

# The Write Stuff

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redattore medico-scientifico

Σύνταξις ιατρικών κειμένων

medisinsk skribent

Rédaction médicale

medicininis rašymas

Redacción médica

Medizinisches Schreiben

Medical writing

MEDISCH SCHRIJVEN

メディカルライター

Lääketieteellinen kirjoittaja

tibbi tercöme

आयुर्विग्यान लेख

医药撰稿专员

ΠΙΣΑΚΕ У МЕДИЦИНИ

redação medicinal

Scribhneoir leigheais

Medicina skribado

## Medical translators



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**Journal insights**

The **Write Stuff** is the official publication of the European Medical Writers Association. It is issued 4 times a year and aims to provide EMWA members with relevant, informative and interesting articles and news addressing issues relating to the broad arena of medical writing. We are open to contributions from anyone whose ideas can complement these aims.

Articles or ideas should be submitted to the Editor-in-Chief (see below) or another member of the Editorial Board.

**Subscriptions**

Subscriptions are included in EMWA membership fees. By writing to info@emwa.org non-members can subscribe at an annual rate of:

- €35 within Europe
- €50 outside Europe

**Instructions for contributors**

- The **Write Stuff** typically publishes articles of 700–2800 words although longer pieces or those with tables or graphics will be considered.
- All articles are subject to editing and revision by the Editorial Board. Any changes will be discussed with the author before publication.
- Submissions should include the full address of the author, including the telephone and fax numbers and email address. Suitable quotes for side boxes can be indicated or they can be selected by the Editorial Board.
- Material should be submitted by email as an MS Word file using Times New Roman (or equivalent), 10 point size, and single spacing.
- Published articles generally include a recent photograph of the author (portrait picture, CV or passport style, min. 930 x 1290 pixels).

**Back issues**

Subject to availability, previous issues of The **Write Stuff** can be obtained for the cost of mailing by contacting the EMWA Head Office (see below).

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Cover photograph from Nadia Meister (nadia.meister@inode.at).

**Photographs on pages 69-70**

The photographs on these pages are from Crispin Hodges (webadmin@emwa.org).



## EMWA 8<sup>th</sup> Autumn Meeting

16-18 November 2006, Brussels

**The Executive Committee has the pleasure of inviting you to the 8<sup>th</sup> autumn meeting to be held in Brussels. The meeting will be held from 16 to 18 November 2006 at the Courtyard by Marriott Hotel.**

Brussels is more than 1000 years old. Today, as the European capital, the city is home to the European Commission and to the Council of Ministers of the European Union. Brussels is also the bilingual capital of Belgium. This means that both French and Dutch are the official languages of the city. So beware, as street names and traffic signs are always in two languages, which can sometimes cause confusion. Furthermore, it is a cosmopolitan city where many different cultures live together and where different languages can be heard on every street. This liveliness and international flair is, of course, intimately related to its role as a crossroads for all of Europe.

The workshop programme will cover a wide range of medical writing subjects and will also include advanced workshops for experienced writers looking to keep their knowledge up-to-date or refresh their skills. Further details and regular updates will soon be available on the website [www.emwa.org](http://www.emwa.org).

Looking forward to seeing you there!

**Michelle Derbyshire**  
EMWA President



### Cover: 'Medical writing' lost in translation

Translating 'medical writing' into different languages proved a difficult task. As highlighted by one contributor "The main reason is possibly the almighty presence of the English language". The result is that usually the term is not translated as evidenced by the following sample from contributors' comments:

- We give medical writing seminars in Germany and tried all sorts of translations but after several attempts and critical comments from participants, the organiser changed everything to 'Das medical-Writing'.
- Translating 'medical writing' is harder than I thought! We always use the English term. A literal translation 'medisch schrijven' would sound very weird to Dutch people.

- Actually those who know anything about medical writing in Norway use the English term.

Many thanks to the contributors. From left to right, top to bottom the languages on the cover and (contributors) are:

- |                                    |                                  |
|------------------------------------|----------------------------------|
| 1. Italian (Albertina Fanellie)    | 11. English                      |
| 2. Norwegian (Kari Skinningrud)    | 12. Finnish (Katja Metsola)      |
| 3. Greek (Anthanasia Benekou)      | 13. Serbian (Sofija Micic)       |
| 4. French (Catherine Mary)         | 14. Hindi (Roopa Basrur)         |
| 5. Spanish (Santiago Rosales)      | 15. Chinese (Zhou Yan)           |
| 6. Lithuanian (Vytautas Abraitis)  | 16. Portuguese (Gudrun Schrodt)  |
| 7. German (Alistair Reeves)        | 17. Irish (Paul Dunne)           |
| 8. Turkish (Gudrun Schrodt)        | 18. Hebrew (Alistair Reeves)     |
| 9. Japanese (Lim Soo Hwee)         | 19. Bulgarian (Daniela Rouskova) |
| 10. Dutch (Anita van den Oetelaar) | 20. Esperanto (Herbert Mayer)    |



From the editor's desk:

## Medical translators and non-native English speakers: Is English so important?

By Elise Langdon-Neuner

The theme of this issue is medical translators and non-native speakers of English. Yet I can't help asking whether English is really so important.

Historically, the variety of languages and the dispersion of mankind have been considered a curse. The Bible (Gen. xi. 9) tells us that there was a single ancestral language. The subsequent diversity of language is explained with an account of the people of Babel attempting to build a tower whose top would reach into heaven. God thwarted them by confounding their language. Without being able to communicate, they could not continue their joint effort. Linguists believe that an ancient single language might have existed, but they are unable to agree on the date when it diversified. In any event, this would have been several thousand years before the story given in the Bible. Probably, the Bible's account is rooted in an ancient North Semitic myth. A similar tradition is found in Central America. Xelhua, one of the seven giants rescued from the deluge, built the great pyramid of Cholula so as to storm heaven. It was destroyed by fire and, as in the Biblical tale, the language of the builders was confounded. Similar stories are also found in the Mongolian Tharus in northern India and were reported by Dr Livingstone to have existed among the Africans of Lake Ngami. There is an Estonian myth of 'the cooking of languages', and similar Australian legends too.

If diversity of language is a curse, then the prospect of eliminating language barriers should be welcomed. Dr Zamenhof devoted his life to establishing Esperanto. His concept was to create a universal language as a neutral means of communication, to avoid inequality in international communication. For political reasons, explained in Herbert Mayer's article in this issue, Esperanto never became the world language.

Successively Egyptian, Greek, Arabic, Latin, French and German have been the language of science. English is not only the current language of science but is also becoming a world language. If the Utopia of a single language is in prospect, why should we worry about minority languages, or other languages at all for that matter? There are two reasons why we should worry.

The first became apparent to me when I was at Kakadu National Park, in Australia, and read some 'Park Notes' that had been produced by the government's Department of the Environment and Heritage. The notes explained that there were about 200 Aboriginal languages at the time Europeans arrived in Australia, some as distinct from each other as English and Bengali. Now only fifty Aboriginal languages have a significant number of speakers. One note explains "Language is the life-blood of culture. The cultur-

### Vital signs

#### Dear TWS

I was pleased to read Keith Dawes' and Katherine Kauper's article, 'Medical writers in drug development and marketing' in the last issue of TWS [15 (1) 18-19]. I think it summarises the activity of the medical writer very well and offers the sort of insights beginners in our field are often seeking. And they made it sound really exciting (which it is!), without leaving out the negative aspects.

What I was not very pleased to see, right at the beginning, is that they wrote: 'To be a successful medical writer there are a number of prerequisites ...: a life science academic education, flawless ...'. I hope it has not escaped their notice that there are really quite few of us 'out there' (and in EMWA) like me who do not have a life science academic education but still manage pretty well! Only the other day, I had to listen to a potential—and very young—

client (who had looked at my website with my references and details of more than 25 years' experience) on the telephone saying to me: 'And you can really do it I mean if I give you a set of tables, you can actually write a report on them—and you're not a scientist?' My answer, of course, was: 'The quality of my work would depend on the quality of your tables. Unfortunately, I'm fully booked for the next six months'. (And actually, I am!). Maybe I am therefore a little sensitive at present!

**Alistair Reeves**

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*Editor's note: in response the authors of the article agreed that they might have got a bit carried away with the life science academic education*

## From the editor's desk

al identity and unique world-view of each people is carried in their language. English versions of Aboriginal concepts such as the Dreamtime can only give a watered-down and somewhat misleading view of the original idea". Paul Dunne, in his article in this issue, presents Irish as a language struggling for survival but concludes that, although government institutions spend money promoting the language, this has not reversed its decline, and the proliferation of English seems inevitable. Without diversity in mankind as represented by cultural differences, the basis upon which human survival through adaptation and evolution can be assured would be annihilated.

The second reason also relates to the march of evolution. English owes its continuing hegemony to American dominance of the world economy. World powers only persist for a limited time. English is in relative decline, as evidenced by a comparison of the estimates of the numbers of native speakers in the world in 1995 for the top 10 languages with the estimated numbers of native speakers aged 15 to 24 years in 2050 (Tables 1, 2). Employers in some Asian countries consider that Mandarin is already becoming the new 'must-learn' language [1]. Hindi and Bengali are also moving up in the world language league. India is increasingly attracting clinical trial programmes and gaining outsourcing contracts from biomedical publishers, both of which provide jobs for medical writers in India. It is apt that this issue of *TWS* includes an article about medical writing in India, by Roopa Basrur.

David Graddol argues that the future of English is to facilitate multilingualism rather than to become a world language. Perhaps this is a new route to equality in language. Monolingual English speakers will have difficulties in a future multilingual society he predicts, adding that "The expectation that someone should always aspire to native-speaker competence when learning a foreign language is under challenge, as is the notion of 'native speaker' itself" [1]. This is also the question raised by Lim Soo Hwee in her article in this issue and commented upon by John Benfield. He contends that proficient communication in medicine is best achieved by teachers who use English regularly, but adds that educators in medical specialties should also be involved. Sonia Vasconcelos helps Brazilian researchers to compete in the medical publications arena. She reports in this issue on the research she has undertaken in Brazil to influence national policy in training scientists to write in English.

As long as English retains its privileged position, so long as world society remains primarily monolingual, and assuming that an efficient Phraselator<sup>1</sup> will continue to elude us, translators and interpreters will be essential in world communication. Many medical writers make a living translating text between English and other languages. Two leading articles on this topic in this issue, by Gabi Berghammer and Susanne Geerkhen, address the problems faced by translators of medical text. In Part II of her article Gabi discusses the fascinating topic of the errors made in translating Sigmund Freud's work from German into English and the far reaching consequences of these errors.

I hope that this issue of *TWS* gives translators and non-native speakers of English some useful guidance and English native speakers something to think about.

**Table 1: Estimates of numbers of native speakers globally in 1995 (top 10 languages)**

Language	No. of native speakers (millions)
Chinese	1113
English	372
Hindi/Urdu	316
Spanish	304
Arabic	201
Portuguese	165
Russian	155
Bengali	125
Japanese	123
German	102

**Table 2: Estimates of numbers of native speakers globally aged 15 to 24 in 2050**

Language	No. of native speakers (millions)
Chinese	166.0
Hindi/Urdu	73.7
Arabic	72.2
English	65.0
Spanish	62.8
Portuguese	32.5
Bengali	31.6
Russian	14.8
Japanese	11.3
Malay	10.5

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### Reference

- Graddol D. The Future of Language. *Science* 2004;303:1329-31

<sup>1</sup> A Phraselator is a robot that translates spoken English into other languages. The American military have used Phraselators in Iraq to replace human interpreters who often have their own political agenda and are not keen to work in danger zones. Phraselators have the drawback that they are not able to translate replies to the questions they ask. They are also not taken as seriously, when they squeak "Drop your weapon" in their Star-Trekky diction, as a human who points a machine gun at enemy soldiers and yells the same words (*The Economist* 28 August 2004).

## Unhealthy numbers

"In most industries, it is argued, advancing technology pushes costs down. In health care, it pushes them up. Patients get a growing choice of costly new treatments, and more of them (often suffering from multiple chronic disease) stay alive for longer, again at great expense. Must health care always be an exception to the general rule? This is one of the most important economic questions of the next 20 years... In a way, America's health-care system is more socialized than most of Europe's: either the government (through Medicare and other programmes) or else the patient's employer is paying. Patients themselves rarely have any incentive to economise."

Source: Telemedicine to the rescue? by Clive Cook. In: *The World in 2006 the Economist*





## Message from the President

by Michelle Derbyshire

It's hard to believe that one year has already passed since I was first voted EMWA's President. Normally I would have moved on to the role of Immediate Past President. But following the resignation of our Vice President (Ian Metcalfe), due to a change in his employment, and your vote at the Annual General Meeting in Lyon, I am to stay with you as President for one more year. The Executive Committee (EC) also accepted the resignation, after many years of hard work, of the Website Manager (Marian Hodges). Marian, with the assistance of her 'other half' Crispin has spent many years developing the website into the valuable tool for EMWA that it is today, and will be sorely missed. Fortunately she is replaced by Shanida Nataraja, who has already spent some years as a volunteer for the website, in particular developing the 'Members' Only' area. She is therefore very familiar with the website and competent to take over the reins from Marian. The EC also lost the Membership Officer (Kelly Goodwin), however, we are very grateful that Kelly is still remaining active in two of

the projects she had already begun whilst in office, namely a salary survey and a mentoring programme. I would like to personally thank both Marian and Kelly for all that they have contributed to EMWA.

EMWA's conference in Lyon was our most successful yet, with more members attending than at any previous meeting. In fact we had a 25% increase in attendance over the previous year! We, the EC, hope that the reason for this is that we are offering more of what you as members want. In Lyon there was a lot more on offer than just workshops. There were discussion forums, demonstrations and medical writers' question time. While EMWA remains highly focussed on the training aspect of medical writing, as it is felt that this is the foundation of good writing, we also hope to expand on this and increase what we offer to experienced writers. This is where your input is especially appreciated. Please feel free to contact either myself (president@emwa.org) or one of the other EC members. Your comments and suggestions are always welcome.

The next dates to note for your agenda are the Autumn Meeting, which will be held in Brussels on the 16-18th November 2006. Being myself based in Belgium, the organisation for this meeting is keeping me pretty busy, while our new Vice President (Julia Forjanic Klapproth) is already getting to grips with the 2007 spring conference, which is to be held in Vienna. The theme of the conference is to be medical communications. We again plan to include not just workshops, but extra offerings to tempt even the most experienced writer. Keep an eye on the website ([www.emw.org](http://www.emw.org)) for further information.

Hope to see you in November in Brussels.

### Michelle Derbyshire

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## Thanks to Marian Hodges



In the many years that Marian has been Website Manager for EMWA, she has tirelessly worked on behalf of the membership to build the EMWA website into the thriving endeavour it is today. Not only is the website a source of information for EMWA members it is also a valuable source of income for EMWA as an organisation, and a powerful recruitment tool for many organisations that employ medical writers. The process of creating such an asset was by no means easy. Without Marian's unwavering commitment to EMWA and its website, and the support and technical skills of her husband, Crispin, the EMWA website would have faded into non-existence a long time ago. For this we owe both Marian and Crispin our warmest thanks. I have thoroughly enjoyed working with Marian and learning from her the intricacies of how to keep the EMWA website up and running. In the years to come, I will endeavour to ensure the EMWA website remains something that Marian and EMWA can be proud of.

### Shanida Nataraja

Website Manager  
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### Participants attending the Lyon conference came from 18 European countries

Austria	Finland	Ireland	Norway	Switzerland
Belgium	France	Italy	Serbia	UK
Czech Republic	Germany	Lithuania	Spain	
Denmark	Greece	the Netherlands	Sweden	

As well as from: Australia, China, India, Japan, Singapore, South Africa and USA



# Translation and the language(s) of medicine: Keys to producing a successful German-English translation

Gabi Berghammer

## Part I: The words of medicine

### Language and the history of medicine

Medical translation, together with religious translation, may be one of the oldest domains of translation: the sufferings of the body and soul have always been our central preoccupation [1]. The scientific methods that characterize modern Western medicine are traceable to Classical and Hellenistic Greece (500-30 BC). During this period, Greek medicine departed from the divine and moved towards logical reasoning [2]. It passed on its traditions first to the Roman Republic (509-31 BC) and the Roman Empire (31 BC-476 AD), and then to Medieval Europe (1100-1500 AD). During this process, medical writing developed as a technique for travelling medical scholars to communicate their ideas [3].

When Greece was absorbed by the Roman Empire (146 BC), the centres of learning moved from Greece to Egypt. However, Greek physicians maintained their importance, and Greek medical writings were translated into Arabic. Only a small part was translated into Latin [4]. After the demise of the Roman Empire in the 5th century, most works of the Greek physicians were lost to Western Europe. For example, the writings of the travelling medical scholar Galen (129-200 AD) were unknown in the West until translated from Arabic into Latin during the 11th and 13th centuries, when Western Europeans began to rediscover Greek scientific texts due to the discovery of Arab repositories of learning in Spain and elsewhere during the Crusades [3]. The Arabic language had contributed comparatively little to the language of medicine, but it provided access to the Greek system of science [3]. In the 15th century, after the Ottoman conquest of Constantinople, Greek scholars migrated to Italy and brought with them the ancient texts, which were then directly translated into Latin [5].

Between 1000-1800 AD, Latin was the teaching medium at the great European universities, and it absorbed Greek and Arabic medical terminology by transliteration or overlay with Latin prefixes and suffixes [3]. Because of the increasing need to communicate with physicians without university training, students, and patients, Latin as the language of medicine had practically come to an end by 1800, and was almost entirely replaced by local languages—all of which, however, retained the Græco-Latin terminological core [3].

Throughout history, dominance in knowledge has had repercussions on language relationships. Since the second half of the 20th century, probably as a direct consequence of U.S. leadership in many technical fields, English has become the *lingua franca* for medical research, and English terms have been imported into many other languages. Even though the advantages of a common language of research are obvious, the predominance of English places native speakers at a competitive advantage over those who first have to acquire sufficient linguistic skills to communicate their ideas and findings in a language foreign to them or to read English material [6]. For medical translators, of course, this is good news.

Many people still believe that anyone who speaks two languages can translate. However, a prerequisite of being a translator is to have an excellent command of both the source and target languages and to have strong translation skills. But how do you become a *medical* translator?—By learning the language of medicine.

## Medical terminology

### Graeco-Latin core

Let us first take a look at terminology. As we have seen, much of the medical terminology of Western European languages is made up of roots and affixes drawn from Greek and Latin. The advantages of the Graeco-Latin core are that it almost serves as an artificial language; it no longer changes because ancient Greek and Latin are dead languages, and it is precise and internationally comprehensible [7, 8]. When I tell people that I am a medical translator, the first thing many say is, “Oh, so you must have a solid command of Greek and Latin”. Well ... not exactly.

It certainly helps to know that *hem* [gr.] means ‘blood’ and *adip* [lat.] means ‘fat’. However, medical parlance has not obeyed the rules of word formation. For example, Greek and Latin components have been freely combined into Græco-Latin hybrid words [9], such as ‘haemoglobin’/*Hämoglobin* or ‘adipolysis’/*Adipolyse*. Even though this applies to both English and German, the translator will soon find that medical texts are full of potential pitfalls, such as changes in spelling, changes in prefixes and suffixes, parallel forms, and root switches from Greek to Latin and vice versa [9].

