CHAPTER 4: RESULTS OF ANALYSIS AND FINDINGS.

4.1 : Introduction.

The analysis of the corpus has led to the findings that Medical Reports have four main Moves. The main function of medical reports is to report what the writer considers important and this reflects the writer’s judgment of what is relevant and what can be left out. It is a straightforward account of what happened during the patient’s illness and serves as an authentic record of what was done and diagnosed.

In this chapter the findings of the analysis of medical reports will be given. Generic structure, the overall organisation of the text, reveals how each part or move of the text has a specific function which contributes to its overall global function. The analysis of the generic structure / Moves enables one to capture the underlying function or intent of the writer found in separate stages in the text.

4.2 : Genre Structure of Texts.

A standard Medical Report has the following structural description in terms of the moves used by the writer to achieve his communicative purpose. The structural interpretation below indicates that the writer has used four Moves. The criteria used for classification of the moves is temporal, all previous medical complaints and procedures not performed in
this hospital are regarded as previous medical history or Move 2. Present medical complaints and procedures undertaken are classed as Move 3 and finally, the last move, Move 4 is seen as the Move which finalises the patient's treatment. Procedures done and described form the bulk of the report and when treatment ends or the patient is discharged marks the end of the episode. The four main moves are:

Move 1. Patient identification.

Move 2. Summary of Previous Medical History.

Move 3. Summary of Present Medical Complaints or Hospitalization.

Move 4. Review or Condition upon Discharge.

Each move is further divided into steps, as illustrated below.

Move 1- Patient Identification.

Step 1A. Name of patient

Step 1B. Identity card number.

Step 1C. Age of patient.

Step 1D. Date of admission.

Step 1E. Registration Number.

Step 1F. Sex.

Step 1G. Date of discharge.
Move 2 - Summary of Previous Medical History.

Step 1. Medical Complaints and/or

Step 2. Tests Done.

Step 3. Treatment given.

Move 3 - Summary of Present Medical Complaints and/or Hospitalization.

Step 1. New Medical Complaints.

Step 2. Physical Examination and findings

Step 3. Investigations and results

Step 4. Diagnosis.

Step 5. Treatment given and advice

Move 4 - Review or Condition upon Discharge/ Follow Up.

Step 1A. Discharge and/or

1B. Follow Up

1C. Death.
4.2.1: Move 1-Patient’s Particulars

The opening Move introduces the report by giving information about the patient. The aim of this is to provide the relevant information about the patient. Information that is printed on medical reports includes the following.

Step 1A. The Patient’s name.

Step 1B. The Identity Card Number.

Step 1C. The age of the patient.

Step 1D. The date of admission.

Step 1E. The registration number.

Step 1F. The sex of the patient.

Step 1G. The date of discharge.

This information is formatted at the top of the page in prescribed spaces. The above information is found in boxes on the text provided for this purpose. It is blocked off into 7 spaces with headings for the following i) medical report on, ii) identity card number, iii) registration number iv) age, v) sex, and vi) date of attendance, and vii) date of discharge as illustrated below.
Table 1. Information Required in Move 1

<table>
<thead>
<tr>
<th>Medical Report On</th>
<th>Identity Card No</th>
<th>Registration No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>Date Admission</td>
<td>Date Discharge</td>
</tr>
<tr>
<td>Sex</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Move 1 is a compulsory Move. It appears in all the reports and is presented in a tabular form in a very consistent manner. The report starts with all this information given first.

The first part of each sentence of every text analysed refers to the patient named. This shows that the patient is the central character of the issue. A medical report is a crucial source document for a number of clinical and administrative purposes and since medical reports can be used in legal cases they need to be identified in a consistent manner by the professional community. It is for this reason and for the sake of keeping records that Medical reports begin with identification of the patient first.
4.2.2 : Move 2 - Previous Medical History.

In order to decide upon the condition of a patient, an account of past medical history is required. A record of past illnesses, relevant medical history, treatment and medication is made. In cases where the patient has sought treatment elsewhere then this written record is given prominence. The doctor receiving the patient will need it to know what treatment has been given and the medical status of the patient. This is usually in the form of a referral letter accompanying the patient when the patient registers at the hospital.

The patient’s medical history may have some bearing on the present illness or the present illness may be related to some past illness. The previous medical history may be the current medical complaint especially in cases where there are complications which may arise in the course of treatment. An example of this is illustrated below.

**Medical History**

- 50 year old Chinese woman, known case of Diabetes mellitus on oral hypoglycemic agents. Apparently well had history of fever for which she was given an injection over (right) gluteal region by a private practitioner. Subsequently, she developed necrotising
factis is expanding from (right) gluteal region to (right) thigh associated with high grade fever.

Previous medical history may give an indication of present medical status and help the doctor establish a diagnosis of the patient's condition. In this case since the patient was presented with complications due to an injection, the doctor accepting the patient will know how to act since he is informed that this patient is a diabetic. Otherwise the doctor would have to do a blood sugar test before he can come to that conclusion. As such previous medical history may help the doctor\ reader to appreciate better the present medical conditions under the next move.

Move 2- Previous Medical History has 3 steps.

Step 1 - Medical Complaints

Step 2 - Tests Done

Step 3 - Treatment given.

Step 1 states the medical complaints which have affected the patient prior to the visit to the doctor in this particular hospital. At the time of registration in this particular hospital any previous medical complaints are classified as previous history. This would be a summary of medical complaints prior to treatment in this particular hospital. In this case
although the patient’s medical problem had started earlier and the patient was being treated elsewhere, and although the medical problem is still the same, it is classified under previous medical history. The current medical problem for this hospital will be from the time the patient is admitted to this particular hospital.

**Step 2** summarises all tests done and is a record of these tests and the results. These would have been done by other doctors who would have treated the patient before that patient was seen at this particular hospital.

