confronts the attending's response, "Anything drawn

inadvertantly, I don't want to know about." As my analysis has suggested, the response constructs a subject position of someone who ought to know what is relevant. It does not construct such a "reader": the reader's knowledge can be invoked but not "constructed" by the text. And while, objectively speaking, readers can choose to adopt subject positions or not, the power dynamics of initiation settings such as the clerkship serve to (en)force the invitation to adopt the offered role.

Teaching and Learning Genres: Genre theorists and writing researchers agree that, in most professional contexts (and in many pedagogical contexts as well), "both genre knowledge and the learning/teaching of genres have typically been tacit" (Coe, "The Rhetoric" Note 4). But genre theorists disagree on the meaning of this predominance of tacit knowledge. Freedman accepts the predominance as natural, and, therefore, argues that explicit teaching is largely unnecessary and only successful under limited conditions.

In contrast, Coe questions the motivations of the predominance of tacit learning, asking

> to what extent the social processes of tacit genre acquisition serve to limit genre knowledge and thus to limit access to power, thereby reinforcing and even recreating existing social hierarchies. ("The Rhetoric" Note 4)

Furthermore, Coe asserts that, notwithstanding the fact that students will eventually learn genres without explicit instruction, the question remains whether or not such instruction might render the learning process more efficient or effective, "just as [coaching does] for all sorts of athletic skills" (Note 4).

Freedman sets out two conditions which she argues are necessary for successful genre instruction: explicit teaching must be accurate, and it must be situated in an authentic context. Certainly Freedman's point is well-taken: inaccurate instruction is often harmful and unsituated instruction is likely ineffective. However, where we do not find such conditions, might it be worthwhile to create them? The student clerkship suggests that cultivating Freedman's conditions is not only a possible alternative but also an ecological strategy.

My observations and interviews in the medical setting

confirm Freedman's expectation that much of the genre knowledge that allows experts to function discursively is tacit, implicit knowledge. Similarly, my findings support her claim (via Krashen) that such knowledge is difficult for experts to render explicit. Furthermore, the fact that these students do sufficiently master the oral presentation genre by the time they graduate seems to confirm Freedman's hypothesis that "explicit teaching is not necessary in the acquisition of genres" (195). In fact, as they become familiar with each new clerkship situation (Internal Medicine, Surgery, Pediatrics, etc.) and its rhetorical requirements, many students will achieve sufficient generic proficiency by the midpoint in a clerkship.

Clearly the "learning by authentic experience" model of the clerkship is functional, since students do learn the genre. However, as the anecdotes in Chapter Five suggest, this model is also, on another level, dysfunctional, creating effects that are not intended by medical educators and may undermine the goal of teaching students to communicate effectively as physicians. This dysfunctionality evolves from a combination of factors:

the nature of language as symbolic action, the students' formal perception of the presentation, the physicians' decontextualized feedback, and the value acquisition that accompanies genre acquisition.

As Judy's story demonstrates, students may interpret acontextually the cryptic feedback that they receive on rounds. Then, seeking rules to expose the mysteries of presentation discourse (rules that, like students in other disciplines, they suspect their teachers are selfishly hoarding), they may readily infer them from advice such as "in rounds [the social information] is not important except what's related to the chief complaint" (Judy's resident). Having inferred a rule, students may then proceed to apply it acontextually, as Judy did, and unknowingly adopt an erroneous orientation towards the patient, his condition, and the medical response to that condition.

Such misunderstandings may be corrected as the student finds that applying this generalized rule creates faulty presentations in some situations (such as the occasion of disposition). But what about the knowledge

constructed by the mistaken "rule"? Are the attitudes encompassed by structural regulations (such as the attitude that social data are not part of the medical physician's arena, not her concern) simply dissolved when the rule is eventually recognized as faulty and relinquished?

Freedman argues that "critical consciousness becomes possible only *through* the performance: full genre knowledge (in all its subtlety and complexity) only becomes available as a result of having written [or spoken]" (206). The clerkship process supports her claim that "first comes the achievement, with the tacit knowledge implied, and then, through that, the meta-awareness" (206). But what if the achievement/performance is repeatedly and unknowingly flawed, as were Judy's presentations until the disposition decision? Then the tacit knowledge implied may also be flawed, and, equally troublesome, the social action of the presentation misdirected and inaccurately motivated.

Further study is required to determine the longevity of the attitudes that potentially accompany such erroneous, acontextual assumptions about the genre. In

the meantime I am concerned about what genre theory can take from this situation, and, potentially, give back to it.

If the requirements that Freedman outlines for avoiding harmful instruction were met -- i.e., the teaching is situated in the context of authentic practice and the teacher is in possession of accurate and explicit genre knowledge -- could explicit instruction in the generic strategies of oral presentation make students' learning more efficient? Could it address the problem of their misinterpretation of and generalization from physicians' feedback on rounds?

The nature of this particular learning situation leads me to argue that there is a role for explicit genre instruction in the context of situated practice. In fact, I would argue that this role is not just the improved *efficiency* of genre acquisition but -- more importantly -- the improved *accuracy* of the accompanying value acquisition. Given that these early experiences in clinical medicine "are fundamental experiences in the medical student's personal and intellectual career"

(Atkinson, "Discourse" 180), the clerkship could benefit from more explicit articulation of "the interrelation of structure, strategy, situation and context of situation that constitutes each genre" (Coe, "The Rhetoric" 186). Tacitly assumed, such issues do not present themselves to learners as matters for consideration or questioning; explicitly asserted, they become propositions that can be questioned and critiqued.

When situated and accurate, explicit teaching can help cultivate in students a meta-awareness of the oral presentation genre. Students may not be protected from erroneous judgements (of both the structural and the attitudinal sort) by this meta-awareness, but they may be empowered by an increased control of their presentations, their interpretation of feedback, and their revisions.

Generic Doublebinds: Currently, genre theorists, perhaps sparked by the problematizing of the unified notion of "discourse community" (Paré; Miller), have turned their attention to the nature and possibility of generic instability and innovation. In this analysis of the oral case presentation, divergences in experts' presentation

"styles" were argued to be a sign not of "personal preference" alone but also of ideological fault-lines running through the medical community. Non-traditional selections and arrangements of past medical history or social and family history data suggested room to manoeuvre within the constraints of relevance and causal explanation; experts were apparently able to reconcile their nonconformist motives with the institutional goals in such a way that both could be satisfied.

A basic claim of genre theory is that genres enjoy a reciprocal, organic relationship with their contexts. Bazerman asserts that "the objections and desires of the growing scientific community" cause the experimental report to continually change in form, as it attempts to satisfy the eternally (if incrementally) evolving demands of its context (*Shaping* 79). The same would appear to be true of the oral presentation genre, evidenced by innovations in the traditional form which, by composing the presentation differently, also recompose the nature of the diagnostic process and the traditional boundaries of medical practice.

Such evidence of strategic manipulations of the genre provides support for Schryer's contention that genres are "stabilized-for-now or stabilized-enough" ("Sites" 107) but not static. Schryer attributes to Bakhtin the notion that "genres are sites of both stability and instability" ("Sites" 108), and Haber's departure from the normative arrangement of history data offers a particularly vivid example of both the instability inherent in genres and the relationship between this instability and what Bazerman characterizes as the fluctuating "objections and desires" of the community of genre users. Desirous of a different understanding of patient illness and a new approach to diagnosis and treatment, physicians such as Haber rightly (if, perhaps, intuitively) seek a different method of discursively constructing patient and practice in the presentation.

This all seems very optimistic: medicine is faced with new challenges and patient demands, and its discourses can and will evolve to meet them. But I wonder if, perhaps in another setting, at an institution not so

self-declaredly "leading edge"[64] in its committment to "humane, respectful care" as San Francisco General Hospital, the oral presentation genre has not advanced even the short distance that Haber's approach suggests is possible. How long do generic evolutions take? What conditions are required to nurture them? And, in the meantime, how many "traditional" physicians will medical schools graduate to reinforce the duality of medical structures?

These questions lead me to the problem of generic doublebinds, and to the conditions necessary for generic innovation to occur. For if we believe our own rhetoric -- that language is symbolic action, that form is persuasive, that to name something is to adopt an attitude and incipient actions towards it, that genre is social action -- then Bakhtin's claim that mastery of a genre is necessary for its manipulation (and any inference that such mastery makes manipulation possible) seems overly optimistic. He argues that, like artistic, literary

---

[64] Such self-definitions are not, of course, unproblematic or disinterested; they are, however, an important aspect of the local "culture" of this teaching hospital.

genres, the genres of

> oral speech communication . . . are subject to free creative reformulation . . . . But to use a genre freely and creatively is not the same as to create a genre from the beginning; genres must be fully mastered in order to be manipulated freely. ("The Problem" 80)

How possible is such free manipulation? How powerful is the "tyranny of genre"?

In the discussion among genre theorists, worries about the tyranny of genre are often neutralized by opposition to the creative, heuristic features of structure which may encourage and stimulate communication. Certainly genres are not only constraining and often -- perhaps paradoxically -- members of a discourse community hold creative transgressions in higher regard than flawless reproductions. But the constraint/creativity opposition may tend to focus our attention on *textual* issues such as how the headings in a formal business report not only constrain but also stimulate the content of sections.

In their implicit emphasis on textual constraint versus textual creativity, such oppositions may be distracting us from a related, and more important, issue.

The generic constraints that are worrisome are not the structural ones but their ideological counterparts, the constraints on our attitudes and our actions, on "the ends we may have" (Miller, "Genre" 38). This study of the oral case presentation suggests the importance of exploring such ideological constraints, particularly in settings of initiation. It also directs attention to a pivotal question that lurks, implicit, in programs to enable students to master genres rather than be mastered by them: "What kinds of ideological creativity will a genre tolerate?"

As the contrastive analysis of Haber's and Keenan's organization strategies suggests, ideological creativity is possible only when ideological constraint is recognized and respected. Haber's "creativity" is possible because his presentations are, in so many other and basic ways, just like everyone else's; therefore, the similarities between Haber's and Keenan's "styles" tell as much about how to be creative as the differences. In Burkean rhetorical terms, Haber persuades his community of listeners and fellow presenters to accept his innovative

clustering of patient data by *identifying* with them on basic matters such as the primary goal of acute-care treatment.

