Linguistica Silesiana 28, 2007
ISSN 0208-4228

ARKADIUSZ BADZIŃSKI
Wyższa Szkoła Zarządzania Marketingowego
i Języków Obcych
Katowice

TRAPS AND PROBLEMS OF MEDICAL SIMULTANEOUS INTERPRETING. NOTES FOR INTERPRETERS (TO BE)

One of the areas in which medical simultaneous interpreting is becoming predominant is the setting of medical (international) conferences. The current paper aims at highlighting certain suggestions and observations made by 5 medical practitioners who participated in the conferences where the simultaneous mode of interpreting was employed. The suggestions provided by them as well as the suggestions of the author who is a medical interpreter himself are believed to facilitate the process of simultaneous interpreting from a purely practical point of view. They are hoped to throw light on the problematic issues connected with this specific mode of interpreting and show interpreters (to be) certain ways of tackling difficult phenomena and obstacles that arise in the process of interpreting. Additionally, the paper also pays attention to another meaning of the term *medical interpreter* which also in Poland has come to stand for any person delivering interpretation in a medical setting usually for the purpose of medical examination of the other person.

Simultaneous interpreting is the oral translation of oral discourse. This mode of interpreting is usually performed in a booth in which an interpreter sits and listens to the source text which is being delivered and than provides the audience with a target language rendition.

The year 1927 is identified as the beginning of simultaneous interpreting. Although it was not highly enthusiastically acclaimed at the very beginning, over the course of time it has gained more and more approval, the reason being mainly time-economy of the process in question.

Since the advent of the development of science particularly in the 1940s and 1950s it has become more and more widespread and evolved into a common phenomenon. Currently, this mode of interpreting is delivered during international conferences and meetings. At the United Nations for instance the delegates communicate by means of simultaneous interpreting in six languages (Setton 1999).

Simultaneous interpreting has also received increasing attention as an object of study and has been subject to close scrutiny both from scientific and theoretical point of view since it covers the whole wide spectrum ranging from psycholinguistics to neurolinguistics. In spite of the methods of research employed, it is still difficult to explore and fully comprehend all the processes that take place in the human mind during the process of interpreting.

In the medical world one can also encounter another form of simultaneous interpreting which is probably as frequent and common as the above-described. It is a mode of interpreting in which the interpreter is next to the delegate who needs the interpreting and then whispers the target-language version of the speech in the delegate's ears. This is a particularly common phenomenon in Poland, especially during the visits of assistant professors in medical centres.

These two settings depicted above illustrate a crucial role of an interpreter and recent interest in the field is associated with the development of specialized forms of professional interpreting.

The reason why there are so few medical interpreters in Poland might be encapsulated in the Gile description of the process itself, which

> encompasses listening, processing of the original discourse and its restitution in the target language with operations with linguistic decoding, bringing into play different types of memory and language production. This [...] implies attention sharing, and decision-taking, with the management of risks and difficulties (Gile 1995:17 cited in Setton 1999:34)

The history of medical interpreting as we know it today is obviously shorter than that of medical translation. As Fischbach (1986:16) states medical translation is 'the most universal and oldest field of scientific translation because of the homogenous ubiquity of the human body'. Medical interpreting differs from other modes of interpreting at least in some respects, which may have a significant bearing on the outcome of the process of interpreting itself.

The very first barrier that an interpreter usually encounters is vocabulary or to be more precise terminology. The fact remains that special languages obey their own laws. The basic feature of such languages is their terminology which is a means of communication via specialist language (Wills 1999:86). It is obviously terminology rather than syntax that permits adequate explanation of medical phenomena.

The majority of medical terms are in themselves delightfully logical indeed. There is a plethora of English words that are formed by various combinations of a comparatively small number of roots and combining forms, often of Greek and Latin origin. It might appear that to those with a smattering of the classical languages, the meaning or at least the general sense should not seem to be opaque.

In fact, the reality is far more complex since the varieties of branches and specialties in medicine are innumerable. Every day many words are coined and added to the medical vocabulary, which is an unavoidable phenomenon in the ever-changing and ever-developing medical world. Obviously, the vocabulary itself presents an innumerable number of lexical items. Years ago Lippert (1979:85) analysed the German medical vocabulary and estimated that it comprised half a million words. If one takes into consideration that nowadays it is English that serves as a lingua franca in medi-

cine and that since the time of Lippert many new disciplines and areas have evolved, extended and appeared, the number of lexical entities is innumerable.

The greatest Polish-English dictionaries provide, however, merely a couple of thousand lexical entries which are of most common usage. The new terms arriving at a stupendous rate with new advances in medicine are mostly highly specialized and technical, taken from vernacular language, sometimes even from fictions (cf. Słomski).

