The Newsletter of the ATA Medical Division

Volume I, Issue I
March 2003

Letter from the Administrator

This past November, a group of between 50 and 75 translators and interpreters met during the ATA Annual Conference in Atlanta to discuss the establishment of a new division dedicated to medical translation and interpreting. By majority vote of those in attendance, the name of the division is to be the Medical Division (MD), and I have volunteered to serve as Acting Administrator during its organizational period.

Our membership currently consists of more than 400 translators, interpreters, editors, teachers, and physicians from the United States and abroad. This first year will primarily be dedicated to deciphering our identity and our needs. Both Marla O'Neill (our division's Acting Assistant Administrator) and I are eager to serve you. We want to hear from all of you regarding the course our division should take and how you think we should differentiate ourselves from other divisions. We cannot succeed without your help, and invite you to share your talents, energy, and passion for languages by working with us.

At the moment, we are seeking short-term volunteers for our Nominating Committee (to accept nominations for the ballot next fall to elect a slate of officers for the MD) and for our Speakers Committee (to help select speakers for the ATA conference in November). In order to become a fully established ATA division, we will also need to generate a petition requesting the establishment of the Medical Division, signed by 20 active ATA individual members, to be presented at an upcoming meeting of the ATA's Board of Directors. Our proposed bylaws, which are also required for ATA approval, are posted in the Files area of the

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Dr. Rivera is a physician and medical translator associated with Florida International University, where he teaches Medical Interpretation. He is Board certified in Internal Medicine, Gastroenterology, and Psychiatry & Neurology, with additional certificates in Medical Management and Medical Law.

Dr. Rivera has peer-reviewed medical articles on record, with recent contributions to *Médico Interamericano* (ICPS), *Panacea* (MedTrad), *Apuntes* (SpanSig), and *Intercambios* (SPD).

Medically Speaking…

Rafael A. Rivera, M.D., FACP

Let's talk about the word *ablation*. Most medical (and nonmedical) dictionaries still carry the word *ablation* – surgical ablation, that is – as a synonym for resection, excision, or extirpation. In other words, the removal of organs, growths, and tissues of various kinds for varied reasons. Traditionally, all of what is surgically removed from a patient, with very few exceptions, must be submitted to the pathology laboratory for study. A small, representative piece of tissue – a specimen – is processed for microscopic examination to determine the histologic (tissue) diagnosis.

The problem with modern ablations is simply that there is no tissue removed! The tissue is destroyed beyond recognition, often pulverized *in situ*; there is no specimen to process. It is likely that the tissue diagnosis was made previously via the removal a small piece of tissue, a biopsy, or some other means.

Examples of modern ablations include a 'fishy' procedure called a prostatic TUNA – trans-urethral needle ablation – of the prostate. As the name implies, moving in via the urethra, the prostatic growth is visualized and zapped with radiofrequency energy. The endometrium (lining of the uterus) is ablated as an alternative to a hysterectomy by means of a heat-generating tool inserted through a viewing tube. Surgery to correct visual refractive errors, LASIK – laser-assisted *in-situ* keratomielusis – (don't try it, it's a bit much) is quite popular these days. A flap of cornea (the protective covering of the lens) is lifted, after which a very impressive computer-assisted instrument, that has been given the refractive error measurement to be corrected, is placed over the eye. The pedal is pushed and 20 seconds later the job is done, and the flap is then restored to its place. Only a little bit of smoke is visible as the laser does its work. A cancer specialist friend tells of his modern approach to cancer: "We cook it or freeze it, it's clean, powerful, without spillage or fear of dissemination" and "there is nothing

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Medically speaking...*continued from p. 2*

to send anywhere."

Interventional cardiologists can now map out the electrical conduction system of the heart when looking for ectopic (out of place) foci that generate aberrant impulses that compete or interfere with the normal heart rhythm. Once over the focus, with a tiny tip of a catheter manipulated into the heart, a burst of high frequency or radiofrequency energy eliminates the problem spot.

All of this is to say that the word *ablation* has a contemporary meaning far beyond what medical lexicographers ever suspected, and should not be used as a synonym for excision, extirpation, or resection. Beyond that lies a translation difficulty. The verb *to ablate* is fairly simple to conjugate in English. Not so in Spanish, where we have yet to decide what the appropriate verb should be. For now the form *ablacionar* is taking hold.

Rafa

The ATA Medical Division has an Internet List!

You should have been invited to join the list when you joined the division. If not, or if you mistakenly deleted the invitation, please contact Mary David to join at mary@atanet.org.

Letter from the Administrator
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ATA_MedDiv group at Yahoogroups.com, and can be accessed via the group on Yahoo! (see ball at bottom of this page). Please let us know if you have any questions or comments regarding the bylaws.

At the initial meeting, Naomi de Moraes volunteered to get our newsletter going. I would like to take this opportunity to thank Naomi for all the hard work she has been putting in! However, even with all her enthusiasm and energy, she needs our help as well. I encourage all of you to contribute articles or other items of interest to the newsletter. In order to be published and have your voice heard, or if you can help with the production of the newsletter, please contact her.

This is only a brief overview of our initial objectives. As our plans take more concrete form in the course of the coming year, I will keep you advised as to the direction(s) in which we begin to move. The hope is to channel the interest and drive of all members in a way that will best serve our common goals. Remember, our division will only be as strong as its members' support and involvement make it.

