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Caduceus

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LETTER FROM OUR ADMINISTRATOR

Dear Medical Division Members,

The 2021 Spring is ending with some good news on Pandemic and the light at the end of tunnel is getting closer and feels more real. I understand that some countries, like the U.S., are ahead in vaccination and some others are far behind. Some, like India, are going through the worst outbreak and some others like Australia and Spain have been able to control the spread and open the borders to visitors and tourists. The reality is that Summer of 2021 is going to be a better summer for all of us compared to the last Summer. I am hearing from our members that their businesses are picking up and there is a hope of getting back to the normality that we had before. We invite you all to join our networking events if you ever want to hear from your colleagues around the globe. These events are not only give you access to the latest news in translation world but help you to find new friends, connections, and potential job opportunities. I highly recommend you join the next event and explore new options in your career.

Here we are proud to present another edition of Caduceus with some wonderful articles. I would like to thank the Caduceus team for their hard work to put together another edition of Medical Division newsletter with such extraordinary articles. I invite you all to read the articles from your colleagues and remember that you as well can write for us. Send your articles to DivisionMD@atanet.org and use this platform to share your knowledge and experience with your friends and also put your name out there!

As I always I like to report to you the latest news of your division;

- As of the next Caduceus edition, we will add a new column for our Medical interprets to write about their experiences through the Pandemic. We are hearing some heroic, shocking and sad stories from our dear medical interpreters that need to be published for the world to know what they have gone through. I highly encourage you to send your stories to DivisionMD@atanet.org and I promise you that I myself will also share my experience. You may find it sad but I think it is extremely important to raise awareness about the interpreters' mental health and discuss how their job affects their life, emotions and mental health.
- There will be an announcement on open positions in the Medical Division Leadership Council soon. If you are interested to join your division leadership and have the expertise and time to devote to this Council, look out for the announcement and send us and email
- The new Medical Division website is up and running, please check the new look at https://ata-md.org. Send your suggestions and resources that you think it will improve our site for a review to our webmaster Mery Molenaar at webmaster@ata-md.org.
- I would like to introduce Sara Baiz, our webinar coordinator and invite you to reach out to her at DivisionMD@atanet.org if you are interested in doing a webinar for ATA Medical Division or know a great speaker that you like to recommend. She will review your suggestions and if accepted will guide you through the process.

Lastly, I like to wish you all a great summer full of joy and health, please get vaccinated as soon as it is available in your country and stay safe. It is time to get excited and look forward to ATA 2021 Conference. Either you are planning to attend virtually or in person, it is exciting to get together once again.

Yasha Saebi

Pablo Mugüerza is an EN>SP medical translator with more than 35 years of translating experience, both in-house (McGraw-Hill) and as a freelancer (most of the time). He received his medical degree in 1987, and since then he has worked for the most important translation agencies in Spain and abroad, and for most major pharmaceutical companies and CROs. He is an external translator for the WHO in Geneva, Switzerland. He is one of the major authorities on translation of clinical trial protocols EN>ES, about which he has published a highly demanded handbook (the 2nd edition was released in March 2018). Since 2009, he has presented more than one hundred workshops, courses and conferences both in English and in Spanish, online and in many countries in Europe and in North and South America. For more details on his intense professional and network activity, please visit his website www.pablomuguerza.com.

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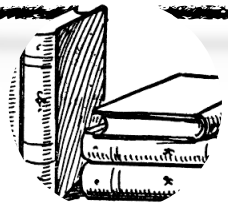
AFTER THE PANDEMIC – ENLIGHTENED OPTIMISM



And after the SARS-CoV-2 pandemic, what?

The point of view of enlightened optimism

"It was the best of times, it was the worst of times"

Charles Dickens: A Tale of Two Cities.

No other of Steven Pinker's important works is as necessary in these times as *Enlightenment now!* -the 2018 book in which the author takes up the concept of "enlightened optimism." These times, which seem like the worst of times -and are so for much of Humanity- are also the best of times for anyone who can contemplate them with perspective. Real scientific data, conveniently analyzed, allow the enlightened person to be reasonably optimistic in the face of this misfortune of the 21st century, which is not even the first -remember the Ebola epidemics in 2014 and Zika in 2015, to name a few.

Enlightened optimism comes to say that whoever has sufficient information and training will agree that any time in the past was worse, and, therefore, the future will always be better than everything we have known so far. All the advances in the dissemination of information, and those to come, especially thanks to social networks, place us in the best of times for the enlightened optimist.

