Medical humanities and translation

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In loving memory of my father,
who, while living with Parkinson’s disease,
remained an enthusiastic storyteller in his native Catalan.

1 Introduction

In this chapter I will explore some of the intersections and entanglements between medical translation, as part of the established academic discipline of translation studies, and the interdisciplinary and intercultural field of medical humanities. I will do so both from historical and contemporary perspectives. Professional medical translators have traditionally focused on biomedical science, a top-down, standardised and autonomous body of knowledge that has dominated medicine and healthcare for a long time. However, biomedical science is the result of often complex historical processes and exists in socially, culturally and linguistically rich and varied contexts. Beyond its professional dimension, translation can also be understood in broader terms, both as an educational tool for health professionals and as a critical frame of analysis, as this chapter will demonstrate. In an era of growing automation and machine translation, my aim is to broaden the topic of health and medicine within the field of translation studies, foreground the human factor, and expand the frame of critical thinking. With this aim in mind, I will first outline the historical perspectives which have preceded biomedical science, with an emphasis on language and translation. Then, I will turn to more recent times, during which the evolution towards a more holistic and humanised view of medicine and health has been accompanied by the emergence of personalised and translational medicine. Medical humanities and some of its entanglements with translation will be the next step in my overview. In the last few years, medical humanities has widened its scope to include critical and reflective factors, which offer an expanded framework for a more proactive presence of the humanities – and consequently, of translation – in the forging of medical and healthcare knowledge. Finally, I will argue that narrative medicine, one of the main contributions of medical humanities, is opening up a rich seam to be mined for translation practice and research.
2 Historical intersections

A paper published recently in *Le journal des médecines cunéiformes* (Arboll 2019) reports on a 2,700-year-old cuneiform tablet from ancient Iraq written in Akkadian, describing medical treatments, and containing a drawing of a demon which Assyrians and Babylonians called Bennu, and which was thought to cause epilepsy. It is the earliest illustration of devilish associations with this condition. The term *bennu* might also have been used to describe ‘convulsions’ (Arboll 2019: 5). At the time, healers were responsible for expelling what they understood as supernatural forces and treating the medical symptoms they caused with drugs, rituals or incantations. The Assyrians and Babylonians believed that there was a connection between the moon, epilepsy and insanity (Arboll 2019). They also believed that the one who knew the true name of things, and of the demons that modified them, possessed magical powers; by pronouncing the true name of a thing one would become the master of it and could rule over it (Lain Entralgo 1958: 47). The power of naming things and the art of the word – *ars dicendi* – are crucial aspects of both these ancient forms of medicine and the contemporary ones, although in different ways.

Before science reached the point when it became able to demonstrate the mechanisms of disease, supernatural forces often provided causal explanations. It was perfectly acceptable and believable to state that convulsions due to epilepsy – a neologism originating in classical Greece with which we now name the disease – were in fact caused by the gods, or indeed, in some cases, by the devil himself.

The oldest detailed account of epilepsy is on a Babylonian tablet dating as far back as at least 2000 BCE. According to the Cuneiform Digital Library Initiative, the earliest known medical text dates from the third dynasty of Ur (also c.2000 BCE) and is written in Sumerian. Other early (14th century BCE) Sumerian texts have been found at Hattusa (Boğazkale, Turkey), but it is not known whether they were originally composed in Sumerian or copied and translated from Babylonian originals – an open question that seems to suggest a very remote origin of medical translation.

From the viewpoint of medical humanities and translation, what is most relevant about this archaeological discovery is the critical importance of interpreting the meaning of the cuneiform tablet and its magical-medical content through a hermeneutically complex process of translation and exegesis. The whole of the first section of the paper mentioned above (Arboll 2019) consists of a semantic analysis of the Akkadian words referring to illness, diagnosis and symptoms, and the various translations into English provided by different scholars. One of the most frequently recurring expressions is ‘[Akkadian word] can be translated as [English word]’. Finding the meaning and making sense of the cuneiform writing require not only translation as a mere lexical tool to establish direct equivalences – in this case between Akkadian and English – but also a translational frame of inquiry in which remote concepts and explanations are critically scrutinised, re-contextualised, reformulated and brought to the here-and-now of new target readers.

In Western medical traditions, supernatural views of medicine can be traced back to ancient times through *The Iliad* and *The Odyssey* of Homer (8th century BCE), who composed his epic poems some four or five centuries before Hippocrates. In his seminal book *La curación por la palabra en la antiguedad clásica* (*The Therapy of the Word in Classical Antiquity*, 1958), Pedro Lain Entralgo, a Spanish psychiatrist and classical Greek scholar, outlined the presence and role of therapeutic speech in Greek culture. Together with surgical, pharmaceutical and dietetic methods, disease was also cured with charms, spells and incantations. Spells were linked to imperative or coercive intentions when trying
to modify phenomena, such as averting the action of a demon or staunching the flow of blood. Charms were used when the dominant intention was to plead for help from divine powers. In these pre-Homeric traditions, words used therapeutically could sometimes be accompanied by music. According to Lain Entralgo (1958), the use of such words in Homer’s epic poems was not always of a magical nature. Sometimes words were used to evoke in the patient a state of mind that would help them to cope with the effects of the illness. Both in magical and non-magical uses of the word the purpose of the healer was to achieve a psychosomatic change in the patient. In current linguistic terminology, these are examples of the performative power of language in action, language as a force capable of transforming minds and bodies. Current uses of language in healing include, for instance, cognitive behaviour therapy (CBT) and mindfulness in psychiatric medicine.

