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Hurwitz, Brian.

Literature and Medicine, Volume 25, Number 2, Fall 2006, pp. 216-240
(Article)

Published by The Johns Hopkins University Press
DOI: [10.1353/lm.2007.0006](https://doi.org/10.1353/lm.2007.0006)



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Form and Representation in Clinical Case Reports

Brian Hurwitz

Representations of clinical encounters have been preserved over many centuries as clinical case reports. These highly stylized accounts concerning individuals who are ill, or believe themselves to be ill, expose diagnostic practices and changing theories of health and disease. Over time, they also reflect changes in the professional-patient relationship and the variable weightings accorded subjective and objective factors in the medical assessment of illness.¹ Focus on the representational form of the clinical case report amid the scientific and numerological clatter of modern medical practice may reawaken interest in the literary and compositional aspects of case history as illuminative of basic medical beliefs and practices.

In 1981, George Rousseau suggested that clinical encounters could productively be examined with the approaches and methods of literary studies. In a paper exploring the historical interweavings and theoretical permeations of literature and medicine, he notes that “every time a patient enters a practitioner’s office a literary experience is about to occur: replete with characters, setting, time, place, language and a scenario that can end in a number of predictable ways.”² By “literary experience,” I take Rousseau to mean (following Aldous Huxley) experience that demands language capable of expressing the aberrant, the anomalous, and the vulnerable, that gives rise to written communication with emphasis.³

Rousseau’s call for a literary critical perspective on medicine has since been echoed by others.⁴ In 1986, Stephen Hoffmann, for example, contended that “a doctor is in essence a literary critic. Invited to hear a tale every time a patient comes to see him, he must evaluate each person’s story in the same way that a trained reader would approach a literary work.”⁵ Calls for literary studies to examine the texts and methods of clinical practice have resulted in a focus on the narrative

features of medical records and the performative aspects—the telling, questioning, listening, and sharing—of clinical encounters.⁶

The clinical case report is a foundational text that enables clinicians to depict, reason, and instruct others about a sick person's medical situation.⁷ By permitting comparison of one case with the written accounts of others, case reports provide vital orientation and contextualization: "Without a storehouse of case exemplars to draw upon medicine could be neither taught nor practiced," concludes Howard Brody.⁸

The case reports I will consider here are generally not the private records of health-care attendants that log illness episodes, symptom development, and response to treatment, but communiqués intended for a wider audience that has neither seen nor attended the sick from whom they arise. Although early case descriptions may originally have been extracts of physicians' private notes—their personal medical records—case reports arise from a more "presentational" impulse. Whatever their purpose—be this to notice new phenomena, associations, or clinical features thought worthy of instruction—case reports involve discursive performances that reorganize clinical data using a variety of narrativizing techniques.

The notion of case precedes that of case report, even though the apprehension of and the classification of cases are bound up with discussing and comparing word pictures of them. My comments in this paper refer, on the whole, to the textual reports of the clinical events and not to the events themselves, although the distinction between the person who is ill (the patient) and the medically constructed picture of him or her is at times difficult to maintain. There are at least three layers to the clinical case. They are exemplified, for example, in James Parkinson's *Essay on the Shaking Palsy* (1817) and in William J. West's 1841 letter to the *Lancet*, entitled "On a Peculiar Form of Infantile Convulsions." Parkinson writes, "The next case which presented itself was that of a gentleman about fifty-five years, who had first experienced the trembling of the arms about five years before."⁹ West reports, "[T]he only case I have witnessed is in my own child."¹⁰ Parkinson's initially genderless case "present[s] itself" in the abstract, but we quickly learn that the patient is actually "a gentleman about fifty-five." Both these examples, and case reports in general, collapse together the reference to a person, the medical abstraction of him or her, and his or her textual realization as a report. In West's case report, his own child is indistinguishable from potential other children with the condition, yet the author's child clearly exists beyond his father's bare-bones depiction of him as the case of an infant who convulses. Clinical case reports

mask or at least trouble the distinctions among the person, the patient, and descriptions of the disease, such elisions lending credence to the proposition of two prominent sociologists that “cases are found, cases are objects, cases are made, and cases are conventions.”¹¹

The root meaning of *case* is derived from the Latin *casus* (the Middle English *cas*) meaning a fall, as in befall. The term refers to something notable, an unfortunate exemplum of a condition or predicament. In Roman law, *case* referred to a cause for action or a statement of the facts of the matter grounded in a narrative, the term *narrative* referring then to a legal statement of alleged facts supporting the claim.

Just as the Roman legal case was an assemblage of evidence and an argument made in narrative terms in front of an audience, the clinical case report also involves the assemblage of noteworthy evidence and an argument made in narrative terms in front of an audience. In its literary construal of clinical scenarios, the case report purports to offer a reflection of reality based on the judicious selection of events, experience, appearance, and points of view that can sway an audience to endorse the presenter’s claims.¹² By examining the following excerpts from clinical case reports from the Hippocratic and Galenic eras and the seventeenth, eighteenth, nineteenth, twentieth, and twenty-first centuries, I seek to highlight some of the enduring features of such narratives while examining temporal shifts that denote transformations in medicine’s goals, methods, and clinical prose.

Hippocratic Era

A distinguishing feature of Hippocratic case histories is ordered engagement of the senses in the task of reasoning clinically: “Vision, hearing, nose, touch, tongue, reasoning arrive at knowledge,” Hippocrates writes in the *Epidemics VI*.¹³ Vision was the primary sense brought to bear on noticing and picturing the body medically, and it remained the dominant channel of knowledge collection in medicine until Freud—giving rise to what Oliver Sacks refers to as the predominance of “eyehood” over the first-person “I” in case reports.¹⁴ The Hippocratic preoccupation with external appearances, signs, surfaces, and colors created a visual primacy that eventually culminated in our own times in the capacity to visualize the body from remarkable new technological vantage points.

