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Equigeneric and Intergeneric Translation in Patient-Centred Care

Key words: patient-centred care, equifunctional translation, intergeneric translation, generic competence.

ABSTRACT

This article reflects on the demands that the paradigm of PCC (patient-centred care) involves for medical translators and writers. We will review the notion of patient-centred healthcare, and will highlight the concept of *empowerment* of the patient in order to improve communication between patients and healthcare professionals, two discourse communities with different conceptual backgrounds and rules of communication, whose mutual understanding can significantly improve the quality of healthcare (Jovell/Navarro 2009). In the area of written communication, medical writing and translation in general and the role of reformulating information to fit expectations in particular may play an important role as a bridge between these communities. Whilst Translation Studies has traditionally been based on the notion of equifunctional and interlingual translation (a notion which is valid as a way of explaining many communication situations), in this article, we shall argue that the notion of intergeneric translation, both in intra- and interlingual contexts, also needs to be developed in order to respond to the requirements of written communication in very specific contexts such as that of healthcare. Following Mason (2000: 6), "while audience design will regulate the interpersonal dimension of meaning, socio-textual practices (genre, discourse and text type) will regulate the intertextual dimension". We therefore need to design genres in the domain of healthcare according to the nature of the audience and in the specific context we are examining, and only sound generic competence will help the writer/translator to appropriately combine the textual dimension with the interpersonal dimension so as to achieve the required *skopos*.

1. Patient-Centred care

Contacts between doctors and patients traditionally tended to be doctor-centred. Doctors had the knowledge and patients did not, because they did not need it, given their passive role as mere recipients in a doctor-centred communicative paradigm in which the doctor's monologue reflects the paternalistic, asymmetric view of such a relationship. Patient involvement was even seen as hindrance in the sense that it may interfere with the doctor's agenda. In recent years, there has been a shift in emphasis, putting patients' agendas first and actively involving them in consideration and management of their own health. This has required doctors to refocus, adopt a different approach to conducting consultations and acquire enhanced active listening and communication skills. As will be argued in this article, this shift of the communication paradigm from the monologic to the dialogic (Montalt/Shuttleworth 2012) is relevant to professional translators and writers as well as to Translation Studies as a discipline. According to Baxter (1993, 1998), there cannot be relationships without dialogue. Therefore, promoting dialogue is critical in order to build stronger relationships that can enhance the quality of healthcare. Interaction is a fundamental step to achieve more active participation of patients within a patient-centred model.

This dialogic shift is rooted in Bakhtin's dialogic theories and is embedded in what communication theorists have called the sociocultural tradition (Littlejohn et al. 2005: 196), which tries to explain communication processes in terms of human relations and interactions. In this episte-

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mological framework, we find two concepts that can assist us in understanding the complexities between healthcare professionals and patients: dialogism and dialectics. On the one hand, dialogism refers to the fact that multiple, distinct voices converge and interact in human relationships. On the other hand, dialectics points to the fact that relationships often contain or provoke contradictions between the different participants in the communicative act (Baxter 1993, 1998, 2004). These concepts can be useful when trying to understand and explain some opposing forces that come into play in the communication between professionals and patients. For example, some medical issues may collide with specific cultural values that given groups of patients may have.

This dialogic and dialectic shift is reflected also in a number of studies that acknowledge the different levels of relationships within healthcare systems. Some researchers propose the idea of relationship-centred care (RCC), a model which focuses on the nature of relationships. Thus Beach et al. (2006) highlight four types of relationships in RCC:

1. Clinician-Patient: In this relationship, the authors stress that the quality of communication between patients and clinicians is not seen as the product of one single party, but as an interactive process dependent on the efforts of both participants.

2. Clinician-Clinician: The authors point out that the energy and enthusiasm practitioners bring to a consultation with a patient are profoundly influenced not only by their own practice, but also by the values of the medical profession in general. Thus, their relationship with other colleagues directly and indirectly influences their relationship with patients.

3. Practitioner-Community: Community here refers to the community of patients as well as wider social and cultural groups.

4. Clinician's Relationship with Self: The authors emphasise that in order to establish a positive relationship with others, it is essential to establish a positive relationship with oneself, based on self-awareness, well-being and integrity.