Plato recognised the therapeutic power of the word and its emotion-stirring qualities, and allowed it a place in his Republic (c.375 BCE). However, he excluded poets and playwrights from his ideal Republic, because he believed no good could come from words that excited passions and obscured reason. Aristotle, on the other hand, thought that emotional catharsis had therapeutic value. According to Lain Entralgo (1958), Aristotle’s Rhetoric (4th century BCE), a treatise devoted to the power of the word, may be considered as a therapeutic oratory. For Aristotle, any doctor whose words were capable of producing psychological reactions in certain patients similar to those of tragic poems, would be more effective than one who only considered therapeutic practice as a silent art: *muta ars*. In Aristotelian verbal catharsis, the action of the word can be of such intensity that it can work as if discourse itself were a drug (Lain Entralgo 1958: 338–343).

Just a few centuries after the inscription on the Akkadian clay tablet mentioned above, Hippocrates wrote *On the Sacred Disease* (c.400 BCE), where he dismissed the religious origin of epilepsy and other diseases in favour of natural causes accessible to rational thought and understanding:

> It is thus with regard to the disease called Sacred: it appears to me to be nowise more divine nor more sacred than other diseases, but as natural cause from the originates [sic] like other affections. Men regard its nature and cause as divine from ignorance and wonder, because it is not like to other diseases. And this notion of its divinity is kept up by their inability to comprehend it [...].

According to Dicciomed, the medical term prior to Hippocrates was *hìròs nòsos*, the sacred disease; and, one of the first tasks Hippocratic doctors undertook was to rename it avoiding any religious connotations. They adopted the medical term ‘epilepsy’ from Greek *epi-* (over, upon) and -*lepsi* (take). Even this intentionally more descriptive, biomedical word retains traces of its magical origins, as if sufferers were ‘taken over’ by some supernatural power. Interestingly, Hippocrates’ view of epilepsy as a brain disorder, and not as a divine punishment, did not begin to take root until the 18th and 19th centuries, the intervening 2,000 years being dominated by the earlier supernatural views.

The Hippocratic tradition thus departs from the magical and religious, focuses on the physical in its understanding and explanation of disease, and, despite Plato and Aristotle, abandons the possibility of curing by the word. *Physis*, the knowledge of nature in classical Greece, takes centre stage and medicine gradually becomes a *muta ars* – or, as Petrarch puts it, *herba, non verba* [herbs, not words]. Nowadays, the muteness of the corpses on which medical students get to know human anatomy shape their purely physical concepts about
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the human body during their university training. For centuries, this orientation away from words and discourse has greatly influenced healthcare, and in particular, doctor-patient communication.

The emergence of Hippocratic medicine as *muta ars* in classical Greece and its subsequent historical development driven by *physis* – and apparently excluding *ars dicendi* – eventually gave rise to current biomedical science. However, when examined from the perspective of the history of translation, medicine can hardly be defined as *muta ars* but its opposite, *ars dicendi*. Translation has been a historical driving force of scientific advancement. Over the centuries, the development of medical knowledge has depended on the transmission of discoveries and ideas through texts across languages and cultures, starting in Ancient Mesopotamia, which, at the moment, is as far back as we can go for material evidence. Modern science and medicine are indivisible from translation; in fact, they began as translation (Montgomery 2000). At every milestone, ‘translation was the key to scientific progress as it unlocked for each successive inventor and discoverer the minds of predecessors who expressed their innovative thoughts in another language’ (Fischbach 1993: 90). In historical terms, translation has been defined as the borrowing or appropriating of the findings of others (Delisle and Woodsworth 1995), a process that often involved innovation and further development, as is the case of Islamic medicine drawing on Hellenic medical tradition to form its own (Savage-Smith 1997). Likewise, medieval and early modern scholars in Europe drew upon Islamic traditions and translations as the foundation of their medical undertaking. It was through Arabic translations that the West learned of the Hellenic medicine (Savage-Smith 1997).

Historically, translation has always been entangled in the process of knowledge production, albeit in rather covert ways. In contrast with the so-called ‘diffusionist’ models of knowledge production and distribution, Delisle and Woodsworth (1995: 101) point out that ’The translators of history should not be regarded as passive conduits of specialised information, but rather as agents fully implicated in the works they reformulated in another language.’ The very process of circulation produces new knowledge. Wisnovsky (2017) argues that even when translators declare themselves to be faithful interpreters, individual acts of recreation and transformation inevitably occur during the process of translating a philosophical work from one language to another. Drawing on Aristotle’s categories of textual kinesis or motion, he shows that in Greek-Arabic translation of philosophical works in the Middle Ages, the interplay between translating, commentating/glossing and transcribing/copying has caused expansions, contractions and mutations in concepts and arguments that can explain some substantive developments of philosophy in general, and natural philosophy and medicine in particular. Focusing attention on the creative aspects of the reception of medical texts in other languages and cultures throughout history helps us to think more critically about the dominant diffusionist, instrumentalist and subservient view that reduces translation to no more than a conduit of previous knowledge.

3 Biomedical science and beyond

The biomedical model has been around since the mid-19th century and still dominates our scientific understanding of health and disease. It focuses on the physical aspects of disease (anatomy, biochemistry, physiology, pathology, genetics, etc.) and adopts a positivist stance in its search for objective biomedical truth, mostly ignoring non-clinical factors. It assumes disease to be fully accounted for by deviations from the norm of
measurable biological (somatic) variables (Engel 1977). Biomedical research provides data which health professionals can use when making decisions of all sorts, giving rise to Evidence-Based Medicine (EBM), which prevails in current approaches to diagnosis and treatment. In the biomedical model, a patient is seen as an object under treatment, a body that is sick and can be managed independently from its mind, family and social circumstances. Biomedicine is presented as a hierarchical, top-down, research-initiated model; it is deemed to be objective, standardised and eschewing cultural and experiential factors. Biomedicine has its own ontological and epistemological norms, and excludes other medicines and forms of knowing and understanding health and disease, such as those with traditional and local roots. In biomedicine, diseases are pigeonholed into categories in which a particular narrative, often predicated on a reductive or mechanistic account, dominates the discourse (Bowman 2014). This can lead to what Carel and Kidd (2014) describe as ‘epistemic injustice’ in healthcare: patients are vulnerable to the privileging of particular ways of describing illness or disease. This occurs, for example, when society as a whole, or health professionals in particular, lack the interpretative framework to understand particular experiences. For instance, this was the case in the 1960s, and later, with sexual harassment. Society did not acknowledge it and the behaviour of the perpetrators was typically tolerated and even excused. As a result, women were victimised, because the wider social context did not label such behaviour as sexual harassment (Carel and Györfy 2014: 1256).

