TRANSLATING MEDICAL TEXTS FOR LEGAL PURPOSES: A GROWING CHALLENGE FOR COURT TRANSLATORS AND INTERPRETERS

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Abstract: Medical translation has been an area of an increased growth in the demand for translation services. It is considered to cover an extensive variety of genres, starting from hospital discharge reports, epicrises, specialist articles in medical journals, patient information leaflets (PILs) or instructions for use (IFU). It also has entered the area of activity of court translators due to e.g. migration or Poland's membership in the EU and resultant EU-law implementation procedures (i.e., implementation of the Medical Devices Directive 93/42/EEC) and commercialisation of medical devices, thus generating the need to deal with an array of texts from the entire realm of various fields of medicine, and related disciplines (pharmacy, pharmacology, biology, etc.). Court translators are therefore facing difficulties and at the same time challenges, among which most important are the lack of medical knowledge, medical terminology (including acronyms and abbreviations) or medical phraseology in general. This entails the development of a new professional approach towards proceeding with such tasks, and requires constant improvement of skills and knowledge as well as special competencies that might be of help for translators (for this reason the notions of professionalism and translation competence shall be briefly elucidated). The focus of the article is placed on translation of medical texts seen from the point of view of translators and the purpose of translation, and not from the perspective of users, thus the approach is translator-centred.

PRZEKŁAD TEKSTÓW MEDYCZNYCH JAKO ROSNĄCE WYZWANIE DLA TŁUMACZY PRZYSIĘGŁYCH

Abstrakt: Przekład tekstów medycznych obejmuje cały szereg różnego typu tekstów, takich jak wypisy szpitalne, epikryzy, artykuły naukowe w czasopismach medycznych, ulotki informacyjne dla pacjenta (PILs) czy też wskazówki dotyczące stosowania leku (IFU). Wkracza również w sferę zainteresowania zawodowego tłumaczy przysięgłych z racji takich czynników jak np. migracja obywateli lub członkostwo Polski w UE i wynikające z tego procedury implementacji prawa unijnego do polskiego oraz wprowadzania wyrobów medycznych na rynek. Tłumacze przysięgli z konieczności więc mają do czynienia z całym szeregiem tekstów z różnych dziedzin medycyny (oraz dziedzin pokrewnych, takich jak np. farmakologia czy biologia). Trudnością i jednocześnie wyzwaniem dla tłumacza w takiej sytuacji stają się: brak wiedzy medycznej, problemy ze znajomością terminologii medycznej (oraz wszechobecnych skrótów i skrótowców) czy ogólnie pojętego dyskursu medycznego. Pociąga to za sobą rozwój nowego profesjonalnego podejścia do tłumaczenia takich tekstów jak również specyficznych kompetencji (dlatego w artykule pokrótce wyjaśnione zostaną pojęcia takie jak profesjonalizm i kompetencja). Podejście zaprezentowane w artykule będzie podejściem zorientowanym na tłumacza.

Introduction

Court translators (certified sworn translators) in Poland now face a new, and still growing, challenge: translating medical texts (and texts from medicine-related disciplines). Obviously, medical translation has a long and admirable history, discussed e.g. in Fischbach 1998 or McMorrow 1998 (these authors give historical insights into the development of the discipline). The focus here shall be laid on the extent to which court translators are to be professionally concerned with medical translation, on features that make medical texts so specific and challenging; also, some implications addressing competences necessary for successful performance of this difficult task shall be presented.

The new task awaiting court translators is an entire bulk of various documents; the necessity to translate those documents stems from Poland's membership in the European Union and, what follows, from the obligation to implement the EU law (e.g. Medical Device Directive 93/42/EEC); also, substantial migration of Poles to other countries is the factor of relevance. The global market trends refer also to medicine and related fields (such as research and experiments) in a variety of disciplines, for instance, pharmacology, biology, etc.; documentation (if it is to be validly applied on the market and if national legal provisions are to be observed) pertaining to the research must be translated by court translators. Those documents cover the following: death certificates, hospital records, discharge reports, test and examination reports, documentation concerning medical devices such as instructions for use, product registration, patient information leaflets (PILs), or clinical trial protocols. It seems impossible to enumerate absolutely all types of medical texts that are translated; the list given, although short for reasons of space, nevertheless shows the multitude of tasks for court translators.

