

Caduceus

Publication of the Medical Division of the American Translators Association



Summer is here!

Happy Summer to our members of the Medical Division! The time for sand, sun, fun, and sunblock. Also, Enterovirus, Norovirus, croup, sunburn, dehydration, and heat stroke. So, grab your favorite drink and get ready to enjoy a new issue of *Caduceus* under the shade. Here is a summary of the articles you will find in this issue of *Caduceus*.



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From the Administrator

Dear Colleagues,

Summer is here and we are getting ready for ATA 59 in New Orleans. Our Distinguished Speaker, Ms. Chineye Anako, will give a presentation on "***Caring for the Other: Diversity and Disparity***," on how the demand for health equity initiatives is expanding, how it is being used to mitigate public health crises and to elevate patient safety from a unique perspective, that of Language Access for All.

Again, thank you for all your support. It will be wonderful to meet you in NOLA and listen to all of your ideas. Our division dinner will be held on Thursday October 25, featuring delicious local cuisine, maybe with some Mardi Gras fun added as well. Feel free to contact any of our team members at divisionMD@atanet.org. Your participation at the conference and at the Medical and Interpreter Division Dinner is very important for us, I hope to see you all there.

I would like to personally thank all of you for the presentation proposals we received for the conference. I wish we could have included all of them. Also, a special note of gratitude to all our members who are actively posting on our forum and social media platforms like Facebook and *Caduceus*. Keeping an open and professional line of conversation makes us stronger, inclusive, and more representative.

I hope you enjoy our Summer newsletter!

Marisa Gillio, CMI-Spanish

Medical Division Administrator

Editorial

Happy Summer Medical Division Members!

We have great articles for you to enjoy! As usual, courtesy of great members. Maria Baker will tell us what the big deal is with Section 1557 of the Affordable Care Act (ACA), Flavia Lima will share with us why she loves the *Grande Dicionário Ilustrado Inglês-Português de Termos Odontológicos e de Especialidades Médicas*, and Justin Lee will open a door into the Deaf culture.

We have an interesting question, and response, on our ethics section "Dear Florence", written by Sean Normansell. "Eponyms and Other Stories" will be introducing us to the cause and symptoms of Canavan disease and Dr. Myrtelle Canavan who first described it.

If you enjoy *Caduceus* and would like to share your knowledge with our members, we love you already! Feel free to send us your articles, suggestions, and ideas (instructions on how to do so are on page 11).

Welcome to the new edition of *Caduceus*!

Best,

Gloria M. Rivera, CMI-Spanish, CHI-Spanish

Caduceus Editor

Insights into Deaf Culture

Flashing lights, hugs from strangers, pounding on tables, and more await those coming into the Deaf Cultural world. After all, how does one communicate with another who cannot hear? From the perspective of one who grew up in the "hearing" world, these cultural norms were anything but normal; yet they have become ingrained, almost second nature. Now these are my norms and are part of my world. My journey into Deaf culture started in elementary school while riding the school bus: a friend of mine named Francis allowed me into her world of American Sign Language. He taught me the manual alphabet and some basic conversational sign language, such as roller skates and "how are you?" Later, I volunteered at a camp for Deaf and hard of hearing children during the summers of my university career: I tutored students and helped them with their homework, and eventually, I became a certified interpreter.

As we all know, delving into a new culture can be jarring. Unsurprisingly, my experience was just that. Let me set the scene for you: An above- garage apartment and a brand-new roommate (who happens to be Deaf). I set my alarm to sound at 7am, then drift off to sleep— and the next thing I know, the floor is shaking and the lights are flashing. An ear- piercing alarm sounds. Panicking, I bolt out of bed, my mind racing, "Is there an earthquake?... No, this is Tennessee... Is there a tornado?... Why isn't Drew waking up?" I then realize that all of the noise is coming from his alarm, and he is sleeping through it! We expect others to behave similarly to ourselves and our

cultural upbringing. These are unwritten cultural rules, or cultural norms. Culture shock strikes when someone behaves dissimilarly or contrary to our expectations. One Deaf cultural norm that stands out to me is hugging: In the American Deaf culture, often times greeting or salutations include a hug or an embrace, at the very minimum a handshake is exchanged. This came as a shock to me because I am not a gregarious, touchy-feely type of person. Also, how does one get the attention of a Deaf or hard of hearing individual? Simply calling out a name obviously will not work. A simple tap on the shoulder or upper arm will work for those in close proximity; however, if you need the attention of someone across the room, what do you do? Some options include: Flashing the lights briefly, stomping on the floor, or simply walking across the room to grab their attention. Another important cultural tidbit: Eye contact is incredibly important. To an outsider it can be a bit unnerving, it almost feels like they are staring you down; however, direct eye contact is expected when someone is communicating with you, as this shows that you are fully engaged in the conversation. Breaking eye contact while in a conversation is akin to interrupting and stating that their conversation is not worth your time.