**Step 3** is a summary of all treatment received and medications prescribed or taken. Written documents are preferred by the accepting doctors for information on medical history. This is because if statements are taken from the patient they may lack accuracy due to a lack of understanding of what may be significant especially information on what drugs are taken and the dosage of these drugs. A statement, ‘I take two orange coloured pills every day’ obviously cannot be taken seriously.

The example below illustrates a Move 2 - Previous Medical History which has all the three steps. The steps are not in sequential order but they are all present. Step 1 states the medical complaint under previous medical history and in this sample it is sentence 2, 3 and 6 which is a listing of medical complaints. Step 2 states the tests done and in this case it was a *C.T Scan*. This is shown in sentence 5. Step 3 is evidence of treatment given which is in sentence 1. It gives the name of the drug taken and the dosage.
<table>
<thead>
<tr>
<th>Move 2</th>
<th>Previous Medical History</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. A known case of diabetes mellitus for 7 years T. Daonil 10 mg a.m. and 5 mg at night.</td>
<td></td>
</tr>
<tr>
<td>2. Complained of weakness of the (left) side of the body since January 1997 when seen in May 91 at the medical clinic. 3. The weakness of the (left) upper limbs and (left) lower limbs is slowly improving. 4. He was treated in Specialist Medical Center for the above complains.</td>
<td></td>
</tr>
<tr>
<td>5. CT Scan done there showed right frontal lobe infarct Initially he had slurred speech in January 97 but speech completely improved now</td>
<td></td>
</tr>
</tbody>
</table>

Table 2. Example of a Move 2 - Previous Medical History.
4.2.3: Move 3 - Summary of Present Medical Complaints and/or Hospitalisation.

Move 3 has 5 significant steps in Medical Report writing. It starts with

Step 1  Medical Complaints
        and
Step 2  Physical examination and findings
        Or
Step 3  Investigations and results
        and
Step 4  Diagnosis
        and
Step 5  Treatment and advice given

Move 3 corresponds to the period or length of time that the patient seeks treatment in the hospital and is a record of medical procedures from the time of admission right up to the time of discharge or follow up or even death.

Step 1-Medical Complaints.

This step includes the current medical complaint or complaints or the reason the patient is seeking medical help at the time that the patient sees the doctor in the hospital. Under Step 1 details of present complaints and present symptoms are given. They are presented in a systematic form and
convey the principal medical problem for which the patient has been referred for diagnosis and treatment

In most cases the medical complaint mentioned under move 2 is similar to the medical complaint talked about under move 3. In cases when a patient is referred from elsewhere it is either due to complications or lack of sophisticated equipment for the further management of the patient or due to the cost factor on the part of the patient. In such cases the medical problem listed under move 2 is similar to that under move 3. In cases such as these Step 1 will be omitted from the report. If a new medical complication arises later in the course of treatment, then it is considered as Step 1.

Step 2- Physical Examination and findings:

The findings of the physical examination follow the medical complaint. A statement of observations and interpretations are written to record this. Information not only indicates the nature of the complaint but also the duration. In cases where the patient is hospitalised, Step 2 may be repeated a number of times. In the course of treatment due to the worsening condition of the sick patient a chronological clinical observation of the hospital stay is recorded. It is the summary of the condition of the patient and a chronological record of the patient's progress throughout the duration of care.
Step 3- Investigations and results.

Step 3 is a record of tests done such as X rays, blood tests, CT scans, ECGs etc and the results of these tests. Step 3 usually helps the doctor to confirm his diagnosis since it is evidence of what is wrong.

Example of a Step 3 - Investigations and results.

His blood test revealed

1) Uric Acid : 452 mmol/l

11) Blood Urea : 4.5 mmol/l

111) Creatinine : 120 mmol/l

And his Urine FEME revealed:

Albumin : Trace

Pus cells : 2-3

Uric Acid Crystals present.

[ MR 15 ]

Step 4. Diagnosis.

After noting the medical complaints and proceeding with tests, a diagnosis of the presenting problem is made. It is presented usually in one or two lines.
Example;

*Diagnosis:*  
1. *Diabetes Mellitus*  
2. *(right) Frontal Lobe Infarct with (left)* *Hemiparesis*

[MR 8]

Diagnoses may change with the worsening condition of the patient and instances of these will be recorded. This is a reflection of the medical judgement of the doctor attending to the patient.

Example,

*A provisional diagnosis of Postpartum psychosis was made*  

.......*the probable diagnosis of puerperal sepsis was made.*

[MR 11]

Step 5 Treatment and advice given

Steps 1-4 help the doctor to decide on the course of treatment needed. Treatment given can be in the form of drugs or procedures performed. A record of these is always included in the report. Dosage of drugs given is included.
Example 1 below states treatment given. It comprises the drugs given to the patient and dosage prescribed.

\[ T \text{ Persentin} \quad 75 \text{ mg tds} \]
\[ \text{Glucophage} \quad 500 \text{ mg tds} \]
\[ T \text{ daonil} \quad 5 \text{ mg bd.} \]

[ MR 8 ]

Example 2 below shows treatment and advice given

\[ \text{Analgesic antibodies given} \]
\[ \text{Wound debriment with K- wiring done for (left) thumb and middle finger.} \]
\[ \text{Refashioning amputated stump of (left) index finger done.} \]
\[ \text{He was treated for diabetes mellitus with oral hypoglycaemic agents.} \]
\[ \text{Advise on daily wound dressing.} \]

[ MR 3 ]

Sometimes certain procedures may be suggested but may not be carried out due to a low rate of success.
Example 3 shows only advice given

*Right cataract surgery was proposed but patient deferred the surgery after being told of the poor and guarded visual outcome in his right eye because of the previous anterior uveitis.*

[ MR 1 ]

Example 4 shows procedures performed under treatment.

