CHAPTER 1: INTRODUCTION.


Reporting and documenting the care given to patients is done routinely in hospitals. It is an integral part of the ongoing activities in all hospitals. For the purposes of medical communication, reporting and communicating between professionals can provide the principal purpose of a medical event.

The medical report is one of the many texts created by professionals regarding the patient’s condition and reaction to treatment. The doctor treats the patient and it is on the medical report that the extent of the illness and the outcome of the treatment is noted. These reports are created for other professionals or for the patient. Medical audiences are especially interested in these reports to better understand the course of the patient’s illness and the type of care rendered. Patients may request a copy of the report to better understand the events during hospitalisation or surgery. Requests are also often made by solicitors and others for medicolegal cases.

The doctor as the writer, is primarily responsible for producing an accurate and adequate medical report for each of the patients regardless of how short their hospital stay may have been. This report serves as a means of communication between the writer and those who request it and the reports are
valuable for measuring the quality of care and treatment rendered. This written communication is accorded more importance than the word of the patient.

Responsibility for an accurate report rests with the writer who is responsible for its completion and accuracy. If a report lacks accuracy, the patient may suffer. In case of litigation, an inaccurate and incomplete report may cause the hospital or the doctor or both to suffer.

Loss of information may occur in the reporting process. It is likely that doctors, surgeons and physicians as writers may be unaware of the loss of information, but it could have medicolegal consequences. In the light of legal implications and in the light of the need to produce a legally defensible account of the patient’s care and treatment, information gaps should be avoided to the greatest extent possible.

Since report writing is an untaught process, and given the increasing role of these reports today, a genre analysis of medical reports offers a system of enquiry into the structure of medical reports and towards searching for regularities in the reports. Language plays a central role in these types of reports but very little is known about how language in reports is shaped by the organisational context or the purpose of the reports.
1.2. Background of Study.

1.2.1. Medical Records.

A person who receives any sort of medical treatment in a hospital in Malaysia will have written documentation of that treatment, whether it is for outpatient treatment or as a patient in the hospital. Although this study is concerned with only one kind of report, it is important to remember that reports do not exist in isolation. They are a part of a body of written documentation created by a number of persons of differing professional backgrounds.

When a patient seeks medical treatment a number of reports are written about his or her condition by a variety of hospital personnel. There are different forms on which these observations are recorded and these are standardised forms used throughout the country. Hospital regulations restrict the privilege of recording on the medical record to certain medical personnel such as nurses, medical assistants, medical officers and physicians.

Medical reports are written based on information found in the medical records. A wide range of documents make up the case record catering for clinical and administrative needs. The content of the medical record will vary from patient to patient. An outpatient’s record will be less sophisticated than that of an inpatient who had surgery and was detained in the hospital. The length and the range of medical treatment given will determine the kind of
information in each record. The individual’s record therefore should have the following:

1. Identification data. Identification data is of prime importance. Sufficient data must be included on the records to adequately identify the patient. The basic data to be included is name, identity card number, registration number, age, sex and date of admission. This data is entered by personnel at the registration counter based on documents provided by the patient or relatives. All this information is filled in a card known as the outpatient department card. This card has allotted spaces for the information needed.

2. Medical history. This includes details of relevant medical history, treatment, and medication. It covers past illnesses, allergies and family histories especially any which may have some bearing on the present illness. This information is usually in the form of a referral letter accompanying the patient who has been treated elsewhere before seeking treatment at the present hospital. If the patient is without a referral letter then the attending doctor gleans the information by questioning the patient.

3. Details of present complaints and presenting symptoms presented in a systematic form convey the principal medical problem for which the patient is seeking diagnosis and treatment. This information indicates the nature and duration of the illness. This data may be expressed diagrammatically depending on the preference of the writer. Diagrams of the body or body parts may be
drawn and affected areas shaded to indicate the injury or disease. Useful information needed here is elicited by the careful questioning of the doctor.