This study concludes that RCC enhances health. In a recent review of the literature, Krystallidou (2012: 75) states:

> The patient-centred approach is strongly advocated in medicine and is associated with positive outcomes in the clinical practice in terms of improved patient satisfaction, higher rates of treatment adherence, patient empowerment and reduced health care costs (Stewart 1984; Roter et al. 1987; O'Hair et al. 1987; Hall et al. 1988; Roter 1989; Smith et al. 1995; Little et al. 2001).

If patients' health is enhanced, so is their satisfaction with the system, and also the system performance itself, which, in turn, means better use of human resources within the system – including the patients themselves as communicative agents that can both provide and make use of relevant information to improve clinical practice. Many authors recommend using the PCC approach to improve not only relationships with patients but also the functioning of the healthcare system in general. This is precisely the main argument employed by researchers who advocate more dialogic, patient-centred models of healthcare, and it is one we endorse in this article from the perspective of Translation Studies.

In the following discussion, we shall focus our attention on the first type of relationship, Clinician-Patient, the basic principles of which are interaction and interdependence among the various knowledge communities involved, primarily patients' and physicians', but also those communities that involve relatives, nursing staff, administrative staff, researchers and health authorities, among others. We shall attempt to explore this relationship through the postulates of PCC, a concept which does not originate directly from patients, but rather from healthcare professionals.

As a result of the critical thinking and research carried out in this area, several terms have been proposed to define the new ways of conceptualising the relationship between patients and doctors.

We would like to highlight the following: **patient-centred care (PCC)**, **participatory medicine**, **cultural competence in care delivery** and **relationship-centred care**. In this article, we shall concentrate on PCC, also referred to as patient-centredness (PC).

This line of thought began towards the end of the 1960s and has been developed by health science researchers on the basis of real healthcare situations in various countries and contexts. Although it is not in itself a recent phenomenon, the empirical studies that have provided the most precise data have been carried out over the past ten years. We would also like to emphasise at the outset that the tendency we are discussing is not restricted to just one healthcare system or country, but is widespread and has been increasingly implemented in the most advanced healthcare systems.

In the following table, we summarise three of the main conceptual studies on which this article is based.

Authors	*Dimensions or perspectives*
Little et al. (*BMJ*, 2001)	- Exploring experience and expectations of disease and illness. - Understanding the whole person. - Finding common ground regarding management (partnership) - Health promotion - Enhancing the doctor-patient relationship - Realistic use of time.
Mead / Bower (*PEC*, 2002)	- The biopsychosocial perspective—a perspective on illness that includes consideration of social and psychological as well as biomedical factors. - The *patient-as-person*—understanding the personal meaning of the illness for each individual patient. - Sharing power and responsibility—showing sensitivity to patients' preferences for information and shared decision-making and responding to them appropriately. - The therapeutic alliance—developing common therapeutic goals and enhancing the personal bond between doctor and patient. - The *doctor-as-person*—awareness of how the personal qualities and subjectivity of the doctor influence the practice of medicine.
Epstein et al. (*SSM*, 2005)	- Communication - Partnership - Health promotion.

Table 1. Perspectives in PCC

The first point we would like to highlight in this synthesis is the importance all the authors attach, either explicitly or implicitly, to communication. Without an improvement in both oral and written communication on the part of all the actors involved, it is difficult, if not impossible, to explore and understand patients' experiences and expectations of health and illness (which can diverge widely in patients with different languages and cultures, as researchers on hospital mediation and interpreting have pointed out). It is also difficult or impossible to understand patients as complete individuals in psychological, social, cultural and other terms. In the absence of this understanding, the sharing of power and responsibility in decision making, and ultimately health promotion, is not a viable option.

Viewing the matter from the point of view of health professionals, Epstein et al. (2005) define the objective of PCC as being "to help practitioners provide care that is concordant with the patient's values, needs and preferences, and that allows patients to provide input and participate actively in decisions regarding their health and heath care".

