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A Review On The Rhetorical Structure And Linguistic Features Of Medical Case Presentation Genre

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Abstract

This paper reviews studies investigating the rhetorical structure of the medical case presentation genre. As a key objective was to examine the rhetorical structure of the genre critically, studies were purposively selected for inclusion in the review paper with this consideration in mind. Using selected keywords search, primary literature was retrieved from various sources such as "Google scholar", "Google search", Science Direct, "Pubmed", Wiley Online Library, SAGE journals, and Elsevier publishing from September 2014 to September 2017. Finally, 22 of the 126 studies initially sampled were selected for inclusion in the review in accordance with pre-defined parameters and the results of the review are presented in this paper. This review provides an overview of the rhetorical structure of the case presentation genre with the aim of establishing a baseline for understanding the genre's rhetorical structure.

Keywords: *Rhetorical structure, medical case presentation, medical discourse community*

1.1 Introduction

The oral case presentation (henceforth, OCP) is a structured discourse in the oral mode used by medical professionals to communicate information about patients' condition, diagnosis, and treatment. It provides an opportunity for individual and group learning, and it is also used to evaluate medical students and residents (Green et al., 2009). The case presentation genre (both oral and written) principally incorporate a ritualized rhetorical format and a "highly conventionalized linguistic rituals, employ a stylized vocabulary and syntax" (Anspach, 1988, p.359). Researchers from various fields, for instance, medical educationists (Donelly, 1986, 1997; Poirier & Brauner, 1988; Monroe et al. 1992) and applied linguists (Lingard, 1998; Lingard & Haber, 1999; Haber & Lingard, 2001; Lingard et al., 2003a; Lingard et al., 2003b; Spafford et al., 2004; Spafford et al., 2006; Schryer et al., 2005; Schryer et al., 2007; Fleischman, 2001; Goodier, 2008; Hung et al., 2012; Murawska, 2013; Chan, 2015; Lysanets et al. 2017) have predominantly investigated the rhetorical structure, the conventionalized linguistic rituals and their communicative functions especially from patient perspectives, and factors related to socialization of the medical novices. The majority of the published studies on the case presentation genre more or less represent the rudimentary rhetorical structure of the case presentation genre such as chief complaint, history of present illness, past medical history, review of the system, family medical history, social history, medication, physical examination, Allergies, diagnostic findings, summary statement; assessment and plan or clinical management (Poirier & Brauner, 1988; Kihm et al., 1991; Lingard, 1998; Wiese et al., 2002; Maddow et al., 2003; Kim et al., 2005; Schryer et al., 2005;

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Davenport et al., 2008; Goodier, 2008; Elliot et al., 2009; Green et al., 2005, 2010; Helan, 2012; Hung et al., 2012; Dell et al., 2012; Lewin et al., 2013; Dhaliwal & Haure, 2013; Chan, 2015). However, only a few studies have attempted to investigate the ritualized language of case presentation (Donnelly, 1986, 1997; Donnelly & Brauner, 1992; Anspach, 1988; Poirier & Brauner, 1988; Monroe et al., 1992; Fleischman, 2001; Helan, 2012; Barry et al., 2001; Murawska, 2013; Lysanets et al. 2017). The rhetorical structure of the case presentation genre is widely represented in published research. However, less attention has been given to the analysis of the language of case presentation, which inherently performs various communicative functions, and perpetuates the subtle epistemological assumptions, values, and beliefs of a medical discourse community. On top of that, to the best of the researchers' knowledge, a paper reviewing both the rhetorical structure and linguistic forms of case presentation is not yet published.

1.2 Methodology

This review paper retrieved studies from different sources, i.e. "Google search", "Google scholar", Science Direct, Wiley Online Library, "Pubmed", SAGE journals, and Elsevier publishing from September 2014 to September 2017. Various keywords search employed such as case presentation, oral case presentations, written case presentations, case reports, case histories, doctor-patient communication, doctor-doctor communication, the rhetorical structure of case presentation, biomedical language, medical students, physicians-in-training, medical teachers feedback, implicit and implicit learning of medical knowledge. Title and thorough reading of the relevant articles gradually increased the choices of keyword lists. A full reading of the studies was preferred for the review paper instead of reading only the abstracts. Proper inclusion and exclusion criteria were adopted. The inclusion criteria adopted for the study included published and unpublished research in the English language representing the rhetorical structure of the medical case presentation genre. The exclusion criteria include Non- English studies and studies which do not discuss the rhetorical structure. The literature search initially identified 126 studies on the case presentation genre. However, in the end, only 22 reviews fulfilled the inclusion criteria.