However, because of some theoretical reorientations in the world of science as well as reclassifications certain notions are given new names. To depict, the Polish laboratory examination known under the name of *odczyn Wassermana* was replaced with *USR*, although both these terms are used, and the first one, in particular, mainly among the older generation of doctors.

Not only interpreters run the risk of making mistakes. The plethora of many terms in the field of medicine sometimes complicates the matters among medical practitioners themselves who for instance very commonly use interchangeably certain terms e.g. *USR* and *VDRL*, which both follow the direction of disease pattern investigation but are different tests of different sensitivity.

Another obstacle may refer to the premises where interpreting takes place. As it was mentioned above, the standard and most common occurrence in which it is performed is related to a booth and the audience, however sometimes, particularly in emergency cases the interpreting is being delivered in the situation where human life is endangered and each second may be of paramount importance. In that case, the interpreter is faced with enormous pressure of time constraint and stress to deliver the message as quickly as possible. Whereas other non-medical specialties are strongly advised to possess a good command of English, its lack is not a matter of life and death unlike in the case of medical interpreting. From that perspective no other field in this instance is as pregnant with meaning as the medical one.

Interpreters ought to bear in mind that medical literature is written primarily for physicians, nurses and doctors-to-be, however a great deal of articles and publications is written for an ordinary layman. Therefore they should be aware of a particular register usage, so as not to repeat certain mistakes that are made by physicians themselves i.e. an unsuitable register usage in the forms of addressing a patient. As Richard Burnt (1987:449) rightly states 'there is an identifiable and isolatable variety of sub-register 'medical English' and it varies according to the roles and status of the participants.' The English used both by doctors and patients has received a considerable amount of attention from a linguistic or sociolinguistic point of view. Critical remarks concerning the inappropriate register usage during conferences were raised by all medical practitioners surveyed for the purpose of this article.

More often than not one may encounter physicians themselves trying to act as interpreters. In majority of cases the effects are rather mediocre. Their medical background and medical knowledge are usually insufficient to cover certain language inefficiency in terms of conveying certain meanings or notions. Therefore, the interpreters very often try to take up the challenge, however the practice shows that only a small percentage is able to succeed in conveying the subject matter at medical conferences.

Being aware of the responsibility regarding the task, very few interpreters challenge the risk and undertake the process of interpreting. The author contacted 15 translation agencies in order to find out how many of them are in fact able to perform the above interpreting. Out of 15 agencies which stipulated that medical interpreting is among their activities only one was able to take up this responsibility. Others rejected the interpreting either on unclear grounds (n=6), or stating that there was no possibility due to shortage of interpreters (n=8).

Beside vocabulary another problematic aspect appears at the level of synonymy. Medical language is an ideal illustration of the plethora of synonymous words and expressions used both in written and spoken form. As Pilegaard (1997:162) states "for a single medical entity, there may be as many as 30 (near) synonyms, each with slightly different shades of meaning".

The problem of synonymous words in medical English has been addressed many times (cf. Newmark 1976). What seems to pose a real problem is the fact that many of the synonyms provided in medical dictionaries are archaic, outdated or obsolete. To illustrate the richness of the notion of synonymy, one can analyse the Polish word *kolka*. Its English equivalents might be as follows *colic*, *crampy abdominal pains* or *gripes*.

Another example to illustrate this phenomenon is even more surprising in terms of the number of synonymous words – the Polish word *otyłość* translated into English as *obesity*, *adiposity*, *adiposis*, *fatness*, *stoutness or embonpoint*. Faced with such a magnitude of choice, the interpreter is often confused.

One ought to bear in mind that in the majority of the cases like the ones depicted above, the criterion that decides what kind of word ought to be used is register and the target audience as well as the context. Among the critical remarks concerning the area in question 4 out of 5 medical practitioners considered the misuse of synonyms to be the cardinal sin of interpreting.

There is a relatively common group of synonymous words with the same meaning occurring in medical interpreting yet in different contexts the case in point being *paleness* and *pallor* which refer to the identical state – that is being pale. However, to the best of the author's knowledge *pallor* appears rather in fields such as internal medicine and *paleness* is very often typical for fields such as anaesthesia or surgery. Similarly, the enzymes involved in the transamination of amino acids are called *transaminazes* or *aminotransferazes*. In Polish however, the usage of these two words is often determined by the setting. It appears that the word *aminotransferazy* is more commonly used by laboratory experts and the term *transaminazy* is more commonly employed among physicians. The exchange of the terms, however, in the above instances does not influence understanding.

Another problem associated with medical interpreting is the similarity of specific words and thereby the likelihood of mishearing either certain words or expressions – an example par excellence being two English words – *lobectomy* and *lobotomy* in which the first term stands for surgical removal of one of the lobes of an organ – *lobektomia*, *wycięcie płata*, and the latter describes surgical operation to treat mental disease by cutting into a lobe of the brain to cut the nerve fibres – *lobotomia*, *przecięcie płata*.

