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APPLIED BIOETHICS

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BIOETHICAL ASPECTS OF MEDICAL DISCOURSE

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There has been insufficient research into the problems of institutional interaction of the participants of health care provision sphere which should be conceptualized from the biomedical paradigm perspective. The article aimed to reveal bioethical aspects of medical discourse. The authors substantiated their understanding of medical discourse and presented its genre typology. The genre of clinicopathological conferences was explored. This type of medical discourse was found to be the concentrated embodiment of the biomedical perspective of conceptualizing health reality. Alongside with the biomedical approach, bioethical principles of considering and presenting discursive medical knowledge were employed by the participants of clinicopathological conferences. The ethical and axiological aspects of the discourse under study were represented by various ways of verbal expression of its personalized nature, its values and types of reasoning.

Key words: medical discourse, biomedical perspective, clinicopathological conference, ethical and axiological aspects.

БИОЭТИЧЕСКИЕ АСПЕКТЫ МЕДИЦИНСКОГО ДИСКУРСА

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Проблемы изучения институционального взаимодействия участников сферы оказания медицинской помощи недостаточно изучены и требуют осмысления с позиций биоэтической парадигмы. Целью статьи явилось выявление биоэтических аспектов медицинского дискурса. В работе обосновано авторское понимание медицинского дискурса и представлена его жанровая типология. В качестве объекта изучения использовался жанр клинопатологоанатомической конференции. Установлено, что медицинский дискурс данного типа является концентрированным выражением биомедицинской перспективы при концептуализации действительности. Наряду с биомедицинским подходом в ходе клинопатологоанатомической конференции выявлены биоэтические принципы представления дискурсивного медицинского знания. Этико-аксиологический аспект рассматриваемого дискурса репрезентирован посредством различных способов вербального указания на его личностно ориентированный характер, ценностную и аргументативную природу.

Ключевые слова: медицинский дискурс, биомедицинская перспектива,

The medical community is a distinct group of individuals who have a common background and share material, intellectual and moral values, as well as rules of conduct, which are conventionally referred to as *professional medical culture*. The main function of the social institution of medicine is to restore and maintain human health which is achieved by various activities which include communication [3]. The process of verbal and non-verbal interaction is seen in two major forms – written and spoken, signified as *professional medical discourse* by us.

On the one hand, medical discourse is a means of reflecting and representing material and intellectual entities inherent in the medical sphere as well as the complicated relationships between them. On the other hand, as S. Pointer and D. Brauner point out, language adjusts and invariably changes the reality which it represents, as it expresses the speaker's perspective [6]. It is the ability of the word to impact the current situation and alter reality is referred to by J. Derrida as 'manipulative' nature of language [5].

When the patient first presents to the doctor, his history is taken. Later it is complemented with further findings and used by various specialists involved in diagnostics and treatment. In this case, the patient becomes somewhat abstract or non-figurative as the anamnestic data are repeatedly reproduced. The patient's history is gradually being transformed from a narrative about their real life and disease into a summary of events manifesting doctor-patient relationships [1]. Medical sociologists point out that a medical history, which is an important and thoroughly structured discourse piece replaces a poorly organized and redundant narrative created by the patient which, in its turn, results in the patient's depersonalization [6]. When taking a case history the doctor takes note of only those aspects of the patient's life which are relevant to the categories and values of medicine and tend to emphasize its objective and precise nature. Therefore, the text format or genre starts to "impose" certain communicative preferences to the speaker.

The main requirement for compiling various medical documents as well as producing spoken pieces is to use biomedical language. Its conceptual aspect rests on the categories of the scientific medical worldview whereas its formal aspect includes the terminology of various fields of

medicine as well as stereotyped patterns of expressing different propositions.