1.3 Review of studies

Kihm et al. (1991) aimed to investigate the content of outpatients OCPs and assess the correlation between the objective and subjective evaluation of the content presented during outpatient case presentations. This study analyzed 36 OCPs presented by 23 residents. The content of the OCPs was analyzed by using a face content validity system which possesses nine components and various variables. Kihm et al. (1991) stated that according to this system, the rhetorical structure of OCP should have to identify information, chief complaint, present illness, past medical history, family history, social history, physical examination, assessment and plan. It was found that residents' OCPs in the outpatient context have some critical deficiencies in content. These deficiencies in content were found by excluding the variables and some of the major components of an OCP, for instance, psychosocial history, assessment, and plan. In this study, the analysis of the content presented in these outpatients OCPs informed teachers and learners about the inclusion of essential components of OCP in their case presentations. Besides the limitations highlighted in this study, this study also lacks in providing details regarding the patients and their medical illness, which can also alter an OCP's content.

Dr Terry Wolpaw and her colleagues conducted a series of studies to improve the teaching and learning processes of OCPs. Initially, Wolpaw et al. (2003) developed a learner-centred OCP model named SNAPPS at the ambulatory setting for facilitating medical educators during active learning conversation. SNAPPS stands for (***S***ummarize the history and findings; (2) ***N***arrow the differential to two or three relevant possibilities; (3) ***A***nalyze the differential by comparing and contrasting the prospects; (4) ***P***robe the preceptor by asking questions about uncertainties, difficulties, or alternative approaches; (5) ***P***lan management for the patient's medical issues, and (6) ***S***elect a case-related point for self-directed learning). Wolpaw et al. (2003) conducted a pilot study on 50 third-year medical students at the ambulatory setting for validating the SNAPPS model. The SNAPPS model was initially introduced to them during 45 minutes workshop.

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Additionally, pocket cards were given to both students and preceptors containing six steps of the SNAPPS model. They found that SNAPPS represents a paradigm shift in ambulatory education because it engages both learner and preceptor and creates a collaborative conversation during patient care. The SNAPPS model can guide towards meaningful educational encounters between preceptor and learner in at office setting. However, such models would be difficult to apply in a hospital setting. Besides, MBBS/MD students might face difficulty even in an office setting because, at this level, medical students face challenges in presenting patients cases. After validation of the model, Wolpaw et al. (2009) and Wolpaw et al. (2012) trained medical students on applying the SNAPPS technique during OCPs. More specifically, Wolpaw et al. (2009) aimed to analyze medical students' focus on clinical reasoning by following the SNAPPS model of OCP. They conducted a posttest-only, comparison groups, randomized trial in 2004–2005 of 64 medical students in three groups: SNAPPS training, feedback training (controlling for training time), and usual-and-customary instruction. They coded 66 SNAPPS, 67 comparison, and 82 usual-and-customary case presentations. Wolpaw et al. (2009) found that the SNAPPS technique can facilitate and enhance students' diagnostic reasoning and uncertainties during OCPs.

On the other hand, Wolpaw et al. (2012) main objectives were to compare the nature of uncertainty expressed by medical students while following the SNAPPS technique and traditional techniques of OCPs. They reached 19 SNAPPS and 41 traditional OCPs of medical students, and it was found that SNAPPS students posed uncertainties almost double than the comparison group. Moreover, SNAPPS students primarily focused on diagnostic reasoning. Therefore, it was concluded that students' uncertainty during OCPs could drive the teaching content and "preceptors are ready to teach at the drop of the question" (Wolpaw et al., 2012, p. 1210). However, in Medical Education SNAPPS technique of OCP has not received valuable attention yet. One probable reason could be the lack of focus on the traditional structure and language use of case presentation genre.

Maddow et al. (2003) divided OCP into traditional and assessment oriented format. The traditional OCP has elements such as: chief complaint, history of present illness, past medical history, social and family history, review of systems, physical examination, laboratory data, and assessment and plan. Maddow et al. (2003) introduced assessment-oriented (AO) OCP at an emergency department. The respondents of the study were 25 residents. They asked them to perform on assessment-oriented (AO) OCP first and then present the patients' cases by following the traditional OCP formats. Ten expert faculty members evaluated their performances. It was found that AO presentations are more effective and efficient and "get to the point" in an emergency setting than the traditional one.

