Caduceus

A Publication of the Medical Divison of the American Translators Association

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CONTENT: Part Two

BEST WISHES FOR 2007

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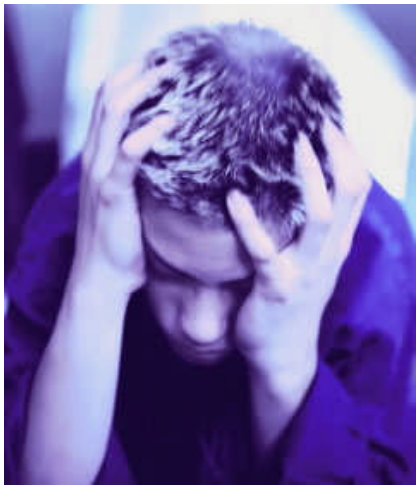
edited by Vonessa Phillips Costa

Are we interpreters taking care of our emotional needs?

Many years ago, I was called into the delivery room. A very young mother was about to deliver twins. As I changed into the gown and mask, I noticed that the mood in the room was somber.



When I saw the patient's face, I realized that she was the same woman I had interpreted for a few days earlier in the ER. She was due to deliver twin girls, but one week before the due date she started to bleed and feel a terrible cramping.

Within minutes, the room was swarming with OB/GYN specialists, pediatricians, nurses and technicians. The patient was moved to a different room. She could see that the providers were concerned, but no one explained the reason for this concern. The patient was simply informed that she would need to have blood tests, a pelvic exam and an echocardiogram.

Finally, her obstetrician arrived and told her that they could not find the babies' heartbeats, and that is was almost certain that they were no longer alive. As he spoke, I interpreted every thought, trying to preserve the register and tone of the message. I mirrored the provider's speech and body language, as expressed by a sad countenance. It was as if I were inside the provider's head and sharing his heart. The same could be said for my interpretation of the patient's reaction.

As one can imagine, the news was devastating to the mother. But the most agonizing detail was that, due to her advanced pregnancy, the providers would have to induce labor. She would return home with two dead fetuses inside her! Meanwhile, she was instructed to be on the lookout for symptoms of infection. "This is not supposed to be this way", the mother said, "Must I carry this pregnancy and wait to deliver two stillbirths?"

Later, I interpreted for the nurse and the obstetrician as the patient was going through labor. She gave birth to the two most beautiful little girls. But they were bluish in color, never having had the chance to take that first breath or utter that first cry!

The mood in the delivery room was dark - almost too quiet. No one told the mother that she did a great job with the delivery. No one told her that they were sorry for her loss. The nurse wrapped them in a blanket and asked the mother if she wanted to say goodbye to them. The mother at first said no, but within a few seconds, she decided to have them brought close to her. These little girls looked just perfect, and it seemed almost inconceivable that they were robbed of their lives. The doctors were never able to provide a scientific explanation for their deaths.

When I left the delivery room after many intense hours of interpreting, I ran to the bathroom and cried. Then I sobbed. Almost thirty years have passed and I still recall every word spoken in the emergency and delivery rooms as if it were today.

At the time, no one, not even me, realized that interpreters need to debrief and to grieve after emotionally loaded sessions. So when I finally stopped crying, I splashed my face with cold water, and a few minutes later I was paged to interpret for a very sick patient in the Intensive Care Unit.

Years later, when I was in labor for my own children, I repeatedly saw the image of this woman's face. The mental picture that played over and over was frozen at the moment when she found out that her babies were dead.

Recently, I had the opportunity to visit with a physician for whom I had interpreted about 25 years ago. Together, we had seen many patients. During this last visit, he told me that he had never forgotten one particular case we had worked on together. In a conference call, I had interpreted a conversation between this provider and a patient's factory supervisor. The patient was clearly developing an allergic reaction to the fumes in his department and this was exacerbating his asthmatic condition. The supervisor agreed to move this patient into another department to work with a machine that would not emit smoke or fumes. A few days later, this same patient showed up in he ER without his right hand, which he had lost in the very machine the supervisor assigned him as a result of our conversation.

This provider went on to relate that at the time, both he and I were simply devastated by this news, and that we had been a support to each other. The strange thing, though, is that I have only a vague recollection of this incident, which has remained so vivid in his mind these twenty-five years. I have struggled to recapture the moment, and sometimes it seems that I do remember pieces of the puzzle, so to speak. I guess that's an improvement from the blank I drew when he first told me the story. I wonder now if interpreting for this young man without a hand was so upsetting to me that I repressed the memory. Perhaps if I had not repressed it, I would not have been able to continue as an interpreter.

As medical interpretation becomes a profession, we need to begin to pay attention to the fact that it is at times an occupation 'hazardous' to our own mental health. We would do well to learn from trained rescue workers, fire fighters, police officers and other professionals who have a system of 'grief and debrief' to turn to when exposed to trauma.

The Centers for Disease Control and Prevention offers valuable information for health professionals on coping with traumatic events. CDS defines "traumatic event" as an event, or series of events, that causes moderate to severe stress reactions. Traumatic events are characterized by a sense of horror, helplessness, serious injury or a threat of serious injury.

