

Karin Band

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Karin Band is a sort of guru among her colleagues in the ITI Medical Network. Over and over again she displays amazing knowledge and creative skills when helping colleagues to find the correct translation of obscure or awkward terms. She draws on her long-standing terminology and search skills, as well as on her knowledge of Latin, to provide insights and solutions, even in languages which are not her working ones. She has been a translator and conference interpreter, working from German and French into English, and from English and French into German, since 1959. Her mother tongue is German; however, for the past 40 years the language she habitually uses has been English. This is why she does not work into German in the written medium any more. Karin has wide experience in planning and teaching medical English courses to translators and interpreters. We consider her approach and achievements in this area to be extremely valuable and focus on them in this interview.

Luisa Fernández Sierra: Hi Karin, thank-you for accepting this interview. Could you tell us briefly what drew you to the medical translation world? Was it just chance or vocation?

Karin Band: Hi Luisa, and thanks for conducting this interview. To answer your first question very briefly: I had meant to read medicine, but later decided against a medical career, for personal reasons; then found, quite by chance, that one could train as a translator or interpreter. I eventually found a way of combining my two life-long interests – medicine and languages.

L.F.S.: One of the best-known things in your career are the courses you have been running for medical translators. Could you tell us about them, with an emphasis on the format and the content of the courses?

K.B.: The courses you are referring to have a long history. It all started with the Medical Module of an English Update Course for conference interpreters, at the Polytechnic of Central London (now the University of Westminster), back in 1986. That course had an interesting format, with lectures by various experts in the mornings, and linguistic work in the afternoons. It struck me that it had great potential for the training of medical linguists (translators as well as interpreters), but that it should, ideally, be held in a clinical environment, with ready access to doctors and allied health care professionals, audiovisual material, etc. When the Poly decided not to repeat the course the following year, I approached a London teaching hospital. The Postgraduate Dean gave his permission, and CMETI (the Course of Medical English for Translators and Interpreters) started in 1987.

The format was maintained throughout the 11 courses I eventually organized: the first two days (of each two-week course) provided an overview of the problems of medical translation and interpreting, as well as a discussion of problem-solving strategies, and an introduction to the medical school library. After that, we had two lectures in the mornings, followed by a terminology wash-up session in the afternoons (where we looked at

interesting terms and phrases used in the morning's lectures) and work on French texts that had been sent out, with English and German background material, prior to the course.

The lectures and the texts were not necessarily related. The texts were used as an additional means of acquiring subject knowledge, and would therefore be taken from fields not covered by the lectures. Occasionally, a text and a lecture were related, and the lecturers were invited to comment on the translations that had been produced in class.

L.F.S.: Did you at this point contrast terms and register between the texts in the two languages?

K.B.: In the wash-up sessions, we would look at major differences and pitfalls such as *faux amis*, or the use, by the French, of an anatomical nomenclature (the *ancienne nomenclature*) that is very, very different from the nomenclature currently used in English. Idiomatic phrases and slang used by the speakers would be commented on. In fact, once we had instituted a system of comprehensive glossaries issued after the course, the wash-up sessions were used to draw attention to aspects that are less easily dealt with in a conventional glossary.

The translation texts were chosen to form a graded system, ranging from newspaper articles on medical subjects, through patient information material, to papers written for scientific journals or for medical conferences. This was done in order to provide an idea of the different registers and styles that medical linguists will need to handle.

Speakers were asked to pitch their lectures at the level of medical undergraduates (i.e. not to "talk down" to us), and to agree to answer questions. Over the years, certain refinements were added. The introduction to the problems of medical translation and interpreting was based upon a worksheet, with answers provided afterwards on a separate sheet. The terminology wash-up sessions were augmented into a formal glossary, provided after each course, with French and German equivalents of the terms and phrases used in the lectures.

In 1997, the course was transferred to new premises, and running CMETI became difficult due to infrastructural problems of all sorts. So the 1997 CMETI was the last in the series.

Late in 2000, I was contacted by colleagues in France, in the SFT, to see whether I would be prepared to run a similar course in Lyon. They would do all the recruiting of participants and speakers, and, in fact, all the administrative work involved. All I would need to do was teach. I agreed, and SAM (the *Séminaire d'anglais médical*) has run annually from 2001 to 2005.

L.F.S.: That really covers a lot of ground. So, your course was designed for people already working as medical translators and perhaps mainly for linguists working in the medical field. Do you think that the SAM/CMETI model could be applied to translation undergraduates? There is some debate going on at

Traductora médica. Las Alpujarras (Granada, España).

university level in Spain regarding the best approach to train future translators—the “generalist” versus the “specialist” approach. Some think that the 4-year undergraduate course is insufficient to properly train medical and science translators, especially bearing in mind that the people doing translation come from the “humanities” and have no scientific background whatsoever. It might seem a Herculean task to cover all the ground required in a few hours a week. What are your thoughts on that?

