The Newsletter of the ATA Medical Division

Volume I, Issue II
July 2003

Table of Contents

Letter from the Administrator

Welcome to the second issue of the Medical Division Newsletter!

It is so exciting to see how much progress the Medical Division has made in such a short amount of time: our division is growing exponentially; our listserv – which has been up and running since mid-April – is a resounding success (comments suggest it has become an addiction); the responses to the first issue of our newsletter have been positively overwhelming thanks to our dedicated members who have been proactively increasing its circulation via hand-outs and e-mail; and finally, by the time you read this, the ATA Board will have met and officially approved our formation!

Congratulations to all those who helped make this happen!

But there is more to be done. The next step is to make sure that our members are getting as much from this division as possible, and to do that, I need to hear from you. There are a lot of ideas floating around, so do not hesitate another moment to voice them.

Also, remember the success of last year's Town Hall Meeting and make sure you attend the next Annual

Continued on page 22

Medically Speaking...

Rafael A. Rivera, MD, FACP

One of the most frequent problems that English-into-Spanish medical translators run into is the word fellow. Fellow has a variety of meanings, both lay and medical. It is, of course, the term given to an unidentified person, usually a male, and is used as a synonym for "person" or "guy," i.e., "See that fellow crossing the street." It is also used for a personal aquaintance, colleague, or partner, i.e., "Dr. James has been a fellow physician at the Holy Cross Hospital for many years." A common use these days is for scholars from highly regarded organizations and "think tanks" who appear on TV and are introduced as a "fellow" or "senior fellow" at the Brookings Institution, the Rand Corporation, etc.

In medicine: A "resident" / "residente" is a physician pursuing training in a primary specialty – internal medicine, pediatrics, obstetrics, psychiatry, etc. Fellow – short for fellow-in-training – most commonly refers to a full- fledged primary specialist who is now pursuing further training in a subspecialty. Cardiology, rheumatology, gastroenterology, and pulmonary diseases are examples of subspecialties of internal medicine; an ophthalmologist (eye specialist) can become a subspecialist in glaucoma or retinal diseases, among others.

The other common medical meaning of fellow refers to a distinction awarded by a medical organization to a physician who fulfills certain requirements. The initials after my name, FACP, mean Fellow of the American College of Physicians; FACOG would refer to a Fellow of the American College of Obstetrics and Gynecology; FAAO is a Fellow in the American Academy of Ophthalmology, and so on.

Next, there is the "research fellow" / "becario de investigación": this term applies to anybody, physician or otherwise, who is pursuing research of any kind, medical or non-medical, under some form of scholarship.

There are also "post-doctoral fellows" in medicine; these are Doctors of Medicine who pursue further academic training, usually customized to the student's wishes, involving a narrow area of medicine applied to non-direct patient care issues, perhaps to international or third world medical problems.

The issue boils down to finding an adequate Spanish translation for "fellow" (or "royal fellow," if we are dealing with physicians in the UK or Canada). There is none. The best we can do is leave the word "fellow," as is, and add "miembro distinguido" in parentheses. This is the best solution we have been able to come up with after many exchanges regarding this term in our international medical translation group.

Dr. Rivera is a physician and medical translator associated with the 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.

Payment Practices Lists

Naomi de Moraes

There are two freelance translator/client models currently in use in the world today: translators working for direct clients and translators working for translation agencies who deal with direct clients. Many full-time career translators prefer to work for direct clients because, by cutting out the middleman, they earn more for the same work. Some also feel it is more satisfying because they have more contact with the client, can ask questions and receive more accurate feedback, and can target their translations. My experience has been that after translating 10 manuals for slightly different products for the same company, I would be happy to never have to deal with that type of product again, even though I can now translate manuals of this type at the speed of light and would make a good profit. Many part-time, beginner and even full-time career translators prefer to deal with translation agencies. The benefits are steady work (they generally have more clients), regular payment checks, and the freedom to go on vacation without having to worry that a client will be left high and dry in his hour of need. The main disadvantage is not knowing who you are dealing with and when or IF they will really pay you.

In either case, I highly recommend you have all clients sign some type of purchase order or contract. The ATA model contract or the ITI terms and conditions guidelines are a start. In addition to looking professional, it helps both you and the client understand exactly what is expected by both sides. You may ask, will this signed contract be valid in a court of law? In today's global marketplace, the main problem is not the legality of the contract, but how much it will cost you to get it enforced. In the US, getting money from a company in another state is difficult enough. Imagine a translator in Brazil trying to collect money from a Danish company!

To protect freelance translators, two kind souls run client reference lists: Ted Wozniak moderates the Payment Practices (PP) list (see references at end of article) and Laura Hastings moderates the Translator Client Review (TCR) list. Both have members from all over the world. The former has over 1,400 members and the latter has about 1,800 members. The PP archive contains over 5,000 messages (queries and responses). Many translators like myself are members of both lists.

How do these lists work?

First, let me explain what they have in common. After a translator is approved for membership, she can send in a query stating as much information as possible about the company: name, contact, address, e-mail address, web site, telephone, etc. The PP list is stricter, and more information must be provided for a query to be accepted. The name of the agency (and often the city and country) is placed in the subject line for easy reference. When the query is posted to the list, members are asked to come forward with their good or bad experiences with the company in question (or one of its previous incarnations). The subject of rates charged by translators is strictly off limits. Both of these lists are moderated, which means that all messages must first be approved (as having con-

Continued on next page

Payment Practices Lists ... continued from p. 3

formed to the rules of the lists) before they are posted.

The differences between the lists

The PP list is very no-nonsense. Queries are submitted by filling out a form on the list site, and respondents complete a response section providing timeframes, amounts, and comments. The moderator assigns a "rating" from 0 (no payment) to 5 (+/– 10 days from agreed terms) based on how late payment was received and inserts that in the subject line. There is almost no room for chit chat. This is nice sometimes. The PP list is also free.

The TCR List is run using a private list service, while the PP list uses the free Yahoo group service. The TCR List only requires that you include one unique identifier, which can be an e-mail address, physical address, telephone or fax number. You should always include AS MUCH information as possible, but if all you have is an e-mail address or phone number, that is enough. (However, if that is all the information you have, do you really want to extend credit to the client?)

The TCR list costs US $12 per year (one-month free trial subscriptions are available to new subscribers, and free memberships and scholarships are also available to those who need them). You can pay by Pay Pal, credit card, personal check (with some restrictions) or money order. Some people get together and pool their resources to send one larger check to pay for several subscriptions rather than each paying the bank fees individually. The TCR list allows some discussion, but a separate list called TCR-D was created for chatting and many times the moderator sends issues there. Sometimes you can get a better feel for an agency's style by reading the long descriptions, which can be just as important as whether a company will pay soon or not. The TCR list produces approximately 20 messages a day, with much less volume on the week ends.

