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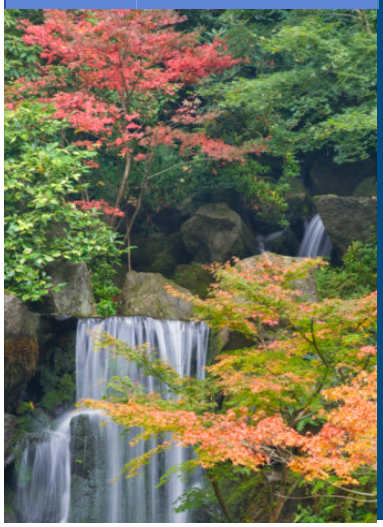
CONTENT: Part Two



ANNUAL CONFERENCE ISSUE

Integrating Medical Interpreters into the Healthcare Team - A More Effective Team and A More Satisfied Patient | A Win-Win Situation for All

by Monica Guelman and Steven Becerra

This is the second of a 3-part series:

1. Ethics in medical translation and interpretation
2. The Issue of Untrained Interpreters and Translators in the Medical Field
3. **The importance of a multicultural and multilingual workforce in a healthcare setting.**

To understand the need for cultural competency, we must first define the concept of "cultural competency" and also examine the demographic factors that compel us to acquire such practices and understandings. "Cultural Competency is a process that requires individuals and systems to develop and expand their ability to know about, be sensitive to, and to have respect for cultural diversity. The result of this process should be an increased awareness, valuing, acceptance, and utilization of and an openness to learn from general and health-related beliefs, practices, traditions, languages, religions, histories, and current needs of individuals and the cultural groups to which they belong…"[i] This article will deal primarily with minorities based on nationality, language, and religion.

Diversity has always been the nature of this country, but there has been an increasing shift towards immigration from countries where language, religion, and customs vary to a higher degree. In 1940, 70% of immigrants were from Europe. By 1992, the pool of immigrants had changed so that 15% came from Europe, 37% came from Asia and 44% came from Latin America and the Caribbean.[ii] The U.S. attracts two-thirds of the world's immigration and 85% of American immigrants come from Central and South America.[iii] Generalist physicians can expect more than 40% of their patients to be from minority cultures.[iv] The problem is compounded by the fact that even though minorities are the fastest growing segment of the US population, our national demographics are not reflected in medical school classrooms. As of 2001, they only represented 7% of the physician workforce.[v]

Physicians and other healthcare professionals are expected to show respect and understanding towards the multitude of heritages, family environments, economic factors, races, genders, sexual orientations, ages, and languages they encounter in the course of their work.[vi] Given the current make-up of our country, the lack of healthcare professionals from the target backgrounds, and the future demographic trend, we as a society, which values diversity and has prospered because of its varied roots, must acquire cultural competency in healthcare. The reality is that cultural differences do exist and they have an impact on health care delivery. It is from our own culture that we learn how to be healthy, how to recognize illness, and how to be ill.[vii] As a society, we can be ethnocentric when it comes to healthcare. We are a culture of lab samples, departmental paperwork, medical jargon, and the omnipotence of technology.[viii] Not being able to bridge the cultural gap can have damaging consequences to the patient and possibly the relationship with a particular community and the way it perceives our medical culture.

Let us look at an example of how a lack of cultural competency can hinder and even worsen a case. Lia Lee was a three-month-old Hmong child with epilepsy. Her doctors prescribed a complex regimen of medication designed to control her seizures. However, her parents felt that the epilepsy was a result of Lia "losing her soul" and did not give her medication as indicated because of the complexity of the drug therapy and the adverse side effects. Instead, they did everything logical in terms of their Hmong beliefs to help her. They took her to a clan leader and shaman, sacrificed animals and bought expensive amulets to guide her soul's return. Lia's doctors felt her parents were endangering her life by not giving her the medication so they called Child Protective Services and Lia was placed in foster care. Lia was a victim of a misunderstanding between these two cultures that were both intent on saving her. The results were disastrous: a close family was separated and Hmong community faith in Western doctors was shaken.[ix]

A call to a qualified interpreter, who could have served as a cultural broker, would have prevented this

unfortunate episode. Though the expense of professional interpreters is often cited as an obstacle, organizations should think of the more expensive monetary and ethical consequences. Poor communication can lead to worse health or liability costs.[x] A provider in Washington, D.C., was sued for $11 million when, due to miscommunication, an abortion was performed on a non-English speaking woman who only wanted contraception.[xi] Concurrently, there are cost-effective ways to train staff in cultural sensitivity and language learning.

