

# Caduceus

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## *Back Translation of Medical Documents with English - German Examples*

by Maria Rosdolsky

**B**ack translation is the process of translating a translated document from the target language back into the source language. Many translation agencies use back translation as an “additional step of quality control”. Whether the back translation improves the quality of the translation is, however, questionable. The back translation usually follows editing, and sometimes it replaces editing. The back translation may be edited by a back editor or may be sent to the original client by the translation agency. If the back translation is edited, the back editor may communicate with the translator to resolve discrepancies (best scenario). If the client (who usually does not know the target language) receives a back translation that does not match the source text, the translation agency may be accused of incorrect translation, and a representative of the agency (who often does not understand the text) accuses the translator of errors. The translator then has to explain the rationale for the translation of particular words or phrases to this representative, who in turn has to explain it to the original client. It is not uncommon for the client to receive an explanation that is different from the explanation the translator gave to the representative of the agency (worst scenario). The process is time-consuming, expensive, and, in my opinion, useless.

Frequently, a back translation is requested by the original client (e.g., pharmaceutical company or medical device manufacturer), in the belief that a translation is perfect if the back-translated document matches or is at least very similar to the source text. To achieve this goal, however, the translation from the source text must be literal. The anticipation of a

back translation by the translator is one of several reasons for the increase in word-by-word translations, often with incorrect sentence structures, incorrect grammar, and – when translated into a language other than English – an ever growing number of Anglicisms. Sometimes these translations resemble machine translations.

Back translations are commonly used for translations of medical device manuals, laboratory assays, clinical trial documents, questionnaires for patients or physicians, and even patient records. The back translator and the person who draws conclusions about the quality of the translation on the basis of the back translation may not have medical backgrounds and thus may not be familiar with the topic of the translated document. The back translator’s native

language is usually the language of the source text (often a requirement). Unfortunately, in some situations, the back translator may misunderstand the target language and may not be familiar with the specific terminology used by the translator.

I was once accused of making mistakes in a translation. The accusation was based on errors in the back translation. I explained the errors, my

explanations were accepted, and I received another document to translate two days later. I was not in the mood for another argument and rejected the translation. The agency repeated their request with the remark: “Please translate word by word”. This event illustrates the general tendency. This would require neglecting correct sentence structures and idiomatic expressions in the target language in favor of a translation that could easily be back translated into a document that would be nearly identical to the source document.



The following examples were selected from **English** into *German* translations. I believe that these examples and my explanations will also be understandable to translators who do not know German.

**Redundancies** in the source document may result in discrepancies between the back translation and the source text. The translator may avoid the redundancy, and the back editor or the client might then believe that part of a phrase is missing in the translation. For instance, sentences describing risks frequently contain additional words to mitigate the fact that a risk exists: Example: **Under treatment with anticoagulants, there may be a potential risk of bleeding.** All risks are “potential” and “may” can be replaced by “is” because the word “risk” includes the possibility of an event, not the certainty. If a complication or a side effect were to occur in all cases, then the treatment would not be used. The back editor may miss the word “potential” and the meaning of “may”.

A word in the target language may have **different meanings**. The translator uses the meaning of the source language, and the back translator (who may misunderstand the context) uses another meaning. Example: **In patients with distant metastases, treatment A was administered.** Translation: *Bei Patienten mit entfernten Metastasen wurde Behandlung A verabreicht.* Back translation: In patients with removed metastases, treatment A was administered. “Entfernt” means “distant” or “removed” –it depends on the context. From the context in this sentence, the back translator should have chosen “distant”.

The **number of words** used to describe a procedure or a statement is not necessarily the same in the source and target languages. Example: If your laboratory is using an alternative temperature monitoring system, please follow the instructions of your alternative temperature monitoring system. In

German, the second use of “temperature monitoring system” should be replaced by “this system”. The back editor may question the lack of repetition of “**temperature monitoring system**”.

**Language specific peculiarities** are no longer taken into consideration. Example 1: **Two tablespoons of blood are drawn.** The literal translation into German may induce the thought of a vampire slurping the blood from the spoon. Therefore, “**10 ml**” is a much better choice than “**two tablespoons.**”. Example 2: **The catheter was inserted into the patient.** A translation of “**into the patient**” into German makes the sentence awkward and is not needed. (Where else would it be inserted?) Nevertheless, literal translations of these phrases into German are now common.