In her review of the literature, Kristallidou (2012: 75) sums up the essential defining features of this emerging paradigm:

> Among the definitions of models of patient-centredness, the one developed by Epstein et al (2005) focuses on the communicative dimension of patient-centredness, aiming at reaching the optimal delivery and receipt of healthcare through a mutually participatory doctor-patient relationship. For Epstein et al. (2005), patient-centred doctors aim at: eliciting and understanding their patients' perspectives, including their concerns, expectations, needs, feelings, ideas; understanding their patients within their unique psychosocial context; reaching a shared understanding of the problem and its treatment with their patients that corresponds to their patients' values; and helping patients to share power and responsibility by involving them in choices to the degree they wish.

From this perspective, providing patients with access to information and knowledge is vital. Many researchers emphasise this point, especially in clinical contexts, as in the case of the diabetes patients analysed by Funnell et al. (1991: 37), who affirm the following:

> We have learned much in the past 10 years about how to help patients to acquire diabetes-related knowledge and skills and how to use strategies to help patients change behaviours. However, the application of knowledge and techniques should be guided by a relevant, coherent, educational philosophy. Empowerment offers a practical conceptual framework for diabetes patient education. Empowering patients provides them with the knowledge, skills, and responsibility to effect change and has the potential to promote overall health and maximize the use of available resources. It is an idea whose time has come for diabetes education.

Patients can only be empowered – in other words, be in a position to participate in the dialogue – if they possess the appropriate information and have access to knowledge. But access to information and knowledge in a system that has not been designed from the patient's point of view is a difficult, if not impossible, task. This situation is certainly changing, but there is still much work to be done. As an example to develop our argument, consider patients with diabetes, Parkinson's disease or any other chronic illness. Many of these patients[1] may wish to know more about their illness, not only with respect to treatment, but also current relevant research. At present, at least in Spain, the healthcare system does not provide access to this type of information.

One means of giving patients access to knowledge and participation is through written communication. Two main categories can be established in this respect:

a. Information about a particular disease, test, technique, drug, etc.

b. The popularisation of advances in the scientific research of a given disease.

Although the second type of knowledge is fully relevant to patient-centred care, it is much less developed than the first one, even in the most advanced healthcare systems. We will not focus on this category in this paper.

As far as the first category is concerned, in the Spanish context we find that there is no unified action supported by a health institution similar to those of the National Library of Medicine (http://www.nlm.nih.gov) or Patient UK (http://www.patient.co.uk), which cover a very wide range of medical topics and specialties, and offer reliable information which has been validated by experts. One could consider that the equivalent in the Spanish context is the website http://www.guiasalud.es, promoted by the Spanish National Health System. However, the amount of information for patients it contains is very limited.

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[1] We are aware that the information needs of different types of patients, and even of individual patients, may vary. Indeed, our research team GENTT (http://www.gentt.uji.es) is beginning to carry out empirical studies on the information that particular genres should contain depending on the profile of the patient, among other things. At the moment, however, we are working with the hypothesis of a moderately cultured patient who wishes to know more and to be involved in his or her therapeutic process.

In the Spanish context, we find two other categories of information resources for patients with a far more limited scope than the examples referred to above:

c. Sites that offer information that is not restricted to one specific specialty and that are supported by experts, such as http://www.saludalia.com, http://www.fisterra.com, http://www.universidadparapacientes.org, or the Spanish version of the Merck Manual (http://www.msdsalud.es/manual-merck-hogar.aspx?u=/publicaciones/mmerck_hogar/index.html).

d. Sites that offer information centred in one particular specialty or aspect of a disease, such as that published by patients' associations – Spanish Cancer Association, Spanish Alzheimer Association, Spanish Asthma Association, etc. – healthcare centres – such as Hospital Clínic de Barcelona – and governmental organizations – such as Junta de Andalucía, Generalitat Valenciana, Servei Català de la Salut, etc. In this section, we could also include online resources that have been translated into Spanish, such as those provided by Medineplus (USA National Library of Medicine).

Although – as we have just seen – there are a number of resources for patients in the Spanish context, there are still three problems that need addressing:

1) Scattering. In Spain there is not a single authorised library for patients – supported by experts and institutions – that provides a unified, complete and accessible view of the types of knowledge relevant to patients.

2) Quantity. The information for patients is not only scattered, but also scarce. The amount of information for patients in Spanish is insufficient to satisfy the needs and demands of patients.