>>>

## &gt;&gt;&gt; Translation and the language(s) of medicine

**Changes in spelling**

Transliteration of Greek and Latin letters has not always resulted in the same spelling in English and German [9]. For example, the English 'haematopoiesis' becomes *Hämatopoese* in German, dropping the 'i' from '-poiesis'. The same is true for 'ovariectomy', which is *Ovarektomie* in German. Conversely, German adds an 'i' to 'hypokalaemia' and turns it into *Hypokaliämie*. Why then, are 'hypocalcaemia' and *Hypokalzämie* spelt the same? The English 'quinone' is *Chinon* in German, and 'sugillation' loses its first double letter and becomes *Sugillation* in German.

**Changes in affixes**

The challenge in translating prefixes is that they do not always tally in English and German [9]. For example, the English 'constipation' becomes *Obstipation* in German, 'disinfection' becomes *Desinfektion*, and 'intestinal absorption' is *intestinale Resorption*. In English, 'disassimilation' and 'dissimilation' are used synonymously, whereas German uses only *Dissimilation*.

The same for suffixes. Thus, the English 'cholesterol' is *Cholesterin* in German. The German translation of 'pulmonary artery' is *Pulmonalarterie*, whereas 'tubal pregnancy' becomes *Tubargravidität*. 'Thymic leukaemia' is *thymogene Leukämie* in German, but the English 'lymphogenous leukaemia' becomes *lymphatische Leukämie*. And 'disinfected' is *desinfiziert* (Figure 1).

**Switches in Greek or Latin roots**

Not only affixes are handled differently in English and German [9]. Sometimes a Greek root in one language gives way to Latin, and vice versa. For example, the English 'mastadenoma', a term based on the Greek root *mast* for 'breast', becomes *Mammaadenom* in German, a term based on the Latin root *mamma*. The English 'oocyte' [gr.] has both a Greek and a Latin equivalent in German, i.e. *Oozyt* and *Ovozyt* [lat.]. The German *Hypertonie* [gr.] is 'hypertension' [lat.] in English.

Conversely, the English 'pituitary' [lat.] is *hypophysär* [gr.] in German. In English, 'seminuria' [lat.] and 'spermaturia' [gr.] exist side by side, whereas German uses only *Spermaturie*. The same is true for the English doublets 'venesection' [lat.] and 'phlebotomy' [gr.], which is *Phlebotomie* in German.

**Parallel forms**

Another pitfall awaits the translator when a term in one language has several equivalents in the other. For example, to translate the English 'metabolism', German offers both *Metabolismus* and *Metabolisierung*. However, the two are not interchangeable. *Metabolismus*, or *Stoffwechsel*, refers to the chemical processes occurring within a living cell or organism that are necessary for the maintenance of life, whereas *Metabolisierung*, or *Biotransformation*, refers to the chemical alterations of a compound which occur within the body to excrete this compound.

**Terms from common speech**

Another characteristic of medical terminology is that it consists of numerous words from everyday speech whose basic meaning has been extended to medical uses [9]. The challenge for the translator is to spot these terms as having a specific medical meaning.

A well-known common-speech word with a specific medical meaning is 'history', referring to the time before the patient's introduction to medical care, and its German equivalent *Krankengeschichte*. An interesting use of language is the phrase 'past medical history'. In common speech, 'past history' would appear redundant. In a medical context, however, 'past medical history' has a specific meaning, referring to the history of previous illnesses as opposed to the 'history of the present illness', terms that may be translated into German as *Vorgeschichte früherer Krankheiten* and *Vorgeschichte der augenblicklichen Erkrankung*.

Another example is the word 'tender', whose medical meaning differs somewhat from its meaning in everyday language. In medicine it has nothing to do with being kind and loving but is used to refer to the feeling of pain when touched. A possible German translation is *druckempfindlich*.

**English terms adopted in German**

As the influence of Greek and Latin on the language of medicine shows, it is sometimes easier to borrow foreign terms together with the science. In line with the predominance of English in science, medical German is full of terms imported from English, such as *Compliance*, which may (but perhaps should not) be rendered in German as something like *die Bereitschaft des Patienten zur aktiven Mitwirkung an therapeutischen Maßnahmen*.

Other English terms may have a German equivalent, such as first-pass effect, in German *First-pass-Effekt*, which could also be rendered as *Effekt der 1. Leberpassage*, or *Acute Respiratory Distress Syndrome*, which translates as *Schocklunge* or *akutes Lungenversagen*, but German usage often prefers the English over the German term.

Many English terms adopted in German do not even have a German equivalent, such as *Face lifting*, *Intent-to-treat*, *Surfactant*, or *Restless-Legs-Syndrom*, to name only a very few.

**Figure 1.** Text on a plastic bag I picked up in the bathroom of a Maltese hotel in May 2005, during the EMWA Conference. I seriously doubt that the glass wrapped up in this plastic bag really was disinfected, but that's not the point. Please consider the English-German translation: a pitfall fallen into.





## False friends

False friends cause difficulty not only in our personal lives, but also in the life of the translator. False friends are word pairs that look like they might mean the same thing in both languages but don't. Some examples that immediately come to mind are 'drug' (Arzneimittel) and *Droge* (addictive drug), 'ambulance' (Krankenwagen) and *Ambulanz* (outpatient department), 'gift' (Geschenk) and *Gift* (poison), 'pregnant' (schwanger) and *prägnant* (succinct), or 'preservative' (Konservierungsmittel) and *Präservativ* (condom).

A perhaps less obvious but potentially dangerous example is the English term 'narcotics', a false friend of the German *Narkotika*. Thus, 'narcotics' and its synonyms 'opioids' or 'narcotic analgesics' translate into German as *Opioide* or *Opioid-Analgetika*. The German term *Narkotika* is synonymous with *Allgemeinanästhetika* and translates as 'general anaesthetics'.

## Synonyms

Speaking of synonyms—'medspeak' is full of concepts that go under several names which are basically equivalent but may differ according to whether they derive from anatomical, pathogenic, historical, or descriptive considerations [9].

For example, 'accessory mamma' is the name given to the presence of more than one pair of breasts, also referred to as 'supernumerary mamma', 'mamma accessoria', 'polymastia', and 'hypermastia'. German equivalents are *akzesorische Mamma*, *Mamma accessoria*, *Polymastie*, and *Hypermastie*. One of these terms, i.e. 'hypermastia'/'*Hypermastie*', also applies to a second concept, i.e. oversize of the breasts, and is synonymous with 'macromastia' in English and *Mammahypertrophie* in German. But beware—'macromastia' is, of course, not synonymous with 'polymastia'.

Also, for many learned terms, both English and German have a synonym in everyday speech, such as 'haemorrhage'/'bleeding' and *Hämorrhagie/Blutung*, 'myopia'/'shortsightedness' and *Myopie/Kurzsichtigkeit*, or 'pruritus'/'itching' and *Pruritus/Juckreiz*. Which of these synonyms is used in writing and translation will depend on the genre or type of text to be translated and on the needs and expectations of its audience.

## Eponyms

Eponyms are terms adapted from names of famous scientists. Sometimes, the same eponyms are used in both languages, such as 'Wolff-Parkinson-White syndrome'. Alternatively, an eponym in one language may have a non-eponymic equivalent in the other, such as the German *Budd-Chiari-Syndrom*, which translates as 'venous occlusive disease'. Also, an eponym in one language may correspond to another eponym in the other language, as is the case for 'Henderson-Jones syndrome', which is *Reichel-Syndrom* in German.

To complicate matters further, some eponyms are synonymous, such as 'Basedow's disease', 'Graves' disease', and 'Flajani's disease'. In German, the only synonym for *Basedow-Krankheit* is *Morbus Basedow*. Conversely, the

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same eponym may apply to different disorders, such as 'Paget disease'/'*Paget-Krankheit*', which applies to three distinct conditions: osteitis deformans, carcinoma of the breast, or carcinoma in the anogenital region. Of course, each of these concepts again has a number of synonyms of their own.

## Abbreviations and acronyms

The fast growth of scientific knowledge in the past half century has generated great numbers of new terms, particularly multiterm words, such as 'chronic obstructive pulmonary disease' or 'gonadotropin-releasing hormone'. Limited journal space and the disinclination to repeat long terms have led to frequent coinages of both abbreviations and acronyms (i.e. abbreviations formed from the initial letters of a compound term serving as pronounceable words). Thus, the above terms are often simply referred to as COPD and GnRH.

Many abbreviations will not pose a problem to the translator because they are the same in both languages, such as GTT ('glucose tolerance test'—*Glukosetoleranztest*) or SLE ('systemic lupus erythematosus'—*systemischer Lupus erythematosus*). However, what the translator should know is that German often simply adopts the English abbreviation. Thus, even though 'chronic obstructive pulmonary disease' translates as *chronisch-obstruktive Lungenerkrankung*, the abbreviation used in German is COPD, and the hormone *Gonadoliberin* may even be better known by its English abbreviation GnRH.

Alternatively, a German author may prefer to use the abbreviation ASS for *Acetylsalicylsäure*, KHK for *koronare Herzkrankheit*, and BKS for *Blutkörperchensenkung*. The English equivalents of these abbreviations are ASA ('acetylsalicylic acid'), CHD ('coronary heart disease'), and ESR ('erythrocyte sedimentation rate').

## Names of active substances

Drug names can present problems during translation because different countries may have different approved names. In most cases, national names are the same as the recommended International Non-proprietary Names (rINNs) introduced in the 1960s by the WHO. In other cases, the national and international names are similar, with only trivial differences, such as the British 'cyclosporine' and the international 'ciclosporine'. Other examples of substances whose British Approved Names (BANs) differ from the rINNs include the anticancer drug 'mitoxantrone', which was converted to 'mitozantrone' because it was considered too similar to the proprietary name of the anticancer agent 'Mitoxana'. Also, the BAN for the loop diuretic 'frusemide' differs from the rINN 'furosemide' because of potential confusion with 'furamide' [10].

In some cases, however, the national names are significantly different from the INNs. Among these are the sympathomimetics 'adrenaline' (epinephrine) and 'noradrenaline' (norepinephrine) or the local anaesthetics 'amethocaine' (tetracaine) and 'lignocaine' (lidocaine). The European Community therefore issued a directive in 1992, decreeing

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that in member countries the rINN should be used exclusively [11]. Despite harmonization on a European level, there are also a number of United States Adopted Names that differ from rINNs, such as ‘isoproterenol’ (INN: isoprenaline), ‘acetaminophen’ (paracetamol), or ‘meperidone’ (pethidine).

### Nomenclatures and classifications

There is yet another characteristic of medical terminology, one which tries to bring order to the chaos of synonyms, eponyms, and acronyms. The precision of ‘medspeak’ is greatly increased by the use of nomenclatures, such as the WHO list of rINNs or the Paris Nomina Anatomica (PNA) and its latest version, the International Nomina Anatomica (INA), and classifications, such as the International Classification of Diseases (ICD), mainly used for coding diseases in hospitals and practices, or the Medical Dictionary for Regulatory Activities (MedDRA). All of these have one common purpose: to agree on a single term for any one organ, disease, or treatment. For example, the rules of the PNA were that each organ should have only one term, the terms should derive from Latin, and eponyms should be avoided [8].

Important as it may be for translators to get their terminology right—synonyms, eponyms, and acronyms are not enough to produce a readable and meaningful text. There is yet another aspect to translation—one that requires a curious and questioning mind.

## Part II: Beyond words

### Medical phraseology

We have so far looked only at medical language on the level of individual words. Yet medical jargon is full of sequences of words and idioms which may sound unusual in everyday speech. For example, most case reports open with a standard sentence, such as “A 56-year-old white man presented to the emergency department with a chief complaint of nausea and vomiting”. The report may go on to say that “His past medical history was significant for...” and finally that “He was discharged home in good condition”. Thus, a case report is strongly conventional in style [12].

The target language also has its conventions. For example, “The postoperative course was uneventful” may be translated as *Der postoperative Verlauf war unauffällig*. You would never think of translating ‘uneventful’ literally as *ereignislos*. Convention determines which phrases are used to describe a particular medical situation or procedure.

In contrast to case reports, which are similar in style and form wherever Western medicine is taught [12], clinical reports differ considerably when written by a doctor in Germany or in the United States [13]. For example, the cryptic phrase taken from an American ‘review of systems’ (*Organanamnese*), ‘Gen: Ø Hx: wt D/dizziness’, could be translated as *Allgemeines: Keine Vorgeschichte von Gewichtsveränderungen oder Schwindel*. As this example demonstrates, style patterns should not always be translated into the target language.

Convention may also determine whether the learned or the standard term is used. For example, where English speaks of ‘nausea and vomiting’, a combination of a Latin-based and a common-speech term, German uses either the Latin-Greek combination *Nausea und Emesis* or the common-speech phrase *Übelkeit und Erbrechen*. To change or omit these standard phrases is to fail to adhere to the conventions of the target text, making it sound less professional and perhaps even compromising its scientific credibility [14].

### Terminology and phraseology – enough to produce a successful translation?

Translation requires more than exchanging terms or phrases in one language for another, adhering to the rules of grammar, and choosing the appropriate register. Because language is closely linked to subject-matter knowledge [13], translators must know the subject they are addressing, not only to successfully master translation problems, but to, first of all, be aware of and identify potential pitfalls [15], some of which have been highlighted above.

The text genres a medical translator is most likely to work in include study protocols, clinical reports, package inserts, biomedical articles, monographs, commercial brochures, and patient education material. All of these genres differ in terms of their function and purpose, their ‘whats’ and ‘whys’, their audiences, and the expectations of these audiences [16]. The translator must have a full understanding of both the source and the target text, and of what the author intends to say and what the recipient needs to hear. In this sense, every translation is a sort of interpretation [17], and even a seemingly minor misinterpretation and mistranslation, e.g. in a package insert, can have serious practical consequences.

An impressive example of how mistranslation can distort what an author intends to say—and what the reader needs to hear—is the English translation of the writings of Freud. Bruno Bettelheim, in his book entitled ‘Freud and Man’s Soul’, argues that “the English translations of Freud’s writings are seriously defective” and have led to misperceptions about both Freud and psychoanalysis [18]. Considering that Freud himself stated that he considered the cultural and human significance of psychoanalysis more important than its medical one, why discuss this in the context of medical translation? Because of the translators’ preference for medical and learned terms over the common-speech words Freud had used, psychoanalysis came to be perceived, in the United States, as a medical specialty instead of the humanistic undertaking that Freud had had in mind.

Freud’s greatest concern was with man’s inner being, to which he referred to as the ‘soul’ (*Seele*, from ‘psyche’ [gr.]). The purpose of his writings was to help his readers understand themselves so they could act more rationally. Language was an essential aspect of Freud’s work. He tried to communicate his concepts in words which his readers had used since their childhood, and he avoided technical and Græco-Latin terms whenever possible.

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His translators, Bettelheim contends, tended to replace words in ordinary use with medical terms and borrowings from Greek and Latin. One example of the translators' preference for medical terms is the translation of *Die Zerlegung der Psychischen Persönlichkeit*. Bettelheim suggests a literal translation, such as 'The Taking Apart of the Psychic Personality'. In English translation, this is rendered as 'The Anatomy of the Mental Personality'. Nothing in the original suggests the translation *Zerlegung* as 'anatomy'.



Sigmund Freud

A particularly striking example is the way two of Freud's most important concepts were translated into English. Freud divided the soul into the conscious, the preconscious, and the unconscious. To name these concepts, he chose words used by every German-speaking child: To refer to the conscious aspects of the mind, he chose the personal pronoun *ich* ('I'), and to refer to the unconscious, he chose the pronoun *es* ('it'). These personal pronouns were translated into English using their Latin equivalents—the 'ego' and the 'id', turning them into impersonal and technical speech. No word has more intimate connotations than the pronoun 'I'. In contrast, 'ego' has the connotation of selfishness, such as in 'ego trip', which was not what Freud had in mind.

A major shortcoming of the English translations is that they eliminate any mention of the 'soul', which is substituted with 'mind' throughout the translation. As we have seen, for Freud the mind (*Ich*, or 'I') is only one of three aspects of our soul, the other two being the preconscious (*Über-ich*, or 'above-I') and the unconscious (*Es*, or 'it'). Therefore, what Freud referred to as the soul, the translators reduced entirely to the conscious aspect of the mind, the 'I'.

Freud describes a number of errors we sometimes make in everyday life when our unconscious plays tricks on us, and he calls these *Fehlleistungen*. This term combines two well-known German nouns: *Leistung* means accomplishment, and *Fehl-* indicates failure. Thus, the word *Fehlleistung* combines an achievement and a mistake. For example, when we produce a Freudian slip of the tongue, we might feel that we said what we wanted to say, but we also know it was the wrong thing to say. One possible rendering of *Fehlleistung*, Bettelheim suggests, is 'faulty achievement'. In English, *Fehlleistung* is translated as 'parapraxis', a word drawn from Greek. In German, we might readily say, "This was a *Fehlleistung*", whereas the word 'parapraxis' sounds like something that is far removed from our own personal experience.

Let me mention one more example amongst many others. What Freud referred to as *Schaulust*—a pleasure in watching something—may be difficult to translate, but a phrase such as 'lust in looking' would make his meaning clear. The word used by Freud's translators—'scopophilia'—does not.

Overall, the English translation of Freud changed his message in significant ways. By making ample use of abstrac-

tion, it allows readers to distance themselves from what Freud tried to say. Psychoanalysis becomes, in translation, something that analyzes the unconscious of another person, but not our own. As a result, in the United States, the main task of psychoanalysis is to cure mental illness, and psychoanalysis is considered the prerogative of physicians. However, Freud, himself a physician, considered psychoanalysis a part of psychology. Freud's goal for his readers was a reasonable dominance of our conscious over our unconscious. The prime requirement for living well, according to Freud, is to control our inner conflicts and to love and be loved—and not—as many have erroneously assumed—to enable our 'ego' to build a more satisfying life for itself.

Bruno Bettelheim aptly sums up the translator's responsibility: "Translators need to be very sensitive not only to what is written but also to what is implied. Their task very definitely includes an obligation to try to transmit not just the words forming a sentence but also the meanings to which these words allude [18]". Overall, therefore, the keys to producing a successful translation are "a love of language, an ear for style, a willingness to pursue arcane terminology, and caring enough to get it exactly right [14]".

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## Challenges of (medical) writing for the multilingual audience

By Susanne Geercken

Sometimes when I tell people that I am a translator working mostly from English into German, I get the response, "But isn't translation a dying profession? Surely, everybody understands English nowadays." And, at least in Germany, developments seem to support this view—recently it has become fashionable for companies in Germany to do their advertising in English. Some time ago, for example, a chain of drugstores came up with the slogan "Come in and find out." However, when German customers were asked what they thought the slogan meant, it turned out that 1) most people were not sure what it said and 2) when pressed to translate the message, many came up with something to the effect of "Come in and find your way out again."

This example illustrates a common lack of awareness on the part of English-speaking authors that writing for an audience whose first language is not English requires special attention. As we shall see below, this can lead to a number of communication problems.

While advertising generally has little in common with medical writing, some parallels can be drawn here. In today's globalized pharmaceutical industry, medical and pharmaceutical texts are typically produced in English and subsequently distributed to audiences whose first language is not English. In some instances, these documents will be translated into local language. However, in the majority of cases, English is used as the 'common' language. In this case, it is assumed that the multilingual target audience will understand English 'in some way similar' to native English speakers.