**The back translation may be correct, even if the translation is incorrect.** Example 1: **Suggested Lumen Utilization: Double-Lumen.** Translation: *Vorgeschlagene Verwendung des Lumens: Doppellumen.* This German phrase is a word-by-word translation, and means that *one lumen* should be used *as* double-lumen. No problem for the back translator. Example 2. **The analyte determinations should be used in conjunction with clinical findings.** Translation: *Die Analytbestimmungen sind im Zusammenhang mit klinischen Befunden zu verwenden.* „Bestimmung“ is the procedure for determining a value – not the value itself. Therefore, *Konzentration* (**concentration**) or *Spiegel* (**level**) should have been used in the translation. In this case, an incorrect translation will result in a correct back translation. If the German translation is correct, the back translation would be „level“ or „concentration“, and the back editor would complain.

Sometimes, literal translation becomes utterly ridiculous. Interactive Voice Response Systems (telephone systems used for the management of clinical trials) frequently contain the phrases “Please enter the patient’s gender. If the patient is female, press 1; if the patient is male, press two.” In German,



there are two separate words for a **male patient** (*Patient*) and a **female patient** (*Patientin*). The literal translation would then be: *Bitte geben Sie das Geschlecht des Patienten ein. Wenn der Patient männlich ist, drücken Sie 1. Wenn der Patient weiblich ist, drücken Sie 2.* This means: **Please enter the gender of the male patient. If the male patient is male, press 1; if the male patient is female, press 2.** My attempt to use a German sentence that would avoid this ridiculousness was repeatedly rejected by more than one client, probably because of the fear of the difference in the back translation. The reason given by the client: “Male patient” is a generic term. How could this happen after so much effort, for so many years, to include gender specific terms into languages? Where are all the feminists who are concerned about “gender sensitivity”? The back translator will certainly not have a problem with the “generic term”, and the client will be happy. When this “generic term” is used, we may even encounter an unusual case of equal opportunity: *Der Patient ist schwanger* (**The male patient is pregnant**).

In conclusion, back translations used for quality control of medical documents may provide the client with a false certainty that a good translation has been submitted. In my opinion, back translation rarely improves the quality of a translation, may reduce the quality, and is a waste of time and money. To my knowledge, there are no studies that demonstrate that back translation improves the quality of a medical translation. In addition, back translation contributes to the mutilation of languages. A competent translator and a competent editor, who are fluent in the source and target languages and have sufficient knowledge of the topic of the text for translation would provide better translations.

I am open to constructive criticism and discussion.



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Can you spot the 5 differences between these two images?



Answers on page 20

by Jill Heske

I began my career as a translator only a few years ago, having spent my entire professional life in information technology, first as a programmer and product manager in a large corporation, and then as a freelance consultant. I had studied computer science in graduate school, but my undergraduate education in international relations and foreign languages was completely non-technical, and as much as I enjoy technology, I've never lost my fascination with other languages and cultures. When I finally decided to become a translator, I hoped that I might find a way to contribute some of my tech skills to my new field. Since my life as a translator revolves around words, and I've had lots of experience designing user-friendly websites, an online glossary system seemed like a great way to do it.

WordVillage is based on a few simple principles: provide free public access to an extensive database of field-specific glossaries, keep the glossaries growing with contributions from the entire world of translators, and maintain high quality by subjecting all new entries to the scrutiny of expert editors. This, of course, is not an entirely new idea, but WordVillage is a single-purpose site, a free and easily-searchable resource dedicated exclusively to its glossaries.

The idea for the site came to me as I attempted to research terminology as part of my volunteer work for Kiva.org, a microfinance organization. Microloan profiles are filled with regional terms, regularly misused words, and commonly accepted misspellings, which cannot be found in any dictionary, and Internet searches often prove fruitless. Translations of terms must come from lucky finds on Google, other translators who have lived in a particular region, and sometimes even intuitive leaps to a correct spelling or usage. I designed WordVillage to be a searchable repository for hard-to-find terms, and perhaps save others the time I spent researching them. Once the site was designed, it was a simple step to add all of my personal glossaries (proprietary client glossaries, of

course, remain confidential), and grow the glossaries by encouraging input from other translators.