These requirements are applicable to both various genres of written medical discourse (case history, case record, examination report, etc.) and the events of spoken medical discourse. The latter include genres of symmetrical equal status communication (medical and clinico-pathological conferences) as well as genres of asymmetrical communication produced by the participants differing in discourse status (doctor-patient encounters). This article sets out to study spoken medical discourse produced by the participants of clinico-pathological conferences. It aims to reveal the bioethical peculiarities of the verbally represented clinico-pathological worldview manifested in this genre discourse.

To carry out this study we used the archives of the recorded clinico-pathological conferences held in the Mount Sinai Hospital published by Fenton Shaffner, Hans Popper, George Baehr [7]. The purpose of clinico-pathological conferences is to make a final diagnosis or ascertain the cause of the patient's death. The scenario of this speech event is very similar to the scenario of case conferences. The latter differs in its outcome which is not lethal. At the initial stage, a brief description of the case history and the patient's death is provided. Later pathologists discuss the clinical features of various diseases described in the case history as well as detected during the autopsy, match them to the systematical scientific knowledge summarized within the medical worldview, and make conclusions about the lethal diagnosis.

From the point of view of its conceptual content the clinico-pathological discourse is the concentrated embodiment of the biomedical perspective of conceptualizing health reality. A clinical case presentation is strictly based on the medical worldview and constructed according to the scenario generally accepted in medical practice:

- Introduction of the patient
- The reason why the patient last sought for medical aid, their complaints
- The past history

The patient's introduction proves to be the concentrated formula of the biomedical approach. Only the information relevant from the diagnostic point of view such as age, gender, ethnicity and occupation is focused on: *a*

70-year-old white male, a retired post office worker, a 51 year old Negro female, a 26 year old Negro male, etc.

At the later stages of the conference the patient who died is generally referred to by means of personal pronouns *he, she* or in one of the following ways - *this man aged 70, the patient, man, this gentlemen, the 21 year old specimen, the woman*.

Another reference feature is that the patient is described in terms of somatic categories in the contexts under study. Moreover, they are considered not as a single whole but as a set of anatomical, physiological and pathophysiological components [2]: *She had bilateral corneal opacification. A 1.5 cm mass was felt in the left lobe of the thyroid. The neck veins were not distended. The lungs were clear, the heart was not enlarged, the pulse was normal and the blood pressure was 130/72. A harsh grade II apical systolic murmur was heard. No organs were felt in the abdomen.*

X-rays revealed a hiatal hernia, a deformed duodenal bulb, a normal colon, osteoarthritis of the spine, a normal cystogram, no visualization on an intravenous pyelogram, vascular calcifications on both sides of the pelvis, and an irregular oval calcific density below the left sacroiliac joint.

Reducing the whole experience of the human existence to a well-structured set of somatic categories in fact results in the patient's depersonalization. Anamnestic information is provided in the way which emphasizes its objectivity and precision. It has also been pointed out that the style of oral presentation of such information is somewhat adjusted to its content – it is read out monotonously and steadily, with neither expressive intonation, nor attendant nonverbal cues (for example, mimic or kinetic cues) [6].

Clinico-pathological discourse is objectivized by its depersonalization, i.e. by obscuring the agents of medical activities. This is achieved by replacing active constructions with passive ones - *the patient was followed in the outpatient clinic; no murmurs were heard; a left varicocele was felt; the cystotomy tube was changed under general anesthesia*), using non-agent constructions in which various diagnostic procedures become the sources as well as “agents” obtaining medical knowledge (*Physical examination revealed; Clinic laboratory tests showed; Electrocardiogram displayed a PR interval of 0.16 sec; X-rays revealed cardiac enlargement*).

The narration is also made more objective due to the fact that the information is presented in the chronological order.

When reflecting medical reality the doctor's biomedical perspective is also embodied by means of technical language which mainly consists of medical terminology as well as a great deal of numerical data:

Urinalysis showed the specific gravity of 1.010, 1+ albumin, no sugar, 28-38 WBC/HPF, with 5-10 clumps, casts and bacteria. Hemoglobin was 11.2 G., WBC 6,600 with 59 % neutrophils and 7 % band forms. BUN was 82 mg. %, blood sugar 76 mg. %, uric acid 5.9 mg. %, acid and alkaline phosphatase 3.2 and 6.0 KA units respectively.