Common responses to a traumatic event can be classified as "cognitive", "emotional", "physical" or "behavioral". The following CDC table lists some of the most frequently observed reactions:

COGNITIVE	EMOTIONAL
❒ Poor concentration	❒ Shock
❒ Confusion	❒ Numbness
❒ Disorientation	❒ Feeling overwhelmed
❒ Indecisiveness	❒ Depression
❒ Shortened attention span	❒ Feeling lost
❒ Memory loss	❒ Fear of harm to self and/or loved ones
❒ Unwanted memories	❒ Feeling nothing
❒ Difficulty in making decisions	❒ Feeling abandoned
	❒ Uncertainty of feelings
	❒ Volatile emotions

PHYSICAL	BEHAVIORAL
❒ Nausea	❒ Suspicious
❒ Lightheadedness	❒ Irritability
❒ Dizziness	❒ Arguments with friends and loved ones
❒ Gastro-intestinal problems	❒ Withdrawal
❒ Rapid heart rate	❒ Excessive silence
❒ Tremors	❒ Increased / decreased eating
❒ Headaches	❒ Change in sexual desire or functioning
❒ Grinding teeth	❒ Increased smoking
❒ Fatigue	❒ Increased substance use or abuse
❒ Poor Sleep	
❒ Pain	
❒ Hyperarousal	
❒ Jumpiness	

One of the recommendations from the CDC is to be alert to the various needs of the traumatized person. Thus, counselors (or at the very least, interpreter department supervisors) are urged to listen to the interpreter and encourage the interpreter to talk about his/her reactions to a potentially traumatic event, not when the supervisor is ready, but rather, when the interpreter feels ready. When the interpreter expresses a feeling, the supervisor should validate this feeling and offer clinical follow-up when appropriate.

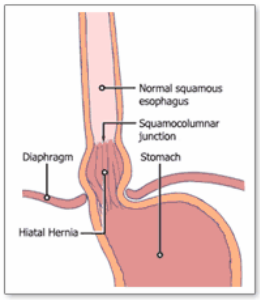
Interpreter department supervisors should set aside time each day for interpreters to debrief so that the day-to-day stresses of their work do not build up to a breaking point. To quote the CDC, "more stress or an accumulation of stressors may create more difficulty". Perhaps interpreters working with potentially traumatic events should debrief with the other professionals involved, meeting periodically with the treatment team to discuss the cultural, linguistic and yes, even the emotional aspects of their interpreting work, instead of being left alone with their traumas.

REFERENCES:

http://www.cdc.gov

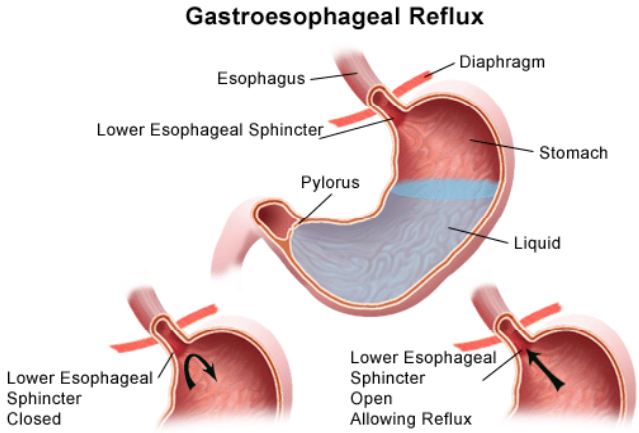
GERD

GERD stands for **G**astro**E**sophageal **R**eflux **D**isease. Reflux of gastric contents into the lower portion of the esophagus occurs when the lower esophageal sphincter (LES) does not close properly allowing this retrograde movement to occur. Stomach acid in contact with the esophageal mucosa (lining of the esophageal tube) causes a burning sensation - known as heartburn - felt most often under the mid chest and possibly all the way to the mouth, if the refluxed material comes all the way up. A subsequent wave of peristalsis within the esophagus sweeps the esophageal contents back into the stomach.

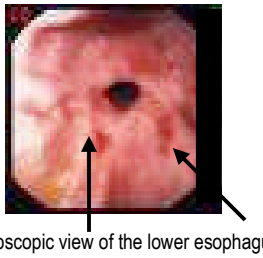


Under normal circumstances the lowermost portion of the esophagus that connects with stomach lies below the level of the diaphragm, within the abdominal cavity. A small amount of GE reflux occurs normally and increases whenever there is an increase in intra-abdominal pressure, commonly due to pregnancy or obesity. Alcohol use and smoking also favor the occurrence of reflux. Infants, as any mother knows, tend to have a lax LES which allows for easy backing up of food.

Longstanding stomach acid reflux into the esophagus damages the lining of the esophagus with subsequent irritation (esophagitis), ulceration, stricture formation and the possibility of malignant transformation. Treatment consists of antacids and medications which reduce acid secretion by the stomach. Weight reduction is imperative as well as moderate use of alcohol and smoking. Repeated endoscopies to visualize the lower esophagus and



biopsy it as necessary are in order. Various forms of surgical intervention are now available to correct a hiatal hernia or reestablish the normal gastroesophageal anatomical relations. This anatomical area was previously quite difficult to reach and manipulate surgically given its location between two body cavities. The laparoscopic approach currently practiced has overcome this problem.



Endoscopic view of the lower esophagus showing erosions of the mucosa.