*Wound debriment with K-wiring done for (left) thumb and middle finger. Refashioning amputated stump of (left) index finger done.*

[ MR 3 ]

*....underwent successful right cataract extraction with posterior chamber intra ocular lens implantation on 30.4.97 under general anaesthesia.*

[ MR 9 ]

*I.M. nailing was done and fracture (right)*
*Tibia- Fibula was treated conservatively.*
*He was given intensive care*
*Active resuscitation was given.....*

[ MR 12 ]
<table>
<thead>
<tr>
<th>Move 3</th>
<th>Summary of Present Medical Complain</th>
<th>Investigations</th>
<th>Step</th>
</tr>
</thead>
</table>
|        | **Comfortable, Blood pressure 150/90.**  
**Temperature 38 C. Hess test - negative.**  
**Lungs - clear, Cardiovascular system - normal, Abdomen - soft, non - tender, no organomegaly.**  
**No lymphadenopathy.** | **ECG - No ischaemic or infarct changes.**  
**FBC - HB - 14.10 %.**  
**Platlet count 1. 61,000  
2. 141,000**  
**Cardiac enzymes - normal**  
**UFEME - Normal**  
**Chest X-ray - normal.** | **Step 2** |

|        | **Diagnosis** | | **Step 3** |
|        | **1. Upper respiratory tract infection.**  
**2. Hypertension**  
**3. Ischaemic heart disease.** | | **Step 4** |

|        | **Treatment.** | | **Step 5** |
|        | **1. T. Ceporex 500 mg tds x 1 week.**  
**2. T. Isordil 10 mg daily**  
**3. T. Metroprolol 200 mg gd.**  
**4. T. Aspirin 150 mg daily.** | | |
The above example is a typical Move 3 with all the steps except for a Step 1. As discussed earlier when the medical problem discussed under Move 2 is similar to that being treated under Move 3, then Step 1 - Medical problem is not repeated in Move 3.

4.2.4: Move 4 - Review or condition upon Discharge/Follow Up.

Move 4 is the final move in writing medical reports. It is seen as the final stage of the treatment given to the patient. The visit or stay in the hospital may end with a discharge or even death. Even though the patient may appear well enough to be discharged, for the time being, some may need to be kept under further surveillance in order to monitor treatment until the patient is well enough. Details included here list the date of follow up and the condition of the patient at the time of follow up.

In Move 4 mention is made of the follow-up upon discharge if there was hospitalisation or if the patient requires a follow up. Mention of death is always followed by the cause of death.

Move 4 - Review or Condition upon Discharge/ Follow Up; has the following three steps:

Step 1A - showing discharge only

Step 1B - showing follow - up only
Step 1A and 1B - showing discharge and follow-up

Step 1C - showing cause of death.

Example 1 shows discharge only: (Step 1A)

_He was discharged on 23.6.97 with no follow up._

[MR 7]

Example 2 shows follow-up only: (Step 1B)

_Patient was advised follow-up review on 1.12.95._

[MR 7]

_Under medical clinic follow-up._

[MR 10]

Example 3 shows Discharge and follow-up: (Step 1C)

_For follow-up at paediatric clinic within one month after discharge from the ward._

[MR 4]

_Patient was discharged.........given appointment ...in SOPD._ [MR 13]
Example 4 shows step 1C - Death and cause of death.

\textit{Cause of death: Subdural haematoma secondary to fracture right temporal bone.} [MR 2]

\textit{Cause of death: Cerebro vascular accident due to cerebral infarct with cerebral oedema.} [MR 6]

4.3. \textbf{Structural Interpretation of Texts and Analysis of the Language in Medical Reports.}

In order to illustrate the Move structure the sample reports below represent the four moves. The move boundaries are illustrated by continuous lines and the step boundaries by broken lines and the functional labels are provided along the margin. The sentences are numbered for ease of reference.

Move 1: Patient Identification (in table form).

Move 2: Summary of previous medical history (sentence 1 and 2).

Move 3: Current Medical Complain (sentence 3-12).

Move 4: Review or condition upon discharge (Sentence 13 and 14).
This sample has all the moves and the steps as illustrated below.

<table>
<thead>
<tr>
<th>Move 1</th>
<th>Steps 1A - 1G</th>
</tr>
</thead>
<tbody>
<tr>
<td>Move 2</td>
<td>Step 1</td>
</tr>
<tr>
<td>Move 3</td>
<td>Step 2</td>
</tr>
<tr>
<td></td>
<td>Step 4</td>
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<td>Step 2</td>
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<td>Step 4</td>
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<td>Step 3</td>
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<td>Step 5</td>
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<tr>
<td></td>
<td>Step 1</td>
</tr>
<tr>
<td></td>
<td>Step 5</td>
</tr>
<tr>
<td>Move 4</td>
<td>Step 1C</td>
</tr>
</tbody>
</table>