3) Quality. By quality we mean reliability and appropriateness. Much of what is available (on the Internet) may be incorrect or misleading, or written in an inappropriate register. For example, high-quality online databases with free access are certainly available (see PubMed, among others), but most of them only provide information – such as abstracts written for researchers – that creates a register barrier between the knowledge communities involved and impedes patients' access to knowledge relevant to them as patients (García-Izquierdo 2009).

These three main types of problems create barriers for the patients' empowerment in terms of readability, accessibility and relevance, either because the information provided has not been properly validated by experts, and therefore is not reliable; or because the register of the texts is nor adequate for the patients.

The deficiency is especially significant in the case of serious or chronic illnesses, such as cancer, asthma or diabetes, where the difficulty of matching the availability of information to the needs and expectations of the user is compounded by emotional involvement and by the impact such information may have on the life of the patient and his or her family, as we shall see later.

Bearing in mind that English is the lingua franca of biomedical research and that most research journals are published in English, we face an additional problem: a language barrier for non-English speakers.

This language barrier normally goes hand in hand with cultural barriers of varying magnitude, depending on the cultural distance between the actors and contexts involved. For example, there are vast discrepancies and asymmetries in the ways cultural practices are conceptualised and the social forms of text genres are used by different health systems. For many patients this is a great, if not insurmountable, challenge.

As has been mentioned, this article's argument is framed in the communicative challenges of implementing a patient-centred healthcare model in which the patient has the right to have access to information and knowledge and to play an active part in communication. In other words, patients must be well-informed and have a good understanding of their illness, the healthcare system and the medical staff within the system. Patients should be able to participate actively with healthcare professionals in their treatment and collaborate with them in decision-making.

Some studies (Jovell/Navarro 2009; Krystallidou 2012) highlight the fact that taking account of patients' expectations and appropriate information may help to improve the quality of healthcare (in personal, time and cost terms), as has already been pointed out. And in this respect, as we shall see in the next section, the role of medical writers/translators as a bridge between the two communities will make a crucial contribution, in the case of written communication, to designing the information provided to patients, since they will seek to marry their expert textual knowledge with the expectations of a very specific audience.

From our perspective, an inescapable issue is the variety and complexity of the profiles that lie behind the term *patient*. Many studies have tried to formulate a typology or classification of patients (García Altés et al. 2000; Jovell/Navarro 2009), albeit with different purposes (management of healthcare facilities, support for planning of services, financing or monitoring of care quality) and criteria (functional capacity, seriousness, etc.). And our experience in certain pilot research studies (2010, unpublished) shows us that in Spain, if we confine ourselves to the purpose of achieving care quality in the case of serious illnesses, the existence of different realities and different kinds of patients is therefore not being taken into account when planning the provision of information, which is conceptually uniform, monolingual and scarce.

Leaving aside the differences in perspective of the various studies, it must be stressed that a key requirement is to empower patients by repositioning them at the centre of the model. Our research pays special attention to some of the issues involved in empowering patients. Specifically, we are interested in researching access to information in multilingual, multicultural situations where there are notable asymmetries and where sound generic and translation competence plays a cardinal role, as will be seen in the following sections.

To conclude this section, we would like to qualify what has been said so far. The argument presented by Little et al. (2001) poses the underlying question of whether patients prefer patient-centred care (to which they responded 'yes', according to the observational study), while Mead/Bower (2002) question whether patient-centred care really contributes to improved outcomes in the healthcare process. If the answer to this question is yes, can the improvements be measured? Mead/Bower (2002) reached the following conclusions from their empirical study: "the findings of the present review do provide some support for the view that specific evidence of the benefits of patient-centeredness is somehow lacking at present", and although the importance of PCC should not be ignored, further research is required in order to measure the true benefits it could bring to health (2002: 59)[2].

2. PCC and Translation

PCC raises a number of questions regarding expert-to-lay written communication. Who writes and re-writes the great variety of genres addressed to patients, from patient information leaflets (PILs) to patient guides (PGs) to informed consents (ICs) to summaries of research for patients (SRPs)? Doctors, nurses, health committees, medical writers, journalists? Would they be suitable for all patients? Are they written by the central (e.g. state) authorities, or are there different versions in different hospitals and other healthcare institutions?

