Caduceus

A Publication of the Medical Divison of the American Translators Association

Fall / Winter 2007- 08

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BEST WISHES FOR 2008

Caduceus
A PUBLICATION OF THE MEDICAL DIVISION OF ATA

by Suzanne Couture and
Rafael A. Rivera, M.D., FACP

WHAT WHERE WHEN

See CADUCEUS, Spring 2007

ENGLISH	ESPAÑOL	REFERENCE
acute care	cuidado agudo durante la enfermedad; tratamiento de enfermedades agudas	3, 5
acute treatment	tratamiento urgente; tratamiento a corto plazo; tratamiento de la crisis	1
adult day services	servicios de cuidado diurno (social o de salud) para adultos	3
ambulatory care: “medical care including diagnosis, observation, treatment and rehabilitation that is provided on an outpatient basis. Ambulatory care is given to persons who are able to ambulate or walk about. A well-baby visit is considered ambulatory care even though the baby may not yet be walking.”	servicios ambulatorios; consultas externas; tratamiento ambulatorio	1, 9, 10
assisted living	vivienda asistida; vivienda de hospedaje con ayuda en los quehaceres diarios	3
case management	manejo (administración) de casos	6
checkup	reconocimiento médico; revisión, chequeo	6
chronic treatment, long-term therapy	tratamiento prolongado	1
convalescence	convalescencia; proceso de restablecimiento; estado de recuperación	1,2
co-payment	pago complementario; copago	6
elderly care medicine	geriatría	1
emergency care	atención de emergencia	5
emergency condition	estado de emergencia; urgencia	6
foster care	tutela de acogida; cuidado tutelar, de crianza	6, 11, 12
Group Adult Foster Care Home Services (GAFC)	Servicios de Hogares Substitutos Colectivos para Adultos (GAFC)	11

ENGLISH	ESPAÑOL	REFERENCE
Health Department	Departamento de Salud Pública; (España: Ministerio de Sanidad)	6
Health Maintenance Organization (HMO)	Organización de Cuidados Administrados de la Salud	6
home health service, home care service, home health care	servicios médicos caseros; servicio de salud en el hogar; atención médica a domicilio; atención médica a domicilio	3, 4, 5, 6
home hospice	atención domiciliaria de cuidados paliativos	1
home medical exams	exámenes médicos en el hogar	5
home visit	visita al hogar; visita a domicilio	4
hospice care	cuidados paliativos	1
hospice program	programa de cuidados paliativos; servicios médicos de hospicio	1, 5
hospital outpatient services	servicios ambulatorios; consulta externa	5
hospital services	servicios hospitalarios	5
In-Home Support Services (IHSS)	servicios de asistencia en el hogar	5
inpatient care	asistencia o cuidado hospitalario	1
Labor, Delivery, Recovery, Postpartum (LDRP)	trabajo de parto; alumbramiento; recuperación y posparto (en español tradicional, puerperio)	6
life threatening	con peligro de muerte; con peligro mortal; potencialmente mortal	6
living will	declaración; deseo; última voluntad en cuanto al mantenimiento o prolongación artificial de vida; testamento vital; instrucciones de no prolongar artificialmente la vida; últimas declaraciones voluntarias en vida	6
long-term care	atención a largo plazo; atención prolongada; atención de larga duración	1
managed health care	atención médica administrada (prestada por empresas de seguros)	6
medical history	historial médico o clínico; historia clínica	6
mental health services	servicios de salud mental	5
newborn nursery care	sala de cuidados para el recién nacido	6
out-of-network	externo a la red; fuera de la red	6
outpatient referral	referencia o remisión a consulta externa	5
outreach	servicios de extensión; servicios sociales	6
pre-admission review	visita previa a la hospitalización	6
respite care	descanso para cuidadores; atención de relevo; servicios de descanso para el que cuida	3, 6, 7