Understanding how experts achieve a balance between ideological constraint and creativity has important implications for the teaching and learning of genres. As Luke argues in his critique of the Sydney School genre project, and as Green and Lee's discussion of subjectivity suggests, becoming literate in a generic discourse means shared attitudes as well as shared forms. And while novices may "fake" such attitudes to some degree, Burke's theory of language as symbolic action suggests that, at some point, the borrowed worldview inherent in the language will become internalized. When novices come to see the world from the perspective of the discourse community through the acquisition of its genres, when they come to share its orientation, then to what extent is their capacity for innovation, difference and dissent undermined?[65]

---

[65] The restriction of innovation can be necessary in a discourse community, constraining naive or dysfunctional changes to the genre. At some point in the community's evolution, however, the restriction itself may become

I am not trying to revitalize a restrictive homogeneous notion of discourse community here, nor am I proposing that we see all successful initiates as "brainwashed" and incapable of individual motivation or action. But it does seem striking to me that the innovations I witnessed in the oral presentation genre were accomplished by attending physicians, safely housed in the upper ranks of the hospital hierarchy. As Susan Miller suggests of the conservatism of generally nontenured (and often female) university composition instructors, the less secure a person's institutional position, the less likely s/he is to cultivate innovation or dissent in discursive practices, and the more likely s/he is to protect the knowledge and values that constitute his/her membership in the community. As Miller puts it, s/he "has a great deal at stake in the model-correctness of his or her own language" (138).

Despite obvious differences (in power, prestige and economics -- both present and future) between composition

---

dysfunctional, disallowing necessary responses to changing contexts and exigencies.

teachers and medical residents, Miller's argument seems relevant because my fieldnotes offer very few records of nonconformist presentations by interns, and only marginally more by residents. And as the "teachers" on work rounds, residents' lack of tolerance for inappropriate presentations is legendary. Earlier I suggested that their traits of impatience and irritation were attributable to their complex role as an audience who already has the information being presented by the student. Perhaps it is also related to the conservatism cultivated by their non-permanent, high-pressure, and closely-evaluated status as not-quite-full-physicians.

What does all of this mean for the issue of innovation and evolution in genres? Given Irby's explanation that oral presentations demonstrate the competence of the presenter, his credibility and his clinical judgement, and Cooke's and Keenan's emphasis on the professional impression or image conveyed by presentation skills, we can conclude that the free manipulation of genres requires more than just mastery of its standards. In the organizational setting of the teaching hospital, it requires community recognition of

competence and credibility.[66] And only those who are consubstantial with medicine's attitudes and interests will attain such recognition.

This consubstantiality engendered by its acquisition is the doublebind of genre, and the reason why genre is such a powerful rhetorical tool of initiation. It is also the reason why accurate, situated, explicit instruction might benefit the clerkship program in a hospital such as San Francisco General. For, if they hope to fulfill their "leading edge" self-definition and nourish a generation of physicians who can respond to medicine's evolving challenges, these educators will need to cultivate in their students a "reflexive consciousness" (Freedman 206), a meta-awareness (Coe, *Process* 413-48) that allows them to adopt various subject positions within medical discourse "yet not assume 'identity' with these positions" (Green and Lee 221). Aware of the symbolic action and social

---

[66] To make the point with reference to another community, consider the difference in reception of a nonconformist academic essay by a known 'A' student and a nonconformist academic essay by a known 'C' student. Lacking the established credibility and competence, the latter student's innovation will likely be less well received.

process of the oral case presentation, students might transcend the doublebind sparked by successful acquisition of its strategies and find ways of negotiating its ideological constructions.

Appendices
(A-F)

Appendix A
"Medicine 110"

INTRODUCTION

Goals (or where to direct your energies)

1. Develop ease in dealing with sick persons and working with health care personnel in relation to delivering optimum medical care in an inpatient hospital setting.
2. Be able to obtain, organize, record and present (written and oral) a complete history, physical examination and diagnostic and therapeutic formulations. A complete differential diagnosis is more important at this stage than a complete therapeutic plan.
3. Learn a certain body of basic information.

HOW WILL YOU LEARN THIS?

1. General - Through close contact with patients.

Digression #1 -

Not all students will be exposed to the same types of patients, necessarily making the experience different for each student. Goals 1 and 2 can be realized through a variety of patients. Goal 3 will be accomplished through a combination of ward contact and didactic sessions (conferences and seminars) through which you will be exposed to at least a minimum amount of basic facts in Internal Medicine.

Digression #2 -

At all times, all patients must be treated with dignity and respect whether or not their personalities or attitudes coincide with yours. Less will not be tolerated.

Patient care comes before education. Through this order of priorities will come your most important learning.

2. Specifics

A. Ward work - Each ward team consists of a PGYII/III medical resident, two interns, a 4th year clerk, a 3rd year clerk and an attending (faculty) physician. Each team may have patients on one or more wards (5C, 5D, 5A) and the Intensive Care Unit. Each 3rd year clerk will be assigned to work with a specific intern and resident.

In addition, each third year student (in groups of 2) will spend one week on the Cardiology Serivce. The Cardiology Service is made up of 4 teams consisting of one resident and one intern on each team. Teams rotate call. Third year students will admit with each team as they come up. Plan on picking up 3 patients during this week. During the Cardiology week students will continue to attend third year student conferences and participate in Med 110 activities (standardized patients, etc.).

B. Conferences - There will be two seminars per week (Monday (1:30 - 2:30pm) and Wednesdays (1:30 - 2:30pm) in which topics basic to medicine will be discussed. In addition, you will meet with Dr. Haber at 1:30pm on Fridays. You will meet with Dr. Haber for case presentations Thursdays at 1:30pm. You will also meet with Dr. Cheitlin for Diagnosis Rounds and the Chief Residents for basic EKG. YOUR PUNCTUAL ATTENDANCE AT THESE CONFERENCES IS IMPORTANT.

C. Standardized Patients - The School of Medicine has arranged for actors to play the part of patients in these half-day exercises (ususall Monday evenings and Saturday mornings). Sessions will be held on hisotry taking and physical examination as well as discussion of advanced directives. Time assignments will be based on call schedule and will be forthcoming from Student Programs. If, for any reason, you are unable to attend this required program please call Lisa Fromm at 476-1964.

OTHER QUESTIONS

1. Patient workups - Each 3rd year clerk must work up a minimum of 16 patients. The written workup must be in the chart within 72 hours of the patient's arrival in the hospital (however for practical purposes you must be ready to present the patient by the next morning). Whether you write the admitting orders is at the discretion of the intern with whom you are working. All orders must be countersigned by the intern or resident. You will have increasing patient responsibilities with time as you develop the necessary expertise, demonstrate your dependability and interest and gain the interns' and resident's trust.

   Each new patient should be recorded on the brown cards provided in your orientation packet (Kay has more). At the end of your clerkship give these cards to Kay in 5H6.

2. On Call Schedule- You are on call whenever your team is on call. You pick up patients on the day your team admits. Call consists of long call (all night) and short call (until 3:00pm, limit of 4 patients), alternating every third night. On long call nights you are responsible for admissions until 10:00pm. There is no educational value to being a martyr and staying all night if there is nothing happening. By the same token, if clinical developments are occurring with your patients, 10:00pm is not a magic number. Guide your decision making - spending time READING about your patients is essential. Try to take one weekend day off each week. Work out with your resident which day is best. Late in the clerkship you may wish to stay overnight. Call room keys are available from Dorothy DeLapp (she can also help you determine what rooms are available). There is a $20 deposit required for each key. You can leave a check made out to "UC Regents".

3. Laboratory - You need to know how to use it, i.e. minimum of CBC including staining and examining the slide, excluding doing your own white count; urinalysis, gram stain; acid fast stain; stool Guiaic. Learn from your intern and resident. The Medical Housestaff Laboratory is located in room 5F36. This is the medical students', interns' and residents' laboratory for performing basic laboratory tests.. The ongoing clinical studies are posted in the laboratory. For supplies or questions regarding the lab, please contact Dorothy. Please keep the laboratory clean! If the lab is locked any call room key can open it (ask your resident or intern)

4. The Lange Medical Reference Room - AKA the residents' room is located in room 5H14 and is available for housestaff and student use. The punch lock code is 1 and 5, 2 and 4, 3. Please keep this door shut after 5pm and on weekends. There are cupboards available to store things you want here instead of your locker, however, please be aware that your locker is the safest place for personal belongings. This room is YOUR library/computer center/lounge so please keep it neat and reshelve the books!

5. Barnett-Briggs Library - is located in Building 30 and maintains an excellent selection of texts and journals. Registration is required for library privileges and services. Registration cards are available at the library. It is open Monday through Friday, 8am - 10pm, Saturday 9am - 5pm and Sunday 1pm - 9pm. The library copy code # is 324.

6. Copying/Fax Machines - The housestaff/student copy machines are located in room 5H12. (Student code: 55500, enter). The fax machine is located in 5H14 (#206-3053). Student code is 5550. For after hours use of the copy machines please ask you resident for the key. Please be sure the doors are closed when you are finished. The Department must pay for copy/fax costs from our operating budget so please use discretion when using these machines.

7. Page System - The Medical Services uses long range digital beepers. They can only be accessed from a touch tone phone. There are two systems of beepers currently in use. Beepers with the first three numbers 719 are accessed by punching 9 + the 7 digit beeper number - then punch in the number you want the call returned to + #. Beepers beginning 997 are accessed in the same way if you are calling outside of the hospital. However, when you are calling a 997 beeper from inside SFGH you will punch 7777, wait for

the tone, punch in the last 4 didgits of the beeper number, wait for the tome and punch in the number you want them to call. The person on the beeper will get a "beep" and a digital display of the number they are to call. Some voice pagers are still in use at SFGH. A voice pager is activated using a SFGH phone line - dial 180 + 3-digit beeper number. After the beep there is time for a short verbal message - usually the extension you wish the person to call (eg. 5164, 5164 call Kay 5164). **IT IS VITAL THAT YOU RETURN YOUR BEEPER AT THE END OF THE CLERKSHIP.** Batteries are available in the resident's room, from Dorothy/Kay or from the operators on the ground floor.

8. Messages/Outside 5H doors - The is a message board located just outside of 5H22. Messages for you can be left with Kay at 206-5164. Please check the message board daily. The 5H doors are locked after 5pm and on weekends. You can gain extrance using the punch code 3, 2 and 4, 1 and 5.

9. Evaluations - You will be evaluated by each ward team (attending, resident and interns) you work with. All evaluators will be asked to consentrate on enumerating strengths as well as weaknesses. During the clerkship Dr. Haber will meet with you to discuss your progress. Your evaluations are available for you to read at any time.

10. Other problems or questions - Dr. Haber is available to you for any problems or questions (or even if you don't have specific problems or questions) at any time (schedule through Kay in room 5H6, ext 5164). He is (he says) relatively easy to talk with, to or at!

11. General Rule - if in doubt first ask Kay (5H6 inside the housestaff lounge, x5164).

TRUISM: Feeling stupid or inadequate at some time (especially) during the first part of your 3rd year Medicine Clerkship is not only NOT abnormal (note the multiple negative), but almost the rule.

Please try to adhere, at least basically, to the suggested form. If you strongly feel the need to modify, please consult me.