Living isolated by a majority of those who live around you, simply because of the mode of communication, can be very difficult. A majority of the Deaf and Hard of Hearing community in the United States communicates with a three-dimensional language known as American Sign Language, or ASL. ASL is a unique language that differs greatly from English. Not only does ASL differ from English linguistically, it also differs in modality. Instead of articulating phonemes with one's mouth, teeth, tongue, and throat, one articulates ASL with one's hands, fingers, face, and surrounding space. As such, an individual whose primary language is ASL may struggle reading and writing in English,

especially in complex situations such as recording a doctor's appointment. Also, the Deaf community shares a unique lexicon used to identify various individuals with whom they come in contact. Another unique feature of ASL and Deaf culture is direct or blunt speech. With a language as descriptive and visual as ASL, there is not room for flowery embellishments to spare feelings. A great example could be two friends who have not seen each other in a few years and one states to the other, "Man, you seemed to have really packed on some weight," which in the wonderfully descriptive visual ASL looks something like, "Wow! You were thin before, but now you have gained weight and are fat!" In American hearing culture, that is just plain rude; however, in Deaf culture this is a sign of respect. It is subtextual commenting to the friend, "Hey, I care enough about you to notice that you gained weight!"

With this in mind, members of the Deaf community refer to themselves as Deaf or Hard of Hearing. Members of this community often view the medical term "hearing impaired" as derisive. It places emphasis on the physical disability. As Dr. King Jordan, the seventh president of Gallaudet University, stated, "Deaf people can do anything hearing people can, except hear;" and the Deaf community proudly bears this as their motto. There are also special monikers for those in the Deaf community but are not deaf themselves. One of the most commonly used terms is CODA, or a child of Deaf adult(s). This is, used to refer to a hearing child of Deaf adults. These CODAs are often used to be interpreters at a very young age. CODAs are the true native ASL signers, because they are exposed to ASL from birth. You may have noticed the term "hearing" throughout the article. This term refers to those who can hear, and usually to the uninitiated of the Deaf community. It is similar to the Blind community referring to those who can see as "sighted". Speaking of the Blind community,

there is a sub-section of the Deaf community that is DeafBlind. Members of this community have varying degrees of a comorbidity of hearing loss and vision loss. The individuals DeafBlind may communicate in a variety of manners, ranging from tactile ASL, ProASL, Braille, tracking, etc. There is no one size fits all.

I would be remiss if I failed to mention and discuss the problems faced by the Deaf community. Members of this community, this culture, all share a common bond and a common frustration. With the passing of the Americans with Disabilities Act in 1990, providing access to individuals with disabilities, e.g., hearing loss, is mandated. Nonetheless, the members of the Deaf community still struggle to gain access in a variety of everyday situations. Things are improving, to be sure; however, common struggles arise daily. For example, many Deaf individuals who communicate mainly in ASL still struggle to obtain quality interpreters for everyday occurrences and situations: doctor's appointments, education, or even an emergency trip to the hospital. Often those in charge balk at hiring an interpreter. As mentioned previously interpreters that are hired frequently lack the proper skills to interpret effectively. An example of this: once I went to interpret in a mental health setting; the doctor came in and asked the patient how their headache was. The patient very emphatically stated that they had been trying to tell the doctor that they were hearing voices, not suffering from a headache. The doctor mentioned that the previous interpreter, who had just graduated from a two-year training program, had never mentioned that. In another setting, I arrived to replace another interpreter for a psychological evaluation. Thankfully, that interpreter realized that they were not skilled enough to interpret that; however, the very same interpreter told the ED staff that the patient, "...has no formal language and

only speaks gibberish..." Turns out that the patient actually communicates with another country's sign language and had no need for the evaluation; the other interpreter was not skilled enough to recognize the structure of language and 'diagnosed' the patient as dysfluent.