Tips for using this type of list

- Look up companies in the archives first. If a company was discussed the week before, your query may be ignored, resulting in a false impression (that no news is good news).

- Try to respond rapidly when you have information to share. The client rarely waits a few days to place a job. However, do not complain if someone responds late. We do work for a living!

- Do not receive list e-mails in your regular account! Create a second account to deal with all list mail. If you use a web-based account, keep it within your storage limits to avoid "bouncing" e-mail. I have a nice sorting scheme set up: all PP/TCR mail is sent from the inbox to a second folder, then sorted by country based on the country provided in the subject line. I also sort on company name for all companies I have worked for so I can quickly respond to queries. Whenever I go on vacation, I use an auto-responder for my business account, but not for the list account. People using one account will have to go on "no mail" to avoid sending automatic responses to the lists and being banned, or filling up their in boxes to overflowing and bouncing all their e-mail.

- If a company does not show up in the archives, or shows up, but with no response, submit a query. Sometimes I have queried the list and received only off-list responses – usually bad, but I sure was glad to know!

References:

Translator Client Review (TCR):

www.tcrlist.com

Payment Practices List (PP):

http://www.trwenterprises.com/payment_practices.htm

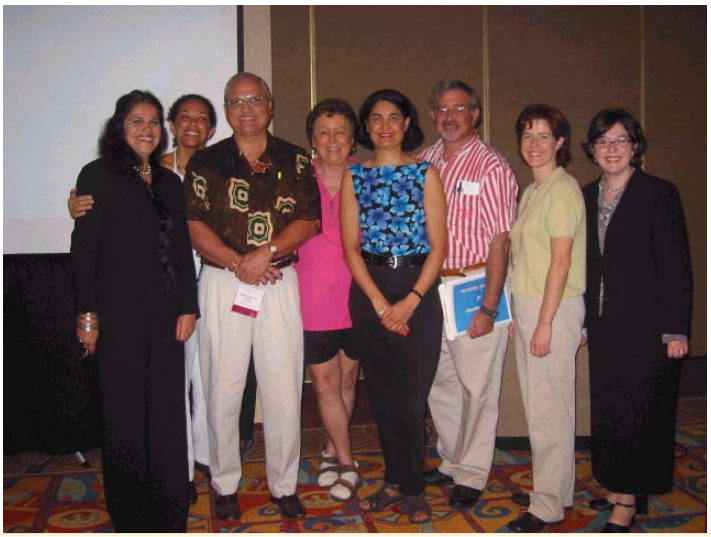
Medical Translation and Interpretation Seminar

Giovanna Lester
President, FLATA-Florida Chapter of the ATA

On March 22-23, the American Translators Association (ATA) and FLATA, its Florida Chapter, held a Medical Translation and Interpretation Seminar at the Renaissance Biscayne Bay in Miami, Florida. There were more than eighty attendees representing numerous languages: Creole, English, French, German, Portuguese, Russian, and Spanish, which clearly reflects the huge demand for this kind of professional development opportunity. I was surprised to see colleagues who had come all the way from New York, California and Illinois, but when I heard our presenters, I could see why they made the long trip to Florida. The seminar was the result of a joint effort by Marian Greenfield, Chair of the ATA Professional Development Committee; Teresa Kelly, from ATA Headquarters; and myself.

By all measures the seminar was a success. The presenters, María Cornelio, Zarita Araujo-Lane, Vonessa Phillips, Dr. Steve Weinreb and Dr. Rafael A. Rivera did a fine job and the attendees' evaluations reflected that.

A fine dinner on Friday evening for the staff and presenters was sponsored by ATA. The usual fine Miami weather was not so cooperative, and yet some of us managed to visit the usual fine restaurants at the colorful Calle Ocho for fine dining and live music.



For those who couldn't be with us this time, get ready for our next educational session in the Miami area in the near future.

From left to right: Zarita Araújo-Lane, Giovanna Lester, Dr. Rafael Rivera, Gloria Nichols. Dr. Maria Cornelio, Dr. Steven Weinreb, Dr. Linda Burt, Vonessa Phillips.

Legalities of Unit Conversion

Jacopo Màdaro Moro

The land of the free hides an unexpected reminder of the old colony. I am not talking of much, it is just a matter of units. The US shares with Malaysia the doubtful merit of sticking to Imperial units, the same units which shaped Queen Victoria's vision of the world.

The length of some forgotten king's arm and foot, and the long-lost love for fractions are still dominating the American scene. The British had plenty of reasons for maintaining their own system. Commercially, it was useful to better control their markets, and politically, it distanced their nation from another disgusting revolution. With UK investors as the largest alien economic presence on American soil, it made perfectly good sense for early Congresses to follow British standards.

Today, the American predicament is an obstacle to commerce. The Imperial system hinders US businesses with several hidden burdens. It raises the start-up costs associated with foreign markets; it marginally increases the cost of training foreign-born workers producing goods, both in the States and abroad; and it substantially complicates multinational tooling and production of goods as well as inventory management.

Conversely, it does not offer much protectionist advantage anymore. As for their British counterparts before them, American corporations did benefit from the permanence of the Imperial system well after the European-Japanese reconstruction, spelling out to every potential competitor the difficulties of entering the US market, with the same finality of the DOD or ANSI standards.

Nowadays, the adoption of a base 4 system does not really seem to deter determined competitors, as proven by current and past foreign trade balances. Almost everybody owns a set of wrenches in fractions of inches made in metric PanAsia, and Armani has lost little sleep in order to come up with suits in American sizes.

This tempest in a teapot affects technical translators in subtle ways, forcing us to dedicate extra time and energy to educating our clients while paying close attention to the maddening complexities of national and, in the case of Europe, Community laws and regulations.

I have encountered two scenarios. Sometimes, clients had to be convinced to avoid "overconversions." It might be nice to give surface equivalents of leather skins expressed in square centimeters, but in

Continued on next page

Jacopo lives in Boston, MA, has a doctorate in sociology, and translates full-time into Italian, mostly from English, but also from Spanish and French. The bulk of his work is in medicine, pharmacy, bioengineering and opto-electronics. He served for a few years as chair of the ATA Dictionary Review Committee and is still involved with that Committee, contributing reviews. The last was published in the October 2002 *Chronicle* (Elsevier's *Dictionary of Abbreviations, Acronyms, Synonyms, and Symbols used in Medicine*). Jacobo's web site is www.jmadaro.com and he can be reached at jmadaro@direcway.com.