Richard J. Haber, MD
Director, Educational Programs
Assistant Chief, Medical Services

Appendix B
Pivotal Terms in Selected Curriculum Documents

Molly Cooke
The Oral Presentation

Important:

1 The oral presentation is an essential **skill** in the practice of medicine.
2 We **get advice, transfer responsibility and supervise** using thee form.
3 Good **skills** in oral presentation are an **asset** to you and an **advantage** for your patients.
4 In addition, physicians **assess** each other primarily based on the **image** each practitioner projects when she presents.
5 A good oral presentation makes the presenter **look** organized, thorough, knowledgeable and enthusiastic.
6 Finally, preparing to present can actually make you more organized, thorough, etc,
7 You can't present well until you have a **position** on what the patient's problem is.

Content:

8 The formal presentation is an **academic exercise** in which one physician, usually **junior**, describes a "new patient" to another physician, typically more **senior**.
9 Formal presentations are typically 5 to 10 minutes long, although some **faculty** can stay awake for presentations as long as 15 minutes long.
10 The content of the oral presentation is similar to the patient write-up but more **edited and concentrated.**
11 It **emphasizes** how the patient is **now** (CC, HPI, PE, lab and assessment) and **discounts "old"** information (OMP, PMH, FH ant SH).
12 The ROS (review of systems) is typically **omitted** entirely; information from ROS which is too **important** to leave out is "**promoted**" to another section of the presentation.
13 Your oral presentation is **building the case** for the **formulation** you eventually make in the assessment.
14 The **listener** should understand why you included each piece of information (what you were

thinking of) and what **diagnoses** you consider most likely.

15 But you shouldn't say anything explicitly about what you think (editorializing) until the last sections.

Delivery

16 Aim for a presentation which is/has: ·**concise, focused** and **directed** ·no premature editorial comments ·quick, fluent delivery ·thoughtful, **developed** assessment[.]

17 Put the information that you cannot memorize on one 3x5 file card (the amount of information which has to be written down will decrease amazingly over the next two years).

18 Practice the presentation several times until you only need to refer to the card for lab information.

19 Listen to your **classmates** and the **residents** - many of them present very well.

Appendix B continued

Craig Keenan, MD.
February 1996.

ORAL PRESENTATIONS

1 Oral presentations are a crucial part of clinical medicine.
2 It is an essential way to present information to and ask questions of your **colleagues** regarding a certain case.
3 It is **a skill** you will find essential throughout your **professional life.**
4 I feel that it also gives people an **impression** of your **clinical skills**-if you present well, people think you are a **good clinician** and if you present poorly, they may think you are a **bad clinician** (though often they are wrong).
5 It is the main way we **present ourselves** to our **colleagues.**
6 Thus, it is an important **skill** to perfect and one that takes lots of practice.
7 In these brief few pages, I present the way I like people to present.
8 This represents my **personal bias** and you likely will get differing **preferences.**
9 It can, however, serve as a guideline as you start out in clinical medicine.
10 Remember that this method is that of an **internal medicine** doc (me), and specifics may need to be changed for other specialties (especially pediatrics and OB).
11 First, a few general tips on how to present well.'
12 (1) Speak up and sound confident.
13 (2) Don't have a lot of pauses or "ums" in your presentation.
14 Speak at a moderate pace and charge through it.
15 Having pauses allows people to interrupt, where they ask questions that you will probably answer later in your presentation, which adds too much length to the presentation time.
16 People will often save their questions to the end if you crank steadily through your presentation.
17 (3) Don't try to present everything known.
18 **Limit** yourself to the **pertinent** data and just outline less **important** data (if you include it

at all) to save time and keep your **listener** awake.

19 I'll try to indicate areas to **shortcut.**

20 (4) Don't simply read off your notes or cards.

21 Like any speech you need to address the **audience.**

22 (5) - Use a normal speech pattern.

23 Monotone speakers are boring.

24 Change your intonation, accent important parts, and sound human.

25 (6) **Limit** your basic presentation for rounds to about 5 minutes.

26 If you go much longer, you'll lose your audience.

27 Think of a presentation as **a story** of the patient's illness.

28 As such, your **story** will be told in such a way that you lead your **listener** down a **path** to the **diagnosis** you have come to.

29 This does not mean that you leave out **important** data or bias your **story** in any way – just that by having a **conclusion,** your presentation will follow a **path** instead of **wandering.**

30 This also doesn't mean that your **listener** won't come to a different **conclusion.**

31 It gives some **structure** to the **story.**

32 Now we will discuss the presentation from start to finish.

ID/CHIEF COMPLAINT

33 Usually you should begin your oral presentation with an identifying statement and chief complaint such as 'Mr. X is a 57 year old white male who presents with a complaint of chest pain for three days."

34 I have a **personal preference** in that I like to tell the patients' **major** past medical problems up front, especially if they are **relevant** to the illness or complaint for which they are seeking help.

35 This can be easily done by adding a few words, e.g., "Mr. X is a 57 year-old white male with a history of CHF, CAD with 2 prior myocardial infarctions, and COPD who presents with a complaint of chest pain for 3 days.

36 You have thus provided very **important** information very quickly, and this will allow your **listener** to include this in their preliminary thoughts as you present.

HISTORY OF PRESENT ILLNESS

37 You should then proceed to your HPI, which is generally done best by giving a **chronological description** of the events/symptoms/etc. that lead up to the patient seeking medical assistance at this time.

38 Be sure to **cover** (at least in your early days) all of the qualities of a symptom when you present-i.e. onset, duration, location (including radiation), character, relieving/exacerbating factors.

39 For example, "Three days prior to admission the patient began having intermittent sharp left-precordial chest pain without radiation that would last for 5-10 minutes.

40 It was brought on by eating and relieved with antacids.

41 This would occur 2-3 times daily.

42 It is **important** to **include** associated symptoms as well, such as shortness of breath in this example.

43 A practical pointer is to use the date of admission or presentation as a reference point to allow your **listener** to follow the **time-line** easily (e.g. 6 months prior to admission (PTA)...3 days PTA...etc.).

44 Always **include pertinent positives** and **pertinent negatives** with regards to other symptoms that may be **related** to the chief complaint, e.g., the patient has no abdominal pain or melena.

45 Some **important** review of symptoms items that very often make it into my HPI are fever, nausea, vomiting, diarrhea, shortness of breath, chest pain.

46 But remember, you do not have to included these if they **bear no importance** to the case--how to decide their **importance** comes with experience.

47 If the patient has separate complaints, you can present them in **distinct blocks**: "Additionally, the patient notes left foot pain for the past year..."

MEDICATIONS/ALLERGIES

48 I usually just mention the allergies briefly.

49 If you have time, you can mention what the "allergy" is specifically (this should definitely be in your written H&P).

50 I then **list** the medications that the patient is

on.
51 I do not usually mention the dose unless it is **important** to the HPI or if I am adjusting the dose of the medication during that admission.
52 Remember that if people want to know the specific doses, they can ask when you are done presenting.

PAST MEDICAL HISTORY/PAST SURGICAL HISTORY
53 I generally just **list** the past medical history problems unless a specific item is **important** to this patients' illness—then I go into more extensive detail.
54 For instance, in a patient presenting with a lung nodule, I would just **list** that he had CAD and gout, but I would probably give more detail about his history of colon cancer (e.g. stage and therapy) given that the nodule may be a metastasis.
55 **List** more **important** illnesses first.
56 Remember that PMH items that are **crucial** to the HPI can be discussed in the HPI if you so desire.
57 For example, in patients who present with chest pain, I will often tell about prior myocardial infarctions and cardiac catheterization data in my HPI.
58 Some would discuss this in the PMH, but I think it depends on your personal **preference** -- if you do it this way, however, you should mention this PMH first.
59 Again, it is important to realize that people can ask more specific questions about aspects of the PMH at the end of your presentation, so **including** every minute detail is not important.
60 It is important, however, to know this information if someone were to ask.
61 **Pertinent** negative history of illness should be **included** in the HPI.
62 For example, "no history of diabetes or rheumatic heart disease.

SOCIAL HISTORY
63 Here, I discuss occupation, living situation, social supports.
64 How much to **include** depends upon how **important** it is to that patient's presentation and care plan.
65 Be sure to **include** occupational exposures if

pertinent.

66 I also **include** sexual history in this portion of my oral presentation, if **significant.**

67 The patients habits are included here.

68 Always mention smoking status, alcohol use, and drug use.

69 If the patient uses intravenous drugs, discuss how and how recently.

70 Sometimes travel history and animal exposures are **included** here, if **pertinent.**

FAMILY HISTORY

71 I usually **limit** this to parents, siblings, and occasionally grandparents.

72 I **personally** tend to mention specifics only if it is **pertinent** to the patient's illness, but otherwise I say "non-contributory.

73 Some people, however, like more thorough information, in which case you can **list** history of **major** illnesses in the family.

74 I include other family members only if particularly **relevant** to the case.

Appendix B continued

Richard Haber, MD

THE COMPLEAT WRITTEN WORK-UP

(1) Hospital data

Patient's name, B#, Date of Admission

Most of this data is included in the patient's card which is stamped on every page and need not be repeated.

(2) Patient Profile -brief outline of patient's prominent personal characteristics and his relation to his social environment.

After reading this, a reviewer should have a reasonably accurate picture in his mind of the patient (i.e., jolly, balding, rotund man who works as a hospital volunteer weekday mornings and spends the rest of the days indoors playing with his 14 cats.

He is still depressed over the loss of his wife 10 months ago.

(3) Source of history and estimate of reliability

(4) Chief Complaint (CC)

In patient's **own words** (use quotation marks liberally).

A premature diagnosis in the CC instead of a symptom or sign can lead you astray.

The CC should **include** age, race, marital status, sex, chief complaint and duration of complaint, i.e., cc-63 y.o. M. c "my head hurts" X 3 days.

Feel free to use abbreviations here and elsewhere in the work-up as long as they are universally understood.

There can be multiple Chief Complaints.

(5) History of Present Illness (HPI)

The CC, HPI, and the Dx and Rx sections of the work-up are the parts that **bear most on** the acute illness, i.e., what brought the pt. into the hospital and all information **pertinent** to his/her care while in the hospital.

The remainder of the work-up is primarily to provide a complete medical data base.

In a practical sense a consultant coming to review the chart will spend most or all of his/her time with the CC, HPI, and Dx and Rx.

Therefore, the HPI must contain all the

information, including symptomatology and known past laboratory date and treatment, **relevant** not only to the Chief Complaint but to caring for the patient while hospicalized [sic].

19 When a person is through reading your HPI, he/she should have no further questions regarding the patient's acute problem(s), or chronic problem(s) that would affect hospital management.

20 This is obviously difficult because it assumes you know what the **relevant information** is (i.e., know the complete **differential diagnoses** and know which past and present illness(es) are **significant**) for each Chief Complaint.

21 The CC and the HPI then become the **focus point** for a **concise** oral presentation of the case, again leaving no **reasonable question** unanswered at its end.

22 For each symptom a notation of manner of onset and disappearance, location, character, frequency, duration, radiation, relation to position and other events (such as eating) and effect of therapy (if attempted) should be made.

23 **Relevant positives and negatives** from "Review of Systems", "Family History", "Past History" and "Social History" (including inability to work and reaction to illness) should be **included** in the HPI.