No one says that contemplating current affairs from the perspective of enlightened optimism is easy or pleasant - the news from various countries around the world right now distresses and saddens us to the point of despair. But our despair will be of no use to the thousands of people, for example, in India, who will die in the coming days from the disease if international measures are not adopted, including, of course, putting an end to the incapacity of their rulers and to a

way of life that, characterized by crowds, tumultuous gathering and a peculiar sense of hygiene, was wonderful when there was no pandemic but has turned out to be lethal now.

The planet has reacted: isn't this great news? In just a few months mankind (while achieving other historic feats, such as sending a rover to Mars and flying a mini helicopter there) has been able to design and produce millions of doses of several different vaccines to tackle the problem and, in many countries, vaccination is progressing at a favorable pace. Science will save us; it is already saving us. Countries that have been able to care for and fund their scientists can breathe a sigh of relief, because the days of the nightmare may be numbered. Of course, these are rich countries, with the brilliant and exciting exception of Cuba. But some rich countries did also suffer from the ineffectiveness of some of their leaders.

A few days ago, the New York Times published the "recipe" of the Pfizer vaccine: *Girls and boys, do not try it at home*. It is enough to read such a summarized article to surrender to the capacity of the human being. Vaccines based on messenger RNA, together with the CRISPR technique and many other discoveries of this century will lead many countries to solve millenary problems. All this deployment coincides with an increase in awareness of the neediest countries. Although there is still a certain timidity (everyone has a lot of problems to help people in their own countries), the world is already reacting and preparing to help those most in need. The debate on the liberalization of vaccine patents is open. The Enlightenment of the 21st century allows us to be optimistic.

Outside the field of SARS-CoV-2, science does not cease to bring us joy. For example: if the results of the Fermilab experiment with the g-2 muon are confirmed, many of the predictions of the standard model of the anomalous magnetic moment of the muon (a large part of particle physics, as it were) will fall apart, but will consolidate those of other scientists who for years have been warning of these anomalies which, hopefully, could have the same cause and end up solving some of the most important pending problems of particle physics. In medicine, it is becoming more and more common every day to have breakfast with news like this one on May 3, 2021. If we keep ourselves well informed and drink from the right sources, we have no choice but to be optimistic.

As translators and interpreters, it is up to us to bring all these discoveries and the optimism inherent in them to the whole planet and in all languages: the challenge is fascinating and enormous. As usual, Cosnautas has taken a giant step forward and, for the translation from English into Spanish, has eliminated the terminology problem in one fell swoop with its free glossary on COVID, which it is polishing and perfecting as the months go by. For its part, the dictionary of medical terms of the Spanish Royal National Academy of Medicine (the RANME's DTM) has been available free of charge for months now, and sooner rather than later we will also have free access to the pan-Hispanic version, whose publication has been delayed by the pandemic.

Free of the outdated elitism that has characterized almost all the authorities in medical translation from English into Spanish, at least in Spain and in the last 20 years, our profession has a panoply of resources, free or very affordable -that all other specialties would like to have. There is still a long way to go on the road to the democratization of medical knowledge and knowledge in general, but the new generations already have tools and instruments that were

unimaginable until very recently and, more importantly, they will witness a revolution in the coming years with text mining and computational linguistics, "but that is another story and will have to be told on another occasion."

On the other hand, the fight against COVID by health professionals, whom we can never thank enough for their humanistic and selfless commitment to their work, has been egalitarian in almost every way (except economically, as I have already mentioned): the barriers of sex, race or religion have been broken down, at least in this field. It was necessary to respond with unanimity, and this has been achieved at least at the national level -not so much at the global level, what can we do?. In most developed countries, the order established by the authorities for vaccination is scrupulously respected. It is possible that in Spain, one of the least wealthy of the wealthy countries, 70% of its more than 47 million inhabitants will be vaccinated by the summer of 2021.

In a few months' time, we will be talking about COVID in the past tense. We will be back on the streets again and will soon be adapting to a new world in which we will apply what we are learning from so many mistakes of the recent past.

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MANAGING DYSTONIA

Aliya Bokash

Many people experience a brief piercing muscle contraction pain while swimming, jogging, or doing other physical activities. Usually, this kind of fatigue lasts for a few seconds, but is enough to cause agony or even panic. Now imagine a chronic condition that throws one's body in hours-long spasms twisting and dehydrating it several times per week or even per day. Most of the patients affected by this illness cannot talk, swallow, control their limbs, hold their heads up, remain still in sitting or lying positions let alone walking. As many as 250,000 Americans suffer from this rare neurological movement disorder known as dystonia. As a mother of an 11-year-old girl diagnosed with secondary early onset generalized dystonia-dyskinesia, I have gained some experience in developing an effective communication strategy to alleviate and manage the pain that dystonia inflicts on patients and their families.