The sample report [ MR 11 ] begins with the opening move—Patient identification which is in table form. Move 1 identifies the patient and all relevant information is provided in the spaces available. All the steps, Step 1A to step 1G under Move 1, are present in this sample.
<table>
<thead>
<tr>
<th>Step</th>
<th>Patient Identification</th>
<th>Medical Report On</th>
<th>Medical Complaints</th>
</tr>
</thead>
<tbody>
<tr>
<td>1A-1G</td>
<td>Identity Card No.</td>
<td>Registration No.</td>
<td>Previous medical History</td>
</tr>
<tr>
<td></td>
<td>Age</td>
<td>Sex</td>
<td>Move 1</td>
</tr>
<tr>
<td></td>
<td>Date admission</td>
<td>Date Discharge</td>
<td>1. The above named patient was admitted to the medical ward on 17.1.97 with a history of change in behaviour from about 2 am in the morning.</td>
</tr>
<tr>
<td>Move 2</td>
<td></td>
<td></td>
<td>2. She had a history of hypertension during her pregnancy and had delivered a child about 1 week prior to the onset of this illness.</td>
</tr>
<tr>
<td></td>
<td>3. On examination she was noted to be conscious and able to move all four limbs, did not obey command.</td>
<td></td>
<td>Physical Examination</td>
</tr>
<tr>
<td></td>
<td>4. Her vital signs were stable.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Move 3</td>
<td>5. A Provisional diagnosis of Postpartum psychosis was made.</td>
<td></td>
<td>Diagnosis</td>
</tr>
<tr>
<td></td>
<td>6. Later that evening, she was noted to have deteriorated and was restless with choreiform movement.</td>
<td></td>
<td>Physical Examination</td>
</tr>
<tr>
<td></td>
<td>7. It was noted that she (had) a foul smelling vaginal discharge.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>8. In view of the current clinical finding, the probable diagnosis of puerperal sepsis was made.</td>
<td></td>
<td>Diagnosis</td>
</tr>
<tr>
<td></td>
<td>9. She had an urgent CT scan of the brain done on 18.1.97 and was reported as normal.</td>
<td></td>
<td>Tests</td>
</tr>
<tr>
<td></td>
<td>10. In view of her condition which was deteriorating, it was advised that a lumbar puncture be done.</td>
<td></td>
<td>Treatment</td>
</tr>
<tr>
<td></td>
<td>11. However the relatives were not keen and no consent was given</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>12. She had a cardio-pulmonary arrest at 8.35 pm on 18.1.97 and despite active resuscitation, she did not respond.</td>
<td></td>
<td>New Medical complaint</td>
</tr>
<tr>
<td>Move 4</td>
<td>13. She was pronounced dead at 10.00 pm</td>
<td></td>
<td>Death</td>
</tr>
</tbody>
</table>
The first sentence begins with Move 2. Sentences 1 and 2 are seen as the introduction since the report starts with these two sentences. The first sentence also makes a reference to Move 1, as it mentions the patient

1. "The above named patient"

After reference is made to the patient mention is then made of her medical complaints. Under Move 2 any complaints prior to the visit to this particular hospital is deemed as history, thus all her medical complaints although as recent as 2 am on that particular morning and those dating back throughout her nine months of pregnancy are considered past medical problems as in:

Move 2

Step 1

Past History

1. "was admitted.....with a history of change in behavior from about 2 am in the morning"

2. "She had a history of hypertension during her pregnancy and had delivered a child about 1 week prior to the onset of this illness."

The past tense is used in the report to refer to events which took place in the past.

1. "Patient was admitted....."

and the past perfect to denote something which had happened at an earlier time and is still continuing as in

2. "She had a history of hypertension........"
The past perfect tense is also used to show an action which was completed or ended before another action or time in the past. It is concerned with the effects of something which had happened at an earlier time in the past, as in

3. "......and had delivered a child......"

Move 3 provides a summary of present medical complaints or hospitalisation. The sample [MR 11] has all the five Steps of this Move although they are not in sequential order.

Move 3 -
Step 2
Step 4
Step 2
Step 4
Step 3
Step 5
Step 1
Step 5

The opening sentence starts with Step 2 - a physical examination which is signalled by "On examination......". It also makes an indirect reference to Move 2 because in this case the current condition is related to her past medical problem. Her current medical problems are the result of hypertension and delivery of her child. A physical examination by the doctor results in a diagnosis, thus Step 2 - physical examination goes on to Step 4 - diagnosis, and a cycle of Step 2 and Step 4 are repeated. This cyclicity occurs in cases where the patient is hospitalised. A change in the
patient's condition warrants a new physical examination and the diagnosis may change.

Step 2: Physical Examination
3. "On examination she was noted to be conscious and able to move all four limbs, did not obey command."

Step 4: Diagnosis
5. "A provisional diagnosis of Postpartum psychosis was made".

Step 2: Physical Examination
6. "Later that evening, she was noted to have deteriorated and was restless with choreiform movement."

7. "It was noted that she had a foul smelling vaginal discharge".

Step 4: Diagnosis
8. "In view of the current clinical finding, the probable diagnosis of puerperal sepsis was made."

This cyclic configuration can also be observed in [MR 12], [MR 13], [MR 16] and [MR 18].
The use of the passive voice stresses the thing done, and not the doer.

In these reports there is no mention of the doctor or surgeon in the narrative itself. Since the report mentions only all that was done to the patient, the focus then, is the patient who is affected by the procedures performed and tests and drugs administered. Mention of the writer or doer who performs the action, is only made outside the narrative, at the bottom of the report, where the name and signature of the writer is found. Thus as the patient is the receiver of the action passive voice is used as in the following sentences.

3. "She was noted to be......"

5. A.......diagnosis of.......was made”.

6. “......She was noted to have .........”

7. “ It was noted that.............”

8. “.....Diagnosis of peuperal sepsis was made”

Step 3 comes after step 4 to confirm the earlier diagnosis, a test, a CT scan was ordered and its results recorded.

Step 3
Investigations
and results

9. "She had an urgent CT scan of the brain done on 18.1.97 and was reported as normal."
Step 4 is a record of diagnoses made. After an examination is done and investigations have been carried out, the doctor makes a diagnosis and records these significant findings. Diagnoses may change with the worsening condition of the patient and instances of these are classified under Step 4. In this sample it is found in sentences 5 and 8.

5. "A provisional diagnosis of Postpartum psychosis was made."
8. "...The probable diagnosis of puerperal psychosis was made."

Step 5 is a record of treatment given or suggested and in cases when the patient is unconscious as in this case, consent from relatives is needed before the doctor can proceed with treatment.

10. "......It was advised that a lumbar puncture be done."

However since the relatives did not give their consent it was deferred. Since treatment could not be carried out a new medical complaint arose which takes us back to step 1.
Step 1  
New medical Complain

12. "She had a cardio-pulmonary arrest at 8.35 p.m on 18.1.97".

Any new complaint needs treatment and in this case a procedure was performed. It is mentioned in the same sentence as in step 1 but the second part of that sentence is classified as Step 5 since it is mention of treatment given to the new medical complaint.