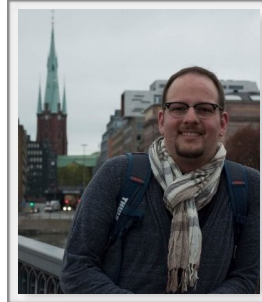
Unfortunately, these types of scenarios are not isolated events but happen daily. This leads to patients being misdiagnosed, given incorrect instructions for medicines, protective services being called, and worse.

Frequently, this unique community, this beautiful culture, is marginalized and even disregarded out of ignorance. The Deaf community has their own cultural norms, such as eye-contact, hugs, flashing lights, and direct or blunt speech. A dash of education and an attempt of understanding will go far to prevent misunderstandings and cultural shock. Always remember: when in doubt, ask. If you are unsure of the correct terminology or cultural protocol, ask. Assumptions about cultural norms and communication preferences often lead to frustration for all parties involved. Take a minute and refer to the resources below if you have any more questions, feel free to reach out to me for specific questions. If I do not know the answer, I will certainly find it for you. Smile.

Resources:

- Moore, Matthew S. For Hearing People Only. N.p.: Deaf Life, 2004. Print.
- "Effective Communication." ADA Requirements: Effective Communication. N.p., n.d. Web. 10 May 2017. <<https://www.ada.gov/effective-comm.htm>>.
- Gallaudet University, <www.gallaudet.edu>

- "Irving King Jordan." Deaf Is | Culture | Celebrities. N.p., n.d. Web. 10 May 2017. <<http://www.deafis.org/culture/celebrities/jordan.php>>.



Justin Lee is an interpreter with over 15 years of professional experience. He is an amateur linguist and aspirational polyglot. He currently works between ASL and English, holding the BEI Master Interpreter

certification and the National Interpreter Certification from the Registry of Interpreters for the Deaf. He loves to travel and experience the world through language, food, and culture. Currently, Justin has a passion for training and mentoring interpreters to raise the standard of quality to better serve those in need of interpreting services

So... What's the big deal with Section 1557 of ACA?

Few bills in recent years have evoked such heated debate as the Affordable Care Act. We have all heard numerous arguments for and against, along with their matching success or horror stories.

However, this act of Congress contains a section that we in the language industry can all get behind[1][2]: Section 1557, which prohibits discrimination of individuals on the basis of race, color, national origin, sex, age, or disability. This prohibition affects any healthcare program that receives federal financial assistance or that is

administered by a federal agency. Since the Civil Rights Act (1964), various implementing regulations, and even the US Supreme Court have established the inextricable correlation between national origin and limited English proficiency.

The wording in this section is quite simple: it resembles (or even quotes) previous legislation, including the Civil Rights Act. What is so special, then, about this new non-discrimination provision? We could list many things, but for linguists, the gold is not in the law itself but in its implementing rule, issued by the Department of Health and Human Services in July of 2016.

This implementing rule was published with a preamble that includes summaries of public comments received for each section and the changes the Office of Civil Rights made based on those comments and their research. This preamble is a great insight into the pressing concerns that providers, patients, and language professionals have when it comes to language access and how it should be provided.

In addition, the implementing rule includes a series of useful definitions. For example, a qualified translator is one who "(1) Adheres to generally accepted translator ethics principles, including client confidentiality; (2) has demonstrated proficiency in writing and understanding both written English and at least one other written non-English language; and (3) is able to translate effectively, accurately, and impartially to and from such language(s) and English, using any necessary specialized vocabulary, terminology and phraseology." A similar definition is given of a qualified interpreter. The qualifications that professional organizations had already included as professional standards of practice, and which federal and state governments had included in some legislation or non-enforceable guidance

documents, are now codified in a federal regulation.

Along these lines, the implementing rule also defines LEP patients, (both for LEP patients and for patients with disabilities), national origin, gender orientation, and myriad other terms. It also sets the standards for video remote interpreting (VRI) to meet the obligation to provide language assistance. Another very important advancement introduced in this regulation is the prohibition for minors or unqualified adults to act as interpreters, except in "emergencies". We've all heard the horror stories that have taken place when untrained interpreters are used. This prohibition had been hinted at in federal publications, but never before included in federal regulation.

