FALL 2017

Caduceus

Publication of the Medical Division of the American Translators Association

ATA58…

… is around the corner! This year it will take place from October 25th to 28th in Washington, DC, our beautiful nation's capital. If you haven't been there, it is a city full of history and tradition.

The conference will take place at the very centrally located Washington Hilton. If you are looking for a roommate, feel free to look for one on our Facebook page: https://www.facebook.com/groups/ata.med.div/

This way you can save money and make a new friend!

From the Administrator

We are very excited about ATA58, not only because it will take place in Washington, DC, which is full of fun things to do and sights to see, but because the Medical Division is working on having its ATA58 sessions approved by CCHI. This will be very beneficial for our medical interpreters. We are working in collaboration with the Interpreters Division to get the session approved by IMIA as well.

Our guest speaker this year will be Bruce Adelson, Esq., a former senior trial attorney for the Civil Rights Division of the US Department of Justice. He is a nationally recognized speaker and is well known for his profound commitment to defending our patients' rights to equitable language access. His presentation on The Legal Case for Language Access and Culturally Competent Health Care will be on Saturday at 10 AM, and he will be highlighting actual cases and academic studies.

I can't wait to see everyone!

Marisa Gillio
Medical Division Administrator

Editorial

Did you miss us? Because we certainly did miss our readers.

In this edition we have great material for our medical translators and interpreters!

Matt Capelle will explain the differences between durable powers of attorney in the US and abroad and their scope. Danielle Maxson will tell us how to use encryption for e-PHI to protect ourselves in this digital world. Helen Eby gives us insights on the book Writing for Today's Healthcare Audiences by Robert J. Bonk.

Our new section "Dear Florence" was written by Sean Normansell, and "Eponyms and Other Stories" talks about Down syndrome and was written by yours truly.

Please continue contacting us with your articles, suggestions, and ideas (instructions on how to do so are on page 10). Welcome to the new edition of *Caduceus*!

Best,

Gloria M. Rivera
Caduceus Editor

I Hope You Never Have to Send this Letter: Using Encryption to Protect e-PHI and Yourself

Dear Agency Owner,

Pursuant to the requirements of the HIPAA/ HITECH Breach Notification Rule[1], I am writing to inform you that my laptop computer was recently stolen. The laptop's hard drive included all the files I translated for you this year, and the passwords to my cloud storage accounts are also on that computer. None of the information is encrypted or protected in any way, so it is highly probable that the thief will be able to access the patient records I have translated for six end clients through your agency over the past four years.

Please forward this information, as well as a list of the files I translated, to all six end clients, so that they may fulfill their obligation to report the breach to the Secretary of Health and Human Services.

Please also notify End Client A that I have translated files for more than 500 of their patients, so they may be required to inform the media of this event.

Sincerely,

Unprepared Translator

None of us wants to send that letter, and if we're prepared, none of us will have to. For medical translators who work with patient records, the HIPAA Security Rule requires us to take special measures to protect those records and the electronic Protected Health Information (e-PHI) in them. But ever since this rule was written, we've witnessed the challenges inherent in following it as insurance companies and large healthcare providers report misplaced or stolen laptops and storage media, ransomware attacks, and even accidental publication of patient information on the Internet. With each passing week, more and more e-PHI is subject to unauthorized access and disclosure. Even the biggest players in the game can't seem to fulfill their legal obligations to protect information that should remain private.

So we're left with questions and concerns about our role in protecting e-PHI. What should we do with a hard drive full of imaging reports and discharge summaries? Is cloud storage allowed, or even possible? Do we need to become computer geniuses in order to protect this information properly?

The good news is that there are ways to handle these issues without breaking the bank or losing our minds. The HIPAA Security Rule offers guidance by defining three types of safeguards we should put in place: administrative, physical, and technical. The technical safeguards are the ones that can address cybersecurity issues. They cover a variety of procedures and technologies, but this article will focus on controlling access to e-PHI we work with and store (e-PHI at rest). One of the best ways to protect it is by using encryption.