As mentioned above, medical translation is necessary for both legal and market-related reasons. Legal requirements cover all commercialised medicines with the approval of the Federal Drug Agency or the European Medicines Agency. Additionally, as Poland is one of EU member states, the entire legislation must be translated into Polish. This includes all EU directives: medicine and related fields are concerned mostly with the Medical Device Directive, In Vitro Diagnostics Directive, Active Implantable Device Directive, or Human Medicines Directive. Obviously, these directives do not have to be translated by court translators, as translating these documents lies within the scope of responsibilities of translators working for the European Commission and the European Parliament. Yet, court translators are 'summoned' when it comes to translating medical documentation for natural persons that is necessary for administrative purposes (e.g. death certificates, hospital records, discharge reports, examination results, etc.) and for corporate bodies that are functioning on the European market and for that reason – to commercialise their products – they need declarations of conformity, instructions for use, EC design examination certificates, etc. These documents can be also used in a variety of legal and court settings, for instance, as evidence in a civil or criminal procedure (forensic examinations, autopsy protocols), as reports from external experts on a given issue, during arbitration proceedings, or cases connected with patent and copyright law, etc. This is where the court translator's responsibility starts and possible problems may

emerge while dealing with a variety of texts (and genres). Those problems seem to derive from the very specificity of the language used in those texts, and those specific features shall be briefly discussed below. The analysis of problems shall follow the English-into-Polish translation direction (with translation into one's mother tongue recommended by international institutions, EU inclusive).

The material corpus embraces the following types of medical texts:

(i) hospital records (5 in total),
(ii) discharge reports (6 in total),
(iii) test and examination results (13 in total),
(iv) research articles (6 in total),
(v) instructions for use (11 in total).

The above texts (41 in total) were translated by the author herself between January and June 2011. Translations were commissioned by natural persons (hospital records and discharge reports to be used for treatment abroad as well as, in 3 cases, for the purpose of enforcement of maintenance). Test and examination results, research articles and instructions for use were commissioned by corporate bodies doing their business in- and outside the EU. Examples were extracted from the texts (during the stage of translation proper; extracted examples in English are duly provided with their Polish relevant counterparts) with the aim of demonstrating potential problems that all translators may face. The first group of examples refers to the influence of Greek and Latin on medical terminology in English; the second group is concerned with 'mixing' ordinary and specialist language, whereas the third (quite frequently the most troublesome group) shows the overwhelming presence of acronyms and abbreviations in medical language.

Problems in medical translation

The ability to understand medical language is the absolute prerequisite for performing the translation task. Obvious as it may seem since comprehension in general is the key foundation of translation, the purpose (purpose is understood here as the general purpose of translation: to transfer information from the source language text into the target language text and shall not be in any way linked with the functionalist perspective) in medical translation is naturally different from the one in literary translation. The priority of the translator while translating medical texts is transferring the complexity of the original, embracing both complex terminological content as well as form with certain features typical of technical (scientific) texts in general. From the traditional perspective, medical language was perceived similarly to other types of scientific language as neutral, objective, and its function was to convey information only, without any references to culture or ideology. This resulted in a relatively impersonal, neutral and uniform style (see also Resurrecció 2007).

The English medical language is in great majority founded on terminology that is constructed out of roots, prefixes, suffixes of Greek or Latin origin. Examples of such prefixes include: pre/ante- (before, e.g. preoperative), endo- (inside, e.g. endothelial), epi- (above, e.g. epigastrium), hyper- (excessive, above, e.g. hyperactive), hypo- (decrease,

below, e.g. hypoglycaemic), mal- (bad, e.g. malfunction), peri- (around, e.g. peritoneal), post- (after, e.g. postnatal), sub- (below, e.g. subdural) or super- (above, e.g. supersensitive). Suffixes embrace such terms as: -algia (painful, e.g. neuralgia), -asthenia (weakness, e.g. myasthenia), -ectomy (removal, e.g. hysterectomy), -itis (inflammation/infection, e.g. otitis), -gram (picture, e.g. cardiogram), -orrhea (flow, e.g. diarrhoea), -pathy (disease, e.g., discopathy), -plasty (surgical repair, e.g. angioplasty), -sclerosis (abnormal hardening, e.g. arteriosclerosis) or -stenosis (narrowing, e.g. arteriostenosis). Terminology relying on Greek and Latin is one of the features of medical language and poses difficulties for the translator (for the discussion on translation problems related to Latin and Greek roots and stems see van Hoof 1998).

