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# Translation of culture in healthcare

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In its effort to join the European Union, Croatia faces many challenges in meeting the requirements set by the European policy-makers. Not least of these is the reform of the existing healthcare system, with the pilot of the newly proposed system currently under way in the Koprivnica-Križevci County. The consultants employed by the Ministry of Health in this project being from the United Kingdom, and the planned system being based on concepts largely foreign to the local healthcare professionals, it is obvious that culture presents an essential element of translation and interpretation "on-the-ground". On the basis of three English examples of *healthcarese* expressions and their translations into the Croatian variety of *healthcarese*, this paper will attempt to show that the prototypical conceptualization of the healthcare process (at least relating to the scope of the examples) is different in the two cultures. The meeting of the two cultures raises two pressing issues: the translators' awareness of the implicit cultural terms, and, more importantly, the ethics of changing cultural perceptions; both crucial in the upcoming process of joining the European Union.

## 1.

According to the "Working programme of the Government of the Republic of Croatia for the period 2000-2004", a strategic objective for the Republic of Croatia is to sign the Stabilization and Association Agreement, and thus become an associated member of the European Union. This Agreement is one of the 0six elements of the EU strategy for southeast Europe (the other elements concern economic relations, reconstruction, development and stabilization assistance, cooperation in legal matters and internal security, political dialogue and democratization, development of civil society, education and institution structure (cf. www.mei.hr)). The "Working programme" of the Croatian Government goes on to specify various areas where change is necessary and the objectives

of change in these areas. Thus, "operational objectives" for healthcare development include: (1) financial reform; (2) improved healthcare planning and management; and (3) strengthened role of primary healthcare. With these objectives in mind, the Government of Croatia employed a UK consulting group to assess the situation in the County of Koprivnica-Križevci, to translate the "operative objective" policy statement into a specific program to be piloted in the County, and, if successful, to be used in the whole country. The assessment showed that the main objective in the County should be to integrate primary and secondary healthcare. This is to be achieved by introducing various new concepts into primary and secondary service delivery layers, such as community health organization, group practice, repeat prescribing, new referrals, electronic patient record, day hospital, day surgery, a single A&E (accident and emergency) service for the whole County, registration for nurses, integrated medical records, integrated care pathways, clinical governance, benchmarking, cascading continuous training programs etc. Final outcomes of such integration would mean fewer hospital referrals, less paperwork, and in turn more time for healthcare professionals to spend with their patients.

The list in the preceding paragraph shows that the reform will be far from easy linguistically, conceptually and in terms of implementing the concepts in practice. The linguistic difficulties of the reform are a result of the fact that the documents produced by the UK consultant group employ a variety of English that can be called *healthcarese*. On the basis of three English examples of healthcarese expressions and their translations into the Croatian variety of healthcarese, this paper will attempt to show that the prototypical conceptualization of the healthcare process (at least relating to the scope of the examples) is different in the two cultures. The meeting of the two cultures raises two pressing issues: the translators' awareness of the implicit cultural terms, and, more importantly, the ethics of changing cultural perceptions; both crucial in the upcoming process of joining the European Union.

The paper sets off with a discussion of culture and translation theory, offering a cognitive viewpoint of the translation process, and enumerating techniques for the translation of cultural items. Next, three healthcarese examples are analyzed, highlighting difficulties of translation and revealing two underlying views of healthcare. Finally, translators' awareness of the cultural items and the ethics of change are discussed.

## 2.

In modern anthropology there are two major views of culture. According to the symbolic view (whose major proponent is Geertz), culture is a system of shared symbols, which does not reside in the individual, but rather in society as a whole. On the other hand, cognitivists (e.g. Goodenough) profess that culture is a system of knowledge

residing within individuals. The major difference between the two views of culture, thus, is that

(…) cognitive anthropology à la Goodenough theorizes the organism, but problematizes the public environment; symbolic anthropologists à la Geertz theorize the public domain of social action, but leave the organism and her capabilities/constraints wholly untheorized. (Foley 1997 : 20)

Goodenough's view of understanding culture as "distinct from [people's] biological heritage" (Goodenough 1964 : 36) will be taken as the starting point here, because of its proximity to cognitive linguistics: a firm statement of connection between meaning, culture and language (cf. Bratanić 1991 : 35; Antunović 2001 : 144).