Of course, there are obvious differences between an English and a non-native English-speaking target audience with the most important difference being that proficiency in English will vary a great deal among the latter audience. To account for this, authors are typically encouraged to use appropriately 'simple' language, avoiding difficult and rare words. Alas, the advertising example above shows that things can go wrong even when this strategy is observed. Why has the strategy not been effective?

It is my experience that, particularly in a medical context, complicated words like 'jeopardize,' 'juxtapose' or 'increment' in fact do not constitute a problem for readers with restricted proficiency in English as long as these terms can be looked up in a dictionary. Interestingly and on the contrary, it is the 'simple' expressions like phrasal verbs ('take care of,' 'care for,' 'look up,' 'look after' or—as in our

example—'find out') that tend to be perceived as difficult and confusing by non-native English speakers. This may be due to the fact that many non-native English speakers in our field typically have received a fair amount of formal training in English and are familiar with the professional jargon in their field. However they may not have been exposed to 'everyday English' long enough to be familiar with more idiomatic expressions.

To the non-native speaker's dismay, English is a language that can be very ambiguous and difficult to interpret. My pet example is the use of the prepositional phrase 'within...of,' which, to my regret, seems to have recently become quite fashionable among English-speaking authors.

The following (real) examples from clinical trial documents will explain my dislike of the preposition:

1. If your child experiences a severe side effect **within** 28 days **of** the last dose of study medication, make sure to tell the study doctor.
2. Informed consent and medical history may be performed **within** 14 days **of** treatment.

In the first example, it is fairly clear from the context that the prepositional phrase 'within...of' means 'after' (events should be reported until 28 days **after** the last dose of study medication) while in the second example the same prepositional phrase can only mean 'before.' Incidentally, this second sentence was mistranslated to read 'after the start of treatment,' which – in a clinical trial context – would have constituted a breach of ICH GCP guidelines.

To my mind a prepositional phrase which, depending on the context, can have opposite meanings should definitely be banned from any texts written to be understood immediately and unambiguously—as is the case with medical texts. This is particularly true when these texts are geared at a multilingual audience.

Even when language is not a problem, there are culture-related issues that can impair comprehensibility in the communication with non-native English speakers.

Some years ago I experienced an awkward situation due to a fairly banal cultural misunderstanding: When I was offered a job in the US, I needed a visa, which was applied for by my future employer in the US on the basis of my German passport. The passport gave my date of birth as 07.12.1961. Especially those of you who have read Alistair Reeves' TWS article on 'Dating made easy...' [1] will not

be surprised that the visa issued stated my date of birth as 12 July 1961 (when, of course, my real birth date is 07 December 1961). As you can imagine, the ensuing corrective action was quite time-consuming and enervating and almost resulted in my having to cancel the flight.

As we all know, this potential confusion about date formats also comes up in medical texts. In a clinical study context, authors writing e.g. clinical study case report forms for multi-country studies typically attempt to resolve the problem by trying to force a particular date format. What I often see is:

DATE OF VISIT (dd-MMM-yyyy)   -     -

This looks quite reasonable at first sight. Yet for the target audience, which will include physicians or nurses whose first language is not English, it may not be clear at all how exactly to enter the date because they are likely to be unfamiliar with the underlying *convention* for the date format, namely to use *capitalized letters* for the month. Thus, unless further instructions are provided to bridge the ‘cultural gap’ (e.g. by giving an example for a date to be entered), this format has a great potential for eliciting incorrect data when used in a multilingual context.

This simple example illustrates that authors addressing a multilingual (and multicultural) audience must take a closer look at their own unconscious and implicit assumptions about culture-specific conventions. Understanding texts is a two-step process: we read the text and relate what we read to what we know about ‘the world.’ Linguists tell us that the knowledge about the world we store in our heads is organized into what they call ‘frames’ and ‘scenes’-prototypical images about concepts such as ‘hospital’, ‘doctor’s visit’ or ‘pain killers.’

These prototypical images evoked in our heads (incidentally together with their attendant emotional reactions) are intrinsically linked with our cultural experience. Hence, as a German when I read ‘pain killer’ I will most likely think of a green and white 20-tablet package of Aspirin while someone from the US might rather think of a bottle of Tylenol.

Admittedly, these culture-related ‘conceptual discrepancies’ between author and audience, (and in fact also between the various groups within the multilingual audience), are most challenging when the cultures involved are maximally different. Yet, even with relatively similar cultures such as the US and Germany, these discrepancies can interfere with communication. Some 10 years ago I worked on a clinical study project with a protocol issued in the US that called for ‘exercise testing.’ During the discussions on how to execute the protocol, it turned out that the authors of the protocol were referring to *treadmill* exercise (at the time the most widely used method in the US) while the European audience understood exercise testing to mean *bicycle* exercise testing since this was the most common

method there. Obviously, the prototypical image of ‘exercise test’ differed between the authors and their audience, creating a communication problem which was detected and resolved only when the two parties began to talk to each other.

This article, like the EPDP short workshop entitled ‘Medical Writing for the Multilingual Audience,’ tries to raise awareness about the linguistic and cultural misunderstandings that can arise when English is used to communicate with audiences whose first language is not English. As we have seen, these misunderstandings tend to be difficult to control. Often when such misunderstandings are uncovered, they come as a surprise to the well-intended author — native English speakers seem to be quite unaware of the ‘within... of’ problem and have reacted with surprise and disbelief. While there are no ready-made answers, I am convinced that authors who take a step back and try to read their own texts with the eyes of their prospective multilingual audience will undoubtedly find ways to ensure successful communication: adding just that extra bit of information does the job of closing the cultural or linguistic gap.

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## Medical writing and more languages in store on Wikipedia

Wikipedia is the enormously successful free online encyclopaedia that anyone can edit and everyone knows ([www.wikipedia.org](http://www.wikipedia.org)). You can even find ‘medical writing’ on Wikipedia, and edit it if you like. In a quick chat with the magazine *BBC Focus* (No.163 May 2006) Jimmy Wales, who is one of its co-founders, was asked what current projects he was working on. ‘Language’ was the answer. It seems that although he feels they are very strong in all the European languages and not so bad in Japanese and Chinese, this is not enough. They want to accelerate the growth of Wikipedia in other languages and currently have projects in over 80 languages.

Another interesting aspect touched on in the interview was their finding that the opportunity to edit had led to far less abuse from the general public than they had predicted. Politicians are the worst abusers but the open editing system is quick to self-correct. Added to which, there’s a small army of monitors including volunteer specialists who check certain fields and over 1000 others who keep an eye on recent page changes.



## What is the definition of a native speaker of English?

by Lim Soo Hwee

“Are you a native speaker of English?” I asked a couple of my colleagues who are Singaporean or Malaysian. “No” came the straight answer. No hesitation on the answer to the question at all. “But look at the dictionary’s definition of a native speaker,” I coaxed, and a lively discussion ensued.

The truth is that when we speak of a native speaker of English, the image of a Caucasian usually comes to mind, does it not? So does being a native speaker of English (meaning, being Caucasian) mean that one speaks and writes it well enough? A check on-line (e.g. [www.english-forums.com](http://www.english-forums.com)) showed that the topic of native speakers of English is alive and well. From the interesting exchanges I found, the “conclusion” one could draw is that clear and comprehensible English (competent, proficient), both spoken and written, is more important than whether one is a native speaker of English.

The word “native” is itself vague and has non-linguistic connotations that are not culturally and politically neutral. To talk about native and non-native speakers is to make an assumption or assumptions about natives and non-natives per se. The terms are perhaps unfortunate in a discussion of language as the etymology of “native” implies birth into a specific community or a particular place. In fact, cases where being born in a particular place automatically entails membership of a specific community and knowledge of a particular language are more the exception than the norm nowadays. I am a case in point. Though I was born into a family that speaks Hokkien (a southern Chinese dialect), I am not fluent enough to carry on a decent conversation in this dialect with my elders.

In Singapore where I was raised and educated, (almost) everyone who had been to school for a couple of years would be able to speak a smattering of English, aka Singlish, a hybrid of the words, Singapore and English. The issue of whether I was a native English speaker or not had never crossed my mind until the day I applied for an EMWA workshop on punctuation. I dithered for a while as to how to answer the question of whether I was a “native English speaker” and then circled “No”, since, being of Chinese descent, Chinese should be my first language. According to the Oxford Advanced Learner’s Dictionary (Oxford University Press 2000), a native speaker is “a person who speaks a language as their first language and has not learned it as a foreign language”. In essence, I never learned English as a foreign language but as a first language, right from the day I entered school. Everything except the pupils’ mother tongue was taught in English. Languages other than English or one’s mother tongue were considered “foreign languages”, which for the talented few were offered as a third language.

An enlightening local news article on Global English caught my eye recently. The article contained interesting quotes from English Next, a recent British Council report authored by applied linguist David Graddol ([www.british-council.org](http://www.british-council.org)). Because English is becoming the corporate language globally, the problem may increasingly be that “few native speakers belong to the community of lingua franca users; in fact, their presence hinders communication. As a result of such incomprehension, China now hires Belgian-trained English teachers who are valued because of their experience in bilingual education. Elsewhere in Asia, the definition of native-speaker teacher has been relaxed to include teachers from India and Singapore” (*The Sunday Times*, 12 March 2006, p30).

English has no doubt triumphed as *the* international language, be it in the area of business or in the field of science, but it is not necessarily the English of the core English-speaking nations nowadays. In China alone, an estimated 176.7 million people were studying English in 2005, and it is possible that in a few years there could be more English speakers in China than in India. This extraordinary expansion has blurred the distinctions between the “native speaker”, the “second language speaker” and the “foreign-language user” of English. In fact, many second language users have become as proficient as native speakers. In a few years, it is likely that the highly proficient English speakers will consist of more non-native speakers than native speakers from Britain, the United States, Canada, Australia and New Zealand. With that, the reverence of native speakers as the gold standard for English is likely to decline in the years to come. A hundred years ago, it was still relevant to distinguish between native and non-native speakers of English. But in this day where the world is a global village and communication just a mouse-click away, this distinction is perhaps of less relevance.

With these thoughts I would like to extend the debate about the ideal qualifications for a medical writer. Before you consider whether you need an English native speaker for your open position of ‘medical writer’ the question to ask is “What is a native speaker of English?” Only after you have the answer to that question can you debate whether the applicant needs to be a native speaker of English. And after that we can start to worry about whether the preferred application should be a linguist or a scientist.

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# A plea for objectivity in assessment of proficiency in scientific communication

By John R. Benfield

Soo Hwee Lim's commentary about the vague and increasingly more meaningless terms "native speaker" and "non-native speaker" of English is interesting and perhaps even provocative. I can express myself well, without foreign accent, in German (Austrian) – my "mother tongue", but I do better in English – the language I use daily for essentially all purposes. I am a "non-native" speaker of English who is more proficient in his second language than in his first. Therefore, if Lim is suggesting that we delete the terms "native-speaker" and "non-native speaker" as indicators of proficiency from our vocabulary, I entirely agree. We must, however, continue to acknowledge the message that these terms represent insofar as language is concerned. There are, and always will be, individuals who can express themselves easily and fully in the international language (now English) and others who cannot do so. Those people who can express themselves well are proficient, and those who cannot do so are less proficient to varying degrees. Acknowledgement and recognition of this fact, in a manner that is neither judgmental, nor prejudicial, is the first step toward increasing the number and quality of good medical

writers with "a good grasp of science" with an associated good grasp of the language of science.

Wouldn't it be nice if we could eliminate potentially inflammatory adjectives like "foreign" and "non-native" and adhere to measures of quality and proficiency? More than 50 years of experience with medical students and physicians in the U.S., and in other countries, have convinced me that there are students and physicians everywhere (including the U.S.) that remarkably lack proficiency in English. Indeed, there are colleagues in countries where English is not the language who are remarkably and admirably proficient in English. Thus, neither geography, nor birthplace is the issue.

How can one measure quality and proficiency, and who should be the professionals to do so? Educators in applied linguistics regularly evaluate proficiency with examinations, but these examinations may not (usually do not) truly reflect communication proficiency. In medicine (and probably in all disciplines) the level of communication proficiency is dependent in part on language skills and, at least in part, upon an understanding of the subject matter.

My conclusion is that the teaching and the development of good medical writers in English is the responsibility of professionals who are privileged to use English regularly [1]. This teaching requires joint efforts between educators in language and in medical specialties. The best available experts in both areas should develop examinations to evaluate communication skills (written and oral) objectively. Programs to improve proficiency in English as the International Language should be designed and implemented by educators in language and in medical specialties working together [2]. Publishers, and other funding sources, should recognize the enormous potential benefit of such programs and make it possible for the design and implementation to be done well and to be made widely available.

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## A comment from David Graddol on Lim Soo Hwee's article

"Being a native speaker of English was never a guarantee of being a good writer. Now the very idea of a native speaker has become more problematic (the issue of monolingualism was probably as important as race). But just as the globalised world has created new generations of proficient multilingual English speakers, it has also created a need for new communication skills. Fifty years ago a skilled writer of English was writing mainly for native-speaking readers. Now a writer needs to be able to communicate clearly to a much wider, global audience.

So what kinds of skills and knowledge are needed by a science writer now? Is it possible that (some) multilingual speakers have skills which monolingual English writers don't?"

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## Correlating English proficiency to international publication rates for Brazilian scientists

by Sonia M. R. Vasconcelos

When it comes to getting published in international journals, especially journals indexed by the Institute for Scientific Information (ISI), non-native English-speakers (NNES) appear to be at a disadvantage. This is the assumption made by some NNES in academia. How difficult it is for NNES scientists to produce a well-written research paper is, however, still an open question. Also, it is difficult to measure the time they spend writing up research, although such finding could reveal whether writing is one of the limiting steps for NNES in getting published. This question has intrigued me for some years, which led me to embark on a doctoral research project to address it. Before the project started I had designed a scientific writing course for researchers at the Federal University of Rio de Janeiro (UFRJ). This university was the first one to offer a writing course for the Brazilian scientific community. Scientific writing is not formally taught at graduate programmes in Brazil, and it has been great to offer novice and experienced researchers an opportunity to attend the classes, which I've taught for 4 years. On the one hand, the offering of such a course on campus may indicate that scientific writing training is not completely overlooked in Brazil. On the other hand, it shows that much has to be done at the national level. Indeed, academic writing policies at university are seriously lacking.

As in many countries, Brazilian scientific output is usually measured by using traditional science and technology indicators. This means that the 1.4% of the science published by Brazilians in ISI-indexed journals may be explained by the amount of research funding, number of international collaborations, and of active scientists. To me, understanding the scientific productivity of Brazilian authors in this "publish in English or perish" arena should also include looking at these authors' ability to write in English. My doctoral project is an attempt to understand the Brazilian scientometric scenario considering Brazil's linguistic scenario. The linguistic scenario includes a reading-oriented approach to English teaching and emanates from a major language project, the ESP (English for Specific Purposes) National Project [1], developed in the 1980s-1990s, which focused on reading and was of critical importance to TEFL (Teaching English as a Foreign Language) in Brazil. Now, with an increasing demand for writing in academia it has left a gap to be filled. In such a linguistic scenario, we have academic programmes that offer reading courses for undergraduate and graduate researchers. However, in the particular case of the sciences, writing courses would be welcome. It is true that this is a long-term goal, as changes in teaching policies involve, among other factors, training professionals, which does take time. Nevertheless, the sooner Brazilian policy makers turn attention to this lan-

guage issue the sooner they will begin to study the possibilities of helping authors and potential authors.

Last year, when I presented the project [2,3], at the Doctoral Forum of the 10th International Conference of the International Society for Scientometrics and Informetrics, Sweden, I drew upon some editors' comments from a pilot survey conducted at the outset of the project. One of these editors mentioned "...of the papers that I handle in my office, which include all papers published from South, North, and Central America, at least 90% of papers written by non-English speaking authors require English revision (in addition to technical revisions), and at least 50% require substantial English revision." Some readers may argue that editors already have a biased approach to manuscripts submitted by NNES [4], causing that editor to report such a high rate. Biased reviews have recently been reported [4], but they certainly cannot account for the number of manuscripts required to undergo substantial English revision. As Alistair Wood reports in *Science Tribune* [5], "many articles are rejected because of inadequate command of English and nobody would expect a journal to publish an article which was full of grammatical mistakes in English." What I aim is to turn claims like Wood's into data in my country, to make possible a discussion of the extent to which language may be a hurdle for potential Brazilian authors in achieving visibility in academia.

### Acknowledgements

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## Medical writing in India

by Roopa Basrur

When I attended the EMWA meeting at Manchester last year, many were surprised. What was a medical writer from India doing at a meeting for European medical writers? Was there that much medical writing being done in India? Was the 'fear' described at the outsourcing discussion at the Malta conference last year justified? How many medical writers are there in India? To the credit of my well read fellow writers, no one asked if I rode to work on elephant back!

India, as most people are aware, possesses a geographically, socially, linguistically and culturally diverse milieu on a scale unlike that of any other country. With the recent information technology (IT) and outsourcing boom, its long-languishing economy has been given a boost, giving rise to a growing middle class and creating new job opportunities for its people. The pharmaceutical industry has developed along with IT and is flourishing. As a result of drug regulatory authorities amending rules on clinical research in India over the last five years, a large number of global clinical research organisations (CROs) have entered the Indian market. All this has naturally increased the need for quality medical writing in this so-called third world country. Here, I have tried to collect a few snapshots of the different types of medical writing in India.

In 2004, one of India's premier medical teaching institutions played host to the "Journal of Postgraduate Medicine (JPGM) Gold Con: 50 years of Medical Writing", probably the first international conference on medical writing in the country [1]. Of course, I immediately signed up and attended the conference in Mumbai, where leading local and international figures in the medical writing and editing world presented such topics as choosing the right journal, publication ethics, statistical errors in medical writing and open access. Although the conference was driven by the academe, I met writers from major pharmaceutical companies, medical communications firms and CROs, in addition to doctors interested in research and publication.

Much of the medical writing in India originates from academic institutions, rather than the pharmaceutical industry. As in other parts of the world, here too, many doctors like to see their work published, some to enhance careers, and others for the love of research and writing. In 1992, it was estimated that Indian doctors wrote over half of the articles that came from third world countries, most of which were perhaps never read by international readers [2]. "A majority of the articles by Indian authors, published in Indian or international journals, come from just eight to ten top academic institutions", says Dr Sanjay A. Pai, Head of Pathology at a private institution. Dr Pai devotes as much as a quarter of his day to editing and writing. He sits on the editorial board of the *National Medical Journal of India (NMJI)* and the *Indian Journal of Medical Ethics (IJME)*, both indexed journals of repute.

A search through the Science Citation Index reveals that Indian journals account for a paltry 0.3% of the total number of science journals worldwide [3]. Dr Samiran Nundy says, "there are about 35 medical journals included in Index Medicus and probably four in the Science Citation Index, all with impact factors of less than one". Dr Nundy, a gastrointestinal surgeon at the Sir Ganga Ram Hospital in New Delhi, is on the editorial board of several journals including the *British Medical Journal (BMJ)*, and was the founding editor of the *NMJI*. He feels that papers published in India are generally of poor quality. This is probably because most authors who produce quality research target international journals as their first choice for submitting their work—for obvious reasons. Dr Pai echoes these thoughts, saying that the *NMJI* rejects about 75% of manuscripts it receives, mainly due to poor science content. Incidentally, journals such as the *BMJ* and the *Journal of the American Medical Association* reject over 90% of papers submitted to them, according to their websites.