Moreover, AO presentations have more brevity, adequate clinical data, medical reasoning, best organization of thoughts, and effective conclusion compared to traditional displays. The rhetorical structure of Maddow et al. (2003, p.842) AO model contains "patient identification, assessment and management/ therapeutic plan, and limited justification of the assessment and plan based on historical and examination information". However, the discourse context that emergency departments usually have is different from other medical settings. Therefore, this assessment-oriented (AO) model would be challenging to apply to patients' cases that need to be presented in other locations.

Kim et al. (2005) determined the feasibility of using encounter cards to evaluate and improve reliability, validity, and medical students' oral communication skills. By applying a randomized controlled study, they found that encounter cards are feasible, valid, and reliable for evaluating medical students' verbal communication skills. However, these encounter cards could not significantly improve the medical students' performance on summative oral presentations. These encounter cards had nine presentation competencies: a history of present illness, past medical history, social/family history, physical exam, studies, assessment/differential diagnosis, plan, organization and coherence of the presentation, and generally speaking ability. Each competency was graded on a nine-point scale where 1 to 3 was unsatisfactory, 4 to 6 was satisfactory, and 7 to 9 was superior. Evaluators could indicate whether a particular competency could be assessed or not at a certain point (Kim et al. 2005, p. 743). However, one major problem that seems in these encounter cards is the lack of further descriptions in the form of variables and steps related to each competency.

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Moreover, Elliot and Hickam (2009) focus on faculty members' dimensions of assessing medical students' OCPs skills. In this study, 11 faculty members individually assessed 17 video-recorded OCPs based on an evaluation form containing four descriptors of content and six attributes of communication skills such as the history of present illness, past medical history, physical examination, laboratory data, the precision of language, logical sequence, economy, fluency, pace, and emphasis. A correlation analysis was performed to know about the association among the individual descriptors and students' overall evaluation. Elliot and Hickam (2009) found that faculty members' OCPs assessment was based on the facts presented and communication skills. Moreover, it was also observed that a significant correlation was found among raters on only three communication skills such as economy, fluency, and precision of language. The correlation among raters on communication skills is significant. It suggests that faculty members give considerable importance to the communication skills of medical students during case presentations.

Additionally, experts consciously or unconsciously know about the language choices required for OCP practices. Elliot and Hickam (2009, p.261) further argued that medical students generally learn OCP skills from presentations modelled by senior trainees. Critically speaking, these researchers from the field of medical education, although pointed out the importance of communication skills; however, could not explicitly describe the case presentation genre's language. Besides, this study also did not describe attributes of assessment regarding the structural organization of OCP at the micro-level.

Further, Green et al. (2010) developed a multifaceted intervention for improving the OCP skills of medical students and residents. The intervention contained the written hand out with detail instructions, pocket cards, model presentations and multiple teaching sessions. The logical order and components of OCP are comprised of the opening statement, source, present illness, another history, physical exam, labs/data, synthesis, and enumerated problem list. Further, a detailed description of each component is also provided in this multifaceted intervention. The multidimensional intervention was given to medical students and residents, and it was found that the participants' OCP skills were significantly improved.

Furthermore, Green et al. (2009) determined internal medicine clerkship directors' expectation from clinical clerks. A survey containing twenty items was surveyed among 110 internal medicine clerkship directors. It was found that these educators shared common expectations for effective OCP. More specifically, eight aspects of OCPs were rated as the essential OCP elements: chief complaint, history, patients' symptoms, the sequence of events preceded patients' hospitalization, physical examination, standardized organization, a prioritized problem list, and assessment and plan. It suggests that an effective OCP should possess at least these eight structural elements. However, the Likert scale items do not differentiate a component of OCP from the other. Besides, Green et al. (2009) further argued that OCP facilitates clinical teachers to assess the apprentices' progress towards becoming an independent clinician in the educational domain. But it is also a fact that preceptors' variety of experiences and cultural background, students' academic and intellectual background, and various patients make learning of OCP and its evaluation a complex process.