There are three basic ways in which linguists nowadays view translation: as establishing correspondence of extra-linguistic content, as establishing correspondence between signs in the de Saussurean sense, and in approximating two languages (absolute equivalence in the third view being impossible due to extreme relativism) (Škiljan 1995 : 163-164). In this paper translation is seen communicatively, with one qualification. Whereas the traditional communicative view describes translation as a method of establishing equivalence of extra-linguistic content (cf. Ivir 1992, Ivir 1991-1992, Larson 1984, Antunović 2001), our position here is conceptualist. Thus, translation is regarded as a way of establishing equivalent *conceptualizations* of the extra-linguistic content (Tabakowska 2001 : 98-100). This corresponds to the cognitive view of the language–world relationship (experiential realism as opposed to objectivism; see Lakoff 1987: xv and Gärdenfors 2000 : 152-153), where meaning resides within the speaker, rather than in the extra-linguistic reality (note the analogy to Goodenough's view of culture). Nevertheless, essential relativity of this view does not preclude translation[1] (in the sense of the third view presented in Škiljan; see above), because universalism and relativism are seen as two extreme points on a continuum. This means that the model does envisage certain universal features (although not as specific as in Wierzbicka 1992 and Wierzbicka 1996). These universal features (relating to, e.g., embodiment and the schematic organization of human knowledge (cf. Johnson 1987)) pre-linguistically facilitate and favor a prototypical conceptualization of a situation. This, coupled with a universally symbolic nature of grammar (cf. Langacker 1987), leaves relativism to cover culturally and linguistically various mappings of the extra-linguistic reality. Therefore, the model does not overstate the importance of either one of the extremes[2].

The establishment of equivalence relies on the translator's knowledge of the language and his/her knowledge of the world. These two kinds of knowledge are, of course, inseparably intertwined[3]. In the translation process, the translator attempts to put his/her

[1] An application of the cognitive model to the translation of literature is given in Tabakowska 2001.

[2] For additional opposing views on universalism and relativism see Stanojević (in press).

[3] For a discussion of the knowledge of the language and the knowledge of the world and their relation see Žic-Fuchs (1991).

conceptualization of a situation into the target language, simultaneously attempting to linguistically profile those elements that stand out as profiled in his/her conceptualization of the source language material. This account is by no means an extraordinary feat of cognitive linguistics. As a matter of fact, it relates closely to the communicative model of translation and all the factors that influence translation according to the communicative model (as laid out in Antunović 2001:32), but with a twofold difference. Firstly, as has already been mentioned, the philosophical background is that of experiential realism as opposed to objectivism. Secondly, certain deeply rooted intuitions about the translation process (appearing in the communicative view of translation) are explained using notions (such as imaging, profiling and grounding) which form the core of the cognitive model of language (Tabakowska 2001:35)[4].

When there is a cultural element in the source culture which is nonexistent in the target culture, the result is a gap (Ivir 1977). According to Reyburn (1969:158), this gap can be of three kinds. In the first case, the target language lacks the referent or the linguistic means to express it; however, there is a different referent with the same function. In the second case, the referent exists in the target language, but its function is different than that of the referent in the source language. Finally, the target language may not have a similar referent, or any other referent with an analogous function.

In bridging the cultural gap the translator has various techniques at his/her disposal. In most cases these techniques have to be combined in order to produce an equivalent translation (Ivir 1987:37). It must be stressed here that the choice of one of the techniques depends on the translator's conceptualization (which is based on the text and context), and profiling of a particular cultural element in this conceptualization. Here is a list of these techniques according to Ivir 1987, with certain healthcarese examples (taken from the UK consultants' reports and their translations):

1. Borrowing (of the source language expression into the target language; e.g. benchmarking > benchmarking)
2. Defining the elements of culture (e.g. cascade education > trajno usavršavanje kod kojeg edukatori educiraju edukatore)
3. Literal translation (clinical governance > kliničko rukovođenje)
4. Substitution (community healthcare organization > Dom zdravlja)
5. Lexical creation (e.g. screening > probir)
6. Omission
7. Addition (of cultural information).

[4] The cognitive model as described here is neutral on the point of basic units of translation: its conceptualist nature does not necessarily presuppose that mental images (schemas, scenes, rich mental images etc.) are the basic units of translation. What the model does claim is that these are unavoidably created in the translation (=conceptualization) process.

Techniques listed above constitute a complete list of techniques a translator can use in dealing with cultural items. As was noted above, their appropriateness in a particular context depends on the relative profiling of the cultural item in the particular conceptualization. The situation at hand, of a highly technical text, requires clarity of all the elements. Therefore, arguably, no cultural elements should be omitted, and their prototypical conceptualizations in the source language should all be given in the target language. This would make defining the elements of culture and addition of cultural information the most adequate techniques.