Legalities of unit conversion ... continued from p.6

Stra and Vigevano (two major centers of *Made in Italy* shoe production), everybody in the trade can visualize square feet with the greatest of ease.

In another situation, to define outside diameters of American high-pressure pipes in metric units can be outright dangerous. Metric wall schedules are different and flow miscalculations can have dire consequences, whereas every engineer from Russia to Argentina is quite familiar with the fractional measurements of pipes, following a tradition more than two centuries old.

Most of the time, the opposite holds true. The client wants the "proper" measures first, followed by their metric equivalent in parentheses, as if the target audience could find a yard stick or a measuring cup in fluid ounces within a 10 kilometer radius. As long as we are talking about cloth or ingredients, the issue is minor. Here, to drop the imperial attitude is a matter of good form, a concrete way to respect the intended readers (and consumers). The implications are much different when we deal with medical devices.

In Europe, nothing should be simpler. Two European Community directives and mountains of national regulations specify the issue in the clearest terms. The DMD 93/42, issued on June 14, 1993 (and last amended on January 10, 2002), states in section 10.3: "The measurements made by devices with a measuring function must be expressed in legal units conforming to the provisions of Council Directive 80/181/EEC," later amended by Directives 85/1 and 89/617.

Directive 80/181, issued on December 20, 1979, defines the units of measurement in clear terms on the basis of the General Conference of Weights and Measures (CGPM) set up by the Metre Convention signed in Paris on 20 May 1875, and the International System of Units (SI).

Referring to Directive 76/770/EEC and ISO standard 2955 of March 1, 1974, Directive 80/181 indicates the units allowed in Chapter 1 of its Annex, and their approved abbreviations (for instance, gram must be abbreviated with a lower case **g**, contrary to the often-seen American **G** or **gm**). Directive 85/1 authorizes the use of **mm Hg** and **barns**. Directive 89/617 is dedicated instead to exceptions to the rule, as found in marine navigation; beer, cider, waters, lemonades and fruit juices in returnable containers; dispensing of draught beer and cider; milk in returnable containers; alcoholic drinks; goods sold loose in bulk; gas supply; road traffic signs, distance and speed measurement; land registration, and transactions in precious metals.

All terms are defined, together with their exceptions[1] and Imperial equivalents. The mandatory nature of such terms for Class IIb and III devices is confirmed by the zero margin of freedom allowed. DMD Art.1 indicates: "The legal units of measurement within the meaning of this Directive which must be used for expressing quantities shall be …those listed in Chapter I of the Annex," whereas Art. 4.3 states: "At trade fairs, exhibitions, demonstrations, etc. Member States shall not create any obstacle to the showing of devices which do not conform to this Directive, provided that a visible sign clearly indicates that such devices cannot be marketed or put into service until they have been made to comply".

Be that as it may, all of the above does not appear to suffice. Some US producers seem strangely reluctant to swim in the metric sea and offer several excuses in order to continue wading in their Imperial pond.

The most common excuse is FDA requirements. True enough, the FDA expects that medical devices marketed and sold in the US will use measuring units and values that follow standard American usage. Nevertheless, products sold abroad fall under the jurisdiction of local agencies and regulatory framework, making FDA wishes irrelevant.

Continued on next page

Legalities of unit conversion ... continued from p.7

No losses will be suffered in humoring FDA requirements and mentioning in every manual translated for the international market an insignificant US regulation indicating those who are authorized to sell medical devices, but American firms should not defy the laws of other countries and deny the authority of local institutions while hiding behind the FDA, its total lack of jurisdiction notwithstanding.

The solution often chosen is believed to be smart, while it is just contemptuous: give them the units they want but keep our measurements in parentheses, so we understand what we are talking about. The legal reasoning I have been offered is that the double units are not expressively forbidden, therefore they are allowed.

Directive 93/42 does not seem to justify this interpretation. Art. 4 defines the only cases in which "The use of units of measurement which are not or are no longer legal shall be authorized for: - products and equipment already on the market and/or in service on the date on which this Directive is adopted [1993], - components and parts of products and of equipment necessary to supplement or replace components or parts of the above products and equipment." Even then, "However, the use of legal units of measurement may be required for the indicators of measuring instruments."

All products bearing the CE mark and marketed after 1993 must conform to the relevant directives. As DMD Art. 8.3 points out: "Where a non-complying device bears the CE marking, the competent Member State shall take appropriate action against whomsoever has affixed the mark and shall inform the Commission and the other Member States thereof."

In Italy, several laws and decrees enact the European legislation. The two most important are Presidential Decree 802, August 12, 1982, (*Attuazione della direttiva 80/101/CEE relativa alle unitá di misura) and Law 473, October 28, 1988 (Attuazione della direttiva n° 85/1/CEE che modifica la direttiva 80/181/CEE sulle unitá di misura giá attuata con decreto del Presidente della Repubblica 12 agosto 1982, n° 802).*

Presidential Decree 802/82 alone clarifies the situation, once and for all. Art. 1 states: "*Le unità di misura legali da utilizzare per esprimere grandezze sono quelle riportate nel capitolo I dell'allegato al presente decreto. ... Per indicare le unità di misura di cui ai commi precedenti si devono usare esclusivamente le denominazioni, le definizioni e i simboli previsti nell'allegato.*"[2] The above-mentioned "allegato" (annex) includes the official Italian translation of the relevant Annex to Directive 80/181/CEE.

To further clarify the issue, Art. 3 is even more explicit: "*… Gli strumenti di misura devono recare le indicazioni di grandezza in un'unica unità di misura legale.*"[3] The terms used (exclusively, single) are crystal clear, and perfectly in line with the spirit of DMD 93/42/CEE.

Still, in at least one instance, no coaching was sufficient to modify my client's position. Knowing that my translation was illegal, that it would have exposed my client to a possible fine of about US $250-1,000 (see PDR 802/82, Art. 4) and the potential revocation of the Ministry of Health authorization for marketing, I had to refuse to certify the sections of the manual which contain the double units. Clearly, a much stronger and more generalized effort is needed to educate the public on this matter.

ENDNOTES

[1]DMD 83/42, Art.1, Sect.5 states:

This Directive does not apply to:
(a) *in vitro* diagnostic devices;
(b) active implantable devices covered by Directive 90/385/EEC;
(c) medicinal products covered by Directive 65/65/EEC;

Continued on next page

Legalities of unit conversion ... continued from p.8

(d) cosmetic products covered by Directive 76/768/EEC (18);
(e) human blood, human blood products, human plasma or blood cells of human origin or to devices which incorporate at the time of placing on the market such blood products, plasma or cells;
(f) transplants or tissues or cells of human origin nor to products incorporating or derived from tissues or cells of human origin;
(g) transplants or tissues or cells of animal origin, unless a device is manufactured utilizing animal tissue which is rendered non-viable or non-viable products derived from animal tissue

[2]The text [my translation] reads: "The legal units of measurement used to express quantities are those indicated in Chapter 1 of the Annex to this decree. … In order to indicate the units of measurement mentioned above it is mandatory to exclusively use the denominations, definitions and symbols stated in the Annex."