Another problem are synonyms that frequently stem from the usage of both ordinary and specialist language; this occurs quite often in e.g. discharge reports or hospital records. Synonyms differ due to the fact that a variety of reasons – of historical, descriptive or anatomical nature – gave rise to a range of equivalent names in use. An example here might be the Heine-Medin disease i.e. 'acute anterior poliomyelitis'; historically, it was translated into Polish as 'choroba Heine-Medina' or 'choroba Heinego-Medina'. With time, it has started increasingly frequently been referred to as 'polio', which is an abridged form of 'poliomyelitis'. At present, the form 'choroba Heine-Medina' would be perceived as anachronic and obsolete. It should be emphasised that, considering the wide range of synonyms used, consistency in translation should be treated as priority, otherwise the purpose, for which translation is to be used, may not be achieved. The abovementioned 'mixture' of ordinary vs specialist language, with examples such as 'stomach' for 'abdomen', 'bowel' for 'intestine', 'collar bone' for 'clavicle' or 'neck vein' for 'jugular vein' are the daily bread for translators who must be careful to retain appropriate register and rather resist the temptation to use ordinary language – which is more understandable for laymen – while translating medical documentation.

The usage of synonyms is further enhanced by eponyms, i.e., terms adapted from names of scientists or physicians (van Hoof 1998). Van Hoof further distinguishes between two types of eponyms. This division depends on the fact whether the proper noun is retained to refer to a disease (e.g. Down's syndrome/ zespół Downa, Graves-Basedow disease/ choroba Graves-Basedowa, Alzheimer's disease/ choroba Alzheimera) or an anatomical notion (islets of Langerhans/ wysepki Langerhansa), or whether the proper noun gave rise to another proper noun, which is the case of e.g. parkinsonism/ parkinsonizm.

One of typical features of medical language is the ubiquitousness of abbreviations and acronyms which pose another big challenge for the translator, especially due to multiplicity of potential meanings. Commonly accepted definitions see abbreviations as shortened forms of words (or phrases), usually not capitalised, whereas acronyms are constructed out of word strings of capitalised syllables or, mostly, initial letters. Therefore, as Kasprowicz (2010) rightly suggests, they are governed by different grammatical rules and thus cannot be confused. Abbreviations and acronyms have a general tendency to occur in specialist scientific language, and the tendency to use them in medical language seems to result from economic reasons to save time and space (see

van Hoof 1998). Moreover, physicians attempt at not disclosing the real meaning of what they say or write, thus making the language hermetic and understood only by professionals. Thus the content of e.g. discharge reports or epicrises is beyond comprehension of patients or persons not directly involved in the profession; this may be of relevance for ethical reasons (see Kasprowicz 2010). Therefore, the majority of medical texts are full of abbreviations or acronyms that are not explained as they belong to the 'lexicon' of medical professionals (that cover term embraces physicians, dentists, nurses, or paramedics, see O'Neill 1998), and acronyms are so widely known and applied that no need exists for putting them in their full form. It is nicely reflected in two examples, and the phenomenon is typical of both Polish and English medical language in names of diseases: 'obstructive sleep apnoea' becomes 'OSA' and 'obturacyjny bezdech senny' is 'OBS' respectively; the same happens with 'chronic obstructive pulmonary disease' becoming 'COPD' and the mechanism in Polish stays the same, with 'przewlekła obturacyjna choroba płuc' becoming 'POChP'. On the other hand, one cannot ignore the fact that full names of diseases or chemical compounds would severely damage effective communication and understanding of the text, thus acronyms and abbreviations substantially add to the precision, accuracy, clarity and brevity of the text. Yet, the excessive use of acronyms and abbreviations without any explanations given renders the text, for less experienced translators that do not specialise in translating medical texts, unclear and ambiguous, especially considering the fact that in many instances one shortened form may denote a number of terms. An example of relevance here would be an acronym 'CF' which may stand for (examples below were found in the material corpus):

(i) cardiac failure,
(ii) Christmas factor, factor IX,
(iii) chromosomal fraction,
(iv) citrovorum factor (folinic acid),
(v) coagulation factor,
(vi) complement fixation,
(vii) coronary flow,
(viii) cystic fibrosis,
(ix) central filling,
(x) centrifugal force,
(xi) continuous focusing

and all of the above are applied in medical language. The context is therefore the key determinant of meaning.

Another example of this kind is 'MA' which may denote the following terms (examples below were found in the material corpus):

(i) maleic anhydride,
(ii) malignant angioendotheliomathosis,
(iii) malonaldehyde,
(iv) medical adviser,
(v) Medical Assistance,

(vi) Medical Authority,
(vii) membrane antigen,
(viii) mental age,
(ix) mental atalia,
(x) mento-anterior,
(xi) metabolic activity,
(xii) metabolic analyser,
(xiii) meter angle,
(xiv) methamphetamine,
(xv) methoxyadrenaline,
(xvi) mitotic apparatus,
(xvii) monoarticular arthritis.