According to the Health and Human Services website, encryption is defined as "a method of converting an original message of regular text into encoded text."[2] It's a safer option than simply password protecting a file, folder, or access to a user desktop because encryption changes the data in the file to make it unreadable. Password protecting a file can be useful for some purposes, but a password can be hacked or bypassed altogether. I've done this myself, with no training in IT or experience in hacking. After forgetting the password for my computer, I started up another computer, did an Internet search, learned a half dozen ways to bypass or reset the password, and regained access to everything in about 20 minutes. If I'd been able to bypass the password on an encrypted file, however, I would have seen only a string of gibberish instead of a readable file. Encryption actually scrambles the content of the file until the proper key is used to unscramble it, so any curious eyes will be disappointed.

To encrypt the files you keep on your computer or other storage media, you'll need encryption

software. There are a variety of options available, from freeware and paid programs to applications like BitLocker, which is built into some versions of the Windows operating system. Some include extra features like secure file deletion or two-factor authentication. Just choose one that you can understand and use easily, and make sure it supports at least AES-128 bit encryption.

If you plan to store your files in the cloud, encrypting them is still possible (and encouraged!), but the logistics are a little trickier. The cloud storage provider becomes a Business Associate, so you must have a Business Associate Agreement (BAA) in place for you to ensure that the e-PHI you store will be protected. Several well-known services will provide a BAA, including Microsoft (for OneDrive), Dropbox, and Google (for business customers only, not the free accounts). As of this writing, Apple does not provide a BAA for its iCloud service, so that option is not HIPAA-compliant. Once you choose a cloud service that can provide a BAA, you may also need to contact your clients and seek their permission to use the cloud for their projects. An NDA or other agreement between you and your client may already prohibit this, so always be sure to check your paperwork and communicate your plans clearly.

Once you've chosen an encryption solution and learned how to use it, don't fall into the trap of thinking this is a one-step solution. Having encryption software doesn't help if you leave a file on an unprotected disk or drive. You will need to make a habit of either encrypting every file or of using only encrypted drives. Most importantly, have a plan to keep and protect your password. As I described above, getting around normal password protection is fairly easy, but if you lose the password to an encrypted file or disk, it's a different story. Without the password, you will not be able to get at the information. Keeping this in mind, choose your password carefully!

If your files are encrypted and your laptop is stolen, how would that affect the letter you send to your clients? For HIPAA purposes, you would not have to notify them at all! The breach notification provisions of HIPAA state that we do not need to report that e-PHI was improperly accessed if we have "a good faith belief that the unauthorized person to whom the impermissible disclosure was made, would not have been able to retain the information."[3] This is called the Safe Harbor provision, and it can save us the stress and embarrassment of telling multiple clients that our work for them has been compromised.

There is one thing, however, that encrypting our storage media cannot do: it cannot protect e-PHI when we send it to or receive it from a client. Those files are called "e-PHI in motion," and protecting them will be the subject of a future article.

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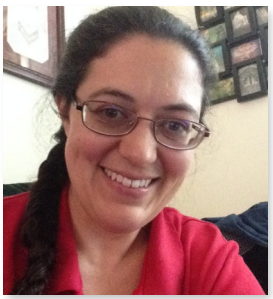
1. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) and The Health Information Technology for Economic and Clinical Health Act of 2009 (HITECH) together established and expanded protections for the privacy and security of patients' sensitive health information. These protections were unified in the Omnibus Rule of 2013. For a brief history of the development of HIPAA legislation, see https://www.halock.com/blog/hipaa-hitech-omnibus-definitive-chronology/
2. https://www.hhs.gov/hipaa/for-professionals/faq/2021/what-is-encryption/index.html?language=es
3. https://www.hhs.gov/hipaa/for-professionals/breach-notification/index.html



Danielle Maxson, CT is an ATA Certified Portuguese and Spanish into English Translator. She earned Bachelor of Arts Degrees in English (*Summa cum Laude*) and Spanish (With Highest Distinction) from the University of Oklahoma, and a Master of Arts in Spanish from the University of Wisconsin-Madison. She is based in New Windsor, NY, where she lives with her husband, their six children, and more yarn than she will ever have time to knit.