[3][my translation] "Measuring instruments shall indicate quantities with a single legal unit of measurement."

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In print:

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Braudel, Fernand (S, Reynolds, trans), The Perspective of the World, vol III of Civilization and Capitalism, Harper and Row Publishers, New York, NY 1986

On the Web:

europa.eu.int/eur-lex/en/index.html

europa.eu.int/eur-lex/it/index.html

www.cittadinolex.kataweb.it

National Standards for Healthcare Language Services

Mario A. Flores

On February 10, 2003, the National Project Advisory Committee (NPAC), convened by the Office of Minority Health (OMH) of the U.S. Department of Health and Human Services, held its first meeting of a 2-year project in Washington, DC, on the ambitious project to establish National Standards for Health Care Language Services.

The NPAC is comprised of national experts in the field of health care, health and medical education, and interpretation. The Committee will provide guidance in the development of the Standards for Health Care Language Services which will be based on the Language Access Standards section of the National Standards for Culturally and Linguistically Appropriate Services in Health Care (CLAS), with an eye to facilitating access to health care as well as to ensuring the quality of such care for Limited English Proficient (LEP) populations.

In addition to the input provided by the NPAC, the OMH will conduct a series of Public Forum Meetings and Tribal Consultation Sessions throughout the country in order to provide opportunities for input from such stakeholders as patients, providers, interpreters, administrators, community agencies, etc. These Hearings will be held September-October of 2003 in the cities of Albuquerque, Atlanta, Austin, Boston, Chicago, Seattle, San Francisco and Washington DC.

Who Cares?
Scientific Investigation vs. the Power of Testimony

(Second in a series that examines the US healthcare delivery system with emphasis on pertinent terminology.)

Rafael A. Rivera, M.D., FACP

When Frieda Freeman returned from her Laetrile cancer treatments at the Mexican clinic her hopes were high. Six months later the apricot pit remedy seemed to be working – she was cancer free and so were two other members of her cancer support group. The word got out and many others went. However, these other cancer patients who visited the same clinic and received the same therapy only showed variable results – some good, some not so good, an occasional remission or no change at all. Essentially, no different from the other members and acquaintances receiving cancer treatments in the well-recognized medical centers in town. So, what's going on here? Similar results for similar illnesses obtained from widely different sources and treatments – the heavy-duty, costly oncologic center or the minor-league friendly clinic across the border.

In the world of scientific medicine, an individual result, good or bad, obtained from unknown or untested medications or therapies is called an *anecdote* – it is simply an individual's personal experience. An accumulation of anecdotes is called *testimonial evidence.* The validity of the anecdotal experience is not in question, but in order to consider the treatment good enough to recommend to the public at large a *scientific study* must be conducted. Basically, a group of individuals with a particular medical condition who are to receive an experimental treatment are compared with another group similar in every other way (age, sex, medical history, etc.) who will receive an inert substance, referred to as a placebo, instead of the experimental treatment. The selection of who is to receive the treatment (the treatment group) and who is not (the control group) is randomly determined and codified. Nobody knows who is getting what, and everybody is followed in exactly the same manner. At a predetermined period of time the code is broken and the results tabulated. If the treatment under evaluation is to be considered effective there should be a statistically significant difference between the treatment and the control groups. Sometimes the beneficial results are so obvious that the code is broken early.

The vexing problem in scientific investigations is that, for reasons that have yet to be explained, 20 – 30% of patients receiving placebo also get better. How come? Nobody really knows. Maybe they were going to get better anyway; maybe they got better just because they were under intense, regular medical scrutiny; maybe other concurrent, beneficial influences of a social, religious, spiritual or other nature played a role. The bottom line for these placebo-responders is that they got better. And such is the bottom line for the Laetrile folks and any other person who seeks help from those who provide alternative forms of therapy.

Alternative therapies, also known as complementary therapies, is the collective name given to a variety of unorthodox treatments that lack the usual medical-biological investigative requirements that underlie modern scientific medicine. Essentially, it includes all those coexisting medical approaches that were marginalized during the turn of the 20th century rise of allopathy – homeopathy, naturopathy, chiropractic, Chinese and Hindu medicines (see Part 1, *ATA Medical Division Newsletter* Vol-

Continued on next page

Who cares? continued from p. 10

ume I, Issue I), plus a wide range of therapies such as therapeutic massage, aromatherapy, hypnosis, reflexology, meditation, herbs, yoga, and a host of others. A striking discovery, published in 1993 (Eisenberg, D. *et al.* Unconventional Medicine in the United States: Prevalence, Cost and Patterns of Use. *N Engl J Med* 1993;328:246-252), was that the number of visits to these alternative therapists (425 million) was greater than the number of visits to orthodox primary care physicians (388 million) for the same or similar complaints – at an expense of nearly $14 million, paid entirely out of pocket since services by these practitioners are not covered by medical insurance. It is obvious that patients do not share the negative view of the medical orthodoxy. It must also be noted that these alternative clients also continue to visit their regular orthodox physicians without necessarily disclosing the fact that they have tried alternative therapies. In contrast to the tension that prevails in the USA between orthodoxy and alternativism, the two approaches coexist harmoniously throughout western Europe. Homeopathy flourishes in England, where it is covered by the British National Health Service and the royal family has its own group of alternativists "in house."

It seems paradoxical that we have the most modern medicine and the greatest technological advances, yet an increasing number of patients, to be called "clients" or "consumers," move away from the technological glitz, the tests or the high-powered medications in search of alternative offerings.

What does the alternative world offer that allopathy doesn't? Well, for one, lower costs: dissatisfaction with the escalating cost of allopathic care is not difficult to understand at a time when patients are asked to share higher and higher portions of the burden. Generally speaking, physicians are not aware of the costs of care: they simply order, as they have always done, what they honestly believe is medically necessary. This is particularly apt to remain unchanged, or get worse, as long as the catastrophic cloud of malpractice continues to loom over their heads. Right behind costs is the fact that therapeutic results often leave much to be desired. Several wars have not been won – cancer, CV diseases, addictions – we seem to march along without a solid victory from our side. Intrahospital mortality due to adverse drug effects has reached startling levels. The return of infectious agents previously eradicated, such as TB, is a most serious concern. The management of pain is still a controversial issue and, lastly, the approach to the end of life has created national debates. A new medical specialty has been created – palliative medicine – which deals with the complex medico-legal issues attendant to our final days.