Words about words and related words

acute - the word **acute** translates to Spanish simply as *agudo* which generally means sharp, pointed. When a patient uses the word *agudo* he most often refers to a completely different meaning than when a physician does. Most often Spanish patients use *agudo* to characterize pain as in, *un dolor agudo*, meaning mean a sharp, severe, penetrating type of pain. Medically speaking, however, the word acute refers to the duration of a medical problem. Acute is part of a **scale of duration** that includes: **acute, sub-acute** and **chronic**. **Acute** means it's happening now, it's current, of very recent onset. Typically: acute appendicitis, acute myocardial infarction, acute cholecystitis, etc. At the other end of the scale is **chronic** which literally means of longstanding, often years as in arthritis. In between is **sub-acute** which is not often used and takes a place somewhere between acute and chronic, but generally closer to acute. Also, somewhere between acute and chronic, lie **recurrent** and **intermittent** which have literal non-medical meanings like: from time to time, every so often or every now and then…

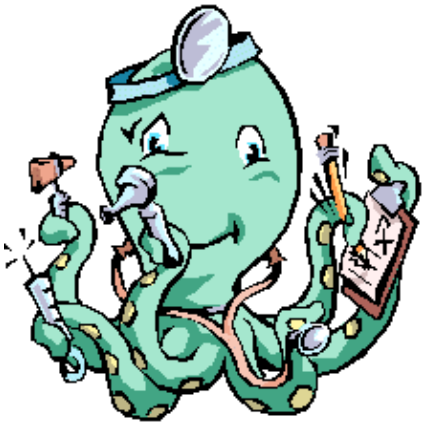
attack - a very medical kindred word to acute is used for medical problems or syndromes that occur suddenly or evolve quickly. Typical examples would be epileptic attack (epileptic seizure), heart attack (acute myocardial infarction), acute appendicitis, acute anxiety attack, migraine headache.

attending physician - is the physician who is medically and legally responsible for everything that happens to his patient while in the hospital. He / she is usually the admitting physician. His name appears in the patient's ID bracelet and in every page of the patient's chart.

pathognomonic - distinctive or characteristic feature of a disease. Its presence alone establishes the diagnosis. *See page 29, illustration of Koplik spots of measles.*

hospitalist - new word. Refers to a new position created within the hospital environment soon to become a widespread specialty of medicine. A hospitalist is a specialist in hospital medicine. Hospital medicine is the discipline concerned with the general care of hospitalized patients. It first appeared in 1996 in the New England Journal of Medicine referring to a specialty organized, not around an organ, like cardiology (heart) or ophthalmology (eye) or a disease, like oncology (cancer) or a patient's age, like pediatrics, but rather around the site of care. We already have examples of this like emergency medicine which centers around care given in an emergency department and critical care which follows as emergency patients are moved inside the hospital's intensive care units. It follows that hospital medicine is the area for specialization in the care of a patient while he is an in-patient.

Two major forces drive the formation of this new specialty currently populated primarily by practicing specialists in general internal medicine. On the one hand, it is increasingly difficult for a physician to manage patients in his private office and visit his hospitalized patients twice a day plus attend to the telephone calls about them. Secondly, the hospital's ever increasing array of diagnostic tests and procedures is difficult to keep up with. So, having a physician well versed and up on the latest the hospital has to offer makes a hospital trained and based physician something we are going to see more of in the near future. Residency programs are increasing in number around the nation.



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HOSPITAL DOCTORS - WHO ARE THEY?

house staff - is the collective term used for all doctors in postgraduate training at a teaching hospital. That is to say, interns, residents and fellows. (See Summer 2006 Caduceus)

medical staff - refers to all the physician members of the hospital staff. Licensed physicians in the community apply to a particular hospital for membership. Following a process of **credentialization** - review and verification of credentials - they are accepted and become members of the medical staff. What functions they can perform in the hospital are delineated as **"privileges".** For example, being able to admit patients to the hospital for inpatient care is called 'admitting privileges'. Some physician, like neurologists and dermatologists, only wish to act as consultants for hospitalized patients, so they are granted 'consulting privileges'. These admitting physicians are collectively called the **attending staff. (**see attending physician next page**)**

full-time medical staff - refers to full time salaried physicians employed by the hospital. They usually run the various medical departments of a hospital i.e., Radiology, Pathology, Anesthesiology, Physical Therapy, Occupational Therapy, Emergency Services.

From the listerv - the difference, if any, between **aseptic** and **sterile**

DORLAND'S MEDICAL DICTIONARY:

Asepsis..1. freedom from infection 2. Prevention of contact with microorganisms
Aseptic .. free from infection, also called sterile
Sterile .. aseptic …… unable to procreate, produce offspring
Sterilize..to render sterile; to free from microorganisms

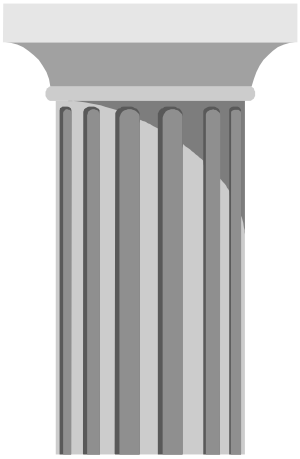
These are interchangeable words. They really mean the same but usage makes one more suitable than the other depending on circumstances. For example: after washing and gowning surgeons and nurses are said to be sterile rather than aseptic. The surgical field is also sterile. Yet the OR uses aseptic measures to maintain sterility.

Caduceus
A PUBLICATION OF THE MEDICAL DIVISION OF ATA
ETHICS | 20

by Michael McCann, MA MITIA

Ethics and Professionalism in Internet Actions — Part II

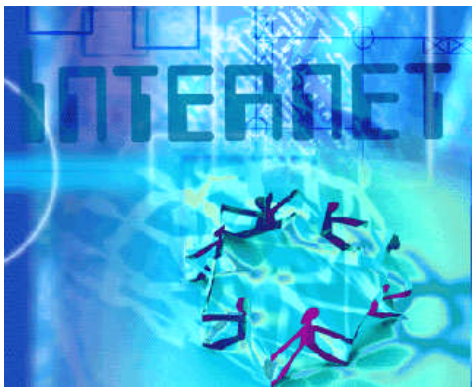
***Tempora mutantur et nos mutamur in illis*.**
— Anonymous



Using the Internet, the 'new' translator is remarkably different to the translator of yore. Generally now, he or she is faceless, known to the client or the agency only as the voice at the end of a phone-line or as the person whose *CV/résumé* has been provided with copies of degrees, diplomas and references.