The following is an arresting account of how a woman met her death twenty-five centuries ago. Its precision is a feature of Hippo-

cratic narration, which displays close attention to observational detail and temporal sequence and typically covers only a short segment of a person's life, usually just the period when the doctor was in attendance: "The foot of Aristion's female slave spontaneously ulcerated in the middle of the foot on the inner side. The bones became corrupted, separated and came off little by little, eroded. Diarrhoea developed; she died."¹⁵ The narrator, assumed to be a Hippocratic physician, plays no part in the unfolding story other than that of careful observer. The flat descriptive tone conveys a disinterested, almost passive, authority. The literalism of this report stems from the witness statement, fashioned here by a seasoned observer of pathological processes. The ulceration, we are told, commenced "spontaneously" in a very specific part of the slave's foot and although the nature of the disease is not named, the narrator categorizes it into distinct stages: ulceration, corruption, separation, erosion, diarrhoea, then death.

The *Epidemics* contain over a hundred case histories exemplifying the rich visuality and acuity of Hippocratic observation. It is not clear if such case reports were intended for publication. Some scholars believe they were rough notes and private logs of doctors' attendances on sick patients, working documents rather than crafted instructional accounts. Others hold that their focus on carefully documented time intervals between crises betrays a primary concern with prognosis rather than diagnosis.¹⁶ Although the narrator-physicians do not entirely reject supernatural possession, godly explanation, and the effects of chance on the course of illness, they favor the view that everything that happens has a preceding cause.¹⁷ Case chronology becomes the Hippocratic pathway to identifying patterns and forming a prognosis, and it is chronological sequence par excellence that the cases exemplify. For example:

In Larisa a bald man suddenly experienced pain in the right thigh. No remedy did any good.

First day. Acute fever of the ardent type; the patient was quiet, but the pains persisted.

Second day. The pains in the thigh subsided, but the fever grew worse; the patient was rather uncomfortable and did not sleep; extremities cold; copious unfavourable urine was passed.

Third day. The pain in the thigh ceased, but there was derangement of the intellect, with distress and much tossing.

Fourth day. Death about mid-day.¹⁸

The temporal range and reference in these reports is restricted to a short segment of a person's life, presupposing that the order of events is to be mirrored by the order of appearance in the text:

The pretty young virgin daughter of Nerius was twenty years old. She was struck on the *bregma* [the middle point of the front of the skull at the topmost point] by the flat of the hand of a young woman friend in play. At the time she became blind and breathless, and when she went home fever seized her immediately, her head ached, and there was redness about her face. On the seventh day foul-smelling pus came out around the right ear, reddish. . . . Again she was prostrated by the fever; she was depressed, speechless; the right side of her face was drawn up; she had difficulty breathing; there was a spasmodic trembling. Her tongue was paralyzed, her eye stricken. On the ninth day she died.¹⁹

These reports were intended to be factual representations of what befell a person, the focus being the clinical course of the condition signifying possible disease processes. Reference to patient experience—"her head ached"—is abbreviated and takes second place to delineation of signs and bodily appearances. The domains of felt experience are not the main interpretive focus of the case story, even when a patient suffers from what might well have been a condition with prominent psychological dimensions, as in the following:

A woman at Thasos became morose as the result of a grief with reason for it, and although she did not take to her bed, she suffered from insomnia, anorexia, thirst, and nausea. . . .

Early on the night of the first day she complained of fears and talked much; she showed despondency and a very slight fever. In the morning she had many convulsions; whenever the frequent convulsions intermitted, she talked at random and used foul language; many intense and continuous pains. On the second day, condition changed, no sleep, higher fever. Third day: the convulsions ceased but coma and lethargy supervened, followed by renewed wakefulness, when she kept leaping up and losing control. There was much random talk and high fever. That night she sweated profusely all over with warm sweat. She lost her fever and slept, becoming quite lucid and reaching the crisis. About the third day the urine was dark and thin and contained suspended matter, for the most part round particles, which did not sediment.²⁰

In this report, a reference to the patient being morose—for which grief “with reason” is surmised—is made only in passing, as it is bodily movements and fever that gain the narrator’s attention, at the expense of a complex, emotional state.

Noticeably absent from these case reports is much textual sign that the physician conversed with the patient. Indeed, Hippocratic reports reveal remarkably little evidence of dialogue or discussion between patient and physician. Perhaps more saliently, these reports reflect not the present’s immediacy but a retrospective account ordered by knowledge of the ultimate outcome. Some of the literary features of the Hippocratic case report can be discerned in the contemporary case report: there is often little evidence of doctor-patient conversation; the contemporary case report is dominated by chronology and written in the past tense; and the case report is the doctor’s story fashioned to order that which the narrator has learned from the patient’s account and from subsequent observation—it is rarely a record of the here and now. Even when the patient may actually be listening to his or her own case being narrated, as in contemporary clinical presentations, it is the reconstruction of what has happened that is recounted. Meticulous attention to accuracy, to correspondence between observation and representation, and to the analytical separation of “the march of diseases” from the patients who are ill appear to be Hippocratic in origin.²¹ These separations support Sacks’s view that “the idea of fate, hence of existential drama, is missing from traditional medical case histories.”²²

The Hippocratic report announces itself to be an objective, disinterested assessment, and the coincidence in the medical attendant of observer, recorder, and narrator grants the Hippocratic physician an almost omniscient status. But even in Hippocratic cases, occasional tell-tale signs of an all-too-human narrator can be discerned. Despite the customary precision in the case report of Neruis’s daughter—it was the *flat* of a *friend’s* hand that struck her in an *accident of play*—there are strong hints of the author’s personal responses to the transmutation of Neruis’s daughter into a speechless person discharging foul pus. In Hippocratic theory the *prettiness*, *youth*, and *virgin state* of the patient have no salience; mention of these features attests to the operation of a narrative licence that allows the author to personify the patient and to heighten readers’ own responses to the terrible story of her injury.