There is no way around the importance that culture has in medicine. We know that having a colorful environment filled with toys and smiling characters would be ideal for a children's hospital. A clinic catering to the LGBT community would do well in understanding their needs, common medical issues, and ensuring that the staff is supportive rather than judgmental. These examples of cultural sensitivity are closer to home and perhaps easier to comprehend. Just as some cultures think of leeches, shamans, or rattles as soon as ill health strikes, we may see a rod of Asclepius (a rod with an entwined serpent) or a caduceus (a winged staff) and immediately think of doctors and hospitals. In other words, their symbols for health and well being are as hard-wired into them as ours are in us.

It is the proper approach and successful communication between cultures that makes us culturally competent. Culturally competent providers respect the power of symbols, traditions, and beliefs in other cultures. They appreciate family ties and realize that they are defined differently for each culture.[xii] They seek to understand, interpret and utilize instead of dismissing or judging. Rather than being insulted by another culture's perspective, culturally competent providers welcome collaboration, cooperation, and the necessary training to avoid pitfalls in communication.

Elements such as language issues, misunderstanding of folk illnesses, vastly different parent/patient beliefs, and ignorance concerning the provider's practices can be obstacles. A patient is more likely to express discomfort and share essential medical information with a provider if he/she can speak their language and/or understand their culture. The dynamics and relationship structure at work, in their family and society may be wholly alien to the provider yet have great importance as to communication and subsequent treatment. Addressing medical issues using cultural awareness and sensitivity will allow for quicker diagnoses and possibly avoid more expensive treatment caused by unnecessary delay due to linguistic/cultural breakdown.

There are some established standards for cultural competency such as the National Standards on Culturally and Linguistically Appropriate Services (CLAS), which the Office of Minority Health developed in 1997. The CLAS standards are mainly directed at health care organizations but individual providers are also encouraged to use the standards to make their practices more culturally and linguistically accessible. Partnership with qualified cultural brokers and the community itself is advisable for their implementation. They were adopted by the federal register on December 22, 2000, and are required of institutions that receive federal funds. There are 14 standards organized by themes: Culturally Competent Care (Standards 1-3), Language Access Services (Standards 4-7), and Organizational Supports for Cultural Competence (Standards 8-14). There are three types of standards of varying stringency: mandates, guidelines, and recommendations.[xiii] I will not list them all here but they can be seen at the Department of Health and Human Services website in the OMH section.[xiv] They include points such as "patients shall receive from all staff members effective, understandable, and respectful care that is compatible with their beliefs and practices as well as language" and "Healthcare organization must offer and provide language assistance services, [including interpreters], at no cost to patient with limited English proficiency at all points of contact, in a timely manner, and during all hours of operation."

Hospitals and other institutions can benefit greatly from complying with these standards and improving their cultural competency. Reduction in health disparities and the improvement of patient care can results from addressing diversity and cultural

competency in an organization. This, in turn, can positively affect the bottom line by improving an institutions market share, lowering health costs, avoiding legal issues, and with rising healthcare costs, large employers and health plans will scrutinize providers to ensure they represent (and can effectively care) for their communities.[xv] Healthcare institutions must endeavor to train their staff in basic language needs as well as cultural competency and sensitivity. They must also provide training for those staff members who are already multilingual but do not possess a firm command of an alternate language and/ or did not grow up in the target culture and therefore may not understand its complexities. Translation of educational material, consent forms, procedural explanations, etc., can put the patient more at ease and avoid complications (both legal and medical). The use of interpreters, both as language facilitators and cultural brokers, as discussed in the previous article, is also essential to achieving a culturally competent healthcare environment. All this brought together allows for increased cultural competency at the individual as well as the organizational level.