Finally, I hope to see you all at the Medical Translation & Interpreting Seminar in Miami this spring (more information on page 17 of this newsletter, and also at http://www.atanet.org/medical). Please do not hesitate to introduce yourself and your ideas to me there.

Martine Dougé
Acting Administrator
ATA Medical Division

The Long Climb: Reflections on the Professionalization of Medical Interpreters

Zarita Araújo-Lane and Vonessa Phillips
Cross Cultural Communication Systems, Inc.
Winchester, Massachusetts

"Every day you may make progress. Every step may be fruitful. Yet there will stretch out before you an ever-lengthening, ever-ascending, ever-improving path."
– Sir Winston Churchill

In 1978, medical interpreting was in its infancy in the Boston area. As the first medical interpreter at a prominent local hospital, my job description was unclear to many. Nursing supervisors asked that between interpreting assignments I wash floors or assist with filling papers. They did not think it fair that I should be paid for merely "talking" to patients and providers. In their minds, I should have been doing some "real work." Meanwhile, a growing number of Portuguese speakers frequented our facilities – a positive change, since the hospital had been hurting for patients.

As other newcomer communities sought treatment at the hospital, I struggled to maintain my identity as a Portuguese interpreter. Demands were made that I interpret for Spanish-speaking patients, a task for which I was not prepared. Yet the pressure to "speak" for one and all continued to mount. At one point, I went as far as City Hall, armed with dictionaries which I used to prove to college-educated city councilors that Spanish and Portuguese were not the same language. I felt compelled to establish that in refusing to interpret beyond my qualifications, I was acting as a responsible, and not a difficult, professional.

I left that council meeting feeling that I hadn't been

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Cross Cultural Communication Systems, Inc. is a SOMWBA and DBE certified business founded in 1996. Its president, Zarita Araújo-Lane, has over two decades of experience working with cross-cultural populations in medical and mental health institutions, as well as designing, implementing, and supervising interpreter programs. She has taught *Portuguese Medical Interpretation* at Bentley College in Waltham, Massachusetts, and *Cross Cultural Communication in the Context of Medical Interpreting* at Cambridge College in Cambridge, Massachusetts.

(Zarita Araújo-Lane)

Vonessa A. Phillips is director of the Cross Cultural Communication Institute. She has worked as a medical interpreter, interpreter trainer and translation services coordinator at Cross Cultural Communication Systems, Inc. Ms. Phillips has also coauthored a variety of articles on medical interpretation and recently contributed to the compilation of

The Long Climb ... *continued from p. 4*

completely successful in my attempt to change their

minds. Some councilors had joked about their command of the Portuguese language. If they could remember the word *chouriço* (pork sausage), then they must be fluent enough to help "my" patients! Wasn't interpreting as easy as that, they asked. Even the mayor, who was of Italian ancestry, told me that he understood Portuguese – after all, it was almost like Italian!

I fought the idea of being anything else but a qualified medical interpreter, so I made it a point to reach out to certain physicians who eventually joined forces for the professionalization of interpreters. We contacted community organizations and asked for their support in exchange for the providers' time as volunteer health educators. Eventually, I became both an interpreter organizer and an ambassador for the hospital's community health events.

While I was gaining much experience as an interpreter, I knew deep inside that I needed a better foundation in medical terminology, a deeper understanding of common illnesses, and a working knowledge of the dynamics between patient and provider in the triadic encounter. My first step toward growth was to sign up for college-level medical terminology classes. I took it upon myself to learn more about subjects such as alcoholism and battered women by signing up for a variety of hospital and community programs. Yes, I knew that to be a good interpreter I had a lot more to learn and I had to learn it quickly!

Now, almost 20 years have passed, and it warms my heart to see how medical interpreting has evolved as a profession, particularly in Massachusetts. Overall, today's interpreters are better trained and have gained a higher level of respect than that attained by the laborers of yesteryear. Indeed, the demand for multilingual services and the professionalization of interpreters has reached new heights thanks to the tireless efforts of organizations such as the Massachusetts Immigrant and Refugee Advocacy Coalition, the BABEL

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The Art of Medical Interpretation series of training manuals.

(Vonessa Phillips)

Cross Cultural Communication Systems, Inc. is a corporate member of the American Translators Association (ATA), the Massachusetts Medical Interpreters Association (MMIA), the American Society for Training & Development, and the New England Translators Association (NETA). CCCS, Inc. is also proud to be a part of the New Hampshire Interpreters and Translators Organization (NHITO) and the California Healthcare Interpreters Association (CHIA).

The Long Climb ... *continued from p. 5*

III Coalition, Massachusetts Law Reform Institute, and the Massachusetts Medical Interpreters Association.

"Climb if you will, but...look well to each step and from the beginning think what may be the end."

– Edward Whymper, British climber

On April 14, 2000, Massachusetts Governor Paul Cellucci signed the "Emergency Room Interpreter Bill" into law. This law requires that all hospitals providing acute emergency room or psychiatric services use competent interpreter services when treating non-English speakers. Thus, the question arises: What makes an interpreter "competent?"