Galenic Era

As a general rule, Hippocratic case reports rarely tell us much about the patient beyond his or her name, station, and location; in the Hippocratic case report, patients usually appear as silent actors performing bit parts in a play about their own illnesses. But this is less true of many of Galen's case histories. For example, in *On Prognosis*, written in the second century AD, Galen records:

I was called in to see a woman who was stated to be sleepless at night and to lie tossing about from one position into another. Finding she had no fever, I made a detailed inquiry into everything that had happened to her, especially considering such factors as we know to cause insomnia. But she either answered little or nothing at all, as if to show that it was useless to question her. Finally, she turned away, hiding herself completely by throwing the bedclothes over her whole body, and laying her head on another small pillow, as if desiring sleep.

After leaving I came to the conclusion that she was suffering from one of two things: either from a melancholy dependent on black bile, or else trouble about something she was unwilling to confess. I therefore deferred till the next day a closer investigation of this.²³

Galen frames this case semiautobiographically as a report of part of his working day, and the way the case unfolds is partially the result of a strategic use of the physician's visiting schedule. Galen's "I" functions here as an epistemological agent introducing readers to a woman who (he is careful to inform readers) is "stated to be sleepless."²⁴ The report recounts a meeting between patient and clinician in which the physician's attempted communication is rebuffed. The failure of exchange is compensated for, to some extent, by the access the report grants readers to Galen's own thought processes and reasoning. The physician-narrator here is a doctor at work, a fellow human with concerns, theories, and uncertainties, whose clinical work places rhetorical exchange between equals as central to his practice.

Physician to the Roman elite, including Marcus Aurelius, Galen has no hesitation in setting out his own case history in the service of communicating it to others and adding perhaps to his renowned powers of reasoning and observation. In *On the Affected Parts* he writes:

I remember that I once had a pain as if I were pierced by a trepan deep in the abdomen, particularly at the exact spot where we know that the ureters descend from the kidneys to the bladder. Shortly after [rectal] application of oil of rue and by straining hard to evacuate I excreted it under severe pain together with a transparent humour. Praxagorus would have called it *hyaloides*. It was similar in consistency and colour to molten glass. I observed this happened also to other people. It is astonishing how cold this humour appears and how even a violent expulsion does not warm it up.

I believed that a stone was impacted in one of the ureters. At least I had that impression from the piercing type of pain. But when the pain subsided after the discharge of the humour, it became evident that the cause of the pain was not a stone and that neither the ureter nor the kidney was the affected part but that the pain came from the intestines, and most likely the large bowels.²⁵

The precision and richness of description here is telling, and its focus on inner experience (the pain and straining) as well as on outer appearances (the temperature, consistency, and appearance of the evacuated humour) portrays a scene of intricate interiority that Galen tries to link to the teachings of Praxagorus and to his own observations on other patients.²⁶

Self-narration of case reports undoubtedly affects their tone and content, for when the physician's "I" becomes the object of observation and description, both the first-person presence of the patient and the importance accorded to subjective experience cannot be downplayed easily. Nevertheless, as we shall see, autobiographical authorship of case reports can be more or less textually masked.

Seventeenth Century

Compare Galen's descriptions with the case notes of Dr. John Symcotts, a physician who practiced in mid-seventeenth-century Huntington and Bedford, United Kingdom:

Mistress Christian Tenum of Cambridge, fifty years of age, could sleep so little that for fifteen years she had scarcely two and only rarely three hours sleep each night. For twenty years she had a pulsing of the arteries and when she first lay down to rest many images of things passed before her eyes. Ringing in the ears. She

felt as if a heavy burden or weight was continually pressing down upon the top of her head. She had a feeling of intense heat at the back of the head. She was usually delirious once a day. Pain in the left abdomen. In colic a concentration of wind. Weakness of the back. . . . Three years ago she was stricken with paralysis and from this she still has a numbness of the head. A continuous cough.²⁷

This account is dominated by experiences reported by the patient, spanning feelings and sensations perhaps suggestive of a spiritual crisis and excluding first-person reference to the physician-narrator. However, another case history from the same doctor does contain personal reference. This case concerns a woman who has become acutely ill and includes comment on the reliability of the history obtained, some descriptive symptomatology, and reference to debate (and perhaps dispute) among the three different medical personages who attended her:

I called on Mistress Paradine of Bedford, a linen draper, who on the 26th of that month [June 1637] had returned from London (but this fact the messenger concealed from me). She fell ill on the journey and when she reached home on the 27th she collapsed, felt pain over all her body, could not sleep. On the 28th she vomited much and was prostrated by a very bad headache, yet she got up for the greater part of the day. Along with the vomiting she was racked by a hiccough, together with a flux of blood from the nose which was thought to be up to ten ounces.

On the evening of the 30th, when I arrived, I found her lying down, and the hiccough . . . was again tearing her to pieces. She was very restless, anxious, found the bed uncomfortable, could not sleep, was delirious but not quite put out of her mind, for she refused nothing that was given her and heard what we were saying.

A surgeon of the name of Rowland . . . applied dry cupping glasses to the stomach and umbilicus and left them for some time, but they had no effect on the hiccough. Her pulse was hard, deep, swift and tumid, and I thought it a bad sign that a sweat broke out over her whole body. She was very thirsty and asked for drink; we gave it to her, but the cold drinks made the hiccough . . . start again. She was still unable to sleep.

On July 1st, Mr Woodcock of Amptill, who had arrived long after me on the previous night . . . wanted to let blood; I was against it, but he was importunate. . . . The blood was drawn; nobody was at fault. The pulse then became weaker and frequently intermitted. . . .