Monica Guelman is Vice President of Sales & Marketing at Congress Network Corporation, as well as a freelance English/ Spanish translator and interpreter with over 15 years of experience in the industry. She is a former FLATA Secretary and NAJIT scholar. She is also an active member of ATA and its Spanish, Medical, Interpreters, Translation Company, and Language Technology Divisions as well as NAJIT. She has contributed articles to the Miami Herald, Multilingual Magazine, South Florida Hospital & Healthcare Association, American Society for Training and Development, and many others. She resides in Fort Lauderdale with her husband and their 4-year old son. She can be reached at 954-328-1286 or via email at mg@congressnetwork.com

Steven Becerra began as an archeologist and then trained as a linguist in both modern and ancient languages. He currently works as a freelance interpreter and translator in the legal field in South Florida as well as a teacher of various languages. Steven can be reached at 786-287-1434 or stevethemaccabee@gmail.com

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DIVISION		
Code	Name	Total
CLD	Chinese Language Division	735
FLD	French Language Division	2,013
GLD	German Language Division	1,483
ID	Interpreters Division	3,910
ILD	Italian Language Division	928
JLD	Japanese Language Division	912
KLD	Korean Language Division	342
LD	Literary Division	2,303
LTD	Language Technology Division	2,511
MD	Medical Division	3,379
ND	Nordic Division	433
PLD	Portuguese Language Division	1,103
S&TD	Science and Technology Division	253
SLD	Slavic Languages Division	1,131
SPD	Spanish Language Division	4,581
TCD	Translation Company Division	3,097
	GRAND TOTAL	29,114

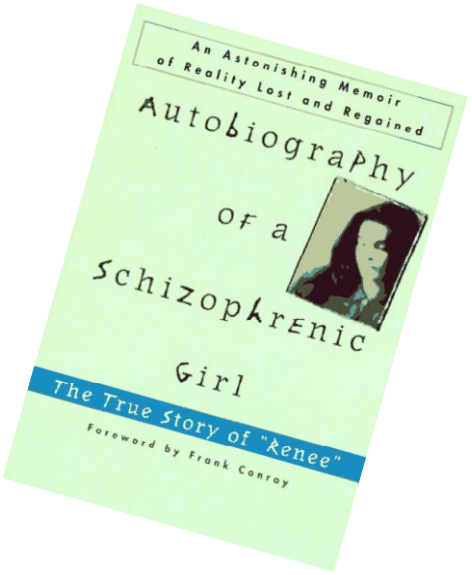
As of August, 2010

by Maria Rosdolsky

Autobiography of a Schizophrenic Girl
by Marguerite Sechehaye

ISBN 9780452011335 Plume Books , 1994
(translated from the French)

First published in 1951, this book has two parts. The first part is the memoir of a “Renée”, a schizophrenic woman. The second part, written by Marguerite Sechehaye, a Swiss psychologist and her psychotherapist, is an interpretation of her disease and response to treatment. The memoir describes, with amazing detail, the onset of schizophrenia at the age 5, the girl’s struggle with schizophrenic symptoms, her treatment, and her recovery.



At the center of the illness is the feeling of unreality, and the enormous fear associated with this feeling. Renée had her first experience with unreality when she passed a school and heard children singing. “It was as though the school and the children’s song were set apart from the rest of the world.” And later in school: “During class, in the quiet of work period, I heard the street noises – trolley passing, people talking … each detached, immovable, separated from its source…” The children appeared to Renée as “robots or puppets, moved by an invisible mechanism.” Though reversible at the beginning of the disease, the feeling of unreality was later present all the time.

Renée calls the analyst “Mama”. Next to her, Renée often feels secure but “Mama” also becomes unreal from time to time. “I perceived a statue, a figure of ice which smiled at me. For I saw the individual features of her face separated from each other...”