## 3.

At this point an analysis of three English expressions (walk in patient/making an appointment, patients and clients and patient centered medicine) and their translations into Croatian is offered. This analysis attempts to show the differences in the prototypical construal that these expressions favor in the two versions of healthcarese, and in the overall construal of the healthcare process.

To the unsuspecting eye, the term 'walk-in patient' seems relatively easy to translate into Croatian: a walk-in patient is a patient without an appointment; in Croatian we can call this person 'nenaručeni pacijent'. To make an appointment, therefore, is 'naručiti se'. The problem with these translations is that there are subtle differences in which the scene of making an appointment is conventionally construed in the two languages. In the UK making appointments is a usual process in seeing your family doctor. Whenever you do see a doctor, you do so by appointment (unless it is an emergency, and most emergencies are handled through the accident and emergency department). Moreover, when you have an appointment you "you have arranged to see (...) [someone] at **a particular time**",[5] and this time is closely adhered to by both the patient/client and the doctor. In the UK it is the walk-in patients that are the exception and not the norm (according to some estimates only around ten percent of patients do not have appointments). Finally, making an appointment is a two-way process, in which the patient/client has an important say: it is **you** (in the Collins-Cobuild definition) who does the arranging.

On the other hand, in the County of Koprivnica-Križevci, which is predominantly a rural area[6], appointments in GP practices are an exception. Although all practices have

[5] In Collins Cobuild Dictionary of English on CD ROM (Lingea Lexicon ver. 3.1.), the third meaning of the word 'appointment' is: "If you have an **appointment** with someone, you have arranged to see them at a particular time, usually in connection with their work or for a serious purpose".

[6] Out of the population of roughly 127,000, only about 1/3 lives in three urban areas (Koprivnica, Križevci and Đurđevac).

computers with an automatic appointment system, only two out of fifteen practices (visited randomly throughout the County) ever use it. The reason given for this by the GPs is that they have patients who are used to walking in, and who, even when they are given a time (primarily for follow-up), do not keep to it[7]. Moreover, it is also quite revealing that 'naručiti se' is a non-reciprocal process in Croatia, and refers to the patient being **given a time** when to come to see the doctor[8], typically with no regard for the patient's time.

Next, we have the problem of referring to patients as 'clients' in healthcarese. This again seems a pretty straightforward translation: 'patients' are 'pacijenti', and 'clients' are 'klijenti'. In this patient=client view of healthcare, "a client of a professional person [=healthcare professional] or organization [=hospital] (...) receives a service from them in return for payment".[9] Many Croatian doctors and nurses in the county laughed at the Croatian terms as used in the translations, and used them only tongue in cheek. The reason for this can perhaps be best explained as put by one of the Croatian doctors: "If we have 'clients' as opposed to 'patients', how are we supposed to treat them?" This important question shows a distinction between the Croatian and UK conceptualization of medicine, both evident in the respective variants of healthcarese. The term 'client' in UK healthcarese favors viewing medicine as a service-providing activity, where clients have certain rights and liabilities (e.g., see The Patient's Charter at http://www.pfc.org.uk/medical/pchrt-e1.htm). Croatian perpetuates the conceptualization of the passivity of the patient, and a lack of choice on his/her part.

Finally, the medicine that the healthcare professionals in the UK practice is in healthcarese called 'patient-centered medicine'. This readily translates into Croatian as 'medicina usredotočena na pacijenta'. It seems from the reports of the UK consultants that the expression 'patient-centered' has the status of a unit (in the sense of Langacker 1987) in healthcarese. Its meaning is connected with two matters. The first one is the contrast of patient-centered medicine where the patient is treated (holistically) and medicine that does not center on the patient, but on his/her disease or condition instead. The second matter reinforces the first, and has to do with the way that the healthcare process is organized: the patient/client need only (physically) come to one place, and all necessary procedures are performed on the spot. 'Medicina usredotočena na pacijenta', on the other hand, is an expression that does not have unit status in Croatian: it is a unique construal. Therefore, neither one of the two facts reflected in the English conceptualization is all that apparent: medicine often does center on the patient's condition; and the healthcare process is organized in a completely different manner: in Croatia the patient has to (physically) move in order to have all the necessary procedures done.

[7] This invites speculations concerning different time construal in Croatia and the UK.
[8] Very often this does not include a time of day, but only a particular date (see note 7).
[9] Cf. headword 'client' in Collins Cobuild Dictionary of English on CD ROM.