Overall, the potential for good medical writing exists in India and, as awareness and opportunity are created, it is sure to improve. Training young doctors at the medical school level and life science graduates at university in the importance of good scientific research together with the ethics and technique of publication will go a long way towards promoting better medical writing.

So, what is the future of professional medical writing in India? As the pharmaceutical and clinical research industries flourish, the demand for quality writing is set to increase. The main advantage—one that makes many jittery—is the low cost of operations and salaries in India compared with Europe or the United States. India's strength also lies in its large number of English-speaking medical professionals. The medical education system is excellent, with premier institutes that approach Western standards.

However, the standard of English used varies widely and ranges from poor to excellent. India has 24 major languages and possibly thousands of dialects that are spoken by its one-billion people [4]. From what I have seen, most Indians learn English as a second language and 'Indian English' is known to be wordy and 'flowery' [5, 6]. General medical journals tend to receive articles of lower standards of English than journals such as the *IJME*, where contributors are well-versed in writing. In my interactions with local medical writers, mostly pharmacy or life-science post-graduates who are non-native English speakers, their language skills definitely need improvement. Increased exposure to Western writing and training will rectify this problem.

Dr Arun Bhatt, President of a CRO (ClinInvent Research International Pvt Ltd), finds the level of English used by

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medical scientists in India above average compared with current use in the country. He is involved with journal editing as well as medical writing in the clinical research industry, and feels that for Indian writers to be accepted internationally, they must acquire global regulatory expertise. It is likely that, in a couple of years' time, the number of medical writers with the requisite skills will increase and this trend will develop into a fully fledged industry. As a medical writer within an international CRO (ClinTec International Ltd), I have been involved in writing clinical study reports, manuscripts, protocols, subject information sheets, position papers and case report forms. "Most of our writing assignments at ClinTec International India are for major pharmaceutical companies in Europe, who have been highly satisfied with the quality and speed of delivery of our projects", says President and Founder, Dr Rabinder Buttar. Awareness of ICH-GCP, regulatory requirements and the International Committee of Medical Journal Editor's Uniform Requirements for Manuscripts Submitted to Biomedical Journals form part of the on-job training process.

In terms of local training, the *NMJI* occasionally offers courses on improving medical writing. The Academy of Clinical Excellence has modules on clinical trial design as part of its diploma certificate courses [7]. The Christian Medical College at Vellore also conducts annual programmes on epidemiology and clinical trials, which cover many topics of interest to medical writers [8]. On the whole, however, very little formal training is available in India and most writers learn on the job. Multinational pharmaceutical companies and some CROs employ life-science (usually with pharmacy or microbiology backgrounds) and medical graduates or post-graduates from all disciplines (such as allopathy, homeopathy, ayurveda, dentistry and veterinary science). They train them in-house to write clinical study reports and other documents such as product reviews and drug profiles. Some pharmaceutical heavies such as Pfizer, Novartis, and GlaxoSmithKline (GSK) have medical writing teams based in India. The study reports or manuscripts are very often finalised by the relevant department at their head office in the United States or Europe. However, Ms Priya Pavithran, Assistant Manager, Scientific Writing at GSK, India says, "At the Clinical Data Management Centre India (CDMCI)—an integral part of GSK—writers undergo rigorous training, and are now contributing as much as our European counterparts, following experience gained over the last 10 years".

Medical writers are also employed by medical communications companies. Home-grown firms like Indegene Life-systems provide digital conference services, continuing medical education and information tools, among other products, to healthcare providers and medical professionals [9]. A number of websites offer medical information online targeted at the Indian professional and patient. Subsidiaries or partners of European or Asian medical communications organisations, such as CMP Medica, also operate in India. Medical writers here primarily cater to the communication needs of the local pharmaceutical industry by producing detailing aids, drug profiles, patient information booklets, training kits for sales personnel and newsletters. However, the marketing departments of most pharmaceutical compa-

nies still prefer to develop their own promotional materials, often with the help of an advertising agency. Several drug directories, produced by writers with strong backgrounds in pharmacy, are also published in India.

Finally there are entrepreneurs like Dr Bhawana Awasthy, an oncologist with clinical research and pharmaceutical experience who recently started her own medical communications organisation. She offers a full range of regulatory and writing services for the CRO and pharmaceutical industries, as well as co-operative groups [10]. Dr Awasthy would naturally like to see the Indian medical writing industry mature and gain international acceptance. She feels that although medical writing in India has the capacity to become an outsourced industry, there is plenty of work for everyone and this should not really be an area of concern to American or European writers.

The growth of freelance medical writing as a full-time occupation is probably not too far off. An Internet search for freelancers in India turned up a half dozen writers, mostly medicos. Another related field is that of mainstream newspapers and magazines, which use the services of freelance or in-house medical journalists who write features and reviews on Indian and international medical and pharmaceutical news. "Online content companies have access to a large network of writers who provide writing services comparable to their European counterparts", says Dr Nishi Viswanathan, Chief Content Coordinator at Chillibreeze [11]. This novel venture started in India in 2004 and today has around 50 medical writers, who mainly work from home, on its database.

Although slow to start, India should soon evolve into a unique centre for medical writing. "Indian medical writing has huge potential and its quality and quantity are going to increase greatly over the next five to ten years", in Dr Nundy's opinion. Only time (and some hard working medical writers!) will tell.

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## Esperanto and the destiny of planned languages

by Herbert Mayer

The term 'planned language' covers more than you might expect: Pasigraphies (universal writing systems), secret sign languages (codes), ideographies (systems of graphical symbols), numeric languages, universal musical languages (such as Solresol), magical and sacral languages, and even imaginary languages like the Klingon language from the series "Star Trek". Not all artificial languages are planned languages. Only languages that are purposely developed to a planned system fall within the definition, which would for example exclude invented children's languages.

The best known planned languages are the world auxiliary languages, created with the ideal of facilitating international linguistic communication. The need for effective international communication became apparent in the nineteenth century with the growth of international interaction. Although French was the language of diplomacy at the time, Russian, English and German began to gain ground in international relations. Which of these languages would succeed as an international means of communication could not be predicted at the time. After World War I the idea of an international planned language came to the fore with strong proponents in the field of science, technology and terminology. Electrical engineers were a particular stronghold of Esperanto speakers, especially in France.

Few world auxiliary languages have persisted. Only Esperanto and Interlingua are of any significance today. Esperanto was created by Dr Lazar L Zamenhof, a Jewish optician born in Bialystok in Russia (now in Poland) in 1859. A climate of hate prevailed in the city between its Polish, Russian, German and Jewish inhabitants, which Zamenhof worked hard to overcome. His basic principle

was that the cultures and religions should conserve their own natures, but encounter between them can take place only on neutral terrain where no proponent dominated any other. In the spirit of his vision he adopted the pseudonym, Dr Esperanto, which means 'someone who hopes'.

The first Esperanto world congress was held at Boulogne sur Mer in France in 1905. It demonstrated that a constructed language worked in a broader setting. The congress gave the Esperanto movement a strong positive impulse, which lasted well into the 1930s, and showed that Esperanto was to be taken seriously as a solution to the language problem.

The aspiring movement was brought to an end by politics: Hitler's Germany-but also other fascist states such as Portugal and Japan-banned Esperanto. Many Esperanto speakers were killed in concentration camps, including two of the founders of the Esperanto museum, Gustav Weber and Alfred Mayr. From 1936, Stalin, at the other end of the political spectrum to Hitler, also began to liquidate the Esperanto movement. Although there was no formal ban, around 10,000 Esperantists were killed. Those who were lucky enough not to be arrested and tried in show trials kept their knowledge of Esperanto secret. It was only after Stalin's death that the Esperanto movement gradually became established again in the Soviet Union.

Currently about 3 million people speak Esperanto. There are associations and publishing programmes and World congresses are held annually with 2,000-6,000 Esperanto speakers from 50-70 countries. A number of international Esperanto organizations devoted to medicine and health are also active, including an international association of medical students. The Universala Medicina Esperanto-Asocio publishes an Esperanto medical journal, *Medicina Internacia Revuo* (<http://ttt.esperanto.org/umea/> access by pass word). This journal was founded in Japan in 1923 and is published twice a year. Up until the 1960s abstracts in several medical journals were published in Interlingua. Information about health (sano) can also be found on the web in Esperanto (e.g. <http://www.google.com/alpha/Top/World/Esperanto/Sano/>).

Esperanto is a regular language which is easy to learn and remember because of its simple but effective word building and because it only has 16 basic rules of grammar. The



The Department of Planned Languages and Esperanto Museum in Vienna was founded in 1927. It holds the biggest collection of artificial languages in the world and includes a linguistic research library for language planning. Even an Esperanto edition of *Asterix the Gaul* and a copy of a Klingon-English dictionary as used in the science fiction series *Star Trek* can be found amongst its tomes.

<http://www.onb.ac.at/ev/collections/esperanto/>

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vocabulary is based on European languages, especially on the Romance languages, and its grammatical system is similar to some Asian languages. Because it can be mastered relatively quickly Esperanto seemed to be a miracle to many of its speakers, and they felt compelled to inform the world of this excellent means of communication. However, the world is a cynical place and was not responsive to the message. There are still Esperantists who strive for Esperanto as a second language for all, according to the original ideals. Based on its linguistic qualities, Esperanto is in a position to solve the language problem once and for all. But this is not the only issue. The reason why Esperanto hasn't attained its goal is due to historical, political and economic circumstances. It would appear today that Esperanto is a long way from reaching its ultimate goal of solving the problem of global language.

There is however another group of Esperantists, for whom the language is simply an excellent tool for intercultural communication. This does not come into conflict with English, as almost every Esperanto speaker can also speak English. For this group of Esperantists, this international language community offers an alternative world wide web, in which everyone speaks their own language-namely Esperanto. Esperanto is not felt to be a foreign language but belongs to everybody who learns it, and is mastered by the Esperantists. A mouseclick in the Internet proves the vitality of these aspects of Esperanto.

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## European Commission's initiative on scientific journals

A report commissioned by the European Commission put forward proposals to make scientific information freely available and at the same time safeguard scientific publishing. Its proposals include ranking journals by quality (which would encompass search facilities and copyright policies as well as scientific excellence), tax advantages for electronic publishers, and setting up a pan-European non-profit research archive (*BMJ* 2006;332:928). The Commission invites feedback on the report ([http://europa.eu.int/comm/research/science-society/pdf/scientific-publication-study\\_en.pdf](http://europa.eu.int/comm/research/science-society/pdf/scientific-publication-study_en.pdf)).

The publishing industry is facing the dual problems of increasing use of the Internet to find information and reductions in libraries' budgets. Subscriptions to journals have also decreased. (*hardly surprising with figures showing price increases of as much as 300% over inflation between 1975 and 1995*).

## How we see W.C.

We have often heard it said in medical writing courses and read it in umpteen medical writing books, "Make no assumptions about other people's knowledge when it comes to the meaning of abbreviations". I found an example of such folly when sorting through my father's old papers.

*A young couple about to be married were looking for a House<sup>1</sup> in the Country. Seeing the House and satisfying themselves it was suitable, they went home. On the return journey the young Lady was thoughtful, and when asked for the reason for her silence, replied, "Did you notice a W.C."*

*He not having done so, wrote immediately to the Landlord as to where it was situated. The Landlord did not understand what W.C. meant, and after thinking it over for a few hours came to the conclusion that it meant Wesleyan Chapel. He replied as follows:*

*Dear Sir,*

*I very much regret the delay in replying to your letter, but I have the pleasure of telling you that the W.C. is nine miles from the House and capable of seating 250 people.*

*This is very unfortunate for you if you are in the habit of going regularly, but you will be glad to know that a great many people take their lunch with them, and make a day of it, others that cannot spare the time, go by Auto, arriving just in time, but generally they are in such a hurry that they cannot wait.*

*The last time my wife and I went was 6 years ago, and we had to stand up all the time.*

*It may interest you to know a bazaar is going to be held to furnish the W.C., with Plush Seats as its Members feel it is long felt in want.*

*I mention the fact that it pains us not to go more often.*

*Yours faithfully,*

The Oxford Dictionary of Abbreviations lists the following possibilities:

w.c.: watch committee, water closet, water cock, without charge

WC: British vehicle registration for Chelmsford, war cabinet, war council, water closet, Wesleyan chapel, postcode for west central London, Western Command (military), Whitley Council, working capital.

**Elise Langdon-Neuner**

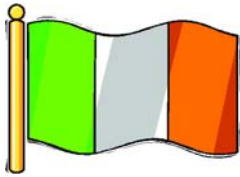
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<sup>1</sup> The capitalisation in this document, which I believe was written in the 1930s, is as originally printed.

## Clinical trials to be overhauled

Elias Zerhouni, director of the National Institutes of Health, has warned that failure to spot serious side effects of drugs quickly enough is eroding public trust in medicine. He has announced an eight point plan to improve clinical trials and reduce the likelihood of side effects being swept under the carpet (*BMJ* 2006;332:991).





## Irish: A story of survival

By Paul Dunne

David Graddol writes in his article, *The Future of Language* [1], "Most linguists agree that roughly 6000 languages exist in the world today. Yet 90% of these may be doomed to extinction, with much of this loss happening in the coming century. This article considers Irish—its history and its future.

The forms for the 2006 Census of population of Ireland were printed in 13 languages and included the question 'Do you speak Irish?' Less than 30,000 people speak Irish daily making it third in line to Polish (140,000) and Chinese (40,000) as the most spoken language after English in Ireland. The Irish language (Gaeilge) emerged as a fully structured language during the Celtic period in the Iron Age (600 BC - 400 AD). Ogham stones, pillars with a peculiar style of tick marks writing the names and indicating the burial sites of tribal chiefs, are found today at sites directly associated with Celtic mythology. Irish myths and legends, passed on through verbal re-telling, surely date back even further to the times of Neolithic man (4,000-1500BC), whose presence in Connemara, County Galway is evidenced by stone terraces, pre-bog walls and shell middens.

At an early age I began reading Celtic legends in the Irish language. Lady Augusta Gregory, a benevolent Anglo-Irish landowner, collected spoken Irish fairy tales in the Kiltartan County Galway area and published them in 1902. The legends were written in Kiltartanese, the local English patois. This book, *Irish Myths and Legends*, was incorporated into the Irish primary school system fortunately preserving these stories for the benefit of future generations. An example is the Tain Bo Cuailgne, the hunt for the brown bull of Cooley (Co Louth). Cattle determined wealth in Celtic mythology. The hunt happened because the Ulster tribes captured Queen Maeve of Connaught's prize bull. The complicated pursuit and re-capture of the bull did no one any good. Disaster dogged everyone even remotely connected with the bull. Legends explain many things including how Fionn MacCumhaill, it looks better written as Finn McCool, the genial Ulster giant, built a causeway of basalt pillars, which is well-known as the Giant's Causeway and links Ireland (Eireann) to Scotland (Alban).

Myths and legends aside, the Irish language is institutionalised by legislation including the official designation of the positions Uachtaran (President), Oireachtas (political assembly), Dail (Parliament), Taoiseach (Chief Minister), Tanaiste (Chief adviser-Vice Premier). The Irish army is given orders through Irish. An Irish person has the right to insist on conducting his affairs through Irish. Planning applications for new houses must be written in Irish in Gaeltachts (Irish-speaking areas). Irish trainee primary school teachers and second level school students are required to attend summer school in the Gaeltacht to improve their Irish.

Although Ireland's place names were anglicised during William Petty's mapping surveys of Ireland in the 1630s, now-a-days both nomenclatures are present on sign posts: Cnoc na Ri (hill of the King), Dubh Linn (black pool), Droichead Atha (the bridge at the ford), Dun na Gall (the fort of the foreigner), Cu na mara (the hound of the sea), An Daingean (the fort), Baile ns hInse (the townland of the islands), Aras na Naomh (the place of the Saints).

Irish has spread beyond its native borders too. The Irish language is part of Celtic studies courses in Hungary, the Czech Republic, Poland and Japan. I engaged in a normal fully comprehensible conversation with Nakinau Yashimoto San of Japan through the medium of Irish in the 1980s. The present Empress of Japan was educated by Irish nuns in her youth and values her early education. I met her when she, then the Crown Princess Michiko, was in Kinvara, Co Galway visiting the convent of the nun's order that had taught her.

Thus the Irish language has survived repression through time. There is also a clear nationalistic feeling of being Irish as evidenced by 2 million people attending the St. Patrick's Day Parade in New York on 17th March this year. The future of the language though is uncertain. Government institutions spend money promoting the language but this has not reversed its decline; proliferation of English seems inevitable.

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Ursula Schoeneberg in her article in the March issue of TWS this year [2] wrote that the etymology of "What a bunch of malarkey" remains in the dark. This expression is a direct translation of 'Ta sin lan de mallarta' [Sic.], (there is no 'k' in the Irish language) and translates to 'That is a load of rubbish' in English. Mallarta means rubbish and implies something is untrustworthy. A number of Irish words have infiltrated the English language, e.g. prizes galore comes from an Irish word (go leor) meaning plenty, smithereens from one (smitirini) meaning broken in small pieces, and whiskey (uisce beatha) means water of life in Irish. 'Boycott' also has its roots in Ireland. Charles Boycott was an English land agent in Ireland who was ostracized in 1880 for refusing to reduce rents.



## Applying for EU funding: Reminiscences of a novice

by Sarah Hills

Most people working in the field of health know that an EU grant is the Holy Grail. In a world of shrinking research resources, the EU is fundamental to a successful investigator-led project and once EU funding is obtained, the project is more likely to attract additional investment. But one thing you find when applying for EU funding is that few people actually have hands-on experience of the process. By 'hands-on' I mean organising a consortium, coordinating the writing of the proposal, preparing a budget and submitting the paperwork to Brussels.

### Strategic considerations before applying

Funds from the EU are public money, and the EU is rightly concerned with ensuring this money is 'invested wisely'. This means that project leaders must ensure their project aims and objectives can be *justified* as being in the public interest and relevant to Europe from a research, social and economic point of view. This issue must be addressed immediately in the proposal and continually during the life of the project.

EU bureaucrats also claim that collaborative research including partners from many countries is more efficient than many small projects working in isolation on similar projects. Collaboration is the keyword and research should be planned to fit with pre-determined themes in order to address European societal problems.

Our experience was with a successful application at the end of the 5th Framework; the 6th Framework is now in progress and the 7th will be under way soon. Each framework lasts several years and is broken down into 'calls' with more specific thematic areas. Before the framework is made public, lobbying is carried out to ensure certain research areas e.g. mental health, cardiovascular health' are included.

The differences in each framework are mainly budgetary (there is more money) and the areas of health being funded. Since our project received funding, the amount of money allocated to projects has grown vastly. We thought our consortium was fortunate to receive a grant of around 2 million euros in 2001, but projects requesting up to 12 million euros are now being funded.

Our project is now a successful enterprise. We have a consortium of 21 partners that span Europe north to south and east to west, which has made the work a challenge but also great fun! The research being carried out is in an area with

high media interest, which is helpful for attracting industry investment, raising awareness of the research, and motivating the consortium. It is worth considering that motivation does flag when work needs completing under pressure and financial reimbursement does not arrive on time from the EU.

### Our first steps

Back to personal reminiscences: our experience with the application process was laborious. We made two applications, of which the first failed after a lot of work. However, this gave us an opportunity to re-evaluate both the preparation of the budget and the way the project was organised and presented. When the scientific referee report eventually arrived it was disappointing reading, but this was serendipitous as it made for a more solid application the second time, backed by collective responsibility.