Durable Powers of Attorney in Health Care in the U.S. and Abroad

None of us wants to think about our own mortality. However, as sure as the sky is blue, the life we live will eventually come to end. When planning for this eventuality, most of us take out life insurance policies, draft wills, set up trusts, etc., so we can make sure our children and loved ones are taken care of once we are gone. One thing some of us do not consider is appointing someone to make decisions on our behalf in the event our mental or physical faculties have diminished to the point where we can no longer decide for ourselves. Medical interpreters and their patients alike will find this comparison of how different countries deal with this especially relevant.

Prior to the 1980s, the only legal process available in the U.S. was long and costly guardianship proceedings, whereby the court would appoint a guardian once incapacity was declared by a physician. Although these proceedings still exist, the U.S. now provides for a durable power of attorney, which is an exponentially faster, easier, and cheaper way to delegate someone trustworthy to handle our affairs and make health care decisions on our behalf. Several countries in Latin America only allow for the court-appointed guardian to make these decisions, although some other countries in Latin America and Spain have taken great strides in providing freedom and flexibility in the appointment of a representative.

Peruvian law establishes the concept of a Curador, Spanish for Conservator or Guardian, an individual who is entrusted with representing incapacitated individuals. The Peruvian Civil Code limited who could be a Conservator to only family members, unless none exist, in which case the judge would appoint one. The appointment is done through non-contentious proceedings filed with the court by the interested party. A physician's certification must be provided indicating the incapacitated individual's mental state, along with the names and addresses of all family members, the petitioner's identification, the birth certificate of the incapacitated individual, and where applicable, marriage licenses or death certificates of family members. Family members are summoned to testify in favor or against the person to be appointed as Conservator. However, this process was expedited slightly by the addition of Article 568-A in 2010, which allowed a fully-capacitated adult to appoint his or her own Conservator, which is done via public instrument in the presence of two witnesses and is recorded in the Registry of Persons. Nevertheless, if an individual has not taken the time to appoint his or her Conservator and register it, the law stipulates who this person will be, and this process is a time-consuming and costly burden.

The Civil Code in Spain also establishes a Guardianship (Tutela in Spanish), which contains similar rules and procedures for the judicial appointment of a Guardian for an incapacitated individual, once said incapacitation is declared by the judge in the appropriate civil proceeding. The Civil Code also sets forth the right to appoint his or her own guardian in the event of a future incapacity. Furthermore, Spain has also enacted several regional laws that give more freedom and flexibility to an individual in the event of his or her eventual incapacity. For example, Law 21/2000 de Cataluna, which has regional application, allows for the establishment of a living will (documento de voluntades anticipadas), which is specific instructions to the attending physician if the individual suddenly becomes incapacitated. This document also allows the individual to name a representative to act in his or her stead to express the will of the incapacitated individual. A living will must be executed either before a notary public or three witnesses, who must be of legal age and in full legal capacity, two of which cannot be first- or second-degree relatives or have any association with the assets of the grantor. Different regions throughout Spain have enacted similar laws allowing for these same rights and protections. Mexico also has similar laws and procedures for appointing a guardian as those in Spain and Peru. The Civil Code for the Federal District not only

provides for the naming of a guardian but also for a conservator who oversees the actions of the guardian. It outlines who may and who may not act as a guardian or conservator and states that a guardianship cannot be granted until the incapacity has been declared in accordance with the law. The Rules for Civil Procedure for the Federal District also sets forth the non-contentious proceedings that must be filed before the court in order for a judge to appoint a guardian. However, five amendments to the Civil Code for the Federal District enacted on May 15, 2007, now afford an individual with the power to appoint his or her own guardian. The law states that the appointment must be done in a public instrument and certified by a notary public. Amendment Four to Article 469 establishes that the public instrument may contain the minimum amount of powers and obligations the guardian will have, which are that the guardian must make appropriate decisions regarding medical treatment and care for the individual's health. These five recent amendments to Article 469 are highly significant, because they expedite the appointment process of a guardian and make it far less financially burdensome.

