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LINGUACULTURAL AND PRAGMATIC FACTORS IN THE TRANSLATION OF MEDICAL TERMS

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Introduction

The translation of medical terminology is often perceived as a purely technical activity involving terminological substitution between languages. However, contemporary translation studies demonstrate that medical translation is not limited to lexical equivalence but involves complex linguacultural and pragmatic negotiation. As emphasized by scholars such as Eugene Nida and Peter Newmark, translation requires sensitivity to both semantic meaning and communicative function. In medical contexts, this sensitivity becomes particularly crucial because inaccuracies may affect patient safety, legal validity, and public health outcomes.

In an era of intensified global communication and health governance coordinated by institutions such as the World Health Organization, medical discourse circulates across linguistic and cultural boundaries at unprecedented speed. The COVID-19 pandemic, for example, revealed how inconsistencies in translated medical terminology could shape public perception and compliance.

This paper argues that the translation of medical terms is shaped by two central dimensions: (1) linguacultural factors that influence how illness and the body are conceptualized, and (2) pragmatic factors that govern how medical discourse functions in communicative contexts. Drawing on translation theory, pragmatics, and medical discourse analysis, this article explores how these dimensions interact and proposes strategies for responsible medical translation practice.

1. Theoretical Framework

1.1 Equivalence and Functionalism

The concept of equivalence has long been central in translation theory. Eugene Nida (1964) distinguished between formal equivalence (focus on linguistic form) and dynamic equivalence (focus on receptor response). In medical translation, strict formal equivalence may preserve technical accuracy, yet dynamic equivalence is often necessary in patient-oriented communication to ensure comprehension.

Later functionalist approaches, especially Skopos theory developed by Hans Vermeer, emphasize that translation strategies must be determined by the purpose (Skopos) of the target text. A medical research article requires terminological precision, whereas patient leaflets demand clarity and accessibility.

1.2 Domestication and Foreignization

Lawrence Venuti (1995) introduced the concepts of domestication and foreignization. In medical translation, domestication may involve adapting terminology to culturally familiar

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expressions, while foreignization may preserve internationally standardized biomedical terminology. Translators must carefully balance these approaches depending on context.

2. Linguacultural Factors in Medical Term Translation

2.1 Cultural Models of the Body

Medical terminology reflects culturally embedded understandings of the body. Western biomedicine is grounded in anatomical compartmentalization, whereas other traditions may emphasize holistic balance. Translating biomedical concepts into cultures with alternative medical traditions requires conceptual mediation rather than direct lexical transfer.

For example, the translation of mental health terms frequently reveals cultural variation. In some cultures, psychological distress is expressed somatically. As a result, literal translation may fail to capture culturally salient meanings.

2.2 Taboo, Euphemism, and Stigma

Medical discourse intersects with cultural norms concerning sexuality, death, and mental illness. According to Newmark (1988), translators must consider the connotative meaning of terms, not only their denotative reference. Terms such as “cancer,” “infertility,” or “sexually transmitted infection” may require pragmatic adjustment depending on cultural sensitivity.

Failure to account for taboo can produce communication breakdown or emotional harm. Thus, linguistic choices must reflect sociocultural expectations.

2.3 Terminological Borrowing and Adaptation

Medical terminology is heavily derived from Greek and Latin roots. Languages differ in how they integrate these forms. Some languages adopt loanwords directly, while others create descriptive equivalents.

The decision between borrowing and calque involves not only linguistic structure but also issues of prestige, education level, and language policy. From a sociolinguistic perspective, the translator mediates between global scientific discourse and local linguistic identity.

3. Pragmatic Factors in Medical Translation

3.1 Audience Design and Health Literacy

Pragmatics emphasizes that meaning is shaped by context and audience. As noted in discourse theory, medical texts differ significantly depending on whether they address specialists or laypersons.

For example:

- Specialist communication: “myocardial infarction”
- Patient communication: “heart attack”

The translator must evaluate health literacy levels and adapt terminology accordingly. This reflects Nida’s principle of receptor-oriented translation.

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3.2 Speech Acts and Illocutionary Force

Drawing on speech act theory (Austin, 1962; Searle, 1969), medical language performs functions such as warning, advising, reassuring, or instructing. Translators must preserve the illocutionary force of statements.

For instance:

- "This medication may cause adverse reactions" functions as a warning.
- "You might feel slight discomfort" mitigates severity.

Pragmatic misalignment may either exaggerate risk or minimize seriousness, leading to ethical and clinical consequences.

3.3 Institutional and Legal Constraints

Medical translation frequently operates within regulatory frameworks. Pharmaceutical documentation, informed consent forms, and clinical trial reports must adhere to standardized terminology.

Organizations such as the World Health Organization maintain classification systems (e.g., ICD) that ensure cross-linguistic consistency. In such contexts, terminological deviation is not stylistic variation but a legal issue.

4. Ethical Considerations

Medical translation is ethically charged. According to professional translation codes, accuracy and clarity are paramount in life-critical contexts. A mistranslated dosage instruction can result in severe harm.

Furthermore, informed consent depends on comprehensible translation. If patients do not understand procedures due to linguistic complexity, ethical standards are compromised.

5. Strategies for Effective Medical Translation

Based on translation theory and medical discourse research, the following strategies are recommended:

1. Functional analysis of text purpose (Skopos-oriented approach)
2. Audience-sensitive adaptation (dynamic equivalence)
3. Consultation with medical professionals
4. Terminological database use
5. Cultural mediation rather than literal substitution
6. Plain language principles in patient materials

These strategies integrate linguistic precision with pragmatic awareness.

Conclusion

The translation of medical terms is not a mechanical act of lexical substitution but a multidimensional process shaped by linguacultural and pragmatic factors. Drawing on

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equivalence theory, functionalism, and discourse pragmatics, this paper has demonstrated that effective medical translation requires sensitivity to cultural models of illness, communicative purpose, audience expectations, and institutional constraints.

In global healthcare communication, translators function not merely as linguistic technicians but as intercultural mediators whose work directly affects patient safety, ethical practice, and public trust.

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