Step 5  
Treatment

12. "......and despite active resuscitation, she did not respond."

Unsuccessful treatment brings us to the last move Move 4- condition upon discharge. This case ends in death and Step 1C is suitable. Death and cause of death are recorded. The signal for Move 4 is "She did not respond". Move 4 has 2 sentences, Sentence 13 stating the death and Sentence 14 stating the cause of death, which are given below,

Move 4.  
Condition Upon Discharge

13. "She was pronounced dead at 10.00 pm."

<table>
<thead>
<tr>
<th>Patient Identification</th>
<th>Medical Report</th>
<th>Step</th>
</tr>
</thead>
<tbody>
<tr>
<td>Move 1</td>
<td></td>
<td>1A-1G</td>
</tr>
<tr>
<td></td>
<td>Identity Card No.</td>
<td>Registration No</td>
</tr>
<tr>
<td></td>
<td>Age</td>
<td>Sex</td>
</tr>
<tr>
<td></td>
<td>Date admission</td>
<td>Date Discharge</td>
</tr>
<tr>
<td>Previous Medical History</td>
<td>History</td>
<td></td>
</tr>
<tr>
<td>Move 2</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>1. Patient presented with shortness of breath, chest pain and difficulty in breathing for two days prior to admission.</td>
<td>Medical Complaints</td>
</tr>
<tr>
<td>Current Medical Complaints</td>
<td>On examination</td>
<td></td>
</tr>
<tr>
<td>Move 3</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>2. Vital signs were stable but air-entry was reduced over the (right) side with vocal resonance increased.</td>
<td>Physical Examination</td>
</tr>
<tr>
<td></td>
<td>3. A diagnosis of (right) pneumothorax was made chest-tube inserted but started on a course of antibiotics and physiotherapy.</td>
<td>Diagnosis Treatment</td>
</tr>
<tr>
<td></td>
<td>4. Symptomatically patient’s condition improved but lung did not expand fully. Air entry reduced slightly.</td>
<td>Physical Examination</td>
</tr>
<tr>
<td></td>
<td>5. Finally on 12/8/96, chest tube removed and on examination, noted air-entry was equal, patient was well after that.</td>
<td>Diagnosis</td>
</tr>
<tr>
<td></td>
<td>6. Diagnosis: (Right) Spontaneous pneumothorax.</td>
<td>Tests</td>
</tr>
<tr>
<td></td>
<td>7. Investigation:</td>
<td>Treatment</td>
</tr>
<tr>
<td></td>
<td>1. FBC - Normal</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2. BUSE - Normal</td>
<td></td>
</tr>
<tr>
<td></td>
<td>3. RBS - Normal</td>
<td></td>
</tr>
<tr>
<td></td>
<td>8. Treatment:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>a) Chest-tube</td>
<td></td>
</tr>
<tr>
<td></td>
<td>b) Antibiotics</td>
<td></td>
</tr>
<tr>
<td></td>
<td>c) Physiotherapy</td>
<td></td>
</tr>
<tr>
<td>Condition upon Discharge</td>
<td>9. Patient was discharged on 14.8.96, he was a symptomatic, air entry equal and lung fluids fully expanded given appointment to see Mr Pasha in two weeks time in SOPD.</td>
<td>Discharge Follow-up</td>
</tr>
</tbody>
</table>
Sample [ MR 13 ] has 9 sentences. It has a number of sub headings, which correspond to certain moves. The first one “History” corresponds to Move 2 - previous medical history. The next four sub headings “On Examination”, “Diagnosis”, “Investigations” and “Treatment” correspond to Move 3 - summary of present medical complaints. This sample has all the four moves:

Move 1- Patient Identification (table form)

Move 2- Previous Medical history (sentence 1)

Move 3-Present medical complaint (sentence 2-8)

Move 4- Condition upon discharge (sentence 9)

The opening move is Move 1, all the patient’s particulars are provided in the spaces available, thus all the steps 1A - 1G are completed. Move 2 is made up of one long sentence explaining Step 1- medical complaints which started 2 days back. The first sentence beginning with "patient presented with...." makes a reference to Move 1, the patient in this case and it continues with an account of the medical complain,

Move 2  Medical History  Step 1

1. "...shortness of breath, chest pain and difficulty in breathing for two days prior to admission".
Noun phrases are used to describe the condition of the patient, which is actually a bunching together of descriptive phrases, as in,

shortness of breath
chest pain and
difficulty in breathing.

The current medical problem is related to Move 2. Move 3 - Current Medical Complain starts with Step 2 - the physical examination. The signal for Move 3 is the sub heading “On Examination”. The findings of the physical examination lead to a diagnosis and then to treatment. In this sample the same sequence is repeated when the patient’s condition improves but not fully.

Step 2 Physical Examination
2. "Vital signs were stable but air entry was reduced over the (right) side with vocal resonance increased”.

Step 4 Diagnosis
3. "A diagnosis of (right) pneumothorax was made...”

Step 5 Treatment
“chest tube inserted and started on a course of antibiotics and physiotherapy”

Step 2 Physical Examination
4. "Symptomatically patient’s condition improved but lung did not expand fully.
Air entry reduced slightly.”

5. "...and on examination, noted air entry was equal, patient was well after that.”
Step 4

Diagnosis:

6. Diagnosis:

(Right) Spontaneous pneumothorax.

After the physical examination and diagnosis the next step is to list out the tests carried out and in this report four tests are listed under the heading "Investigations".

Step 3

7. Investigation:

Tests

1. F.B.C

- Normal

2. BUSE

- Normal

3. RBS

- Normal


After the diagnosis is made, tests conducted and results studied, treatment given is listed under Step 5.

Step 5

8. Treatment

a) Chest tube

b) Antibiotics

c) Physiotherapy.