Doctors and other health professionals certainly need to be involved, but are they necessarily the best communicators when it comes to written communication in intercultural and interlingual contexts? Doubtless some are, but many are not, simply because they have not been trained for it.

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[2] See also Stewart (2001).

Our point is that translators (in collaboration with medics) are well placed to understand the kind of work involved in PCC by virtue of their insights into linguistic and cultural aspects of communication, which are incorporated into their training as translators. In addition, they are trained in adapting to different registers, familiar with a wide variety of genres and aware of the differing needs of their readers and the different functional/practical uses their writing may serve.

Research in medical translation has enhanced understanding of the great variety of genres involved in written communication. In their definition of medical communication, Montalt/González (2007: 46) go beyond the terminological aspects of the text and describe how genres are manifested differently according to the interaction established between participants, among other factors. These authors state that:

> Medical communication is not limited to written interaction among researchers in highly specialized research journals. Rather it can be a rich, dynamic continuum moving from research articles to educational television documentaries on relevant health topics or news in the press about health and medicine.

This model is clearly in consonance with the complexity of the relationships between subjects in the healthcare field (Beach et al. 2006), which was commented on in the previous section. These complex relationships are reflected in the complexity of the text genres displayed in this field, because in this investigation, at least, it concerns a relatively new area, involving multiple genres which can function differently depending on factors such as the producer, the receiver, the communication situation, the purpose or the degree of formality. These situations and parameters are not always interpreted correctly, as we shall see.

The role of medical writers/translators as mediators to ensure that specialists and patients understand each other properly is crucial, because successful communication will largely depend on appropriate written expression of the information, depending on patients' expectations and the context in which it is used.

Some researchers who focus on this area have detected barriers to communication between patients and other knowledge communities, such as physicians or researchers. Thus Pilegaard/Berg (2012) conclude that there are significant barriers to understanding in the case of the Patient Information Sheet (PIS) genre. According to these authors: "The language, structure and format of the PIS [patient information sheet] should be improved. Avoiding technical jargon or explaining it when it is used, using more common words when they are available and a clearer structure were identified as potential targets for intervention" (2012: 1).

No one can fail to be aware that in Spain a high proportion of patient information genres, as well as research genres, are largely an equifunctional transfer of genres written mainly in the United States, and in any case in English:

> As the scientific discussion is carried out in English, also these texts that are drawn up in any other language than English will include parts that are translated from English or based on studies written in English (Van Vaerenbergh/Schubert 2010: 16).

This implies that the equivalence is therefore formal rather than functional. In other words, the *skopos* (Reiss/Vermeer 1984) of the translation, specifically the particular features of patients in the target culture, is not properly considered.

Translation studies have traditionally been based on the notion of equifunctional and interlinguistic translation (a notion which is indisputably valid, in our opinion, as a way of explaining some communication situations). However, new social realities with a direct impact on people's lives, especially in sensitive areas such as medicine and healthcare, make it essential to address this notion from a broader perspective. It needs to be borne in mind that as well as situations of intra- and intergeneric symmetry, we may also find ourselves faced with situations of asymmetry produced not only by interlinguistic differences, but also by differences in the expectations and needs of receivers of a single language or culture. We therefore need to argue for developing the notion of equigeneric and intergeneric translation, both intra- and interlinguistic, in order to respond to these specific requirements of written communication.

Indeed, in a recent study K. K. Zethsen (2009) argued the need to increase the number of empirical studies analysing the relationship between interlingual and intralingual translation and to put intralinguistic translation on the map of Translation Studies, because, in her opinion, today's society demands "different kinds of translation or translation-like activities which often exceed the boundaries of what translation theory traditionally terms *translation proper*" (2009: 796) and current studies on translation do not provide a clear response to that demand, systematically excluding intralingual translation either deliberately or *de facto*. Accordingly, using Wittgenstein's concept of **family resemblances** (1953/1958), she proposes a broad definition of translation that "is open and inherently non-finite and is an attempt to define the discipline of translation studies as an open field which relies on an open, inherently non-finite, yet describable concept and not on necessary or sufficient conditions or audience assumptions" (2009: 798), and she includes a wide range of translation phenomena, including intralingual translation, that share family resemblances with translation proper.