Green et al. (2011) also aimed to know what undergraduate internal medicine teachers expect from clinical clerks. Before conducting this research, it was observed that medical students generally think that clinicians do not have common expectations from all students' OCPs. However, it was hypothesized that physicians have typically common expectations regarding OCPs of third-year medical students. In this study, these researchers asked two open-ended questions and administered 42 items survey to 136 internal medicine faculty members from 5 medical schools in the United States. Statistical tools were applied. Green et al. (2011) found that some OCP elements are rated more important than others. For instance, chief complaint, history of present illness, factual details that support the assessment and plan, organization and proper structuring of OCP are more critical than the others. They also found that an OCP length should be between 9.9 to 5.4 minutes. Besides, statistically significant differences were also found among the institutions. Overall, it was concluded that internal medicine faculty members had shared expectations for OCPs. Once again, instructions like a comprehensive report and accurate organization are implicit in nature, and it is already established in current literature that such implicit instructions lead to the acquisition of unintended professional values (Lingard & Haber, 1999; Afzaal, & Xiangyi (2020).

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Heiman et al. (2012) developed a curriculum of online learning and deliberate practice. They created a checklist for an effective OCP, which was further classified into content-specific items and general items. The content-specific things are the opening statement, history of present illness, additional medical history, physical exam, and assessment and plan. Heiman et al. (2012) 's main objective was to develop a curriculum of online learning and deliberate practice for facilitating medical students to improve OCPs skills. An interactive web-based curriculum was created first, and then the experimental design was used to evaluate the presentation skills of second-year medical students. They presented OCPs based on simulated patients' cases. Heiman et al. (2012) found that medical students' deliberate practice based on the online curriculum improved their OCP skills.

Dell et al. (2012) focused on teaching and evaluating OCP as required by the Council on Medical Student Education in Pediatrics (COMSEP). They described in detail the topical categorization of OCP currently applied, such as chief complaint, history of present illness, physical examination, laboratory data, summary statement, assessment, and plan. The content and requirement within each topical category are briefly discussed in their study as tips for teaching. Moreover, the RIME model as a benchmark is explained, which can help physicians organize their observations to evaluate students' performance. Hence, in this study, Dell et al. (2012) briefly described an effective OCP's current expectations. However, these expectations of an effective OCP and the topical categorization offered in this study reflect the insider experiences. Such specialists' experiences would always have few limitations because the amount of professions knowledge that competent specialists know cannot be fully expressed (Schon, 1983).

Dhaliwal and Haure (2013) opined that OCPs based on night float admission require an additional structural element. However, trainee doctors are not explicitly informed about the format and expectations of the OCPs of night float admission cases. In this article, Dhaliwal and Haure (2013) therefore proposed a form of OCP suitable for presenting night float admission cases. They stated that such OCPs should have opening line/chief concern, history of present illness, past medical history, medications, social history, family history, physical examination, laboratory and radiologic data, assessment and plan, and analysis of reasoning, safety, quality (Rarely). This study also compared the traditional format of the OCP genre and the proposed one (for night float admission). However, the instructions of structural elements that differentiate these formats are too implicit, (Kanglong & Afzaal; 2020).

Lewin et al. (2013) investigated the inter-rater reliability of OCPs. By applying the patient presentation-rating tool, three raters marked 15 recorded OCPs performed by 3rd-year medical students. This study's primary purpose was to develop an OCP rating-tool containing elements of clinical reasoning, with the intention to facilitate students OCP learning process effectively and assess their progress. The patient presentation-rating tool was developed by faculty members involved in the teaching of 3rd-year medical students. They finalized 18-items and some sub-sections for History, Physical Exam and Diagnostic Study Results, Summary Statement, Assessment and Plan, Clinical Reasoning and Synthesis of Information, General Aspects, and Overall Assessment in the patient presentation rating tool.

More specifically, the history section should have a chief complaint, history of present illness, past medical history, family history, social history, and system review. The physical exam and diagnostic study result carry some components such as: general statement, vital signs and growth parameters (if the patient is a child), targeted physical exam, organized lab data and results. The summary statement usually has summary of patient's case before assessment. Assessment and plan includes a prioritized problem list, provide appropriate differential diagnosis for each problem, and state the diagnostic and therapeutic plan. The clinical reasoning of information part includes the pertinent positives and pertinent negatives form the H&P to support the differential diagnosis and the plan, and clear the picture of the patient's situation. Finally, the general aspects are overall organization, speaking style, answers to the questions, and overall assessment of presentation. It was found that the patient presentation-rating tool is highly reliable and has high face validity.