Parents of non-verbal disabled children have to overcome tremendous daily difficulties **to understand** the needs, pain, and preferences of their loved ones. Another challenge is **explaining** to others, including medical professionals, the child's rare condition in a clear and succinct way, especially during emergencies. In this article, I am going to share efficient communication techniques, which my family and I have developed over the years, for the above mentioned two challenges.

Speaking to Her

Studying the facial expression of our dystonic child was a vital element in establishing a two-way communication with her; this led to timely recognizing the signs that indicate her basic choices and preferences. For instance, a silent smile means 'Yes,' laughing loudly or giggling - 'I'm excited,' a quick smile - 'I like it, but not now,' an emotionless look - 'Not interested,' and frowning - a firm 'No.' We started using an augmentative alternative communication device when our daughter turned five. It has been an extremely helpful instrument for her not only to express herself through eye control and tracking technology, but also receive necessary education.

'Reading' body movement has been another way for us to understand our daughter's condition and reaction. Contractions, twisting, stiffness, or floppiness have unique patterns signaling about her discomfort or excitement. Sometimes tooth pain or a favorite TV show might cause similar movements such as neck twisting; while fear, pain, or extreme weather conditions send her into involuntary full-body extension. Defining her state allows us to decide what she needs whether it is the right medication, a gentle massage to relax her muscles, or simply the right cartoon.

Monitoring our daughter's **breathing** has become an important task for us to instinctively perform 24/7; I have been on alert every night since she became ill. By the time, my ears learned to catch even a slight change in her breathing that tells me a lot: it might be mucus buildup after she eats her favorite ice cream, reaction to a medicine, or bad positioning. Unfortunately, due to weak esophagus muscles, dystonic children have both breathing and swallowing difficulties. That is why, in many cases, a gastro tube can be the only solution to providing a child's body with necessary nutrients without challenging airways.

A regular **body examination** might reveal so many unexpected answers to parents' questions about their dystonic child's unusual behavior or restlessness. Insect bites, accidental bruises, allergic reactions, diaper rash, or wrong positioning in a wheelchair and bed are often found as the main reasons causing discomfort. If this is a case, a non-verbal dystonic child's body speaks for itself asking a parent to perform a thorough check-up. Therefore, whenever my daughter starts extensively spitting or sticking out her tongue, I know that either she is bitten by mosquitos or something irritates her skin.

It would not be an exaggeration to say that by **supporting** our daughter's **emotional well-being**, we have built even stronger family ties. It is a blessing to see her happy face and "chatty" clever eyes thanking us for respecting her freedom of choice, offering morning, bedtime, and shower time rituals interwoven with role plays, cuddling, reading sessions with her elder sister, including family activities starting from cooking in the kitchen and ending with gardening in the backyard, regular group hugs, and family vacation trips. Her rare medical condition has transformed our world views, lifestyles, and careers, as well as helped us to increase our awareness about the lives of many other people with special needs.

Speaking on Her Behalf

By learning **medical** terms and acquiring additional **knowledge** about the diagnosis and medications of my daughter in several languages, I have been able to freely communicate with her doctors in Central Europe, the United Kingdom, and lately, the United States. It helped me to timely realize that in some post-Socialist countries "dystonia-dyskinesia" is not as well-studied as in the West. For instance, medical specialists in those countries can vaguely categorize many movement disorders as "cerebral palsy," while "dystonia" might refer to a heart disease.

A relevant "elevator speech" (I call it "**ER speech**") that I prepare for emergency cases has saved my daughter's life several times during hospitalization. I regularly update my ER speech including exact dates of her recent procedures, major events, and current medications to make it easy for my daughter's doctors and nurses to deal with her case. In some situations, I had to ask an ER doctor to check my child's CK level and mention that she might be entering a red zone of "*status dystonicus*" (life-threatening severe muscle contractions).

Having **realistic expectations** regarding our dystonic daughter's improvement has benefited us in many ways. We managed to set small goals prioritizing occupational therapy based on the Bobath approach to prevent the deformation of her body and develop muscle memory. Comparing our daughter to kids with the same condition, not to her healthy peers, has allowed us to see small but important improvements and appreciate medical professionals' work.

I would like to stress the importance of understanding the kernel concept of dealing with dystonia: there is no magic therapy, medicine, or surgery that leads to a complete recovery. It is all about managing the pain, slowly but steadily improving the life quality of a child without comparing it to one of able-bodied kids, celebrating even a tiny positive change, as well as staying optimistic and healthy (the most difficult part); and my story is only one way of doing so.