We created a Project Management Board (PMB) from leaders of the scientific workpackages (the way in which the project is structured) and decided to take the advice of an EU consultant who was working in the university of one of the PMB. The PMB members were able to work together prior to consultations and spend some time considering what information was needed from the consultant. Our consultant was rather like an old-fashioned school-master (drawing on the blackboard and setting group exercises to explain certain points) – which worked excellently.

### Feedback from Brussels

A sub-group of our PMB made a visit to the Research Directorate in Brussels for some feedback on our initial failed attempt. We were greeted unenthusiastically, and if we had followed the advice of the scientific officer who talked to us, we would not have resubmitted. Happily, after considering the situation later while sipping coffee in a café in the Grande Place, we decided to make a second attempt – feeling somewhat like David against Goliath, such had been the negative response. It is worth the time of any project coordinator to go to Brussels and meet some of the people in the directorate. Many of the personnel will follow the project through its lifetime, so establishing a relationship early on is helpful.

Completing the proposal documents (carried on the train from Italy to Paris and then on to Brussels and handed in personally) was a good feeling, despite last minute panic over signed contract preparation forms (CPFs) almost not arriving in time from far-flung partners. The following few

## Applying for EU funding

months brought snippets of good news, but also additional hurdles. Each encounter required renewed discussion and reassessment, which would have been easier if we had had more information. If I had any advice for EU novices, it would be to get as much information about the entire application process, what to do at each step and how long it will take – *before you begin writing a word*. This is easier now that many projects are funded by the EU and knowledge about the application process is much more accessible by Internet.

Requests to rewrite various parts of the technical contract came at us out of the blue – with very tight deadlines, which caused some sleepless nights! You have to remember that you are preparing a contract for *real* work, *real* people and *real* implications for local budgets – easy to forget during the months of writing.

The most difficult part was completing the CPFs in so many different countries by investigators who had even less idea of how to undertake the process than I did. After several long distance telephone calls and emails the original signed forms would arrive by courier – sometimes still not correct. We were restricted in our budget and although we were told that negotiation was possible, the contract negotiation phase was over before we realised it had begun! However, there are ways to ensure that the system works to your advantage once you are under way. Although the process appears to be inflexible, budget changes can be made after approval from the scientific officer is obtained.

Once you have made the decision to apply to the EU for funding there are certain things that will help you to make life easier:

### Before you start

Ensure your project theme ‘fits’ with the EU call. Allocate one responsible (and detail-oriented) person to coordinate the application process, collate the written workpackages, research the application process, correspond with the EU and collect the consortium documents on time.

### Do some research

If possible look at proposals from other projects (obviously respecting issues of confidentiality), nothing else is quite as helpful. If you can also get hold of the evaluation and the scoring, this is even better. Our first submission was rejected and the second submission was accepted with high points – the proposal essentially being the same, but the ‘presentation’ was significantly improved.

Get to know the CORDIS website ([www.cordis.lu](http://www.cordis.lu)). It is a mine of information, from guidelines for project management, all the financial information you will ever need, along with news of other projects. You have access to a helpdesk and specialist help with intellectual property issues (and you can sign up for an email news service).

Find a colleague who has gone through the process previously (the person who actually ‘did the work’) or who is

responsible for running projects. They are usually working in university grants and contracts departments. Alternatively locate when and where seminars and courses on Framework 7 take place (you can also find these on the CORDIS website). If you can get things right the first time this may save a costly mistake that will haunt you for the next few years (e.g. “if only we had realised that we needed to take account of the person-months for ...”).

### Submitting the proposal

Take into account the cost of actually preparing and submitting the proposal. Anecdotal estimates put the cost at around 10 000.00 euro (in our experience not far from reality). Do you have sufficient time and personnel *for just the application*? There is a large amount of writing and considerable correspondence and negotiation between the consortium. If you employ an EU consultant for the application, how much will that cost? Is the charge a one-off payment or will it be a percentage of some part of your grant if successful? Ask to see a curriculum of their previous applications and their success rate. Talk to other groups who have used the consultant. Remember you may need more advice during the negotiation process – if you are successful there are still several stages to undergo before you receive the funds.

A good consultant has inside knowledge of what is happening in Brussels, the type of project being funded and the level of funding you can expect. Consultants can advise you on how to write the proposal, and therefore increase the likelihood of success. However, they cannot write the proposal for you. Discuss within the consortium what level of offer your project will accept. Almost no project receives the full amount requested.

### Preparing the legal documents and the budget

There are several detailed forms to be completed by each institute. Give each of your partners clear instructions about how to complete the documents and give deadlines ahead of time for when you want the forms returned. Be prepared for things to go wrong at the last minute! Ensure each investigator realises that they must ask the ‘legal representative’ of their university to sign the contract (this may not be the investigator him/herself).

When the scientific issues have been considered give *a lot of attention to the budget*. Find out from the EU (can be gleaned from the CORDIS website) how the budget will function through the duration of the project lifetime and make sure everyone in the consortium understands the process (this will need repeating constantly). Relate the project budget to a realistic estimate of person-months to spend on each task. Don’t underestimate the time factor to attempt to make the project look good! Remember that in different countries different levels of staff take different responsibilities. Be economical but don’t cut quality or safety.

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>>> **Applying for EU funding****Project management**

Many projects are very strong and novel scientifically, but fail miserably by not providing sufficient information on management issues:

- *Who* will be responsible for *what* and *how* will they undertake this work?
- Will management be centralised for all aspects of the work?
- *How* will meetings and other communications function (e.g. a website is essential, a newsletter is an asset), *who* will take responsibility for these?
- Indicate how you have addressed issues of collaboration and cohesion of the consortium.
- In the Gantt chart include personnel training, preparation of documents, ethics committee submissions – allocate time generously – then double it!
- Make liberal use of Gantt and Pert charts and organigrammes.
- Keep the list of Milestones and Deliverables short and simple; the same for the Workpackages
- Remember to justify every aspect of the project.

**Ethics**

If the project requires human or animal experimentation a separate and detailed review will be carried out by the EU, if the project passes the first stage. Check beforehand that your project complies in every way with European and national ethical guidelines.

**The proposal document**

Be prepared to justify the science, the management and the social and economic value of the project.

- Keep the text simple and straight to the point, attractive and consistent.
- Make liberal use of bullet points and other indicators for emphasis.

Remember: the reviewers have limited time to assess your project against many others.

**Collaboration**

Finally, try to find partners with whom you can work – a shared motivation is important. You will need to obtain a CV from each partner to ensure they can carry out the work in the time allocated and that they have the personnel with specialist knowledge. Are your partners good communicators? Do they make good use of email and respond to your email communications promptly? This is a taste of things to come when managing the network.

And if you fail ...? Try again – don't waste your time and experience!

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A further article 'Grant writing: Satisfying all the criteria by Ian Metcalfe' will be published in the September issue.

**Writing Chinese names**

Chinese names consist of the family name followed by the first name. The family name is written first because roots are important to the Chinese. Family names say many things about one's ancestral and cultural roots. In early migrant societies, many clan associations were established based on family names, dialect groups and common geographical areas. These clan associations assist new migrants to integrate into the society of the foreign land in which they have come to seek a better life outside of China.

In China, the written form of Chinese has been 'romanised' and is called 'han yu pin yin'. However, among migrant Chinese, Chinese names are pronounced as they would be in Chinese, depending on the dialect group they come from and many 'romanised' versions exist. Hence, a few written forms exist for one family name. For example, the romanised family name, 'Lin' in China, also takes the written form of 'Lim', 'Lam' or 'Lum' among migrant Chinese. Other examples are as follows:

Cai - Chai, Choi, Chua, Tsai  
Chen - Tan, Chan  
Huang - Ng, Wong  
Li - Lee  
Liu - Lau, and the list goes on

Chinese first names usually consist of one or two characters. For example, in Lee Peng, Lee is the family name and Peng is his first name. In Lee Peng Hui, Peng Hui is his first name.

For Chinese who adopt an English name (religion is one of the many reasons for doing so), there are various ways of writing it. For example, Benjamin Lau Shun Tung can also be written Lau Shun Tung, Benjamin or Benjamin Lau. Rarer are two-character family names like Ou-yang (Ouyang or Auyong), Si-tu (Situ or Seetoh). Examples of names would be Ouyang Fen Qiang or Situ Ying.

Unfortunately for Western audiences no 'standardisation' is applicable for writing Chinese names. There may be instances where Chinese names are written with the first name as hyphenated words, for example, Peng-Hui Lee or Lee Peng-Hui. If Chinese names are written the Chinese way, that is, family name followed by first name, an English name may be added before the family name or after the first name. Confused?

I would be happy to clear up any confusions you may have about Chinese names.

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## More myths about English

by Alistair Reeves

In the last issue, I discussed 4 myths about the English language [1]. I promised to explode more myths in this issue, so without further ado, I do just that below. If you disagree with me, please let me know!

### Myth 5: ‘...ize’ is American and ‘...ise’ is British; ‘...ize’ is better (some people) and ‘...ise’ is better (other people)

‘...ize’ is indeed American, and this is what American readers expect to see. Both can be used in British English, although British writers more often use ‘...ise’. Neither is better than the other. What is important—and this will be no surprise to you by now—is to be consistent. The following does not look good: ‘To standardise our reports, we harmonized procedures for report preparation’. (This applies to mixed US and British spelling in general, but only within self-contained texts or documents, not across dossiers<sup>1</sup>.) The Oxford Dictionary lists ‘...ize’ and ‘...ise’ as ‘variant spellings’ in its introduction, and settled on ‘...ize’ for all its entries, to be consistent. Many other British dictionaries list both, some with ‘...ize’ first and some with ‘...ise’ first.

By the way: not etymologically but phonetically related to ‘...ize’ or ‘...ise’: ‘analyze’ and ‘catalyze’ are correct in American English. The British English equivalents are ‘analyse’ and ‘catalyse’. ‘Analysis’ and ‘catalysis’ are correct in both.

### Myth 6: The number of the verb after ‘none of’ is always singular

Oh, for a rule as in German (and presumably many other well-regulated languages) that the number of a verb is always determined by its subject, at least when writing!

I have seen this one almost lead to fisticuffs. The subject of many pointless discussions is the claim that there is an incontrovertible ‘rule’ in English and that you must *always* follow ‘none of’ with the singular. Who says?

What’s the story on ‘none of’? Here we go: it’s all to do with ‘countable’ (concrete) and ‘uncountable’ (abstract nouns) and whether you mean ‘not part of a whole’ or ‘not one of a group’. It is complicated by 2 things: we unfortu-

nately have a lot of ‘mixed’ nouns that are used both countably and uncountably, e.g. ‘medication’; and you often cannot distinguish between the number of a verb in the simple past in English, e.g. ‘None of the subjects developed rash’—the verb could be singular or plural here as the verb form in the simple past is the same. In many other languages, the number of the verb can always be recognised by different endings—a linguistic luxury unknown to native English speakers unfamiliar with other languages, except when using the verb ‘to be’.

What follows are not rules, they are just my pragmatic suggestion to give some guidance on this.

**Countable noun used in the singular.** Assume that a bolus injection was to be given over several minutes. You are talking about only 1 injection, even though the word ‘injection’ is countable (i.e. it can be used in the plural). In the report you are writing, it is important to document whether all or only part of the injection was given, or if it was not given at all. The injection was not given and you decide to use ‘none of’. You write: ‘None of the injection was given’. Fine. The singular is the only possibility here because you are talking about part of a whole, i.e. only 1 injection. Of course, you could have said: ‘The injection was not given’, but this is not always what you want to say.

**Countable noun used in the plural.** A patient was due to receive a series of injections over 1 week. The patient decided to withdraw from the study before treatment started. To document that the patient received no injections, you decide to use ‘none of’. You have the choice between ‘None of the injections was given’ and ‘None of the injections were given’. Both are correct. There is a *well-established convention* amongst British writers to opt for the second possibility, using the plural—and this now ‘sounds right’ to most. My impression is that American writers more often opt for the singular, but plenty of them do use the plural. If your house style, your boss or your client requires the singular, use it. If I have my choice, I prefer to use the plural. Don’t let anyone tell you that the singular *must* be used.

I have to add here that, as in the first example, you could write: ‘The injections were not given’ and avoid the problem entirely!

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<sup>1</sup> Clinical reports and summary documentation often have the text in British spelling and the ‘end-of-text’ tables or appendices in US spelling, or vice versa. Don’t worry about this. Just make sure that all of the text and all of the tables are consistent within themselves, even if they differ.

>>> **More myths about English**

If the discussion on 'none of' gets too heated, suggest a rewrite or avoidance of the verb 'to be'.<sup>2</sup>

**Uncountable nouns.** These have no plural, e.g. 'information' and 'advice', so it follows that if they can only be used in the singular, the verb following 'none of' must always be in the singular: 'None of the advice was heeded', 'None of the information was collected'.

Speakers of German, and I suspect other North-West European languages and Slav languages, please note: 'informations' and 'advices' do not exist. To render both in the plural, you have to say 'pieces of'. That's just how it is.

Thanks to the evolution of language, many nouns that were once only uncountable are now used countably, e.g. 'medication'. If you considered the series of injections in the second example above as the 'study medication' (using this as an uncountable noun), then you would write: 'None of the study medication *was* given' as opposed to 'None of the injections *were* given'. If the series of injections consisted of 2 injections of *different* drugs at each time point, you might choose to say: 'None of the study medications *were* given', but you could just as well say: 'None of the study medication *was* given'. I am not keen on using medication as a countable noun, but many writers like to use it this way.

### **Myth 7: The number of the verb after 'a number of' is always singular**

Another instance where I wish for an 'Académie Anglaise' to settle this sort of question. Like the number of the verb after 'none of', this one also leads to endless (and equally pointless) heated discussions. This is governed by the use of the definite (the) or indefinite article (a) before the word 'number'.

Consider the sentence: 'A number of variables *were* studied'. The word 'number' is clearly not plural, but the message conveyed by the phrase 'a number of variables' when it is used as the subject of a sentence clearly means 'more than 1', and 'a number of' has come to mean an indeterminate small number, 'some' or 'several' that you do not need to count. The accent here is therefore on the plural word 'variables' as the determinant of whether the verb is in the plural or singular. This is the reason why there is a *well-established convention* that 'A number of' is constructed with the verb in the plural. Again, there is no rule here, it 'sounds right'. But if you wish to persevere with the singular, nobody can tell you that you are wrong. Decide what you want to do, or do what your company or client wants you to do, and you never have to think about it again! Just be consistent.

'The number of' is different. 'The number of variables in this study *was* too high' is correct, and to use 'were' would be incorrect. 'The number' in this sense does not indicate an indeterminate number, but a definite number you have

probably counted. The accent here is therefore on the singular word 'number' as the determinant of whether the verb is used in the singular or plural.

By the way: 'The majority of ...' constructed with the singular now sounds wrong. Not 'The majority of patients was enrolled before Amendment 1', but 'were'. Government is a difficult one: official 'BBC language' is still to say 'The government are ...', so this is heard every day in the UK and plenty of people use this. I have always preferred 'The government is ...', and plenty of people use this too.

### **Myth 8: 'Prior to' is better than 'before'**

Writers—particularly those from American English-speaking areas—seem to have forgotten that the word 'before' exists, and that 'prior to' can *always* be replaced by 'before'. As is often the case, good (and bad) American English usage often eventually creeps into British English usage, and this is definitely happening with 'prior to'. I have heard claims from both native speakers from the US and the UK and non-native speakers that they have been told that 'prior to' is 'more correct' because it means 'really before' or that it is 'more scientific'. One wonders where these misconceptions come from. 'Before' really does mean 'really before' and 'prior to' does not improve upon it. As a minimalist as far as language is concerned, I prefer 'before', simply because it is a single word and has only 2 syllables. Please don't ever write 'prior to' again—but use it to your heart's content when you speak!<sup>3</sup>

A recent unfortunate development amongst non-native speakers of English and, I hate to say, some native-speakers when writing, is to use prior as a preposition: 'Prior the study...' or 'Prior the investigation...' instead of 'before'. 'Prior' without the 'to' here is definitely wrong, because 'prior' is an adjective ('In a prior study, we investigated ...'). To use it prepositionally (see above) or adverbially, it needs the 'to': 'He did it prior to me' ('before' is better anyway!).

### **Myth 9: 'Following' is better than 'after'**

'Following', when used to mean 'after' at the beginning of an adverbial phrase, should always be replaced by 'after'. Following is not better and does not add any extra meaning. Except perhaps ambiguity: 'Following the guidelines, they published a report on their findings'. Does this mean that 'They followed the guidelines to produce a report on their findings' or 'After they published the guidelines, they published a report on their findings.'? Because 'following' is a participle formed from a verb, your readers will very quickly want to see a subject they can relate to 'following'. In this case, it can only be 'they' and can only mean 'They followed the guidelines to produce a report on their findings'. If you want to express the idea of the second option

2 Speakers of Romance languages please note: English speakers will almost always write 'No injections were given' and not use a singular subject or verb when referring to a situation where it was intended to have given more than 1 injection to a group of patients or a series of injections to 1 patient. If you are describing a situation where a patient was due to receive 1 injection at a particular time and the patient did not receive it, you could write: 'The injection was due at 18:00. No injection was given and the patient was therefore withdrawn from the study'. Otherwise, the plural 'sounds right'. I have been looking for an explanation for this for years. If anyone has one, please let me know! Similarly, if no adverse events occurred in a group or study, the plural is used: 'No adverse events occurred in Group 3', and not 'No adverse event occurred ...'.

3 A note for users of 'prior to': 'before starting X' is a good substitute for 'prior to the commencement of treatment with X' and sometimes even just 'before X' is enough!



and want to start with the adverbial phrase, 'after' is necessary, even if you think it is clear from the context.

It is interesting that in our area of writing 'subsequent to' (which also just means 'after' and can also always be replaced by 'after'—it does not mean 'as a consequence of')—does not seem to have gained such wide currency as 'following' used incorrectly or 'prior to'. Maybe that it still to come!

### Myth 10: 'In vitro', 'in vivo' and 'ex vivo' should always be italicised

I give workshops on punctuation. One of the questions I ask participants is whether 'in vitro', 'in vivo' and 'ex vivo' should be hyphenated (see below) and I put up a few questions about this on the screen. I can guarantee that one participant per session will say: 'Yes, but isn't there a rule that "in vivo" must be italicised?' Not that I have heard of. This invariably causes more discussion than whether it should be hyphenated. I can't express my feelings on this better than Edith Schwager in 'Medical English Usage and Abusage' [2]:

"In vitro and in vivo are not italicised in American English usage, although they used to be. Their italicization in current American medical journals is a sign that the person in charge is not au courant or is intransigent".

As far as I am concerned, this also applies to British English. Not italicising these terms means that you never have to check that you have always italicised them—and why bother, when scores of other Latin and Greek terms are not italicised?

There are, however, 2 principles to follow:

- If a journal, your boss, your client or your conscience wants them in italics, just do it! Don't even think about it. But make sure you are consistent. This will give you

hours of fun checking with 'Search and replace', especially if you are also required to italicise 'et al', 'i.e.' and 'e.g.' (which is actually equally inappropriate). If you are a freelancer, make sure you add the time to your invoice; if you have an employer, make your employer aware that this is wasting your valuable time, but don't argue too much!

- If you have a choice, decide what you want to do and also be consistent.

