2024 SPRING

Caduceus

Medical division

Publication of the Medical Division of the American Translators Association

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1a

LETTER FROM OUR ADMINISTRATOR

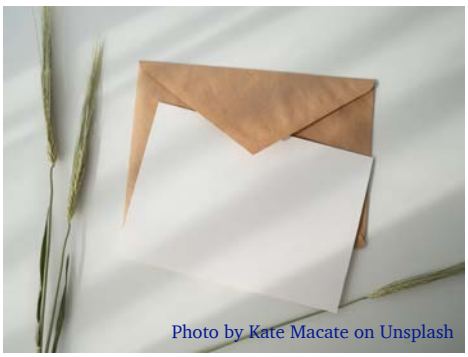
Dear Medical Division Members,

I hope you have had a very good start to 2024. Let me briefly introduce myself. My name is Paula, and I am the elected administrator for our division for the 2023-2025 term. I am originally from Argentina but have lived in Uruguay for five years. I am a medical translator specializing in clinical trials, health insurance, and employee benefits. I am also a subtitler. I have been involved in different roles within ATA's Medical Division for four years, and I am very proud of all the work the Medical Division Leadership Council has accomplished.

Looking forward, you can expect many instances of networking and learning this year. We already had a networking event in January and a MED Talk (our new free presentation series) on communicative autonomy by María Baker in February. We have also scheduled the next few networking events and MED Talks with experienced, knowledgeable speakers. Additionally, our webinar team is working to bring you some great medical-related ATA webinars this year. We will always let you know about these events by email and through our social media channels (LinkedIn, Instagram, Facebook, and X), as well as our group email. For now, you can expect our next networking event on March 26, 2024. If you have never attended one of our networking events before, I recommend you give it a try. This is your chance to meet colleagues and discuss industry-related matters. You can also ask questions or help other members. There is always a friendly, positive environment at our networking events and attendees always enjoy them. You can expect our next MED Talk in April. Speaking of which, if you would like to give a free MED Talk, contact me with your proposal!

I think it would be nice for you to know who is behind the Medical Division. Therefore, during the next few weeks, we will be sharing on social media who are our Leadership Council members and what they do for the Medical Division so you can get to know them a little bit more.

Lastly, I would like to thank you for being members of our division. I am honored to serve as the administrator, and I would love to hear from you with any suggestions or ideas of what you would like to see from the Medical Division. You can contact me at divisionMD@atanet.org.



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I hope you enjoy our spring newsletter!
Sincerely,

~María Paula Plazas

1b

LETTER FROM THE EDITOR IN CHIEF

Welcome to the spring issue of *Caduceus*.

Healthcare and medical interpreting involves complex topics and settings. Challenges of all types abound. This issue features two articles presenting two important challenges in medical interpreting: remote interpreting and healthcare literacy.

Dr. Esther de Boe presents strategies to navigate the challenges found when interpreting in remote healthcare settings, based on her empirical research findings on this topic. Dr. Gloria Rivera presents the challenges of low healthcare literacy in the U.S. limited-English proficient (LEP) population, especially among minority groups such as Hispanic Americans, and how it affects the interpretation encounter for both the patient and English-speaking provider. Dr. Rivera's article makes an appeal for education about the role of healthcare literacy in medical interpreting not just for the interpreter, but for all involved, including the healthcare providers and interpretation agencies.

I hope the articles presented inspire ideas and strategies for the ongoing and ever-present challenges. Whether you are a healthcare provider to limited-English proficient patients and families, an interpreter, or have a corresponding responsibility at a language services company providing interpretation services, all of us have a role in recognizing the challenges and implementing solutions to address them in our day-to-day work.

Last year was the Medical Division's 20th anniversary, and we were fortunate enough to reach out to past administrators and ask them to share their thoughts about their experiences through interview questions. We have a few more interviews to share with you in this issue. One is with Jorge Ungo, who was a founding administrator. Another is with Maria Paula Plazas, who completed two years as assistant administrator and is now the division's current administrator. Sara Greenlee also provided some words in response to some of the interview questions. And we also interviewed the most recent past administrator, Yasha Saebi.