4. Report of Physical Examination. Findings on physical examination are also included with sequential progress notes recording the patient’s response to treatment and details of further clinical examination. The progress notes are the core of the medical record. It reflects the observation function of medical care. It also provides a summary of the condition of the patient at the onset and a chronological record of the patient’s progress throughout the duration of care from day to day. The aim of this is to ensure that diagnosis and treatment are justified and that in the event of transfer of care, the next doctor will be provided with an immediate appraisal of the problem presented.

5. Clinical Observation. In cases of hospitalisation, observation and interpretations of the patient’s condition are made by members of the medical staff. These are notes that chart the course of the patient’s disease. These notes also chart the patient’s chronological course during the hospital stay. The purpose is to indicate any change in the patient’s condition along with the results of treatment.

6. Laboratory and X-Ray records. The attending doctor may give orders for certain tests to be done. Results of these may include notes on pathology, radiology, metabolism, E.C.G, X-rays and other tests including results and
reports from other departments in the hospital. A record of all tests carried out should be included in the patient’s folder.

7. Treatment records. This is a record of the prescription ordered for the patient. This record also indicates the dosage and length of treatment.

8. Follow up records. For some diseases, it is not possible to be sure at the end of the period that a patient has been cured effectively, even though the patient may appear well enough to be discharged for the time being. Such patients are required to come for follow up treatment at the out patient clinic and the progress is hence recorded.

Medical records are an essential tool in the practice of medicine. They involve the use of written communication and the prompt recording of all findings to create a complete record of care and treatment of the patient available to any clinician concerned with the care of the patient. As medical records make up the storehouse of knowledge concerning the patient and his medical history, it should contain sufficient data written in a sequence of events to justify the diagnosis and warrant treatment and end results.

These records serve a variety of functions. Firstly the records serve as a means of communication and planning among professionals in the medical profession who care for the patient. It also provides a documentary evidence of the patient’s medical evaluation, treatment and change in condition. Once filed away these records are a source document which can be traced, if needed in
future; and can be used in post discharge activities such as medicolegal cases, to protect the interests of the hospital or doctors. The records can also be used as a medium of evaluation for good recording reflects good medical practice.

1.2.2. Medical Reports.

Hospitals are frequently asked by solicitors and others for information about patients who have been, or are being treated by them. There are two main types of situation in which hospital authorities are likely to be asked for information: (1) where the patient or his representative is taking or contemplating proceedings or making a claim against the hospital or member of their staff or both; and (2) where the patient is, or may be engaged in litigation with a third party (the proceedings being taken either by or against the patient) and neither the hospital authority nor the staff are directly involved.

Insurers may seek medical reports in advance of trials to elicit the plaintiff’s medical history. It is the practice for the courts in personal injuries action to assess damages on the basis of agreed medical reports which have been agreed upon in joint medical examinations in which both the plaintiff’s and the defendant’s medical advisors have been present. Insurance companies seek these reports in compensation payouts to their policy holders in cases of personal injuries or illnesses against which they are insured.
Requests for the medical reports are sent to the Medical Records Office in the hospital. The office staff sort out the requests and send them to the various departments in that hospital. Rightfully a doctor who has seen or treated the patient whose report is needed has the privilege of writing it. However over time doctors get transferred to other units and other hospitals. This being the case, the remaining doctors in the unit are then required to write the reports. The folder with all the patient's records is then sent to the writer.

The writer of the medical report has to abstract from the individual case history salient information to form an adequate summary of the patient's episode of illness. This summary is based on data which exists in the many records in the patient's file. It should provide a description of the medical problem with which the doctor was confronted, the action taken, and what the consultant's view is, of the immediate outcome and the prognosis.

It is written from the case notes which is a noting of symptoms, to the description of findings, to noting the progress of the disease and finally to the prescription and treatment of the patient. All this information is textualised into a medical report. Some of the case notes and patient histories are lengthy and the doctor has to decide which to include and which to leave out. The final report has to be a brief but accurate document and since it is used for medicolegal purposes, the accuracy will protect the interests of the patient, the hospital and the attending doctor. The writer has to totally depend on the notes
in the folder and accuracy of the report depends a great deal on the completeness of the records.