We left the bedside and were just about to leave for breakfast when the woman made a sign to her husband to enquire about the pain in her abdomen. Straightway he urged Rowland to see what it was and to look and see if any plague bubos were coming up. The latter did so and asserted most emphatically that a bubo had broken out in her groin. There was little for us to advise in this case.²⁸

Wracked by hiccoughs that are “tearing her to pieces” and by restlessness and delirium, Mistress Paradine is attended by three different doctors, all of whose treatments are abruptly truncated—as is the case report itself—by the appearance of a single bubo in her groin. At the sight of this, there is a complete change of mood, from one of mystery and perplexity concerning the patient’s condition to one of hopelessness and despair. The attendants abandon the fatally stricken woman, and readers are left pondering why the messenger concealed from Dr. Symcotts that Mistress Paradine had returned to London on the 26 of June, how the doctor subsequently found out about the visit, and why it was important for him to know about it. Contrary to Sacks’s view, this seventeenth-century case report evinces considerable existential drama and a strong sense of the operation of fate.

Eighteenth Century

In her doctoral dissertation, “A Curious Literature: Reading the Medical Case History from the Royal Society to Freud,” Margaret Kennedy argues that despite considerable pressure to expunge it, textualized evidence of medical authors’ own interests and subjective responses to their patients, as apparent in the seventeenth century, are not narratively eclipsed from case reports until the twentieth century. Kennedy finds such responses in the eighteenth century, expressed in the curious rhetoric of the unusual and the extraordinary. She cites Dr. Francis Monginot’s “Account of an unusual Medical Case,” published in *Philosophical Transactions of the Royal Society* in 1701:

I was surpriz’d yesterday with a very extraordinary case. . . . Madam R-’s Girl fell into violent Convulsion fits; and while she was in them voided a large quantity of Blood by the Mouth, the Nose, the Ears, and the Eyes. . . . All these symptoms were over in half an hours time, and the young girl . . . was very well presently. I am apt to believe they are Epileptick Fits; but the sudden

relief and cessation of them by bleeding through all these parts, I must confess is wonderful to me.²⁹

Early volumes of *Philosophical Transactions* and, a century or so later, of *Medical Transactions of the Royal College of Physicians* include case reports with titles that herald perplexity, mystery, and access to secrets. Titles such as “An Extraordinary Case” and “An Unusual Case” announce reports featuring clinical appearances with ascriptions such as “wondrous” and “prodigious” appended to them. These linguistic features, Kennedy maintains, engender a voyeuristic reading enabling readers to position themselves at the threshold of intimate details of the lives of strangers—their private, domestic situations and bodily details sometimes bordering on the immodest—and allows them to see through the eyes of an attending physician. The patient is framed as a spectacle, and secrets are revealed in a text narrated by a physician who finds himself agog at the sight of the case.³⁰

Kennedy illustrates this thesis with a report from Dr. John Green, published in the *Philosophical Transactions* in 1739 under the title “A Girl, three Years old, who remained a quarter of an Hour under Water without drowning”:

May 6 1737 Rebecca Yates of Billson near Market Bosworth in Leicestershire, had a Daughter about three Years of Age, that fell into the Mill dam at the Head, near to the Mill-Wheel; and by force of the stream, was drawn under the water to said Wheel, with her legs forwards; one of her legs went under the Mill-Wheel; and by reason of Nearness of the Wheel . . . the Child’s leg stopped the said Wheel from moving at all. The sudden stopping of the Mill so much surprised the Miller that he went immediately and let down the shuttle. . . .

The First Word she spoke was Help me, repeating this three times. For God’s sake help me out if you can. She spoke very briskly after she was put to bed. . . . But the Mill Wheel had tore away all Skin, Muscles, Sinews and Tendon of her leg quite to the Bone.

Child lived Monday to Friday then died of her wounds and bruises; otherwise in all Appearance, she might have lived to have made a fine Woman. The whole Time of her being under Water depth 4 1/2 feet was near 15 minutes.³¹

The report is considerably longer than the excerpt shown here. Kennedy remarks that although the title announces that the child

survives fifteen minutes underwater, reference to this subaquatic period is delayed until the very end—to considerable dramatic effect. The narrative of the case is further intensified by the way the author emphasizes the tragic loss of life by envisioning the child's maturation and transformation into a fine woman whose life was cut short by a violent and premature death. At a time when the Royal Society proclaimed the importance of plain speech and exclusion of "specious Tropes and Figures" and "vicious Abundance of Phrase" as threats to the reporting of scientific observations, this "curious discourse"—revelatory of the secrets of human bodily misfortune—positions itself in the slipstream of the experimentalists' lingo even though it "arouses feelings in the observer, not just of intense interest associated with voyeuristic and spectacular . . . but also . . . other emotions—cries of sympathy, concern, pity, wonder, horror."³²

As the century progresses, appeal by title continues to be made by narrators, but case reports come to be written in a much more sober language that downplays or avoids expressions and literary devices that are likely to arouse strong emotions in readers:

"[S]eeing, among the extracts of the *Medical Transactions* your account of a disorder, which you term *angina pectoris*" an anonymous doctor wrote to William Heberden in 1772, 'I found it so exactly corresponds with what I have experienced of late years that it determined me to give you such particulars, as I can recollect. . . . I am now in the fifty-second year of my age, of middling size, a strong constitution, a short neck and rather inclined to be fat. My pulsations at a medium are about 80 in a minute; the extremes . . . beyond which I scarcely ever knew them, 72 and 90. I have enjoyed from my childhood so happy a state of health as never to have wanted, nor taken a dose of physic of any kind for more than 20 years. As well as I can recollect, it is about five or six years since, that I first felt the disorder which you treat of; it always attacked me when walking and always after dinner or in the evening. I *never once* felt it in the morning, nor when sitting, nor when in bed. The first symptom is a pretty full pain in my left arm, a little above the elbow; and in perhaps half a minute it spreads across the left side of my breast and produces either a little faintness or a thickness in my breathing; at least I imagined so, but the pain generally obliges me to stop.'³³

Three weeks after Heberden received this letter its anonymous author died, and when he later published it in *Medical Transactions*, Heberden included the results of the autopsy on the dead doctor.