Finally a record of the patients condition when discharged is given under Move 4 step 1A and 1B which is a discharge with instructions for follow up.
Move 4
Condition upon
Discharge

9. Patient was discharged on 14.8.97, he was a symptomatic, air entry equal and lung fully expanded. Given appointment to see Mr Pasha in two weeks time in SOPD.

4.4. THE MOVE STRUCTURE ANALYSIS.

Most narrative texts contain information about the setting and the participants in the event within the body of the narrative itself. In medical reports however such information is found outside the narrative part of the text and is formatted on the page above and below the report.

A number of details of the setting such as the hospital in which the patient was treated and the particulars of the patient treated is not in the narrative. These particulars are found formatted in specific spaces above the report. Patient identification will be discussed in greater detail under Move 1.

Other information is found below the text. This includes the name and signature of the doctor who wrote the report. Other information which is of bureaucratic rather than medical interest which relates to the production of the text itself is also located outside the actual narrative. The clerk who typed the report, the date of typing, the initials of the doctor for whom the clerk typed are all stated below the report. Also included is the receipt number and the date of payment. A specific sum is charged to write a
medical report and this payment is made by the patient, a note of which is made below the report.

4.4.1 MOVE 1- Patient Identification.

Establishing patient identification is more or less obligatory so far as positioning is concerned. Patient identification is always assigned the opening position. A patient has to be identified and personal particulars recorded. A table format for Move 1 allows consistency in the identification process. Types of particulars recorded are fixed according to the format given; including name, identity card number, age, date of admission, registration number, sex and date of discharge. In the corpus analysed, name, identity card number and sex are present in all the reports. Age is missing in [MR13], registration number is missing in [MR 4], date of admission is missing in [MR 8, 9 and 13]. The date of discharge is missing in [MR 3, 8, 9, 10, 13]. The only reason for this missing information could be, the staff recording this information or the doctor writing the report or the clerk typing the report could have inadvertently left it out. Table 4 below shows the frequency of Steps in Move 1.
4.4.2. MOVE 2- Previous Medical History.

Move 2 is present in all the 20 reports. Step 1 - Medical Complaints is present in all the reports and is obligatory. Step 2 - Tests done is seen in 30% of the reports. It is stated only if tests were carried out. Step 3 - Treatment given in the past prior to admission in the hospital is seen in 40% of the reports. Under Move 2, Step 1 is the most important step. In all the reports analysed (20 in number) the first sentence is seen to refer to the patient. Although here the patient is not named we know who it refers to. This is achieved by a number of discourse choices as illustrated below.

*The above named patient* .......... [MR 6, 11, 15]

*The above named* .................. [MR 5]

*The above patient* .............. [MR 4]

*50 year old Chinese woman* ...... [MR 19]

*67 year old Chinese man* .......... [MR 7]

*72 year old Indian man* .......... [MR 14]

*Term baby boy* .................. [MR 20]

*Patient presented* ............... [MR 16]

*Presented to* .................... [MR 1]

*Presented with* ................. [MR 9, 13]

*Motorcyclist alleged* .......... [MR 12, 18]

*Alleged* ....................... [MR 3, 17]

*Admitted unconscious* .......... [MR 2]

*A known case of* ............... [MR 8]

*Known* ....................... [MR 10]
<table>
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<th>I/C NO</th>
<th>AGE</th>
<th>DATE OF ADMISSION</th>
<th>REG NO</th>
<th>SEX</th>
<th>DATE OF DISCHARGE</th>
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</tr>
</tbody>
</table>

% 100  100  95  85  95  100  80

* Information in report
- Information not in report

Table 4 - Frequency of Steps in move 1
All the above examples have a referent. The most frequent pattern observed is "*The above named patient"*. It is always initial. Table 2 shows the frequency of the expressions used to introduce the referent.

<table>
<thead>
<tr>
<th>Expression</th>
<th>Frequency (Number)</th>
<th>%</th>
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<tbody>
<tr>
<td>The above named patient</td>
<td>3</td>
<td>15</td>
</tr>
<tr>
<td>The above patient</td>
<td>1</td>
<td>5</td>
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<tr>
<td>The above named</td>
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</tr>
<tr>
<td>Patient presented</td>
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<td>10</td>
</tr>
<tr>
<td>Presented to</td>
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<td>5</td>
</tr>
<tr>
<td>Presented with</td>
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<td>50 years old Chinese woman</td>
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<td>67 years Chinese man</td>
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<tr>
<td>72 year old Indian man</td>
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<td>5</td>
</tr>
<tr>
<td>Term baby boy</td>
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<td>5</td>
</tr>
<tr>
<td>A known case of</td>
<td>1</td>
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</tr>
<tr>
<td>Known</td>
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<td>5</td>
</tr>
<tr>
<td>Motorcyclist</td>
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<td>Motorcyclist alleged</td>
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<td>5</td>
</tr>
<tr>
<td>Total</td>
<td>20</td>
<td>100</td>
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</tbody>
</table>

Table 5. Frequency of discourse choices for referent
The reports start with mention of the referent and go on to state the previous medical history. The most frequent choice is “with a history of”.

“Presented with poor vision right eye on 25.2.97 with a history of trauma to right eye 2 years ago.”

[MR 9]

“.................admitted to ward 6B with a history of puffiness of the face....”

[MR 4]

“.............admitted to the medical ward on 17.1.97 with a history of change in behavior.............”

[MR 11].

Other discourse choices used in Move 2 to establish past illnesses are

“A known case of..........”
“a known..........”
“known..........”

These discourse choices indicate that the medical problem talked about is a persistent one. It also indicates that this problem has been treated before or
is one that needs regular treatment. Other discourse choices which are used under Move 2 are as listed below.

"Is diabetic for 3 years."

"............recurrent left lumbar and loin pain .."

"painful eye 2 days duration."