An important side note must be included here regarding notary publics. The requirement to execute this appointment before a notary public is not as cost effective and is far more elaborate in Latin American than in the United States. Due to cultural, historical, and legal events that will not be discussed here, the notary public in every Latin American country has become a highly important and prominent figure, because the notary public is vested with a very particular and formidable power, which in the civil law system is referred to as *Fe Pública* (literally this translates as Public Faith, but conceptually it refers to the full faith and credit vested by law in public instruments that are certified by a notary public). Therefore, the content of any document certified by a notary public is considered by law as irrefutably true and these services are thus widely used in all official legal and judicial acts. They are not cheap either. Depending on what type of document requires certification, a notary public's services could cost hundreds of dollars. As a result, these amendments are not quite as cost effective as they could be.

In the United States, normal guardianship proceedings are also lengthy and expensive, which eventually resulted in the examination of potential alternatives, and the granting of a power of attorney was adopted. A power of attorney is a legal document which grants power to an agent (grantee) to act on the behalf of the principal (grantor). One particular problem with this in the past is that a power of attorney would automatically be revoked by operation of law once the principal died or became incapacitated, which is an inherent problem when dealing with incapacitated individuals. This problem was solved when Virginia enacted a law for a durable power of attorney in 1954, which allowed the power of attorney to "endure" after death or incapacity. This later evolved into a living will, which permitted terminal or potentially terminal patients to instruct medical professionals on how to deal with a terminal or permanently unconscious state.

Then in the 1980s, California was the first to enact legislation on durable powers of attorney for health care, and by 1997, every state in the U.S. had enacted some type of law which set forth the limits of these powers of attorney, the procedure for validly executing it, and the content therein. Sections 4670-4678 of the California Probate Code, for example, establish the regulations and guidelines for a "written advance health care directive," California's version of the durable power of attorney, which also includes provisions for a living will. Among those regulations and guidelines are the following:

1) The power of attorney for health care may authorize the agent to make health care decisions, such as determining where the principal will live, and it may also include individual health care instructions.

2) The provisions include the requirements for a legally-sufficient written advance health care directive.

3) The provisions also include the requirements for the witnesses who sign the directive.

4) A written advance health care directive or similar instrument validly executed in another state or jurisdiction is valid and enforceable in California.

The process is extremely simple. California provides a form that is to be filled out by the grantor, which outlines the grantor's rights, including the right to limit the agent's authority, should the grantor so decide. The form requests information on the agent, such as his or her name and address, and the same information for two substitutes. It indicates when the agent's authority becomes effective and the agent's post-death authority. Living will instructions may also be included in the form, if the grantor wishes. Finally, the form must be signed by the grantor and two witnesses before a notary public, and one of the witnesses may not be related in any way to the grantor or cannot be entitled to the grantor's estate upon his or her death.

Although Latin America and Spain have recently undergone significant changes to their respective laws to afford more flexibility and freedom to individuals to make future medical decisions and the appointment of a guardian through more cost-effective and efficient means, jurisdictions throughout the United States have gone a step further and provide even more cost-effective and flexible means for the appointment of a guardian and special instructions on what health care providers are to do in the event of any incapacity. The U.S. also makes easier the procedure for declaring the incapacity of an individual: instead of requiring a declaration by a court, the U.S. allows for this declaration to be made by the attending doctor, psychiatrist, or attending nurse.

Steps like these that the U.S. has taken have simplified the lives of those with the durable power of attorney in a health care setting, which could perhaps provide a model for other countries that may want to follow suit. Spain and Mexico have recognized the importance of expediting the guardianship process, which is definitely a step in the right direction, but much more still needs to be done.

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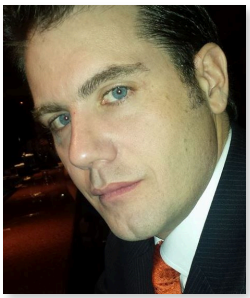
1. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2980344/
2. Idem
3. Article 569 of the Peruvian Civil Code
4. http://resultadolegal.com/interdicto-2/
5. https://derechoperu.wordpress.com/2009/08/26/codigo-civil-peru-libro-iii-derecho-de-familia-instituciones-supletorias-de-amparo [Articles 561 et seq. of the Peruvian Civil Code] /
6. http://enfoquederecho.com/consultas-legales/consulta-legal-cuales-son-los-requisitos-para-obtener-la-curatela-de-un-adulto-mayor-enfermo/
7. Article 199 of the Spanish Civil Code
8. Article 223 of the Spanish Civil Code
9. http://noticias.juridicas.com/base_datos/CCAA/ca-l21-2000.html
10. Articles 618-630 of the Civil Code for the Federal District
11. Articles 449-469 of the Civil Code for the Federal District
12. Article 462 of the Civil Code for the Federal District
13. Third Amendment to Article 469 of the Civil Code for the Federal District
14. Fourth Amendment to Article 469 of the Civil Code for the Federal District
15. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2980344/
16. Idem
17. Idem
18. Idem
19. http://codes.findlaw.com/ca/probate-code/#!tid=N054FC95F95974116A9AA69285DDA41E1
20. http://www.wvlegalservices.org/medpoa.pdf