Later, she describes a “System” punishing her and giving her orders such as burning her hand. The “System” wanted to reduce her to nothing, and she felt she was getting younger, and at the same time she “discovered” that she was 9 centuries old, which meant to her that she was not yet born. Voices told her to eat, although the head of the “System” knew that it was forbidden. She was only allowed to eat apples, symbols of the mother’s breast and milk. With the help of a plush monkey (“My First Double”) and a doll Renée called Ezekiel (“Reborn in Ezekiel”), the analyst helps Renée to finally find her way back to reality.

This memoir conveys the schizophrenic condition that captures the entire personality, and is written in such a vivid way that the reader can empathize with the girl and understand schizophrenia in a way that no text book can provide.

Based on psychoanalysis, which may be considered obsolete by some, the second part of the book is an interpretation by Renée’s psychotherapist. Marguerite Sechehaye had developed a method she called "symbolic realization" for treatment of schizophrenia, and she describes how it led to the girl’s recovery. Sechehaye adopted Renée, who later became a psychoanalyst.

Maria Rosdolsky has worked as a physician in Austria, Switzerland and Germany, specializing in neurology and psychiatry. Since 1980, she has lived in the Philadelphia area, and she has worked as a biomedical information specialist, medical writer, and English<>German medical translator for more than 20 years. She has published several articles on medical translation and teaches German-English medical translation online at New York University.

Schizophrenia Glossary

ENGLISH	DEFINITION	GERMAN
ABULIA	Absence of will power, reduced impulse to act and think	ABULIE
AFFECTIVE FLATTENING, FLATTENING OF AFFECT, FLAT AFFECT	Diminished emotional reactivity	AFFEKTVERFLACHUNG, FLACHER AFFEKT
AKATHISIA	Motor restlessness with constant movements. Side effect of antipsychotics	AKATHISIE
ALOGIA	Inability or reduced ability to speak	ALOGIE, SPRACHVERARMUNG
ANTIPSYCHOTICS, ANTIPSYCHOTIC AGENTS, NEUROLEPTICS	Drugs with antipsychotic and sedative effects	ANTIPSYCHOTIKA, NEUROLEPTIKA
CATATONIC BEHAVIOR	Bizarre or inappropriate postures with resistance to changes	KATATONES VERHALTEN
CATATONIC STUPOR	Unresponsiveness with immobility and mutism	KATATONER STUPOR, KATATONER SPERRUNGSZUSTAND
CATATONIC TYPE	Type of schizophrenia with motor immobility (catalepsy, stupor), or excessive purposeless (repetitive, non-functional) movements, extreme negativism, echolalia, and echopraxia (DSM)	KATATONER TYPUS
CATATONIC SCHIZOPHRENIA, CATATONIA	Obsolete terms for catatonic type of schizophrenia	KATATONE SCHIZOPHRENIE, KATATONIE
CATALEPSY, WAXY FLEXIBILITY, FLEXIBILITAS CEREA	Maintenance of postures or positions (including positions of arms and legs) into which they are placed by another person	KATALEPSIE, FLEXIBILITAS CEREA
CIRCUMSTANTIALITY	Overinclusion of irrelevant details that impede getting to the point	UMSTÄNDLICHKEIT
DELUSION	A false belief that is firmly maintained even though contradicted by reality	WAHN
Delusional jealousy, delusion of infidelity, pathological jealousy	Delusion that one's sexual partner is unfaithful	Eifersuchtswahn
Erotomanic delusion, erotomania	Delusion that another person, usually of higher status, is in love with the individual	Liebeswahn, Erotomanie, Paranoia erotica
Delusion of being controlled	Delusion in which feelings, impulses, thoughts, or actions are experienced as being under the control of some external force	Wahnphänomen der Beeinflussung oder des Gemachten
Delusion of reference	Delusion whose theme is that events, objects or other persons in one's immediate environment have a particular and unusual significance	Beziehungswahn
Persecutory delusion	Delusion in which the central theme is that one is being attacked, harassed, cheated, persecuted, or conspired against	Verfolgungswahn
DEPERSONALIZATION	Feeling of being detached from oneself, of having lost one's personal identity; feeling of being an outside observer	DEPERSONILISATION
DEREALIZATION	Feeling of changed reality or unreal environment	DEREALISATION
DERAILMENT (LOOSENING OF ASSOCIATIONS)	Associations without or with oblique relationship to one another	ENTGLEISUNG (ASSOZIATIONSLOCKERUNG)
DEREISM	Mental activity that deviates from the laws of logic and experience and fails to take the facts of reality into consideration	DEREISMUS