## 4.

The above examples show a different conceptualization of medicine, visible in the different scene construals in the two languages. In the UK the prototypical conceptualization of the patient is as a client with certain rights and liabilities. The client, standing on an equal footing with the healthcare professional, is entitled to the best possible service. This service is to be provided in such a manner that it treats the patient holistically. The UK version of healthcarese, to put it semantically, favors conceptualizing the patient as an agent: his role in the treatment is an active one. In Croatia, on the other hand, 'pacijent' is an 'undergoer'[10]: a passive entity in the healthcare process. Furthermore, it is not the patient that is treated, but the particular disease within him/her. The footing is completely unequal: the doctor has all the power; in certain cases (walking-in, doctor-patient communication) we could venture into calling it a power game[11].

Keeping in mind that the texts were written for a healthcarese-speaking receiver, the first problem for the translator is **recognizing** the difference in the conventional scene construal between 'making an appointment' and 'naručiti se'.[12] In order to overcome this difference (in view of the fact that precision is important in this particular context of the situation) the translator would need to use the technique of defining and adding information. The problem is that the information that would need to be added greatly surpasses in quantity what is considered to be acceptable. In the second case (patient=client), contruals in both cultures are the same outside healthcarese, but are regarded as inadequate by Croatian healthcarese-speaking receivers. Additional information would again be required (saying that patient=client construal is usual in the UK). Finally, in the third construal ('patient-centered medicine') definition and additional information are necessary.

These and all other problems which are a result of differing conventional conceptualizations would have been dealt with in the implementation phase of the healthcare reform project in the Koprivnica-Križevci County, in a process known as 'change management'. In the Croatian healthcare system, change may indeed be for the better, and may finally result in better service. The catch is that 'better service' is also a conceptualization. The main task of change management is introducing new concepts and creating new construals in which these concepts are seen as better than the existing

[10] Many doctors, indeed, believe that their aim can be achieved without communicating with the patient (Kryžan-Stanojević 1996:269).

[11] This power game is also very much visible in the doctor-patient communication (cf. Kryžan-Stanojević 1996). For a more general treatment of the dangers of medicine (very often expressed in highly debatable terms) see Illich 1977. Especially interesting is the part dealing with the relation of culture and healthcare, pp. 133-210.

[12] Notice that "biti naručen" shows the passivity of the construal on the linguistic levels as well as the conceptual.

ones[13]. Change management, therefore, perpetuates a certain conceptualization of the world.

## 5.

In medicine this may not be a great difficulty. Medicine as we know it is an empirical science, which relies heavily on certain indicators to show its results. And although the choice of these indicators already favors a certain construal, our western-world conceptualizations of the aims of medicine from the times of yore (starting with the Hippocratic Oath) have not been that different. The issue, however, is much more problematic if we venture into change management in other areas of life, where the specific culturally-dependent conventional conceptualizations may differ considerably. Going back to the introduction, for example, political dialogue, democratization and civil society are all areas in which Croatia is to receive help. Undoubtedly, change manage-ment will have to play an important role here in making Croatia more 'European': changing conceptualizations into those more palatable to the European Union, which means moving towards *less different* in the cultural sense. Here, the issue of ethics of change is essential.

Moving towards the less different, though, does not present such a bleak prospect. The most apparent advantages here concern translation: scene construals and conceptualizations being closer, translation should become easier. In the meantime, however, culturally-specific scene construals remain a problem, or shall we term it a blessing: it is all merely a matter of conceptualization.

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[13] This is where axiology comes in (for a cognitive treatment of axiological terms see e.g. Krzeszowski 1997).

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# PREVOĐENJE KULTURE U ZDRAVSTVU

Prije pridruživanja Europskoj uniji Hrvatsku čekaju mnogi izazovi. Jedan je od ovih izazova i reforma postojećeg zdravstvenog sustava, koja je započeta pilotiranjem novoga sustava na području Koprivničko-Križevačke županije. Konzultanti iz Velike Britanije predlažu uvođenje mnogih novina u zdravstveni sustav, te je, dakako, za razumijevanje tih novina od strane hrvatskih praktičara «na terenu» prevođenje od ključnog značaja. U ovome će se radu na osnovi triju primjera engleskog administrativnog jezika i njihova prijevoda na hrvatski pokušati pokazati da se prototipne konceptualizacije zdravstvenog procesa u dvije kulture uvelike razlikuju. U navedenom doticaju kultura javljaju se dva problema, oba ključna u nadolazećem procesu pridruživanja Europskoj uniji. Prvi se odnosi na prevoditeljevu svijest o postojanju implicitnih kulturnih referenci, a drugi, bitniji, na etiku mijenjanja kulturno-uvjetovanih konceptualizacija.