The analyzed extracts do not provide any information on the patient's social life given that they possess no diagnostic value. As this part mainly enumerates investigations and treatments received by patients and is based on the well-confirmed findings, epistemic modality (from Gr. *Episteme* – knowledge) is expressed in the above-mentioned propositions.

The representation of the abovesaid semantic features in medical discourse rests on the laws of conceptualizing reality employed by the scientific medical worldview. There is an abundant use of short sentences and parallel sentence structures which promote monotony and stereotypicality of the narration (all the information is confined to a number of discourse patterns complying with clinical thinking - *No malarial organisms were found and blood cultures were negative. No urinalysis was reported but urine culture grew pneumococcus and enterococci*).

The next stage, the discussion stage has a number of specific features. When diagnostic information is discussed, each specialist's personal opinion becomes valid and crucial. This fact significantly modifies the way the discourse is verbally expressed [4]. The agent and the referent of the discourse become explicit and are verbalized by means of personal pronouns *I, my, we*. In addition, the pronoun *we* becomes inclusive (includes all the pathologists and doctors present) which points to the fact that they share responsibility when make diagnostic decisions.

The discussion of pathologists participating in a conference is argumentative. According to the formal logic principles, a proposition is put forward, then it is either argued for or against using a number of arguments. Moreover, reasoning is done in a few possible ways: the

pathologist's diagnostic conclusion is preceded by the statement of reasons inferred by them or it is countered by some arguments provided (*The first impression one might have would be that this man, aged 70 had prostatism with hypertrophy of the prostate, on which was superimposed an infection of the left kidney, destruction of renal parenchyma, and uremia. The arguments against this thesis are obvious in the sense that evidence of renal failure occurred before he developed evidence of prostatism. The hypertrophy of the prostate and the ascending urinary tract infection were added to the underlying and more significant renal disease; Therefore, the possibility that this was an amyloid nephrosis secondary to a retroperitoneal tumor or other tumor causing a rapidly progressing nephrotic syndrome with renal failure not responding to any therapy is a reasonable hypothesis. This would even be consistent with the fact that the left kidney is smaller than expected in most amyloid nephrosis since in time the amyloid kidney may become contracted.*

In other cases the clinician appeals to the vast experience of other specialists:

Let us for a moment consider the probability of polycystic kidney disease in this case. Less than ten per cent of polycystic kidney disease is unilateral. More important is the report by Campbell on 42 autopsies in children in whom, at least microscopically, he found 20 cases of unilateral kidney disease although he states that the potentialities of what appears to be a normal kidney on the contralateral side could very well go on to develop polycystic disease in later life.

Some actual evidence (the findings of the previous instrumental examinations, autopsy) can be presented. In such cases the features typical of the stage when a clinical case is presented are observed:

The pyelogram showed no hydronephrosis and no malconfiguration. At the autopsy there was ankle edema and an accumulation of some 2,000 ml of fluid in both pleural cavities. In view of the convulsion we were interested to demonstrate abnormal changes in the brain, but the gross examination was entirely normal and not even sclerotic changes were seen. Microscopic examination also failed to reveal any significant changes.

The fact that pathologists are trying to reach the truth during their discussion, changes the discourse modality which becomes probabilistic. This is achieved through a wide use of subjunctive constructions, modal

verbs and expressions such as *likely, possible, possibility, assume, it seems to me* (*What could have been the reason for the nephrectomy? In the first place, this could not have been a chronic diffuse glomerulonephritis. There would be no conceivable situation in which the physician could possibly mistake a chronic diffuse nephritis for a surgical kidney).*

This discourse move stimulates discussion and bears evidence of the most pronounced trend in today's medicine towards collective decisions. It is a complicated task to make the correct and adequate conclusion which may require the information about social life of the patient: *In the lengthy history of this gentleman, 42 years before his death when he was a soldier in the Philippines, he had sprue.*

The axiological aspect of the discourse under study is mainly represented by evaluative words and statements. The statement *We were fortunate enough to get the 21 year old specimen from the other hospital* embodies the following evaluative presupposition – a study of such a complicated from the clinical point of view case will promote the development of medical science. The evaluative judgment is constructed by means of a phrase expressing a positive attitude *fortunate enough* as well as the special way of referring to the dead patient destined to contribute to science as *specimen*.