Schizophrenia Glossary

ENGLISH	DEFINITION	GERMAN
DISORGANIZED TYPE	Type of schizophrenia with disorganized speech, pronounced thought disorders, disorganized behavior (e.g., bizarre movements and grimacing, inappropriate laughter and crying, aimless activities), and flat or inappropriate affect (DSM)	DESORGANISIERTER TYPUS
DESORGANIZED BEHAVIOR	Any absurd or inappropriate behavior	DESORGANISIERTES VERHALTEN
ECHOLALIA	Repetition of another person's words and phrases	ECHOLALIE
ECHOPRAXIE	Repetition of another person's movements	ECHOPRAXIE, ECHOKINESE
FREE-FLOATING ANXIETY	Anxiety that is not attached to ideational content	FREI FLOTTIERENDE ANGST
HALLUCINATON	A sensory perception in the absence of an external stimulus.	HALLUZINATION, SINNESTÄUSCHUNG
Auditory hallucination	Hallucination of sound, most commonly voices	Akustische Halluzination
Gustatory hallucination	Hallucination involving the perception of taste	Gustatorische Halluzination, Geschmackshalluzination
Olfactory hallucination	Hallucination involving the perception of odor	Olfaktorische Halluzination, Geruchshalluzination
Somatic hallucination	Hallucination involving the perception of a physical experience (e.g., feeling of electricity in the body)	Körperbezogene Halluzination
Tactile hallucination, haptic hallucination	Hallucination involving the sensation of touch	Taktile Halluzination, haptische Halluzination, Tasthalluzination
HEBEPHRENIA, HEBEPHRENIC SCHIZOPHRENIA	Obsolete term for desorganized schizophrenia.	HEBEPHRENIE
ILLUSION	Perceptual misinterpretation of a real external stimulus (e.g., a tree is believed to be a person)	ILLUSION
MISPERCEPTION	Includes illusions and hallucinations	TRUGWAHRNEHMUNG
NEGATIVE SYMPTOMS	Include flat affect, alogia, abulia, and apathy	NEGATIVE SYMPTOME
NEGATIVISM	Resistance to instructions, opposition to suggestions and advice	NEGATIVISMUS
NEOLOGISM	Invention and use of new (non-existing) words	NEOLOGISMUS
PARANOIA	Not included in current official terminology but still frequently used. Historically, the meaning of the term has changed frequently. Today, it is mostly used for a delusional state without hallucinations and preserved clear and orderly thinking.	PARANOIA
PARANOID IDEATION	Suspiciousness of belief that one is being harassed or persecuted	PARANOIDE VORSTELLUNG
PARANOID TYPE	Type of schizophrenia with delusions (mostly persecutory), and auditory hallucinations (DSM)	PARANOIDER TYPUS
PRODROMAL PHASE	Phase before active-phase symptoms, e.g., social withdrawal, loss of interest in activities	PRODROMALPHASE
PSEUDONEUROTIC SCHIZOPHRENIA (DMS: BORDERLINE PERSONLITY DISORDER)	Condition with anxiety, phobias and other symptoms followed by the development of psychotic symptoms.	PSEUDONEUROTISCHE SCHIZOPHRENIE (DSM: BORDERLINE PERSÖNLICHKEITSSTÖRUNG)
PSYCHOSIS	Mental disorder in which the thoughts, affective response, ability to recognize reality, and ability to communicate with others are sufficiently impaired (Kaplan & Sandock's)	PSYCHOSE