As we write this article, a fast-growing number of interpreter associations are being formed in the United States. Many, like the Massachusetts Medical Interpreters Association (MMIA), have already conducted extensive research on cross-cultural communication in the healthcare setting, have defined standards of practice, and are now discussing educational and certification requirements for medical interpreters. For example, the California Healthcare Interpreters Association (CHIA) recently published a set of ethical principles, protocols, and guidance on roles and intervention for healthcare interpreters. It is hoped that soon such standards will serve as the basis for the development of tests for California state accreditation, certification, or licensure for healthcare interpreters. Likewise, The National Council on Interpreting in Health Care (NCIHC), a nationwide group composed of medical interpreters, interpreter service coordinators, trainers, clinicians, advocates, and researchers, is in the process of establishing a framework that promotes culturally competent healthcare interpreting by setting forth standards for the provision of interpreter services and an interpreter code of ethics. Clearly, the backbone of interpreter professionalization is taking shape.

With a finger on the pulse of the profession, various colleges and universities have developed training programs for medical interpreters, some more promising than others. Politicians are invited to interpreter graduation ceremonies, and they tell the new graduates that as medical professionals they can make a real difference. Yet, coming out of these programs, many new interpreters are conscious of their need for continuing education and hunger for something more, for a higher level of training.

"You know you will never get to the end of the journey. But this, so far from discouraging, only adds to the joy and glory of the climb."

– Sir Winston Churchill

Cross Cultural Communication Systems, Inc. and the Cross Cultural Communication Institute have responded to the needs of this great crowd of interpreters by designing *The Art of Medical Interpretation*, an innovative holistic training program for medical interpreters. Its instructors are a dynamic team of professional interpreters and healthcare providers who approach interpreter education by combining contrasting perspectives, thus connecting with student audiences in ways its members could never accomplish as individuals.

The Art of Medical Interpretation training program is the culmination of decades of exhaustive clinical research and the real-life experiences of countless medical profession-

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The Long Climb ... *continued from p. 6*

als. Additionally, the staff of Cross Cultural Communication Systems, Inc. continues to compile a vast library of educational texts, charts, and videos that compliment an interactive teaching style.

Training sessions focus on learning ethics and the implementation of cultural competency tools, mastering medical terminology through the *Samurai!* method, developing specialized bilingual glossaries, and increasing memory power. Learning is measured through role-play and the application of interpreter evaluation tools.

Our methods are modeled on the work of Paulo Freire, a prominent Brazilian educator who believed it necessary to understand the culture of a student audience and to teach within its framework. In *Teachers As Cultural Workers, Letters To Those Who Dare Teach*, Freire wrote that adult students must develop a relationship with the information they are learning. Likewise, in our trainings, if a student group is made up of clinical assistants employed by a clinic specializing in diabetes management, our first role-play and memory exercises will focus on issues related to diabetes.

We have seen that the best interpreters are those able to evaluate their own learning curves and willing to challenge themselves through active learning. For this reason, we cultivate an environment that gives the interpreter a measure of control over the learning process. Each training session is riveting, and students are encouraged to personalize the materials presented. In designing *The Art of Medical Interpretation* manual, we've provided space for the interpreter to take notes and draw diagrams. Just as the majority of our trainees are *working* interpreters, ours is a *working* manual, and we hope that they make it their frequent companion and guide, revisiting it continually throughout their careers

Sharpening interpreting skills is an ongoing process, and formal training is merely a start. Upon graduation, the interpreter must take full responsibility for personal development, honing skills through research, personal study, attendance at specialized workshops and seminars, and communication with the established student network.

In conclusion, *The Art of Medical Interpretation* was developed primarily for bilingual individuals, long involved in the world of medical interpretation, who wish to be trained as professionals. Numerous graduates of the program who were already working as medical interpreters before undergoing our training have commented on their surprise at finding out just how much they did not know when it came to interpreting. Maria, a graduate of our program, noted, "I really liked the fact that the speakers are clear and show great knowledge of what they teach. I didn't have a moment to get bored!" And Jennifer, a native English speaker, commented, "I really liked the whole training on cultural sensitivity. I think anyone who provides any kind of medical care should receive this training, whether they are bilingual or not."

We invite you to further explore *The Art of Medical Interpretation* by attending our training program in a city near you! For more information, contact Vonessa Phillips at vphillips@cccsorg.com.

Who Cares? Modern Medicine - The Rise of Allopathy

Rafael A. Rivera, M.D., FACP

(This article is the first in a series that examines the US healthcare delivery system, with an emphasis on pertinent terminology.)

Attack! – to the heart (myocardial infarction), to the brain (stroke or epileptic seizure), to the lungs (asthmatic attack), to your emotional steadiness (panic attack); even, in olden days, to the appendix (acute appendicitis). Have you noticed how aggressive and militaristic our medical jargon is? We speak of "the war against cancer"; of "the war on drugs" for which we have a 'drug czar'; of "germ warfare"; and others..., with our ever increasing "therapeutic armamentarium." In fact, the initial definition of the Merrian-Webster dictionary for *armamentarium* is: 1) the equipment and methods used especially in medicine. Most of our treatments are an anti-something or other: antibiotics, antihypertensives, anticonvulsants, antispasmodics, antipsychotics, and so on. Moreover, we hear of how patients "fight their disease" or "give up" when the end is near.