Haber and Lingard (2001) aimed to investigate the socialization of novices into the values and goals of medical discourse community by practicing on OCP. Moreover, they also analyzed the learning processes of OCP. The

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participants of the study were 12 3rd year medical students and 14 teachers (8 Residents and 6 Attendings). They employed rhetoric theory, genre theory and grounded theory approach for investigating 73 OCPs on rounds (42 OCPs of students and 31 OCPs of teachers) and 160 hours ethnographic observations. For identification of rhetorical structure of OCP, the text was classified into emergent themes by following the grounded theory approach. Variations were found within the presentations skills of experts and novices. Haber and Lingard (2001) found that students recognize the fact that effective presenters modify the rhetorical structure but they cannot explain how, when or why these alterations are chosen because OCP is taught based on implicit articulation of rules consequently they do not understand how experts present effectively. Moreover, experts were unable to define and explain "relevance" however in actual performance they demonstrated "relevance" effectively. Haber and Lingard (2001) also found that novices learn OCP by trial and error and explicit rhetorical model is not followed during teaching. By not following an explicit rhetorical model, novices would not only delay acquisition of OCP but also learn the unintended professional values. Moreover, novices perceive OCP as rigid and rule based activity whereas experts understood it as dynamic and context based means of communication. This rhetorical genre based study do not investigates the language features of OCP because in rhetorical genre based studies, (see Afzaal, Khan, Bhatti & Shahzadi, 2019; Afzaal; 2020) linguistic features of a text and its structural forms are not investigated in isolation rather they emphasis on analysis of the rhetorical situations, social purposes and social actions in a particular social context and how some genre aspects change over time (Hyon, 1996; Paltridge, 1995).

Lingard et al (2003a) also investigated the role of case presentations in socializing the novices into the values and goals of medical discourse community. They investigated 16 OCPs of medical experts and students, and 05 specialists' feedback on the presentations during inpatient pediatric medical rounds. Altogether 11students and 10 specialists participated in this study. By applying grounded theory approach, Lingard et al. (2003a, p.62) found that OCP work like a mediating tool that enables its users to "negotiate agency across generations and across level of expertise as sets of strategic choices". Moreover, they also found that OCP genre carry ideological consequences consequently they could affect students' communication behavior negatively with patients. This study however is lacking in focusing on the effects of social structure and linguistic resources on the production of a text and negotiation of agency. This study also found that novices strategize the genre as student and as doctor at a time. Students are more concerned about their evaluation. Therein, they shape their presentations with intention to get good marks. In contrast, experts utilize OCP as a resource to construct shared knowledge about the patients' ailment. The findings of this study further revealed that there is a tension between experts' and novices' approach to OCP genre. Novices strategize OCP as a school genre whereas experts understand it as a workplace genre. Novices follow traditional instructional rules during their presentations whereas experts are concerned to purpose and practice and rules are taken just a resource (Lingard, et al. 2003a). Moreover, the oral case presentations of experts and novices are not only different based on the biological knowledge; they also vary rhetorically (Lingard, et al. 2003a). These differences in perception of OCP genre would ultimately shape different rhetorical structure and discourse practices of experts and novices which has not been investigated yet.

Elsewhere, Lingard et al. (2003b) also examined the OCPs of novices in order to reveal the rhetorical features of certainty and uncertainty by considering pragmatic and problematic implications for students' professional socializations. The objectives of the study were to investigate the ways novices learn "strategies associated with the situated language practices of case presentation" and how the language acquisition practices help them to develop the professional identities (Lingard et al., 2003b, p.605). The research data was collected during field observations and interviews. Nineteen OCPs of third year medical students were observed, recorded and transcribed along with 10 teachers' exchanges at tertiary care pediatric hospital. Moreover, individual interviews of 21 participants (11 students and 10 teachers) were also conducted. Grounded theory approach was applied to analyze the research data of the study. Consequently, five themes were emerged namely: "thinking as a student, thinking as a doctor, strategies of case presentation, teaching strategies, and identity formation". This study analyzed only two of the thematic categories such as: thinking as a student, and thinking as a doctor. Lingard et al. (2003b) found that students mostly avoided or disguised uncertainties during their presentation however teachers in contrast modeled 'professional rhetoric of uncertainties' by accepting uncertainties and showing methods of managing and minimizing uncertainties. Moreover, it was also found that some students gradually moved towards 'professional rhetoric of

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uncertainties'. It suggested not only advances of their clinical knowledge but also indicated the ways rhetoric shapes professional identity and interactions.