Ethical and deontological standards of medicine may account for the penetration of the bookish style elements into the clinico-pathological discourse. The latter are used euphemistically (to replace socially unacceptable taboo words with more appropriate speech formulas), for example *died* → *ceased/expired*.

The expression of negative attitude may result from the fact that pathologists admit that their competence is limited and it is difficult to reach the ultimate truth: *The thing I have difficulty with is the fact that there is no evidence whatever of any antecedent renal damage; I am not able to explain the high blood uric acid level; I am hard-pressed to believe that.*

Summing up the study of the main bioethical features represented in the clinico-pathological discourse we have made a number of conclusions.

Firstly, the analyzed genre of the spoken medical discourse is fully based on the biomedical approach to conceptualizing subjects, objects and tools of medical activities. This fact is reflected in a wide range of specific

bioethical features of verbal and non-verbal representation of the categories of medical activities. Both subject and object depersonalization of the discourse is inherent as both the doctor and the patient, the participants of this discourse, are obscured which is achieved by either eliminating any reference to them or restricting all the reference to the biomedical parameters.

During the discussion stage, the discourse becomes more person-centered which is reflected in its referential aspect. Alongside with the biomedical perspective of conceptualizing reality evaluative and argumentative constructions revealing the axiological and ethical standards of pathological activities are employed in these texts.

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INTERPRETATION OF THE AVAILABILITY OF MEDICAL CARE FOR PATIENTS WITH ARTERIAL HYPERTENSION IN THE CONTEXT OF THE PRINCIPLE OF JUSTICE

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The principle of justice is discussed in bioethics as the availability of adequate medical care. The article presents the results of a study of the availability of drug therapy to patients with arterial hypertension. Found that 40.1 percent of respondents do not accept the assigned antihypertensive drugs due to the lack of funds to any medicine. It is noted that none of the patients included in the study had received anti-hypertensive drugs means of additional medicinal maintenance, i.e. at the expense of the regional or Federal budgets. 48.7% of respondents have a high risk of progression of hypertension and complications associated with unavailability of adequate hypotensive therapy.

Key words: principle of justice, access to health care, hypertension, deprivation.

ИНТЕРПРЕТАЦИЯ ДОСТУПНОСТИ МЕДИЦИНСКОЙ ПОМОЩИ ПАЦИЕНТАМ С АРТЕРИАЛЬНОЙ ГИПЕРТЕНЗИЕЙ В КОНТЕКСТЕ ПРИНЦИПА СПРАВЕДЛИВОСТИ

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Принцип справедливости обсуждается в биоэтике как доступность необходимой медицинской помощи. В статье представлены результаты исследования доступности медикаментозной терапии пациентам с артериальной гипертензией. Установлено, что 40,1% респондентов не принимают назначенные гипотензивные препараты из-за отсутствия средств на лекарственные препараты. Отмечено, что ни один из пациентов, вошедших в исследование, не получал гипотензивные препараты из средств дополнительного лекарственного обеспечения, т.е. за счет средств областного или федерального бюджетов. 48,3% респондентов имеют высокий риск прогрессирования артериальной гипертензии и возникновения осложнений, связанных с недоступностью адекватной гипотензивной терапии.

Ключевые слова: принцип справедливости, доступность медицинской помощи, артериальная гипертензия, депривация.

The majority of Russian citizens think justice in medicine to be a general right to receive free medical care. Article 41 of the Constitution of the Russian Federation guarantees possibility to obtain free medical care: «Medical