ENGLISH	ESPAÑOL	REFERENCE
routine care	atención de rutina (según Navarro, en español “de rutina” tiene un sentido peyorativo y convendría utilizar otros calificativos como “sistemática”, “periódica”, etc.)	1, 6
schedule a visit	concertar una visita o consulta al médico; programar una consulta; hacer una cita	6
skilled nursing services	servicios especializados de enfermería, cuidado experto de enfermería	3, 5
standby assistance	asistencia de guardia	6
standing referral	remisión fija	6
terminal care	cuidados médicos durante el fin de vida; o en fase terminal ;cuidado de enfermos incurables	1, 5
tertiary care	atención terciaria; cuidado terciario	5
urgent care	cuidado urgente; atención urgente	5
walk-in	cuidado sin cita previa; atención sin cita previa	6
well-baby care	programa del bebé sano	6
well-care	mantenimiento del buen estado de salud	6

REFERENCES

REFERENCE NO.	TITLE / SOURCE	HYPERLINK
1	Navarro. Diccionario de dudas críticas de medicina.	
2	McElroy, Grabb. Spanish-English/ English-Spanish Medical Dictionary.	
3	Alzheimers Associaion. Glosario de términos.	www.alzheimersassociation.com/national/documents/HL_glossary.pdf
4	Disability Related Terminology.	www.ataccess.org/resources/fpic/terms.pdf
5	L.A. Care Health Plan. Managed Care Glossary of Terms. 2004.	www.ccah-alliance.org/providerspdfs/Eng%20Span%20Glossary%20of%20Terms.pdf
6	Términos comunes en el sistema de salud de Estados Unidos. *Apuntes*. Vol. 9, Núm. 2, Primavera de 2001.	www.apuntesonline.org/art.vol9no2.terminossaludok.htm
7	Caring for the Alzheimer's Disease Patient / Cuidando al Enfermo con la Enfermedad de Alzheimer. Geriatric Mental Health Foundation.	www.gmhfonline.org/gmhf/consumer/factsheets/caring_alz_diseasecg_sp.html
8	Diccionario de cáncer. Instituto Nacional del Cáncer (National Cancer Institute).	www.cancer.gov/Templates/db_alpha.aspx?CdrID=44520&lang=spanish
9	MedTerms Medical Dictionary A-Z List. MedicineNet.com.	www.medterms.com/script/main/art.asp?articlekey=4700
10	L.A. Care Health Plan. Glosario para miembros.	www.lacare.org/opencms/opencms/es/members/glossary/index.html

REFERENCES

REFERENCE NO.	TITLE / SOURCE	HYPERLINK
11	Glossary of Social Security Terminology / Glosario de Terminología del Seguro English-Spanish. Social Security Administration.	www.socialsecurity.gov/espanol/04_eng_spanglossary.pdf
12	English-Spanish Glossary of Terms Relating to Higher Education & Student Financial Aid. December 2004.	http://gearup.ous.edu/documents/pdf/English-Spanish_Glossary.pdf

At the MD website you will be able to access current and past issues of CADUCEUS, join the Medical Division, join the Medical Division's listserv, download glossaries, and access multiple links to useful sites.

and

For the "techies" out there, the website has the following features:

1. The website is search engine-friendly.
2. It is mobile device-friendly, which means that the information contained on various pages of the website is easily accessible via mobile devices that have acess to the Internet.
3. It is cross-browser-compatible, which means that its design will be displayed consistently in various platforms, e.g. Mozilla Firefox, Opera, Internet Explorer, Safari.
4. It is web standards-compliant, which means it is not attached to any company or proprietary technology; you can use technologies that are independent of platform requirements; web site code maintenance is simplified, because we do not need multiple versions for different browsers; pages will have a longer life and will not be dependent upon evolving technologies.
5. Website is accessible in compliance with Section 508 of the Rehabilitation Act concerning accessibility of web-based information for people with disabilities. Besides making the website accessible to the 8-10% market of disabled Internet users, this will also provide faster downloading times in browsers and mobile devices and improve the website's search engine-friendliness.

Insights from translational research into disease prevention and healthy living

(Continued from Caduceus Spring, page ---9)

by Elena Sgarbossa, M.D.

PART II

2. Micronutrients

Vitamin A

Vitamin A comprises a family of compounds called retinoids which are essential for normal vision (especially night vision). Retinoids also help maintain normal immunity and tissue function and protect against infection.