24 **Summary** of past hospitalizations (here or elsewhere) should be **included** in the HPI if **relevant.**

25 (**Include** dates, procedures, appropriate test results, therapy and status on discharge).

26 (5A) Since **significant** medical problems affect a patient's care in the hospital, even if they are not directly **relevant** to the Chief Complaint, they should be **listed** in the HPI after a discussion of the Chief Complaint.

27 A brief **summary** of current status, past work-up, end organ effects and present therapy is appropriate.

28 (5B) Similarly, since any medications and allergies to medications will affect all disease processes and management thereof, these should appear in the HPI even if not directly **related** to the Chief Complaint.

29 Probably best **listed** as "Medications": followed by the **list**; and "Allergies": followed by the **list.**

30 If a person states he/she is allergic – also note the type of reaction encountered.

31 Include over-the-counter medicines, such as vitamins, aspirin, etc., which the patient may not consider "medicine".

32 (5C) For Patients with multiple presenting complaints and/or multiple **significant** medical problems (or if you like for all patients) a problem-oriented organization can be followed by consecutively numbering the discussions of the presenting complaint(s) and significant medical problems.

33 If the patient already has a problem **list** from previous admissions or outpatient care, use the already existing numbers.

34 Whichever system or organization is used, the philosophy behind and the content of the HPI is the same.

Appendix B continued

Student Clerkship Evaluation Form
Oral Case Presentations (Section 4)

1 Presentation very **disorganized** and incomplete.

2 Presentations incomplete.

3 "Holes" in characterization, **chronology** and **diagnostic information.**

4 Very dependent on written prompters.

5 Historical diagnostic information incomplete.

6 Acceptable **delineation** of primary problems with reasonable characterization.

7 Attempts to **chronicle key events** in patient's illness.

8 Presentation contains acceptable **diagnostic information.**

9 Presentations complete but not always appropriately **focused.**

10 **Early** clear **delineation** of **primary problems** with excellent characterization and **accurate chronology** of **key events** in patient's illness.

11 Presentation contains appropriate **differential diagnostic information.**

12 Consistently appropriate **focused** presentation.

"Rhetorical Rituals of Passage" **Lorelei Lingard, Interviewer**
Resident and Attending Physician Interview Questions

A/General Questions:
1. Do you instruct your students about the oral presentation? Before or after the first presentation? What do you tell them?

2. What do you see as the key weaknesses or difficulties in student case presentations on rounds? *(work rounds for residents, attending rounds for attendings)*

3. What are the standard comments or stock feedback you find yourself repeating to students when they give presentations?

3. What do you see as the main purpose of student's oral presentations on (work or attending) rounds?

4. Are there certain skills and values that students should acquire by giving presentations? What are these?

5. Are there any "golden rules" for giving oral presentations?

6. Howdid you learn to give presentations this way?

B/Questions regarding the sample presentation passage (explain that it comes from a student presentation transcribed):

1. a. Would you make any changes in this oral presentation? Any material you'd omit or add? Any changes you'd make in organization/order?

b. Does context matter? (work or attending, day of admission, followup, pre-discharge) Is there more than one form of presentation?

c. Why are these changes necessary?

d. How did you learn to do it that way?

e. Do most people do it that way? If there are variations, why do you think this is so? *(if the response is "personal style", ask "Are there main "styles" that you would recognize? Are they related to different medical goals, pressures, or principles?)*

2. a. Would you present the SH, FH and ROS data in the way that this sample does?

b. If not, what changes would you make?

c. Why are these changes necessary?

d. Does context matter?

e. How did you learn to do it that way?

f. Do most physicians do it that way? If there are variations, why do you think this is so? (--this question perhaps unnecessary, based on response to #1.e.)

C/Questions about Feedback:

I'm going to read you some comments that resident and attending physicians have offered as feedback on student presentations. These comments, and others closely resembling them, recur often in my observations of student presentations on work and attending rounds. Imagining the most reasonable or common interpretation, could you suggest what the feedback is meant to teach the student about the oral presentation?

Questions: "When, and why, might a resident or attending say this to a student who's presenting?"

1. Resident feedback on work rounds:

a. "Just give me a bullet on him--why is he here, and why now."

b. "Pertinent positives only--I'll ask for the negatives if I want them."

c. "Just give me the social context stuff when it's warranted, when it's related to the presenting illness."

2. Attending physician feedback on attending rounds:

a. "Dont put so much in your HPI."

b. "Work from "the usual suspects" [or, "the bread and butter"] on down."

c. "So what do you think she's got?"

Sample Student Case Presentation (history sections only):

ID/CC: PG is a 47 year old Samoan man with a 10 year history of "asthma" and a 6 year history of obstructive sleep apnea, who was brought to the ED with extreme shortness of breath and somnolence.

HPI: PG was brought to the ED this morning after his visiting nurse found him difficult to arouse and very short of breath. PG has a 10 year history of progressive dyspnea with exertion that has progressed to hypoxia at rest and limits his activity to brief ventures within the house. He states that he receives oxygen 18 hours daily, usually sleeps in a chair and uses albuterol, funisolide and metaproternal inhalers twice daily. In 1990, PG was diagnosed with "sleep apnea" and has been treated with CPAP at 12-13 mmHG while sleeping and a cardiac pacer for bradyarrhthymias. 3 weeks ago, PG was discharged from SFGH after being treated for "pneumonia," during which time he was intubated for 4 days. Since leaving the hospital, his difficulty breathing has increased and he has developed a cough that is productive of "green" sputum with streaks of blood. He has also noticed fevers with chills on 3 or 4 occasions in the past 3 weeks. PG states that he tested negative for tuberculosis during his last admission. Over the past 2-3 days, PG has stopped using the CPAP at night because he has been coughing up sputum. PG's physical state is significant for morbid obesity (480 lbs) without significant change in the last year. Patient reports never being told he has diabetes.

PMH: PG has had 4 previous hospitalizations for "pneumonia" in the past 5 years. PG has an 8 pack/year smoking history, but quit 1 year ago. He reports no history of heart trouble and denies chest pain, orthopnea and paroxysmal nocturnal dyspnea. He suffers from chronic venous stasis and non-healing ulcers on both legs for which he is followed in the wound clinic at SFGH. In 1994, PG was hospitalized for a GI bleed that was diagnosed as gastritis. On his last hospital visit, PG was diagnosed with nephrotic syndrome. Patient had a right hernia operation at age 31 without complications and a tonsillectomy and an adenoidectomy at age 5.

SH: PG lives with his sisters in San Francisco. He states that he is homosexual and has not had intercourse in "years". He claims to have "felt depressed for years" as a result of his homosexuality and isolation. He is not currently employed and receives disability for "asthma." He was last employed 2 years ago as a "shipyard worker." He denies alcohol and drug use. His last HIV test was negative in 1994.

FH: PG believes there is no history of pulmonary or heart disease in his family. His father died of "natural causes" at age 65, mother died of colon cancer at age 75. He has two sisters and one brother in good health.

ROS: Patient denies abdominal pain or flank pain, bright red blood per rectum, melena, diarrhea or constipation. Patient denies dysuria, urinary frequency, hesitancy, hematuria or history of renal stones. Patient denies joint pain or swelling.

Meds: PG is presently taking Metaproternol - 2 puffs BID, Flunisolide - 2 puffs BID, Albuterol - 2 puffs BID, Furosemide - 40mg BID, Nifedipine - 20 mg BID, Colace, Dulcolax, and Aquaphor with bacitracin dressings to the legs. No known allergies.

"Rhetorical Rituals of Passage" **Lorelei Lingard, Interviewer**
Third-Year Student Interview Questions

A/ Previous Instruction in Oral Case Presentations:

1. What did you learn about the oral presentation in your preceptor instruction?
2. Did you receive any written instructions from your preceptor or anyone else?
3. How much time was spent on oral presentations in the preceptor situation?
4. Do you think this instruction was successful? If not, why exactly?
5. What did it teach you about the order of the oral presentation?
6. How should you deliver the oral presentation?
7. Are there any "golden rules" for giving oral presentations? If so, what are they?

B/ The Content of the Oral Presentation:

1. a. When you are making up your notes for the oral presentation, how do you decide what material to include from the Physical Exam and Patient History?

b. (*ask student to define any terms that arise in response to this question, such as "relevance" or "contributory"* --e.g. "What does "relevant material" mean? How can you tell?")

2. a. From the data in Passage One, what details would you exclude from your oral presentation of this patient (presuming that this is the first presentation after admission to the service)?

b. Would you do anything differently if this were a presentation on attending rounds rather than work rounds?

3. a. How did you decide to exclude, for example, **data X** (*detail that student is quite certain about excluding; then try another detail that student seems not so certain about excluding*)?

b. Might there be circumstances under which you could decide to put it back into the presentation?

c. If yes, what circumstances are those?

4. How would you organize the data which you have decided to include? Indicate on the passage what information you would put into the **HPI** and what you would put into the **PMH**.

5. a. Would you feel comfortable presenting this material if I moved **data Y** (*particular data that students have put in PMH in written cases and attending physician has indicated should be moved to HPI*) out of the **PMH** and into the **HPI**?

b. If you would not agree with this change, can you explain why? What is affected by such a reorganization?

6. **a.** The patient's just been admitted. This is the first presentation. How would you decide which **Social, Family, or Past History** data to include?

b. What would happen if I put back into your presentation **data Z** (*Social , family or past data already excluded by student in Question #3 above*)? Would it matter?

c. How, exactly?

C/ The Context of the Oral Presentation:

1. **a.** About how much time do you have to present your patient on work rounds?
b. On attending rounds?

2. **a.** What is the primary goal of the oral presentation on work rounds?
b. On attending rounds?

3. **a.** Who are you presenting to on work rounds? Is there anything you need to know about this audience, in order to present well? *(for example, is it important to know how much this person already knows about your patient?)*
b. Who are you presenting to on attending rounds? Is there anything you need to know about this audience, in order to present well?

4. How might the following factors influence your oral presentation?
a) your team's call schedule (i.e., post long-call)*,
b) the possibility of a rare condition *(would this be the first diagnosis you'd offer?)*,
c) the imminent discharge of the patient,
d) the attending's presence on work rounds,
e) the number of patients on the service.