A note here on hyphenation of 'in vivo', 'in vitro' and 'ex vivo': it should never be necessary and *there is no rule*, whether you use them as modifiers ('in vivo investigations') or adverbially ('This was demonstrated in vivo.'). If you have the formulation 'We demonstrated in in vivo investigations that...' you might feel the need to hyphenate it thus: '...in in-vivo investigations...' because of the successive 'ins'. Expend some energy on avoiding this rather than using the hyphen. Possibilities here are: 'We demonstrated in vivo that ...'; or 'In vivo investigations showed that ...'.

*Streptococcus faecalis* and all similar names (genus plus species) are italicised. This is one of the best accepted conventions throughout the world. I have yet to hear anyone object to it! This does not apply, however, to the general use of a genus in the plural (streptococci) or adjectives derived from a genus (streptococcal). Another 'by the way': 'Haemophilus' retains the 'a' in American English because this is its official name.

More myths in the next issue!

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## Addressing Japanese

Although family names are given first in Japan, the Japanese are comfortable switching the order in a non-Japanese context. So, for example on the English side of a Japanese/English business card, the name is given in the Western order of family name last. They graciously extend this courtesy of changing their names to suit Western understanding when addressing non-Japanese, so if you receive a letter from "Kyoko Higuchi," then "Higuchi" will most likely be the family name. There is no clear rule that would help one differentiate a family name from a first name. One possible clue is that many women's first names end with "-ko" as with Kyoko, Yoko, Kumiko. So if the author is Kumiko Tanaka, you have a reasonable chance of being correct that the author is a woman and her first name is "Kumiko." But the "-ko" only helps sometimes. If the author is Kumiko Kaneko, you're in trouble. One way to solve the problem would be to employ the Japanese "san," which is not gender-specific.

If you write "Dear Kaneko-san" you can't go wrong.

Greetings should use the formal Mr/Ms/Mrs—for example "Dear Ms Higuchi." Never assume a first-name relationship since in Japan even good friends and co-workers use the last name, "Higuchi-san" or "Ms Higuchi," when speaking to each other. And don't forget the title. Calling someone just by their family name, i.e. "Higuchi" is rude rather than chummy.

A typical way of beginning a personal letter in Japanese is to open with a remark about the seasons—the beauty of the cherry blossoms or fall color. For business letters in English, however, the Japanese follow Western form. There are loads of books in Japan on how to write business correspondence in English. Even so, adopting the Japanese sensibility of beginning a letter with a polite inquiry or remark is never a bad idea.

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## You can reduce but not decrease a patient's temperature

Every sentence contains a subject and a verb. Not all sentences contain an object. The verb in a sentence is either transitive or intransitive. If it is transitive it transfers action from the doer to the direct object. If it is intransitive it does not transfer the action and the action solely relates to the subject. Therefore only sentences with transitive verbs contain an object. Many verbs can be used either transitively or intransitively. In the sentence 'The patient was lying on the surgery table' the patient is the subject and the verb 'was lying' is intransitive because it does not transfer action to any object. According to Robert Iles' guidebook to better medical writing, in the sentence 'The assistant helped lay the patient on the surgery table' the verb, 'lay' is a transitive verb because it transfers action direct to the patient, who is the object [1]. To complicate matters it could well be argued that in fact 'lay' is not the main verb but rather it is 'helped' (i.e. lay is an infinitive with the 'to' in 'helped lay' understood).

Perhaps the patient was lying on the table because she had a temperature and the doctor reduced/decreased/lessened/diminished/abated/lowered her temperature.

Although reduce and decrease, like lessen, diminish, abate, and lower all denote making or growing less, they aren't exactly the same. Decrease is the 'odd verb out'. It isn't idiomatic English to decrease something because decrease is an intransitive verb. You can cause someone's temperature to decrease but you cannot decrease a per-

son's temperature. Likewise you can cause someone's temperature to fall, but you would never think of writing 'fall their temperature' because in the present tense 'fall' can only be used intransitively. By contrast 'reduce' and the other verbs listed can be used as transitive verbs so you can reduce (lower etc.) someone's temperature.

But it's more than a matter of grammar. Decrease is precisely used only when it retains its etymological implication of the process of growing less. Decrease suggests a progressive decline, as, for instance, his temperature decreased (or fell).

Reduce suggests the operation of some agent, as to reduce the amount of drug needed to be given. Reduce also applies to lowering a status or condition, as in 'his temperature was reduced from a high temperature to normal'.

With thanks to David Loshak<sup>1</sup> for the 'temperature' explanation.

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<sup>1</sup> The term prospective trial is a pleonism<sup>2</sup> was the title of an article in the *Lancet* [2]. David Loshak wrote a letter to the *Lancet* in which he agreed that the pleonastic use of the word prospective in combination with trial should be stopped. He also suggested that authors could do the English language a favour by not confusing gender and sex<sup>3</sup>, decrease and reduce, continuous and continual, and demonstrate and show all of which he had spotted in one day's reading of medical literature [3].

<sup>2</sup> See De Looze S. All Gendered up. *The Write Stuff* 2004;13 (3):73-75

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## Meeting the final goal of trial registration

The May 2004 the International Committee of Medical Journal Editors (ICMJE) editorial proposing trial registration before the onset of patient enrolment as a prerequisite for future journal publication, started what can be considered a revolution in access to clinical trial information [1]. This initiative has two aims. Firstly, information on recruiting trials should be available to all patients willing to participate. Secondly, after finalisation of a study, study results should be accessible irrespective of study outcome, thus preventing publication bias or even suppression of negative results. As treatment decisions in evidence-based medicine can only be as good as the respective publicly available information, unbiased access to study results is of crucial importance to treatment quality.

So far, no statement has been made by the ICMJE concerning the impact of publication of study results in a trial registry on the chances of journal publication. Some journals are not accepting manuscripts of data that have been

previously posted in a publicly accessible clinical trial registry because they consider this to be prior publication. They ask authors to postpone results publication in a registry until the manuscript is in their online-journal. A clear commitment from the ICMJE to accepting a manuscript for publication, although data are already available in a trial registry, would ensure full transparency of trial performance and reporting, defined as the final goal of the 2004 editorial. Rejection of a manuscript because it is considered a redundant publication of data is contradictory to the original goal. This approach delays public access to study results and might even encourage misconduct: by deferring the journal publication process, the publication of study results in a registry could be by-passed with excuses that a 'manuscript is under preparation'.

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## More about clinical trial registration

The comment section of the *Lancet's* 20 May 2006 issue has some interesting articles about clinical trial registration. Relevant to prior publication and trial result registration is an item entitled 'Trial summaries on results databases and journal publication' by F. W. Rockhold and R. L. Krall of GSK (p 1635-6). The authors report experiences of editors considering registry of trial results as prior publication. They state that already with the advent of results data bases the reporting of clinical trials is beginning to follow a new sequence: first as summaries on public websites, then at scientific congresses, and then in peer-reviewed journals. The authors encourage the International Committee of Journal Editors (ICMJE) to support early posting of International Conference on

Harmonisation E3 summary results without prejudice to subsequent opportunities to publish.

At the ICMJE's meeting held in Oslo in January this year the Committee reported increasing trial registrations. Both *JAMA* and *NEJM* had refused to publish a trial that had not been registered. *NEJM* employs a person to check registry entries before a trial is accepted for publication. The ICMJE also expressed an intention to change their uniform requirements to include something on acknowledging medical writers and their funding sources (*European Science Editing*, May 2006;32(2):30).

For information about which registries are acceptable to the ICMJE see the FAQ at [www.icmje.org](http://www.icmje.org).

## Quality and translations: Will the new European guideline help?

When browsing through a bilingual in-flight magazine on an Iberia flight last year, I was surprised to read that "Stephen Frears is shooting The Queen". Of course, from the context (a section about the film industry), Stephen Frears was not planning an assassination and the syntax of the sentence is fine. Nevertheless, this translation is obviously flawed and, unfortunately, the same can be said for many other translations. Spain, for example, seems plagued by "cowboy" translation agencies that deliver shoddy work because they pay translators poorly and don't properly review the translations they send to the client (at a high mark-up). Clearly there is room for improvement.

Enter the new European guidelines drawn up by the European Committee for Standardization (abbreviated to CEN) that will come into force later this year. They are designed to ensure that, in these days of closer European integration, translation companies in different countries are held to the same quality standards. The quality of a translation is hard to actually measure and so the guidelines focus on the translation process itself. For a company to be certified as compliant, it will have to have in place certain procedures, not just for the translation process itself but also for giving quotes, project management and billing. A detailed discussion of the new guidelines can be found at the following web page: [www.lisa.org/globalizationinsider/2005/04/the\\_en15038\\_eur.html](http://www.lisa.org/globalizationinsider/2005/04/the_en15038_eur.html)

For the purposes of this brief overview, three main points are of interest:

- Translators should either have a recognized qualification or proven experience in translation.
- The translation should be revised by someone other than the translator. The reviser is required to be competent in both the source and target languages.

- The translation may optionally be reviewed by a specialist in the field (e.g. a physician for a biomedical translation).

There is some debate about what effects the implementation of these guidelines will have on both translation agencies and freelance translators. The hope is that the guidelines will weed out abusive agencies that provide poor translations. Freelance translators can, in principle, become certified if they can guarantee that another translator will revise their work. In practice though, certification is expensive and this may discourage most freelancers, and some freelancers worry they may be squeezed out by the big translation companies. We hope to debate possible implications of the new guidelines for freelance translators at the upcoming Mediterranean Editors and Translators' Meeting in Barcelona this October (see [www.metmeetings.org](http://www.metmeetings.org) for further details).

A further topic of debate is whether the guidelines will actually do what they set out to do—improve quality. A revision of the translation by another pair of eyes may well pick up small (or big) mistakes, but obviously a revision will only be as good as the reviser. If the reviser is not sufficiently knowledgeable in the field of the translation, he or she may well be tempted to make inappropriate changes. Fluid dialogue between the translator and reviser could go a long way towards avoiding this problem, although this is not provided for in the guidelines. At the end of the day, the truism that "you get what you pay for" will probably still apply, and the new guidelines will simply add an extra guarantee.

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# On the Net...

## Drug Testing, Adverse Reactions, and the TGN1412 Disaster

by Karen Shashok

*Internet coverage of the TGN1412 Phase 1 trial disaster, 20 March to 29 April 2006.*

Compliance with the protocol, ethics committee approval and informed consent were not enough to protect healthy volunteers for a phase 1 trial in a London hospital from life-threatening cytokine release syndrome, which nearly killed two of the first human recipients of a new biological agent. The patients' clinical ordeal, attempts to explain the severe adverse reactions, and experts' discussions of what should be done to prevent similar mishaps were quickly covered on the Internet. If you're in a hurry for more information about the catastrophic failure of the TGN1412 phase 1 clinical trial, I recommend the weblog run by Health Care Renewal [1], the collection of UK and US news clippings compiled by the Alliance for Human Health Research Protection [2], the Black Triangle blog run by Anthony Cox [3], and the Wikipedia entry for TGN1412 [4]. If you want a broader overview of web coverage, read on. This review does not cover all the issues this case raised, but looks at some of the most informative sites and singles out a few highlights, as well as a few missed opportunities to use the Net to best advantage.

### What happened?

On 13 March 2006, a monoclonal antibody designated TGN1412, developed by the German biopharmaceutical firm TeGenero AG (founded by researchers who discovered the "superagonistic" mechanism of action of certain monoclonal antibodies), began its first phase 1 trial at the clinical pharmacology unit operated by contract research organisation (CRO) Parexel International in Northwick Park Hospital, London. Eight paid volunteers were given an injection; six received the active agent, two were given a placebo. Within hours (or minutes, according to some reports) each of the six men who received the drug became critically ill with multiple organ failure; their lives were saved because they were already in hospital when their symptoms appeared, and so were immediately given high-quality care. Two of the men fell into a coma that lasted 8 days in one case and nearly 3 weeks in the other. As of late April 2006, all patients were recovering from the cytokine release syndrome triggered by TGN1412, but one was expected to lose some fingers and toes to dry gangrene, and the long-term sequelae (if any) in the other volunteers had not been made public. Neither TeGenero nor Parexel had posted any updates about the incident since 5 April 2006.

The monoclonal antibody was designed to stimulate regulatory T cells of the immune system via surface receptor

CD28, and had been approved for phase 1 testing by the UK's Medicine and Healthcare Regulatory Agency (MHRA) and the local ethics committee. The protocol had reportedly been followed correctly, although reports varied regarding the timing of administration of the dose to successive participants. Not all specialists concurred in hindsight, but toxicology studies done before testing in humans had seemingly not given any warning that such a severe adverse reaction might ensue.

The MHRA immediately investigated the incident, and in early April concluded that the adverse reactions were most likely caused by an unpredicted biological action of the drug in humans, ruling out errors in manufacture, formulation, dilution or administration. The UK Secretary of State for Health announced it would establish a group of international experts to study how the case could affect clinical trial regulations worldwide. In the interim, the MHRA will require additional expert opinion to rule out the possibility of similar adverse events for first-in-human trials of any monoclonal antibody or other novel molecules that target the immune system. How the incident will change procedures for approving phase 1 trials of biologicals remains to be seen.

### What was useful about Internet coverage?

Coverage of the TGN1412 phase 1 disaster on the Internet quickly provided several different angles on the story. Although rather little information was provided by TeGenero [5], Parexel promptly issued a media advisory about the adverse reactions, with frequent updates and a list of FAQs about TGN1412 [6]. The hospital where the trial was run also issued press releases on its website [7].

News articles initially emphasised concerns for the patients' lives and reflected health authorities' surprise at the adverse reactions, which were completely unforeseen. When the MHRA investigation found no error on the part of the manufacturer of TGN1412 or Parexel, later articles wondered how the mishap could have occurred despite the fact that all appropriate regulations had been followed and all necessary permissions had been obtained. Editorials in medical journals called for greater transparency in the process of developing new drugs. As Goodyear noted in the *BMJ*, "We have been assured repeatedly that proper procedures were followed, when the real question is whether they were the right procedures" [8]. Commentators concluded that although the clinical protocol had been implemented correctly and all oversight measures had been followed, the oversight process itself was not sophisticated

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enough to detect the risk to humans of testing a monoclonal antibody designed to “override” the immune system.

**Blogs to the rescue**

Some of the most up-to-date information and insightful discussion about the case were found on weblogs run by people familiar with health care and the pharmaceutical industry. Postings on Health Care Renewal, run by Dr RM Poses [9–14], raised several issues ahead of journals and news agencies, and this may have been the first source to call publicly for “complete transparency about the drug or device to be tested, and how testing will be performed and supervised.” Other postings on this blog summarised information published in the press and journals, and editorialised on their implications for the drug and device industry, informed consent procedures and approval of phase 1 trials for new biologicals.

A couple of threads on the Black Triangle blog (maintained by Anthony Cox, MRPharmS) also contained judicious evaluations of the failed trial and the MHRA interim report [15]. Interestingly, one of the bloggers who responded to the initial posting [dsquared, posted 8 April 2006] thanked Cox for his “hard work updating the Wikipedia entry on this subject.” Indeed, the Wikipedia entry for “TGN1412” was packed with clearly written information on the experimental drug and the events surrounding the adverse reactions [4]. Cox later reported the partial recovery of the last of the patients to be moved out of critical care, several days after the media’s attention had turned elsewhere [16]. His editorial on the failed phase 1 trial, published in *Prescriber* on 5 April and posted on the blog on the same day, is, however, gentler on the pharmaceutical industry than the debate that took place on Black Triangle [17, 18].

Random John reloaded [19], a blog run by a biostatistician who worked in the pharmaceutical industry before he became interested in alternative medicine [20], frequently tracks information about the drug industry. The postings here—many from experts, with only a few of the more inane sort of messages some blogs attract—were lucid and contained interesting links. “Random John” provides biographical information about himself that enables readers to decide how biased (or objective) his postings on health care, the drug industry and other scientific matters are likely to be—an example that ought to be imitated more widely.

**Calls for transparency heeded**

Both the CRO and the MHRA were criticised for not making public the consent form Parexel had used for this phase 1 trial, and questions were later raised regarding whether the risks of the study had been explained clearly enough to participants [21]. The Bloomberg news agency, cited by Health Care Renewal as the source of information on the consent form, faulted the risk-disclosure form on several points and noted that Parexel had “declined requests to release the document,” adding ominously that TeGenero “says it doesn’t have a copy to provide.” Eventually the informed consent form was made available, along with many other documents relating to the case, by Citizens for

Responsible Care and Research [22]. Meanwhile the case stirred anew suspicions that CROs, their clients, and even regulatory agencies might be cutting corners in order to speed approval for new drugs. At the time of this writing, documents relating to the phase 1 trial, including the clinical trial assessment report, investigator’s brochure, investigational medicinal product dossier and protocol, had been released on the MHRA website [23].

**Newspapers, magazines and news agencies**

As media attention turned toward analysis of the causes and consequences of the mishap, the Bloomberg news agency joined many online sources in concluding that existing mechanisms of scientific and ethical oversight for risky phase 1 trials were inadequate, and in suggesting that the commercial nature of CRO operations in general may undermine ethics and transparency. One article [21] noted that a previous investigation by the agency found “conflicts of interest and lax oversight in the US for-profit drug-testing industry,” but missed a golden opportunity to include a link to that story.

*New Scientist’s* coverage emphasised immunological aspects of the drug’s effects, and was the first to report on information available in the scientific literature about the possible risk of non-specifically activating natural killer T cells [24], an angle that the Times Online also quickly pursued [25]. The weblinks provided with this and an earlier *New Scientist* article dated 15 March [26] were generally useful. Coverage of the case by the Guardian Unlimited was timely if somewhat superficial, and the links in their articles were generally less useful because they tended to link to sources about medicine and health, but not to pages that contained up-to-date information specifically on the TGN1412 case. An early article on the case in the Times Online did a fine job of giving readers enough accurate background information about clinical trials so they could grasp the importance of the TGN1412 failure, and made technical information understandable for lay readers without oversimplifying things [27].

In an article uploaded on 20 March, the Breitbart news agency [28], which compiles news from Reuters, Associated Press, AFP and the Drudge Report, cited Janet Derbyshire, head of the clinical trials unit of the British Medical Research Council, as saying that the accident could not have been avoided with current testing methods. The article suggested that better ways to assess the safety of new drugs might involve laboratory animals genetically modified with human genes, using miniscule doses in a part of the body “isolated” from the rest of the body, testing new drugs in one person at a time rather than several simultaneously, or allowing compassionate use in patients with the condition the drug is intended to treat (which would amount to using a cohort design rather than a randomised design).

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**Ethics and economics**

Under the heading “Medical Wonder Drugs” [29] former US congressman turned news writer Martin Frost posted a series of articles about the TGN1412 trial that touched on big issues (such as how regulatory oversight has become difficult given the “sheer volume and complexity of modern drug cures”) as well as specifics concerning the drugs’ mechanism of action in experimental animals and humans, with an interesting detour into the history of legal and ethical measures to protect human guinea pigs. Like Frost, other sources wondered whether the MHRA might be hampered by conflicts of interest. DrugResearcher.com cited and linked to a parliamentary select committee report filed a year before the TGN1412 calamity that “casts doubts on whether the MHRA should be investigating itself” [30]. According to the report, “[t]he organisation has been too close to the industry, a closeness underpinned by common policy objectives, agreed processes, frequent contact, consultation and interchange of staff.” This report, like an article from the excellent collection compiled by Alliance for Human Research Protection, suggested that the MHRA could not objectively investigate Parexel’s role in the events because “The organisation, process and techniques of the MHRA are focussed on bringing drugs to market fast.” Another ethical concern raised by the parliamentary report was the possibility that participants in clinical trials were sometimes given “limited information” and exposed to “unacceptable risks” [31].