The design for WordVillage was inspired by what is known in the software world as *open source*, which can best be described as free software not belonging to any corporate entity, developed and supported by the software community at large. **Thunderbird**, a high-quality, free alternative to Microsoft Outlook, is an excellent and extremely popular example of an open source application. I developed the WordVillage site using a whole variety of open source products. Even the little icons that appear all over the site come from the **FamFamFam** website, made available to all by a talented and generous icon designer. Open source projects rely on dedicated volunteer experts to forward development and maintain quality. In the case of WordVillage, translators and editors are the experts: translators keep the glossaries growing and editors keep tabs on accuracy. In any open source project, what the experts gain in return varies from simple satisfaction to publicity and even professional opportunities.

The WordVillage glossaries contain words and phrases extracted from actual translated texts. The translation for each entry is based on one specific context, so there may be multiple entries for each term. I also encourage translators to add phrases, common misspellings, and oft-misused words, which you might not expect to see in a typical glossary, but which can be a real find! I am especially interested in the hardest-to-find terms, like country-specific abbreviations that never seem to show up in the dictionary. The Microfinance subfield (in the Commercial field), in particular, is full of words that can't be found in any public source, even through Google searches, but may be part of the everyday lingo in a particular country.

The site is designed for easy searching and sorting of terms. Glossaries are organized by **Field** (major professional categories such as medical, legal,

commercial, etc.) and **Subfield** (subspecialties of the Fields). The **Search** box at the top of the home page provides extensive search capabilities, allowing the user to search for words, or parts of words, quoted phrases, etc. The user can search the entire database, or restrict results to a Field or Subfield. The search box accepts multilingual input so the user can type in either the source or target language. **Sort By** and **Per Page** dropdowns allow the user to sort results and limit the number of entries displayed per page.

Results are shown right on the home page. Colored icons to the left of each entry indicate whether the entry is new, or if it has already been reviewed and approved by an experienced editor. For each entry, Field and Subfield are listed, followed by the Term and its Translation. In addition, because screen space is limited on the home page, the far right column contains icons indicating the availability of additional information for a given entry, including context, source, and notes. Click on the hyperlink in the Term column and a small popup box appears, showing the entire entry, including the additional information, which can be quite lengthy.

As its name implies, WordVillage is designed to bring translators together. I invite other translators to register so they can add new terms. I welcome comments and suggestions for improving the site, and I especially encourage veterans in the field to become editors because their input will keep quality and credibility high. My future plans for WordVillage include adding an Abbreviations and Acronyms Subfield for each Field; providing export capabilities to a variety of text and CAT tool formats; and, of course, adding support for more

languages. With the help and support of the community of translators at large, WordVillage can continue to grow, while maintaining the highest quality standards. Above all, it's my hope that my fellow translators will bookmark the site, <http://WordVillage.net>, and make it one stop in their quest for information.

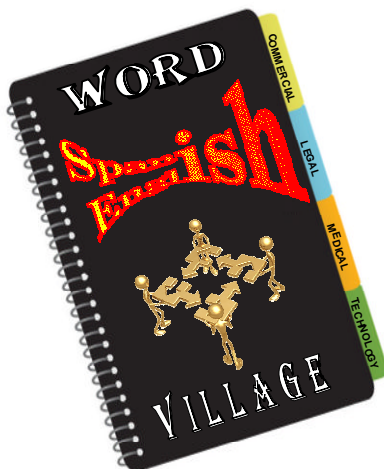
WordVillage currently offers Spanish-English glossaries for the following fields.

**Commercial:** subfields include Banking and Microfinance

**Legal:** subfields include General, Civil, Commercial, Corporate, and Intellectual Property

**Medical:** subfields include General, Instruments, and Pharmaceuticals

**Technology:** subfields include Automotive, Casting, Electrical Engineering, Fasteners, Glassmaking, Heat Treatment, Machine Tools, Petrochemistry, and Welding.



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by Patricia Thickstun

Advertising for oral medications used in the treatment of erectile dysfunction (ED) has raised awareness of this condition. If all you know about ED is what you have learned from the media, read on to discover how these drugs work, how ED is diagnosed, and some new treatments on the horizon. Some of these new treatments include drug-eluting stents and nanoparticles. First, some background on the anatomy and physiology of erectile function.

#### *What is erectile dysfunction?*

Erectile dysfunction (ED) is the inability to consistently achieve and sustain an erection for sexual intercourse.

#### *How prevalent is it?*

In the United States, it is estimated that around 50% of all American men over age 60 have experienced erectile dysfunction. Approximately 20 million have received prescriptions for ED drugs.

#### *Who treats erectile dysfunction?*

The medical specialties most frequently involved in the treatment of erectile dysfunction are primary care and urology.