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Be a Better Translator/Interpreter and Writer: A Book Review of Writing for Today's Healthcare Audiences

As medical translators and interpreters, it is important to understand the linguistic code (terminology and usage, punctuation, syntax, etc. in a given language) we are working with, as well as continually improve our own writing abilities. *Writing for Today's Healthcare Audiences* by Robert J. Bonk spells out the requirements for medical texts for those who read them in the United States; an added bonus is that it provides suggestions on how to better our composition skills as both translators and interpreters.

This book focuses on all healthcare audiences: managers, practitioners, and lay people. It is an excellent resource for all medical translators to have on their shelves. Good translators are good writers! This book is also relevant to interpreters, since good writers write good emails to their clients and put together persuasive resumes.

Each chapter has a series of headings to guide the reader. Starting with the first chapter, the first heading caught my eye,: Thinking as Readers, Not Writers. What exactly did he mean by that? As a translator, should I keep my audience in mind as well? Often we are told that translators should be invisible and render the text as written. However, as we translate with our audience in mind, we might ask some questions that cause the author of the source text to make improvements to the text. Our readers, after all, can only refer to our translated text, and we are often held responsible for any problems in understanding, even if they are attributable to ambiguous source text. I have started to translate with a view to promoting clarity.

I was hooked. I went on to the next heading: Inputs and Outputs of Healthcare Writing. He started with the following formula:

Audience + purpose + context = medium + content + strategy

He explains the formula, saying that every publication has a different **audience**, a different **purpose**, and a different **context**. It is published in different **media** (print, online), has different types of **content**, and is distributed with a different **strategy**. If I had that information for the documents I work on as a translator, I would be far more effective! I imagine I would not have made the mistake of translating a 30-second radio spot as a piece of straight text, for example. On that occasion, my client asked me to start over, basing the new text on the literal translation of his source text. My original translation was not readable in the radio spot they had bought: 30 seconds! We had to go back and forth on a complete rewrite to decide what to cut and what to keep. When I was given the original assignment, I had no idea what the medium or the strategy of distribution of my translated text were! I ask more questions now.

On page 20, under the heading Social Contract of Professionals, it says, "All professionals are responsible to the individuals whom they serve." As a translator, I have a responsibility to communicate the source message accurately and clearly so that the target reader can understand it immediately, without unnecessary confusion. I should not be the one adding confusion to the document! This is a point that is supported on every page of the book, with every example and supporting point. I believe we need to take this point into consideration more often and not be satisfied with "Well, that's how the author wrote it, so ... it's the author's fault it's unclear." In my opinion, that attitude can be acceptable only in court transcripts. Healthcare audiences need to understand texts without wasting time.

Each chapter has specific learning objectives to help specific readers, but in Chapter 8 there is material we can all learn from. In the chapter called Writing Mechanics for Healthcare, the author discusses writing fundamentals like syntax and sentence structure and shows us how to avoid problems with our writing by applying syntactic analysis.

I believe this book should be on every translator's shelf. It is not available electronically. Thinking of

ourselves as the authors of the text in the target language, as co-authors, in a sense, will help us view our responsibility in a different way. As we edit our text, we should be aware of the editing standards that healthcare writers follow, so when our text reaches their desk they do not have to redo our work in the editing process. Working in collaboration with our allied professions, such as medical writers, improves our standing as a profession and the quality of our work.

Bonk, Robert J. *Writing for Today's Healthcare Audiences*. Peterborough, Ontario: Broadview, 2015. Print.