Several sites worried that more lax ethical guidelines in the UK than in other countries might be attracting clinical trial business that stricter countries have eschewed. On 19 March, a Times Online article said, “[r]ecruiters favour the UK because the regulatory process here is seen as speedy. To critics, the regime is also inadequate” [32]. An item in the Wiley-produced website Pharmafocus.com that provided the points of view of major pharma and biotech industry groups in the UK observed that “[t]he UK is home to around half of all Europe’s phase 1 studies, and some fear disproportionate safety measures could be put in place, potentially undermining the country’s research base” (and possibly scaring away lucrative clinical trial business?) [33]. Mathaba.Net, citing an article published on 19 March in The Independent, reported that Parexel’s application for institutional review board approval for a phase 1 trial of TGN1412 at a German centre had been denied because of ethical deficiencies [34]. (On 26 April 2006 Google found about 288 hits for “IRB shopping.”) The recruitment pitch used by Parexel was quoted on many websites because it gave the impression that voluntary participation in the phase 1 trial for TGN1412 was akin to a paid holiday in restful, entertaining surroundings, with free food, no housekeeping responsibilities, and plenty of time to relax, watch digital TV, play video games or pool, use a DVD player, and enjoy free Internet access [35]. Despite media reports of the extreme distress and critical illness the vol-

unteers experienced, several sites noted the paradoxical surge in interest in volunteering for clinical trials, since information about the payments volunteers sometimes receive figured prominently in media reports. [36].

The implications of the disaster for future efforts to develop therapeutic monoclonal antibodies were the subject of an item on Pharmaceutical Business Review Online. As a “PBR Staff Writer” noted, “The indications for which TGN1412 was targeted, namely oncology and immune and inflammatory disorders, are areas forecast to see the strongest growth, and the trend toward [...] humanised products, rather than murine and chimeric antibodies, is also expected to gain momentum [...]. The high-profile failure of TGN1412, a drug candidate that falls within the most promising sub-categories of this new drug class, could have negative implications for drug development within this sector” [37].

**Conclusion**

The Internet enabled institutions put under pressure by the adverse reaction—the manufacturer of the new drug, the CRO hired to run clinical trials, the hospital where the volunteers were treated, and the UK drug regulatory agency MHRA—to quickly disseminate their press releases and the results of their own internal investigations. Errors in the manufacture or administration of the drug were ruled out, and the cause of the severe adverse reactions was identified by exclusion as the experimental drug itself. Immunologists and ethicists could then turn their attention swiftly to a review of the scientific literature to search for information that might explain why TGN1412 triggered cytokine release syndrome. Earlier research reports were soon found that suggested this possibility, raising new questions over whether the phase 1 trial that almost killed six men should have been approved. Internet dissemination of calls for more transparency was probably a factor in decisions to release documents about the trial to the public. Regulatory agencies, health authorities, ethics committees, and especially clinical trial sponsors, organisers and would-be participants are now awaiting the outcome of efforts this incident has spurred to improve the oversight of phase 1 or first-in-human trials of biological agents.

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**Note:** The MHRA released its final report on the trial on 25 May; see [http://www.mhra.gov.uk/home/idcplg?IdcService=SS\\_GET\\_PAGE&useSecondary=true&ssDocName=CON2023822&ssTargetNodeId=389](http://www.mhra.gov.uk/home/idcplg?IdcService=SS_GET_PAGE&useSecondary=true&ssDocName=CON2023822&ssTargetNodeId=389) and references 5 and 7.

## Grammar comes naturally

Surprisingly some fundamental characteristics of grammar are common to all languages. Researchers at the University of Rochester, USA, lead by Elissa Newport, studied gestures made by three deaf Nicaraguan boys. The boys had independently developed their own gestural-based language at home. Their 'home sign systems' were not influenced by any spoken language because they had been deaf since birth, or from any written or sign language because they had received no formal education.

The boys watched 66 short videos after which they explained what they had seen by using their home sign gestures. Each of the boys were found to have created a grammatical component for 'subject' which they used in the same form as highly evolved languages use it. The concept of 'subject' is complex because it can be the instigator (active) or the recipient (passive) of action in a sentence. That the boys developed the 'subject' concept without any outside linguistic influence and used it in the same way as other languages use it indicates humans have an innate ability to develop such grammar concepts. The researchers are continuing their search for further innate aspects of language.

It was Newport who established that there are crucial times in children's development when they are primed to learn languages after which this ability declines.

Source: Newport EL, Coppola M. Grammatical Subjects in home sign: Abstract linguistic structure in adult primary gesture systems without linguistic input. *Proc Natl Acad Sci U S A*. 2005 Dec 27;102(52):19249-53



## O frabjous day!

by Ursula Schoenberg

At the risk of boring you, I can only repeat that language is a wonderful thing. A token of the resilience of the human spirit is the fact that new words are being born daily, even while their creators are slaving in the midst of corporate life. I've collected a few examples to amuse you:

**bobbleheading:** The mass nod of agreement by participants in a meeting to comments made by the boss - even though most have no idea what he just said.

**C-gull:** A C-level executive with the habit of swooping in and out meetings and leaving a huge mess for subordinates to clean up.

**clockroaches:** Employees who spend most of their day watching the clock instead of doing their jobs.

**marginalienation:** Cryptic comments scribbled in the margins of a document that leave you questioning the author's sense of reality.

**meanderthal:** Someone who has a difficult time getting to the point when giving a presentation.

**mercky:** Pharmaceutically dubious, as in "Data from the Vioxx trials are in and the results appear to be mercky."

**monopologue:** A one-sided "discussion" in which an individual monopolizes the dialogue, giving no one else a chance to get a word in.

**pajamahadeen:** The new media watchdogs. Bloggers who spend their days surfing the Net, challenging and fact-checking the traditional media.

**prairie dogging:** A modern office phenomenon. Occurs when workers simultaneously pop their heads up out of their cubicles to see what's going on.

**salmon day:** The experience of spending an entire day swimming upstream only to get screwed and die in the end, as in "I've really had a salmon day."

**sarchasm:** The gulf between the author of sarcastic wit and the person who doesn't get it.

**verbicidal:** Condition that exists when a person believes he or she is skilled in the use of words (a verbalist), but in reality is grammatically challenged.

**See also:**

<http://www.buzzwhack.com/buzzcomp/indac.htm>

**Ursula Schoenberg**

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### A limerick for EMWA

Do medical writers thrive in their trade  
presenting research that others made  
are they wizards with words  
or bookworms and nerds  
do they like to hide in the shade?

In EMWA we meet and take courses  
on CTDs, adverbs and how to find sources  
ghostwriting guidelines  
tasting of wines  
Come to EMWA, let's join our forces!

**Kari Skinningsrud**

*Public Relations Officer*

*Kari invites members to submit their limericks to her at [pr@emwa.org](mailto:pr@emwa.org)*

### Who spoke Pidgin English?

At seaports in China in the middle of the nineteenth century Chinese traders bartered with Europeans in a special form of simplified English. The language they used became known as 'bidgin' English, reflecting a Chinese pronunciation of the word 'business'. 'Bidgin' later corrupted to 'pidgin' and became the expression for any kind of simplified language used by those who were otherwise unable to communicate. But making assumptions can be imprudent. A typical story is that of a lady who found herself sitting next to a Chinese man at an official dinner. Throughout the dinner she spoke to him in Pidgin English. At the end of the dinner he was called to give a speech, which he delivered in perfect English. On returning to his seat he asked the lady "Likee speechee?"

Source: Collins Dictionary of Curious Phrases by Leslie Dunking, HarperCollins, Glasgow, 2004. ISBN 0 00 716596 X



## Report from the Freelance and Small Business Forum in Lyon

by Alison McIntosh

The Lyon meeting was our 4th Freelance and Small Business forum—a much-needed fixture. Five members were with us for the first time. The total gradually grew from 17 to around 30, as we started earlier than the end of the advanced workshops finished. Many of the freelance writers also attend advanced workshops, so we'd appreciate it if this could be taken into account in future.

Questions from new freelance writers included the perennial: what to charge for work and finding sources of work. The results of a survey on charges carried out by Alistair in 2003 are available in the 'Members only' section of the website. The survey is being repeated in a simplified form, and we were each given a questionnaire to complete. If you would like to copy of the questionnaire, please contact Alistair (a.reeves@ascribe.de). Abbreviated results will be published in TWS and a full summary on the website (Members only).

The EMWA freelance listing was praised as a good source for work. There was also some discussion around the increased charges for advertising on the EMWA website (€ 100)—an increase of 100%! The EMWA treasurer (also a freelancer) advised us that the cost had been maintained at a very low level for a number of years and that an increase in charges was inevitable. Developing your own website was also recommended as a worthwhile way to advertise your expertise and services. The redesigned website will offer a separate opportunity for those running a small business—with more than one employee—to advertise in a similar way.

An animated discussion took place around completing test pieces of work. Generally, it was felt that when you were busy, slotting in unpaid work was difficult. Others commented that they would refuse to complete a test as their experience in the field should be what potential clients appreciate. In reality, it is a balance between how much work you have, how much time you have to devote to writing tests, and whether or not you really want the work! If you have examples available and can release these outside confidentiality agreements (texts in the public domain, for example), it is worth sending these to clients. Testimonials from other clients might also be useful.

Professional indemnity insurance was touched upon again. It was still felt to be too expensive and available sources don't yet cover our type of work. In the UK, the Institute of Clinical Research is negotiating an affordable package for its members. Useful information for those in the UK.

On a positive note—we managed not to raise the issue of VAT at this forum. Does this mean we have all got to grips

with it at last? Thanks once again to Alistair for organising and chairing the meeting and also undertaking the new survey of pay rates.

A bientôt, auf Wiedersehen - see you in Vienna next year!

**Alison McIntosh**

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### Mediterranean Editors and Translators **METM 06: International Communication-Promising Practices**

27-28 October 2006, Barcelona, Spain  
[www.metmeetings.org](http://www.metmeetings.org)

METM 06 will promote training for and networking among editors, translators, linguists and oral communication coaches who work in the European and Mediterranean area. A new feature in 2006 will be one afternoon of training workshops.

The program will consist of

- Plenary lectures on big issues: working with demanding clients, and plagiarism
- Panel discussions on communication organisations and translation standards
- Short presentations with discussion
- Short workshops with tasks and discussion of concepts or practices
- Training workshops with task-based learning experiences that go more deeply into editing, translation, or oral communication skills

For information on how to register for METM 06, please visit  
[http://www.metmeetings.org/pagines/metm06\\_call.htm](http://www.metmeetings.org/pagines/metm06_call.htm)



# A "Hello" from Lyon: EMWA conference lunchtime discussions

## Medical writers: Are we all dilettantes?

*'Dilettante – One who interests himself in an art or science merely as a pastime and without serious study' (The Shorter Oxford Dictionary)*

Our discussion group had members from a range of European countries (including Serbia) and it was interesting that the word 'dilettante' was used in all the languages represented in the group. Dictionary definitions are useful but don't always convey the full sense of a word as it is used; impressions implied by 'dilettante' in the different languages included:

- Pretence (of competence)
- Knowing a little about many subjects
- Vague
- Superficial
- Lacking formal education
- Jack of all trades.

Everyone agreed that medical writers must be able to learn new subjects rapidly, and that rather than being experts in a particular subject, medical writers are experts in communicating about that subject. A key skill is in knowing how to acquire knowledge rapidly and when to ask a true expert; all in the group had good access to literature-searching facilities. An advantage of having a shallow knowledge spread widely is that we can often facilitate communications between those who are true experts in disparate fields. All in the group had at one time or another taken on projects involving topics or documents types they had never worked on before. Apart from gaining knowledge from the world-wide web and PubMed, one ploy was to ask the client to send a recent document "...as I'd like to follow your in-house style." We agreed that while we may not be experts per se, we are expert at becoming experts.

The overall conclusion of the group was that we liked the idea of being thought of as dilettantes – perhaps we should add it to our business cards – "A.B. Smith, Medical Writer and Dilettante".

**John Carpenter**  
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## Freelancing in the German speaking countries: For those considering or already doing it and for those who employ freelancers

As it turned out the majority of the lunchers were actually interested in setting up a freelancing business in the German speaking countries for a variety of reasons:

- one, a postdoc, is approaching the end of her contract in an academic setting,



- one, presently in industry, is fed up with being moved around,
- one, presently at home for family reasons, wants to break out and
- one, presently in the States, is looking to expand his business into Germany because his freelancing opportunities have decreased as pharmaceutical companies have started employing more in-house staff and are outsourcing less.

It was strange that almost all of the conversation was held in English. Freelancers in Germany seem to be very comfortable in the language.

**Rosie Bischoff**  
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## Who makes the better medical writer: The linguist or the scientist?

Whether they have a science or arts background, the most important 'prerequisites' for medical writers are enjoyment in communicating with the written word, and an interest in medicine or 'science' in general. The 'linguists' (4) and scientists' (5) (who—quite by chance—had broadly distributed themselves into two separate camps around the lunch table) all agreed on this point (there was also one person who had degrees in English and Physics). Whatever their background, and even if they have a 'talent' for writing, writers in our field have to develop the specific writing skills required to be able to communicate scientific information to very different expert and lay audiences. These skills do not come automatically. 'Having an analytical mind' is not the preserve of the scientist, and gaining a degree or a doc-

## A "Hello" from Lyon

torate in the humanities or life sciences does not mean that you can write well—or even enjoy writing. Many of those at the lunch table had discovered that they 'liked writing' or 'seemed to be able to do it better than others' whilst originally pursuing other activities where the focus was not on writing (academic research, teaching, clinical research activities). Also, simply being a native speaker of English is not a passport to good writing in English in our field, and non-native speakers—whether 'linguists' or 'scientists'—with the 'prerequisites' are capable of writing high-quality documents in English, even if it is usual to have a 'quality check' done by a native speaker with the appropriate skills. EMWA offers an excellent opportunity for medical and scientific writers and communicators with backgrounds in the humanities and sciences to come together. An opportunity that members with the different backgrounds and the organisation should—and do—exploit, but this could be intensified.

**Alistair Reeves**

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### Selling the science: Developing a marketing mindset

The idea of this discussion table was that, as conventional medical writers move out of pharma companies into groups or freelance operations, they increasingly find themselves working on projects with a commercial communications aim. This table aimed to allow an exchange of experiences of coping with the transition. However, it developed into other areas.

Some table participants working in communications had found the transition from a scientific environment to the commercial world difficult. Two training needs and possible topics for future EMWA conferences emerged: selling yourself, which would focus on personal aspects such as confidence and could be taught by a personal trainer, and how to market your (or your company's) services.

**Geoff Hall**

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**Medical writing made easy at the EMWA conference in Lyon.**

### Who is a medical writer?

Few EMWA conference attendees were interested in discussing who is a medical writer; only 1 person signed up, 2 others showed up at the table and 4 or 5 others sat down because the table was empty and they wanted to eat their lunch in peace.

I am interested in the topic because I have been asked by the American Medical Writers Association (AMWA) to write an article on who is a medical writer. Initially I thought defining a medical writer would be an easy task. I surveyed the websites of AMWA, EMWA, and the International Committee of Medical Journal Editors and interviewed the grande dame of Biomedical Writing in the US, Edie Schwager, who lent me old books describing the history of the professional medical writer since 1912.

In the postgraduate degree program in Biomedical Writing that I run at the University of the Sciences in Philadelphia the definition is "Medical writers are trained scientists who translate data that they have analyzed, and may have created, into prose, tables, and figures, on behalf of a sponsor from the private or public sector". One of my lunch partners objected strenuously to this definition because she believes data has to be approved by experts such as medical officers and statisticians. I believe medical writers need to be experts in statistics, document templates, regulatory agency requirements and laws and also therapeutic areas.

Interestingly two students from my program gave feedback on my article. Both were named authors on the article, and both withdrew their names immediately before publication because they feared for their jobs. Why were they afraid? Probably because of my brief discussion of the ethics of authorship, which EMWA and AMWA is bravely sorting out. However, has a single medical writer not been asked "What is that?" and how many physicians, nurses, lawyers, engineers are asked the same question?

**Susanna Dodgson**

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### Medical writing tips of the month in *Chest*

The April 2006 issue of *Chest* announced a medical writing series. The first article in the series published in that issue was 'Preparing Manuscripts for Online Submission' and related primarily to submissions to *Chest* through the Manuscript Central system. May's article was 'Some Concrete Ideas About Manuscript Abstracts' by Mary Ann Foote and June's article will be 'How Authors Cope with the Burden of English as an International Language' by Benfield and Feak (cited in Benfield's article in this issue of TWS on page 48).

[www.chestjournal.org](http://www.chestjournal.org)

## &gt;&gt;&gt; A "Hello" from Lyon

**Helping non-English native speakers overcome publication barriers**

Natives of China, Germany, Japan, Singapore, and The Czech Republic took part in this discussion as well as two English native speakers working in Germany and Austria. All non-native English speaking participants had a foundation in science.

A couple of participants had experienced prejudice from international journals when submitting manuscripts from countries in which English was not the national language. If a request that an English native speaker edit the manuscript was made after acceptance this would not constitute prejudice in the review process.

International journals are receiving an increasing number of articles from China. The editor of the *New England Journal of Medicine* recently toured Chinese cities giving lectures in which he encouraged manuscript submissions from China. The Chinese participants said authors are eager to write well in English. Writing courses are being provided in China by Elsevier publishers. A Japanese participant had arranged for an American to give medical writing courses to members of her team.

**Monkey business in Lyon**

These monkey will be familiar to attendees of the 'Time management for Medical Writers' workshop held by Debbie Jordan at EMWA's Lyon conference. The monkeys are part of a time management exercise called 'who's got the monkey?'. Each monkey is a project that sits on its owner's back and has to be kept under control and looked after. Otherwise it breeds and suddenly you have lots of monkeys (problems) to deal with or it gets neglected and dies (or it can be shot and you then have the post-mortem, but we are probably best not going there!).

Chinese and Japanese participants working in international companies described difference practices for writing regulatory reports. In China they are first prepared in English, then approved by their headquarters in Europe, then the medical writers translate the reports into Chinese because they are required to lodge them with the Chinese health authorities. In Japan documents are first prepared in Japanese, then translated externally if submission to authorities outside Japan is intended or if they need to be approved by their head office.

On participant, who taught medical English in Germany, was concerned that teachers did not have any certification to prove their credentials to teach medical English. She also felt that a non-native English speaker could not produce a document of such a high standard of English as a native speaker was able to. She always had her own work checked by a native English speaker.

Whether a native English speaker applicant would be preferred for a medical writing position was not discussed.

**Elise Langdon-Neuner**

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**Can medical writing save Western Civilization?**

Several people came to this lunch discussion table curious to find out the answer, although some had doubts as to whether Western Civilization could be saved or was even worth saving, let alone by medical writers. The idea behind this topic was to examine the role of science communicators, such as medical writers, in helping to increase scientific literacy in the world. Most of the greatest and most difficult problems facing the world are related to the fact that human society has become extremely dependent on sophisticated technology and yet with the exception of a small, highly educated elite, the majority of the world's population is deeply ignorant of science. It was generally agreed that science writers could play a vital role, but everyone also agreed that in general it is not done very well. We heard various tales of horror from around Europe of the misreporting of science information in the press or the misuse of science by politicians. The conclusion seemed to be that society is not being very well served by science journalists, who are journalists who just happen to report science. What we need are more scientists who have been trained to communicate.