Schizophrenia Glossary

ENGLISH	DEFINITION	GERMAN
PSYCHOTIC EPISODE, ACTIVE PHASE, EXACERBATION	Phase with active psychotic symptoms	PSYCHOTISCHE EPISODE, PSYCHOTISCHER SCHUB
RESIDUAL TYPE	Condition after an acute episode with negative symptoms and eccentric behavior (DSM)	RESIDUALER TYP
SCHIZOAFFECTIVE DISORDER	Condition with symptoms of schizophrenia and mood disorder (DSM)	SCHIZOAFFEKTIVE STÖRUNG
SCHIZOPHRENIFORM DISORDER	Schizophrenic symptoms that last at least 1 month but less than 6 months (DSM). Patients return to their baseline level of functioning after the episode.	SCHIZOPHRENIFORME STÖRUNG
SHARED PSYCHOTIC DISORDER, INDUCED PSYCHOTIC DISORDER, FOLIE A DEUX	Psychotic delusions transferred to another person. The two people usually have a close relationship.	INDUZIERTES IRRESEIN, FOLIE A DEUX
SIMPLE DETERIORATIVE DISORDER, SIMPLE SCHIZOPHRENIA	Condition with gradual social withdrawal, loss of drive and ambition (DSM)	EINFACHE DETERIORATIVE STÖRUNG, SCHIZOPHRENIA SIMPLEX
TANGENTIALITY	In response to a question, the patient gives a reply that is appropriate to the general topic but not an answer to the question.	TANGENTIALITÄT
TARDIVE DYSKINESIA, LATE-APPEARING DYSKINESIA	Involuntary, slow, rhythmical, automatic movements. Side effect of long-term treatment with antipsychotics	TARDIVDYSKINESIE, SPÄTDYSKINESIE
THOUGHT DISORDER	Any disturbance of thinking caused by disease	DENKSTÖRUNG
FORMAL THOUGHT DISORDER	Disturbance in the process (rather than the content) of thought; thinking characterized by loosened associations, neologisms, and illogical constructs.	FORMALE DENKSTÖRUNG
Thought blocking	Sudden disruption of thought	Gedankenabreißen
Thought broadcasting	Belief that one's thoughts are being broadcast and can be perceived by others	Gedankenausbreitung
Thought echoing, thought hearing, audible thought	Hearing one's own thoughts coming from within the patient or from outside (auditory hallucination)	Gedankenhören, Gedankenlautwerden
Thought insertion	Belief that thoughts are being inserted into one's mind by other people or forces	Gedankeneingebung
Thought pressure	Belief that thoughts are forced into one's mind	Gemachte Gedanken
Thought withdrawal	Belief that one's thoughts are removed from one's mind by other people or forces	Gedankenentzug
Disorder of thought content	Disturbance of the content of thoughts including delusions, obsessions, preoccupations	**Inhaltliche Gedankenstörung**
Undifferentiated type	Type of schizophrenia with schizophrenic symptoms and without prominent features of another subtype (DSM)	Undifferenzierter Typus
Word salad, schizophasia	Incoherent mixture of words and phrases	Wortsalat, Schizophasie

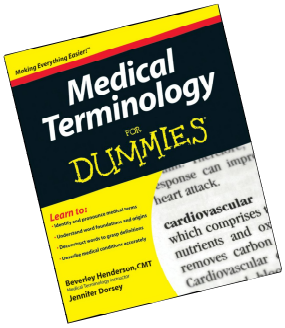
by Carmen Cross

Medical Terminology for Dummies
by Beverly Henderson and Jennifer Lee Dorsey

ISBN 9780470279656
Wiley Publishing , Inc. 2009

Part I contains a brief introduction to medical terminology. It discusses how these terms are formed and introduces root words, suffixes and prefixes. In addition, eponyms and acronyms, very common in medical terminology, are given some attention. How to derive the plurals of such terminology is also briefly touched upon. Even though this information may seem extraneous and redundant, I found it to be potentially beneficial, especially for newcomers to the medical field.