Helen Eby, CT, CHI is the owner of Gaucha Translations and an ATA-certified translator (Spanish to English). She is also an ES state-certified (OR) court interpreter and a Certified Healthcare Interpreter. She is also the co-founder of the Savvy Translator Blog and part of the Cuatro Mosqueteras blogging team. http://www.4mosqueteras.com/ She lives in Beaverton, Oregon.

Dear Florence

Dear Florence,

I am a new interpreter and I have heard a lot about our ethics and standards. Do we really need them? Why isn't common sense just enough?

Newbie in New York

Dear Newbie,

Why do we even have to follow a list of ethics, adhere to these standards of practice? Everywhere I go, I am "the best interpreter they have ever seen". I am "the only one who they have ever seen deliver a pre-session", How is this possible? I hear my colleagues on social media commenting to the same effect. "I was told that I am the first to insist that a provider be present to review a consent form with the patient", or "no other interpreter has ever stood out in the hall to avoid being alone with the patient." Throughout my years as a medical interpreter, I have never been more proud of my performance than when I am completely ignored by all parties and allowed to simply facilitate transparency. When an interpreter is performing at such a level as to facilitate transparent communication, all parties should enjoy an interactive experience equal in comprehensibility as would a similar group of speakers of the same language. This is the goal of every encounter. Or it should be, anyway.

The challenge is not to make sure that one never colors outside the lines; never spill anything on the carpet. I think it is easy for lines to get blurred between facilitating communication and swooping in to save the patient, CMI badge shining brightly in the eyes of all self-declared bilingual naysayers... I care. I feel. This work is important like none other. However, I as a medical interpreter am not going to coddle the LEP patient. I know nothing about their background, medical knowledge or understanding of their condition(s) or planned procedure(s).

The true purpose of the code of ethics for medical interpreters (such as the working paper published by NCIHC) is not to bind the interpreter in place or restrict our behavior, but to define our purpose and empower us as communicators. To all my colleagues who step in and help, the cane holders and wheelchair pushers, even the tissue-passers, (I am looking at you too) I am here, now saying: I have done things like this myself. I have left my role behind when caught up in the moment because my heart is in this work. Too often medical interpreters, are tempted to make decisions based on *emotions*, or their *perceptions of a situation*.

Why is this? Well, we are human. We are only doing the decent thing, trying to help. It should be fine, as long as it's casual. Besides, it should be fine to stay in the room with the patient, as long as conversation and chatting is kept to small talk, and pleasantries. Here's the thing: aside from the

possibility of any potential liability issues that could present, or any physical dangers to the interpreter themselves, stepping out of the box and into the grey areas between your roles is a Jedi-level move. It is not easy to remain impartial or keep one's personal feelings aside when a dying patient grabs your hand tightly while singing a hymn out loud in their hospital room along with 5 other relatives on five separate speakerphones. How could anyone leave a woman who has just lost a baby in stillbirth all alone in a room, wailing?

It is of course vital to facilitate in a way that preserves the spirit of the message, with no omissions additions, or alterations. More importantly, I say let us not forget to strive to maintain the LEP patient's dignity. We are not there to help. We are not there to explain things to the LEP patient for the provider. We are not the compliance police. I see too many of my colleagues assume that the patient does not understand what was just said to them, and then embellish the utterance with a simplified explanation. To my colleagues who are content to stay in the room with the LEP, I can introduce you to an ex-coworker who was black-balled by a patient who claimed they stole something and then immediately fired by the hospital. I knew one colleague who bought a patient a disposable 35mm camera while out on an assignment (just to be nice) which resulted in negatively affecting the patient's mental state and causing the interpreting agency to lose the contract with the health-care provider.

Each of us represents all of us. The code of ethics exists to establish a level of uniformity in our field. To outline expectations as to medical interpreter behavior and performance, to formalize and elevate the medical interpreting profession, while also protecting patient and interpreter.

Sean Normansell, CMI is a native English speaker from Texas who completed the Bridging the Gap medical interpreting training as well as legal interpreter training at Georgia State. Sean has extensive experience in the legal, medical and social services interpretation fields. He lives in Austin, TX with his wife and daughter.