Vitamin A is fat-soluble. It is absorbed after ingestion in the small bowel. Insufficient intake of vitamin A predisposes to severe infections and is the main cause of preventable blindness in children worldwide. The most common manifestation of vitamin A deficiency is abnormal dark adaptation and night blindness. Other problems include xerophthalmia (eye dryness and conjunctivitis) and dry skin and hair. Dietary deficiencies occur among young children living below the poverty line, vegans, persons with alcoholism, and recent immigrants from developing countries. Inadequate intake of vitamin A is rare in the United States, but the risk of vitamin A deficiency does exist for patients with abnormal fat absorption. These include patients with pancreatic insufficiency, cholestasis, fat malabsorption, small-bowel bypass, and inflammatory bowel disease.

Good dietary sources of vitamin A include liver, fish oil, eggs, and fruits and vegetables rich in carotenoids ("provitamin A"), as well as fortified foods and vitamin A supplements. It should be noted however that because many multivitamin supplements contain 5000 IU of vitamin A (the maximum daily dose), vitamin A intake can be excessive. Hypervitaminosis A can lead to birth defects, intracranial hypertension, bone abnormalities, liver damage, and hair loss.

Iron

Iron helps to maintain a healthy immune system and is essential for the synthesis of oxygen-carrying proteins in red blood cells (hemoglobin) and muscle (myoglobin). Paradoxically, while iron is the second most abundant metal in the earth's crust, iron deficiency is also the most widespread nutritional disorder. It is highly prevalent even in industrialized countries. Iron content is rather low in the American diet, especially in that of young children and women of childbearing age. It can also be low in vegans and in athletes with high intake of carbohydrates.

Iron deficiency leads to anemia. Symptoms include fatigue, shortness of breath, poor cognitive performance and reduced productivity. It is important to consider that iron deficiency can result not only from inadequate intake but also (and sometimes exclusively) from reduced absorption. This is the case when substances that inhibit absorption are regularly consumed (foods containing phytates or tannins), or when gastric acid production is impaired by antacids.

Dietary iron is available in two forms: heme (very efficiently absorbed by mammals) and nonheme (less efficiently absorbed). Good sources of heme iron include animal foods such as seafood, liver, beef, sardines, and turkey. Non-heme iron is present in vegetables such as lentils, spinach, dried beans and peas.

Antioxidants

The human body constantly generates molecular particles negatively charged called free radicals. Free radicals cause oxidation—the process called *rusting* in metals. It is known that the more calories an animal eats, the more free radicals it generates.

Oxidation causes cell and tissue damage, a phenomenon that increases with age (or promotes aging). It is also associated with many disorders such as atherotrhombosis and cancer.

Oxidation can be counteracted by antioxidants. Antioxidants are compounds that stabilize free radicals by donating an electron (without becoming free radicals themselves). This prevents cell damage and protects against cancer and vascular disease. Many antioxidants also have anti-inflammatory and anti-allergic effects.

Antioxidants are produced by the body and are also present in fruits and vegetables. Dietary sources of antioxidants include carotenoids such as lycopene (in tomatoes and watermelon), the precursor to vitamin A beta-carotene (in sweet potatoes, carrots and apricots), vitamins A, C, and E. Flavonols are antioxidants found in tea, berries, citrus fruits, apples, onions, tomatoes, nuts, cruciferous vegetables (cauliflower, broccoli), and chocolate.

The antioxidant resveratrol has recently attracted attention. Resveratrol reduces plaque formation and atherosclerosis. It is naturally present in the skin of grapes and in red wine, and it might explain in part the “French paradox”—the fact that people in France eat more saturated fat yet have less cardiovascular disease than people in the US. People in France are also regular drinkers of red wine. It is known that a moderate intake of red wine is associated with a reduced risk of heart disease. Interestingly, mice fed a high-fat diet plus a large daily dose of resveratrol do not experience the high blood glucose and insulin levels of mice fed a similar diet but without resveratrol. More research in humans is needed, however; the reports pertain to mice fed a dose of resveratrol of 24 milligrams per kilogram of body weight, and red wine has only 1.5 to 3 milligrams of resveratrol per liter. This means that to obtain similar benefits, an adult would need to drink more than 700 bottles of red wine per day.