Moreover, in order to be to develop their translation competence properly, translators need resources and tools, mainly in the form of descriptions of genres and genre systems, as understood by Bazerman (1994: 79 ss.), that is, as interdependent genres "that appear as certain typical sequences, form relations with one another and have interacting purposes and forms". This idea is of vital importance for defining different disciplines, such as medicine, because they allow the processes to be established in the 'rituals' (Swales 1994) developed in a specific socio-professional field. Only by properly understanding how the system works will we be able to predict new needs (as in the case of patient-centred care) or the existence of specific asymmetries that a translator would have to face.

In a study published in 2000, Mason proposes redefining the notion of *skopos* from a more pragmatic perspective, using certain concepts provided by sociolinguistics, especially that of **audience design**, suggested by Bell in 1984, in the sense of interaction between the participants in a communicative act, and including the response of the interlocutor/reader in a specific textual universe. The writer/translator will therefore have to take into consideration the differences between the audience of the source text and the audience of the target text. In other words, in this author's opinion (2000: 6), "while audience design will regulate the interpersonal dimension of meaning, socio-textual practices (genre, discourse and text type) will regulate the intertextual dimension". Although the research so far conducted by Gentt[3] has essentially focused description on the intertextual dimension, we now feel that it needs to incorporate a consideration of the interpersonal dimension in order to respond appropriately to the particular *skopos* involved in PCC and to the different requirements of inter- and intralinguistic translation.

We therefore need not only to replicate, but also to design the information genres in the field of healthcare according to the audience and in the specific context we are analysing, and only sound generic competence (Montalt/García-Izquierdo 2002) will help the writer/translator appropriately combine the textual dimension with the interpersonal dimension so as to achieve the requisite *skopos*.

In general, as far as the translation (inter- and intralinguistic communication) of genres is concerned, the complexity we have discussed can initially be summarised in two main categories: symmetry and asymmetry.

Symmetry is produced when the same text genre exists and works (or can work) in the same manner in both the original and the target culture. This situation is called **equifunctional transla-**

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[3] The Gentt research group (Textual Genres for Translation, www.gentt.uji.es) at the Universitat Jaume I conducts research precisely on the ways in which this context is useful in specialised multilingual domains. Indeed, this study is derived from the research carried out within project FFI2012-34200 financed by the Spanish Ministry of Economy and Competitiveness.

tion (Nord 1997). An example would be an assignment to translate a PIL from English into Spanish for a similar type of reader profile, as seen in one of the examples below. In the context of the theory of genres, we could say there is generic symmetry or **equigenres**.

By contrast, we find situations of asymmetry between the two languages and cultures involved in particular assignments. One type of asymmetry occurs when the target text is addressed to a group of readers with different needs and expectations and backgrounds, as in the first example we shall cite. Here, the strategy is **heterofunctional** or **intergeneric translation**. What is interesting about the case study is that the target text for the less literate group of readers does not belong to one particular genre, but rather contains elements from different genres.

Another type of asymmetry occurs when the target language does not yet possess the genre in question. In this case, genres are imported into target languages and cultures through translation: for example, a summary for patients from biomedical research journals, such as *Annals of Internal Medicine*. Since participatory healthcare, as has already been noted, was first developed in the English-speaking world, its tools and resources, and often its conceptual apparatus, were created in English and have been exported to other linguistic and cultural contexts.

To illustrate some of the problems patients encounter during the process of acquiring health knowledge on serious illnesses in Spain, as mentioned earlier (mainly three: register, interlinguistic differences, and differences of sociocultural form), we shall now focus on the results of two brief case studies[4] involving translation of specific text genres, from English to Spanish, intended for patients, as described in Montalt (2010).

In the first example, the project consisted of translating a series of guides, originally written in English and published by the American Society of Clinical Oncology (ASCO), into Spanish for cancer patients. ASCO develops numerous programmes, tools and resources specifically tailored to the needs of practising oncologists for the promotion of high-quality cancer care. According to ASCO, “Good cancer care starts with good cancer information. Well-informed patients are their own best advocates and invaluable partners for physicians” (Cancer.Net 2011). The printed materials provided by ASCO are based on reliable, authoritative information which has been reviewed by oncologists and other oncology professionals, members of ASCO, making ASCO materials an up-to-date and trusted resource for cancer information.