Many of these definitions and mandates were already present—or at least implied—in other documents issued by the Department of Health and Human Services, the Department of Justice, and other agencies. The novelty is that this time, they have been codified into law. In other words, when healthcare providers use translators or interpreters that do not meet the qualifications, they are effectively discriminating against LEP patients. They can therefore be investigated through a Civil Rights claim—and even sued.

It is true that since the government change, the Affordable Care Act has undergone even stricter scrutiny, with a firm resolution to do away with it. The American Health Care Act, a bill that would repeal the Affordable Care Act, was passed by the House of Representatives in May. This and other repeal attempts have not prospered. None of them, however, included any reference to Section 1557. Those of us following the progress of legislation remain cautiously optimistic about this section and its implementing rule remaining in place, even if the health system is again changed.

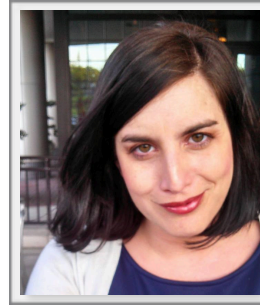
Are you a qualified interpreter or translator according to the law? Do the healthcare providers you work with have procedures to ensure their staff meet these qualifications? Reading the implementing rule is a great way to find out the answers to some important questions, to get acquainted with the concerns in our industry, and how the government has responded.

Although there are still challenges ahead, such as the effective enforcement of the implementing rule, its arrival signifies progress for language professionals whose presence is no longer optional. Section 1557 and its implementing rule are a gem within the Affordable Care Act, as they open windows of opportunity for linguists, and more importantly, contribute greatly to patient safety.

Resources:

1. Lau v. Nichols, 414 U.S. 573 (1974)
2. Department of Health and Human Services. Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons, Notice. 68 FR 47311 (August 8, 2003), pp. 47311-47323 Retrieved from <https://www.hhs.gov/civil-rights/for-individuals/special-topics/limited-english-proficiency/guidance-federal-financial-assistance-recipients-title-VI/index.html>. Accessed on 3/7/2018
3. Department of Health and Human Services. Nondiscrimination in Health Programs and Activities, Rule. 81 FR 31375 (May 18, 2016), pp. 31375-31473. Retrieved from https://www.federalregister.gov/documents/2016/05/18/2016-11458/nondiscrimination-in-health-programs-and-activities?utm_campaign=subscription+mailing+list&utm_medium=email&utm_source=federalregister.

[gov#footnote-153-p31410](#). Accessed on 3/7/2018



Maria Baker, CMI, CHI is a language instructor, medical interpreter, and translator. She obtained her B.A. in TESOL in Santa Fe, Argentina, and her M.A in Spanish and TESOL from West Virginia University. She has several

years of experience as a translator, and became an interpreter 4 years ago. While working as a staff interpreter, she mentored and oriented other interpreters through workshops about the interpreting profession. She is currently a freelance medical interpreter and translator, and a member of the IMIA Education Committee.

Grande Dicionário Ilustrado Inglês-Português de Termos Odontológicos e de Especialidades Médicas

Do you love the smell of printed books as much as I do? If you are a Portuguese/English interpreter and/or translator looking for a reliable dictionary with relevant terminology for the medical interpreting and translation profession, then this illustrated dictionary is for you.

The dictionary titled *Grande Dicionário Ilustrado Inglês-Português de Termos Odontológicos e de Especialidades Médicas* in its third edition and contains more than 23,000 entries, including terms, expressions, and more than 160 illustrations of medical devices. I purchased the third edition in June of last year and the third edition is very

promising: all entries have been revised and updated to reflect recent healthcare and dentistry technological innovations.

This is a masterpiece written by pioneers in the medical translation profession: Dr. Ana Julia Perrotti-Garcia, a dentist and PhD in English and literature who has been actively teaching translation and organizing translation conferences in São Paulo, and Dr. Sergio Jesus-Garcia, an otolaryngologist and her husband. Both authors are medical translators and have relevant experience in the medical field as well, a rarity in our profession and one more reason to love and trust this reliable resource

What do I love the most about this dictionary?

The dictionary offers simple definitions that can facilitate the linguist's understanding of any given term and are complemented by over 160 images and a wide variety of terms that can greatly benefit interpreters and translators who are dying to get an all-around resource. I also love the fact that it is an English-into-Portuguese piece since the majority of my work involves English as the source language.