Nineteenth Century

By the nineteenth century, case reports adopt less personal and conversational tones, contain many more technical terms related to clinical findings, and increasingly focus on pathological findings. It is not only clinical instrumentation—deployment of the newly invented thermometer, ophthalmoscope, and stethoscope—that diminishes the patient's account to the status of a remnant within the case report. Nineteenth-century case reports are sectorized into accounts reflecting the procedural order of the clinical encounter. The report opens with bare demographic details concerning the patient, the clinical development of the complaint is then outlined, and the conclusion presents the findings of the examination and investigations. For example:

Case LVII

William Midwinter, age 34, was admitted into Guy's Hospital under my care, October 27th, 1826. He had been suffering from a cough for about four months, in consequence of a neglected cold; during the last month he had been under medical treatment, without deriving any relief. His cough had gone on increasing, but was chiefly troublesome when lying in bed; and there was a remarkable hoarseness in his voice. He found some difficulty in deglutition, and experienced a pain from his throat toward his ears when he swallowed. His expectoration, though considerable, had never been tinged with blood. On examination, it was found that the posterior fauces and right tonsil were slightly ulcerated. Pulse 140. Respiration about 30. Countenance sallow; tongue red at the point; frequent night perspirations.

SECTIO CADAVERIS

By no means emaciated. Larynx affected with two very confirmed ulcers just below the rima glottidis each side. . . . The upper lobe of each lung was thickly filled with miliary tubercles collected into large clusters, with hard, semi-transparent central masses. A few tubercular abscesses were formed in each superior lobe, about the size of nutmegs. The greater part of the lungs, more particularly the

lower lobes, although they contained some milary deposits, were freely pervious to the air.³⁴

A division between the onset of the patient's condition and the account of clinical and pathological findings is thus instituted. This report focuses on the hospital admission of William Midwinter under the care of his physician-narrator, but personal references to caring ("under my care") and to the patient's identity fade as the language shifts to the passive voice and focuses on behaviors. "His cough had gone on increasing" and "there was a remarkable hoarseness in his voice" have the effect of stripping the patient of presence and agency within the case description. As Janis McLarren Caldwell argues, the omission of pronouns and verbs related to this patient dismantles Mr. Midwinter's personhood.³⁵

Such linguistic shifts in nineteenth-century case reports, accompanied by growing doubts about the reliability of patient testimony, give clinical literalism a new shape. Patient testimony is seen as superficial, jumbled, and potentially erroneous, so the representation of patient presence diminishes.³⁶ In nineteenth-century clinical case abstracts such changes are particularly apparent:

1—CB—, 62, a painter, colic and constipation 3 weeks; frequent similar attacks—well-marked blue line round retracted gums. Paralysis of extensors of both forearms. Treatment:—purgatives, galvanism, and anodynes. In hosp. 63 days.

2—HT—, 25, a carpenter, lead poisoning 10 yrs. Had fits shortly before admission. Could not stand or walk. Bowels kept open by aperients. Wrists dropped. Treatment:- Potass. Iodid. Potassae Bicarb., Potassii Bromid.; blisters behind ears, splints to forearms. In hosp. 47 days. R³⁷

Here the narrative of the report continues although it is severely disrupted by the staccato form of the abstract, which is populated with mindless bodies, depersonalized behaviors, and fragmentary body parts.³⁸ The language of clinical abstracts supports Kennedy's thesis that in the nineteenth century the aim of the case becomes "to achieve the tone and distance of the autopsy report whilst the patient is still alive."³⁹ Ruthless curtailment of patients' accounts and the denial of their agency within case reports are accompanied by a clinical attentiveness that focuses now on the normality of body systems: "[S]hould a system be

investigated and nothing found wanting, the word 'normal' may be written after it," writes John Southey Warter in 1865 in *Observations in Medicine: The Art of Case Taking*, and "[S]hould anything wrong be detected 'otherwise normal' should be added."⁴⁰

Breach of the impersonal register and suggestions that procedures may not have been properly followed could lead to serious questions concerning the reliability of case narration.⁴¹ In respect of a report on ovariectomy, published in 1824, James Johnson, the editor of the *Medico-Chirurgical Review*, casts doubt on its authenticity:

A woman supposed to be parturient, was visited by Dr Macdowal at the instigation of two physicians, who considered her in the last stages of pregnancy. Dr M found the uterus unimpregnated, but a large tumour in the abdomen moveable from side to side . . . the operation lasted 25 minutes! Dr Macdowal visited the patient *at the end of five days*, though she had come [sixty miles] to his residence to have the operation performed!! He found her engaged in making her bed!⁴²

Extreme surprise to the point of incredulity is here expressed not only in the face of possible breaches of surgical procedure but also in response to flouting of the etiquette of case reportage in revealing that on a home visit the patient was stumbled upon when making her bed. In a related vein, common-sense evaluative expressions meet with disapproval in some journals that counsel against use of terms such as "better," "worse," "rallying," "sinking," "relapsing," and "recovery" in the writing of case reports, on the grounds that they are imprecise and "unscientific" expressions.

Distance from the suffering subject of the case is achieved in other ways—for example, by editing out the patient's responses. Before the advent of anaesthesia, nineteenth-century surgical case reports are striking for the contrasts they draw between the meticulous concern for surgical technique and the formulaic focus on the effects of the surgery on the conscious patient, which generally gain only the most abbreviated mention:

Case 1 Thomas Waterman, aet, 40, Weaver

Oct. 25, 1832.—A healthy man, of regular habits, is the subject of hydrocele . . . [which] has gradually increased in size, but unaccompanied with pain.

Nov. 2, 1pm. - A trocar and canula having been introduced about eight ounces of fluid were drawn off, and during this

time the man fainted. . . . [A] needle six inches in length and as thick as a probe . . . was introduced armed with twelve threads of ordinary seton silk. . . . After he recovered from the faintness he was sent to bed, complaining of great pain extending up the cord to the loins.⁴³

The stays required to keep patients still during the preanaesthetic days of surgery gain little mention; usually, “faintness” and “exhaustion” overwhelm the patient, who is put to bed with a glass of wine or spirits after the procedure.⁴⁴

Twentieth Century to Present

Distancing strategies continue to be used in twentieth-century case reports:

The patient is a 62-year-old professor of anatomy who was suddenly taken ill during a lecture trip. He had had no serious ailments. About a year before, one evening in the course of a few minutes he suddenly developed paraesthesia around the left corner of the mouth, in the radial side of the left hand and in the left great toe. There was dizziness on vertical movements of the head. The paraesthesiae and the dizziness persisted, although in diminishing intensity, for nine months. An examination as well as X-ray examination of the skull and an EEG two weeks after the onset showed no changes.