K.B.: CMETI was not designed specifically for people working already as translators, nor for linguists already working in the medical field. I always thought that it would be useful for complete beginners – final-year students or recent graduates – to see what translation in general, and medical translation in particular, involves. Those who had no experience of medical translation were warned that the course might put them off doing this kind of work, but reassured that the principles taught could be applied to any subject area. By the way, there was very little “theory of translation” – about a quarter of an hour, on the second day. To my way of thinking, there are really only two principles: Martin Luther’s dictum “*Man muss [dem Volk] auf das Maul sehen*” (“You got to say it like they say it”), and Lewis Carroll’s “Take care of the sense and the sounds will take care of themselves.”

Regarding the generalist versus specialist argument, as I said earlier, we were trained to be “general” translators, but had to have a field of specialization as well. Also, I used to work as a “generalist” for many years. Much of what I came across in that practice has been useful in the medical work I am doing now. For example, there is a lot of mechanics and metallurgy in orthopaedics – because of all those joint replacements, etc. And in simultaneous interpreting, all sorts of things can come in unannounced, and it is useful then to have experience of a wide variety of subjects. The advantage of being a “specialist” is, of course, that one has a certain knowledge base (which may, however, need broadening, and will certainly need updating from time to time). Since one does not have to read one’s way into a new subject every time, one can accept shorter translation deadlines, or accept conference interpreting jobs at shorter notice. And working in a field that one knows is more stimulating and intellectually more satisfying.

Students coming from the humanities will have to accept that, if they want to do scientific translations, they will need to study the subjects – engineering, medicine, agriculture, whatever. And this acquisition of knowledge will be required for every translation and every conference the individual linguist decides to accept.

As regards the last of your questions, I see no reason why the SAM/CMETI model should not be applied to other fields.

L.F.S.: This leads us to another hot topic. In David Shea’s interview in the last issue of *Panace@*, Peter Newmark said that in general he thought a doctor would produce a better result than a translator in a medical text. Do you agree?

K.B.: I am asked sometimes whether, in order to be a medical translator, one should have been to medical school. In other words, do trained doctors make better medical translators? Obviously, having had a thorough grounding in anatomy, physiology, pathology, and all the other -ologies is an enormous advan-

tage. The same goes for a knowledge of medical discourse – the way medics talk. However, medical translation may involve a level of knowledge that a young doctor, or a GP, has not acquired; and even a consultant may have problems when working outside his or her specialized area. An orthopaedic surgeon may not find a cardiology text all that easy, and a cardiologist may struggle with the minutiae of joint replacement. Also, doctors may not have sufficient linguistic competency. I have known health care professionals to commit absolute howlers in their translations, or to provide terminological advice of questionable quality. When all is said and done, the requirements are the same for translators with, and those without, medical qualifications: they have to have subject knowledge, and they have to know their languages. Obviously, doctors also have to master certain skills – giving injections, performing surgery, etc. As a “simple” translator, I do not have to have these skills; however, I would need to be able to describe what happens, say, in the course of a surgical procedure; and the description would need to be in the sort of language a surgeon would use. Doctors and translators alike need to keep up with technical and linguistic developments – both medicine and language have changed a lot over the last 30 or 40 years.

L.F.S.: Getting back to SAM/CMETI model – it seems like the lectures given by the doctors were a key factor in the programme. How long were the lectures and what kind of topics were addressed by the doctors? Maybe you can give us some examples of lectures you remember as particularly successful, and the way you structured knowledge acquisition.

K.B.: There were two slots each day – a 1-hour one, and a 90-minute one. Something like the structure of the skin could be dealt with in an hour; a subject such as HIV/AIDS would be assigned a longer slot.

Over the years, we covered a large number of subjects. To quote just one year’s timetable: in 1996 we had lectures on pain, analgesia, anaesthesiology, embryology (general and cardiac), congenital cardiac malformations, immunology, immunodiagnostic techniques, allergy, the anatomy of the eye, eye disorders, helminthic disease, drug dependence, and maxillofacial fractures (internal fixation). The translation texts were about a nursing technique for premature babies (newspaper article), cholecystography (patient information), ports, the etymology of *chlore*, wasp stings, pruritus (clinical case), and oncology in the 20th century.

Obviously, not everything could be covered. However, as the 1996 syllabus shows, a structured approach to the subjects was used: anatomy (or even embryology) and physiology first, then the disorders and their treatments. This is how medical students learn medicine, and how non-medics should go about acquiring subject knowledge. Participants were encouraged to do some background reading themselves, and lecturers were always willing to answer questions in class. The lecturers also seemed to find the right level more or less instinctively, and were amazed at how profound some of the questions from the students were.

L.F.S.: This sounds really interesting and a model universities and translators’ associations could draw on to design their own courses. What do you actually teach in the SAM programme?

K.B.: Virtually the same as at CMETI – the problems, the problem-solving approaches, and terminological issues arising

from the various lectures. We have also covered such linguistic subjects as figurative language in medicine, transcultural problems, and anatomical nomenclatures.