How was the dictionary created? How did the dictionary come about?

The database was extracted from another dictionary, a shorter version, titled *Pequeno Dicionário de Termos Odontológicos e de Especialidades Médicas*. That version only had 12,000 entries, while the new expanded version has 23,000. More terms were added later from 50 different books and hundreds of medical chapters from scientific books from highly specialized publishing companies and translated books.

Certain software was used to gather all the corpora (concordances, aligners, and word lists) so that the most relevant medical terms could be extracted from and added to the dictionary.

Moreover, detailed explanations and cross-references were added to handle the false cognates, one of the biggest challenges for us, as well as polysemous and binomial terms.

And what's more? This dictionary is practical, relevant and above all, very reliable. And we love when something is already put in place and ready to go before we spend numerous hours working on our personal glossaries, don't we?



Flávia Lima is a freelance Portuguese interpreter and translator with experience in U.S. immigration, medical, legal, and conference interpreting. Originally from Rio de Janeiro, Brazil, she holds a Licentiate degree in

linguistics from Centro Universitário de Barra Mansa and a Graduate Certificate in Translation from Universidade Estácio de Sá and is attending the Glendon Master of Conference Interpreting program at York University. Ms. Lima also holds a Core CHI credential with the Certification Commission for Healthcare Interpreters and is a Registered State Court interpreter in Florida. She is the Assistant Administrator of the ATA Medical Division.

Dear Florence, Our Ethics Section

Dear Florence,

I am an independent interpreter located in Indian Village, Indiana. I keep having the same problem

with a patient at one of the local Cardiac Rehabilitation Clinics.

There is a patient who doesn't let me interpret. She keeps interrupting me. She said she doesn't trust me because she doesn't know who sent me. The insurance company? Her lawyer? It is very frustrating because I lose my train of thought, it is embarrassing, and a lot of the time it is when we are in the room with the provider.

What should I do?

Interrupted in Indiana

Dear Interrupted,

OK if they won't let you talk, it's kind of a choose-your-own adventure. The first time the obstacle presents is the crossroads. The choice to simply ignore the efforts of the LEP to derail the conversation is one option, (though a difficult path to tread as the individual would still be crowing on about whatever is in her mind, until one hopes she would get the point that she was being ignored.)

The confrontational option is, in the opinion of this author, the best choice. The interpreter is in charge of the encounter; responsible for the flow of conversation. The interpreter is the one who must ensure that they can hear everything clearly so that everyone in the encounter can hear their renditions clearly. As interrupting is the opposite of listening, the message will most certainly not be received if the LEP is in an adversarial and also distrustful position or state of mind. In all cases, the interpreter can look to the provider to codify the illusory one-on-one conversation they are having with the LEP by instructing their patient to allow the interpreter to facilitate the communication. When a patient says that they do not trust the interpreter, this utterance should simply be rendered in the target language as any other throughout the

course of the dialogue. Any response to such an outburst from the patient by the interpreter will disrupt this fomented dynamic, further reinforcing the idea that the patient and their perceptions, (however misguided) are valid and solicited.

Remember, each of us represents all of us, so your colleagues already appreciate you educating this individual as to how a professional interpreter maintains transparency.



Sean M. Normansell, CMI-Spanish is a native English speaker from Houston, Texas. He has extensive experience in the legal, medical and social services interpretation

fields. He has worked as an escort interpreter and as an onsite staff interpreter at hospitals in Atlanta, GA and Austin, TX. Sean is currently QA lead for a LSP, monitoring calls, while providing feedback and support to over 225 interpreters. He lives in NC with his wife and daughter.

Eponyms and Other Stories

Canavan Disease

Canavan disease is a rare inherited autosomal recessive condition. This disease is named after Dr. Myrtelle Canavan, who first described the disorder in 1931. This American physician and medical researcher was born in St. John's, Michigan, in 1879 and received her medical degree in 1905. She was a bacteriologist, pathologist, neuropathologist, acting director of the laboratories of the Boston

Psychopathic Hospital, and from 1920 until her retirement in 1945, curator of the Warren Anatomical Museum at Harvard Medical School.