Meanwhile, Spafford et al. (2004) examined the professional identity formation and its relationship with OCPs. Thirty-one OCPs and teaching exchanges related to these presentations were recorded and transcribed. In total, 6 optometrists and 8 optometry students participated in the field observations. During the field observation, 4 students and 4 faculty members were interviewed. These interviews were recorded and then transcribed verbatim. The 45 minutes interview session informed the researchers about the trends and issues arose from the observational data. Grounded theory approach was applied for emergent themes. Consequently, the theme of 'communicating standards of practices' was emerged. Spafford et al. (2004) found that in these OCPs, teachers employed three ways of communicating standards of practice to optometry students namely: official way, our way, and my way. Differences were found between these standards however teachers did not inform students about the disparities explicitly. Students were left to inference and interpret these by themselves. They found the risk of tacit messages where the underlying standard practices were not explained to students consequently they misunderstood the optometry ways. It was found that eventually teachers missed the opportunity "to assist students in making responsible decisions, locating their position in practice, and shaping their professional identity" (Spafford et al. 2004, p. 800). In conclusion, they insisted teachers to apply innovative ways that explicitly express the logic behind their action particularly when they teach apprentices.

Moreover, Spafford et al. (2006, p.121) examined 16 OCPs of medical novices "for the amount and patterns of time devoted to student learning and expert teaching, the difficulties created for participants, the sometimes misunderstood implicit messages delivered by experts, and the opportunities to address educational objectives". Spafford et al. (2006) applied genre theory, situated learning theory and grounded theory. Further this study aimed to develop a model that might provide a methodology consisting of both quantitative and qualitative techniques "to assess the effects of competing activity system in the development of communication expertise" (Spafford et al. 2006, p.121). The participants of the study were 12 pediatricians and 14 third year medical students. Grounded theory was applied in order to classify the text into thematic category. Moreover, quantitative methods were also used to count words for mapping the airtime per speaker. Consequently, for the quantitative analysis, they divided each OCP into four Quartiles. Furthermore, the participants were divided into three groups: students, pediatricians, and others (residents and fellows). Kruskal-Wallis test was applied for the comparison of these groups. Finally, they found that complex patient cases had not only affected students' abilities to organize their presentations but also teaching strategies of teachers. Moreover, students' discourse during presentations displayed their identity as novice members of the medical discourse community and "savvy survivor of the evaluation process" (Spafford et al. 2006, p.131). Findings of the study also revealed the importance of feedback, role-play and communication and management skills. This study supports the need for explicit instructions to avoid misunderstanding and misinterpretations that can occur due to the tacit messages.

Furthermore, Schryer et al., (2007) investigated the role of OCP in socialization of medical and optometry students. In particular, main focus of their investigation was on "how the novices learn the strategies associated with the situated language practice of case presentation and how this language acquisition shapes novices' developing social identities" (Schryer et al. 2007, p.236). This study found that OCP functions like a "school genre" that helps "the interaction of accepted knowledge (textbooks facts) new knowledge (current research findings), and the specific details of a clinical case" (Schryer et al., 2007, p.256). They also found that OCP practices develop professional identities of novices.

Finally, Hung, et al. (2012) investigated the rhetorical structure and linguistic features in written case presentations of international and Taiwanese medical practitioners. Hung et al. (2012) found nine moves in written case presentation section such as: M1 History of present illness, M2 Past medical history, M3 Personal and social profile, M4 Family medical history, M5 Drug history, M6 General physical examinations on admission, M7 General Laboratory and diagnostic findings on admission, M8 Clinical course after admission, and M9 Medical records after discharge. They found that the rhetorical structure of case presentation written by Taiwanese and native medical

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doctors was similar however there were differences in use of linguistic features i.e. temporal dimension, the chronological order, transition words and the records of the time of admission. These researchers argued that unclear time frames potentially cause for "confusion, misunderstanding, and incomprehension" (Hung et al. 2012, p.225). Moreover, not writing the record of the time may not influence the content of the report however "it can lead to a weal logical structure" consequently the text "may create medico-legal problems" (Hung et al., 2012, p.227). The most interesting finding of this study is the establishment of a framework of the rhetorical structure of written case presentation genre.