All of this is not a historical accident, but the evolutionary result of a defined plan of action called ***allopathy*** – also known as conventional, orthodox, or western – it's the brand of medicine we practice. Allopathy, from the Greek *allos,* meaning contrary or different, and ~*pathy,* of course, meaning disease, ailment, malady, affliction – a medical approach contrary or against the disease. Even though our medical school diplomas do not mention the word and most American physicians are not even aware of the term, the discovery comes late for most allopathic M.D.s – Medicinae Doctoris. Before the rise of allopathy, other medical practices coexisted throughout America.

Homeopathy, founded circa 1810 by Samuel Hannehman, a distinguished German physician (for whom both a recognized allopathic and homeopathic medical school exists in the United States), was probably the most widespread in the late 19th century. From the Greek *homo,* meaning equal or same, and colloquially referred to as "like cures like," the homeopathic approach relies on the "law of similars." An extremely dilute solution of a substance that, when given to patients, could produce their very symptoms, and induce or enhance the body's own inherent defenses, thus effecting a cure. For example, a solution of ipecac is normally used in emergency rooms to induce nausea and vomiting in a patient who has swallowed the wrong thing. A homeopathic solution of ipecac, on the other hand, would be useful in a patient with chronic upper gatrointestinal symptoms that include nausea and vomiting. It is an 'immunizing' sort of approach. This tenet is inconceivable to allopathic contrarians, and similarly Hannehman could not stomach the alarming approaches of the 'heroic' orthodoxy. Hannehman also coined the word allopathy.

Osteopathy, 1892 – the conceptual belief that all diseases are caused by a malfunctioning, disordered spine in need of realignment – survives today with significant modifications towards the allopathic perspective. Osteopaths, D.O.s (Doctors of Osteopathy) and

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Who Cares? *... continued from p. 8*

allopaths, M.D.s (Doctors of Medicine) have equivalent legal standing in the United States, though the academic preparatory superiority favors the allopaths. Once osteopaths pursue postgraduate training in an allopathic hospital, the differences are insignificant. Most modern osteopaths I know learned to manipulate the spine, but hardly ever do so.

Naturopathy also dates to 1892. As the name implies, this approach uses natural products, botanical remedies, and health inducing formulations that are not subject to federal regulatory standards and are widely available in health food stores.

Traditional Chinese Medicine (TCM) has forever been in our midst. Certainly, acupuncture has received a healthy dose of recognition and has become part of the modern anesthesiologist's pain management possibilities.

Traditional Hindu Medicine (THM, Ayurveda) has received an invigorating infusion with the bestselling books and seminars of Dr. Deepak Chopra, an Indian-born, British-trained physician. THM relies on herbs, meditation, yoga, and aromatherapy.

Chiropractic, our traditional foe, came into the picture in 1895 under the belief that all diseases are the result of a spinal misalignment. Chiropractors are increasing in numbers and advocates throughout the nation. It is probably the largest non-orthodox alternative in America.

At the turn of the 19th century allopathic medical education in the US was in need of reform. Admission requirements and curricula were as varied as the communities where the schools were located and the population of candidates to draw from was equally diverse. Three events were to forever change the face of American medicine:

• 1893 – The Johns Hopkins Medical School, the first academic center dedicated to scientific medicine, opened its doors.

• 1901 – The Rockefeller Institute for Medical Research, the first of its kind financed by private capital, initiated its work.

• 1910 – The Flexner Report. The American Medical Association commissioned the Carnegie Foundation to conduct an in-depth study of the status of medical education in the United States. Data compiled by this study was used to establish the prototypical requirements that have governed American medicine ever since:

- a university degree;
- a 4-year medical school curriculum;
- rigorous academic standards;
- emphasis on research; and
- use of the hospital as the center of education and training during the clinical years.

Besides the educational directives, the theoretical basis of scientific medicine was established as follows:

- the premise that all diseases are of an organic nature caused by agents or mechanisms known or to be discovered;
- the fact that patients play an entirely passive role; and
- the requirement that any and all known treatments be used to reestablish a state of normal equilibrium (known as health). Therefore: a defenseless person assaulted by disease becomes a patient, for which reason any and all manner of treatments contrary to the disease will be unleashed until the enemy is subdued.

Allopathy takes over, war has been officially declared. The 75 years since have been an unbelievable straight line of scientific advances of all kinds - diagnostic, pharmaceutical, surgical, and otherwise. Surgical robots are manipulated from afar for the performance of heart surgery, for goodness sake!

The war on disease–a disease-centered ap-

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proach–demands continuous vigilance over the enemy and less concern for the unsuspecting victims, the patients. Technology has taken over and the personal touch of the physician has faded noticeably. Patients nationwide declare that the physician-patient relationship no longer exists, and that visits to physicians have become a depersonalized flash encounter. Reliance on technology coupled with the escalating costs of malpractice insurance, the ever-increasing demands of managed care, and ever-decreasing Medicare fees have come together to further the therapeutic distance between physicians and patients. This vacuum for personal concern has been filled right under our allopathic noses by the world of alternative medicine. All of those brands of medicine that were marginalized by the rise of allopathy have reentered the US healthcare arena, and their popularity at the moment is beyond anyone's expectations. Millions of *medical consumers* or *clients*, as they are now called, find solace in a world of nonscientific approaches that seem to fill the need for patient centeredness quite well.