#### *What causes ED?*

Causes of erectile dysfunction may be **psychogenic** (psychological), **organic** (physical), or a combination of the two. Some organic causes include chronic diseases, such as compromised blood supply to the pelvic region associated with cardiovascular disease, nerve damage secondary to diabetes, and complications of surgery and radiation, particularly those associated with treatment for prostate cancer. Diuretics, antihypertensives, and antidepressants are among the more than 200 medications that list ED as a side effect.

#### *How does normal erectile function (EF) occur?*

Erection is a vascular event controlled by the neural system. Achieving and maintaining an erection depends on a sequence of events involving both the neural and the vascular systems that results in **engorgement** (filling with blood) of vascular tissue in the penis.

#### *How are anatomy and physiology involved in erectile function?*

The penis has three cylindrical chambers – two **corpora cavernosa** and one **corpus spongiosum**. The two **corpora cavernosa** are located above the **corpus spongiosum**, which contains the urethra. These chambers are filled with spongy tissue having **sinusoids** (vascular spaces) surrounded by **trabeculae** (walls) containing **smooth muscle**. Blood flows into the penis through the **pudendal artery** to the **cavernosal arteries** to the **corpora cavernosa** and **corpus spongiosum**. Blood flows out through the **emissary veins** in the **tunica albuginea**, the inelastic membrane surrounding the **corpora cavernosa**.

**Figure 1. Arteries and veins of the penis**

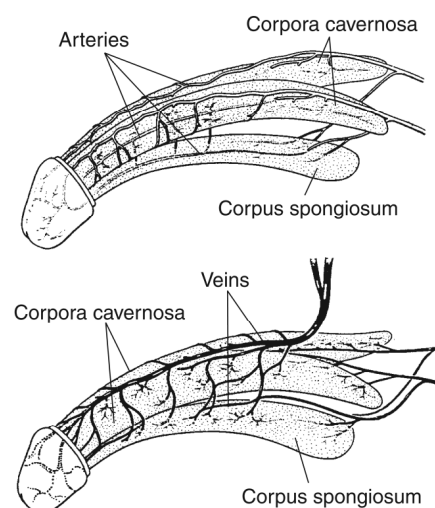


Image courtesy of National Institute of Diabetes and Digestive and Kidney Diseases, National Institutes of Health at [www.catalog.niddk.nih.gov](http://www.catalog.niddk.nih.gov)



An erection can be initiated via two different mechanisms. A **reflex** erection occurs in response to direct physical stimulation of the genitals and involves nerve impulses that travel via the pelvic nerves to the sacral spinal cord to the pelvic plexus at the base of the bladder. The **cavernous nerves** pass around the prostate and beneath the pubic arch, where they enter the *corpora cavernosa* to innervate the blood vessels, smooth muscle, and endothelium of the penis. A **psychogenic** erection occurs in response to erotic mental stimulation (emotional, visual, auditory) and involves the cerebral cortex and the limbic system. The resulting stimulation of parasympathetic nerves extending from the *sacral plexus* into the *arteries* supplying erectile tissue causes the release of **neurotransmitters** that induce smooth muscle relaxation. These neurotransmitters include **acetylcholine** and **nitric oxide**, which also acts as a vasodilator. This parasympathetic nerve stimulation also induces the release of nitric oxide from the vascular endothelium surrounding sinusoidal spaces in the *corpora cavernosa* and *corpus spongiosum* where it penetrates smooth muscle cells and induces relaxation.

During erection, nitric oxide-induced relaxation of **trabecular smooth muscle** causes increased blood flow to and expansion of the *corpora cavernosa*, resulting in compression of the emissary veins of the *tunica albuginea*. When the emissary veins are compressed, they are less able to drain blood. Nitric oxide produced in the cavernosal arteries in response to signals delivered via the cavernous nerves causes the trabecular smooth muscle to relax, which induces dilation of the cavernosal arteries. When these arteries dilate, erectile tissue in the *corpora cavernosa* and *corpus spongiosum* fills with blood (**tumescence**), and the emissary veins constrict. Drainage of blood from the veins is blocked by the *tunica albuginea*. When physical or mental stimulation is discontinued, nitric oxide release is halted, resulting in constriction of the cavernosal arteries, which forces blood out of the erectile tissue, and the erection subsides (**detumescence**).