* explore, in these cases, *both* if they know that change is necessary *and* what strategies they would employ to make the changes. For example, in the post long-call situation, will they know of the option to allow the resident to guide the data selection, with questions such as "Do you want all of these lytes?" (these are strategies that interns demonstrate, and some third-year students seem to pick up sooner than others)

Interviewee's Name:_____

Patient Data Passage

PG was brought to the ED this morning after his visiting nurse found him difficult to arouse and very short of breath. PG is a 47 year old Samoan man with a 10 year history of "asthma" and a 6 year history of obstructive sleep apnea, who was brought to the ED with extreme shortness of breath and somnolence. PG has a 10 year history of progressive dyspnea with exertion that has progressed to hypoxia at rest and limits his activity to brief ventures within the house. He states that he receives oxygen 18 hours daily, usually sleeps in a chair and uses albuterol, funisolide and metaproternal inhalers twice daily. He denies alcohol and drug use. His last HIV test was negative in 1994. He has no known allergies. PG is presently taking Metaproternol - 2 puffs BID, Flunisolide - 2 puffs BID, Albuterol - 2 puffs BID, Furosemide - 40mg BID, Nifedipine - 20 mg BID, Colace, Dulcolax, and Aquaphor with bacitracin dressings to the legs. In 1990, PG was diagnosed with "sleep apnea" and has been treated with CPAP at 12-13 mmHG while sleeping and a cardiac pacer for bradyarrhthymias. 3 weeks ago, PG was discharged from SFGH after being treated for "pneumonia," during which time he was intubated for 4 days. Since leaving the hospital, his difficulty breathing has increased and he has developed a cough that is productive of "green" sputum with streaks of blood. He has also noticed fevers with chills on 3 or 4 occasions in the past 3 weeks. PG states that he tested negative for tuberculosis during his last admission. Over the past 2-3 days, PG has stopped using the CPAP at night because he has been coughing up sputum. PG has had 4 previous hospitalizations for "pneumonia" in the past 5 years. PG has an 8 pack/year smoking history, but quit 1 year ago. He reports no history of heart trouble and denies chest pain, orthopnea and paroxysmal nocturnal dyspnea. He suffers from chronic venous stasis and non-healing ulcers on both legs for which he is followed in the wound clinic at SFGH. In 1994, PG was hospitalized for a GI bleed that was diagnosed as gastritis. On his last hospital visit, PG was diagnosed with nephrotic syndrome. Patient had a right hernia operation at age 31 without complications and a tonsillectomy and an adenoidectomy at age 5. He believes there is no history of pulmonary or heart disease in his family. His father died of "natural causes" at age 65, mother died of colon cancer at age 75. He has two sisters and one brother in good health. PG lives with his sisters in San Francisco. He states that he is homosexual and has not had intercourse in "years". He claims to have "felt depressed for years" as a result of his homosexuality and isolation. He is not currently employed and receives disability for "asthma." He was last employed 2 years ago as a "shipyard worker." PG's physical state is significant for morbid obesity (480 lbs) without significant change in the last year. Patient reports never being told he has diabetes. Patient denies abdominal or flank pain, bright red blood per rectum, melena, diarrhea or constipation. Patient denies dysuria, urinary frequency, hesitancy, hematuria or history of renal stones. Patient denies joint pain or swelling.

Appendix E

Invocations of Relevance in Keenan's "Oral Presentations" and Haber's "The Compleat Write-up"

Keenan's Document

(S18) Limit yourself to the pertinent data and just outline **less important data** (if you include it at all) to save time and keep your listener awake.

(S29) This does not mean that you leave out **important data** or bias your story in any way — just that by having a conclusion, your presentation will follow a path instead of wandering.

(S34) I have a personal preference in that I like to tell the patients' major past medical problems up front, especially **if they are relevant** to the illness or complaint for which they are seeking help.

(S44) Always include **pertinent positives** and **pertinent negatives** with regards to other symptoms that may be related to the chief complaint, e.g., the patient has no abdominal pain or melena.

(S46) But remember, you do not have to included [sic] these **if they bear no importance** to the case--how to decide their **importance** comes with experience.

(S51) I do not usually mention the dose **unless it is important** to the HPI or if I am adjusting the dose of the medication during that admission.

(S53) I generally just list the past medical history problems **unless a specific item is important** to this patients' illness—then I go into more extensive detail.

(S55) List more **important** illnesses first.

(S56) Remember that PMH items **that are crucial** to the HPI can be discussed in the HPI if you so desire.

(S61) **Pertinent** negative history of illness should be included in the HPI.

(S64) How much to **include** depends upon **how important it is** to that patient's presentation and care plan.

(S65) Be sure to **include** occupational exposures **if pertinent.**

(S66) I also include sexual history in this portion of my oral presentation, **if significant.**

(S70) Sometimes travel history and animal exposures are included here, **if pertinent.**

(S72) I personally tend to mention specifics **only if it is pertinent** to the patient's illness, but otherwise I say "non-contributory.

(S74) I include other family members **only if particularly relevant** to the case.

Appendix E continued

Haber's Document

(S15) …what brought the pt. into the hospital and all information **pertinent** to his/her care while in the hospital.

(S23) **Relevant** positives and negatives from "Review of Systems", "Family History", "Past History" and "Social History" … should be included in the HPI.

(S24) Summary of past hospitalizations (here or elsewhere) should be included in the HPI **if relevant.**

(S26) Since **significant** medical problems affect a patient's care in the hospital, **even if they are not directly relevant** to the Chief Complaint, they should be listed in the HPI after a discussion of the Chief Complaint.

Name_____

Oral Presentation Project
Third-Year Student End of Clerkship Questionnaire:
(Please complete and return to Andy Jones in 5H6 or Dr. Haber in 5H24 before the end of the clerkship)

1. What is the accepted order of sections in the oral presentation (E.g., Chief Complaint, History of Present Illness, etc.)? Does it ever change? If yes, when or why?

2. What do you find to be the most difficult aspects of preparing and delivering an oral presentation? List them and explain why you find them difficult.

3. The patient described in Passage A (attached) has just been admitted, and you are presenting him for the first time on attending rounds. Circle the data you would put in the History of the Present Illness and underline the data you would put in the Past Medical History for this presentation. Explain below how you made these selections.

4. The patient in the passage has just been admitted. This is the first presentation on work rounds. On passage B (attached), circle the Social and Family History and Review of Systems data that you would include. Explain below how you made this decision.

5. Think back to an oral presentation that went poorly. What would you say you did wrong, and how would you change it if you could do it again?

6. What tips would you give other students beginning a Medicine clerkship about giving successful oral presentations?

7. Can you suggest anything that would make your learning of the oral presentation form more efficient and effective?

Patient Data Passage (B)

Patient was brought to the ED this morning after his visiting nurse found him difficult to arouse and very short of breath. Patient is a 47 year old Samoan man with a 10 year history of "asthma" and a 6 year history of obstructive sleep apnea, who was brought to the ED with extreme shortness of breath and somnolence. He has a 10 year history of progressive dyspnea with exertion that has progressed to hypoxia at rest and limits his activity to brief ventures within the house. He states that he receives oxygen 18 hours daily, usually sleeps in a chair and uses albuterol, funisolide and metaproternal inhalers twice daily. He denies alcohol and drug use. His last HIV test was negative in 1994. He has no known allergies. Patient is presently taking Metaproternol - 2 puffs BID, Flunisolide - 2 puffs BID, Albuterol - 2 puffs BID, Furosemide - 40mg BID, Nifedipine - 20 mg BID, Colace, Dulcolax, and Aquaphor with bacitracin dressings to the legs. In 1990, Patient was diagnosed with "sleep apnea" and has been treated with CPAP at 12-13 mmHG while sleeping and a cardiac pacer for bradyarrhthymias. 3 weeks ago, he was discharged from SFGH after being treated for "pneumonia," during which time he was intubated for 4 days. Since leaving the hospital, his difficulty breathing has increased and he has developed a cough that is productive of "green" sputum with streaks of blood. He has also noticed fevers with chills on 3 or 4 occasions in the past 3 weeks. Patient states that he tested negative for tuberculosis during his last admission. Over the past 2-3 days, Patient has stopped using the CPAP at night because he has been coughing up sputum. He has had 4 previous hospitalizations for "pneumonia" in the past 5 years. He has an 8 pack/year smoking history, but quit 1 year ago. He reports no history of heart trouble and denies chest pain, orthopnea and paroxysmal nocturnal dyspnea. He suffers from chronic venous stasis and non-healing ulcers on both legs for which he is followed in the wound clinic at SFGH. In 1994, Patient was hospitalized for a GI bleed that was diagnosed as gastritis. On his last hospital visit, Patient was diagnosed with nephrotic syndrome. Patient had a right hernia operation at age 31 without complications and a tonsillectomy and an adenoidectomy at age 5. He believes there is no history of pulmonary or heart disease in his family. His father died of "natural causes" at age 65, mother died of colon cancer at age 75. He has two sisters and one brother in good health. Patient lives with his sisters in San Francisco. He states that he is homosexual and has not had intercourse in "years". He claims to have "felt depressed for years" as a result of his homosexuality and isolation. He is not currently employed and receives disability for "asthma." He was last employed 2 years ago as a "shipyard worker." Patient's physical state is significant for morbid obesity (480 lbs) without significant change in the last year. Patient reports never being told he has diabetes. Patient denies abdominal or flank pain, bright red blood per rectum, melena, diarrhea or constipation. Patient denies dysuria, urinary frequency, hesitancy, hematuria or history of renal stones. Patient denies joint pain or swelling.

APPENDIX G

Draft of Consultant's Report

Curriculum Strategies

There are, as I see it, three primary ways to address the genre gap that plagues the clerkship experience for many students and threatens to create dysfunctional effects in the education process. These are:

1. Destabilize the normative sense of the genre, that it is natural, that "it's just done this way", by making students aware of scholarly debates about the form.

2. Shift parts of the clerkship experience to other contexts, outside the boundaries of acute care.

3. Implement an exercise designed to challenge students' formalized sense of the presentation genre, and raise their rhetorical awareness of its contextual reciprocity.

After a brief explanation of the first two strategies, the third (which relates most directly to the study presented here) will be more comprehensively described and theorized.

Communicating Intercommunity Medical Discourse Debates

Medical educators might consider offering students access to the published debates on the form of written records and oral presentations, reflective as they are of tensions in the genre and illustrative of sites for resistance. Such knowledge could contribute usefully to students' development of critical literacy and their awareness of the ideological issues at stake in different presentation "styles".

There are rhetorical and pedagogical advantages to introducing students to socio-rhetorical debates *within* their medical community. For, as medical humanities faculty frankly admit (see, e.g., Wear's *Privilege in the Academy*), "humanities" (non-science) curricula tend to remain on the periphery of the medical landscape. The scholarly debate about the oral presentation among publishing physicians is a resource that should be investigated (whether it takes an explicitly rhetorical approach or not), as it offers a vehicle for bridging the divide between "us and them" -- that

is, between folks who care about language and folks who care about medicine.

Outpatient Care Contexts: Preparing for Chronic Care

While resident training in Internal Medicine has moved into the wider context of ambulatory (out-patient) care, the formative student clerkship experience remains confined, in most institutions, to the acute care, in-patient context. This choice is supportable in that, in order to learn as much medicine as possible in these short clerkships, students need to encounter as many medical conditions as possible, and witness the course of each. The in-patient setting provides this dense learning experience in a way that the out-patient context simply cannot. But given that students learn to present like physicians in this acute care context, and, as this paper has argued, to *think* like physicians, the restricted clerkship site has serious implications for medical education.