In addition, the physician-patient relationship, the sacrosanct centerpiece of medical practice (as was mentioned in Part 1), has suffered significantly. It has become, many say, a frustrating "flash encounter" that centers on the disease or the symptoms with little or no time or desire for explanations or inclusion of the patient's viewpoint in the treatment plan. The Internet has become an electronic lifesaver, providing educational materials, directories, informational bulletins from nationally known medical centers, support groups, lists of centers conducting studies open to new participants, access to databases (in a variety of languages) – all of this at no cost.

Besides the patients who seek these sources of alternative care, a high-powered segment of the allopathic medical community understands and supports a complementary, holistic mix of ranks. The leadership of this pacesetting group comes from the allopathic bastion of American medicine, Harvard University. Harvard has endowed the first Mind-Body Institute chair, which is currently held by Dr. Robert Benson, a research cardiologist and renowned author who wrote the best-selling book (and coined the term) *The Relaxation Response*. Also from Harvard, Dr. David Eisenberg directs a center for alternative medical studies and research

Continued on next page

Who cares? ***continued from p. 11***

at Boston's distinguished Beth Israel Hospital. Following suit, Stanford University exposes medical students to alternative methodologies. Cornell, Yale, Duke, Georgetown, Columbia-Presbyterian and Arizona State University also participate in this body-mind holistic thinking. Holistic physician-authors Bernie Siegel, David Spiegel, Mark Ebstein, Dean Ornish and Andrew Weil have the credentials and the actual experience necessary to lead this allopathic-alternative integration.

Next issue: Allopathic-alternative integration in the US.

Medical Translation Research

Lydia Stone, Editor of SlavFile (newsletter of the Slavic Languages Division)

I am looking for someone (or possibly two someones) to participate with me in a brainstorming session at the next ATA conference to generate ideas for medical translation research. I am a literary and technical translator (specializing in medicine) of Russian; in a previous life I was an experimental psychologist and even taught statistics and experimental design. I also teach ESL and am heavily involved in the new immigrant community since we frequently have students living with us in exchange for Spanish lessons.

I have become more and more interested in the idea of objective research on medical terminology, I guess a subspecies of both psycholinguistic and cross cultural research. The first topic I would like to research is objectively validated equivalents for terms describing pain (e.g., Is very painful really the equivalent to muy doloroso to a Mexican and/or Peruvian, or would some other term be better?), I know exactly how to design the experiment to do this, but do not have a source of subjects or wonderful ideas about obtaining funding. Hence the panel in Phoenix: I hope it will generate ideas for research topics (actual needed topics for cross-cultural medical terminological research), sources of subjects, and, last but not least, sources of funding. I am looking for someone to moderate this panel with me, preferably someone with complementary experience and skills—for example, a Spanish interpreter working in a hospital. Any takers? If you wish to write/speak to me directly I am at lydiastone@compuserve.com or (703)768-5441 (eastern time). Additionally, if you are not planning on attending the conference but have some ideas on this topic, please send them

Another idea a student and I have had is to develop a Handbook of Medical Terms for non-English-speaking baby-sitters. A large number of our women students work as nannies and, even in the advanced ESL class, are likely not to know the meaning of such phrases as: fussy, fretful, listless, diaper rash, tugging at the ear, flushed, etc., even after they have worked at this job for a while. We were thinking of starting with Spanish and Russian and then expanding to other languages. However, we have not yet gotten this one off the ground. Anyone interested in working on this?

Pharmaceutical Dosage Forms and Delivery Systems: The How, What and Why

by Michèle Hansen

"Brain 'Viagra' Could Boost Memory"

"Amazing Once-a-Year Shot Can Mend Brittle Bones"

"Easy Spray May be Quick Rx for PMS"

We've all seen headlines like these. Pharmaceutical companies have drugs in their pipelines that will cure cancer, prevent Alzheimer's disease and make us slimmer. Often these articles contain a caveat that the miracle drug in question has only been tested in, say, mice. We're left with the impression that as soon as the researchers figure out if the drug works the same way in people, we're on our way to being cancer-free, sharp as tacks and ready for the beach. What many people forget, however, is that all these mice aren't popping miniature pills with their meals. No, they're receiving injections, something humans prefer to avoid. Transforming an injectable solution into an easy-to-swallow tablet, it turns out, is no easy feat. Even if it were, just as one size rarely fits all, one dosage form or route of administration does not fit all patient populations or disease states. This is where the science of drug formulation comes into play.

Michèle A. Hansen is an ATA-accredited (French > English) freelance translator specializing in medical, pharmaceutical, and intellectual property translation. She earned a degree in French and Chinese from the University of Wisconsin-Madison, and holds a Certificate in Medical Writing and Editing from the University of Chicago Graham School. She is a member of both the American Medical Writers Association and the European Medical Writers Association, and is working towards a certificate in pharmaceutical writing from the former organization. She is currently the administrator of ATA's French Language Division.

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Why, part I

The **active ingredient** (or active pharmaceutical ingredient, **API**) of a drug product is incorporated with other substances – such as fillers, binders, lubricants, stabilizers and disintegrating agents – into various formulations for a variety of reasons. For many drugs today, the amount of active ingredient is quite small, on the order of 5 to 20 milligrams. Most people don't have high precision scales at home, and it is no mean feat to eyeball 5 mg of powder correctly. Some drugs react or degrade in the presence of light or water, while others have offensive tastes or odors that must be masked. Drugs must be fairly portable; patient compliance would be quite low if we were required to pick up our prescriptions at a pharmaceutical plant! The list goes on, but the point is clear: some sort of vehicle is needed to get the correct dose of

Continued on next page

Pharmaceutical Dosage ... ***continued from p. 13***

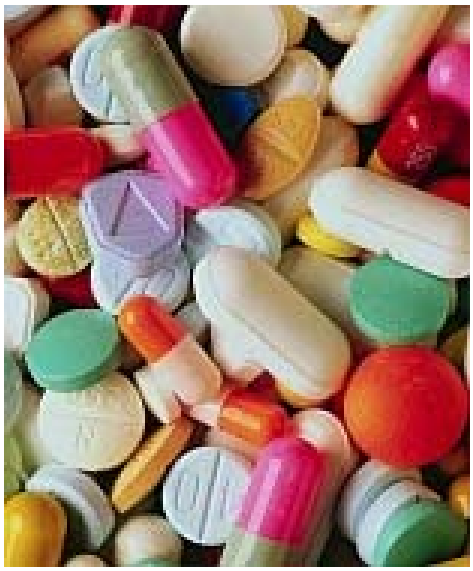
drug into a person's body.