These nitric oxide-induced events (relaxation of trabecular smooth muscle and increased blood flow) can be inhibited by **phosphodiesterase enzymes** (PDEs), which act by degrading nitric oxide. Most current ED drugs act by inhibiting these enzymes.

#### *How is ED diagnosed?*

The first steps in diagnosis are the history and physical. A medical and sexual history is taken, with particular emphasis on erectile function. For an example of a questionnaire used in clinical practice and in clinical trials, see the International Index of Erectile Function Questionnaire (IIEF) at <http://www.menshealthboston.com/forms/IIEF.pdf>.

A physical exam can include measurement of blood pressure and an examination of the external genitalia. Laboratory tests may include a complete blood count (CBC), blood glucose, hormone levels (thyroid, testosterone), liver, kidney, and thyroid function tests, and urinalysis. Diagnostic imaging tests may be ordered. These include **Doppler ultrasound** to evaluate blood flow, atherosclerosis, and scarring of erectile tissue and **magnetic resonance angiography** (MRA) for imaging of blood vessels in the pelvic area. A contrast agent is introduced intravenously to produce images that provide information on blood supply and vascular features.

#### *Which drugs are used to treat ED?*

The first-line medical therapy for erectile dysfunction is treatment with prescription ED drugs. Recall that both nitric oxide-induced relaxation of the trabecular smooth muscle and increased blood flow can be inhibited by phosphodiesterase enzymes (PDEs). Coffee, tea, and chocolate contain nonspecific **PDE inhibitors** (caffeine, theophylline, and theobromine). The most widely used prescription ED drugs are **phosphodiesterase-type 5 (PDE-5) inhibitors**. These include sildenafil (Viagra), vardenafil (Levitra), and tadalafil (Cialis). PDE-5 inhibitors enhance erectile function by relaxation of the smooth muscle in the *corpora*



*cavernosa* and the *corpus spongiosum* which facilitates dilation of the cavernosal arteries.

However, orally-administered PDE-5 inhibitors can cause systemic, potentially serious side effects, including hypotension, headache, facial flushing, nasal congestion, upset stomach, and abnormal vision. Research studies have explored alternate methods to the oral route of drug delivery – **drug-eluting stents** and **nanoparticles**.

### DRUG-ELUTING STENTS

*What is a stent?*

The most common method for increasing blood flow to any part of the body is the placement of one or more stents. A stent is a short length of metal scaffold placed into an artery) to counteract a localized constriction. The most common types of stents are the bare metal stent (BMS) and the **drug eluting stent** (DES). The drug-eluting stent provides for the slow release (elution) of a drug, achieving high concentrations of the drug locally with minimal systemic side effects.

**Figure 2**

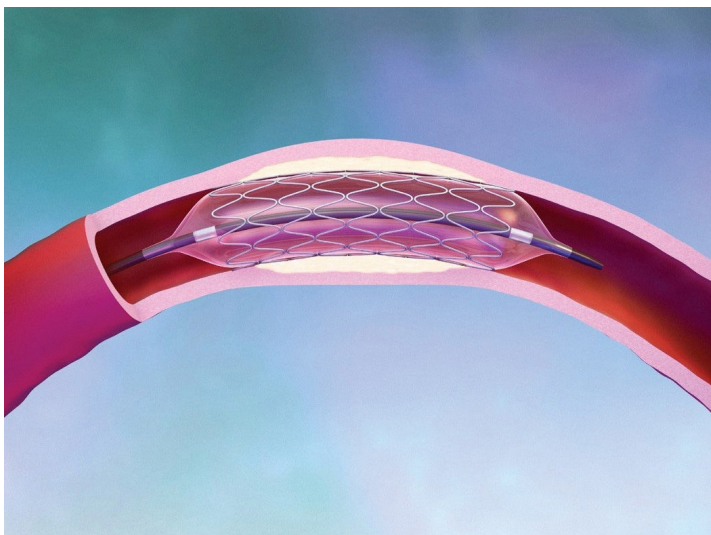


Image courtesy of Medtronic Image Library [http://www.medtronic.com/Newsroom/ImageLibraryDetails.do?itemId=1198776840552&lang=en\\_US](http://www.medtronic.com/Newsroom/ImageLibraryDetails.do?itemId=1198776840552&lang=en_US)

*How do stents work?*

Stents are placed to counteract **stenosis** (narrowing) and re-stenosis not only in the coronary arteries of the heart, but also in the carotid arteries that supply the brain, the abdominal aorta and its tributaries, and the femoral arteries that supply the legs. In 2008 a zotarolimus-based drug-eluting stent received FDA approval for use as a coronary stent. Zotarolimus is a cytostatic agent that also prevents re-stenosis.