Dr. Canavan's research focused on the effects of nervous system damage on the mind and body. She published 79 articles about bacteriology; and she also examined cases of sudden death, multiple sclerosis, and microscopic hemorrhage. In 1925 she published *Elmer Ernest Southard and His Parents: A Brain Study*, a report about her examination of the brains of her mentor and his parents.

She studied the pathology of diseases affecting the optic nerve, the spleen, the brain, and the spinal cord and examined cases of sudden death, multiple sclerosis, and of microscopic hemorrhage. Her most famous notable accomplishment came in 1931 when she published a paper she had co-written with a colleague that described the condition now known as "Canavan's Disease." The paper discussed the case of a young child who had died at only sixteen months of age, and whose brain had a soft, spongy section that had turned white. Canavan was the first to diagnose the disease pattern for of this degenerative disorder of the central nervous system.

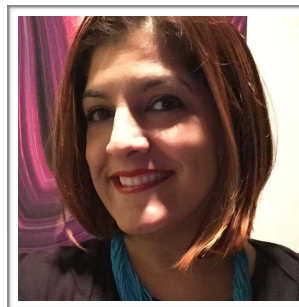
This progressive neurological degenerative disorder is caused by results from the absence of a vital enzyme known as aspartoacylase (ASPA). ASPA breaks N-acetylaspartate acid (NAA) into building blocks essential for building myelin. Myelin is a fatty membrane (also known as white matter) that forms a protective coating around each nerve, ensuring that the nerve functions properly. The disruption of the growth or growth or maintenance of the myelin sheath causes spongy changes in the brain that affects the ability of nerve cells in the brain to send and receive messages.

It is one of over 50 genetically inherited disorders known as Leukodystrophy Diseases. Infants affected by this disease may appear normal at

birth, but usually develop symptoms between 3 to -6 months of age. The typical symptoms are macrocephaly (abnormally large head), lack of head control, severely diminished muscle tone resulting in "floppiness," and delays in reaching developmental milestones such as independent sitting and walking. Most affected children develop life-threatening complications by 10 years of age. A cure for Canavan does not yet exist, but there are many strategies for managing life with Canavan disease.

Resources:

- <https://ghr.nlm.nih.gov/condition/canavan-disease>
- <https://rarediseases.org/rare-diseases/canavan-disease/>
- <https://www.ntsad.org/the-diseases/canavan>
- <http://jnnp.bmj.com/content/75/10/1410>
- https://cfmedicine.nlm.nih.gov/physicians/biography_54.html
- <http://www.whonamedit.com/doctor.cfm/438.html>
- <http://oasis.lib.harvard.edu/oasis/deliver/~med00067>
- https://en.wikipedia.org/wiki/Myrtelle_Canavan



Gloria M. Rivera is a physician and surgeon (U. San Martín de Porres, Perú) who holds a Professional Certificate of Translation and Interpretation (UCSD Extension). She has been working as a translator and

certified medical interpreter for the past 8 years. Currently, she is Core Faculty and develops teaching material at the National Center for Interpretation (U. Of Arizona). Gloria is the President of Blue Urpi and Caduceus Editor. She is the recipient of CHIA's 2018 Trainer of the Year Award.

Submission Guidelines

Share your knowledge with your fellow medical translators and interpreters. We are always looking for new, interesting, and educational content for our newsletter. Here are some of the ways you can contribute:

- **Articles:** 800 to 2,500 words. They can be educational, informative, etc.
- **Reviews:** 600 to 1,000 words. Could be reviews about books, conferences, you name it.
- **Letters:** 300 words. Dear Florence letters are about ethics and standards of practice in medical interpreting.

All submissions must be written in **English** and may include examples in other languages. Also, they should have a title, copyright notes, citations/references, and other observations, if applicable.

Contributing to Caduceus also brings benefits to our authors. ATA Certified Members can earn two (2) ATA Continued Education Points (CE) per published article (maximum of 8 points per reporting period). More information can be found at: https://www.atanet.org/certification/aboutcont_record_requirements.php Also, the Certification Commission for Healthcare Interpreters (CCHI) grants four (4) CE points (per year, maximum) per published article (for more information visit: <http://www.cchicertification.org/63-cchi/certifiedinterpreters/252-ce-topics-non-instructional>). In order to be awarded said CE points, the published articles must be related to medical translation and interpreting topics.

Please send all comments, questions, and submissions to: caduceusnewsletter@gmail.com

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