Parts II, III, IV and V delve deeper into prefixes and suffixes and provide a list of the most common ones, e.g. "macro-"(large). The author also provides some popular examples of words with these prefixes and suffixes, e.g. "bradycardia" (slow heart rate). Root words, suffixes and prefixes are discussed in more detail. Examples are also provided with their meanings. Each anatomical system (musculoskeletal, muscular, integumentary, sensory, cardiovascular, respiratory, gastrointestinal, endocrine, nervous, urinary and male and female reproductive systems) is given its own chapter. Each chapter is laid out in a similar fashion with a brief overview of the system, relevant diagrams, roots and suffixes pertaining to that system, e.g. "metacarp/o" (bones of the hand). Each chapter concludes with a brief discussion of relevant common conditions and diagnostic tests, surgeries and procedures. One of the most helpful sections of Part II is a chapter on breaking down medical words into their composite parts and explains their general meaning, e.g. "peri-" (during) and "-ectomy" (surgical removal of an organ). The author even includes tips for deciphering such vocabulary such as "the suffix indicated a procedure, disease, disorder or condition, and you look at it first" (p. 94).



Part VI is the Part of Tens, which is a common feature of *For Dummies* books. Ch. 24 presents ten essential terminology references, both printed and electronic, e.g. medilexicon.com and Taber's Cyclopedia Medical Dictionary. Ch. 25 presents useful mnemonic devices to remember medical terminology. Ch. 26 includes word-building activities to help to memorize medical terminology.

Overall, I found this book to be a refreshing reference for medical terminology as opposed to sources that just list terms in dictionary-fashion. It is laid out in a uniform manner for ease of reference and is written in clear and simple language. So, not only medical professionals, but also translators can benefit from the layout and information contained in the book. There are several features that make this book as entertaining as it is helpful. For example, "Did You Know?" callouts give extra information and "Tips" provide information to help in the master of medical terminology, e.g. "It is important to know the difference between 'ostomy' and 'otomy'-there is only one letter difference, but a big difference in meaning" (p. 95).

Due to its simple style and diagrams, this book may not be appropriate for medical professionals who often have a need to refer to detailed diagrams and more in-depth information. However, it was clearly written for non-professionals in the medical field, and I highly recommend it.

Carmen Cross has been a fulltime German/Arabic to English translator since 2005. Her areas of specialization are medicine, technology, legal/patents and finance. She is also an academic advisor for Saudi Arabian students in the United States.

Comments on Maria Rosdolsky's "Back Translation of Medical Documents"

by Leon McMorrow, Ph.D.

There are 3 ways of spelling "back translation" in current usage: as Maria does, and also "back translation" and "backtranslation". It is a new term that has not yet settled down linguistically, so we are free to choose.

I fully agree with Maria's assessment. I have been asked since the 1990s both to perform back-translations and to edit them. Regrettably there seems to be a false idea among clients and project managers (agency owners please note!) that a "blinded" back-translation is the ideal way to check translation quality, especially accuracy. They are unhappy with the use of a good translator + good editor. This idea started in the 1990s (possibly earlier) with legal translations and then spread to clinical trials, which is where I have routinely encountered them, especially with patient informed consent forms. The idea of "blinding" is a key method of ensuring scientific quality in clinical trials, but some smart person decided to apply it also to localization of the informed consent forms. The result is nicely described in Maria's exposé. A language crime is being committed in the name of improved process.

Editing a back-translation is a pernicious task unless certain pitfalls are avoided. On the one hand, an inexperienced editor (one with good language skills but low-to-moderate knowledge of the subject) will correct the document linguistically, but another editor (possibly the client or end user) will be needed to detect factual errors without knowing their source – an extremely wasteful process. On the other hand, an experienced translator/editor will very quickly suspect the existence of an earlier ("original") document behind the document to be edited, understand the topic and what needs to be said, and regardless of the translation will consciously or unconsciously reflect what was most probably said in the original. As Maria noted, a bad translation can result in a good back-translation because of the editor's skills. What an anomaly! It defeats the whole intent of the back-translation procedure. My own response to such a suspicion is to contact the client/agency immediately and *demand* to know if the document sent for editing is a back-translation. If it is, I explain the pitfalls of such a practice. Then I ask for the original (English in my case) and if they will not supply it, I drop the job, because it is a useless or wasteful exercise. If they send it, then I have the three documents on my screen and do a simple 3-way editing job:

1. compare the back-translation to the original (a speedy process, one language involved);
2. identify any discrepancies;
3. determine and flag their source – either the translation (step 1) or the back-translation (step 2);
4. draw attention to any linguistic defects (misspellings, etc.) in the translation (step 1).