The Internet translator assume a huge responsibility in translating while based in one country for a client on the far side of the earth. It is not simply the question of the rendering of a text into an acceptable standard within the target language or one of its variants. It is also a question frequently nowadays of working to a client's time deadline of hours in a different time zone, as opposed to a more relaxed deadline that of days or weeks, as would have been the case in the past, where texts were mailed on once completed. A present generation of translators under 35 years has no idea what translation involved prior to the arrival of the Internet.

The 'new' Internet translator whether working individually or in a collective situation bears the same burden of professional ethics as the pre-Internet translator. The over-riding principles stay the same; the relative conditions change with every text. However, the 'new' translator whose conscience is provoked or aroused by moral principles as to a translation situation has all the advantages of the advances of the Internet in seeking help quickly from other professionals or from an association body.



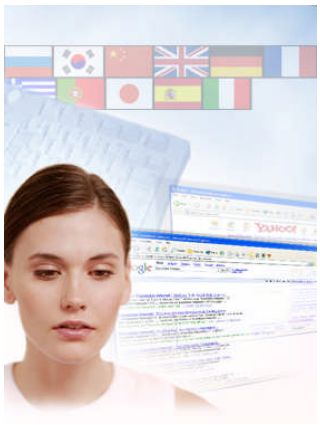
The principles of ethics governing a translator's work are applications of the great moral principles, based not on the quicksand of relativism, but solidly founded on the absolute foundation of what is good in itself, to the avoidance of what is wrong, for the pure, simple and unadulterated reason, that good is right, and that bad is wrong.

Each translator, in his or her own daily endeavours will normally apply without thinking ethical principles. Here, one is making the huge assumption that the translator is of sound and healthy mind.

The Internet, as a tool, does not make the translator's life automatically better. It can. It may. It depends on the translator. The use of the tool is dependant on the translator. Not the other way round! If the translator lives a blissful life without the use of a spellchecker, that translator must possess perfect keyboard fingering and a photographic proofreading capacity! Modern translation tools are eschewed at one's professional peril.

What the Internet – and here one is talking of the more serious side of its communications - has brought to our lives is essentially immediacy and information. It is up to the translator to know how to use both of these in a responsible manner, guided not just by personal relativistic convenience, but by a principled focus on what is right in itself, not right by circumstance.

There is also the question of ethical non-translation which trustfully will not rear its head too frequently in a professional life. Non-translation is an underdeveloped concept in the whole area of translation. It refers to four areas: the translator, the client, the text, and the conditions under which the first three come about.



The translator is under no professional or ethical obligation to translate everything that comes across his/her desk. This is a very difficult statement to make but it stands to reason, even for translators who are full-time employed by a client/ employer. Simple examples prove the point. The translator is competent in translating from Spanish. A client may request a translation from Portuguese – are they not very similar languages? [a true life example]. The translator must refuse out of professional competence.

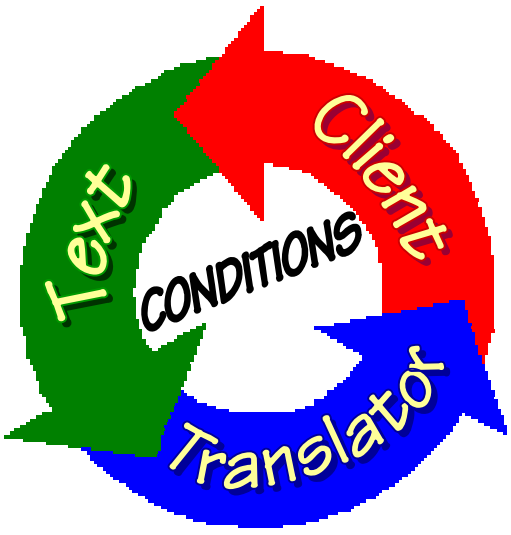
The client may ask for some correspondence and a mechanical specification to be translated. The business correspondence is fine, but the mechanical specification turns to be a motorised machinegun emplacement [a true life example]. The translator could refuse as her CV clearly states that she does not translate military or scientific texts.

The ethics of non-translation can extend very simply to texts where the translator states that he/she, being an expert in that field, will only translate pharmaceutical texts, and will rightly decline any other text where experience is lacking. Please note that non-translation also has a moral foundation where a translator will also rightly decline to translate porn if ethical or religious sensibilities are offended.

The interaction of all three aspects above – translator, client and text – give rise to the fourth aspect, namely the conditions. Ethical considerations also attach to the conditions. The translator may well decline the work because it is known in the business that the client does not pay on time. This may be of small importance to the translator, but can be of huge importance to an agency where cash flow is king, and the agency's own translators have to be paid on time. There may also be the ethical aspect of a rate which is cut-throat, or of a deadline which is impossible to meet under normal professional conditions, or even the simple ethical nature of a translator's promise to be home for Thanksgiving which would have to be set aside to meet the client's demands [a true life example].

There is a debate also raging as to areas of competence. Interpreters know this and will seek out terminology before going into conferences on specific topics. Translators must also know and recognise the moral limits of their competence. Speaking fluently and knowing both source and target languages is no guarantee of accuracy of translation in a myriad of fields.

The presence of a tool such as the Internet, nor even the acknowledgement of a number of underlying principles for working in translation are no guarantee



for the perfectly fair, true and accurate translation. All translators will still commit errors while they continue to be human; some will undoubtedly

misrepresent their capacity for work or their abilities and skills. The Internet does make that easier for the unscrupulous, hence the need for a recognised 'professionalism' copperfastened by scrutinised membership of national or international associations and groupings.