How, part I

Drugs are delivered to the body via **routes of administration** using different **delivery systems**. There is no hard-and-fast rule for categorizing these routes; often they are grouped as follows:

- Parenteral (intravenous (IV) bolus, IV infusion, intramuscular (IM) injection, subcutaneous (SC) injection)
- Enteral (buccal or sublingual (SL), oral (PO), rectal (PR))
- Transdermal
- Inhalation

Each of these routes has advantages and disadvantages, which we will consider later.



What

The route of administration determines the **dosage form** (and vice versa), typically but not formally categorized as:

- Solids (powders and granules, capsules and tablets)
- Semi-solids (ointments, creams, gels)
- Liquids (solutions, suspensions, emulsions)

Why and How, part II

Many factors determine a drug's final dosage form and route of administration: its absorption characteristics, bioavailability, solubility, stability, half-life and particle size, to name a few. Marketing and psychological factors have an influence as well: as noted above, given their druthers, people would much rather pop a pill than give themselves an injection. The vast majority of drugs sold today are tablets and capsules. After all, they are convenient, easy to dose and identify, and more stable than liquids. However, they are not always appropriate and do have some drawbacks, as we'll see below.

Two things happen when you ingest a substance, be it lima beans or Lipitor™: (1) the substance acts on your body; and (2) your body acts on the substance. In the case of lima beans, they provide protein, fiber, iron and potassium to your body, and your body digests, metabolizes and excretes them. Simple enough – but not so simple in the case of Lipitor™ or other drugs. In pharma-speak, (1) above is called **pharmacodynamics (PD)** and (2) above is called **pharmacokinetics (PK)**. These two processes are significant factors in determining a drug's formulation.

The PD and PK profiles of a drug are evaluated early in the development phase, in **preformulation studies**. One important preformulation study is **bioavailability**. Bioavailability refers to the amount of active ingredient that is available to act on the disease condition after the drug has been subjected to natural processing and elimination (PK) by your body. For example, if you take a pill for arthritis whose active ingredient is destroyed

Continued on next page

Pharmaceutical Dosage ... *continued from p. 14*

by gastric juices it will not reach the desired site of action, and you will not feel better. Such a drug is called "poorly bioavailable." In the pharmaceutical industry, PK processes are broken down into four components and referred to as **ADME**, for **absorption**, **distribution**, **metabolism**, and **excretion**. [Note that the "E" of ADME does not stand for "elimination": metabolism is part of the process of elimination, so "elimination" refers to both the "M" and the "E" of ADME.]

Each ADME process can be a rate-limiting step in the delivery and availability of a drug, and thus a major factor in its formulation.

A: **Dissolution** is often a problem in *absorption*. If a drug does not dissolve at the absorption site, then it cannot become available to the body. Particle size and surface area are important factors here. Particles are often micronized to increase their surface area and thus the rate of dissolution, making them more bioavailable.

D: The *distribution* of a drug can be uneven and incomplete, depending on its characteristics. Some drugs bind with blood proteins and thus do not leave the circulatory system to reach the desired site of action. Others leave the system too quickly to be effective. Still others accumulate in the system and become toxic.

M: One issue in *metabolism* (also known as **biotransformation**) is the **first-pass effect**. When a drug passes into the liver it is metabolized, and some of the active ingredient is removed before the drug product continues on into the blood stream. If enough active ingredient is removed, the drug becomes ineffective. This is a common difficulty with oral delivery systems. Intravenous injection, on the other hand, delivers a drug directly to the circulatory system, bypassing the liver and the problem of first-pass elimination.

E: Two related concepts are key in *elimination:* the **half-life** (time in which half a substance is eliminated from the body) and **clearance** (rate of elimination from the body) of a drug. A drug with a short half-life and a high clearance value obviously requires more frequent dosing or – better yet – an extended-release dosage form. The kidneys are central to drug excretion, so many drugs are contraindicated for people with kidney diseases (ditto for liver ailments because of that organ's primary role in metabolism). Drugs that are excreted into the breast milk of lactating mothers will carry label warnings as well.

Given the above, we can draw up a chart of the pros and cons of various dosage forms and routes of administration:

Continued on next page

Route of Administration		Advantages	Disadvantages
Parenterals:	IV bolus, IV infusion	Complete absorption; immediate bioavailability; no first-pass effects	Difficult to self-administer; can be painful; increased chance of adverse reaction; bulky
	IM	Bioavailability can be slow (oil solutions) or fast (aqueous solutions)	Absorption rates vary depending on muscle used
	SC	Bioavailability is fast from aqueous solutions	Blood flow, injection volume affect absorption
Enterals:	Buccal / sublingual	No first-pass effects; rapid absorption	Drug may be swallowed; not appropriate for high doses
	Oral	Safe, easy, convenient; can be immediate-release or coated for modified-release	Possible uneven absorption; significant first-pass effects
	Rectal	Used for local and systemic effect; useful for patients who can't swallow	Possible uneven absorption; discomfort
Other:	Transdermal	Patches are easy to use; useful when slow absorption is desired	Many variables in skin permeability (condition, site, age)
	Inhalation	Rapid absorption	Particle size determines depth of penetration; some drug may be swallowed.

Now that we've looked at the how, what and why of drug dosage and delivery, we have a better understanding of why there is no "one route fits all." Dissolution, bioavailability, half-life and clearance all play a role in formulation. And these are just the PD and PK considerations! There are so many others: patient compliance, marketing, stability and sterility. Take manufacturing, for example, and you have a whole new set of issues. How do you get slippery particles to stick together? How do you package a substance that must be kept cool and dry, especially if it is to be shipped to a hot, wet climate? How do you ensure that the API is distributed evenly in a batch of drug product, or between batches? Once again, the list goes on and on… but we'll leave that for another day.

Letter from the Editor... *continued from p. 23*

Last but not least, we really need book reviews. Please take a second to pluck your favorite medical reference book off the shelf and send me a few lines about why you love it. I will then harass you for more detailed information in a follow-up e-mail to build up a review that conforms to our format. A big thanks to Marla for her editing help!

New Broker System Causes Setbacks for Medical Interpreters in the State of Washington

By Mario A. Flores

Mario A. Flores has 18 years of experience in the fields of translation and interpretation. He is an experienced Interpreter Trainer as well. As an Adjunct Instructor for The Cross Cultural Health Care Program, he has been teaching the Medical Interpretation Program "Bridging the Gap" throughout the United States since 1996. He also conducts court interpreter training sessions and has facilitated statewide workshops in telephonic interpreting for Washington's Administrative Office of the Courts, and routinely trains law enforcement and medical providers on working effectively with interpreters.