Eponyms and Other Stories

The Origin of Down Syndrome

Trisomy 21, or, as we most commonly know it, Down syndrome, is a genetic disorder caused by the presence of a third copy of chromosome 21. This syndrome is characterized by physical traits (flat face, short neck, heart defects) and mild to moderate mental retardation.

It was first described by Dr. John Langdon Down in 1866 and named "mongolism" or "Mongolian idiocy" due to the resemblance to people of the Mongoloid race (back then, there were five distinct races: Caucasian, Mongolian, Ethiopian, Malaysian and Native American). Also, he was of the notion that the "Caucasian race" was superior to the "Mongoloid race" in intellect, because to him these patients were a "regression" in the evolution of man.

Thankfully, this negative designation changed in 1961 when genetic experts wrote to the medical journal *The Lancet* and urged *that "the expressions which imply a racial aspect of the condition be no longer used." They suggested the following options instead: "Langdon Down Anomaly," "Down's syndrome or Anomaly," or "Congenital Acromicria".* The editor selected "Down's syndrome" and the World Health Organization confirmed that term in 1965.

Resources:

- WebMD: http://www.webmd.com/children/tc/down-syndrome-topic-overview#1
- MedlinePlus: https://medlineplus.gov/downsyndrome.html
- Mayo Clinic: http://www.mayoclinic.org/diseases-conditions/down-syndrome/home/ovc-20337339

- Genetics Home Reference: https://ghr.nlm.nih.gov/condition/down-syndrome
- CDC: https://www.cdc.gov/ncbddd/birthdefects/downsyndrome.html
- National Human Genome Research Institute: https://www.genome.gov/19517824/learning-about-down-syndrome/
- National Down Syndrome Society: http://www.ndss.org/Down-Syndrome/What-Is-Down-Syndrome/
- Healthline: http://www.healthline.com/health/down-syndrome#overview1

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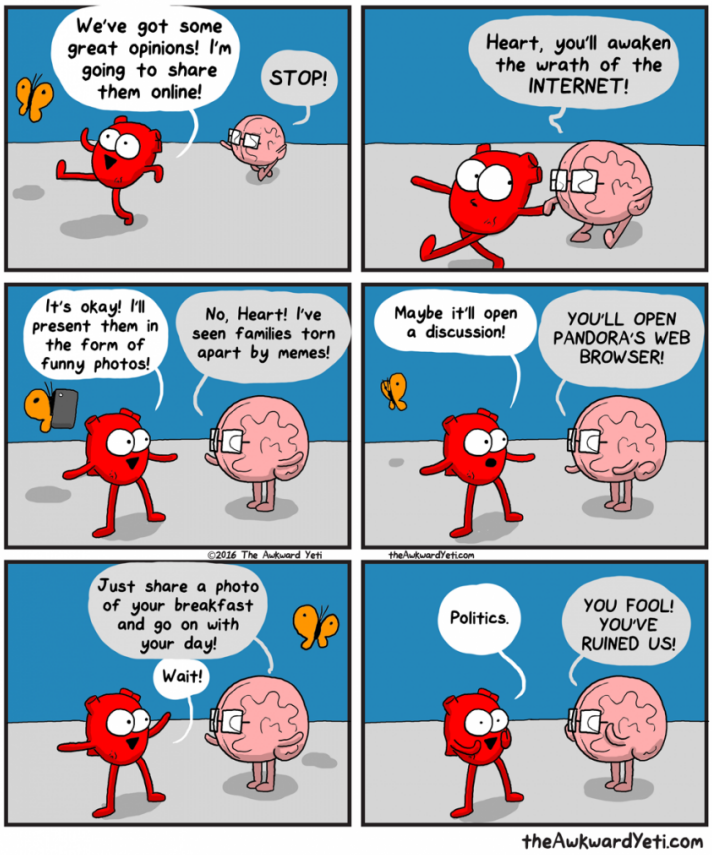
Doctor's Orders: Comic Relief



Caduceus is a publication of the Medical Division of the American Translators Association, a non-profit organization dedicated to promoting the recognition of translating and interpreting as professions.

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Comic by cartoonist Nick Seluk Printed with permission

Submissions
Readers' submissions are encouraged.
Suggested maximum lengths:
Articles: 800 to 2,500 words
Reviews: 600 words, Letters: 300 words
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