The interaction which the Internet brings in our professional work is primarily and essentially a juncture of opportunity for both the client and the translator. The resulting translation or non-translation prove the quality of the principles being applied.

Ethics and morals invariably end up by being prescriptive either under the pricks of conscience, rules and regulations, applied case law, or even in the law of the land. The translator cannot eschew the prescription. The translator must not overreach either the natural ability or the learned science.

The conscience of the translator should not exist suffering from a poverty of principles but rather should enjoy the luxury of comfort which those principles offer in adherence to truth, accuracy, fairness, and legality.

Whether the translator is paid early or late, much or little, or not at all, is the economic reality of life. However, the translator must be able to stand over each text and say hand on heart "I really could not have done better. This, professionally, is a proud moment for me". If such can be said Internet interactions will have found translator ethics and professionalism at their very best.

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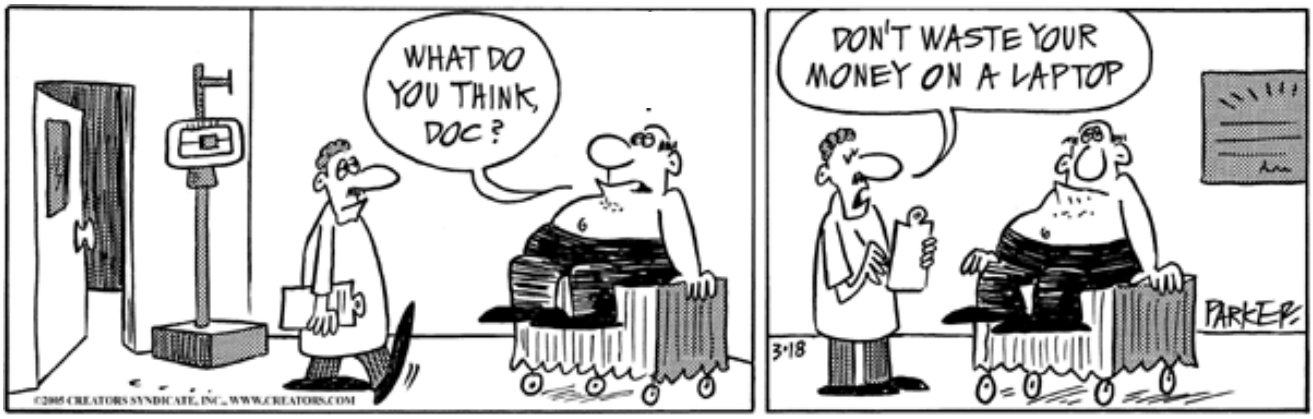
Physical Examination

Der Allgemeinstatus wird durch Inspektion, Palpation, Perkussion und Auskultation erhoben.	The findings of the physical examination are based on inspection, palpation, percussion, and auscultation.
Palpation: Fühlen von Organen, Pulsen, Lymphknoten, Tumoren etc. **Perkussion:** Abklopfen der Körperoberfläche zur Bestimmung der Größe und Lage eines Organs oder des Luftgehaltes der Lunge. **Auskultation:** Abhören eines Organs mit dem Stethoskop.	**Palpation:** Feeling of organs, pulses, lymph nodes, tumors, etc. **Percussion:** Tapping the body surface to determine the size and location of an organ or the air content of the lungs. **Auscultation:** Listening to the sounds of an organ with a stethoscope.
Status präsens, internistischer Status, Allgemeinstatus, Aufnahmebefund	**Physical examination**
AZ (Allgemeinzustand) gut reduziert stark reduziert EZ (Ernährungszustand) normal reduziert kachektisch adipös Adipositas permagna Größe: Gewicht: RR (Blutdruck): **PULSE** Radialis re li Femoralis re li Poplitea re li Tib. post. re li Dors. pedis re li tastbar nicht tastbar **LYMPHKNOTEN** zervikal axillär inguinal tastbar nicht tastbar	General condition good impaired severely impaired Nutritional condition normal reduced cachectic obese severely obese Height: Weight: BP (blood pressure): **PULSES** radial artery right left femoral artery right left popliteal artery right left posterior tibial artery right left arteria dorsalis pedis right left palpable not palpable **LYMPH NODES** cervical axillary inguinal palpable not palpable

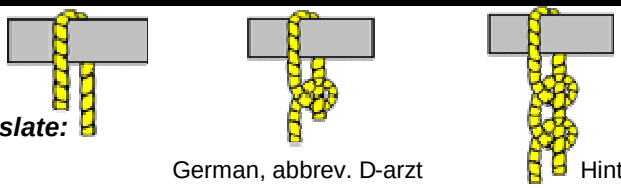
Physical Examination

KOPF/HALS	**HEAD/NECK**
Zunge:	**Tongue:**
o.B. (ohne Befund, normal)	unremarkable
belegt	coated
Rachen:	**Pharynx:**
o.B.	unremarkable
gerötet	red
entzündet	inflamed
Zähne:	**Teeth:**
saniert	repaired
fehlend	missing
abgebrochen	broken off
Zahnprothese	denture
Schilddrüse:	**Thyroid gland:**
nicht vergrößert	not enlarged
vergrößert	enlarged
HAUT	**SKIN**
Farbe	color
normal	normal
blass	pale
zyanotisch	cyanotic
Ödeme	edema
Operationsnarben	surgical scars
Hämatome	hematomas
Wunden	wounds
Dekubitus	decubitus
Exanthem	exanthema