Medical language is not only confined to technical vocabulary, but it is also pregnant with jargon (Hoof 1970), which poses another difficulty on the interpreter.

When one discusses the problems connected with medical interpreting, one also ought to remember that cultural phenomena are usually not relevant to the notion of medical interpreting as far as conference interpreting is concerned. Interpreting a word for something that does not exist in another country does not usually arise in medical interpreting in the abvove described setting (cf. Newmark 1976:41).

To balance that, however, an interpreter should bear in mind that in other disciplines in certain circumstances it might be plausible to coin a particular phrase or expression provided its author accounts for it yet in the case of medical interpreting such kind of conduct is not permitted. In extreme cases, however, occasionally a detachable prefix such as *anti-*, *pre-*, *peri-* can be risked (Newmark:1998:158). Situations in which the above prefixes appeared were not a rarity as the surveyed medical practitioners admitted.

Another misconception among interpreters is a very common belief that medical language is devoid of any metaphors and is always of solemn and sober nature (cf. Newmark 1976). In fact, again it is the register that sets the rules for the usage of a particular style. However, the interpreter should be conscious of the fact that also in a highly specialized interpreting metaphoric expressions may occur or even prevail.

There is hardly any part of the body that has not been attributed its metaphorical meaning. The examples below are taken from two medical conferences interpreted simultaneously to illustrate that even in a highly specialized speech the appearance of metaphors is not a rarity.

Although metaphors and metaphoric expressions may be used by a doctor to a layman in order to highlight and clarify certain medical terms or phenomena that do seem to be opaque to a patient, the metaphors mentioned below concern the highly specialized language – the case in point being the interpreting provided to doctors at conferences.

In the first 4 sentences the metaphorical concept *drug is machine* is used and in the other two the metaphorical concept *fighting illness is war* is applied.

> Oxymorphone acting as a narcotic analgesic, and used with diazepam, *produces* a state of sedation and analgesia that permits the surgeon to perform minor procedures.

> In addition to showing that the benzodiazepines are more *potent* in depressing the intralimbic response, the results of the study also indicate a qualitative difference between benzodiazepines and barbiturates.

> The collected data indicate that alprazolam, but not diazepam, *activates* brain alpha 2-adrenoceptors involved in rat GH regulation.

> Moreover, when patients have been fairly well adjusted on benzodiazepines for a long time but succumb, after a successful withdrawal procedure, almost immediately to a modified recurrence of their anxiety illness, the proof that there had been a continuing therapeutic *activity* of benzodiazepines could hardly be stronger.

After the development of these antibodies, the body can now *destroy* the disease if it were to reappear in the body.

Among the *antagonists* of TNF, thalidomide is the most promising.

Three medical practitioners stressed the notion of *faux amix* and misleading associations of some terms, the interpretation of which they found particularly disturbing during interpreting. Both these phenomena constitute a significant part of the language of medicine.

Certain words adopt a different meaning when used in medical register, e.g. *livid* when used in non-medical connotations usually denotes the state of fury or anger, yet in the case of medical language it usually concerns the bluish skin colour because of asphyxiation.

The common word *angina* is an example par excellence as far as the notion of *faux amix* is concerned (Badziński 2004). The term usually has nothing to do with the Polish word *angina* since its English definition denotes chest pain often caused by narrowing of arteries. In that case its equivalent is *dusznica bolesna* or *choroba wieńcowa.*

Infamous cases of inaccuracy in medical interpreting and one of the cardinal sins of interpreters as noted by medical practitioners is the violation of the context. It is true indeed that simultaneous interpreting is considered to be the most challenging mode of rendition primarily because of the fact that decisions are taken on the spot which in consequence leaves very little time to collect thoughts.

The instance where one word stands for two completely different medical entities is best reflected in the English word *myelitis.* Its two meanings vary to a large extent – in the neurological context it stands for inflammation of the spinal cord and in the orthopaedics the meaning of the term denotes inflammation of bone marrow. Sometimes, however, the confusion appears in one branch, most commonly in internal medicine. The English word *infusion* is even more confusing than *myelitis* since it may stand for (i) a drink made by pouring water on a dry substance – *napar* (in Polish), (ii) the act of putting liquid into a body, using a drip – *kroplówka* or (iii) a slow injection of a substance into a vein or tissue – *wlew.*

Medical interpreting is gaining on popularity abroad. What is more, in Poland it is also becoming more and more appreciated. The above-described phenomenon refers to conference interpreting, however for a couple of years another trend has been observed, its setting particularly concerns the hospital or surgical environment.

Many physicians are facing a dilemma when they are to examine a foreigner in their surgery. Much has been written on the doctor-patient relationship from the communicative approach (Korsch 1972). This phenomenon is, however, even more challenging adding to the fact that a third party – an interpreter – has to be engaged in conversation and thus in interpreting. In that case the use of interpreters is a multifaceted issue.