The multitude of meanings requires from the translator a deep and thorough insight into the text and its context. Without the knowledge of the context and the knowledge of the subject matter the translator is going to feel at a loss, or at least uncertain, which obviously leads to deficient translation.

Due to the global effect of English and its *lingua franca*-role in specialist communication (including medical texts), English acronyms and abbreviations tend to occur increasingly frequently in test results, hospital records, discharge reports or epicrises produced in Polish hospitals and healthcare institutions by Polish physicians. A bulk of those shortened forms are of international use, and we can observe nowadays a systematic replacement of once national terms for English ones.

It is perfectly reflected in blood test results where in Polish the blood cell count is, in majority of cases, presented with the use of English acronyms such as WBC (white blood cells), Hgb (haemoglobin), RBC (red blood cells), PLT (platelets), MCT (mean corpuscular thickness), MCHC (mean corpuscular hemoglobin concentration), HCT (hematocrit), etc. In discharge reports CRP (C reactive protein) is given mostly not as 'białko C-reaktywne' but rather as either 'CRP' where the whole acronym is copied, or as 'białko CRP' where the word 'protein/białko' is repeated. The same mechanism can be observed in the usage of CSF (cerebrospinal fluid): it frequently appears in Polish documents as CSF (e.g. in a phrase noticed in a hospital record saying 'duża ilość CSF w przestrzeniach wewnątrzczaszkowych') or 'płyn mózgowo-rdzeniowy'. For reasons of space, the natural choice will be made to the benefit of the acronym, but this is yet another example how English suppresses Polish. The same tendency refers to 'HBV'/'HCV' denoting 'hepatitis B/C virus' which in Polish stays the same or is given in its full (though less spatially economic) form of 'wirusowe zapalenie wątroby typu B/C' or a shortened form ('WZW typu B/C). Another example concerns computer imaging when MRI ('magnetic resonance imaging'/'rezonans magnetyczny') is not translated, no equivalent for the examination is being given but it is more frequently used in its English form, e.g. 'w badaniu MRI' instead of a longer name in Polish; further, 'DNR' ('do not resuscitate') is not translated into Polish but referred to as 'protokół DNR'.

Examples such as 'abd HE', which stands for 'abdominal hysterectomy', show how intricate, to say the least, medical language may be, and how extensive subject

matter knowledge and competence is required to decode the context-related meaning of acronyms and abbreviations. Moreover, the translators may face another set of problems related to the quality of the source text such as ambiguities, wrong lexical choices, typing errors that change the meaning of the phrase or term (e.g. 'arthritis' vs 'arteritis', 'ureteritis' vs 'urethritis'; 'milligram' (mg) vs. 'microgram' (μg) sometimes, although incorrectly, abbreviated also as 'mg').

Irrespective of the quality of the source text (or its potential deficiencies) or severe time constraints imposed on the translator by the person or institution commissioning the translation (that quite frequently seem to disregard the fact that professional and high quality translation needs ample time), the first and foremost aspect to be discussed is the competence of the translator. S/he is to be not only a language expert but also a person responsible for the final product of the translation process: a text that is comprehensible, accurate and adequate in terms of terminology applied. The examples of terms or phrases provided above can be multiplied *ad infinitum*, yet the question remains to be asked: what kind of competence is necessary for the translator to perform the task successfully and to produce high-quality translation. To answer this question, a brief insight into the concept and models of competence that could be of relevance for medical translation seems to be in order.

Translation competence

Initially, the problem emerges if one tries to delineate the terminological limits of general translation competence to be possessed by translators. Descriptive terms occur in ever increasing numbers since competence was referred to as 'transfer competence' (Nord 1991), 'translator competence' (Kiraly 1997), 'translational competence' (Toury, 1995), and even 'translation performance'(Lörscher 1991). For the purpose of this article translation competence shall be perceived as an expert-like type of knowledge in a given area combined with necessary experience. If we analyse reference sources, then the implicitness of the nature of translation competence comes into the fore as one precise, accurate, unambiguous – and short – definition is hard to be found. Instead, what the sources seem to suggest are increasingly longer lists of either potential factors affecting the operation of translation competence or componential models. Those componential models embrace ideas put forward by e.g. Bell (1991), Hansen (1997), Hatim and Mason (1997), Neubert (2000), Risku (1998) and Nord (1991), and the PACTE group (cf Beeby 2000). The models distinguish between various types of operating translation competencies (or even subcompetencies) that address linguistic, extra-linguistic, transfer, strategic or cognitive domains. The focus of our considerations shall be the definition propounded by the PACTE research group since, in contrast to other models based on theoretical and idealised conditions, it relies on the entire triangulated body of underlying research. Thus translation competence is perceived as the ability to translate derived from the underlying system of knowledge and skills.