Iodine

Iodine is necessary for the synthesis of thyroid hormone. Thyroid hormone has widespread effects on the body; it regulates metabolism, muscular and skeletal function, and the function of the cardiovascular and nervous systems. It is essential for normal growth and development.

Iodine is not produced by the body. In coastal areas of the world, iodine is present in the water from rainfall that had, in turn, evaporated from the ocean. Inland, however, iodine is available only from food.

Iodine deficiency is prevalent worldwide. Serious iodine deficiency during pregnancy can result in devastating effects including stillbirth, miscarriage, and cretinism—an irreversible form of mental retardation from hypothyroidism. Less evident but more common is a mental impairment that reduces intellectual capacity.

Iodine deficiency is easily preventable. The main strategy—implemented since 1993— is universal salt iodization. Salt is widely available, is inexpensive, and it is consumed regularly throughout the year. However, people who live inland and do not consume fish or who replace iodized table salt by salt substitutes (including preparations such as garlic salt) are still at risk for iodine deficiency.

Exercise, activity

A sedentary lifestyle is often the result of a sedentary type of work that leaves little time or energy for physical activity. In addition, over the past decade, the boundaries between time spent at work (plus compulsory activities) and discretionary time have blurred. Yet it is clear that overall, more time is increasingly being spent on a screen. Time devoted to surfing the Internet, e-mailing, interacting in virtual communities and chat,

watching TV, and playing non-physical video games has reached unprecedented levels. This is alarming because statistically, screen time is negatively associated with physical activity and positively associated with obesity. Other problems are also associated with a sedentary lifestyle. A study among people without diabetes who underwent oral glucose tolerance tests (which predict diabetes type 2) showed that people with longer television viewing time had poorer results than those with shorter viewing time. These findings are more significant in women.

Indeed, adults need a minimum of 30 minutes of moderate physical activity five days per week to stay healthy. Regular exercise should also include some strength training. Exercise helps to maintain a normal body weight and prevent cardiovascular disease, diabetes, osteoporosis, some cancers, and anxiety and depression. Physically fit people not only live longer; they feel better.

Conclusion

Translational research has shed light on the importance of everyday habits to maintain health. Eating healthful, varied foods with the essential micronutrients and exercising regularly have shown to the best vaccines against disease and premature aging.

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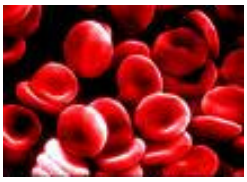
by James R. McAninch, MD

What Translation Texts are Likely to Discuss Anemia?

The medical translator may be asked to translate medical records or pharmaceutical industry texts that refer to anemia as part of a complex of clinical problems. If the translator has a basic understanding of the most frequent causes and treatments for anemia, the text translations will most likely be easier to complete in a meaningful and accurate manner.

Numerous texts, for example, deal with the body's natural stimulator of red blood cell production which is called erythropoietin. This substance is now produced in the laboratory by so-called recombinant DNA technology and is administered to anemic patients with cancer and kidney disease. It is available under several brand names.

A variety of somewhat confusing terms may appear in medical texts, all related to anemia. **Anemia in its simplest definition is a deficiency of red blood cells in the patient.** As a translator, you will see terms such as hypoproliferative anemia, macrocytic (abnormally large red cell) anemia, hemolytic anemia and nutritional anemia. The anemia of chronic blood loss may be referred to as a microcytic (abnormally small red cell) or iron deficiency anemia. Anemia is never a normal state. Every practicing hematologist has seen patients (usually women) with red blood cell (hemoglobin) levels a little below the norms, but who are perfectly well. These patients are not truly anemic.



As we explore the causes for anemia, we can keep the likely medical texts in mind that will mention the various types of anemia. Pharmaceutical texts will often contain discussions in which specific treatments are presented.

What are the Causes of Anemia?

References often provide the simple definition, "a deficiency of red blood cells" to define anemia. The definition is functional but not completely accurate. As will be described, sometimes the cells are "too small" and do not contain enough of the red pigment, called "Heme." Their actual numbers may be normal, but the patient lacks adequately functioning red cells. This is the case in some anemias.