The initiator’s main objective for the translation project was to empower the patients with the tools and resources necessary to enable them to play a more active role in their treatment –such as shared decision making, treatment adherence, behavioural change, etc-, while at the same time staying in tune with the patient-centred care concept discussed above.

This project displayed three specific features. The first was that the group of readers – patients – was entirely female, as the texts dealt with the topic of breast cancer. The second was that the patients were all outpatients, that is to say, patients who visit the hospital on a regular basis for follow-up care. The third was that the readers were heterogeneous. The women varied in age (young to elderly) and came from different cultural backgrounds. However, two large subgroups were identified. The first consisted of patients with higher levels of education, meaning that they had better reading and writing skills. The second group, on the other hand, was made up of patients with lower levels of education, and thus poorer reading and writing skills.

Once these specific features had been detected in the target reader group, the main problem arose: judging from the length, structure, phraseology, terminology and style of the source text, it was clear that it was intended for the more literate group. An equifunctional translation would only have resolved part of the communication problem. In other words, there was an asymmetry between the profiles of readers of the source context and of the target context.

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[4] The outcomes of these case studies gave rise to a big research project – funded by the Spanish Ministry of Economy and Competitiveness – that we have just started in collaboration with two hospitals, one in Valencia and one in Castelló (Spain).

The problem was resolved by choosing two different translation strategies according to the genre function. In the target context, the translators composed two target texts. On the one hand, a complete guide was written in Spanish for the readers with a similar profile to that of the source text in English: in other words, an equifunctional translation. On the other, a shorter, more simplified version was created for the other patients – a heterofunctional or intergeneric translation.

In the second case study, Montalt (2010) describes a translation project which also illustrates asymmetry between the readers' profiles in the source context and the target context. The source texts belong to the genre of Summary of Product Characteristics (SPC) in a simplified version (terminology, structure, types of information, etc.) intended not for doctors but for nurses, who assist patients when they are taking their medicines. An SPC is a description of the contents, use and effects (including adverse reactions) of a drug product. The SPC is the basic information provided for health professionals on how to use the drug product safely and effectively. The PIL is drawn up in accordance with the SPC.

The need for the translation arose from a Spanish hospital with an outpatient programme for administering drug products to cancer patients. Having examined the communication situation, it was initially decided that the pharmaceutical information should be included not only for the health professionals in charge, but also for the patients who would be taking the medication.

A twofold strategy was chosen: an equifunctional translation for the professional group of readers and a heterofunctional or intergeneric translation for the patients. Unlike the first case study, the target genre for the patients' profile in this second study was very limited and conventional: a patient information leaflet.

In both cases, the heterofunctional or intergeneric translation emerged as a necessity from a detailed study of the target communication situation. The professional translator is positioned as an expert in intercultural and interlinguistic communication, analysing the context of reception in all its complexity.

In short, the attempt to describe information genres for patients in the medical domain for writing and translation purposes must start from an understanding of the established conventions of the genre concerned in the working languages (cultures). However, in this context one must take account of variables which will be strongly determined by the translation assignment itself (Nord 1997), and therefore by consideration not only of whether the translation we are dealing with is intralinguistic (involving register) or interlinguistic, but also whether it is equigeneric (between symmetrical genres) or intergeneric (heterofunctional), as we have pointed out. Hence systematic research is needed to describe the genres which exist in specific communication environments in all their complexities and varieties. This is precisely the kind of research we are developing in GENTT (*Textual Genres for Translation*).

It is essential to specifically define the asymmetries that arise from the production of patient-centred care genres. Depending on the degree of asymmetry, we should use different translation and writing strategies. Along with the interlinguistic differences, we should also pay special attention to the asymmetries that stem from communication contexts, specifically those involving potential users. The change of addressee could give rise to translation situations that allow for different levels of action, such as maintaining the same genre, translating a genre into one of its subgenres, and even, in specific cases, resorting to a different genre or **intergenre**. All this leads us to conclude that more thought must be given to the importance of heterofunctional or "intergeneric" translation, especially where specialised contexts are involved.