The medical careers that most of this new doctors will undertake will involve far more out-patient than in-patient medicine, yet their clinical reasoning skills, their medical values and goals, will have been shaped by the exigencies of acute care. Elliot and Hickam argue that "the structure of medical ward rounds reflects tradition, rather than experimentation with the impact of different structures on educational and patient care objectives" and suggest that "new educational strategies and a shift towards ambulatory experiences are forces to alter in-patient teaching and foster the development and testing of new paradigms" ("Attending Rounds" 507).

In an attempt to determine the actual benefits of the increasing trend towards ambulatory-care-based education, Wisdom et al. surveyed students who had completed an optional four-week ambulatory care component in the third-year Internal Medicine clerkship. They outline as among the *potential* benefits the hope "that medical students will develop their knowledge, skills, values, and attitudes through . . . exposure to the spectrum of acute and chronic patients seen in an ambulatory care setting" ("Ambulatory" 534). As the Wisdom study asserts, curriculum reform to address the clerkship context issue is already underway at medical institutions. For example, at the University of Hawaii John A. Burns School of Medicine, a study is being conducted to compare two, third-year clerkship models. The two curricula are "(1) a clerkship comprised of sequential

specialty experiences in hospitals and other tertiary care settings" (the model used at UCSF) and "(2) a longitudinal clerkship in which concurrent education is provided . . . primarily in ambulatory clinics and emphasizes primary care" (418). Researchers will evaluate and compare students' competence in "knowledge acquisition and application, cognitive skills, clinical skills, and habits and attitudes" (419) but the article suggests neither their motives for introducing the longitudinal option nor the hypothesized outcomes.

When a study's objectives are articulated, they do not necessarily echo the objectives that motivate me in this conclusion. For instance, Grum and Woolliscroft praise the ambulatory clinic experience for fostering students' "ability to rapidly recognize and categorize patient problems" and enhancing their "development of clinical diagnostic expertise" (420). They give no indication of trying to expand students' sense of the influence of context on the determination of relevant diagnostic information, the range of therapeutic options, or the nature of physician/patient relations. Grum and Woolliscroft's persistent focus on ostensibly objective (acontextual) medical tasks reinforces my earlier claim that it is insufficient and ineffective to just reform medicine's discursive regulations or educational contexts: we must also address the community's values and goals if we hope to encourage the development of a new paradigm of care. I have raised the possible strategy of wider contexts for the clerkship so that students might develop a heightened sense of the influence of context on both their presentations and their patient relations. I am influenced in this position by the growing literature questioning traditional medicine's ability (as it is now commonly taught) to adequately address the exigency of chronic care. But as the published record of ambulatory care studies suggests, the change in educational context is a necessary but insufficient aspect of medical curriculum evolution.

A Rhetorical Exercise

As a future stage in this project, Haber and I are considering the incorporation of a rhetorical exercise into the medical curriculum, in which students would discuss how sample presentations respond to varying contexts. In a manner similar to our discourse-based interviews, a group of students would read a patient data passage that is

representative of a number of difficult selection and organization decisions. Students would then individually construct an oral presentation out of the passage. Making reference to problematic sections such as the History of the Presenting Illness and the Past Medical History, a facilitator would request that students support their selection and organization decisions. Questions addressed to students would be designed to highlight the rhetorical concerns of audience, exigency, situation, and purpose. As in the interviews, students' references to such principles as "relevance" would be highlighted, and explicit definition of such principles attempted. Then students would be asked context questions such as "Can you think of a presentation situation where this [order, selection, etc.] might not be appropriate, might not achieve your presentation's purpose?

It is hoped that such an exercise would suggest to students what rhetorical questions to consider -- or ask -- when drafting a presentation. Additionally, this exercise may remind "expert" presenters (teaching faculty facilitators) what new clerks do not know, and create a context where these teachers are more apt to make explicit their own tacit knowledge and reasoning. This is important to the initiation process, since "being reflective and articulate about one's thinking process helps novices to understand how a skilled practitioner approaches a problem" (Irby "Three Exemplary" 952).

The purpose of such a rhetorical exercise would be to give students more than just an early "edge" in their oral presentations. Beyond this, it would be designed to encourage a meta-generic awareness in students, a sense of rhetorical reciprocity that could be transported to new contexts, from subsequent hospital clerkships to outpatient care experiences. For as Woolliscroft et al. argue, in medicine's uncertain future students will need strategies (285). A useful curriculum revision must offer students a heuristic for analyzing the contexts and conventions of this and other related medical genres (such as the chart record), so that they can adapt to various rhetorical situations as they arise (cf. Coe on "Metaheur" in *Process* 412-48).

While my interview sample suggests that residents and attendings are giving some attention to the presentation genre in their orientation comments to new students, these comments are sporadic and may be misleading because of their vague or metaphorical nature (recall the fairytale analogy to explain the concept of relevant data). The genre approach of

the rhetorical exercise suggested here does not shed the political in the way that a focus on discourse as a "product" does; rather, it helps place the crafting of the presentation as a social act firmly in organic relation to its contexts, and allows for the tension between normalizing and innovative forces at work in discourse. This understanding lets us teach students about multiple and competing communicative contexts, about the social and ideological issues at stake in decisions about form and content, and about heuristics for analyzing and negotiating diverse genres.

As we draft the proposal for such a "rhetorical intervention" exercise, Dr. Haber and I hope that it might increase students' awareness of the reciprocity between form and context, making them better equipped to interpret feedback correctly and less likely to make problematic generalizations[1]. This reflexive consciousness may enable novice physicians to use the professional discourse critically: to have an awareness of what it means to so orient themselves. For the role of this genre -- the oral patient presentation -- in the initiation of medical students is an ideological one: this genre, like all genres, is "neither value-free nor neutral" and implies/inscribes "hierarchical social relationships" both among physicians and between physicians and their patients (Coe & Freedman "Genre Theory" 3). It encourages communication in keeping

---

[1] Two benefits of such an exercise are that it might be accomplished in a relatively short period of time, and that teaching faculty could be trained to facilitate. The first would be determined by research trials to determine the relationship between the type and duration of exercise students participate in and the effect (if any) on their ability to adapt the form learned in the classroom to the hospital's shifting contexts. The second benefit relates to our goal to keep potential solutions to the oral presentation problem inside the medical community. Cathy Schryer has called such an approach a "consultancy model of research", in which the researcher develops analytical constructs which are both familiar to the community and yet distant enough to provide critical insight, so that literacy solutions can be implemented by the members themselves. The "bridging mechanisms" advocated in this conclusion reflect Schryer's notion of a research ethic that "advocates social action rather than appropriation and control" ("Consultancy Model" 135).

with Western medicine's characteristic paradigm, and constrains against alternate ideologies of care. Those students who use this genre expertly (albeit, perhaps naively) are empowered by it, embraced into the professional fold. But consubstantiality comes at a cost: their potential for critical perspective may be undermined as they step onto medicine's shared ground, its sub-stance. Metageneric awareness may enable the novice to walk the tightrope between consubstantiality and critique, between adopting functional strategies in appropriate situations and adapting naively to formal structures and the ideologies they embody.

Works Cited

Anspach, Renée. "Notes on the Sociology of Medical Discourse: The Language of Case Presentation." Journal of Health and Social Behavior 29 (1988): 357-75.

Arluke, Arnold. "Social Control Rituals in Medicine: The Case of Death Rounds." Health Care and Health Knowledge. Ed. Robert Dingwall, Christian Heath, Margaret Reid and Margaret Stacey. London: Croom Helm, 1977. 108-125.

Atkinson, Paul. "Discourse, Descriptions and Diagnosis." Biomedicine Examined. Ed. Margaret Lock and Deborah Gordon. Dordrecht: Kluwer, 1988: 57-97.

---. Medical Talk and Medical Work: The Liturgy of the Clinic. London: Sage, 1995.

---. Sociological Readings and Re-readings. Aldershot, UK: Avebury, 1996.

---. "The Reproduction of Medical Knowledge." Health Care and Health Knowledge. Ed. Robert Dingwall, Christian Heath, Margaret Reid, and Margaret Stacey. London: Croom Helm, 1977. 85-106.

---. "Rhetoric as Skill in a Medical Setting." Qualitative Studies in Health and Medicine. Ed. Michael Bloor and Patricia Taraborrelli. Aldershot, UK: Avebury, 1994. 110-130.

Bakhtin, M.M. "The Problem of Speech Genres." Speech Genres and Other Late Essays. Ed. C. Emerson and M. Holquist. Trans. V.M. McGee. Austin: U of Texas P. 1986. 60-102.

---. The Dialogic Imagination: Four Essays. Ed. M. Holquist and C. Emerson. Trans. M. Holquist. Austin: U of Texas P. 1981.

Bateson, Gregory. Steps to an Ecology of Mind. New York: Ballantine Books, 1972.

Bateson, Gregory, and Jurgen Ruesch. Communication: The Social Matrix of Psychiatry. NY: Norton, 1951.

Bazerman, Charles. Shaping Written Knowledge: The Genre and Activity of the Experimental Article in Science. Madison, Wis.: U of Wisconsin P, 1988.

---. "Systems of Genres and the Enactment of Social Intentions." Freedman and Medway Genre 79-101.

Berkenkotter, Carol and Thomas Huckin. Genre Knowledge in Disciplinary Communication: Cognition/Culture/Power. New Jersey: Lawrence Erlbaum, 1995.

Berkenkotter, Carol and Doris Ravotas. "Genre As Tool in the Transmission of Practice Over Time and Across Professional Boundaries." Mind, Culture, and Activity 4.4 (1997): 256-74.

Berliner, Howard. "Medical Modes of Production." The Problem of Medical Knowledge: Examining the Social Construction

of Medicine. Ed. Peter Wright and Andrew Treacher. Edinburgh: Edinburgh UP, 1982. 162-85.

Bitzer, Lloyd. "The Rhetorical Situation." Philosophy and Rhetoric 1 (January 1966): 1-14.

Bourdieu, Pierre. Language and Symbolic Power. Ed. John Thompson. Trans. Gino Raymond and Matthew Adamson. Cambridge: Basil Blackwell, 1991.

Bradley, Graham. Disease, Diagnosis and Decisions. Chichester: John Wiley & Sons, 1993.

Brinton, Alan. "Situation in the Theory of Rhetoric." Philosophy and Rhetoric 14.4 (1981): 234-48.

Brose, J.A. "Case Presentation as a Teaching Tool: Making a Good Thing Better." Osteopathic Association Journal of the American. 92.3 (1992): 376-8.

Brown, Gillian and George Yule. Discourse Analysis. Cambridge: Cambridge UP, 1983.

Burke, Kenneth. A Grammar of Motives. Berkeley: U of California P. 1969.

---. A Rhetoric of Motives. Berkeley: U of California P. 1969.

