**Why are discourse communities important?**

“Code 23, 3rd floor, room 126,” is heard over the intercom of the 3rd floor of the hospital. On queue the team of doctors pagers go off and a herd of medical staff rush to the patient’s room. A crash code is common in a medical facility. Codes are a way of announcing a situation to the medical staff without alarming the patients or visitors. Those whom work in a medical facility are required to understand and know all codes the facility uses. A medical facility is an example of a discourse community. Each medical discourse community has a set of rules, standards, and codes to follow. These take time to memorize and become accustomed to and it is very important that people working in medical facilities know what these rules, standards, and codes are because people’s lives could be at stake. But first we shall address what a discourse community is.

**What exactly is a discourse community?**

James Porter defined the discourse community as: “A local and temporary constraining system, defined by a body of texts (or more generally, practices) that are unified by a common focus. A discourse community is a textual system with stated and unstated conventions, a vital history, mechanisms for wielding power, institutional hierarchies, vested interests, and so on.(Porter)” A discourse community is untied by a common interest. The interests of a discourse community can range from collecting stain glass art from Italy to special operations in the pentagon. Regardless of interest the participants of the discourse community need to have knowledge of the matter which the discourse observes. The standards to what qualifies as a discourse community have been argued. James P. Swales believes a discourse community must meet six standards before being considered a discourse community. These six defining characteristics are:

- The community has a broadly agreed set of common public goals.
- The community has mechanisms of intercommunication among its members.
- The community uses its participatory mechanisms primarily to provide information and feedback.
- The community utilizes and hence possesses one or more genres in the communicative furtherance of its aims.
- The community in addition to owning genres, it has acquired some specific lexis, or language.
- The community has a threshold level of members with a suitable degree of relevant content and discourse expertise (Swales, p.472)

The discourse community must have all these qualities or it is not a community. Swales definition sets a professional tone to the term discourse community. A community can exist without these one of these six rules. Gee argues there are many sets of Discourses with in society. In Gee's work, discourse ("little d") refers to language-in-use. When we set the language to use in daily practices, such as work, school, talking among friends, is when we engage in Discourse ("big D").

**How does this apply to the medical community?**

Both Gee’s and Swales’s requirements to discourse community fit the medical community. A medical facility meets all six of Swales characteristics.

The medical community fits all six of Swales requirements:

- Its public goal is to improve the wellbeing of man and to improve treatments of health conditions.
- The medical communicates over a number of forums and discussions, which will be covered later.
- The medical community has a number of journals and book published in order to exchange knowledge.
• The community has a common interest and knowledge of the human body.
• Specialized terminology in Medical discourse is always changing and required to know, which will be covered later.
• Without prior training one cannot enter the medical discourse.

Swales’s definition allows for one of less knowledge to be accepted into the community and allowed an allotted amount of time to learn the acceptable practices, this fits more discourse communities. Gee sees acceptance into a Discourse community more exclusive, “…Discourse (and therefore literacies) are not like languages in one very important regard. Someone can speak English, but not fluently. However, someone cannot engage in a Discourse in a less then fully fluent manner. You are either in it or you’re not. (Gee, p.487)” Gee believes if one does not possess all the knowledge required to be successful in a discourse community, then one cannot be part of it. In medical discourse a person cannot enter the community without any knowledge at all. But one can enter a discourse community with almost all the knowledge.

Most discourse communities allow for some time to adjust and fully immerse into what is considered normal. Student studying under a nursing program or pre-med program are required to learn terms commonly used in the hospital before going into clinical care. Although students had preparation to the medical community and developed the genres in writing and speaking, they will enter the medical world still needing to learn the terms experience co-workers use day to day for effective communication.

Communication in the medical discourse community

A medical discourse community would not exist without a way of communication. This is true for any other discourse community. Without some form of communication there can be no discussion, movement of innovations pertaining to the community, or discussion of ideas. In any discourse community, when the group’s main means of communication cease the community itself ceases to grow and soon dies out.

Communication between each medical facility is highly important to advancements in technology. Communication within each medical facility is highly important to the general patient care and treatment. Communication between physicians, paramedics, and/ or nurses must be clear, concise, and contain no ambiguity. Proper paper or electronic documentation of the patient’s history and care provided is critically important when moving a patient to the next echelon of care.

Medical Documents

The patient history (Figure 1) forms can be filled out by the patient, physician, or nurse. The form gives the medical staff the ability to communicate chief complaint, visual signs/ symptoms, or daily habits without having to refer to patient frequently. The main objective of the patient history form is to gain knowledge
The physician gains knowledge on past prescription medication, any known allergies, past surgeries, past hospitalizations, and any known conditions that the patient has such as diabetes or high blood pressure. The patient history form is often filled out by the patient, or by a nurse before the doctor enters the examination room. The patient history form can be the primary use for diagnosis. Dr. Axman says it is sometimes difficult to get a diagnosis from just a patient history form, so he also likes to have a SOAP notes form filled out. An example of a medical history form can be seen to the right.

SOAP notes forms (figure 2) are used to gain both patient experience and medical observation. SOAP standing for “Subjective, Objective, Assessment, and Plan.” An example of SOAP notes form would go as such:

Subjective (S) covers the patient’s experience: Male, 23yrs old, an avid runner is experiencing sharp pain in their left foot. He says it has been getting worse with each run.

Objective (O) covers what the medical provider sees and further question asked: the patient was limping when entering the room and pain is near the 2nd metatarsal. Cannot apply pressure, he cannot stand on his toes...

Assessment (A) is what diagnosis to the patient’s complaint: possible stress fracture and will need an X-ray to confirm.

Plan (P) is the plan of treatment, which is filled out by the physician: Refrain from running for at a minimum of 5 weeks. Rx: Ibuprofen 200mg as needed. Must wear air cast to relieve impact on left foot and provide proper recovery.

Both forms are tools within the medical community. Medical providers can look at these documents and decipher what the patient’s diagnosis should be. Patient history grants the medical providers with background history of habits, medical problems, allergies, or past surgeries. SOAP notes form gives the patients input, possible back story to the injury, and also the provider’s initial impression of the patient.

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