In the past, translators mainly operated within the framework of biomedicine, owing to its economic and political power and prestige. They focused mainly on expert-to-expert communication, that is, on highly specialised text genres, in which the abstract language of biomedical research excludes the human, lived experience of patients and obscures the fact that where illnesses are unique, disease labels are classificatory terms only (Haggerty et al. 2003). That is why for decades, at least in countries such as Spain, trained doctors with some knowledge of foreign languages were at an advantage in the field of medical translation and led the biomedical translation market, whereas trained linguists and translators tended to be marginalised on the grounds that they did not have the disciplinary knowledge nor the terminological command required to understand and translate biomedical texts in an accurate and reliable way. The development of translation studies as a discipline and the provision of specialised training programmes have meant that more linguists are now involved in biomedical translation. Although these recent developments are encouraging, factual accuracy, conceptual precision, terminological equivalence and adherence to strict textual norms of the biomedical genres continue to be the core concerns of translators working in biomedicine, whether they are health professionals or linguists.

Between 1960 and 1980, George Engel, an American internist and psychiatrist, published a set of papers in which he outlined the limitations of the biomedical model and called for a new, more holistic approach, which he called the ‘biopsychosocial model’. Through this model, he introduced psychosocial factors which would be taken into account without sacrificing the advantages of the biomedical approach, so that patients would continue to be cared for from a disease standpoint, but, additionally, psychological and social information would be given equal standing in the care process (Farre and Rapley 2017). Subsequently, today’s patient-centred care (PCC) took these principles on board. Patient-centred doctors aim at eliciting and understanding their patients’ psychosocial context and perspectives, taking into account their ideas, concerns and expectations.
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(Epstein et al. 2005). They aim at reaching a shared understanding of the problem with their patients and involve them in decision making and management of their illnesses. Patient-centred care has galvanised some new thinking and prompted responses in translation studies, which I will come back to in the next section.

Two distinct, and sometimes opposing, perspectives constantly interact in clinical communication: that of health professionals, doctors in particular, and that of patients. Or, in Jürgen Habermas’ theory of communicative action (2015), that of expert systems and that of lifeworld (Lebenswelt), respectively. Both have their own particular motivations, expectations, resources, values, conceptual systems, discourses, stories, strategies for public presentation and social roles; and, this dichotomy of socio-professional cultures causes problematic asymmetries that can be understood and bridged in intra- and interlingual translation terms. Intralingual translation, or genre shift (Montalt and González-Davies 2007), is particularly relevant in some intergeneric relationships, such as between a Summary of Product Characteristics (SPC, a technical genre describing the properties and officially approved conditions of use of a medicine that forms the basis of information for healthcare professionals) and a patient information leaflet (a genre derived from the SPC typically aimed at patients taking medicines) (Montalt and González-Davies 2007; Ezpeleta-Piorno 2012). It is also relevant in translational medicine precisely because it can help to bridge the gap between experts who write the information they want to convey and their lay readers, who may require a register more suited to their needs.

In recent years, biomedical science has diversified into Personalised Medicine (PM) and Translational Medicine (TM). PM springs from the notion that, in biomedical and pharmacological terms, one size no longer fits all. PM can then be defined as targeted medicine. What at first sight might seem a radical move towards patient-centred care is, in fact, a biomedical model that uses characterisation of individuals’ phenotypes and genotypes (e.g. molecular profiling, medical imaging, etc.) for tailoring the right therapeutic strategy for the right person at the right time, and/or to determine predisposition to disease, and/or to deliver timely and targeted prevention. Personalising therapeutic strategies, and pharmacological treatment in particular, does not necessarily mean reinforcing patient-centred care or including the psychosocial factors mentioned above. No matter how much PM individualises diagnosis and treatment, it is still very much within the biomedical paradigm of muta ars. Patients are still the individual recipients and beneficiaries of biomedical innovation, the silent bodies that passively receive the targeted cure based on the best possible biomedical evidence. Biomedical translators are there to facilitate this impersonal, detached, and ‘neutral’ flow of information and knowledge. Their main objectives are to target specific groups of patients, or even to convey individualised diagnoses, prognoses and treatments.

Translational Medicine (TM) goes a step further than either Evidence-Based Medicine (EBM) or PM. It aims to transform scientific discoveries arising from laboratory, clinical or population studies into new clinical tools and applications that will hopefully bridge laboratory and clinical practice, and improve human health by reducing the incidence of disease, morbidity and death. It is focused on ensuring that proven strategies for disease treatment and prevention are eventually implemented within a patient population. Ensuring this translatability of knowledge involves encouraging the flow of information from the laboratory to the clinic (‘bench to bedside’), and from the clinic back to the laboratory (‘bedside-to-bench’). TM is based on the notion of knowledge translation (KT), whose aim is to bring pure scientific knowledge from ‘bench to bedside’, by testing...
its validity in clinical practice, while at the same time keeping the scientific knowledge ‘intact’ throughout the process of translation across various social fields and sectors of the healthcare system (Engebretsen, Sandset and Ødemark 2017). KT reflects a subordinate and mechanistic view of translation as no more than a conduit for knowledge dissemination, in which true scientific knowledge remains ‘uncorrupted’ after crossing multiple social, cultural and linguistic barriers. In translational terms, the ‘target culture’ (that of clinical practice and the sphere of the patient) is subordinated to the ‘source culture’ (that of biomedical research). The aim of the translation is to be a hermetically sealed container and a safe carrier of the original message from the source to the target culture. Engebretsen, Sandset and Ødemark (2017) critique TM in the following terms:

We maintain that KT relates to the ‘original scientific content’ as a double supplement. On the one hand, KT offers new approaches to the communication of scientific knowledge to different groups in the healthcare system with the aim of supplementing a lack of knowledge among clinicians (and patients). On the other, it demonstrates that a textual and cultural supplement, namely a concern with target audiences (clinicians and patients), is inevitable in the creation of an ‘autonomous’ science. This creates an inherent paradox in existing KT models – while these models presuppose that the principal duty of adequate KT is to implement the original scientific message in new social contexts and textual forms without altering its content, the same models, paradoxically, also state that it is through translational modifications and adaption to new audiences, i.e. through synthesis and development of guideline recommendations, that the message becomes scientifically trustworthy. Hence, translation both threatens and fulfills the original scientific message.

This paradox reflects the current entanglements between biomedicine and translation, and the need to think about them in critical terms. Further research is needed to expand the critique to the ‘bedside-to-bench’ dimension of TM. Translation-oriented research and critical thinking are also needed to address the issue of patients reporting outcomes in clinical trials through genres such as PRO (Patient Reported Outcomes). The patient is not only the recipient of a treatment in a clinical trial, but also plays an active role by contributing feedback in the form of personal experience on issues of interest to the pharmaceutical company. This subjective data, called health outcomes, is of vital importance in determining the benefits and risks of a drug, providing better understanding of diseases, improving adherence to a course of treatment and, most importantly for pharmaceutical companies, obtaining approval for a drug.

4 Medical humanities and its entanglements with translation

The increasing specialisation of the different branches of biomedicine, together with their growing social prestige and economic and institutional power, have caused a fragmentation of knowledge, a narrowing of perspectives on health and wellbeing, and a hegemonic relationship with other medicines and other ways of knowing about sickness and health. This reductionism has been identified as a driver of change in the direction of rebalancing between biomedicine and humanities: ‘[…] there has been a paradigm shift away from what might be called medical reductionism to medical holism, where patients are not reduced to diseases and bodies but rather are seen as whole persons in contexts and
in relations’ (Cole, Carlin and Carson 2015: 8). In the ‘Introduction’ to *Medicine, Health and Being Human*, Lesa Scholl presents her project as ‘a conversation between medical practitioners and researchers, alongside humanities and social science scholars, from across the globe, who are concerned about the narrowing of medicine to medical science that has been occurring since the early modern period’ (2018: 2). This monological (and largely monolingual, i.e. mainly in English) limitation of medicine to medical science has affected, in a somewhat negative way, how we currently understand, teach and research medical translation.

The move towards a more holistic, comprehensive and inclusive model of medicine and healthcare, together with a burgeoning interest in ethics and values, is the main driving force behind the emergence and consolidation of the field of medical humanities, more recently also called ‘health humanities’, in academia. In ‘The Almost Right Word: The Move from Medical to Health Humanities’, Jones *et al.* (2017) offer a detailed discussion on the name the field should adopt. They argue that medicine is but one component of health and wellbeing, and that health humanities is a more encompassing label than medical humanities, because it accurately captures theoretical and pedagogical developments in the education of health professionals. The publication of several peer-reviewed journals such as the *Journal of Medicine and Philosophy* (since 1976), *Journal of Medical Humanities* (since 1980), *Literature and Medicine* (since 1982) and *Medical Humanities* (since 2000) shows the vigour of the field and the successful expansion it has undergone in the last few decades.

The field of medical humanities provides an interdisciplinary approach to understanding and investigating the effects of illness and disease on patients, health professionals and the societies in which they live and work. Medical humanities includes areas as diverse as medical ethics and law, pedagogy in physician training, medical anthropology, narrative medicine, history of medicine, cultural studies, science and technology studies, sociology, economics, philosophy, literature, theatre, film and visual art. In the introductory chapter of *Medical Humanities. An Introduction*, Cole, Carlin and Carson (2015: 12) define medical humanities as follows: ‘[…] an inter- and multidisciplinary field that explores contexts, experiences, and critical and conceptual issues in medicine and health care, while supporting professional identity formation’. In *The Edinburgh Companion to the Critical Medical Humanities*, Whitehead and Woods (2016) synthesise these elements in what they call ‘the three Es’ of medical humanities: Ethics, Education and Experience. Translation and multilingual communication intersect with these main components of medical humanities in a variety of ways, as I shall explain below.

Perhaps the most long-lasting of these intersections is the translation of the works of doctor-writers who have written about the great dramas of human existence and the practice of medicine, such as John Keats, Anton Chekhov, Arthur Conan Doyle, William Carlos Williams, Oliver Sacks, and Nawal el Saadawi. The study, translation, adaptation and staging of the works of playwrights such as Shakespeare (Montalt 2015, 2016), who used the medical knowledge of their time to reflect upon the connections between body, mind and emotions in their characters, is another fruitful area which crosses disciplinary boundaries.