Silvia Villacampa is managing director for Liberty Language Services, a language services and interpreter training agency, with the largest pool of qualified and trained medical interpreters in the Washington, D.C. metropolitan area. Previously, she was a freelance medical interpreter in the Washington, D.C. metro area. Ms. Villacampa has over 20 years of experience using her bilingual English/Spanish skills at federal health information centers as well as with local and global health programs. She has a bachelor's degree in International Affairs from the University of Mary Washington and achieved national certification as a Certified Medical Interpreter in 2013. Ms. Villacampa serves as editor of The Beat, an interpreter professional development e-newsletter with over 2,000 subscribers. During the COVID-19 pandemic, she experienced firsthand the turbulence to language access services, local communities, and to the work of medical interpreters. She has had to navigate with her agency the new realities for on-site medical interpreting from PPE to vaccines.

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THE CURRENT NEED FOR IN-PERSON INTERPRETERS

In-person medical interpreters are needed now more than ever

The idea that on-site, face-to-face medical interpreters are being replaced or will eventually all be replaced by remote interpreters has not come to fruition even after a year into the COVID-19 pandemic. It has been shown that in-person interpreters are a necessity. And the demand for interpreters to work in person will not be going away. Furthermore, having to choose between remote and on-site interpreting is a false dilemma—medical interpreters are needed in all modalities—phone, video, and in-person, depending on criteria and circumstances.

I have been working with a language services and interpreter training company for almost ten years and will share my viewpoint and experience from the past 12 months. For some perspective, our company has made a name for itself largely on its consistently high-quality pool of on-site interpreters, mostly medical interpreters. We also provide remote interpreting services, both telephonic and video, and were prepared for an increased volume of remote interpreting as hospitals and other medical providers had to adapt to seeing patients via telemedicine visits over phone or video.

Some people have been surprised to hear when I tell them that our on-site work did not completely disappear and that on-site interpreters were still being requested in the first months of the pandemic. The volume of on-site assignments decreased at first and the volume of remote interpreting increased for much of the past year. Many formerly on-site only interpreters accepted being trained and making the switch to video remote interpreting. They had the

internet connection, appropriate device and physical space that allowed them to do this. This was of great benefit to all: to interpreters, who could continue to work with our company and be provided assignments; to our company so that we could continue to provide requested services; and to the hospitals and medical settings we serve so that they could continue to provide language services to their limited-English proficient (LEP) patients.

The desire and need for in-person interpreters is not simply wishful thinking or because a company wants to continue to enjoy business from that modality. Often, in-person interpreters offer the best possible solution for quality language interpretation. This modality generally increases patient satisfaction and clear communication—especially communication between a patient and provider that is more complex such as dealing with sensitive or difficult topics, diagnosis, discharge instructions, or complex care and treatment discussions.

The benefits and advantages of having an on-site, in-person interpreter are discussed in a study of interpreter perspectives and indicate that in-person interpretation is better for "establishing rapport and for facilitating clinician understanding of patients' social and cultural backgrounds."

Additionally, the mere presence of an in-person interpreter is powerful. The interpreter becomes the person in the room who not only ensures communication between parties, but also gives a voice to the LEP, can more readily check for understanding, meaning and also manage cultural issues and "bumps" if they arise. Remote interpreters also provide this voice. However, there are important differences due to the limitations of an interpreter appearing on a screen. The interpreter behind the screen has limited ability to view all body language, all participants, and the entire room. Other barriers to effective communication when a remote interpreter is provided include difficulty by all parties being able to use their devices, the app or program, and the "technology" not working for various reasons including poor connection or no connection, not to mention that not all individuals possess a smart phone or device.

Even before the COVID-19 pandemic, hospitals had protocols in place regarding when to use in-person versus remote interpreters. There is specific guidance on what types of medical encounters require an in-person interpreter versus a virtual or remote interpreter. These protocols continue to be in place and for in-person interpreters, now include personal protective equipment (PPE).

Remote interpreting alone will never be able to provide the quality and health equity that an in-person interpreter provides. Remote interpreting should not be considered a complete solution. Unfortunately, remote interpreting technology can have the effect of compounding already existing barriers to healthcare experienced by LEPs.

The COVID-19 pandemic forced a faster move to use the technology available for language services. This is generally seen as a good advance—the use of technology to bring together a provider, LEP and interpreter so that critical communication takes place. Except for whoever was left behind. How many LEPs were not reached or served in the past 12 months due to this forced change? Who was left behind due to technological requirements and other constraints for a

telemedicine visit? Remote interpreting only cannot be considered a complete solution as far as equal access is concerned.

There is a continued demand and need for on-site interpreters. Aspiring and already working interpreters can plan on returning to or continuing to work alongside frontline healthcare workers. Working on-site is an experience like no other and many interpreters prefer to work in medical settings in person. Those who train and mentor interpreters should continue to guide and advise new interpreters on how to work properly and effectively on-site with medical teams at hospitals and other medical settings.

Reference:

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