1. Iron deficiency anemia

A deficiency of iron in the body results in red cells lacking adequate "heme" for oxygen-carrying capacity. The bone marrow produces abnormally small and abnormally pale (lacking enough of the iron compound "heme") cells. The cells are described as **microcytic** and **hypochromic**. The cause is almost always chronic blood loss. However, failed iron absorption and inadequate dietary iron uncommonly can cause iron deficiency anemia.

2. Megaloblastic anemia

A deficiency of vitamin B12 (as in pernicious anemia) or folic acid in the body (example: a pregnant woman who fails to take pre-natal vitamin supplements and eats a folic acid deficient diet). In both B-12 and folic acid deficiency, the bone marrow produces abnormally large (**macrocytic**), dysfunctional red cells

3. Hemolytic Anemia

All anemias related to abnormal red cell destruction are called **hemolytic** anemias. The causes are many and include immune mechanisms, incompatible transfusions, bacterial infections and destruction caused by parasites (some types of malaria). In all cases, the average life span of the red cell is markedly shortened from the normal 120 days. This class also includes anemias due to an inherited

defect in the red cell wall or in the chemical composition of hemoglobin (Hemoglobin is the iron compound [heme] attached to a protein [globin]. Examples are sickle cell anemia, thalassemia and glucose-6-phosphate deficiency.

4. Anemias related to a failure of bone marrow production of red cell precursors

The specific cause of failure may be cancer infiltrating the marrow, leukemia or suppression of marrow function due to chemotherapy, radiation or a drug reaction.

5. Anemias resulting from combinations of above causes

An example is the anemia of advanced alcoholism, in which folic acid deficiency, liver disease and its associated enlargement of the spleen with red cell destruction and chronic blood loss due to alcohol related gastritis all work together to cause anemia.

How is anemia treated?

The answer to the question of how to treat is usually: *treat the underlying cause.* However, treating the underlying conditions, such as advanced alcoholism, disseminated cancer or sickle cell anemia can be difficult and ineffective. The use of bone marrow stimulators (erythropoietin *Epogen*®, *Procrit*®) may be effective in patients being treated for cancer or kidney disease. Giving iron to a patient with an iron deficiency anemia without performing an exhaustive search for a source of chronic blood loss can be a serious medical error. A potentially curable cancer somewhere in the digestive tract may be overlooked in such a case.

When can translation texts involving anemia become problematic?

German language texts may use several German terms to describe anemia, sometimes using all of them in the same text. For example; you might find *die Anämie, die Blutarmut* and *ein Mangel an rotem Blutkörperchen* in the same text. The terms essentially mean the same thing, that is, anemia. You might encounter a jaw-buster like *myelodysplastische Anämie*. How do you contextualize such a word to understand its meaning and assure a better translation of the text? You can do something like this: First, you see Latin/Greek roots in most words like this. Then, it is quite likely that the word is nearly the same in English medical terminology. Suppose that the English term is "Myelodysplastic Anemia" (or myelodysplastic syndrome). It refers to an anemia due to a dysfunctional bone marrow. In this case the dysfunction may be part of a pre-leukemia picture in which genetic aberrations can already be found in the cells.

Now that you've gotten that far, you will most likely find further discussion in the text regarding chromosomal abnormalities and aberrant genes predictive of an evolving malignant disorder.

Finally, it is a "good bet" that you can find a very helpful parallel article in the English medical literature to help you with that German, Spanish, French or other source-language text related to anemia.

Conclusion

When presented with a source text discussing anemia, whatever the cause, the medical translator is likely to encounter several terms that essentially describe the same entity. It is very important to understand the pathogenesis (the mechanism through which the anemia develops) of the disease process being described in the source text. English language parallel documents are especially helpful and may contain Latin/Greek derived terms that are explained by the English language discussion. Using the knowledge so gained will make the translation less difficult to complete. The medical translator needs a basic understanding of anemia and its causes.

Paying Attention to the Interpreter's Professional Growth

by Zarita Araujo - Lane LICSW and Vonessa Phillips Costa

Many "gems" have been uncovered as a result of our nationwide dialogue around national certification for healthcare interpreters. One is that the road to national certification must be paved with input from many specialties and that it is an ongoing and deliberate process that cannot be rushed if it is to be done well. Along the way, we will need to consult linguists, psychometricians, ethicists, providers, patients and members of many allied professions. As a group, we will need to decide what will be tested, who will develop and administer the tests, and how are we going to prepare the interpreters who will be taking these tests.