3. Conclusion

Two of the questions our article raises are to what extent translators are aware of the challenges and possibilities posed by PCC, and how PCC might impact on traditional concepts of translation and the translator's role.

Equifunctional (or ‘equigeneric’) translation seems to be dominant in translation theory nowadays. For some people, a translator’s job is to impart content as closely as possible to the original text and in the same register. We have already expanded this straight-jacketed concept to include considerations regarding the end-user that may affect not only the amount and types of information contained in the text but also its structure, tenor and other pragmatic aspects relevant to communication: in other words, considerations that may affect the choice of genre or even the combination of elements from different genres if and when they are needed.

More attention should therefore be paid to asymmetries in communication and knowledge that require heterofunctional or intergeneric translation in specific domains such as healthcare. Some thought has already been given to intralingual translation and the limits of translation, as we have already noted (see Zethsen 2007 and 2009), but we need to continue making progress in the empirical study of the new realities modern society imposes.

We suggest that looking through the lens of genre is crucial when trying to detect the emerging communication needs that have to be addressed by translators/writers in the context of patient-centredness. Responding to the demands of patient-centred care will require systematic descriptions of specific groups of genres, especially those addressed to patients, such as patient information leaflets, fact sheets, guides for patients, informed consents, summaries for patients and many more genres and subgenres. These descriptions are useful tools for acquiring the generic competence that is needed to carry out an intergeneric translation in a professional way.

However, the intertextual dimension governed by socio-textual practices must go hand in hand with development of the interpersonal dimension through what Mason calls **audience design**. From our perspective, audience design is an essential element which will enable the translator/writer to move beyond textual forms and communicative practices that have become routine and thereby respond to emerging needs.

Finally, the special nature of the medical field, with specific problems related to social cognitive reality, could lead us to argue that asymmetries in the field of Patient-Centred Care between English-speaking and Hispanic cultures may be correlated to translation competence, based traditionally on equifunctionality. Ignoring these developments and failing to address them may impoverish not just Translation Studies as a discipline, but students and professional translators as well.

4. Further Research

Given our awareness of the asymmetries referred to in the previous section, the specific needs of patients with serious illnesses, such as cancer, asthma or diabetes, and the virtual non-existence of information for patients in Spain that takes account of their expectations, the immediate aim of the GENTT research group is to concentrate on research into equigeneric and intergeneric translation/writing, both inter- and intralinguistic, placing particular emphasis on the interpersonal dimension (Mason 2000).

Accordingly, we intend to use qualitative techniques to analyse the opinions of a group of breast cancer patients in the Hospital Clínico Universitario in Valencia and Hospital Provincial in Castelló on the written information they receive in order to establish possible ways of classifying these patients. Following this, and in consultation with specialists at every stage, we aim to carry out legibility tests on the written documentation provided for patients on their illness, evaluating the opinions of the various groups and including family members, as an essential part of the process. The results of these tests will enable us to assess the degree to which the *skopos* of the genre is being fulfilled in the Spanish context, in relation to the source genre (almost always written in English, as has been pointed out earlier), and to improve the information aimed at a specific group of patients.

As regards the intertextual dimension, on the basis of the qualitative results it will be possible to make the appropriate adjustments of register in those cases where it is considered necessary (intralinguistic drafting) and even to assess the need to use intergeneric and intralinguistic translation when it is felt that an equivalent or hybrid genre, made up of sequences (moves) from other genres of medical information, may better meet the expectations of a particular group of patients.

Finally, once the typology of patients and the various possibilities for equigeneric and intergeneric writing/translation have been established, we shall also assess the need to use interlinguistic equivalence to incorporate the other Peninsular language used in the same social context, Catalan, as well as the most relevant languages of immigrants.

We hope thereby to contribute to enhancing the information, communication and participation (empowerment) of a group of patients with a serious illness in a specific context on the basis of an analysis of audience design and of the customary socio-textual practices in this community, genres (Mason 2000), which will make it possible to continue developing the PCC paradigm and thus improve the results of healthcare. In addition, a study of this kind will enable us to redefine information genres for patients in Spanish, taking account the expectations and needs of its producers and recipients, and this will undoubtedly also help to enhance professional writers' and translators' knowledge of this process of interaction.

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