L.F.S.: Could you tell us a bit more about how problem-solving strategies are addressed in the course? What are your favourite sources of information? How does one judge if a given source is reliable or not? I think that Google and the Internet have dramatically changed the way translators go about solving terminological problems.

K.B.: To my way of thinking, the basic principle of translation – any translation – is that the translator has to understand what the author is saying, and to produce a translation that “says it like they say it” (where “they” is the user of the translation).

Therefore, problem-solving strategies are designed to familiarize the translator with the subject matter of the text, and with such other aspects as text formats (the style of a French patient information leaflet will be different style from that of a leaflet on the same drug or procedure written in an English-language country), register (different levels – e.g. lay audiences, patients, health care professionals – have different styles and terminologies), and cultural aspects (political correctness, food items in dietary instructions, etc.).

Students are advised (1) not to trust the bi- or multilingual medical dictionaries (many of which are suboptimal, to put it mildly); (2) to use monolingual dictionaries for definitions; and (3) to work from parallel texts. At CMETI and at SAM, the texts to be translated have been accompanied by similar material (e.g. patient information leaflets, case reports, textbook chapters) in the target language. I also insist that students study any target-language references cited in journal articles or textbook chapters. From the very earliest CMETI, I used to take most of my private library of textbooks to the course venue, to enable the students to see how much information can be obtained from the actual medical literature (as opposed to dictionaries), and to do terminology exercises by looking at the same subject in English, French, and German textbooks. My “desert island” textbook is *The Merck Manual*, which is several textbooks rolled into one. I use (and recommend) it as a source of technical information and as a guide to style and terminology.

Nowadays, of course, there is the Internet, and I do not know what we did before we had Google. However, the big problem with this resource is how to tell the authoritative sites from the poorer ones. The answer is that, in order to judge the quality of a site (or, for that matter, any other resource) one has to have a certain amount of knowledge. And this knowledge will need to have come from conventional printed or oral sources, which are still indispensable. To give you just one example: There is a *Gray’s Anatomy* available, free of charge, on the Web. What is not immediately obvious is that the edition on the Web dates from 1918. Many of the terms have changed since then; new structures have been discovered; and the illustrations in the current 39th edition (2005) are infinitely better. However, in order not to fall for the outdated edition, one would need to be aware of what is there now.

One absolutely essential source of information, to my way of thinking, is what I call “humanware” – people: the author(s) of a text, university professors, doctors, anyone that could provide a definition of a term or an explanation of a passage that is less than clear. The Internet is extremely helpful since it often

supplies contact details of human informants.

L.F.S.: Interesting about *Gray’s* on the Internet. I was not aware of that myself. I totally agree with you about the value of people’s expertise over other sources. Lists like Medtrad or ITIMed are witness to this.

Turning to another issue, you mentioned the importance of knowing about register and the cultural aspects involved in a translation; how about style issues?

K.B.: Any translation should “read right.” That means that the grammar and syntax must be correct, but also that the translation should sound as if it had been written by a native user of the target language. In order to achieve that, certain changes may have to be made. I did mention patient information leaflets earlier on. In the English-speaking countries, this material tends to be written in short sentences using short, simple words. In French, the sentences will be longer and more “elegant.” When working from French into English, one will have to simplify the terminology and phraseology and, very often, break up sentences. The converse is, of course, true when going into French.

The different text formats – newspaper articles, patient information leaflets, case notes, histology reports, prefaces – all have their own style, which can and should be learnt from similar material in the target language. I once had to translate a French obituary, which required major transformation, since a direct English rendering of the French style would have been unbearably verbose and cloying.

L.F.S.: Yes, your comments apply to Spanish and English as well. It is interesting to reflect on this from the cultural point of view. Some years ago there was a more definite difference between what “good” scientific style was in English and Spanish. We used to read Spanish scientists who wrote clearly but with long sentences, clauses within clauses and plenty of synonyms. However, the influence of the English concept of “good scientific writing” might be migrating rather unconsciously to other languages to their detriment. Many Spanish researchers are now beginning to write in Spanish in a dry, soulless style: direct order, plenty of full stops and very short sentences. Soon we will all be using this “controlled” language style to the delight of machine translation companies.

Finally, would you like to tell us about your best and worst moments in your career?

K.B.: I have many happy memories, of conferences that went well, translations that were appreciated by clients, feedback from courses I had run. I think one of the highlights of my career was receiving the John B. Sykes Prize, from the Institute of Translation and Interpreting. The announcement came completely out of the blue, and I was very, very pleased.

The worst moment – perhaps we should draw a veil over that. In a career spanning almost 50 years, there will have been hitches and glitches and, sometimes, worse. However, overall, it has been a great time. And for this I am grateful to my parents, who provided the necessary genes, to my teachers, who equipped me for this profession, and to my colleagues and students, from whom I have been learning throughout these years.

L.F.S.: Thank you very much, Karin, for your time and thoughts.

K.B.: Thank you, Luisa