However, as individual interpreters, we currently share a responsibility towards our own professional growth. The individual interpreter's critical thinking abilities and application of standards of practice are two important ingredients in the making of a true professional interpreter. Included, of course, as "a must" is fluency in source and target languages and an understanding of the medical area in which we function.

According to the NCIHC National Standards of Practice for Interpreters in Health Care, there are at least nine general areas in which the professional interpreter must successfully navigate: accuracy, confidentiality, impartiality, respect, cultural awareness, role boundaries, professionalism, professional development and advocacy. As interpreter trainers, we continually emphasize in our teaching these commonly accepted principles and their practical applications. However, interpreter trainees who have themselves been patients or who have witnessed the treatment of LEP patients often share stories of interpreters and healthcare providers who time and again have violated the ethical principles that we hold so dear.

Such situations are so common in every area of healthcare that they sometimes seem anecdotal. Doctors who openly discuss cases in elevators, medical assistants who share patient information over lunch, nurses who leave sensitive messages with patients' family members - gross violations of HIPAA regulations and of the codes of ethics of medical and allied professions happen everyday. Interpreters witness the breaking of so many rules at so many levels that it is easy to understand why they themselves might at times succumb to the temptation to step outside the defined boundaries of their practice.

One situation that seems to come up in each new training is the struggle over what information belongs to each of the players in the multilingual, multicultural encounter. Interpreters will often argue that a patient's culture dictates that information should be shared first with family members, or that family members waiting outside the session should be filled in on what was said by the provider. They are passionate in their arguments that not sharing this information would lead to a loss of trust and to alienation from the community at large.

These interpreters' fears are not wholly unfounded. Losses of trust and negative community reactions are equally possible scenarios resulting from an interpreter's refusal to divulge confidential information. Experience has shown, however, that information is best received when careful attention is given to the manner in which it is transmitted to the listener. For example, in response to a family's request for information, one interpreter might say, "I can't tell you anything. It's against the rules". While this is a correct answer, it will likely not enhance the family's relationship with the interpreter, medical

staff, and, by extension, the healthcare institution as an organization. Is there a way to uphold the patient's right to confidentiality and still show respect for a culture that values family and community decision-making processes over patient autonomy?

In our work as interpreters in inpatient units, we have met many families who were afraid of discussing a diagnosis or prognosis with the patient-they did not want to upset their loved one. In some cultures, there is a generalized belief that 'what you don't know can't hurt you', in the sense that if a patient is informed of his true condition, he will worry unnecessarily or in some cases, die faster. Shrewd patients would often understand a lot more about their illnesses than their families wanted to believe, but others were left in the dark, lonely and with little information regarding their situations.

One patient developed a cardiomyopathy after giving birth. The provider relayed his observations through her husband, who was upset by the explanation that the weakness of his wife's heart muscle was a result of the labor. The husband and family minimized the seriousness of the situation, never fully explaining to the patient the details of her condition. Soon, she was pregnant again and died of a major heart attack right after giving birth to a second child at a very young age. Imagine if you as an interpreter had collaborated with the family's decision to keep the patient out of the communication. How would you have felt about yourself when she later died?

Stories such as this, though heartrending, can be used as tools for self-evaluation and professional growth. Our everyday challenges related to the diversity of cultures we serve are in some ways greater than those faced by many providers, and there are no easy answers. Providers have more freedom when it comes to their behavior in any given session. Unlike interpreters, they can try to persuade patients to adopt certain attitudes or to choose a course of treatment. Think of how many times you've heard a doctor say, "If you were my mother, I would recommend this treatment", or "There are no guarantees, but I strongly suggest this approach." As interpreters we could never make this type of intervention because we are neither medical professionals nor stakeholders in the decision-making process. And yet, interpreters have reported that certain providers have asked them to stay a bit longer and "convince" the patient to accept a recommended treatment or agree to a plan, and from this type of request stems the interpreter's confusion regarding what is acceptable in the triadic encounter.