Medical humanities strives to better understand contexts and bring to the fore critical and conceptual issues in medicine and health. In this endeavour, translators are well placed, since they are aware of the usefulness of text genre, a notion that helps them to critically understand language in action and the connection between text and context.
Beyond the naive, uncritical idea that medical language is uniform, univocal and non-rhetorical, translators tend to be very discerning, both within a given language and between different languages, of its great textual and terminological variability and intentionality. They understand the influence that the situations and contexts in which texts are embedded exert on both ‘original’ writing and translating. Formal and critical analysis of the myriad genres used in medical and health communication in multilingual and multicultural settings is paramount for translators; first, to become aware of the variations between genres, not only in different languages and cultures, but even within the same language and culture; second, to accommodate their target texts to the implicit and explicit norms of what is considered adequate and acceptable in a given context. In addition to the down-to-earth uses of genres in translation practice, such as the use of parallel texts for different purposes, medical humanities can nurture other critical perspectives on genres, in particular their historical and ethical dimensions. Text genres are dynamic rhetorical constructs. The genres we are familiar with today are the result of social and textual developments throughout time. Take, for instance, a biomedical research article. Scientists in the 18th and 19th centuries did not report their findings in the same form as they currently do. What we understand by a research article at present is the result of many diachronic changes that have shaped it structurally and rhetorically into a highly useful tool for creating and spreading knowledge, and also for establishing given conventions that affect writer-reader interactions and hierarchies. In addition to this historical dimension, different text genres have different ethical priorities. Ensuring that experiments can be repeated through the provision of detailed and accurate explanations is a central issue in an original article (OA), but in a patient information leaflet (PIL), comprehensibility and reliability of information take centre stage as ethical priorities, which affect the notion of quality as well as the methods and resources to achieve it.

Communication with the patient is the origin of mainstream medical humanities, which is rooted in ethical principles and is closely linked to patient-centredness. Ethical considerations are important in areas such as access to healthcare through adequate provision of information and means of communication, decision making and informed consent in clinical practice, participation in clinical trials and end-of-life care. In all these areas, communication plays a central role; and, the medical consultation, with its doctor-patient interactions, is the central genre of healthcare in which many of these ethical issues unfold. Expert-lay translation (Askehave and Zethsen 2002), intralingual translation (Zethsen 2009, 2018) and patient-centred translation (PCT) (Montalt, 2017a) are developments which are linked with the more holistic and ethically-oriented approach to medicine and healthcare promoted by medical humanities. In PCT, for example, the target patient’s perspective takes centre stage. It aims at empowering patients by making texts comprehensible and empathetic through grammatical, terminological, stylistic, textual and pragmatic choices as well as by the use of non-verbal resources, such as diagrams and drawings. It takes into account educational backgrounds, clinical situation, specific needs, and preferences in the presentation of information of both individual and well-defined subgroups of patients. Intralingual translation (Zethsen 2009) is a fundamental component of PCT, which relies on constant testing and feedback from real target patients (Montalt 2017a; García-Izquierdo and Montalt 2017).

Another area that intersects with medical humanities’ ethical dimension is translation and multilingual communication in crisis situations – from climate-change-induced disasters to wars and pandemics – in which there is a growing awareness of the moral need to respond in a spirit of international solidarity and collaboration. Translation in
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crisis scenarios is becoming a global priority. Federico Federici, a leading researcher in this emerging area of translation studies, sees an ‘urgent need to establish a concerted and multidisciplinary debate on the role of intercultural communication in international multilingual missions that respond to emergencies across the world’ (2016: 3). In *Intercultural Crisis Communication. Translation, Interpreting and Languages in Local Crises* (2019), editors Christophe Declercq and Federico Federici address diverse issues of multilingual, multicultural and multimodal infrastructure in all stages of the crises. This collection includes a contribution in the field of medical translation where three main components are established to plan for the complexity of medical and health communication and translation in such critical situations: *logos, ethos* and *pathos* (Montalt 2019). *Logos* (Greek word for ‘reason’, ‘discourse’) refers both to content and communication logistics. The focus is on accuracy, reliability and clarity of the medical content and the terminology of the messages. Paramount here are logistics and accessibility, and more particularly, the rational organisation and distribution of relevant information, the creation of effective messages and coordinated communication, using the most appropriate resources. *Ethos* (Greek word for ‘attitude’, ‘character’) refers to the set of values and attitudes of a particular individual or group, and the ethical codes that regulate multiple professions (translators, interpreters, doctors, nurses, etc.) and communication in crisis scenarios. *Pathos* (Greek word for ‘suffering’) brings to the fore personal and collective suffering and empathy. Feelings and emotions should not be overlooked nor removed from the logos and ethos dimensions in multilingual and multicultural communication in crisis scenarios. Medical humanities can contribute to the much-needed multidisciplinary debate on how to respond to crises and enhance the human factor.

Education is another principal interest of mainstream medical humanities. It focuses on new curricula and educational materials, which aim to draw on the perspectives and methods of inquiry of the humanities and social sciences, and bring them into medical and health education (Whitehead and Woods 2016). The link between medical translation and the training of doctors in communication skills can be illustrated in a recent study (Bittner *et al.* 2016), in which 57 medical students from German universities participated in the following experiment: 25 of them translated medical documents for real patients on a platform using plain and understandable language, while the other 30 did not translate such documents. All the students then engaged in communicative interactions in a virtual consultation with six simulated patients, who connected via Skype and evaluated the students’ communication skills. Based on the transcripts of the conversations, an expert conducted a blind assessment of the communication skills of all 57 students. In addition, all participants answered a self-assessment questionnaire focusing on their own communication skills. According to the authors of the study, students in the first group (i.e. those who had translated patient documents) obtained a significantly higher assessment result than students in the second group, which shows that written translation of medical documents for patients is associated with significantly more frequent use of plain, comprehensible language in doctor-patient interactions.

That ‘all the world’s a stage’ is well known in the sociological tradition of Kenneth Burke and his theory of dramatism (1969), and Erving Goffman and his dramaturgical perspective in the study of social interactions (1978), as well as in the sociological understanding of health provision and health communication. In clinical interactions, patients play different roles from those performed by health professionals. Simulated interactions between patients and medical students aimed to enhance the latter’s communication skills have been developed by linguists such as John Skelton (2008). Role-plays
have been used in professional development programmes in multilingual and multicultural settings, such as the Building Bridges Programme of the Refugee Council (UK). The programme provides a useful model conceived for refugee doctors and nurses wanting to work for the National Health System in the UK that is transferable to other countries (Butt et al. 2019). Role-plays can also be used as a research tool to investigate mediated and unmediated interactions in consultation processes and informed consent. The GENTT (Text Genres for Translation Purposes) research team (Universitat Jaume I, Spain) has used this methodological tool in a number of funded research projects involving doctors, nurses, actors, interpreters, translators and linguists, in order to investigate the multiple dimensions of clinical interactions (non-verbal and verbal language, comprehensibility, ethics, empathy, implicit and explicit norms of the health system, cultural factors and medical content) in multidisciplinary teams.