---. "Fact, Inference, and Proof, in the Analysis of Literary Symbolism." Symbols and Values. Thirteenth Symposium of the Conference on Science, Philosophy, and Religion. Ed. Lyman Bryson, et al. NY: Harper, 1954. 283-306. Rpt. Terms for Order. 145-72.

---. Language as Symbolic Action: Essays on Life, Literature and Method. Berkeley: U of California P, 1966.

---. Permanence and Change, 2nd ed. Indianapolis, IN: Bobbs--Merrill, 1954.

---. Perspectives By Incongruity. Ed. Stanley Hyman and Barbara Karmiller. Bloomington: Indiana UP, 1964.

---. The Philosophy of Literary Form: Studies in Symbolic Action. Baton Rouge: Louisiana State UP, 1967.

Charon, Rita. "To Listen, To Recognize." The Pharos 49 (1986): 10-13.

Cicourel, Aaron V. "The Reproduction of Objective Knowledge: Common Sense Reasoning in Medical Decision Making." The Knowledge Society: The Growing Impact of Scientific Knowledge on Social Relations. Ed. G. Bohme and N. Stehrif. Dordrecht: D. Reidel, 1986: 87-122.

---. "Theoretical and Methodological Suggestions for Using Discourse to Recreate Aspects of Social Structure." What's Going On Here? Complementary Studies of Professional Talk (Volume Two of the Multiple Analysis Project). Ed. Allen Grimshaw, et al. Norwood NJ: Ablex, 1994. 61-88.

Clark, Herbert. Arenas of Language Use. Chicago: U of Chicago P. 1993.

Coe, Richard M. "'An Arousing and Fulfillment of Desires': The Rhetoric of Genre in the Process Era -- and Beyond." Freedman and Medway Genre 181-190.

---. "Burke's Act" and "Burke's Words." Excerpted chapters from "Toward a Better Life; or, Why and How to Read Kenneth Burke". Unpublished manuscript. Copyright reserved by author, 1995.

---. "Eco-Engineering Workplace Genres." Conference on College Composition and Communication. Nashville. 18 May. 1994.

---. "Logic, Paradox and Pinter's Homecoming." Educational Theatre Journal 27.4 (1975): 488-97.

---. "Metaphor." Encyclopedia of Rhetoric. NY: Garland, 1996. 438-444.

---. Personal communication. August 1997 and July 1998.

---. Process, Form and Substance: A Rhetoric for Advanced Writers, 2nd ed. Englewood Cliffs, NJ: Prentice Hall, 1990.

---. "Rhetoric 2001." Freshman English News 3.1 (1974): 1-13.

Coe, Richard and Aviva Freedman. "Genre Theory [in Composition: Australian and North American Approaches." Theorizing Composition. Westport, CT: Greenwood, in press. Copyright reserved by authors, 1997.

Cooke, Molly. "The Oral Presentation." Copyright reserved by author. Date unknown.

Creswell, John. Research Design: Qualitative and Quantitative Approaches. Thousand Oaks, Calif.: Sage, 1994. Debs, Mary Beth. "Reflexive and Reflective Tensions: Considering Research Methods from Writing-Related Fields." Spilka 238252.

Debs, Mary Beth. "Reflexive and Reflective Tensions: Considering Research Methods from Writing-Related Fields." Spilka 238-252.

Devitt, Amy. "Generalizing About Genre." College Composition and Communication 44.4 (Dec. 1993): 573-586.

---. "Intertextuality in Tax Accounting: Generic, Referential, and Functional." Textual Dynamics of the Professions: Historical and Contemporary Studies of Writing in Professional Communities. Ed. Charles Bazerman and James Paradis. Madison, Wis.: U of Wisconsin P. 1991. 336-355.

Doheny-Farina, Stephen. "Research as Rhetoric: Confronting the Methodological and Ethical Problems of Research on Writing in Nonacademic Settings." Spilka 253-67.

Doheny-Farina, Stephen and Lee Odell. "Ethnographic Research on Writing: Assumptions and Methodology." Writin in Nonacademic Settings. Ed. Lee Odell and Dixie Goswami. NY: Guildford Press, 1985. 503-35.

Donnelly, William J.,MD. "Lingua Medica: The Language of Medical Case Histories." Annals of Internal Medicine 127.11 (1997): 1045-48.

Douglas, Mary. How Institutions Think. Syracuse, NY: Syracuse UP, 1986.

Ede, Lisa and Andrea Lunsford. "Audience Addressed/Audience Invoked: The Role of Audience In Composition Theory and Pedagogy." The Writing Teacher's Sourcebook, 3rd ed. Ed. Gary Tate, Edward P.J. Corbett and Nancy Myers. NY: Oxford, 1994.

Elliot, D.L. and D.H. Hickam. "Attending Rounds on In-patient Units: Differences Between Medical and Non-medical Services." Medical Education 27.6 (1993): 503-8.

Emerson, Robert, Rachel Fretz and Linda Shaw. Writing Ethnographic Fieldnotes. Chicago: U of Chicago P, 1995.

Engel, George. "The Need for a New Medical Model: A Challenge for Biomedicine." Science 196.4286 (1977): 129-36.

Evans, Elizabeth. "Ritual." The Encyclopedia of Cultural Anthropology, Vol. 3. Ed. David Levinson and Melvin Ember. NY: Henry Holt & Co., 1996. 1120-23.

Feinstein, Alvan. Clinical Judgement. Baltimore: Williams and Wilkins, 1967.

Fieldnotes. Researcher's notes recording conversations and activities witnessed during observation on work and attending rounds, Oct./Nov. 1996 and Jan. 1998

Foucault, Michel. The Birth of the Clinic: The Archeology of Medical Perception. Trans. A.M. Sheridan Smith. NY: Pantheon, 1973.

---. The Archaeology of Knowledge. Trans. A.M. Sheridan Smith. NY: Pantheon, 1972.

Freadman, Anne. "Anyone for Tennis?" Freedman and Medway Genre 43-66.

---. "Uptake." Second International Symposium on Genre. 5 January, 1998.

Freedman, Aviva. "Do As I Say: The Relationship Between Teaching and Learning New Genres." Freedman and Medway Genre 191-210.

Freedman, Aviva and Peter Medway, eds. Genre and the New Rhetoric. London: Taylor & Francis: 1994.

Freedman, Aviva and Peter Medway. "Locating Genre Studies: Antecedents and Prospects." Freedman and Medway Genre 1-20.

Freedman, Aviva, and Peter Medway. Teaching and Learning Genre. Portsmouth, NH: Boynton/Cook, 1994.

Giddens, Anthony. Central Problems in Social Theory: Action, Structure and Contradiction in Social Analysis. London: MacMillan, 1979.

---. The Constitution of Society: Outline of the Theory of Structuration. Cambridge: Polity Press, 1984

---. Modernity and Self-Identity: Self and Society in the Late Modern Age. Stanford, Calif.: Stanford UP, 1991.

Giltrow, Janet. "Genre and the Pragmatic Concept of Background Knowledge." Freedman and Medway Genre 155-78.

Giltrow, Janet and Michelle Valiquette. "Genres and Knowledge: Students Writing in the Disciplines." Freedman and Medway Teaching 47-62.

Glaser, Barney and Anselm Strauss. The Discovery of Grounded Theory: Strategies for Qualitative Research. Chicago: Aldine Pub. Co., 1967.

Good, Byron J. and Mary-Jo DelVecchio Good. "'Learning Medicine': The Constructing of Medical Knowledge at Harvard Medical School." The Anthropology of Medicine and Everyday Life. Ed. Shirley Lindebaum and Margaret Lock. Berkeley and Los Angeles: U of California P, 1993: 81-107.

Gordon, Deborah. "Tenacious Assumptions in Western Medicine." Biomedicine Examined. Ed. Margaret Lock and Deborah Gordon. Dordrecht, Netherlands: Kluwer Academic Publishers, 1988. 19-56.

Gorroll, Allan and Gail Morrison. "Student Clerkship Evaluation Form." Core Medicine Clerkship Curriculum Guide. The Society of General Internal Medicine and The Clerkship Directors in Internal Medicine. March 1995.

Green, Georgia M. Pragmatics and Natural Language Understanding. Hillsdale, NJ: Lawrence Erlbaum, 1989.

Green, Bill and Alison Lee. "Writing Geography: Literacy, Identity, Schooling." Freedman and Medway Teaching 207-224.

Grum, C.M. and J.O. Woolliscroft. "What are Students Learning During Ambulatory Rotation? Implications for Generalist Education." Academic Medicine 69.5 (1994): 420.

Haber, Richard MD. "Interview." San Francisco General Hospital, January 1998.

---. "Medicine 110." Internal Medicine Clerkship Handout, San Francisco General Hospital. Copyright reserved by author. Date unknown.

---. "Orientation." Oral Presentation to Incoming Students, San Francisco General Hospital. November 1996.

---. "The Compleat Written Work-up." Internal Medicine Clerkship Handout, San Francisco General Hospital. Copyright reserved by author. Date unknown.

---. Personal communication. January 1998.

Hammersly, Martyn and Paul Atkinson. Ethnography: Principles in Practice, 2nd ed. London: Routledge, 1995.

Halliday, M.A.K. and James Martin. "General Orientation." Halliday and Martin 1-21.

Halliday, M.A.K. and James Martin. Writing Science: Literacy and Discursive Power. Pittsburgh: U of Pittsburgh P, 1993.

Herndl, Carl. "Teaching Discourse and Reproducing Culture: A Critique of Research and Pedagogy in Professional and Non-Academic Writing." College Composition and Communication 44 (1993): 349-363.

---. "Writing Ethnography: Representation, Rhetoric, and Institutional Practices." College English 53 (1991): 320-32.

Herzberg, Bruce. "Rhetoric Unbound: Discourse, Community, and Knowledge." Professional Communication: The Social Perspective. Ed. Nancy Roundy Blyler and Charlotte Thralls. London: Sage, 1993. 35-48.

Hull A.L. et al. "Validity of Three Clinical Performance Assessments of Internal Medicine Clerks." Academic Medicine 70.6 (1995): 517-22.

Hunt, Russell. "Speech Genres, Writing Genres, School Genres, Computer Genres." Freedman and Medway Teaching 243-261.

Hunter, Kathryn Montgomery. Doctors' Stories: The Narrative Structure of Medical Knowledge. Princeton: Princeton UP, 1991.

Irby, D.M. "How Attending Physicians Make Instructional Decisions When Conducting Teaching Rounds." Academic Medicine 67.10 (1992): 630-8.

---. "Three Exemplary Models of Case-Based Teaching." Academic Medicine 69.12 (1994): 947-53.

---. "What Clinical Teachers In Medicine Need to Know." Academic Medicine 69.5 (1994): 333-42.

Kassirer, Jerome and Richard Kopelman. Learning Clinical Reasoning. Baltimore: Williams and Wilkins, 1991.

Keenan, Craig. "The Oral Presentation." in "Tips to Survive the Wards." Craig Keenan and Alex Go. Copyright reserved by author. February 1996.