In 2003, Mr. Flores joined the National Project Advisory Committee established by the Office of Minority Health of the U.S. Department of Health and Human Services through the American Institutes for Research to set up National Standards for Healthcare Interpretation Services. He can be reached at Interpreters@aol.com.

Washington's Legislature passed Senate Bill 6832 during the 2002 session due to concerns regarding the escalating expenditures the Department of Social and Health Services (DSHS) was incurring in the provision of interpretation services for its Limited English Proficient (LEP) clients. Sponsored by Senators Brown, Winsley, Thibaudeau, Deccio and Franklin, the bill was signed into law by the Governor on March 27, 2002, directing DSHS to procure and deliver interpretation services by "means which it determines to be most cost-effective" and amending state law to allow interpretation services and interpreter brokerage services to be exempt from the statutes governing competitive procurement of non-client services. As a result, on January 1, 2003, DSHS launched a new system for scheduling oral interpretation services, turning that function over to nine regional brokers around the state effectively ending the competitive procurement process that had been conducted jointly by DSHS and the Department of General Administration.

The regional brokers, who already book transportation services for DSHS's Medical Assistance Administration and its Medicaid program, are paid a flat administrative fee per appointment based on their costs, while the interpreter agencies assigned to the appoint-

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New Broker System ... ***continued from p. 17***

ments are paid an hourly rate, capped at $28 per hour. DSHS is counting on the change to reduce their interpretation services costs and create a more competitive marketplace for interpreters.

Interpretation services at public hospitals and local health jurisdictions are not included in the new broker system. Washington is one of only a handful of states to access the Federal Financial Participation (FFP) Interpreting Program for Government and Public Facilities, known as Federal Match, that helps cover the cost of interpreting for LEP Medicaid patients while receiving Medicaid services at public facilities.

DSHS's rationale for switching from language agencies to the regional brokers is that they are "pure brokers without the conflict of interest involved in scheduling themselves to provide the service." According to Doug Porter, Assistant Secretary of the Medical Assistance Administration, "the change will benefit interpreters overall." Porter also said the change came about after the Legislature approved a challenging budget that set a savings goal for DSHS "of $8 million over the next year and a half" and that DSHS is planning to meet its first legislative savings target of $2.6 million for the first six months of 2003.

At a meeting DSHS held with stakeholders on October 28, 2002, the impression was given that the new brokerage system would undergo review six months from its launch before permanent implementation. However, Nora Guzman-Dyrseth, Interpreter Program Manager of the Medical Assistance Administration, affirms "the DSHS brokerage for interpreter services was implemented on a permanent basis [on] January 1, 2003." Still, Senator Rosa Franklin is circulating a flier to get feedback on the new system which states that if enough complaints are aired, the broker system will be terminated. Guzman-Dyrseth also adds that the feedback from stakeholders shows much improvement since implementation and that any issues, such as quality of interpretation services, are addressed "as quickly as possible."

There are approximately 180,000 LEP residents who are DSHS clients throughout the state who often require the services of an interpreter. DSHS is expected to spend $36 million this biennium on interpreter services, with about two-thirds of that expense for medical interpreters helping Medicaid providers. According to Porter, "the Legislature's clear signal is for providers to help us control these costs or be prepared to take them over." DSHS insists their payment for medical interpretation services is intended to supplement, not replace, medical providers' responsibility to overcome language barriers.

The new broker system requires that in order to arrange for an interpreter, a DSHS contract service provider (i.e., medical provider) or DSHS staff must contact one of the nine Language Interpreter Services brokers on the broker list to request an oral language interpreter for scheduled appointments. The interpreter services broker is responsible for making sure that interpreters used for DSHS clients are certified, qualified, or authorized by the DSHS Language Testing and Certification section to act as social services or medical interpreters.

Continued on next page

New Broker System ... ***continued from p. 18***

DSHS reimburses for interpretation services only when the request is placed by an appropriate "Requester," either a DSHS contract service provider or DSHS staff. Clients and interpreters are not considered Requesters. Additionally, arrangements for interpreter services must be made in advance of the scheduled appointment time. The brokers are required to respond to all requests within 48 hours, confirming whether or not the interpreter appointment can be filled.

DSHS does not reimburse for interpretation services when the interpreter was not scheduled by the broker in advance of the appointment time, nor do they reimburse for no-shows or cancellations: it is considered that when a client or medical provider no-shows, such cancelled appointments are a cost of doing business for the broker and its subcontractors. Brokers, brokers' subcontracted interpreter agencies, or individual interpreters are not allowed to bill DSHS or DSHS medical providers for the cost of no-shows or cancelled appointments. No reimbursement is provided for interpreter services for in-patients at public health agencies, public hospitals, and local health jurisdictions since they are the responsibility of the hospital and are not covered by DSHS. Mileage is reimbursed if the encounter is outside a 30-mile radius of the interpreter's place of business, home, or last appointment.

Interpreters are now being paid an average of $20 per hour (down 20% from $25), and are having to wait up to 90 days for reimbursement, although MAA says brokers are being paid within 60 days. Since most interpreters are freelancers who travel from place to place for appointments and pay both income and self-employment taxes, their earnings are effectively reduced to $8-10 per hour. DSHS aims to have the contract brokers create a more "efficient and competitive" marketplace and seek relationships with as many interpreters and agencies as possible, though brokers are currently being discouraged from contracting directly with interpreters. Contrary to DSHS's expectations, however, this confluence of factors has led to the disillusionment of many medical interpreters who have either opted not to accept any DSHS assignments or have left the field altogether. This, in turn, makes it more difficult for agencies to fill appointments and has led to the frustration of medical providers who find themselves without the tools to overcome language barriers.

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 our panel of three judges:

Nicole Paul

Francesca Samuel

and Rafael Rivera

at mdnewsletter@yahoo.com

by August 15, 2003.

Meet... Ginette César

interview by Naomi de Moraes

Ginette was born in Haiti and grew up in Haiti and the United States. She currently makes New York her home.

She has a BA in Spanish and French (with a minor in Italian) and took graduate classes in Spanish Language and Literature at the University of Seville, Spain, and at the University of Baeza, Spain. She also studied translation and interpretation techniques for two years at the Translation and Interpretation Institute in NYC.

Her plentiful language combinations are:

English, French <> Haitian Creole

English <>French

Haitian Creole, French, English>Spanish

She is an approved interpreter for the Office of Court Administration in New York and New Jersey, has a Lawyer's Assistant Certificate from Adelphi University in New York, and a Certificate in Vocational Educational Methods (teaching certificate) from NY State Association of Career Schools.

How long have you been working as a translator and interpreter?

15 years in translation and 10 years in interpretation.

Which do you enjoy more and why?