Physical Examination

HERZ	**HEART**
Perkussion:	**Percussion:**
normal groß	normal size
vergrößert	enlarged
Auskultation:	**Auscultation:**
Sinusrhythmus	sinus rhythm
rhythmische Herzaktion (HA)	rhythmic heart beat
absolute Arrhythmie	absolute (perpetual) arrhythmia
Extrasystolen	extrasystoles (premature beats)
Herztöne (HT):	**Heart sounds*:***
normal (klar, rein)	normal
leise (schwach)	faint (weak)
gespalten	split
laut	loud
knallend	scorching
Herzgeräusche(HG):	***Heart murmurs:***
systolisch	systolic
diastolisch	diastolic
kontinuierlich	continuous
holosystolisch	holosystolic
Perikardreiben	pericardial friction rub
Ort:	***Location:***
Aorta (Aortenareal)	aortic valve
Pulmonalis (Pulmonalisareal)	pulmonary valve
Mitralis (Mitralisareal)	mitral valve
Trikuspidalis (Trikuspidalisareal)	tricuspid valve
Erb'scher Punkt	Erb's point
Herzspitze	cardiac apex
Punctum maximum (p.m.)	punctum maximum (p.m.)



Loose Ends

How would you translate:

Durchgangsarzt	German, abbrev. D-arzt	Hint, there is a U.S. board specialty
Prüfpräparat	German	there are 2 possibilities, depending on context)
Einnahmepause (einnahmefreies Intervall)	German, drug trials	The English is an unusual term in medicine.
Durchdrückpackung	German, pharm.	You use them all the time; does pop mean anything?
Beinahe-Vorkommnis	German, drug trials	Not what the doctor ordered!
Autorizzazione all'immissione in Commercio (AIC)	Italian	drugs, give 2 English equivalents and state the difference between them.
oo ortoforico	Italian, an ophthalmologic report	Think graphically.

Physical Examination

Lungen Perkussion: *Klopfschall* sonor (SKS = sonorer Klopfschall) hypersonor gedämpft tympanitisch Atemverschieblichkeit Auskultation: Vesikuläratmung (VA) Bronchialatmung Keuchende (pfeifende) Atmung Rasselgeräusche (Rgs) amphorisch blasend fein giemend knisternd	**Lungs** Percussion: *Percussion sound* resonant (sonorous) hypersonorous dull tympanic lung expansion with inspiration Auscultation: vesicular respiration bronchial respiration wheezing rhonchi (rales) amphoric bubbling fine sibilant crackling
Abdomen: Bauchdecken weich Abwehrspannung (AS) Darmgeräusche (DG) laut (lebhaft) mäßig leise keine Leber: tastbar x Querfinger (QF) unter dem Rippenbogen (RB, RiBo) Milz tastbar x Querfinger (QF) unter dem Rippenbogen (RB, RiBo)	**Abdomen:** Abdominal wall Soft abdominal guarding Intestinal sounds loud moderate weak absent Liver palpable x inches (cm) below the costal arch Spleen palpable x inches (cm) below the costal arch
Gelenke frei beweglich Bewegung eingeschränkt geschwollen	**Joints** unrestricted motility motility restricted swollen

by Leon McMorrow

It is an exciting new experience for medical translators in the U.S. to see specific medical questions and answers flowing on the ATA Medical Division's listserv, and to follow some very lively discussions on terminology. The listserv offers an excellent counterpart and complementary service to the less urgent topics discussed in Caduceus.

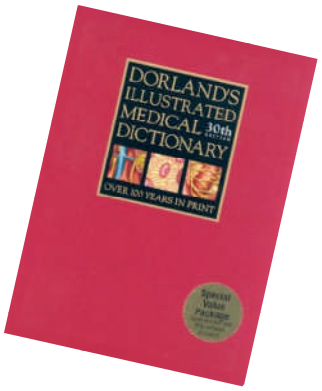
In this issue, I would like to address two topics that cause ongoing difficulties for the translator: first, the *currency* of medical terms, and then the occasional non-equivalence of medical systems (and I am not thinking about allopathic vs. homeopathic medicine, or conventional vs. complementary medical systems).

Translation Controversy: Should translators use archaic/obsolete words in their translations?

It is very interesting to glance at the column in the weekly Journal of the American Medical Associations (JAMA) called "JAMA 100 years ago." It reproduces segments or articles of interest that appeared in the same journal exactly a century ago. The March 06 column is titled: *Heart Block and the Stoke-Adams Syndrome*.
This column may represent no more than a medical curiosity in diagnostics and therapeutics for most readers today, but for a linguist or translator it is much more – it provides a lesson in terminology evolution. Terminology is no more fixed in stone than is language in general, although Greco-Roman medical terminology for the most part has survived the evolution of language very well across the centuries. The JAMA column is an excellent example of communicational stability or consistency – *for the most part ...*