Majority of the studies reviewed under the rhetorical structure of case presentation genre only highlighted the importance of the rhetorical structure (Kim et al. 2005); Dell, et al. 2012; Lewin et al. 2013; Dhaliwal & Haure, 2013) and offered few implicit instructions regarding the importance of communication skills (Kim et al. 2005;) Elliot & Hickam, 2009) required for an effective presentations. However, they did not offer a framework that may clearly exhibits not only the moves of an OCP but also steps of each move systematically. Further, these studies, hardly informs about the language of case presentation genre and the communicative functions of the medical discourse. Keeping in mind the importance of the language of the genre in question, this paper also reviewed below some of the important studies which described the ritualized language used among doctors for patients' case presentations.

1.4 Critical Review

It is a recognized fact that the rhetorical structure of the case presentation genre is modified depending on its context. So far, the published literature seems less critical on the dynamic nature of the rhetorical structure. An attempt has been made to critical review the flexible nature of the rhetorical structure of case presentation genre in this section. Additionally, there is a great debate on whether the biomedical language of case presentations should be appreciated or a more humane and patient-centered discourse should be inculcated. The protagonists of patient centeredness highly criticized the ritualized medical discourse practices. Therefore, it is an established fact that the biomedical language of case presentation is not simply used as a medium for delivering health care information. And it is not random rather it is purposeful because the rituals of biomedical language training and day-to-day practices teach trainee-doctors to declare patients as '*complainers, male and female, poor historian,* and *non-complaint'* (Donnelly, 1986, 1997; Poirier & Brauner, 1988). Besides, the language of case presentation also serves various communicative purposes for the medical discourse community. It has adequate practical implications. Keeping in mind the debate of whether medical doctors should use the biomedical language of case presentations or not, the researchers attempted to provide the world view of both patient-centeredness and physician regarding the language of case presentation genre in this section. Finally, this paper also presented the communicative functions of the medical discourse.

1.4.1 The rhetorical structure of the case presentation genre

As it was evidenced above, the related literature underpinned the rhetorical structure of case presentation genre practiced in medical discourse community. However there was slight variation observed in the rhetorical structure of OCP practiced in different contexts. For instance, the patient introduction part of OCP is classified into various names namely: Introduction and Identifying information (Kihm et al., 1991), General statement and Chief Complaint (Brose, 1992), Identification/Patient profile (ID/PP) & Chief Complaint (CC) (Lingard, 1998), and Opening statement, Opening line (Dhaliwal & Haur, 2013). Interestingly, Kim et al. (2005), and Elliot et al. (2009) declared the chief complaint as one of the variables of the history of present illness. Meanwhile, Green et al. (2010), on the one hand, stated that the introductory section should have variables such as: chief complaint, reason for admittance, relevant historical information, name of the patient, and site of care, Heiman (2012), on the other hand, illustrated that this section should cover age, gender, and occupation of a patient, relevant historical information, and chief concern. Moreover, even the variables or descriptors such as patient name, age, and marital status suggested by Green et al. (2010) and Heiman (2012) are not identical. For instance, Green et al. (2010) additionally mentioned to include reason for admittance and site of care whereas, Heiman (2012) included occupation as one of

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the variables of the opening statement. It speculates that medical experts possess different stance on including the descriptors for introducing patient profile and for the chief complaint itself.

History of present illness and physical examination are the only two components that were equally focused and represented. However, the descriptors suggested for history of present illness extremely unmatched in the published literature. For instance, Green et al. (2010) stated that history of present illness should have differential diagnosis, chronological and organized state of health, temporal aspects, past history, medications, family history, social history including psychosocial factors, pertinent positive and pertinent negatives, reports facts and events, and summarize course using problem list. Kihm et al. (1991) argued that history of present illness should have descriptors like location if pain, duration, associated symptoms, character if pain, exacerbating/relieving factors, diagnostic or therapeutic thus far, functional status, persistence of symptoms, severity, course i.e. increasing acuteness of onset. Heiman (2012) illustrated that history of present illness has variables such as cardinal features of symptoms, significance, pertinent positives and pertinent negatives. Dell et al., (2012) postulated that history of present illness should be organized chronologically, tells a clear story, includes pertinent positives and pertinent negatives that help distinguish among possible diagnosis, include element of past history i.e. medications, family history that specially contribute to the history of present illness. Lewine et al., (2013) stated that history of present illness should have clear patient introduction i.e. patient's age and sex, pertinent active medical problem, reasons for admission, chronologically organization of events. As it is mentioned in above, the descriptors provided for history of present illness also suggest variation. For instance, Green et al. (2010) and Dell et al. (2012) included past history elements such as: medications, social history and family history in the history of present illness section. However, in other context, since medications, social history, and family history are considered as important elements of past history, therefore these are considered as main components of oral case presentation (Kihm et al., 1991; Schryer et al. 2003; 2007). Further, Lewin et al. (2013) included the patient profile and chief complaint in the history of present illness as variables and Dell et al., (2012) included the past medical history as one of the important variables of history of present illness. Once again, variation in including different descriptors among the practitioners is clearly recognized. However, the importance of narrative technique for history of present illness (Green, et al. 2010; Lewin et al. 2013) is equally recognized.