Another source of confusion for newly trained interpreters is the behavior of "veteran" or "seasoned" interpreters. New hires are often paired with long-time employees at the beginning of their work for shadowing in interpreting sessions. One newly trained Portuguese interpreter was shocked to be paired with a Spanish-speaking interpreter who explained that even though he doesn't really speak Portuguese, the patients "usually" understand him. This interpreter is the primary interpreter for all Portuguese-speaking patients at his institution, a blatant violation of at least six NCIHC standards ranging from the categories of accuracy and respect to role boundaries, professionalism and advocacy.

In another facility, a newly hired Spanish interpreter was told by his supervisor, "We don't use the first person here in our hospital. It's too confusing." At that particular facility, interpreters are required to use the third person in all interpreting encounters, a clear violation of the standards upheld by the International Medical Interpreters Association, standards by which this interpreter had recently been trained.

Trainings and certifications are tools to establish a baseline of skills and practices in our work. But those who are trained, and in the future, those who achieve certification, cannot afford to lose their humility and abandon their study of the art of medical interpretation. In our move towards professionalization, it would be unwise to take two steps forward and three steps back.

As in other medical and allied health professions, we must continue our training. Each one of us must continually fine-tune our understanding and practical application of the principles that govern our work. We will become better interpreters when we respect and follow our own standards. We will become better interpreters when we stop limiting our actions with justifications of culture and ethnicity.

So coming back to our first story where the interpreter feels the need to respect community while upholding the principle of confidentiality. How can this be done? While there are many different approaches to this conversation with the patient's family, we might look to the social work and mental health professions for some advice in this regard. One technique that family therapists frequently implement is to verbally echo the concerns that the family has. For the interpreter, this might sound like, "I understand that you are truly concerned about your father/mother/sister. Can I help you by interpreting these concerns to the provider?" This simply worded reply will do much to calm the family and deflect any negativity around the interpreter's decision to not break confidentiality.

As professionals, we need to apply our critical thinking skills to our daily interactions with providers and patients. When analyzing a situation, challenge your initial assumptions. Try to see the interaction from the viewpoint of each person involved. Never blindly follow the lead of a veteran interpreter without first checking applicable standards of practice to determine if a professional interpreter's association would support your action.

Write about your experiences in a way that preserves the confidentiality of those involved, consult colleagues and supervisors, and bring your questions to the community at large by making use of forums such as open calls, list-serves and study groups. Attend ongoing training at different levels and make it a point to be an active participant in interpreter association conferences and other key events. Make this work 'your own', and take responsibility for your professional growth. You will become a fine example to the public of everything an interpreter should be.

PRIORITIES FOR THE MEDICAL DIVISION IN 2008

- **Identify speakers for next ATA Conference in Orlando**
  - Quantity and level of sessions presented in San Francisco were okay
  - Subject areas should be ½ translation-related and ½ interpreting-related
  - Would like sessions on training medical interpreters (not beginning)
- **Plan for Medical Division social at next ATA Conference**
  - This year's breakfast and icebreaker (translator bingo) were fun, but not well attended. (Too early for some.)
  - Considered lunchtime and evening events. Agreed to try box lunch at conference hotel.
  - Need to publicize in Caduceus, listserv, and conference program
- **Plan Medical Division Mid-Year Conference for 2009**
  - Possible locations: Medical center in
    - Toronto – University Health System (free meeting rooms)
    - Philadelphia
    - St. Louis
    - University of Minnesota Medical Center - Minneapolis
    - Georgetown University
- **Possible sponsors**
  - Pharmaceutical companies
  - Medical device manufacturers
- **Possible topics**
  - Distinguished speaker: Language services coordinator from Mayo Clinic or MD Anderson
  - Certification update
  - Training of trainers for medical interpreters
  - English Terminology, then break into language-specific groups
  - Post neurology surgery
  - Genetic counseling
  - Mental health – Maria Rosdolsky (terminology), Zarita Araujo-Lane (practice). Possible pre-conference workshop.
- **Possible dates for the 2009 Medical Division Mid-Year Conference**
  - June?
  - Work around dates/locations of other conferences and ATA's Professional Development Seminars

Your comments and opinions about our priorities for 2008 are needed and welcomed. Please write to: mediaz@austin.rr.com.