Efforts to bridge the gulf between biomedical science and experience in the medical humanities can be seen in the distinction between pain and suffering (bodies feel pain but people suffer), as has been argued by Cassell in The Nature of Suffering and the Goals of Medicine (1998), and between disease and illness. Disease happens to bodies and is described and understood through biomedical science, whereas illness refers to what people feel and experience, and is understood through eliciting their stories. It is through language that both patients and professionals are able to shape and express what they experience in their own narratives. This will be explored in the next section in more depth, but first let me conclude this section by focusing on some more recent responses to medical humanities.

In the last few years, mainstream medical humanities has been criticised by some scholars (Viney, Callard and Woods 2015; Whitehead and Woods 2016; Kristeva et al. 2018) on the grounds that it has been limited to a subsidiary role of ‘repairing’, as a soft, ‘subjective’ and cultural supplement to a stable body of ‘objective’, biomedical and scientific knowledge (Kristeva et al. 2018), and that it should be proactive in embracing more fundamental issues of knowledge production. In ‘Critical Medical Humanities: Embracing Entanglement, Taking Risks’, Viney, Callard and Woods (2015) challenge the utilitarian model on which medical humanities is based, i.e. providing a service to biomedical sciences. They argue that it should intervene more explicitly in ontological questions, in particular, aetiology, pathogenesis, intervention and cure, rather than, as has commonly been the case, leaving such questions largely to the domains of life sciences and biomedicine (ibid. 3).

According to these critical scholars, this more radical programme should acknowledge the pathological and healing powers of culture, and consider the body as a complex biocultural fact. Issues of race and ethnicity, sexuality and gender, disability, mental health, technology and media, economics, and social and environmental inequalities are central to the production of medical knowledge as well as to the experience of health and illness (Viney, Callard and Woods 2015). Other key aspects in such a programme are non-medical notions of health, illness and wellbeing; rethinking of the concept of ‘evidence’ in healthcare; and, the acknowledgement that humanities and social sciences may play a more proactive, constitutive role in shaping such knowledge.

5 Narrative, medicine and translation

Interlingual translation in medicine deals with communication problems between and among patients and healthcare professionals interacting in different languages and with
different cultural backgrounds. However, difficulties can also occur when the language and culture is the same; intralingual translation helps – often unacknowledged – to bring participants together by adapting texts and contents for the lay reader. Narratives of patients and health professionals also make a contribution by bridging divides between them and by promoting mutual understanding. Patients and health professionals removed from their original societies, cultures and languages living in foreign countries often feel the need to make sense of – and perhaps modify their own systems of values and beliefs to accommodate to – the target healthcare system. Some of them may recount their experiences in oral, written or multimodal narratives, thus making their voices heard in the society. These in turn may prompt questions that not only mobilise conventional biomedical research but also contribute to a better understanding of illness and health. Biomedical research and healthcare can be seen as intertwined chains of translations and narratives. The entanglements between translation, narrative and medicine are the main themes of this section.

In his essay 'The Storyteller', Walter Benjamin (1986) states that the art of storytelling is reaching its end because the epic side of truth – wisdom – is dying out. This profound distinction invites us to think about the difference between biomedical truth and the wisdom in the embodied and culturally embedded experiences individual patients and health professionals have of that abstract truth – a wisdom that can be revealed through personal narratives.

The relationship between medicine and narrative is as old as ancient myth. Homer’s epic narratives in *The Iliad* and *The Odyssey* – the root and seed of Western civilisation and medicine of the last 25 centuries (Lain Entralgo 1958: 11) – contain some of the earliest ideas about health and illness that we have inherited from the past. In current scientific medicine, narrative, as opposed to argumentation or instruction, is a rhetorical strategy used to organise events chronologically – such as the course of a disease or the steps carried out in an experiment – in a number of genres, including the clinical case. In it, the author, typically a physician, gathers relevant clinical information about a patient, who is turned into a ‘case’, and translates them into a narrative with a conventionalised structure and form for their peers to read. Other medical genres also have a strong narrative element, such as original articles reporting on current biomedical research.

In recent times, some authors have expanded the links between medicine and narrative beyond the conventions of biomedical genres. Because of his humanistic approach to neurology and his ability to combine scientific accuracy with narrative excellence, Oliver Sacks is a good example to mention here. In the preface to *The Mind’s Eye* (2010), he states:

I grew up in a household full of doctors and medical talk – my father and older brothers were general practitioners, and my mother was a surgeon. A lot of the dinner table conversation was inevitably about medicine, but the talk was never just about ‘cases’. A patient might present as a case of this or that, but in my parents’ conversation, cases became biographies, stories of people’s lives as they responded to illness or injury, stress or misfortune. Perhaps it was inevitable that I myself became both a physician and a storyteller.

*Sacks 2010: ix*

His ‘case histories’, as he calls them, are based on real patients and told in non-academic narrative prose taking advantage of literary techniques to make them truly understandable and appealing to the lay reader. Thanks to their literary quality and readability,
Oliver Sacks’ narratives have been bestsellers for decades and have contributed to the public understanding of rare neurological disorders and how they impact on the lives of sufferers and their families. His patients are not presented simply as people displaying symptoms that require treatment. He is interested in their social, cultural and psychological dimensions and gives us authentic characters who come to life in the text.