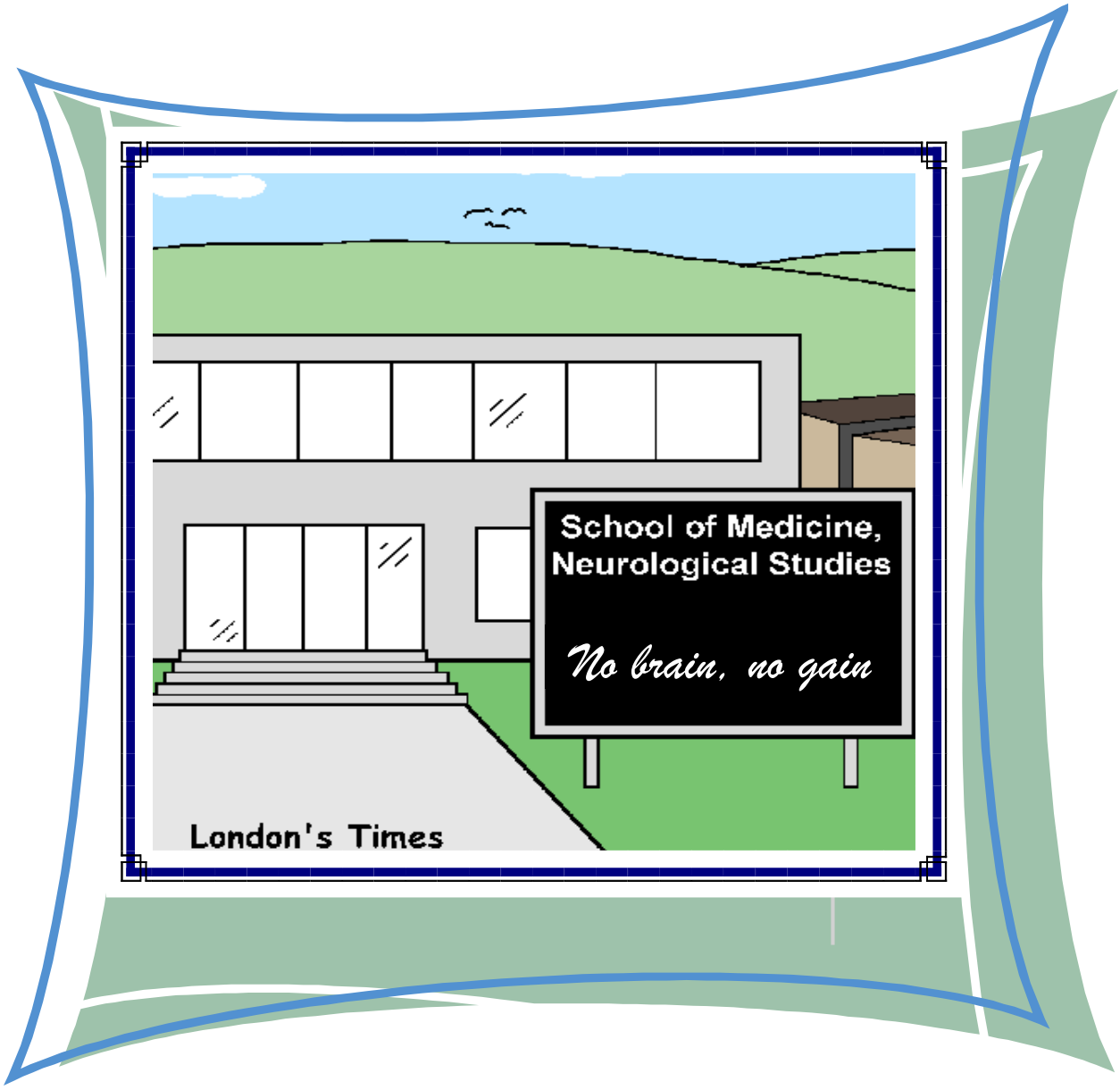
The March 1906 article uses the anatomical term "auricle" consistently for the now familiar "atrium"; the intended meaning is the same. But the word "auricle" in the sense of "atrium"(upper chamber of the heart) is now archaic or obsolete (Dorland's calls it "formerly atrium"). Today, "auricle" means exclusively the "atrial appendage".

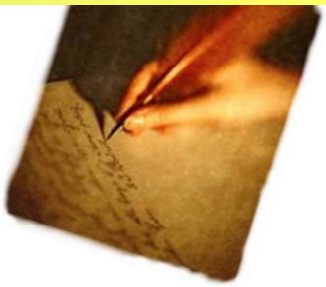
I constantly refer to a useful book written not for lexicologists, linguists or translators, but for medical transcriptionists who must churn out millions of current medical words per day from dictated audiotapes. Since many doctors' voices or the tape quality are lacking in clarity, transcriptionists often



have to get help for an unclear word from clues. The clue is the context: *one expects similar words to recur in similar context*s. The book is Lorenzini & Lorenzini: Medical Phrase Index. 5th Ed. 11/2006. PMIC. A typical example helps to illustrate what they do. Key word: ***ataxic***. Phrases: *a. amimia, a. aphasia,* a. gait, *a. paraplegia*. So, if you found an unusual noun following "ataxic …," one way to tackle it would be to look up *ataxic* in Lorenzini, and see if any of the associated nouns matches your source. Additionally, if you were toying with an English phrase – trying to decide on the best choice, for example, among the words 'ambulation,' 'walk,' and 'gait' to match your source word – you can often see what is currently in use. As it turns out, you would find that "ataxic gait" is the currently used term (and therefore for me the *correct* term), not "ataxic ambulation," or "ataxic walk," although these would be understood by a clinician; using them would just show you were not "familiar" with the field, a non-professional. A lot of my own translation time is spent ensuring that my medical language is "current."

Some translators, however, either obstinately or unconsciously ignore usage or currency of medical words. I even heard one translator argue heatedly at an ATA Conference that there is "no such thing as an obsolete word". This is technically true for lexicologists: every word needs to be recorded for posterity as a medium of communication, even if 1,000 years old (this justifies the study of Old English, Old French, etc.). But even a lexicologist still needs to label usage in parentheses (obsolete, archaic), as the OED and other good dictionaries do. However, most of our bilingual dictionaries consistently fail to do this, stringing archaic and modern usages and/or meanings together as if all are equivalents. I think the translator has a greater responsibility to the reader: if words are no longer understood by our modern professional readership without the help of a dictionary, then they no longer represent communication but miscommunication and should not be used, except in a historical context such as the JAMA 1906 column. Any thoughts about this?