Doctors have little or no formal training in producing reports when they begin their training. The skill of describing procedures and findings is not particularly emphasised in medical school prior to their training. As a result doctors often adopt self teaching strategies to learn how to produce these reports. Strategies commonly used by them is to attempt to read reports other doctors have written in order to gain some idea of the type of information to be included.

The writer prepares a handwritten report which is sent back to the records office, where the clerks type the handwritten reports. Once typewritten, the reports are sent back to the writer who scans it for errors. A corrected version is later sent back to the records office, where it is recorrected and finally sent to whoever has requested for it.

1.3. Purpose of study.

Reports are all written narrative descriptions of a professional's observation and description of a person, event or procedure. While such records may be crucial to the person reported on, to the professional involved
and to the functioning of the organisation itself, very little research has been done to examine the genre of medical reports.

Even though language plays a central part in this type of reporting, little is known about how language in the reports is shaped by the organisational context or the purposes of the records. Moreover, while part of the professional's competence is the creation of such reports, writing these textual reports is rarely formally taught, nor has the acquisition of such genres been studied.

Although the writer has a lot of freedom to use linguistic resources in any way he/she likes, he/she must conform to certain standard practices within the boundaries of that genre. Medical reports are created for other professionals or for the patient itself. In medical reports the communicative purpose it is intended to fulfill is to report past medical history, current complains, findings, diagnosis and treatment. This communicative purpose shapes the genre and gives it its internal structure.

The purpose of this study is to use genre analysis as a means of studying written discourse used for writing medical reports. Genre analysis will be used to investigate the Moves involved in writing medical reports as well as the varying realisations of each move. It will determine if a Move structure generalisation can be made. The objective here is to determine a Move
structure that is representative of medical reports. An in-depth investigation of each Move will also be carried out.

This study offers a way of making sense of the communicative events that occur in getting a report written. It intends to give an explanatory account of how medical reports are structured, illustrating the efficacy of genre based move structure as a system of enquiry into the structure of medical reports. It will also show preferred ways of communicating intention in medical reports.

1.4. The Research questions.

This study attempts to answer three research questions.

Question 1. How are medical reports structured?

Question 2. What are the regularities that exist in these medical reports?

Question 3. What are the communicative events that influence Medical Report writing?

Since genre analysis is descriptive rather than prescriptive, a comprehensive investigation of medical reports will be able to reveal the way these reports are structured. On the basis of this interpretation, a Move Structure for a typical medical report will be drawn up. This Move structure
will also be based on regularities that are evident in the medical reports and an explanation of these will be given.

The Move Structure will then serve to show the communicative purpose of this type of genre. It will look at the operation of language in a complete text and see the text as a system of features and choices. Since selection is made according to the communicative purpose of the writer who has freedom to use linguistic choices in a way he/she likes, he/she must conform to certain standard practices of writing reports and construct an overall text. Construction of the overall text is usually shaped in response to the context of the situation. The third question will therefore explore the communicative purpose of this type of medical reports.

1.5. Significance of study.

An analysis of the moves and steps in medical reports and the findings will be useful to those involved in teaching ESP and EAP and readers and writers of these documents. When first confronted by the problem of writing these reports new converts need lines of attack for making sense of how this kind of writing is structured. Concepts such as the 'Move Structure Analysis' can offer help on how the reports may be successfully written. These surface rules will aid in the writing of medical reports.
From the reporting and medicolegal point of view the writer or the doctor as the writer is the responsible party for reporting. Loss of information may occur in the reporting process. The writer therefore has the important task of selecting relevant and accurate information to be included in the narrative. Since these written reports are accorded more credibility than the actual patient’s words, it acts as the intervening document and is evidence of the evaluation. Therefore an accurate and adequate report which effectively provides the information will aid all concerned parties.