The PACTE model

The PACTE model appears to encompass the most extensive area of domain-related operation of translation competence: source and target language communicative competence, extra-linguistic competence, transfer competence, instrumental competence, strategic competence and psychophysiological competence. The model is the 'final product' of a series of empirical research that was started in 1998 (Beeby 2000) and postulates that translation competence is a system of knowledge indispensable for translation that has four key properties:

(i) the knowledge is an expert-like type, and *ex definitio* is not possessed by all bilingual persons (but see the notion of 'native translator', Toury 1995; also Harris and Sherwood 1978),
(ii) this knowledge is rather procedural (i.e., related to knowledge stored as procedures, rules and strategies) than declarative (which is related to knowledge stored as patterns, cf Sternberg 1999),
(iii) the knowledge relies on a range of interrelated (sub)competencies,
(iv) procedural knowledge is substantially affected by strategies.

The PACTE model of translation competence is constructed of five (sub)competencies and psychophysiological components. Bilingual (sub)competence covers pragmatic, sociolinguistic, textual and lexical-grammatical knowledge in any language. Extralinguistic (sub)competence consists of encyclopedic, subject matter and cultural knowledge (embracing source and target language culture). Instrumental (sub)competence denotes the ability to use documentation sources and information technologies applied in translation performance. Translation (sub)competence refers to the knowledge of translation principles (processes, procedures, methods, etc.) as well as professional ethics (types of briefs, translation users). The model stresses the key role played by strategic (sub)competence which enables the process of problem solving and is responsible for the efficient operation of the entire translation process. The working of strategic (sub)competence is revealed in the planning stage of the process and connected with a specific (commissioned) translation project, evaluation of this project as well as assessment of partial results. A range of (sub)competencies and compensation techniques is activated, translation problem areas are identified and effective ways of solving those problems are applied. The psychophysiological components comprise cognitive factors such as memory, personality features, attention, creativity, etc. There seems to a be a general concord among researchers as to the selection of (sub)competencies typical of the operation (and manifestation) of translation competence: these are strategic, instrumental and translation knowledge (sub)competencies. A crucial result of this long-term research (first pilot tests were performed as early as in 1998) was a stipulation that the expert knowledge of translators to a substantial extent determines both the process and the product of translation, and translation competence is thus reflected both in the process and in the product (PACTE 2009, 209). In the data collection process five types of instruments were applied:

(i) Texts and translations: subjects had to translate two texts (the first from a foreign language into their mother tongue, and vice versa).
(ii) Translation protocols: commercial software programs PROXY and Camtasia were used to record translation protocols (for more information about the software see PACTE 2009).
(iii) Direct observation: one researcher was observing directly each experiment subject during the translation process, and was also taking notes to provide for the data that could not be recorded.
(iv) Questionnaires: three types of questionnaires were applied. An initial questionnaire was prepared to verify whether all candidate subjects meet relevant criteria, the second questionnaire addressed translation problems encountered while translation; finally, the aim of the questionnaire on knowledge about translation was to find whether subjects had any knowledge of translation.
(v) Retrospective interviews: retrospective interviews were conducted to see the correlation between information in the questionnaire on translation problems and ways in which those problems were successfully solved.

The PACTE model can be, to quite an extent, applied empirically since it refers to features characteristic of a professional translator (in contrast to aforementioned lists of components, potentially vital for the operation of translation competence, that one needs to acquire in order to become a professional). The focus on the function the translation is to perform is also nicely reflected in the PACTE's approach that views translation as a "communicative activity directed towards achieving aims that involves taking decisions and solving problems, and requires expert knowledge" (PACTE 2003, 44). We could therefore hypothesise that a professional translator is to possess all the (sub)competencies enumerated, yet the knowledge of the subject matter is not that extensive. In contrast, a medical professional – if s/he were to translate a text – is bound to have extensive knowledge of the subject matter thus ensuring precision and accuracy of the text translated (cf O'Neill 1998). His or her bilingual (sub)competence is not that extensive as in professional translators, which is obvious since medical professionals do not naturally possess translation (sub)competence. This might result in translation problems such as literal translation (cf e.g. Askehave and Zethsen 2002), thus making the text incomprehensible. Medical professionals also seem to lack translation experience and skills (for obvious reasons of having worked as practicing medical professionals, and not as practicing translators), and that is another factor contributing to the potential problem with the quality of the final product of the translation process.