*How can drug-eluting stents be used in the treatment of ED?*

Recall that the pudendal arteries provide the vascular supply to the genital area. Most patients who have coronary artery stenosis usually also have pudendal stenosis and thus respond poorly to PDE-5 inhibitors. Researchers at University of California Davis Medical Center, Sacramento, CA, are conducting a feasibility study for a clinical trial of a zotarolimus-based drug-eluting stent implanted in the pudendal artery. Criteria for inclusion in the study are stenosis of pelvic arteries and previously failed drug therapy with PDE-5 inhibitors. This clinical trial is using pelvic angiography and selective visualization of the genital vasculature to evaluate the effect of this drug-eluting stent on erectile dysfunction. It is expected that prevention of re-stenosis will result in drug therapy success with PDE-5 inhibitors.

### NANOPARTICLE-BASED ERECTILE DYSFUNCTION THERAPY

*What are nanoparticles?*

Nanoparticles are extremely small particles that encapsulate drugs or other medically useful substances. They are designed to release their contents in a controlled and sustained manner. A research team at Albert Einstein College of Medicine of Yeshiva University is conducting animal studies to investigate a method that combines the transdermal delivery of ED drugs (PDE-5 inhibitors) and nitric oxide (NO) directly to the penis. To determine if this method will prevent the unwanted

systemic effects of PDE-5 inhibitors, a gel incorporating nanoparticles containing encapsulated ED drugs with and without NO is applied locally. Preliminary results indicate increased erectile function after stimulation of the cavernous nerves.

*How is this an improvement on oral medication for ED?*

Nanoparticles slowly release the drugs to locally achieve high concentrations, thus avoiding systemic side effects.

### NOTE:

This article has covered some of the current and future erectile dysfunction treatment modalities. Many thanks to **Caduceus** editor Rafael Rivera for starting this article. It was a great learning experience completing it.



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Can you spot the 5 differences between these two images?



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

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.

In the first article of this series, we discussed the issue of ethics in medical translation and interpretation. We explained how important it is for hospitals and medical institutions to have a well-defined code of ethics for medical translators and interpreters encompassing: Accuracy, Confidentiality, Impartiality, Respect, Cultural Awareness, Role Boundaries, Professionalism, Professional Development and Advocacy.

In the second article of the series, we will focus on the issue of untrained interpreters and translators in the medical field.

Clearly, in a medical setting mutual understanding is crucial to an effective patient-physician relationship and to shared decision making. If asked, nearly everyone who works in the medical profession would say that because of this, language barriers could severely compromise the quality of care that patients receive. When marketing a product abroad or simply including multilingual content on a product, those in the medical and pharmaceutical manufacturing field would never use a translator who did not have the needed technological, pharmacological, or engineering knowledge to translate vital disclaimers, instructions, and ingredients for their target demographic. Yet, there are still medical institutions that routinely use

**by Monica Guelman and Steven Becerra**

unqualified parties to interpret medical examinations, doctors' visits, disclaimer forms, test results, etc. In some cases, even children have been asked to interpret for family members, which raises clear ethical and medical concerns. There is, in fact, ongoing litigation against institutions that have allowed children, who may lack the emotional fortitude to handle certain situations (to say nothing of lacking terminology) to serve as "interpreters."

Recently issued guidelines established by the U.S. Department of Justice already entitle patients of limited English proficiency (LEP patients) to have access to language assistance through what the guidelines refer to as "qualified sources" (1) when seeking services from hospitals, pharmacies, federal programs and physicians who accept payment for their services. The purpose of this measure is to ensure that everyone receives quality medical care regardless of linguistic differences. This leads us to the obvious question: who would be considered a "qualified source"?

It is far easier to identify those who would *not* be considered qualified. Those in the interpreting field have often said, "a bilingual person does not an interpreter make." Just because an individual is fluent in two languages does not necessarily mean that he/she has the skills necessary to interpret or translate. Therefore, a "qualified" translator and/or interpreter can be defined as someone who has studied and been trained to perform the function of a translator and/or interpreter.