In the case of accident cases, Previous Medical History states the nature of the accident, the date of occurrence and a brief mention of the injuries under Move 2. Previous medical history in this case refers to the injuries already sustained at the time of registration at the hospital. Although the injuries are actually "Current medical problems" to be dealt with under Move 3, the fact that it occurred before the patient sought treatment qualifies it as Previous medical history. Of the four reports on accident cases, two indicate just the accident and date of accident. The remaining two mention injury, one briefly and the other with more detail.


[ MR 12 ]

Move 2. 1. "Motorcyclist alleged involved in motor vehicle accident on 22.11.96"

2. "No loss of consciousness".

[ MR 18 ]
Move 2. 1. "Alleged involved in Industrial Accident on 29.10.96 sustained crush injury of (left) hand while working".

[ MR 3 ]

Move 2. 1. "Had alleged involved in motor vehicle accident on 29.4.95.
2. "Sustained head injury with loss of consciousness."
3. "He had fractured (Right) parietal bone and had intra cerebral bleed which was treated by surgical unit".

[ MR 17 ]

4.4.3. MOVE 3- CURRENT MEDICAL PROBLEMS.

Of the four moves, Move 3 is the most important. It forms the bulk of the report and comprises 5 steps.

Step 1. Medical complaints
Step 2. Physical Examination and findings
Step 3. Investigations and results.
Step 4. Diagnosis
Step 5. Treatment given and advise.
Step 2 - physical examination by the doctor is found in all the reports. Step 5 - treatment is found in 90% of the reports studied. This is followed by Step 3 - tests done, in 75% of the reports. Step 4 - diagnosis is in 40% of the reports and the least important step is Step 1 - new medical complaints which is seen only in 30% of the reports. It leads to the conclusion that Step 1 - New medical complains listed as the first Step is the least important of all the five Steps under Move 3. In most of the cases, the medical complaint talked about in Step 1 of Move 3 is similar to that talked about under Move 2. This is seen in 95% of the reports. The medical complaint differs only in 5% of the reports.

Of all the Steps in Move 3 the combination of Step 2 followed by Step 3 and 5 is the most common seen in 30% of the reports. This is followed by the sequence of Step 2, 3, 4 and 5 in 20% of the reports. The sequence of Steps 1, 2, 3 and 4 is found in only 10% of the reports. The rest have no specific sequence of steps. The pattern and frequency of the steps in Move 3 is illustrated in Table 6.

Table 7 shows the presence of steps in each report and the frequency of each step. This table only shows whether a step is present or not in a report. A step may occur more than once in each report, thus the frequency referred to here is the presence or non presence of the particular steps. It should be noted that the steps do not occur in sequence, each report has its
own order however the table below only shows whether the step is in the report or not.

<table>
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<tr>
<th>Move 3</th>
<th>Step 2-Physical examination</th>
<th>30%</th>
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<tr>
<td>Summary of Present Medical Complains</td>
<td>Step 5-Treatment</td>
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<tr>
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<td>Step 2-Physical Examination</td>
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</tr>
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<td></td>
<td>Step 3-Tests</td>
<td></td>
</tr>
<tr>
<td>or Hospitalisation</td>
<td>Step 4-Diagnosis</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Step 5-Treatment</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Step 1-Medical complain</td>
<td>10%</td>
</tr>
<tr>
<td></td>
<td>Step 2-Physical Examination</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Step 3-Tests</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Step 4-Diagnosis</td>
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</tr>
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</table>

Table 6. Pattern and Frequency of Steps in Move 3.
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<tr>
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<th>STEP 3</th>
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* Information in report
- Information not in report

Table 7 - Presence of Steps in Move 3-
Current Medical Problems.
All the texts are factual and straightforward using concrete and precise language. It reflects an impartial unemotional weighing of evidence presented in economical, clear and concise language. The writer gets to the point with little fanfare. The writing is characterised by specialised medical vocabulary, numbers and acronyms which is most evident in Steps 3 and 5 under Move 3. Evidence of technical writing is reproduced below.

**Move 3**

17. "FBC-Hb - 17.1 / TW - 9.7 / Plat -41000

**Step 3**

18. PCV - 55.1%


20. RBS - 9.3.

21. CT Scan Brain - Subdural haematoma with fracture (Right) Temporal bone.

22. Chest X-ray - Haziness (Right) upper lobe."

**Move 3**

23. "ECG - sinus tachycardia

**Step 5**

24. Patient given IV fluids 6.0 over 24 (H).

25. IV Open / Chloromycetin started.

26. Kept Nil Orally

27. IV Zantac 50 mg tds.

28. NG Tube inserted.

29. 4 units platelet concentrate transfused

30. 2 units FFP.

31. Vitamin K 10 mg daily given."

[ MR 2 ]
55% of the reports analysed are with sub headings. Many of these correspond with certain moves and steps as listed below.


Each medical report analysed is a narrative whose organising principle is chronological. Parts are put together in a sequence which corresponds to the temporal order in which the activities are performed in the task. The temporal sequence in the text has a parallel to the temporal sequence of the event. In all cases this temporal order is manifested by the mention of the date. This allows a change of state to be inferred throughout the text. An illustration of this is presented below.

“Presented to eye clinic on 10.6.94”.

“eye examination on 10.6.94 revealed…..”

“Ultrasound B scan Right eye on 30.6.94..........”

“Cerum Toxoplasma on 6.7.94 was...............”

“Patient was refered to medical clinic on 28.2.95 for…..”
"The right vision had no perception to light on 5.3.96 and...."

"On 22.6.95 - the best corrected vision was...."

"Patient was advised follow-up review on 1.12.95."

Another added feature other than date is the chronological sequence indicated by date and day, or adverbials of time as in the following report.

"Patient presented with recurrent left lumbar and loin pain...since January 1991."

"He was planned for left pyelolithotomy on 15.8.91"

"Postoperatively patient was put on IV Netilmicin............" 

"He had one episode of low grade fever but settled on Day 3."

"Abdominal drain was off on Day 4 post op."