While discussing translation competence one cannot ignore another aspect vital for translation performance which is very frequently perceived as co-existent with competence, i.e., professionalism. A professional translator is viewed as competent, and some remarks on professionalism seem therefore in order for the clarity of further discussion.

Professional translator

Translation professionalism *per se* addresses not only those aspects that are related to the linguistic domain, but also those pertaining to the extralinguistic context of translation. Professionalism of the translator is manifested in his/her education and training, range of experience accrued and effective use of translation-related instruments (this is what PACTE names 'instrumental (sub)competence') such as CAT tools, computer technologies, or dictionaries and glossaries (either traditional or, increasingly frequently, on-line databases and resources).

Gouadec (2007) quite aptly claims that the professional translator must have a perfect command of languages (both the source and target language), writing skills and ability to use state-of-the-art (computer) technologies as well as specialist knowledge on his/her area of specialisation. An interesting approach is presented by Englund Dimitrowa (2005) who differentiates between translation competence and translator competence. Translation competence is a feature of everyone with the knowledge of a foreign language who is capable of performing basic translation operations. The result of these operations is a text, not always perfect and still in need of corrections from the linguistic point of view. Translation competence may be the start of a continuum towards developing translator competence provided that translations already performed are subject to verification and meticulous analysis, and persons (or institutions) commissioning and assessing translation give their feedback on those texts.

An 'evergreen' question arises here whether any optimal way exists that could be useful for the evaluation of degrees (or stages) of professionalism. The answer is complicated as professionalism has been for quite a long time perceived from the angle of translation quality. Quality seems to be immeasurable in explicit terms since criteria applied for its assessment vary and have not been consolidated; this leads to comparative analyses of professional and non-professional translators in terms of quality of their performance (see Englund Dimitrowa 2005, Jakobsen 2002, Kussmaul 1995, Tirkkonen-Condit 1996, Tirkkonen-Condit 1992).

Professional translation denotes the production of high quality, i.e., accepted and well-structured texts, which in our case would be highly recognised, coherent and accurate translations of medical texts. The translator accepts full responsibility for the quality of the text produced, where the text is the final product of the translation process; the text is further subject both to linguistic and extra-linguistic verification (and its operational efficiency in terms of the purpose for which it was produced).

In view of medical translation yet another aspect deserves here our attention, i.e., the perception of text quality (and its operational efficiency) naturally varies among different user groups as they have varying expectations pertaining to the translation. Those expectations assumingly refer to such areas as linguistic and extralinguistic communicative efficiency reflected in text comprehension. Court translators, while

translating medical texts, do not have their readers in mind, since they are focused on the purpose of translation: the priority is ascribed to the normative (legal) function the text and its translation are to fulfil. In other instances, translating medical texts is strictly connected with answering the question about the prospective readership: who are potential users? Are they experts, semi-experts or laymen?

Generally, five various reader profiles can be distinguished; readers read texts for practical (thus functional) reasons, yet their needs and expectations concerning the text are different. Those varying profiles determine the choice of a specific genre. Resurrecció (2007, 52-53) categorises those profiles as follows:

(i) general reader – who wants to prevent a (potentially occurring) disease,
(ii) patient – who wants his or her disease to be effectively treated,
(iii) student – who wants to acquire knowledge and become a medical (health) professional,
(iv) health professional – who wants to implement his or her knowledge,
(v) researcher – who wants to advance the knowledge.

Even if the court translator is not focusing on the readership, the dynamically changing situation on the market and resultant factors determining his or her performance may impose new requirements. A huge area deserving a separate discussion are patient information leaflets (PILs); they seem to reflect a new trend that medical language is no longer to be used exclusively by professionals. PILs are specifically produced for non-professionals (persons outside medical professions) and the EU has implemented a number of requirements to be fulfilled (that also implicitly pertain to translation), and thus Human Medicines Directive (Art. 63, subsection 2, p.43) provides for the following:

> "The package leaflet must be written and designed to be clear and understandable, enabling the users to act appropriately, when necessary with the help of health professionals. The package leaflet must be clearly legible in the official language or languages of the Member State in which the medicinal product is placed on the market" (HMD, 43).