A U.S. study recently explored the role of professional medical interpreters working for two Midwestern interpreting agencies (2). An analysis of practices showed that the interpreters that lacked sufficient training assumed some of the clinicians' communicative goals. Some did so by initiating information-seeking behaviors such as asking questions not posed by the attending physician,



editorializing information for the purpose of emphasis, and volunteering medical information to the patient. These behaviors are in clear violation of the interpreter code of ethics. They potentially pose risks to patients' health, or at the very least could have unintended clinical consequences. They may also breach privacy and interfere with the clinician-patient relationship (3).

Health care professionals sometimes believe it would be more straightforward and sometimes even preferable to rely on the assistance of family members or friends who accompany the patient and who speak the language of both the patient and the medical professional. Their reasoning is that these individuals are usually already on the premises and can assist free of charge. In addition, they already have a relationship with the patient, which might make for increased levels of



comfort and trust between patient and translator (1). The problem with this is that the patient's family and friends most often lack training in the areas needed for competent medical interpretation.

As detailed in our first article, medical translators need to have an in-depth knowledge of very specific and sometimes complex medical terminology. Family members generally lack this knowledge, thus inhibiting the ability of the clinician to communicate the clinical details of diagnosis and treatment. Medical interpreters must also adhere to a strict code of ethics. Family members are likely to be unaware of the code of ethics governing medical interpretation, and may compromise patient confidentiality. It is true that friends and family may have an insider's perspective on the LEP patient's culture and can therefore assist in addressing

sensitive cultural or religious issues related to treatments. However, this *does not* outweigh the need for a qualified language facilitator who should have the same cultural sensitivity and understanding. At best, having family members act as medical interpreters may lead to compromised quality of care and breaches of privacy. At worst, it could lead to severe medical complications and complex legal issues including liability and negligence claims.

According to a 1988 Lancet article, referring to Resolution 245, A-01, studies show that using language interpreters who are not qualified to provide interpretation services results in 23% to 52% of words and phrases being incorrectly interpreted. Based on these percentages, it is clear that as messages get distorted, medical conditions are more likely to be misdiagnosed, thereby compromising patient welfare (1, 5). In addition, health care facilities and providers are placed at increased legal liability if patients incur negative consequences that could be attributable to errors in interpretation.

It is interesting to note that breakdowns in communication sometimes happen intentionally, for example when family or friends wish to protect their loved ones from a difficult truth or spare them what in their culture would be deemed as embarrassing or shameful. In the May 2008 issue of *The Oncologist*, a physician mentions a case in which a Yemeni man had to receive news about his advanced lung cancer and the suggestion that perhaps he should return home, consider end-of-life care, and put his affairs in order. Despite the oddly muted emotional response from the man's family, the interpreter seemed to be doing a fine job since it sounded as if the segments were roughly the same length as the doctor's. But an attendant on hand who just so happened to speak the language, informed the physician that the "interpreter" had told the man and his family that "it was just an infection and he would be given antibiotics and sent home without any further problems." The attendant explained that because the

interpreter's social status was lower than that of the patient, it would be inconceivable for him to deliver such news (6). This clearly demonstrates how cultural elements can lead to compromised decision making and impede proper care, which in turn can make for serious legal issues for the practitioner and/or the medical institution. This type of situation is much more likely to happen when the interpreter involved is unskilled and uninformed as to the Interpreters' Code of Ethics.

An example of legislation passed in this area is Resolution 245: "Discouraging the Use of Ad Hoc Interpreter Services in Medical Practices." The Medical Student Section introduced this at the 2001 Annual Meeting of the House of Delegates. It called for "...our American Medical Association to include [...] information for health care providers on the ethical and legal implications of using ad hoc interpreters to communicate with patients when trained interpreters are available" and to publicize the importance of using trained interpreters when they are available. (1)

There have been numerous lawsuits filed against hospitals and emergency rooms by individuals who requested sign language interpretation under the Americans with Disabilities Act and were allegedly denied adequate services. An example is the case of Dr. Hand, a psychologist who allegedly failed to provide a deaf teenager with a sign language interpreter.

Another example of such a case is *Gillespie et al v. Laurel Regional Hospital* No. DKC 05-CV-71 (D.C. Md. Consent Decree 7/14, 2006) in which seven deaf individuals sued Laurel Regional Hospital claiming that despite their specific and repeated requests for in-person qualified sign language interpreter services, these requests were denied. Of particular import in this case were the allegations of inadequate video interpreting services (VIS). These services provide an off-site interpreter through video conference technology over high-speed internet

lines. In this case, the plaintiffs alleged that the services provided were inadequate.