More recently, the exploration of the links between medicine and the patient seen as a person has led to the development of narrative medicine in consultations. Rita Charon (2004) tells the story of one of her patients and summarises the essence of narrative medicine:

A 36-year old Dominican man with a chief symptom of back pain comes to see me for the first time. As his new internist, I tell him, I have to learn as much as I can about his health. Could he tell me whatever he thinks I should know about his situation? And then I do my best not to say a word, not to write in his chart, but to absorb all he emits about his life and his health. I listen not only for the content of his narrative, but for its form – its temporal course, its images, its associated subplots, its silences, where he chooses to begin in telling of himself, how he sequences symptoms with other life events. I pay attention to the narrative's performance – the patient's gestures, expressions, body positions, tones of voice. After a few minutes, he stops talking and begins to weep. I ask him why he cries. He says, 'No one has ever let me do this before'.

Her patient’s narrative revealed to Charon ‘the connections among his symptoms, his illiteracy, his failures as a breadwinner, his familial losses, and his life in an alien culture’ (2004: 863). In other words, through active listening and viewing she was able to understand not only her patient’s musculoskeletal symptoms from the angle of disease but also the complexities of his illness. Through observing the way in which the patient performed his narrative, she was better able to understand his most pressing concerns. Such performances – with voice, gestures and silences – provide relevant information about the patients’ feelings and emotions, attitudes and values, and their ability to make sense of (or misunderstand) what goes on in the interaction. Health narratives like this can help narrow the gap between disease (as a concept referred to by professionals) and illness (as the ‘same’ thing experienced by individual patients), between biomedical and lay discourses and terminologies. Narrative medicine focuses on active listening to patients’ accounts of their suffering rather than merely considering abstract pain as a symptom. According to Charon (2004), without the narration not only treatment but suffering, too, might be fragmented.

Narrative medicine has led to a resurgence of interest in writings both by patients and physicians (Shapiro 2012: 309). Beyond the oral interaction between patient and doctor in a consultation, patients have increasingly chosen to reclaim their voices from the healthcare system by telling their own stories on different platforms. This has also stimulated many physicians to cross the disciplinary and professional boundaries and to tell stories about their patients and about themselves both as doctors and, in some cases, as patients or relatives. In books such as Henry Marsh’s Do No Harm (2014), Atul Gawande’s Being Mortal (2014) and Paul Kalanithi’s bestseller When Breath Becomes Air (2016), doctors and surgeons share with lay readers and colleagues their anxieties and fears, insights and reservations, insecurities and ethical dilemmas. All these narratives have a clear educational value to help the medical professionals and trainees ‘[…] develop critical thinking, challenge facile assumptions, think more deeply about patients and themselves in relation
to their patients, become more aware of their and patient’s emotions, and ward off cynicism and disillusionment’ (Shapiro 2012: 309). They also offer non-specialists rare glimpses of the difficulties experienced by those practicing the art of medicine. Narrative medicine can contribute to humanizing healthcare, because it can provide a deep and therapeutic understanding of the people who display symptoms, as well as of the people who ‘treat’ them.

In addition to narrative medicine, the term ‘life narrative’ is used in the field of autobiographical studies. In Reading Autobiography. A Guide for Interpreting Life Narratives, Smith and Watson (2010) enlist more than 60 genres of life narrative, some of which are especially relevant to medical humanities and translation: addiction narrative (254–255), autobiography (256), case study (264–265), digital life stories (268), gastrography (271), or scriptotherapy (279). Patients’ autobiographies are becoming a very dynamic field of study. Emotional and spiritual healing may sometimes be as effective as physical curing. Holistic healing can be particularly useful in some cases of trauma. For example, pianist and public intellectual James Rhodes recounted his traumatic childhood experiences in the form of a memoir and shared it with the general public (2015). Rhodes launched into circulation a series of motifs, themes, styles, discourses, narrative structures, presentations of the ‘I’, and rhetorical strategies of all kinds, which can be used and adapted later by others to advance the process of discovering repressed causes of suffering when recovering from trauma (Montalt 2017b). Above all, his memoir suggests that it is possible to construct a personal and sincere voice that empowers others who decide to make their own audible, however scattered and incoherent this voice may seem on the surface. The coherence (and also the difficulty) lies precisely in the continuity between personal experience and the way the author uses language in the telling of his own story (ibid.).

Many teenage cancer patients relate their experiences in online blogs. Inspired by Susan Sontag’s ideas about health, illness and metaphor (2009), a recent study (Sapiña, Domínguez and Montalt 2017) analysed the types of metaphors patients use in English and Spanish in two comparable corpora. In another recent study, Moreno (2019) looked at a similar set of examples in German and Spanish. One of the most relevant findings in both studies is that patients use a wide range of metaphors to talk about their experiences and that their choice of metaphors varies between languages and cultures. Patients who communicate on the Internet discover how others coping with the same disease express themselves in other languages. New narrative and experiential models can thus be combined with the ones they are already familiar with. Exploring how patients construct their narratives in different languages, cultures and healthcare systems can shed light on the variability and richness of such stories.

In this context, beginning and end-of-life narratives are particularly interesting, because in many Western societies both occurrences have become medicalised and bureaucratized over the centuries, and in that process their human dimension has been eroded. Neither birth nor death are per se health problems, but both have largely been removed from the family and society, and, to a considerable extent, have lost their experiential meaning. Gynaecology, obstetrics, gerontology and geriatrics are fertile grounds for research in the medical humanities from a multilingual and multicultural angle. Recent lines of research in this field include the study and translation of birth narratives (Susam-Saraeva 2020), translating the experience of dying into a performative phenomenology (Robinson 2017) and the exploration of aging in theatre and its intersections with translation, adaptation and dramaturgy (Montalt 2020). Mental health is another area of potential interest. Its historical, cultural and social dimensions are more complex and intertwined than in other,
more ‘physical’ diseases, and biomedical and pharmacological approaches can provide only partial indications of the best treatment to adopt.