A few years ago an agency in Germany began sending me these sets of 3 documents with a *single* instruction: locate any defects in the translation (step 1) and mark them with a Comment (in Word). They had no interest in the back-translation as such, but since the client required 3 people to be involved for quality control, they had to include both a back-translator and an editor. They streamlined the process, however, by removing the silly "blinding" factor. I think translators should educate clients and agency project managers/owners about this efficient and effective way to handle quality assurance in translation, whenever the input of 3 people is (wrongly) required.

Translating "LKP – Leiter der klinischen Prüfung"
by Leon McMorrow, Ph.D.

There seems to be a cloud of confusion on how to translate this frequently occurring term into English. It is possible that the abundant German literature contains different understandings of the title and

functions/responsibilities of the LKP; I am not qualified to address that issue. However, I believe the most accurate translation of this term into English is "Coordinating Investigator" (upper or lower case as required).

I have seen it translated (e.g. in ProZ.com) as "Director of Clinical Trials"; "Clinical Trial Director"; "Clinical Trial Manager"; "Head of Clinical Trials" (UK translation); "director of clinical investigation" (in quotation marks! ATA Divisions/GLD glossary).

All of these are literal translations. The translation would be more accurate if based on the functions/ responsibilities of this investigator. Furthermore, such titles already exist for *company* personnel; see the advertisements for such titles on the Internet. All are within medical/pharmaceutical companies, not at the clinical trial sites themselves, where the LKP/ coordinating investigator is active; this is the key factor.

The coordinating investigator coordinates the implementation of the trial and the activities of investigators at multiple study sites (multicenter trial). At a single site, these functions would be performed by the "principal investigator" (Hauptprüfer).

Helpful information can be found at:

- de.wikipedia: „Wird eine Prüfung in einer Prüfstelle von mehreren Prüfern vorgenommen, so ist der verantwortliche Leiter der Gruppe der Hauptprüfer. Wird eine Prüfung in mehreren Prüfstellen durchgeführt, wird vom Sponsor ein Prüfer als Leiter der klinischen Prüfung benannt (§ 4 Abs. 25 AMG)."
- „Der Leiter der klinischen Prüfung bei multizentrischen Studien ..." (springerlink.com)

A SOP sent to me by a German medical company states:

„Andere Beteiligte: Leiter der klinischen Prüfung, Coordinating Investigator (klinische Prüfung außerhalb Deutschlands)".

On the English side, there are numerous hits for 'clinical trial terminology' on Google in which our term of interest is found. A recurring definition on several sites (e.g. Glossary of Terms. Boehringer Ingelheim Global Trials) is: "An investigator assigned the responsibility for the coordination of investigators at different centers participating in a multicenter trial."

A general discussion of coordinating investigator functions (responsibilities) is found in the article by Nathan Clumeck, Elizabeth O'Doherty. The EU Directive: Practical Implications for Clinical Research Teams (online address: http://appliedclinicaltrialsonline.findpharma.com/appliedclinicaltrials/EU/The-EU-Directive-Practical-Implications-for-Clinic/ArticleStandard/Article/detail/92959).

Because of the uncertainty attached to the other titles listed above (as in-house titles in medical/ pharmaceutical companies) I believe the most accurate title in English is "coordinating investigator."

Before he enthusiastically became a full-time freelance medical translator in 1994, Leon McMorrow, Ph.D., tested other roles in translation (agency manager) and medicine (paramedic, medical records auditor and coder, medical device company writer and translator). He somehow survived the tectonic change from typewriter and carbon copy to translation memory and online searches.

HAPPY HOLIDAYS