"It is far better to know the patient who has the disease than to know the disease the patient has."

– *Hippocrates*

Next Issue: Scientific investigation vs. the power of testimony

What's News

One article speaking poorly of medical interpreters was published by Reuters Health (http://12.42.224.165/HealthNews/reuters/NewsStory0106200312.htm).

This news item supposedly summarizes an article in *Pediatrics* 2003;111:6-14 (I do not have access to the original article).

They say that an analysis of 13 doctor-patient visits that involved a Spanish-English interpreter found interpreters made an average of 31 mistakes per visit, 19 of which could have negative consequences for the patient.

However, the article then goes on to state that half of the interpreters were professionals employed by the hospital while the other half were untrained family members, friends, or others. No data comparing trained interpreters and untrained "interpreters" is given, but this could be a problem with the original study. This is just one more sign that we need to get the word out to our clients and the press.

An article in the *New York Times* also summarizes the same *Pediatrics* article. Published in the Health section of the January 7, 2003 issue and entitled "Communication: Perils in the Language of Medicine," it makes the common mistake of calling interpreters translators, and actually switches back and forth between the two terms. One important difference between this article and the one above is that

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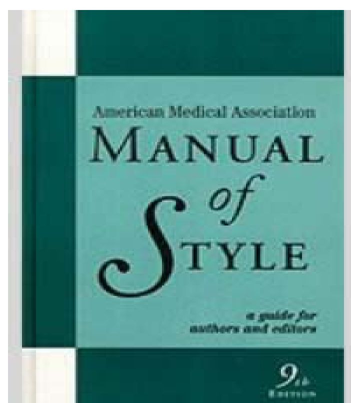
The Medical Shelf

The new Medical Shelf column of ATA's Medical Division Newsletter was created to bring to the ATA membership useful reference sources submitted by members interested in medical translation. The following were submitted for the first issue of the Newsletter and compiled by Alexander Rainof. Please send your contributions to Naomi at the e-mail address listed in the contact section.

American Medical Association Manual of Style



- Cheryl Iverson (Editor) 1998
- ISBN 0-683-04351-X
- Can be purchased from amazon.com for $39.95

The *American Medical Association Manual of Style* was prepared by editors from *JAMA* and AMA specialty journals, and provides physicians and other authors of medical articles with general rules for the preparation of medical articles. The manual consists of sections on manuscript preparation, grammar, punctuation, capitalization, correct and preferred usage, commonly misused words and phrases, abbreviations, nomenclature, units of measure, numbers and percentages, statistics, and more. The manual also contains recommended readings, a description of medical databases, copyediting and proofreading marks, and a detailed bibliography.

Although this manual is not essential for medical translators, it is a very useful tool. You certainly can live without it, especially if you do mostly technical translations (manuals for devices, assays, etc.) rather than translations of medical texts such as journal articles or books. I do not know of any similar manuals, and, as far as I know, this is the only manual of its kind.

The text is well organized and easy to understand. For each rule, examples are given, which make understanding and memorization of the rules easier. By following the rules, you remain consistent in your own style. Since the manual is considered standard for medical writing, you can always refer to it if clients complain about your style.

*Submitted with an evaluation by Maria Rosdolsky

Diccionario Critico de Dudas Ingles-Español de Medicina

- Author: Fernando Navarro MD
- McGraw Hill. Interamericana de España
- ISBN 84-486-0286-4
- Languages: Continental Spanish / English

This is not really a dictionary, but a large compilation, by a Spanish physician-linguist, of common English medical terminology defined in Spanish with all possible meanings and usage examples. Very useful when dealing with tricky, "not too sure about this one" terms. Its perspective is strictly Peninsular Spanish without much regard to Spanish usage in other Spanish-speaking countries. Nevertheless, it has become the first place to look. The second edition is currently in progress.

*Submitted with an evaluation by Rafael Rivera

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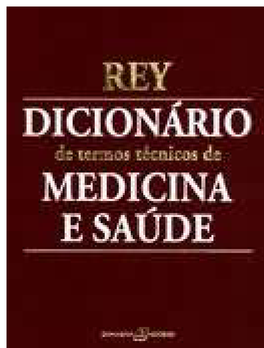
The Medical Shelf *continued from p. 11*



Dicionario de Termos Tecnicos de Medicina de Saúde

- Author: Luis Rey (Professor de Medicina da Univ. de São Paulo)
- Editora Guanabara Koogan S.A., Rio de Janeiro, RJ 1999. 825 pages
- Languages: Brazilian Portuguese headwords, Br. Portuguese definitions and translation of headword at end of each (PT>EN only, no EN>PT index at end)
- Can be purchased through www.livcultura.com.br for 199 Brazilian reals
- ISBN 8527704943

Translators of Brazilian Portuguese have had to deal with imperfect translations of Stedman and Dorland until the release of this wonderful resource, written in Portuguese by Brazilian physicians and meant for physicians, not translators. Since many Brazilian physicians write their technical articles directly in English, the English equivalent is provided for each headword. It is useful for translators translating into English, as it is alphabetically arranged in Portuguese. It is also a great reference for translations into Portuguese because the entries provide collocation information and words that do not always have their own entries. Its organization is very similar to that of Stedman.