The present illness started when the patient woke up and turned in his bed on the morning of April 12th 1972. In the course of a few minutes an initial heavy, but uncharacteristic, dizziness was followed by dysarthria, double vision and a marked paresis of the left arm and leg. There was no loss of consciousness, no headache or vomiting and no stiffness of the neck.⁴⁵

Here, an autobiographical account is framed as a third-person observation. But for the title of the report, “Self-Observations and Neuroanatomical Considerations after a Stroke,” the reader must be forgiven for not appreciating that its author is none other than the patient, who refers to himself as “the patient” and as “he” and who, in the description of his own subjective awareness—“paraesthesia around the left corner of the mouth”—adopts an objectified and technical lingo.

One of the first case descriptions of the clinical syndrome of SARS, entitled "Haemorrhagic-Fever-Like Changes and Normal Chest Radiograph in a Doctor with SARS" and published in the *Lancet*, is coauthored by the patient, Dr. Eugene B. Wu (EBW), and the examining doctor, Dr. Joseph J. Y. Sung (JJYS):

The index case of severe acute respiratory syndrome (SARS) was admitted to ward 8A in the Prince of Wales Hospital, Hong Kong, on the [sic] March 4, 2003. On March 10, 2003, a 33-year-old doctor (EBW) working on ward 8A developed a fever of 39.6°C. He was examined by JJYS. His fever had gone by March 12, and his chest radiograph was normal. His platelet count was $94 \times 10^9/L$ and white-cell count was $3.4 \times 10^9/L$ (monocytes $0.4 \times 10^9/L$). A nasopharyngeal swab grew no pathogens. He was admitted to the SARS triage ward on March 13, and was started on oseltamivir phosphate 75 mg twice a day and levofloxacin 500 mg daily. Further blood tests showed disseminated intravascular coagulopathy (platelets $61 \times 10^9/L$, D-dimer 630 ng/mL, prothrombin time 11.1s, activated partial thromboplastin time (APTT) 43.3s). His white-cell count was $1.8 \times 10^9/L$ (neutrophils $1.1 \times 10^9/L$, lymphocytes $0.5 \times 10^9/L$, and monocytes $0.2 \times 10^9/L$). His chest radiograph showed a prominent right hilum. CT of his thorax showed an ill-defined opacity with an air bronchogram in the apical posterior segment of the right lower lobe and diffusely in the right middle lobe. He was started on oral ribavirin 1.2 g thrice daily and intravenous methylprednisolone 500 mg daily. His fever settled the next morning and his coagulopathy improved (APTT 40.7 s, platelet count $105 \times 10^9/L$, and D-dimer of 564 ng/mL). On March 19, 2003, oral prednisolone 1 mg/kg was started.

On the evening of March 20, he had a fever of 38.9°C. His white blood cell count rose to $15.7 \times 10^9/L$ (predominantly due to an increase in neutrophils). A secondary bacterial chest infection was suspected, and cefipime 2 g was given intravenously. Over the next 2 days he became increasingly breathless and his coagulopathy became worse (D-dimer 716 ng/mL, prothrombin time 11.9 s, platelets $199 \times 10^9/L$). The patient was given a single dose of methylprednisolone 500 mg intravenously and 4 L/min of oxygen. After this, he began to get better. Coagulation parameters returned to normal, he was weaned off of oxygen, and was discharged from hospital on March 31, 2003, on 0.3 mg/kg prednisolone and ribavirin 600 mg orally three times a day. On April 7, his chest radiograph showed worsening consolidation of the consolidation of the right middle

zone and the prednisolone was increased to 0.5 mg/kg. $105 \times 10^9/L$, and D-dimer of 564 ng/mL). On March 19, 2003 oral prednisolone 1 mg/kg was started.

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Anon, Updated interim case definition. Update: outbreak of severe acute respiratory syndrome—worldwide, 2003, *Morb Mortal Wkly Rep* 52 (2003), pp. 241–248.

N Lee, D Hui and A Wu *et al.*, A major outbreak of severe acute respiratory syndrome in Hong Kong (<http://nejm.org/earlyrelease/sars.asp#4-7>) (accessed April 7, 2003).⁴⁶

This report shows remarkable similarities with the rhetorical forms of the Hippocratic case report. It has a standardized format, referring to the patient by initials, role, and place. The precise date of onset of the man's symptoms is stated, with subsequent findings set out thereafter as in a log. For those familiar with laboratory printouts, the report creates a highly visual picture, not composed of observations of a patient—temperature remains the only vestigial clinical finding—but of the patient's unfolding biochemical, haematological, and imaging investigations. The report, anchored not only in the observation of its observer-narrators but also in references, is written in the third person, coauthored by the patient himself, who therefore refers to himself as "he." Neither the patient-author's feelings nor any other symptoms appear in the report—throughout the course of his hospital stay, as reported here, there is hardly any reference to *in what way* the patient may have felt ill ("became increasingly breathless" is the only mention). Dr. Wu has since written a personal account of his illness in which it is clear that his first symptom was fever, but he reports it as if he cannot quite shrug off his physicianly perceptions: "My usual Monday morning ward round is disrupted when I notice many of the nurses on the ward wearing facemasks. The sister informs me that a number of patients with undiagnosed chest infections have spiked a fever this morning. Since I have been working on the ward for several months, I figure I am probably already infected by this presumed viral illness. Sure enough, that evening I become pyrexial."⁴⁷

Subsequent symptoms include dizziness and fear, mostly triggered by witnessing so many of his clinical colleagues dying on the ward.