**Barry Drees**

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**More Pidgin**

When the Duke of Edinburgh visits Vanuatu, in the Pacific, he is addressed as 'oldfella Pili-Pili him b'long Missy Kween, while Prince Charles is 'Pikinini b'long Kween'.

Source: The meaning of Tingo by Adam Jacot de Boinod Penguin Books 2005



## A "Hello" from Lyon

**Chocolate for body and soul: Searching for the best chocolate in Lyon**

I spent my first day in Lyon doing research for my lunchtime discussion. It was tough work, but someone had to do it! Lyon is considered the gastronomic center of France and its chocolate culture is vibrant. My prework identified a must-visit institution, Le Bernachon, considered one of the finest chocolate houses in the world. Le Bernachon is one of a scant handful of chocolate makers who roast and grind their own cocoa beans on a daily basis, respecting the craft *à la lyonnaise*. Its selection of over 50 varieties of tablettes alone proved rather daunting! Say nothing of the dozens of special hand-made delicacies, such as le palet d'or, fresh cream and dark chocolate ganache adorned with gold leaf...and priced accordingly!

After visiting Le Bernachon, I simply wandered the streets of central Lyon and discovered many delightful chocolatiers, all of whom had a different specialty and a story to share. I dutifully collected specimens from each shop to tell with my EMWA colleagues.

An eager group joined my table, and a few disappointed diners were turned away. We introduced ourselves by divulging our favorite chocolate...and a few private obsessions that will not be passed along in these pages. With the exception of one member from Belgium and two from the UK, the table was dominated by chocolate-loving Germans. A brief discussion of health benefits, the trend toward single-estate chocolate, and the concept of menus plaisirs, small, satisfying doses of pleasurable foods, lead to what everyone was waiting for...tasting. We compared two brands of 70% cocoa tablettes. The savvy group immediately noticed a difference in color, texture, and smell before anyone got a sample into their mouth. Appearance does matter; the satiny chocolate exploded on the palette while the dull chocolate, well...sat there. We finished by tasting a bizarre blue creation resembling a sea anemone—just for the fun of it—and the happy group left with a list of Lyon chocolatiers complete with addresses and bus/metro instructions in hand. Later that afternoon, I met two eager colleagues on the number 4 bus headed out for a Lyon chocolate adventure!

**Suzann Johnson**  
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**'Lay/lie', Bob Dylan and the late Pope**

The distinction between 'lay' and 'lie' is also on the way out. When Bob Dylan sung "Lay, lady, lay" on my big brass bed' standard speakers regarded it as an error, common enough but subliterate. But when the late Pope died, I heard a very well-spoken BBC commentator refer to the Pope 'laying in state'. Normally, it is in set phrases like this that obsolete terms survive longest. If 'laying' has replaced 'lying' even in this sort of phrase, the distinction is dead.

**Nick Hudson**  
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**'Might/may' be a tragic loss**

As an editor I apply a test for the changing usage of words. If I 'correct' something, do my authors say 'Thanks' and accept that they slipped, or do they defend their usage as a respectable variant? When I make corrections between 'effect' and 'affect' my authors still say 'Thanks'. This may not be the case in a few years, and then we will have to admit that the battle has been lost. But it will not be a tragic loss. For an example of a tragic loss, try the following:

'As a girl, the Queen had many suitors whom she might have married'

'As a girl, the Queen had many suitors whom she may have married'

When the latter appeared in the Sydney Morning Herald in about 1995, it was greeted with roars of laughter and an avalanche of letters saying that the sense demanded 'might'. Everybody seemed to recognize that 'might' implied 'but she didn't', whereas 'may' implied 'and probably did'. This is because both 'may' and 'might' can be used for outcomes which are possible; but if the chance never existed or has past us by, the only word is 'might'.

However, today, 'may' is almost universally used in both senses. It has been a startlingly quick change which has created a genuine ambiguity. I have heard 'may' used more and more in the old 'might' sense. But it also continues to be used in the old 'may' sense, so that the possibility of making this subtle distinction is no longer available.

Two recent anecdotes illustrate how complete the change has been:

1. Only this evening I heard 'might' used in the old way, and thought to myself 'Thank God someone still recognises this usage'. In short, it is now so rare that I was surprised when it was used, not shocked when it wasn't. And I suspect that many people would (if they noticed it at all) have thought that it was a quaint and old-fashioned usage.
2. I lecture regularly to trainee editors, and sometimes throw in that 'Queen' story to see how many of them find it funny. Last time I did this, just one of a class of 25 laughed. I asked her to explain the joke, and she said she was only laughing out of politeness because I clearly thought it was funny.

My advice for an editor faced with this problem is that if the distinction is critical (as it might be in medical discourse) it is best either to rephrase entirely or to add a few words which makes it clear, e.g. 'may or may not have married' and 'might have married, but didn't'.

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**Webscout:**

## Online resources for science writers

by Joeyn Flauaus

There are a number of career options in the field of science writing such as medical writing, science journalism, technical writing/editing, marketing, science textbook publishing, etc. Because writing careers are extremely different, every science writer has different desires and needs. To know which topics are hot at the moment, you need to keep up to date by using a broad range of media and sources to discover the most interesting discussions, information, and ideas emerging around the world. Various new forms of media such as blogs, videoblogs, podcasts, and photo sharing sites also render assistance to broaden your horizons.

Are you interested in science writing or science communication, but don't know where to begin? Are there any workshops or fellowships to help you to develop your science writing? Do you need practical tips on how to get started in science writing? What are the challenges of science journalism? So many questions arise.

Since the Zen master said "Questions are good, answers are better", a selection of links for those interested in becoming science writers is provided below. The sites seek to improve the standard of science writing by putting members in touch with each other as well as with sources and markets for their work by providing opportunities to meet leading scientists and by organising trainings and seminars.

### <http://www.cjr.org/>

The Columbia Journalism Review (CJR) is one of America's media monitors. The site is a watchdog of the media and monitors newspapers and magazines, radio, tel-

evision, and the Web. The CJR analyses the media not only on a daily basis but also analyses the many forces influencing the media, such as politics, economics, science, etc. A CJR magazine is published six times a year (available online) and offers a good mixture of reporting, commentary, and media criticism.

### <http://www.bbctraining.com/styleguide.asp>

This site, a service of the BBC, allows downloading the comprehensive BBC News styleguide to improve writing. The styleguide aims to raise writing standards by confronting you with bad journalistic style such as clichés and jargon to encourage you to improve your writing style. The site also offers the possibility to comment on articles as well as to submit your own articles.

### <http://www.councilscienceeditors.org/>

The mission of the Council of Science Editors (CSE) is to promote excellence in the world of scientific communication. The CSE's purpose is to serve members in the scientific writing community by promoting networking, training, and discussion.

### <http://www.esf.org/eusja/>

The European Union of Science Journalists Associations (EUSJA) enables science writers throughout Europe to keep in touch with each other. The members of EUSJA are the national associations of science writers throughout Europe. The site provides some useful links on the EUSJA "Resources for Science Writers" page, and also offers a quarterly newsletter.

### <http://www.badscience.net/>

If you are in the mood for some distraction then you should dive into the world of "Bad Science". Weekly columns are published in The Guardian to point out common misinterpretation of scientific findings in the media worldwide. Every week they either comment on some barking pseudo-scientific quack, or a science story.

### Joeyn Flauaus

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## Jinxed in translation

Is a spade really a spade or is it a boat or a sword? Plutarch who wrote in Greek coined the phrase 'to call a boat a boat'. Erasmus erred in translating the phrase into Latin thinking the word Plutarch had used derived from 'to dig'. The Latin translation became 'to call a spade a spade'. Spade caused translators another problem when the phrase 'as black as the ace of spades' was translated into English from Spanish. The phrase refers to the playing cards. Although the translation might seem logical the original word used was 'espada', which actually means 'sword' in Spanish.

Source: Collins Dictionary of Curious Phrases by Leslie Dunking, HarperCollins, Glasgow, 2004. ISBN 0 00 716596 X

Please email me at [joeyn@trilogywriting.com](mailto:joeyn@trilogywriting.com) with any URLs comments or suggestions for the next issue.



**Journal watch:**

## Ghostwriting: EMWA fights back

by Helen Wiggett

Following on from the last issue, we continue with the topic of 'ghostwriting' and ethical publication practices. You will remember that the *Clinical Journal of Oncology Nursing (CJON)* spoke out recently against the use of medical writers in publications [1]. According to their editor, Joyce P Griffin-Sobel, the use of medical writers is not only unnecessary, but also fraudulent. Unwilling to sit back and take the flack, a group of EMWA and AMWA members fought back with a letter to the editor, which clearly pointed out some of the journal's misguided opinions [2]. The letter began by applauding the *CJON* in their efforts to eradicate unethical publication practices and to develop the publication skills of nurses, but pointed out that banning all papers written by medical writers was not the way to go about things, and could actually lead to important papers falling by the wayside. The letter went on to point out that trained medical writers are highly skilled in the art of communication - that is what we do. Specialised training in cancer care does not necessarily give you the skills to write effectively, and vice versa. The letter ended by introducing the efforts of AMWA and EMWA to prevent undisclosed ghostwriting, with reference to the AMWA position statement and the EMWA guidelines [3, 4], and an appeal to the *CJON* to join us in our efforts.

Unfortunately, the editorial board at the *CJON* failed to see our point of view. In their response, they openly reject the premise that medical writers are better prepared to describe data and its interpretation than nurses [2]. The problem, as they see it, is that 'medical writing associations have not taken an enforceable stand against ghostwriting.' Try telling that to the EMWA Ghostwriting Task Force!

Happily, the *American Journal of Health-System Pharmacists (AJHP)* has taken a more realistic approach. A recent editorial in the *AJHP* outlined the journal's efforts to encourage authors to disclose the use of professional medical writers in publications [5]. The editorial openly acknowledges that 'With proper disclosure, the involvement of medical writers benefits all'. *AJHP* also admitted to using professional writers to assist busy practitioners and stated that their policy is to identify the practitioner as the author and the writer as the interviewer who prepared the text.

The issue of conflicts of interest has also been in the medical news. The *British Medical Journal (BMJ)* reported that the *Journal of Thoracic and Cardiovascular Surgery* has developed a new form for obtaining specific information on conflicts of interest from authors. In addition, the journal has introduced a 1-2 year ban on publishing in the jour-

nal for any authors deliberately failing to disclose any potential conflicts of interest [6]. The journal's editor, Dr Wechsler, highlighted the need for transparency and emphasised that papers would not be rejected on the basis of conflicts of interest. The *BMJ* also sought opinions on the proposed ban from professionals in the field of publication practice. Professor Michael Callahan, professor of emergency medicine at the University of California and vice president of the World Association of Medical Editors, felt that such a ban would fail to solve the problem and that journals would do better to report failure to disclose conflicts of interest as possible scientific misconduct to the author's institution. In contrast, Michael Farthing, principal of St George's Hospital Medical School, London and former chairman of the Committee on Publication Ethics, felt that the ban could act as a deterrent and might be most effective in small specialities where there are few available journals in which to publish.

Finally, in AMWA's bid to raise awareness about ethical publication practices, a number of AMWA members were interviewed for an article on ghostwriting that appeared on the front page of *The Wall Street Journal* at the end of last year [7]. Interviewees were quizzed on AMWA's code of ethics and position statement and reasons for its development. Unfortunately the article contained some misinformation. This was corrected in a response letter from representatives of EMWA and AMWA, which *The Wall Street Journal* published in a subsequent issue albeit minus all the authors' names except one, which doesn't suggest they care too much about authorship [8].

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Hey, it's only my opinion:

## What's the patter?

By Diana Epstein

Although born and bred on the south side of Glasgow, I left the city when I was a child and moved to Israel and then to Germany. Last year I relocated to my native English-speaking city. I thought this would be a good step for myself and my two daughters and of course we all speak English. But what happens when the natives do not speak—ahem—the Queen's English?

This question was raised within the first week of my return. I decided my *bairns*<sup>1</sup> should experience public transport. We took bus number 44A into town. Somewhere between Crosshill and Bridge Street we heard a resounding "*Scummindooninbuckits!*"<sup>2</sup> exclaimed by a fellow passengers. My younger daughter asked "Mum, what language was that? Don't they speak English in this country?"

The broad Glaswegian accent can almost be considered a foreign language. Michael Munro states in the introduction of his book *The complete Patter* [1], 'Glasgow language is a valid and creative dialect of Scots, not, as some would have it, a slovenly corruption of standard English'. And Stanley Baxter explains in the forward to his book, 'Glaswegian is the lingua franca of Scottish comedy' [2].

Glasgow must be the only city which encourages pupils at the local comprehensive to study *The Broons*<sup>3</sup> as part of the English curriculum. My daughters learned to write and pronounce words such as *caurs*, *canny*, *filla*, *sumdy* and *wallies*<sup>4</sup>.

I began to watch a soap opera called *River City* to pick up the native language again. The stories are like everywhere else but offer a fascinating insight into the language. I hardly understood the dialogue or the storylines when I watched the first two programmes. By the third I was able to point out who was married to whom, who was cheating on whom and who was related to whom. To give you an insight the word *doolander*<sup>5</sup> comes up regularly.

What's more I believe that the Glasgow patter is becoming quite international. For example, *Whiddje*<sup>6</sup> is now in daily use in parts of England. The prefix is generally used when asking a question of importance, for example, *Whiddjewaant?*, *Whiddjehinka um?*, *Whiddjefur?*<sup>7</sup>

However one tends to view and respond to the natives in this city nobody seems to be put off by the lingua franca. Indeed Glasgow is the only European destination in this

year's Frommer's guide book to make it to the world's top ten 'must see' destinations. The guide describes Glasgow amongst other things as 'more cosmopolitan and modern than its capital neighbour'.

I hope that the readership of this column will not be put off from visiting. I can thoroughly recommend the beautiful city of Glasgow to enrich your English beyond even what you can learn at the EMWA conferences.

But hey, it's only *ma* opinion

**Diana Epstein**

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## English may not curry favour

The concept of bilingualism let alone multilingualism is one that often bewilders English native speakers. Take Queen Victoria for example. When she became Empress of India in 1887 she thought it politic to learn Hindustani. To this end she appointed an Indian, Abdul Karim, to teach her the language. Soon after the Munshi's arrival, the Queen recorded in her journal: 'Am learning a few words of Hindustani to speak to my servants. It is a great interest to me, for both the language and the people.' The Queen failed to master Hindi although she did developed a much talked about relationship with her 'Munshi' or teacher. Through Karim the Royal household developed a taste for curry. Oddly enough 'curry' is an English word with no direct translation in any Indian language. It is not clear where the word came from but the COD refers it back to the Tamil word 'kari' (pronounced 'curry') which means a type of sauce.

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1 Bairns = children

2 Scummindooninbuckets = raining cats and dogs, raining heavily.

3 The Broons is a comic strip of the Brown family with cult status in Scotland.

4 Caur = cars; canny = can't; filla = fellow, any male person; sumdy = somebody; wallies = dentures, false teeth.

5 Doolander = a powerful blow; a thump.

6 Whiddje = what do you?

7 Whiddjewaant = what do you want?; Whiddjehinkaum = what are you thinking of?; Whiddjefur (e.g. in a restaurant) = what would you like?

## Thanks to Rosie Bischoff and Pamela Johnson

The EMWA Professional Development Committee (EPDC) was set up in 1999 to develop an EMWA training programme for medical writers/communicators in Europe. Founder members of the committee were Julia Cooper, Wendy Kingdom, Rosie Bischoff, Stephen de Looze, Pamela Johnson, the late Nick Thompson and myself.

As a result of the hard work of the committee not only do we now have an extensive number of foundation level workshops and an established foundation certificate, which is being increasingly recognised as a valid qualification by employers, but we also have a rapidly expanding advanced programme.

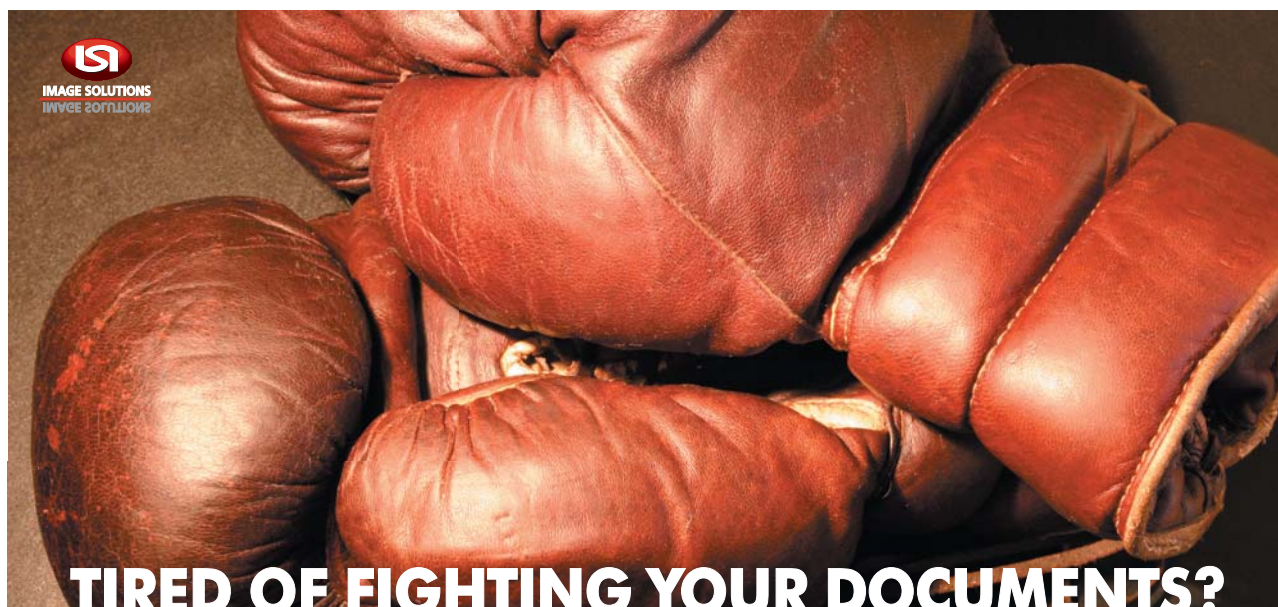
It was agreed with the EC at the end of last year that a period of tenure should be introduced and that existing members would retire from the committee after 7 years. In future, all new EPDC members will serve for a maximum of 5 years. As a result, Rosie Bischoff and Pamela Johnson agreed to retire at the end of the Lyon conference. (Stephen de Looze and I will retire from the EPDC in 2007).

I would like to express my thanks to both Rosie and Pamela for the stalwart support, hard work, dedication and time that they have given to the EPDC over the years. In addition to the work associated with the EPDC, they have developed and run their own workshops and Pamela has also provided support to workshop leaders through the 'train the trainer' sessions. They have both made a significant contribution to the EMWA Professional Development Programme. I know that they will miss the challenge of the EPDC but I am equally sure they will welcome a break and appreciate having some free time during future EMWA meetings.

John Carpenter and Helen Baldwin-Ferreira have been appointed to replace Rosie and Pamela and join Stephen, Beate Wieseler, Julia Donnelly, Barry Drees and myself on the EPDC. I hope they enjoy serving EMWA in this capacity and I welcome them to the committee.

### Virginia Watson

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