I have not decided yet. However, what I enjoy is the topic or passage being interpreted or translated, how much I can learn from it, and how precise my translation or interpretation can be.

Why did you decide to be a translator/interpreter?

Actually, I wanted to be a language and literature teacher. As I was taking language and literature classes in college, I became fascinated with the translation classes. Also, as a foreigner in the United States, I became very much aware of the fact that other foreigners were having difficulties adjusting to and understanding the US system because of the language barrier. When I was younger and attending school, just like many other children of foreigners, I had to accompany several friends of the family and relatives to places so that I could "tell them what is said." So, I think I received a lot of encouragement there.

What is the greatest challenge of your work?

To be able to convey the right idea, especially when I work in Haitian Creole.

Continued on next page

Meet...Ginette César ... *continued from p. 20*

What other work do you do that is related to languages?

I teach workers' education and business subjects (e.g., computer software; administrative, medical and dental secretarial and office administration subjects) and I am also a paralegal. In the law office, my skills are used constantly. As a workers' education instructor, especially when working with unionized employees, I often get assigned classes because of my language skills. This is mostly teaching computer and office skills to students with limited English proficiency. I really enjoy that because I get to incorporate some of my language knowledge.

What percentage of your work is medical?

About 22%.

What do you enjoy most about medical translating and interpreting?

Being able to convey life-saving and valuable information between two parties, one seeking help and one giving help, but both unable to communicate directly.

Do you do mostly hospital medical interpreting, or also conference medical interpreting?

I do mostly *telephonic* hospital medical interpreting and some on-site medical interpreting in doctors' offices.

What piece of advice would you give to new translators/interpreters who want to specialize in medicine?

Learn a lot of medical terminology and the different medical procedures. Learn to be as accurate as possible. Learn as much as possible about the different cultures and the medical customs or beliefs of the people who speak the language that they are interpreting. Try not to be emotionally involved, concerned or attached.

What are your favorite medical references/ resources, and why?

The Garnier Delamare *Dictionnaire des termes de médecine*, a French monolingual dictionary with a lexicon of pharmaceutical terms and an English <>French medical lexicon. It provides detailed and specific explanations about medical terms, in French. I use it in connection with the P. Lépine dictionary.

The *Dictionary of medical & biological terms* by P. Lépine (French <> English) This is a terminology dictionary, but no meaning is given. I use it in conjunction with the above dictionary.

The *Medical Encyclopedia - World Book Rush-Presbyterian-St. Luke's Medical Center* is a monolingual English medical encyclopedia where one can look up detailed and specific explanations about medical terms. It provides more insight into the meaning and specific use of a term.

For Haitian Creole, I use *Haitian Creole <> English Medical Dictionary* by Bryant C. Freeman. It has a very limited lexicon, but so far it is the only Haitian Creole medical dictionary, so I make use of it.

Kote ki pa gen doktè (Where there is no doctor), by Dr. David Werner. It is a book that has been translated into both Haitian Creole and Spanish (for Mexico) and medically adopted to both cultures. It is about primitive/alternative/local/ethnic medical practices in these

Continued on next page

Meet...Ginette César ... *continued from p. 21*

countries. It has a brief list of pharmaceutical and medical terms and a section on leaves or plants used for medicine. It is monolingual, in Haitian Creole.

Living in NY, you must interpret Spanish often. Do you try to interpret only for certain nationalities, or do you try to keep track of all the regionalisms?

I do not pick and choose. I try to keep track of regionalisms and ask natives, when necessary. I also watch telenovelas (Spanish soap operas) from different countries, and I listen to Spanish-language radio stations. Many regionalisms are used because the program announcers are from different countries. However, if I am asked to interpret for someone from a particular region in the countryside of a Spanish-speaking country, I decline, because they have ways of saying certain things that are particular to that part of the country.

Ginette and her son, Brian

Which language would you most like to learn, just because the language fascinates you? Hungarian and Cape Verdean Creole are on my list!

Swahili, Wolof and Fulani, because I believe they would probably help me better understand Haitian Creole grammar, and perhaps Chinese.

Have you considered literary translation, especially from Haitian Creole?

Yes, I have. As a matter of fact, I have translated some children's literature. Haitian literature is unique and is written in both French and Creole.

Letter from the Administrator ... *continued from p. 1*

ATA Conference this November in Phoenix, Arizona. This year's topic is tentatively set to be medical interpretation and translation, and we have a handful of interesting sessions planned. We will also be hosting our first MD reception, a delicious dessert and coffee buffet in the hotel, on the first night of the conference.

So, make your plans early to come to Phoenix, and until then, have a wonderful summer (or winter, for those in the southern hemisphere)!

The Medical Division of the American Translators Association

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

Letter from the Editor

Naomi J. Sutcliffe de Moraes

Dear Reader,

This, our second issue, has as many interesting articles as the first. Thanks to all who contributed. We still need your participation, though. Some issues that need to be covered are news related to medical translation and interpretation, client education methods, and training programs. All of these subjects are critical to our professional development.

Speaking of professional development, the Medical Division ListServ has been the site of many interesting discussions on the ATA accreditation continuing education requirements. What do you think? Some compared these requirements with those applied in health-related professions. I, however, find the education program offered by the American Medical Writers Association very interesting (see http://www.amwa.org/). I know many of our members are also members of this organization or a similar European organization and would like to hear from you. What do you think of their program? Should the ATA try to emulate some of their methods? Should Medical Division members consider joining one of these associations, too? Another possibility mentioned on the list was "colleague editing." I am fortunate in that all my work is edited by my partner, who works in the same language pair as I do, but in the opposite direction; but many of us work alone with almost no feedback. One member mentioned that having a few hours of concentrated editing by an esteemed colleague would do more to improve her skills than sitting through talks, and could be done without leaving the office.

Interviews! Who wants to be put on the spot? Please send us names and contact information for colleagues you would like to know more about.

Continued on page 16

American Translators Association's 44th Annual Conference

- Pointe South Mountain Resort - Phoenix, Arizona - November 5-8, 2003

Plan now to attend ATA's Annual Conference. Join your colleagues for a rewarding experience in Phoenix, Arizona.

ATA's 44th Annual Conference will feature:

· Over 150 educational sessions offering something for everyone;

· The Job Exchange where individuals promote their services and companies meet translators and interpreters;

· Over 50 exhibits featuring the latest publications, software, and services available;

· Opportunities to network with over 1,200 translators and interpreters from throughout the U.S. and around the world;

· and much more!

Preliminary information, along with the Registration Form, will be mailed in July to all ATA members. The conference rates are listed below. ***As always, ATA members receive significant discounts.***

Mark Your Calendar Today for November 5-8, 2003!