The above considerations pertaining to various aspects of translation performance show that apart from linguistic and extra-linguistic domains, translation competence is manifested in the cognitive domain as well which is a set of factors such as e.g., (general) knowledge, experience or motivation. Experience contributes to effective use of the knowledge accumulated, thus enabling the translator to capitalise on the entire assortment of translation tasks performed previously, and to activate any information existing in the memory resources. Experience is an inherent (even design) feature of professional translators; it is accrued if the translator possesses a high degree of motivation (see Amabile 1996) to learn and develop his or her skills constantly. In translating medical texts this refers to constant broadening and mastering specialist knowledge in the field that translators specialise. High quality – professional – product of the translation process is the direct result of the interaction of knowledge and experience,

the efficiency of which is absolutely indispensable in any field of translation activity, including such demanding areas as medical translation.

Concluding remarks

The language of medicine and related fields is an area deserving wider discussion and coverage on language studies or translation studies (at least in Poland). Potentially, implications for the future may provide for including medical language in translation courses curricula to a much more extensive degree that it has been done before.

Contrary to medical professionals who have contact obviously with medical language during their education and further training, translators (and court translators in our view) must have first learn the language of medicine to be capable of understanding it. Comprehension is related to having access to medical texts, to the aforementioned internal motivation to expand one's knowledge, or to have more extensive in-depth knowledge of particular fields of medicine and related disciplines in order to be able to translate. This process must take time, and the experience accrued within that time is indispensable for high-quality translation performance.

Apart from specialist and specific terminology (as well as profession-related type of discourse) court translators have to deal with implicit knowledge behind the text. Wrong interpretation of references might result in mistranslation, which in case of the normative or law-related purpose of texts is dangerous as even one information item may matter. An ideal situation would be the one postulated by O'Neill:

> "it appears that either a medical professional or a medically knowledgeable linguist can do a good job with a medical translation; but given the relative strengths and weaknesses of both sides, the ideal situation would be for the medical professional who translates to be edited by a linguist, and the linguist translating medical work to be edited by a medical professional. However, this happens all too infrequently in the real world, due to cost and time constraints" (O'Neill 1998, 76).

Recommendations for court translators dealing with translating medical texts concern the aspects of competence required to face the challenge. The priority is ascribed to the knowledge of medical terminology; without that knowledge text comprehension is not possible and thus translation will not realise the purpose assumed. Translators should have access to any information resources available, starting from conventional bilingual and monolingual dictionaries, through glossaries, lexicons and handbooks to on-line databases and resources. The awareness of the role of language and writing skills should be also stressed. A very important role is played by such cognitive factors as long-standing experience in the profession, combined with personal attitude towards the tasks commissioned, i.e., constant motivation for development and knowledge expansion. Last, but certainly not least, consulting an expert (a medical professional) is always of relevance and contributes to higher quality of texts produced and, what follows, more effective intercultural communication and knowledge transfer.

As a way of concluding we could say that "(…) a love of language, an ear for style, a willingness to pursue arcane terminology and caring enough to get it exactly right are

the keys to true success" (O'Neill 1998, 80). In other words, a desire to be more knowledgeable and more competent is transposed into more successful, thus better and of higher quality, performance of court translators in their quest for perfection in translating medical texts.

Bibliography

Amabile, Teresa. 1996. *Creativity in context.* Westview: Boulder, Co.

Askehave, Inger and Karen Korning Zethsen. 2002. "Translating for Laymen". In *Perspectives: Studies in Translatology,* 10(1), 15-29. London: Routledge.

Beeby, Alison. 2000. Choosing an Empirical-Experimental Model for Investigating Translation Competence: The PACTE Model. In *Intercultural Faultlines. Research Models in Translation Studies I. Textual and Cognitive Aspects,* ed. Maeve Olohan, 43-55. Manchester: St Jerome.

Bell, Roger. 1991. *Translation and Translating. Theory and Practice*. London and New York: Longman.

Englund Dimitrova, Birgitta. 2005. *Expertise and Explicitation in the Translation Process.* Amsterdam/Philadelphia: John Benjamins.

Gouadec, Daniel. 2007. *Translation as a profession.* Amsterdam/Philadelphia: John Benjamins.

Hansen, Gyde. 1997. Success in Translation. In *Perspectives: Studies in Translatology,* 5(2): 201-210. London: Routledge.

Harris, Brian and Bianca Sherwood. 1978. Translating as an Innate Skill. In *Language, Interpretation and Communication*, eds. David Gerver and H. Wallace Sinaiko, 155-170. New York & London: Plenum.

Hatim, Brian. and Ian Mason. 1997. *The Translator as Communicator*, London & New York: Routledge.