Kirmayer, Lawrence J. "Mind and Body as Metaphors: Hidden Values in Biomedicine." Biomedicine Examined. Ed. Margaret Lock and Deborah Gordon. Dordrecht, Netherlands: Kluwer Academic Publishers, 1988. 57-93.

Kleinman, Arthur. The Illness Narratives: Suffering, Healing and the Human Condition. New York: Basic Books, Inc., 1988.

Konner, Melvin. Becoming a Doctor: A Journey of Initiation in Medical School. New York: Penguin, 1987.

Kuhn, Thomas S. "Postscript-1969." The Structure of Scientific Revolutions, 2nd ed. Chicago: U of Chicago P, 1970. 174-210.

Lave, Jean and Etienne Wenger. Situated Learning: Legitimate Peripheral Participation. Cambridge: Cambridge UP, 1991.

Luke, Allan. "Genres of Power? Literacy Education and the Production of Capital." Literacy in Society. Ed. Ruqaiya Hasan and Geoff Williams. London: Longman, 1996.

Malinowski, Bronislaw. "The Problem of Meaning in Primitive Languages." Ogden and Richards. 296-336.

Miller, Carolyn. "Genre as Social Action." Freedman and Medway Genre 23-42.

---. "Rhetorical Community: The Cultural Basis of Genre." Freedman and Medway Genre 67-78.

Miller, Susan. Textual Carnivals: The Politics of Composition. Carbondale, IL: Southern Illinois UP, 1991.

Odell, Lee, Dixie Goswami and Anne Herrington. "The Discourse Based Interview: A Procedure for Exploring the Tacit Knowledge of Writers in Nonacademic Settings." Writing in Nonacademic Settings. Guildford Press, 1985.

Orientation Notes. Researcher's notes taken during Dr. Richard Haber's Orientation Talk to students, November 1996.

Oxford English Dictionary. Glasgow: Oxford UP, 1971.

Paré, Anthony. "Discourse Regulations and the Production of Knowledge." Spilka 111-123.

Paré, Anthony and Graham Smart. "Observing Genres in Action: Towards a Research Methodology." Freedman and Medway Genre 146-154.

Perelman, Chaim. The Realm of Rhetoric. London: U of Notre Dame P, 1982.

Pomerantz, Anita, Jack Ende and Frederick Erickson. "Precepting Conversations in a General Medical Clinic." The Talk of the Clinic: Explorations in the Analysis of Medical and Therapeutic Discourse. Ed. G.H. Morris and Ronald Chenail. Hillsdale, NJ: Lawrence Erlbaum Associates, 1995. 151-169.

Random House Unabridged Dictionary. Ed. Stuart Berg Flexner. NY: Random House, 1993.

Reiser, Stanley. Medicine and the Reign of Technology. Cambridge: Cambridge UP, 1977.

Richards, I.A. and C.K. Ogden. The Meaning of Meaning: A Study of the Influence of Language upon Thought and of the Science of Symbolism. NY: Harcourt, Brace & World, 1923.

Roter, Debra. "Communication Patterns of Primary Care Physicians." JAMA 277.4 (1997): 350-6.

Russell, B. and C.W. Penney. "Reorganizing 'traditional' Case Presentation Enhances Learning, Clinical Experience." Journal of the American Osteopathic Association 92.8 (1992): 967-8.

Schryer, Catherine F. "A Consultancy Model of Research for Literacy and Writing Across the Curriculum Researchers." Contextual Literacy: Writing Across the Curriculum. Ed. C. Schryer and L. Steven. Winnipeg: Inkshed Publications, 1994.

---. "Records as Genre." Written Communication 10: 200-34.

---. "The Lab vs. the Clinic: Competing Sites of Genre." Freedman and Medway Genre 105-24.

Segal, Judy Z. "Strategies of Influence in Medical Authorship." Social Science Medicine 37.4 (1993): 521-30.

---. "Writing and Medicine: Text and Context." Spilka 84-97.

---. "Patient Compliance, the Rhetoric of Rhetoric, and the Rhetoric of Persuasion." Rhetoric Society Quarterly 23.3-4: 90-102.

Segal, Judy, Anthony Paré, Doug Brent, and Douglas Vipond. "The Researcher as Missionary: Rhetoric and Reform in the Discplines." Forthcoming in College Composition and Communication.

Sperber, Dan and Deirdre Wilson. Relevance: Communication and Cognition. Oxford: Blackwell, 1986.

Spilka, Rachel. Writing in the Workplace: New Research Perspectives. Carbondale, IL: Southern Illinois UP, 1993.

Stein, Howard. American Medicine as Culture. Boulder: Westview Press, 1990.

Sullivan, Francis. "Dysfunctional Workers, Functional Texts: The Transformation of Work in Institutional Procedure Manuals." Written Communication 14.3 (1997): 313-359.

Sullivan, Patricia and James Porter. "On Theory, Practice, and Method: Toward a Heuristic Research Methodology for Professional Writing." Spilka 220-237.

Swales, John. Genre Analysis: English in Academic and Research Settings. Cambridge: Cambridge UP, 1990.

Tenner, Edward. Why Things Bite Back: Technology and the Revenge of Unintended Consequences. New York: Alfred A. Knopf, 1996.

Waitzkin, Howard. "A Critical Theory of Medical Discourse: Ideology, Social Control, and the Processing of Social Context in Medical Encounters." The Sociology of Medicine. Ed. William C. Cockerman. Aldershot, UK: Elgar Reference Collection, 1995. 45-64.

Wear, Delese. Privilege in the Medical Academy: A Feminist Examines Gender, Race, and Power. New York: Teachers College Press, 1997.

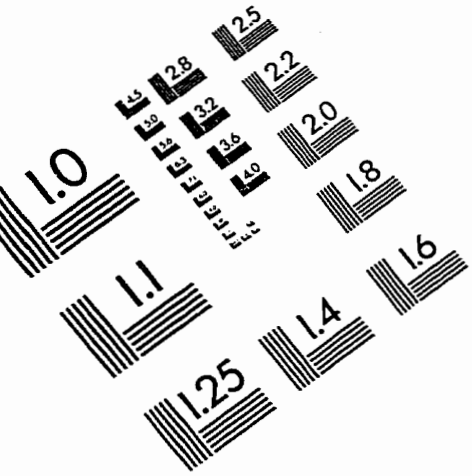
Weed, L.L. Medical Records, Medical Education, and Patient Care: The Problem-Oriented Medical Record as a Basic Tool. Cleveland, OH: Case Western UP, 1969.

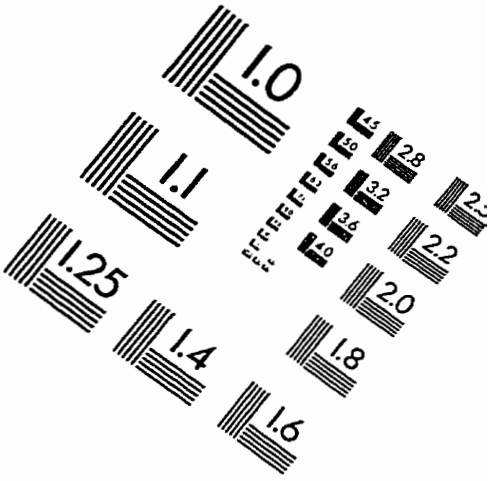
Wilden, Anthony. System and Structure: Essays in Communication and Exchange, 2nd ed. London: Tavistock Publications, 1980.

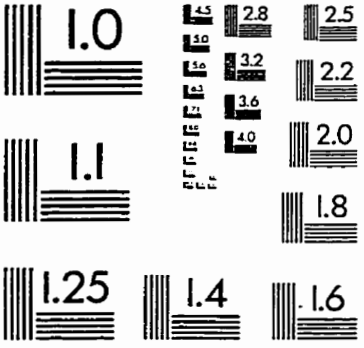
Wisdom, K. et al. "Internal Medicine Ambulatory-Care-Based Education: A Comparison of Three Models." Academic Medicine 68.10 (Supplement, 1993): s34-6.

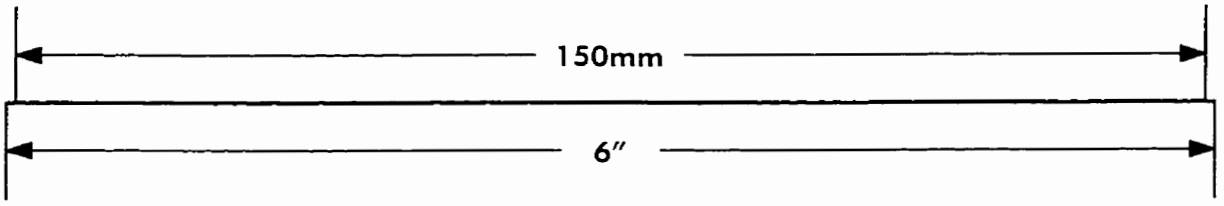
Woolliscroft, J.O. et al. "Medical Students' Clinical Self-Assessments: Comparisons with External Measures of Performance and Students' Self-Assessments of Overall Performance and Effort." Academic Medicine 68.4 (1993): 285-94.

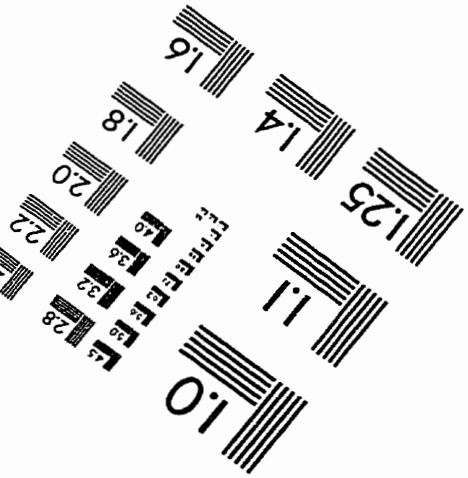
IMAGE EVALUATION TEST TARGET (QA-3)

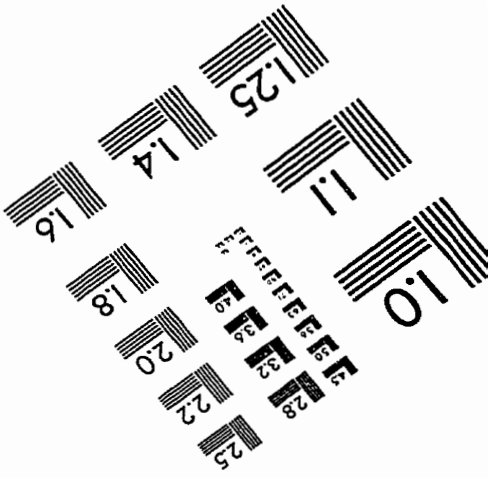












APPLIED IMAGE, Inc
1653 East Main Street
Rochester, NY 14609 USA
Phone: 716/482-0300
Fax: 716/288-5989