"Antegrade pyelogram was done on 27.8.91....."

"Patient was discharged on 28.8.91".
Some clauses are introduced by adverbials of time such as:

"Patient was previously well". [MR 4 ]

"Since admission Blood pressure stable". [MR 4 ]

"Subsequently he came for review". [MR 5 ]

"Subsequently he developed secondary pneumonia" [ MR 20 ]

" He is due for review " [ MR 5 ]

" Initially he had slurred speech". [ MR 8 ]

"Further his general status deteriorated". [ MR 12 ]

"Finally on 12.8.96 chest tube removed..." [ MR 13 ]

4.4.4. Move 4. Review or condition upon Discharge.

Move 4 is more or less obligatory. It is a record of follow-up or review and the condition of the patient upon follow up. This closing move is present in 95% of the reports. Only one report [ MR 15 ] has no mention of discharge or follow up. The frequency of the steps in move 4 is shown as follows.
<table>
<thead>
<tr>
<th>Steps</th>
<th>Number</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Step 1A</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Discharge only</td>
<td>3</td>
<td>15</td>
</tr>
<tr>
<td>Step 1B</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Follow up only</td>
<td>8</td>
<td>40</td>
</tr>
<tr>
<td>Step 1A and 1B</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Discharge and follow up</td>
<td>3</td>
<td>15</td>
</tr>
<tr>
<td>Step 1C</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Death</td>
<td>5</td>
<td>25</td>
</tr>
<tr>
<td>None of the above</td>
<td>1</td>
<td>15</td>
</tr>
<tr>
<td>Total</td>
<td>20</td>
<td>100</td>
</tr>
</tbody>
</table>

Table 8  Frequency of steps in Move 4
4.5 The Communicative purpose.

The communicative purpose of the medical reports is achieved through the four Moves which give this genre its typical cognitive structure. It serves as an authentic record of treatment received. These reports are taken as faithful records of the facts of the illness and the judgements of the doctors. It is recorded evidence of the status of the patient, which may be useful to people who have an interest in it namely employers, lawyers, doctors and the patient himself. These reports are documentary evidence of the patient’s medical evaluation, treatment and change in condition. They can serve as the patient’s intermediary, since it is an accurate written summary of the patient’s medical condition. It acts as an intervening document which may sometimes be accorded more credibility than the actual patient.

Reporting constitutes the primary purpose of the event. The purpose of certain activities that occur during the course of a patient’s hospitalization is mainly communication to the doctor responsible for the patient’s care. The report constitutes the end result of that activity. It would have started first as an oral report, then written and finally as a summarised version. Records such as patient’s history and case notes are at first simply handwritten on the patient’s cards, following oral consultation with the patient. When writing the final report, all the stages of medical investigation are textualised into the medical report.
Some type of care is given to the patient and subsequent to that care the event is reported on. In this case, communication between specialist is not necessarily the focus of activity. Because of the nature of medical decision making and of accountability of medical personnel to the attending doctor or physician, reporting on the activity plays an important role. The reports do not summarise the questions and answers during consultation, rather they are summaries of procedures performed on the patient and medical reports summarise these procedures as well as some observations which were noted. The writer then has the difficult task of identifying what is important and what can be left out when writing the final report. Information reported is based on other information in the case notes and progress notes of the illness. The parts put together are ordered by pragmatic principles that take into account the users of the texts' needs. The economical and concise language takes the reader to the point quickly giving only the essential points and leaving out unnecessary details.

These medical reports are frequently requested by insurance companies, lawyers, other doctors, the SOCSO board and patients themselves. It is a document used to make insurance claims and to evaluate the extent of disability in workman's compensation claims. Although the legal interest in these reports is not necessarily adversarial against the doctor or hospital the document is required to be precise in order that the extent of disability may be determined. An adversative audience may have an interest in a report
since treatment or hospitalisation or surgery may create a new chain of events resulting in negative life changes for the patient.

The patient may have a troublesome complaint and may require further medical attention, therefore for future caregivers the report is extremely useful to pin point the stage of the disease which is inferred from the contents of the report. Medical audiences are especially interested in the reports when the patient has a problem and needs future care. In events of contingency both medical and adversary audiences may have an interest in these reports.

4.6. Findings and Discussion.

The analysis of the corpus has led to the findings that medical reports have 4 main Moves; which are as follows:

Move 1 Patient identification.
Move 2 Summary of previous medical history.
Move 3 Summary of present medical complaints or hospitalisation.
Move 4 Review or condition upon discharge.
Each move is further sub divided into steps:

Move 1 - Patient identification has seven sub-steps ranging from
Step 1A - 1G.

Step 1A    Name of patient.
Step 1B    Identity card number.
Step 1C    Age of patient.
Step 1D    Date of admission.
Step 1E    Registration number.
Step 1F    Sex.
Step 1G    Date of discharge.

Move 2 - Summary of previous Medical History has three basic steps.

Step 1    Medical complains
Step 2    Tests done
Step 3    Treatment given.
Move 3 - Summary of present Medical Complains and or hospitalisation has 5 Steps

Step 1 Medical complain.
Step 2 Physical examination and findings.
Step 3 Investigations and results.
Step 4 Diagnosis.
Step 5 Treatment given and advise.

The final move, Move 4 has 3 steps;

Step 1A Discharge
Step 1B Follow Up
Step 1C Death and cause of death.

Moves 1-3 are all obligatory but the steps are not. One report [MR 15] does not have a Move 4. The writer has the option of choosing which steps are to be present. Reports function in our culture to store information. It is about what things are like; it informs others about the 'what' and the 'how' but does not really answer the question 'why'. The main function of medical reports is to report what the writer considers important from a number of records that have information of one event after another in the
sequence in which they occurred. It is therefore a written narrative
description of a professional’s observation of events and procedures. Such
reports are crucial not only to the person reported on but also to the
professional involved.