Case reports—particularly those concerning hospital patients—generally omit mention of such personal perceptions and anxieties. Today, case reports usually commence ritualistically with a brief account of a patient's complaint as translated by the doctor. There is a trend toward less focus on the subjective experience of the initial complaint and the patient's own words and more focus on the findings—first of clinical, then of laboratory and imaging examinations—before the attention shifts to diagnosis and the instituting of treatment. Finally, the case report moves toward some sort of closure (a cure, complication, or deterioration), perhaps relaying other developments along the way. However, it would be an oversimplification to claim that the template of the hospital case report just sketched dominates all case reports today. Certain disciplines, such as psychiatry, pediatrics, and family medicine, influenced to some extent by psychoanalysis and its various clinical offshoots as well as the work of Michael Balint, have shifted the case report away from this particular pattern. The following report, written up in the *Journal of the Royal College of General Practitioners* in 1977, as part of a paper about primary-care nosography, reveals a quite different approach:

The day before I wrote this paper I saw a patient, whom I will call Hilda Thomson, during a morning surgery at a village health centre. She was new to the district, having moved into the village about 3 months ago. She was in late middle age, a large, rather untidy woman with an angry looking face. It was clear she did not have very high hopes of the consultation. She told me that she had increasingly severe pains in her arms and legs, and that these had been made infinitely worse by a visit to an osteopath in the city. Her only reason for visiting him, she said, was the signal failure of doctors to help her in the past.

Some years ago she had been diagnosed as suffering from rheumatoid arthritis. In support of this story she produced from a canvass bag some eight or nine remedies for this condition and, of course, by way of an hors d'oeuvre and a dessert, a selection of choice psychotropic drugs and a sleeping tablet. The pain had been made much worse by her move to the village. Three years ago, she and her husband had bought a grocery shop in the nearest town and had commuted about 30 miles from their previous home. A year ago her husband, Peter, who had previously taken a large part of the burden of the shop, had had a coronary thrombosis. Since then he had become a complete invalid, demanding constant attention, refusing to venture beyond the garden gate, and taking no part at

all in the running of the business. She had been taking the sleeping tablet for 3 years, but habitually woke in the small hours of the morning. Three years ago blood tests had suggested the diagnosis of rheumatoid arthritis. Inspection of her joints now revealed little evidence of the disease, although her eyes filled with tears when I began to examine her. She told me that the Government was unfair to small shopkeepers and that nobody in society cared about the "little man."⁴⁸

In this report, Hilda Thomson's concerns are brought to the fore in a way that avoids much of the rhetorical separation of observer and observed of previous reports. Her case is framed by a doctor-narrator who is not in thrall to the visual, and its language is different from the clinical literalism of earlier reports. It substitutes a chatty author-physician for that of a detached Hippocratic observer of the body. The epistemological "I" of the doctor is engaged in dynamic contact and negotiation with the patient and seems to be at ease in inserting evaluative viewpoints into the very body of the report, mingling aspects of noticing, narrator response, judgment, reasoning, and conversation. In *this* report a vivid, embodied sense of an unhappy woman who is physically and psychologically in pain is conjured up, and we gain a sense of "casework," of the performativity of everyday medical practice, in contrast to the more static pictures of previous cases.

This report offers a story that is "in full flow." Is it telling its medical readers to repeat the relevant blood tests and request new X-rays of Hilda Thomson's joints? Or is it suggesting that the needs of Mrs. Thomson's husband—if they could be ascertained and met—are the key to her problems? Or should the report be read as a cautionary tale about respecting and tolerating clinical uncertainty, as a case that illustrates the importance of allowing the complexity of the patient's story to unfold at its own pace in a way that allows expression of pent-up feelings? This case report does not assume one interpretive consensus. On the contrary, it creates what Gillian Beer terms "a simultaneity of reading levels," degrees of ambiguity and possibility, which are generally eschewed in hospital case reports.⁴⁹

Fallout

The form and representation of clinical case reports is a literary-historical achievement whose authorial stance, at different times, has adopted some species of literalism. This legacy, as Julia Epstein notes,

aggregates corporeal and affective details in a "stripped down language" that radically omits the subject of suffering and illness.⁵⁰ But, as we have seen, the legacy is many-stranded, and there are signs that today patients are writing themselves back into clinical discourse.⁵¹

In Hippocratic case reports, the narrator is a dispassionate and solemn observer of surfaces who rarely betrays any degree of personal involvement with the suffering subject. The text is highly controlled and the focus on bodily surfaces makes the separation of the Hippocratic observer's eye from his responsive "I" apparent. Galenic case reports are generally richer in patient viewpoint, have a more conversational tone, pay great attention to anecdote and idiosyncrasy, and hint at more egalitarian doctor-patient relationships.

Yet in the seventeenth and eighteenth centuries, the case report is more conversational in tone and contains a great deal of the patient's voice. It is frequently constructed within the terms of a curious discourse not confined to medicine, but found also in the study of geology, fossils, and meteorology, a discourse that Kennedy shows uses limited novelistic techniques to depict the marvellous and keep it as a legitimate object of investigation by experimental and natural philosophy. Such case descriptions employ dramatic devices to delay the moment of diagnosis or the outcome of a story, in order to heighten narrative tension and degrees of physician involvement with suffering subjects.

Seventeenth- and eighteenth-century case reports display a dialogical quality, reflecting what Roy Porter calls "a rough parity in the doctor-patient relationship, indeed, an element of client control, in sharp contrast to the relative authoritarianism of later scientific hospital medicine."⁵² However, as we have seen, authoritarian elements are clearly discernible in much earlier clinical reports and cannot be ascribed solely to the growth of scientific medicine.

The contemporary case report is much more standardized and abstract than its predecessors, partly due to the influence of the reporting of bedside measurements and partly as a result of the growing importance attached to biochemical, pathological, and imaging investigations.⁵³ These developments are accompanied by a sectorization of the case into distinct elements devoted to the history of complaint, the examination, the investigation, and the treatment.

