



The Newsletter of the ATA Medical Division

Volume I, Issue II

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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

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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 acquaintance, 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-

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Legalities of Unit Conversion

Jacopo Mádaro 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 of-

fer 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

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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 stan-

dard 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 exceptions¹ 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.

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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”

This is where the science of drug formulation comes into play.

Why, part I

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.

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

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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

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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:

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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
	Transdermal	Patches are easy to use; useful when slow absorption is desired	Many variables in skin permeability (condition, site, age)
Other:	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!



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.

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

By Mario A. Flores

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.

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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 free-lancers 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.

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

15 years in translation and 10 years in interpretation.

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.



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.

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.

What is the greatest challenge of your work?

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

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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

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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.

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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!