*Submitted with an evaluation by Naomi J. S. de Moraes

Health Care Interpreter Training in the State of California, Including an Analysis of Trends and a Compendium of Training Programs

Author: Cynthia E. Roat, under a grant from the California Endowment

Can be downloaded from the web by going to:

http://www.calendow.org/pub/frm_pub.htm

An excellent survey of medical translator and interpreter training and trends. Worthy of note, amongst others, is the first B.A. in Translation and Interpretation (with a strong medical component) in the U.S. (pp. 41 and 42), and an online Introduction to Medical Interpreting (pp. 50-51).

* Submitted with an evaluation by Alexander Rainof

What's News *continued from p. 10*

training is stressed, and this article mentions that "the researchers...urged that insurance companies pay for the services of professional translators [sic]." The issue of payment is one of the main reasons hospitals continue to use ad hoc volunteers...

Another article regarding medical interpretation appeared in the *Wall Street Journal* on Jan 9, 2003. With the headline "Language Gap: For Ill Immigrants, Doctors' Orders Get Lost in Translation," it describes in detail the effects of the interpreting efforts of an 11 year old boy and how the doctor completely misinterprets the results of their communication.

It also mentions the opinion of Dr. Yank Coble, the president of the American Medical Association, who "sees little need for specialized training." He thinks it is wonderful that non-English patients bring in family members, someone the "doctor knows and trusts." All medical interpreters should send Dr. Coble a letter of protest!

Meet ... David Coles

Naomi James Sutcliffe de Moraes

Personal Information: Born in Aden, in what was formerly South Yemen, on 12 February 1958. My father worked in the British Council, a government-sponsored cultural institution. Until I was nine and a half, I lived with my parents in Aden and then in Calcutta, India. But then I was old enough to go to boarding school in England and the fixed point in my youth became education in England – preparatory school, secondary (or "public") school, and university, while as a backdrop my parents continued moving around—Uganda, Lebanon and finally Thailand—places my brother and sister and I visited twice a year. I've been in Brazil since 1985: six years in Brasilia, two in Porto Alegre, and now we're coming up to nine years in São Paulo.

Education: A B.A. in English Literature from Cambridge University. I also have an M.Ed in TEFL from UWIST, Cardiff, which was a course of study that involved linguistics and educational technology. On top of these, I have a diploma in translation (Portuguese into English) from Britain's Institute of Linguists, and a "Full Diploma" from Associação Alumni in São Paulo, Brazil, which means I was deemed able to both translate and interpret from Portuguese into English and vice-versa.

What language combinations do you work with?

Portuguese into English. I have a diploma that says I can translate and interpret English into Portuguese, but in fact I only go into Portuguese when interpreting. I'd like to add French and Spanish to my arsenal, at least passively, into English. My French isn't too bad; Spanish is very rudimentary, but after doing an interpretation assignment in Paraguay I realize that acquiring Spanish would open up Latin America to me.

How long have you been working as a translator? Soon after I achieved a reasonable level of fluency and accuracy in Portuguese, which I acquired in Lisbon in my first posting as an English teacher in 1979, people began to ask me to translate a variety of documents into English. The very first translation I can remember doing was a longish, wide-ranging power of attorney for someone in Portugal back in 1981.

I wish I'd had the foresight to keep a copy of that and all the other translations that I tackled over the 1980s, building up a portfolio. I remember having to look up virtually every word, and the feeling of being firmly stuck in that typical apprentice translator's position of looking up translingual "signifier"-equivalents without really having much of a clue as to what the "signifieds" were. Seleskovitch mentions this somewhere, how T/I is the only profession where people can confidently manipulate meaning tokens (e.g. GDP—gross domestic product— 'equals' PIB—produto interno bruto— without having any idea what either term actually means). This is a feeling which still comes over me frequently in the legal and financial fields!

And so I continued, fairly informally, until we moved to São Paulo, where I became aware of the existence of the well-

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Meet David Coles ... *continued from p. 13*

known Associação Alumni course. I decided to try it, mainly in order to have some kind of certificate of competence in Portuguese, since as a self-taught speaker, I felt at a disadvantage compared with people who'd learned the language at university.

Which do you enjoy more and why?

There's more adrenaline and more elation in interpreting, of course. I imagine that being an actor or a performing musician is similar. But bills have to be paid, so in reality I do far more translating and teaching than interpreting. This reflects the slower process of breaking into the interpretation market and the need for consolidating and cultivating a reputation. I never gave up teaching English and training English teachers. My main goal is to achieve a balanced mix of these activities, all of which satisfy me in different ways and for different reasons.

What percentage of your work is medical?

It varies slightly according to the time of year. I'd say about 10 to 15% in written translation, and about 10% in interpreting. Actually, the only reason I do medical translation or interpretation is because my wife works in the area of public health at a university in São Paulo, and so an assortment of doctors, researchers, and public health workers have asked me to translate a variety of documents for them over the years, ranging in size from short abstracts to manuals for biostatistical software packages. Therefore, I began to specialize to a certain extent, investing in dictionaries and doing background reading in textbooks. Another thread in this particular ball of wool is that within the area of TEFL I spent several years reading a lot of medical literature in order to write tests of reading comprehension ability in English for candidates to post-graduate courses in medicine and public health, so I acquired a certain feel for the way English is used in medical texts.