If patients can sue a medical facility because it failed to provide adequate sign language interpretation, it is logical to assume that they could sue medical facilities that failed to provide them with adequate language interpretation.

The problem of reliance on untrained interpreters is compounded by the lack of education, training, and awareness of the use of language facilitators in medical scenarios. Hospitals should make a greater effort to educate their employees on the importance of using qualified translators/interpreters and brief them on proper translation and interpretation procedures. A study published in the *Journal of the American Medical Association* reported on a national survey of resident physicians in 2004 that evaluated their education and practices in relation to the use of interpreters (7, 8). The residents were asked if they received any type of instruction in hospital policies and procedures relating to the use of interpreters. About one third reported receiving no instruction in how to work with interpreters. When facing language barriers, 77% of residents said they sometimes or often used professional interpreters, 84% used ad hoc interpreters, 77% used hospital employees, and 22% (an unsettling amount) used children. More than half said they faced moderate or major problems in delivering cross cultural care because of a lack of access to interpreters, lack of time, and lack of access to written materials in other languages. The authors concluded that residents need further training in patients' legal rights and in procedures and techniques to work with interpreters and reduce misinterpretation errors. This would lead to reduced use of ad hoc or unqualified interpreters. It is interesting to note that family interpreters evaluated in the study acted mostly as participants rather than interpreters, often asking their own questions and voicing their own concerns rather than providing accurate renditions of both the doctor's and the patient's comments.

Further legislation, standardization, and even penalization are on the horizon in the field of language facilitation in medical settings. Some of this is already in place at national and state levels. Realistically, there may well be some opposition to this, in some cases because of budgetary constraints. The Michigan Interpreter Bill introduced in 2006 met with this kind of criticism. It stated that the cost of business would rise to the point where institutions would be reluctant to treat LEP patients. However, it has been widely documented that unqualified interpreters and translators charge the same if not more than qualified, reputable language facilitators (9). The use of trained language personnel and workshops for medical staff with the goal of successfully interfacing with these qualified facilitators would be a better alternative to possible issues of liability and subsequent litigation.

In the last article of the series, we will discuss some of cultural benefits for healthcare organizations associated with a having a multicultural and multilingual workforce.

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SESSION	TITLE	SPEAKER	Date	Day	Time
<b>MED-1</b>	Where Right Brain Meets Left: Translating for Medical and Pharmaceutical Marketing and Promotion	Erin M. Lyons	10/28/2010	Thursday	11:30-12:30pm
<b>MED-2</b>	Bioethical Issues in Translation: Informed Consent	Eric S. Bullington	10/28/2010	Thursday	2:30-3:30pm
<b>MED-3</b>	Interpreter Quality Assurance and Professional Development Through Mentorship	Jucelei Pereira	10/29/2010	Friday	11:30-12:30pm
<b>MED-4</b>	Heard It Through the Medical Grapevine	Rebecca Brown	10/29/2010	Friday	2:30-3:30pm
<b>MED-5</b>	Medical Division Annual Meeting	Patricia M. Thickstun & Suzanne M. Couture	10/29/2010	Friday	4:00-5:00pm
<b>MED-6</b>	Don't Miss the Bus! Best Practices for Medical Interpreters Working in School Settings	Fabio Torres	10/30/2010	Saturday	8:30-9:30am
<b>MED-7</b>	Medical Terminology Challenges in the Southwest	Patrick J. O'Connor	10/30/2010	Saturday	10:00-11:00am
<b>MED-8</b>	The Ins and Outs of Managing Hospital Interpreters	Elena Langdon	10/30/2010	Saturday	11:30-12:30pm
<b>MED-9</b>	When Your Limited-English-Proficient Patient Is an Older Adult	Ariel Lenarduzzi	10/30/2010	Saturday	2:30-3:30pm
<b>MED-10</b>	Stress Busters for Interpreters	Julie P. Burns	10/30/2010	Saturday	4:00-5:00pm
<b>Seminar F</b>	Community Interpreting: Ensuring Language Access and Compliance to the Code of Ethics and Standards of Practice	Thelma D. Gomez-Ferry	10/27/2010	Wednesday	9:00-12:00noon
<b>Seminar G</b>	Biomedical Translation Seminar	Damián Vázquez	10/27/2010	Wednesday	9:00-12:00noon
<b>Seminar H</b>	Introduction to Medical Terminology	Maria Rosdolsky	10/27/2010	Wednesday	9:00-12:00noon