Hewson, Lance and Jacky Martín. 1991. *Redefining Translation. The variational approach*. London: Routledge.

Hoof van, Henri. 1998. The Language of Medicine: A Comparative Ministudy of French and English. In *Translation and Medicine,* ed. Henry Fischbach, 49-65.Amsterdam/Philadelphia: John Benjamins.

Jakobsen, Arnt .Lykke. 2002. Translation drafting by professional translators and by translation students. In *Empirical Translation Studies Process and Product,* ed. Gyde Hansen, 191-193. Copenhagen: Samfundslitteratur.

Kasprowicz, Małgorzata. 2010. Handling Abbreviations and Acronyms in Medical Translation. *Translation Journal,* vol. 14, No 2. http:// translationjournal.net/journal/52abbreviations.htm.

Kiraly, Don. 1997. Think-Aloud Protocols and the Construction of a Professional Translator Self-Concept. In *Cognitive Processes in Translation and Interpreting,* eds. Joseph H. Danks et al., 137-160. Thousand Oaks, London, New Delhi: Sage.

Kussmaul, Paul. 1995. *Training the Translator.* Amsterdam/Philadelphia: John Benjamins.

Lörscher, Wolfgang. 1991. *Translation Performance, Translation Process, and Translation Strategies.* Tübingen: Gunter Narr Verlag.

McMorrow, Leon. 1998. Breaking the Greco-Roman Mold in Medical Writing: The Many Languages of 20th Century Medicine. In *Translation and Medicine,* ed. Henry Fischbach, 13-27. Amsterdam/Philadelphia: John Benjamins.

Neubert, Albrecht. 2000. Competence in Language, in Languages, and in Translation". In *Developing Translation Competence,* eds. Christine Schäffner and Beverly Adab, 3-18. Amsterdam: John Benjamins.

Nord, Christiane. 1991. *Textanalyse und Übersetzen*. Heidelberg: Julius Groos.

O'Neill, Marla. 1998. Who Makes a Better Medical Translator: The Medically Knowledgeable Linguist or the Linguistically Knowledgeable Medical Professional? A Physician's Perspective. In *Translation and Medicine,* ed. Henry Fischbach, 69-80. Amsterdam/Philadelphia: John Benjamins.

PACTE. 2003. Building a Translation Competence Model. In *Triangulating Translation: Perspectives in Process Oriented Research,* ed. Fabio Alves, 43-66. Amsterdam: John Benjamins.

PACTE. 2009. Results of the Validation of the PACTE Translation Competence Model: Acceptability and Decision Making. In *Across Languages and Cultures*, 207-230. Vol. 10. No. 2.

Resurreccio, Vicent Montalt and Maria Gonzalez Davies. 2007. *Medical Translation Step by Step.* Manchester: StJerome.

Risku Hanne. 1998. *Translatorische Kompetenz. Kognitive Grundlagen des Übersetzens als Expertentätigkeit.* Tubingen: Stauffenburg Verlag.

Sternberg, Robert. 1999. *Cognitive Psychology.* Fort Worth: Harcourt Brace College Publishers.

Tirkkonen-Condit Sonia. 1992. The Interaction of World Knowledge and Linguistic Knowledge in the Processes of Translation: a think-aloud protocol study. In *Translation and Meaning. Part Two,* eds. Barbara Lewandowska-Tomaszczyk and Marcel Thelen, 433-440. Maastricht: Euroterm.

Tirkkonen-Condit, Sonia. 1996. What is in the Black Box?. In *Übersetzungswissenschaft im Umbruch*, eds. Angelika. Lauer et al., 251-257. Tübingen: Günter Narr Verlag.

Toury, Gideon. 1995. *Descriptive Translation Studies and Beyond.* Amsterdam/ Philadelphia: John Benjamins.

EU directives:

Medical Device Directive (Directive 93/42/EEC of the European Parliament and of the Council of 14 June 1993 on medical devices).

In Vitro Diagnostics Directive (Directive 98/79/EC of the European Parliament and of the Council of 27 October 1998 on in vitro diagnostic medical devices.

Active Implantable Device.

In Vitro Diagnostics Directive (Directive 98/79/EC of the European Parliament and of the Council of 27 October 1998 on in vitro diagnostic medical devices.

Active Implantable Device Directive (Directive 90/383/EEC of the European Parliament and of the Council of 20 June 1990 on active implantable medical devices).

Human Medicines Directive (Directive 2001/83/EC of the European Parliament and of the Council of 6 November 2001 on the Community code relating to medicinal products for human use).