Contemporary hospital case reports are generally written from the point of view of treating physicians in the third person and in the voice of anonymous, effaced narrators, coauthored by a medical team that betrays little of the differentiated involvements of its contributors.⁵⁴ Although traces of the dramatic and curious can still be found in

modern cases, particularly in their titles, linguistic analysis finds passive sentence construction depicting agentless events and processes to be the discursive norm.⁵⁵ Yet cases such as Hilda Thomson's, together with the appearance of interactive case reports offer voice to new narrators, challenge the constraints imposed by traditional formats and manifest growing desires to experiment anew with different forms of literalism in the writing of clinical case reports.⁵⁶

NOTES

*I'd like to thank Ruth Richardson, Neil Vickers, and two anonymous reviewers for comments on earlier drafts of this paper. Many thanks also to the Society of Apothecaries London for asking me to give the 2006 MacDonald Critchley Lecture in the Medieval Humanities.

1. See Monroe, Holleman, and Holleman, "Is There a Person in this Case?"; and Epstein, *Altered Conditions*.

2. Rousseau, "Discourses of Literature and Medicine," 10.

3. See Huxley, *Literature and Science*, 13; and Fish, "How Ordinary Is Ordinary Language?" 110.

4. See Kleinman, *The Illness Narratives*, 42.

5. Stephen A. Hoffmann, *Under the Ether Dome: A Physician's Apprenticeship at Massachusetts General Hospital* (New York: Charles Scribner's Sons, 1986), 170, quoted in Brody, *Stories of Sickness*, 4.

6. See Charon, "Literary Concepts for Medical Readers."

7. See Kennedy, "A Curious Literature."

8. Brody, *Stories of Sickness*, 9.

9. Parkinson, *Essay on the Shaking Palsy*, 13.

10. West, "On a Peculiar Form of Infantile Convulsions," 724.

11. Ragin and Becker, *What Is a Case?* 9–10.

12. See Burke, *A Grammar of Motives*, 59; and Fineman, "The History of the Anecdote."

13. Hippocrates, *Epidemics VI*, 285.

14. See Sacks, "Clinical Tales."

15. Hippocrates, *Epidemics V*, 185.

16. See Nutton, *Ancient Medicine*.

17. See King, *Greek and Roman Medicine*, 7–8.

18. Hippocrates, *Epidemics III*, 267 (Hippocrates's italics).

19. Hippocrates, *Epidemics V*, 191 (Hippocrates's italics).

20. Hippocrates, *Epidemics III*, translated and quoted in Lloyd, *The Revolutions of Wisdom*, 22.

21. Jones, introduction to *Epidemics, I, II, III*, 144.

22. Sacks, "Clinical Tales," 20.

23. Galen, *On Prognosis*, 213.

24. See Montgomery, *The Scientific Voice*, 100.

25. Galen, *On the Affected Parts*, Book II, 48.

26. See Monroe, "Performing Persons."

27. Quoted in Reiser, *Medicine and the Rise of Medical Technology*, 4.

28. Quoted in Reiser, 6.

29. Monginot, "Account of an unusual Medical Case," 756.

30. See Kennedy, "A Curious Literature," 84.
31. Green, "A Girl, three Years old," 167–8.
32. Thomas Sprat, *History of the Royal Society*, edited by Jackson I. Cope and Howard W. Jones (St. Louis, MO: Washington University Press, 1958), quoted in Montgomery, *The Scientific Voice*, 81; and Kennedy, "A Curious Literature," 98.
33. Heberden, "A Letter to Dr Heberden," 1–2 (italics in original).
34. Richard Bright, *Reports of Medical Cases, Selected with a View to Illustrating the Symptoms and Cure of Disease by a Reference to Morbid Anatomy* (London: Longman, Rees, Orme, Brown and Green, 1827), 161, quoted in Caldwell, *Literature and Medicine in Nineteenth-Century Britain*, 149.
35. See Caldwell, *Literature and Medicine in Nineteenth-Century Britain*, 149–50.
36. See Gillis, "The History of the Patient History since 1850."
37. Anonymous, "Chronic Lead Poisoning," 561–2.
38. See Crites, "Religion As Story."
39. Kennedy, 130.
40. Warter, *Observations in Medicine*, viii.
41. See Harré, "Some Narrative Conventions of Scientific Discourse."
42. Johnson, "Extirpation of the ovaria," 215–6 (Johnson's italics).
43. Anonymous, *New Series, St Thomas' Hospital Reports*, 59.
44. Barry, "Case of Carotid Aneurism Successfully Treated," 441, 442.
45. Brodal, "Self-Observations and Neuroanatomical Considerations after a Stroke," 675.
46. Wu and Sung, "Haemorrhagic-Fever-Like Changes and Normal Chest Radiograph in a Doctor with SARS," 1520–1.
47. Wu, "SARS—A Personal Account by Dr Eugene Wu," 44.
48. Marinker, "The Chameleon, the Judas Goat and the Cuckoo," 200.
49. Beer, *Open Fields*, 170.
50. See Epstein, 7–75.
51. See Wiltshire, "The Patient Writes Back."
52. Porter, "The Patient in England c1660–c1800," 109. Porter cites two papers by Nicholas Jewson: "Medical Knowledge and the Patronage System in Eighteenth Century England," *Sociology* 8 (1974): 369–85; and "The Disappearance of the Sick Man from Medical Cosmology 1770–1870," *Sociology* 10 (1976): 225–44.
53. See Risse and Warner, "Reconstructing Clinical Activities."
54. See Downie, "The Doctor-Patient Relationship."
55. See Samarasekera and Dorman, "The Case of the Forgotten Address"; and Anspach, "Notes on the Sociology of Medical Discourse."
56. See Bligh et al., "Interactive case report"; and Reis et al., "Case Report of Paroxysmal Atrial Fibrillation and Anticoagulation."

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