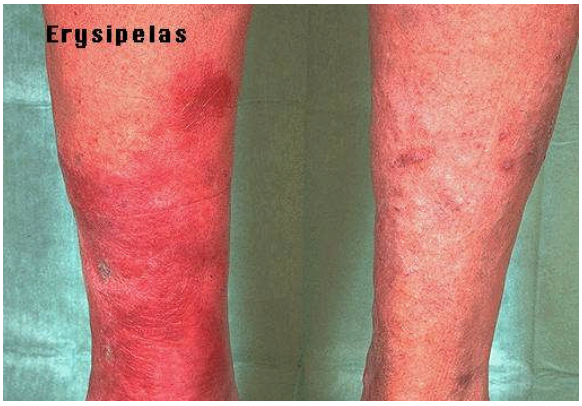




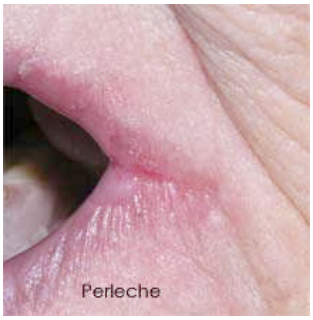
Thanks to all who submitted answers to the list of archaic terms that appeared in our Spring 2006 issue.

- **Miner's diseases** - anthracosis, pneumoconiosis… prolonged exposure of miners to environmental irritating substances gives rise to chronic pulmonary fibrosis

- **St Anthony's Fire** - erysipelas, an eruptive fever that St. Anthony was supposed to cure

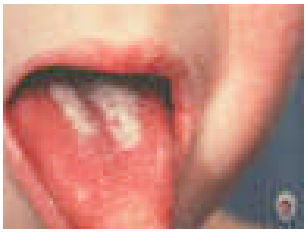


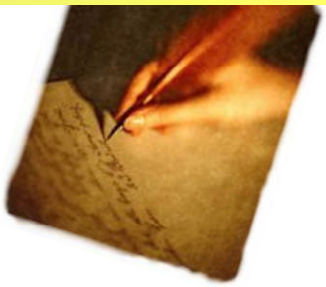
- **Perleche** - a moist red or white harmless eruption between the skin folds at the corner of the mouth in the elderly



- **Blackbain** - a synonym of anthrax

- **Strawberry tongue** - patients with scarlet fever, Kawasaki's disease or other conditions may develop a distinctive reddish coloration to their tongue





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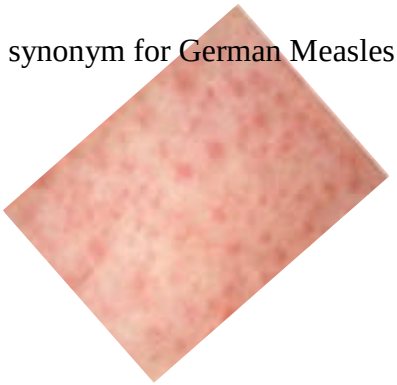
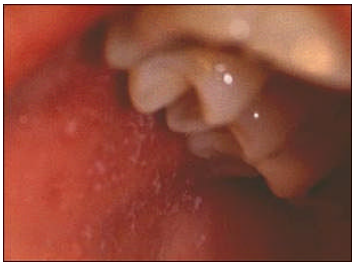
- **Floating kidney** - a kidney that is normal but anatomically displaced and movable. Also called a wandering kidney

- **Trench back** - soldiers in front line trenches developed illnesses that carried the word “trench in the name ,e,g,. trench mouth, trench back

- **White plague** - one of the names given to tuberculosis probably because the wasting disease made patients appear very pale

- **Fire measles** - synonym for German Measles (Rubella) or Rotheln





Koplik spots are small, white spots seen in the buccal mucosa early in the course of measles. This is a pathognomonic sign.*

- **Colliquative diarrhea** - colliquative is an old term given to various body discharges - sweat, vomiting, diarrhea - the loss of which produced rapid exhaustion

- **Prosector’s wart** - cutaneous form of tuberculosis, tuberculosis verruca cutis. Small, red, popular nodules in the skin appearing 2-4 weeks after infection. An occupational disease of prosectors (old term) those who dissect cadavers for anatomical instruction or pathological examination.

* A distinctive or characteristic sign of a disease or pathologic condition. On the basis of this finding, a diagnosis can be made.

http://www.antiquusmorbus.com/
is an excellent source for archaic medical terms as various readers suggested

- The administration of the Medical Division has undergone some changes. Assistant Administrator Anja Lodge resigned her position for personal reasons. At the New Orleans annual meeting of our division Patricia Yacovone volunteered to be the Acting Assistant Division Administrator. She is currently minding the budgetary end of our mid-year conference planned for May 31- June 3, 2007. A hearty welcome to Tricia.

- Please note that 2007 will be an election year for our division. Elections for the positions of Administrator and Assistant Administrator will be up for the current incumbents during the next Annual Conference in San Francisco.

- The participation of the Medical Division during the proceedings of the 2006 Annual Conference was noteworthy. I believe we led or equaled the leading position in total number of presentations, including a full day Pre-conference seminar. Our thanks to all the speakers.

- Our first Medical Division mid-year conference in Cleveland, Ohio has our full attention. The program is taking form and the budget - which is a new experience for those not necessarily versed in these matters - has now the full attention of the Acting Assistant Administrator. NOTA *(Northern Ohio Translators Association)* has provided support for this effort from the beginning and the CCIO *(Court and Community Interpreters of Ohio)* stands by as well.

- **A new survey monkey will be coming your way soon asking your opinion on matters on the "To Do" shown on the cover pertaining to our Division.**