Of course, medicine is a fascinating area, and one in which as a translator you can always flatter yourself that you are making some small contribution to health sciences and the general well-being of mankind yourself. Paradoxically, I feel that not having a specific medical or even a general scientific qualification myself helps in that I always feel I'm on the verge of committing some dire mistake. This helps me keep a sense of due care with regard to "the signified," and possibly prevents me from releasing unchecked texts.

Why did you decide to be a translator/interpreter?

Mainly to have a second string to my bow. As an EFL teacher, I was always in that "have qualification, will travel" situation, but once I put down roots in Brazil, translation clients appeared, I attended them, and so it began.

What is the greatest challenge of your work?

Changing this question into the past tense, so I can be anecdotal for a moment, I'd like to just describe a recent interesting challenge in medical translation. I have a client whose company makes educational videos in the area of medicine: filmed surgical procedures that are narrated by the surgeon, recordings of presentations at congresses, and so on. He recently decided he wanted to release some of these films into the international market. He asked me to translate a couple of videos: one, a neurosurgical procedure, the other, a liposuction. What he wanted from me was a translation of the running commentary and, somewhat later, a voice-over into English.

The challenges were, first, overcoming squeamishness--the images were graphic; second, understanding the surgeon's commentary, which was coming from behind a mask and wasn't always clearly recorded; third, the translation of the verbatim transcript into English; and fourth, the timing of the voice-over in English so as to match the image and synchronize with the original message. In the end, the plastic surgeon didn't

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like my British accent and wanted an American whose voice matched his in timbre, so we had to get a colleague of mine to redo the voice-over.

There were several interesting issues raised by the third stage I described above, but I'll just mention two. The overall tone of the plastic surgeon was rather tongue-in-cheek and ironic, and I felt it hard to achieve a suitable tone in English. I felt that a similar tone would be somewhat inappropriate in a teaching video to be marketed to an international culture (which could guarantee the failure of the product), and yet I was in doubt whether I ought to "clean up" the English, making it more formal than the original (which might offend one of the clients—the surgeon). There were also some interesting phenomena at a discourse analysis level. For example, there was an overwhelming tendency in both videos to produce sentences like this: "*This area here, you have to be careful with it,*" as opposed to "*You have to be careful when working in this area*." Nominating the subject and then making a comment about it also created an overall effect that was strange, especially when stretched out to some 20 pages of translated text. So my approach was when the image was the surgeon's hands working on the patient's body, and the surgeon's voice in the background, I tended to impose a "normal" referential style on the English. Whenever the surgeon himself talked to the camera, my translation was much more verbatim, so as to enable the person doing the voice-over to virtually lip-synch the image.

What other work do you do that is related to translating/interpreting?

The most relevant thing I could mention is that I have done a lot of interpreter training, and this is something I find fascinating and rewarding.

What do you enjoy most about medical T/I?

I feel that, indirectly, I may be helping people in some way. I feel fairly flattered just to be entrusted with medical translations. I have one long-standing client, a neurosurgeon whose work I mainly proofread, since he already writes extremely well in English. He once paid me the compliment of saying that he thought his work became much clearer and better expressed after I had proofed it. I can't remember exactly what he said.

Would you recommend medical T/I to new professionals?

Certainly, especially if they had a medical or biosciences background – something that I lack.

What piece of advice would you give them?

I suppose, distilling all my "wisdom" into one or two drops, to approach the task in a spirit of humility—never to think you know a lot about the subject—and therefore to work in tandem with the author. Develop a relationship with the author in which you can ask for advice as to the best term. Usually they have a pretty good idea, from reading in English for their research, of the optimal term—something that is often not clear in the dictionary.

What is your favorite medical reference or resource and why?

I have a number of trusty reference tools for medical translation, and it hurts to reject some of them for this answer, but I would say that the tools I most use are the on-line *Encyclopedia Britannica*, the *Concise Oxford Medical Reference Dictionary*, and a Brazilian dictionary of medical and health terms by Rey. What the Rey and the Oxford have in common is that they explain the entries very clearly, one in Portuguese and the other in English. The Britannica provides me with a model of concision and clarity that I always aim to emulate. As a lay person, I also greatly appreciate texts aimed at medical or nursing students: textbooks on anatomy, physiology or pathology.

Which language would you most like to learn and why?

If I could outlive Methuselah I would try to learn

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Meet David Coles ... *continued from p. 15*

all languages, especially perhaps the dying languages. Within the limitations of my own lifetime, I think I would like to perfect a few languages that I have already dabbled in: Welsh (the language of my forebears); German, which I missed out on learning at school because I did Latin and Greek instead; Esperanto, just out of curiosity; Russian, which I've started a million times; and Spanish for professional reasons—it could open doors for me in Latin America. Then to really answer your question, I would like to try a language such as Basque, Finnish, or Turkish.

What was your hardest medical-related job?

Sometimes people ask you to translate papers that are very state-of-the-art, where it becomes difficult to use dictionaries. The fall-back then is to use your Internet-searching resourcefulness, and exploit any bilingual doctor you may happen to know. It's hard to find good information about surgical instruments, for instance, and I faced this problem with a recent translation about a neurosurgical procedure. Another tricky situation was at an interpretation where an American psychologist was answering questions from the audience after her presentation. Several of the questions were asked by sufferers of the condition in question (obsessive-compulsive disorder) and were extremely rambling and anguished. I was very concerned to be able to do justice to these individuals' questions, and really hoped that I could enable communication to occur between the visiting physician and these people. It worked out OK and I felt, as I said earlier, moved to have been able to help people in any slight way.

