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The role of progress notes in the professional socialization of medical residents

Pamela Hobbs

University of California, Los Angeles, Los Angeles, CA USA

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Abstract

This paper examines the role of physicians' progress notes in the professional socialization of medical residents. As a component of their specialty training, residents are principally responsible for making the physician entries in the medical charts of the patients who are under the joint care of the residents and the hospital's medical staff. This includes the initial physician chart entry, the comprehensive 'admit note' which records the initial assessment of the patient upon presentation for medical care. Admit notes, which complement the oral case presentations that they reproduce, constitute a key training tool by means of which residents experience and internalize the cognitive processes which constitute medical reasoning and analysis. However, although a number of researchers have examined residents' oral case presentations, their written communications have seldom been studied. This paper examines the generic conventions that structure residents' admit notes, including abbreviations, telegraphic syntax, the 'SOAP' format, and reliance on background knowledge. Through the analysis of an admit note written by a first-year obstetrical resident, this paper demonstrates how the ability to operate these conventions evidences both the resident's professional socialization and the growth of his or her clinical judgment.

Keywords: Medical discourse; Physicians' progress notes; Professional socialization

1. Introduction

Medical knowledge is circulated through language, and it is largely through language that the work of medicine is carried out (Atkinson, 1999: 77, 104). However, sociolinguistic research has rarely addressed the question of how medical knowledge is constituted (Sarangi and Roberts, 1999: 22). As a result, although a number of ethnographic studies have

E-mail address: p37954@earthlink.net (P. Hobbs).

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explored the professional socialization of medical residents (see, e.g., Pettinari, 1988; Hunter, 1991; Atkinson, 1995; Cicourel, 1999; Erickson, 1999), the linguistic processes by which medical judgment is developed and exercised have rarely been subjected to fine-grained analysis (but see Pettinari, 1988). Moreover, because sociolinguistic studies of medical discourse have overwhelmingly focused on physician–patient interactions (see, e.g., Bryne and Long, 1976; Fisher and Todd, 1983; Mishler, 1984; Heath, 1992; Maynard, 1992; Roter and Hall, 1992; Heritage and Maynard, in press; Peräkylä, 1998; West, 1998a,b, 1984;), oral physician–patient communications are over-represented in the literature, while physician–physician communications, including the medical record itself, have been largely ignored (but see Hobbs, 2003, 2002; Atkinson, 1999; Cicourel, 1999, 1983; Erickson, 1999; Anspach, 1988; Rees, 1981).

This paper examines the role of physicians' progress notes in the professional socialization of medical residents. These notes, which complement the oral case presentations that they reproduce, constitute a key training tool by means of which residents experience and internalize the cognitive processes which constitute medical reasoning and analysis, through the application of general principles to specific individual cases. They thus represent the record of the resident's acquisition and exercise of clinical judgment.

2. Background

Medical interactions are shaped by the context in which they occur (Anspach, 1988: 358); thus, an understanding of residents' progress notes must begin in the hospital itself. Residency training takes place in university-affiliated teaching hospitals, which are characterized by their dual focus on patient care and physician training and are thus referred to as academic medical centers. My own socialization into the discourse of medicine occurred at one such center between March 1993 and December 1995. At that time, I was a lawyer employed by a law firm located in the Midwestern United States and specializing in the defense of medical malpractice cases. In 1993, I became one of the senior members of the practice group responsible, on behalf of an urban teaching hospital which is one of the largest obstetrical centers in the United States, for the handling of cases alleging obstetrical malpractice. As such, I was expected to acquire an understanding of the principles of obstetrics as they apply to the management of high-risk pregnancies, which would allow me to become actively engaged in the complex medical issues that are central to the defense of these cases.

Abruptly thrust into a clinical setting to which I had no prior exposure, and forced from the outset to grapple with the difficult cases that are selected for litigation, I learned to read and interpret medical records and fetal monitor strips, identify and analyze the medical issues raised by the data and information recorded, and discuss and critique the patient's medical management, clinical course, and outcome with the members of the hospital's obstetrical staff from an informed insider's perspective. This total-immersion trial by fire was an experience that was in many ways analogous to that of a first-year obstetrical resident as, guided by the doctors who were my clients, I learned, tentatively at first, and then more confidently, to isolate and extract, from the often confusing or incomplete evidence presented by the patient's narrative account and recorded clinical signs, the data