6 Final remarks

Muta ars was a fundamental principle in Western medical knowledge and for centuries shaped the relationship between body, health, language, culture and being human. Today, the biomedical paradigm is still largely influenced by muteness in its approach to understanding disease and restoring health. However, science in general, and biomedical science in particular, have always used words to generate and circulate knowledge, especially in a multilingual and multicultural world. The entanglements between translation and medical humanities reviewed in this chapter point in the direction of re-introducing the human element which has been eroded both in healthcare and in translation. This will entail developing a holistic view in which the biomedical coexists with the historical, ethical, emotional, cultural and social dimensions of language and communication. It also means putting the patient centre stage and ensuring that medical technology and machine translation are always used in their best interest.

Medical humanities has shown doctors how they can approach patients in a more sensitive and humane manner, and restore the human face of the physician without detracting from their clinical expertise. It is now expanding its scope in a more critical and reflexive way to play a proactive role in the generation and shaping of medical knowledge and the provision of healthcare. Likewise, using translation as a tool for communication in the professional arena is fully compatible with developing it as an educational tool for health professionals, and as a frame of critical enquiry about how medical knowledge is generated, circulated, received and put to good use. Translation studies can benefit from medical humanities in its move to a more critical and plural approach to medicine and healthcare. Similarly, medical humanities can benefit from translation studies’ focus on the semiotic (verbal and non-verbal), hybrid, dynamic and transformative nature of knowledge, by learning from the work of writers such as Walter Benjamin (1992), Roman Jakobson (1959) and George Steiner (1992). What seems to be the ‘original’ is in fact linked to a long tradition of words, texts and ideas; and, what seems to be the ‘target’ is no more than a step further in the transformation of that particular text, concept or argument, beyond which more transformations will occur.

As I finish this chapter, the COVID-19 outbreak is spreading rapidly around the world. Pandemics show us in a clear and poignant way how our individual bodies (which may be carriers of the virus) are entangled with our collective body, the rest of society. Biological and societal ecologies coexist. In the COVID-19 pandemic, the epidemiological and medical debate has suddenly gone well beyond the expert circles and is uppermost in the thoughts and actions of every member and facet of the society: family, health organisations, government, education, transport, business and commerce, and the press. We are witnessing the extent to which many aspects of the outbreak lie beyond the scope of biomedicine. Understanding the causes and effects of pandemics and responding to them globally require people from all academic fields to pull together. This crisis is bringing about a growing awareness on at least three fronts: the limits of science and the need for multidisciplinary research; the importance of strong healthcare systems; and the crucial role of both national and international communication. There will be opportunities for people with imagination and flair to embrace change, increase knowledge, and find new and more effective ways of communicating within and beyond the medical profession.
In these uncertain times, the rapid technological innovations in areas such as e-Health and machine translation may submerge the advances made in humanising healthcare and alter the translator’s role and ethos in unexpected ways. Once we get through the initial stages of this crisis, however, there will be patients whose illnesses will be exacerbated by their changed personal, familial and economic circumstances. Some elements of patient-centred care may have to be set aside for a time, but what will continue to be needed is the holistic treatment of patients. What will be cherished, most of all, is the memory of nurses and doctors who, in frightening and exhausting conditions, were still moved to offer those dying in isolation many small acts of kindness.

Notes
1 I would like to acknowledge support from two funded research projects I participated in: Generalitat Valenciana (AICO/2019/182) and Ministerio de Ciencia, Innovación y Universidades (PGC2018-098726-B-I00).
4 Diccionario médico-biológico, histórico y etimológico [Medico-biological, historical and etymological dictionary], University of Salamanca, https://dicciomed.usal.es.
5 For evidence of these transformations, see the articles in Wallis and Wisnovsky (2016).
6 https://washabich.de.
7 www.refugeecouncil.org.uk/get-support/services/refugee-health-professionals-building-bridges-programme/.
8 www.gentt.uj.es.
9 In this context, the term means ‘[…] life writing in which the story of the self is closely linked to the production, preparation, and/or consumption of food’ (Smith and Watson 2010: 271).

Further reading

In this textbook Cole et al. use concepts and methods from the humanities to explore ethical and existential issues related to the experience of disease, care of the dying, health policy, religion and health, and medical technology. Case studies, images, questions for discussion, and role-playing exercises help readers to engage in the practical, interpretive and analytical aspects of the material, developing skills for critical thinking as well as compassionate care.


Medical Translation Step by Step provides a pedagogical approach to medical translation based on learner and learning-centred teaching tasks. Starting from a broad communication framework, the book follows a top-down approach to medical translation: communication → genres → texts → terms and other units of specialised knowledge. It is positively focused in that it does not insist on error analysis, but rather on ways of writing good translations and empowering both students and teachers.


Robinson offers four essays exploring four complementary dimensions of the links between translation and medical humanities: ‘The Medical Humanities’, ‘The Translational Humanities of Medicine’, ‘The Medical Humanities of Translation’, and ‘The Humanities of Translational Medicine’. The history of medical literature understood humanistically through both the act and the pretence of translation, or, as Robinson (2017: 47–128) terms it, ‘the translational humanities of
medicine (literary history as performed translationality) is another line of inquiry entangling translation and medical humanities.


Whitehead *et al.* comprehensively introduce the ways in which interdisciplinary thinking across the humanities and social sciences might contribute to, critique and develop medical understanding of the human individually and collectively. The 36 chapters in this book range widely within and across disciplinary fields to explore the intersections between medicine, as broadly defined, and critical thinking.

**Related topics**

Knowledge Translation, Disability in Translation, Dissemination of Academic Medical Research Through Translation

**References**


Lain Entralgo, P. (1958) La curación por la palabra en la antigüedad clásica. Madrid: Revista de Occidente.