What was your biggest medical-related blooper?

So far, I don't think I've made any really terrible mistakes. But I can certainly remember being in tight spots in interpreting. In Brazil what tends to happen, in my experience anyway, at the congresses I've worked in, is that the normally excellent Brazilian presenters often don't require translation into English because the visiting speakers are not present in the auditorium, since they're being given the VIP treatment by the organizers of the event – being shown around São Paulo, or the hospital, or consulting with researchers, or whatever. So when I do this type of work I usually interpret "the wrong way," i.e. into Portuguese, where I feel much more out on a limb than I would going into English.

Newsletter Naming Contest

What should we name our newsletter?

We are having a contest!

Please send newsletter name ideas (and artwork, for those who are artistically inclined) to the e-mail listed in the contact info box. The best name will be chosen by a panel of three judges and the winner will win a free year's membership in the Medical Division, in addition to seeing his/her idea used for the newsletter. We already have two suggestions: "The Hippocratic Messenger" and "Caduceus."

Can you do better? Let us know!

Contact info: Please send any suggestions to Martine (see contact box on last page).

MEDICAL TRANSLATION & INTERPRETING SEMINAR

Register today!

MEDICAL TRANSLATION & INTERPRETING SEMINAR

Hosted by the American Translators Association and the Florida Chapter of ATA March 22-23, 2003 Renaissance Biscayne Bay Hotel - Miami, Florida

SEMINAR DAY 1 • Saturday, March 22

The American Translators Association (ATA) will provide a full day of in-depth presentations on medical interpreting and translating. A continental breakfast is included in the registration fee. Members of FLATA may register at the ATA member rate.

- **"How to Translate for the Healthcare Consumer"**
  Maria A. Cornelio
- **"AIDS and HIV for Medical Translators"**
  Dr. Steven Weinreb
- **"Beyond Conduit: Finding Your Cultural Center as a Medical Interpreter"**
  Zarita Araújo-Lane and Vonessa Phillips

All Saturday sessions will be conducted in English and will be submitted for Continuing Education Credit for the States of California and Washington. Sessions are pre-approved by the State of Oregon.

Abstracts and speaker biographies can be found at

http://www.atanet.org/medical/abstracts.htm.

And take advantage of a great opportunity to make connections at the NETWORKING SESSION being held immediately after the last presentation on Saturday, March 22.

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MEETING REGISTRATION RATES FOR SATURDAY, MARCH 22

Registration Fees After March 14 and Onsite:

- ATA Members $215
- Non-Members $330

SEMINAR DAY 2 • Sunday, March 23

The Florida Chapter of ATA (FLATA) will provide a half day of sessions on medical interpreting and translating.

- **"Ethical Issues in the Role of the Medical Interpreter"**
  Zarita Araújo-Lane and Vonessa Phillips

- **"The Language of Clinical Medicine"**
  Dr. Rafael Rivera

- **"Miami-CSI: The Real Thing"**
  Speaker to be announced

MEETING REGISTRATION RATES FOR SUNDAY, MARCH 23

Registration Fees After March 14 and Onsite:

- FLATA Members $70
- Non-Members $95

Members of ATA may register at the FLATA member rate.

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ATTEND BOTH DAYS AND SAVE!

MEETING REGISTRATION RATES FOR

SATURDAY, MARCH 22, and SUNDAY, MARCH 23

Registration Fees After March 14 and Onsite:

- SAVE $20! ATA and FLATA Members $265
- SAVE $30! Non-Members $395

Space is limited. Register today!

Registration forms are available on the ATA website.

Click on: http://www.atanet.org/medical

ATA ACCREDITATION EXAMINATION

An ATA accreditation exam sitting is scheduled for Sunday, March 23, in the same hotel. This will be a standard exam; it is not specialty specific. Separate registration is required for the exam. For additional information and registration, please visit the ATA website at http://www.atanet.org/acc.htm.

QUESTIONS? NEED MORE INFORMATION?

Contact Maggie Rowe at ATA Headquarters.

Phone: (703) 683-6100 x3001

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The opinions expressed herein are not necessarily those of the ATA.

Letter from the Editor

Dear Reader:

This newsletter, the first for the soon-to-be official Medical Division, is one of the division's most important aspects and the foundation for cooperative learning and communication among members. I have tried to include articles on interpreting and translation from professional translators/ interpreters and from those who teach. We do, however, need more articles on the business side of things and important news regarding governmental regulation of our profession. This newsletter should not be something just you can learn from, but something you can pass on to clients to enable them to become better informed purchasers of our services.

What would you like to see here ?

Drop me a line to let me know!

Naomi J. Sutcliffe de Moraes
Newsletter Editor, ATA Medical Division

Will you be attending the

American Translators Association
44th Annual Conference
at the
Pointe South Mountain Resort in
Phoenix, Arizona, November 5-8, 2003

?

If so, the Medical Division invites you to propose a medical presentation for ATA's Annual Conference. Proposals are being accepted even after the March 14 deadline. If you are interested, but need convincing, please contact Martine.