The past medical history of oral case presentation is also classified into various names such as: past medical history (Kihm et al., 1991), other medical history (Brose, 1992; Green et al., 2010), and additional medical history (Heiman et al., 2012). Kihm et al. (1991) suggested that past medical history should have variables such as: past illness, review of systems, medications, and allergies. Lingard (1998) in contrast considered medications and allergies as separate components of oral case presentation. Moreover, according to the list of the descriptors provided by Kihm et al., (1991) and Green et al. (2010), review of systems should also be included as part of the past medical history. However, Brose (1992), Lingard (1998), Maddow et al., (2003), and Lewin et al. (2013) categorized review of systems as a separate component that comes after the family history. In contrast, Schryer et al. (2003; 2007), Elliot et al. (2009), Heiman et al. (2012), Dell et al. (2012), and Dhaliwal and Haur (2013) excluded the review of systems from the suggested rhetorical structure of oral case presentation. As it is noticed in above, medications and allergies are the components which are usually merged into the past medical history (Kihm et al., 1991; Green et al., 2010; Heiman et al., 2012). In addition, others researchers classified them as separate categories or components (moves) of oral case presentation genre (Lingard, 1998; Schryer et al., 2003; 2007). Overall, it is observed that some of the categories (moves) may be compulsory for a group of practitioners but for the others, it may be optional. To sum up, the prioritized criteria of the components of oral case presentation genre in different contexts are unpredictable as it is depicted in the critical review of the literature.

1.5 Conclusion

This review paper aimed to review the rhetorical structure the medical case presentation genre. Additionally, a critical review of the study was presented. In the critical review section, this paper reviewed the flexible nature of the rhetorical structure of case presentation genre. Altogether, 22 relevant studies were systematically reviewed.

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The flexible nature of the rhetorical structure of case presentation genre is further established in this review paper. It is an established fact that the rhetorical structure of the genre in question would be modified according to the context of situation.

Hence, the study set out to argue that assumption of the language of case presentations as medical doctors deliberate tactics employed for dehumanizing the subjective feelings of patients could be contested. Because, the ritualized language of case presentation potentially conveys not only the clinical reasoning but also perpetuates the white-coat doctrines and epistemological assumptions practiced in medical discourse community. Moreover, this review also indicated that medical practitioners do not simply use linguistic resources for imparting health care information and/or depersonalizing, dehumanizing, and down toning patients in case presentation; additionally, they also achieve various personal and professional goals at the best interest of health care. Hence case presentations "are formative institutions that shape as well as reflect the thought, the talk, and the actions of trainees and their teachers" (Donnelly, 1997, p.1045). Nevertheless, literally speaking, these medical slangs, clinical vernaculars and other typical lexico-grammatical strategies used for patients are "passwords" for novices in the medical world and these ritualized linguistic resources perform a gate keeping function at the threshold of the medical discourse community. Above all, preference of objective over subjective is embedded in the culture of hospital practices because physician's quantifiable data is more factual and scientific whereas patient's narration is unreliable mode of communication (Monroe et al., 1992, p.47). Hence, doctors' quest for objectivity should not be compromised; meanwhile, they should also find ways to acknowledge the humanitarian values of both patients and doctors (Monroe et al., 1992, p.47).

The researchers hope that the findings of this review would provide a base line for understanding the more implicit viewpoints of medical discourse community inherent in the language of case presentation. Similarly, future comprehensive empirical research focusing on investigating the epistemological assumptions of medical discourse community in the language of case presentation would further shed light on understanding the physicians' vantage viewpoint. This review paper would be proofed as a base line for interpretation of such investigations. Moreover, once clear understanding of the language of case presentation from patient-centered approach as well as doctor-centered approach would be established in literature. Finally, this review paper would further open the discussion for future researchers whether medical pedagogy should inculcate the ritualized language of case presentations or neutralize and/or substitute the biomedical language with the one which may empower patient

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