Firstly, it is the physician who is ultimately responsible for communication. If a physician's mastery of a foreign language is insufficient, the best alternative is to resort to the skills of a trained medical interpreter or translator.

More often than not, however, it is a frequent phenomenon that the role of an interpreter is taken over by a relative or a friend of a patient. Such an instance is of common occurrence in the USA, among Hispanics in particular where sometimes non-professional interpreters engage themselves in the above activities.

In Poland since we joined the European Union the above procedure has also been observed. The author of the article has faced such a phenomenon five times on different occasions in different hospitals.

Although providing language services to patients with limited English proficiency is the realm of medical interpreters whose task is to provide help for patients in terms of communication with doctors, nurses, and other members of medical staff, being emotionally detached but still aware of the patient's condition constitutes a crucial factor if the interpretation is to bear fruit. Sadly, that is the condition which can be hardly fulfilled in the case of family members or friends acting as non-professional interpreters.

In the USA, however, policies in hospitals across some states prohibit the use of untrained "interpreters" in medical settings for fear of considerable mistakes that might occur. However, from the patient's perspective it is obviously more convenient to be in the presence of friends or family members (rather than an unknown professional interpreter) due to their ongoing relationship and their deep knowledge of the patient's needs.

Hardt (2003) shows how devastating such conduct may be by providing the example of the research of Glen Flores. The study shows that lack of adequately trained medical interpreters can lead to the increased number of medical errors – an average of 19 serious interpreter errors of clinical consequence were made per pediatric encounter by untrained interpreters, such as family members, making significantly a higher percentage of all the mistakes when compared with the number of errors made by trained interpreters whose mistakes did not entail clinical consequences.

One does not have to mention that such errors obviously stem from insufficient interpreting and language abilities of the 'interpreters' in question. Therefore a number of mistakes may occur among which omissions are to be the most frequent and in fact may have the most detrimental consequences regarding the patient's condition.

In conclusion, the skills of medical interpreters next to mastery of medical and colloquial terminology include cultural sensitivity and respect for all the parties engaged in the process of interpreting. Fulfillment of the above criteria might contribute to the elimination of misunderstanding and building of mutual trust and accurate and successful communication both in terms of medical simultaneous interpreting at conferences and interpreting in emergency cases as it has been outlined above.

References

Badziński, A. (2004). On the necessity of cooperation between the professional translator and the medical practitioner in the process of translation. Borkowska, E. and A. Łyda (eds.). *Studies in Language, Culture and Literature*, Katowice: WSZMiJO.

Brunt, R.J. (1987). My watermarks are playing me up something chronic. Lorscher, W. and Rainer Schulze (eds). *Perspectives on Language in Performance. Studies in Linguistics, Literary Criticism and Language Teaching and Learning*, 447–469. Gunter Naar Verlag.

Collin, P.H. (2001). *Słownik medycyny.* Peter Collin Publishing.

Fischbach, H. (1986). *Translation and Medicine.* Amsterdam/Philadelphia: John Benjamins Publishing.

Gile, D. (1995). *Basic Concepts and Models for Interpreter and Translator Training.* Amsterdam/Philadelphia: John Benjamins Publishing.

Hardt, E.J. (2003). Errors in medical interpretation and their potential clinical consequences in pediatric encounters. *Pediatrics*, 554–558.

Korsch, B.M., B. Freeman, V. Negrete. (1971). Practical implications of doctor-patient interaction analysis for pediatric practice. *American Journal of Diseases of Children*, 110–114.

Lippert, H. (1979). Sprachliche Mittel in der Kommunikation im Bereich der Medizin. Mentrup, W.F. (ed.). *Fachsprache und Gemeinsprache. Jahrbuch 1978 des Instituts für deutsche Sprache.* Düsseldorf.

Newmark, P. (1976). A layman's approach to medical translation. *The Incorporated Linguist*, 41–47.

Newmark, P. (1998). *A textbook of Translation*, Phoenix Elt.

Pilegaard, M. (1997). Translation of medical research articles. Trosborg, A. (ed.). *Text, Typology and Translation.* Amsterdam/Philadelphia: John Benjamins Publishing.

Setton, R. (1999). *Simultaneous Interpreting: A Cognitive-Pragmatic Analysis.* Amsterdam/Philadelphia: John Benjamins Publishing.

Słomski, P., P. Słomski (2003). *Podręczny słownik medyczny angielsko-polski i polsko-angielski*, PZWL.

Van Hoof, H., (1970). La traduction medicale et pharmaceutique. *Meta* 15,2, Montreal.

Wills, W. (1999). *Translation and Interpreting in the 20th century.* Amsterdam/Philadelphia: John Benjamins Publishing.