During the next few months, there will be several events and conferences related to medical and healthcare interpreting. Medical Division Leadership Council members will be reporting back on these events in the next issue, so look out for that so we can compare notes.

Happy end of winter and welcome spring in the Northern Hemisphere.

And, speaking of astronomical topics, I plan to attend the 2nd National Healthcare Interpreter Certification Summit, April 6th in Houston, Texas. Hope to see some of you there. I look forward to this important gathering and the learning opportunities surrounding the 15th anniversary of the CHI credential. After the summit, I plan to visit other parts of Texas and, if possible, experience the total solar eclipse on April 8th.

~ Silvia Villacampa

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REMOTE HEALTHCARE INTERPRETING: CHALLENGES & STRATEGIES

DR. ESTHER DE BOE

Dr. Esther de Boe is a research fellow at the University of Antwerp, Belgium. She has a keen interest in the application of technology in interpreting and has published and edited several works that investigate remote interpreting in healthcare settings. Her recent co-edited volume, *Interactional Dynamics in Remote Interpreting: Micro-analytical Approaches* (Routledge, 2024), examines how remote interpreting impacts on communication dynamics. Before starting her academic career, Esther de Boe worked as a sworn interpreter in the Netherlands.

The rising diversity and multilingual nature of our societies create a great need for language mediation (Tipton & Furmanek, 2016) that can simply not be fulfilled with onsite interpreting services only (González Rodríguez & Spinolo, 2017, p. 242). Healthcare interpreters, professionals and patients are therefore increasingly confronted with remote interpreting by telephone and video link. In some European countries, such as the Netherlands, the number of interpreting services performed by telephone nowadays greatly surpasses on-site interpreting in healthcare.

Yet, among interpreters and healthcare professionals, remote interpreting has never been undisputed, and researchers also argue that it is not simply a technical solution but "a complex social practice" (Braun, 2018, p. 416). Whereas studies carried out by medical scientists often paint a rather favorable picture of remote interpreting in terms of patient satisfaction and cost-effectiveness (Pöchhacker, 2006), studies from a communications perspective, such as interpreting studies, point towards several negative side effects associated with this modality. These range from interpreters' working conditions, including ergonomics and remuneration (Alley, 2012) to emotional and social aspects of the interpreter's virtual presence instead of physical (Skinner et al., 2018), and rapport-building between participants (De Boe, 2020). Research has established a link between cognitive and linguistic issues: the lack of (full) visual access may lead to cognitive overload, inducing fatigue and a potential decline in interpreting quality, such as the omission of content (Braun, 2006).

Recent studies on remote healthcare interpreting by Hansen (2020), Hansen and Svennevig (2021), and myself (De Boe, 2020-2024) demonstrate how mediation by technology shapes the communication processes at work in healthcare interpreting. This is important since, as Dr. Elaine Hsieh rightly put forward in the previous *Caduceus Newsletter* (Fall 2023, p. 11), "in interpreter-mediated encounters, the communication process can be an essential indicator of the quality of care."

In the next segment, I will discuss how remote interpreting may pose challenges to effective communication processes in healthcare, particularly those related to coordination of the interaction. I will also discuss strategies that can be put into use to navigate through these challenges, based on my empirical research findings on this topic.

How technology shapes communication

Many of the communication challenges posed by remote interpreting can be traced back to technology. Some of these are obviously very direct: any person who has experience with telephone and video calling has inevitably also come across issues with connectivity, inferior sound quality, and glitches.

In remote interpreting, the occurrence of technical issues may lead to an increased need for coordination, which is often carried out by the interpreter. However, the use of technology also has less direct effects that may equally hamper effective communication. To analyze these, we first must look into how communication in conversations is organized, as outlined by conversation analysts such as Sacks et al. (1974) and first applied to dialogue interpreting by Wadensjö (1998) and Roy (2000), who studied how mutual understanding is established interactionally and determined by the sociocultural context.

Interpreting as a multimodal turn-taking process

When we enter a dialogue with another person – or in a trialogue, as is the case in interpreter-mediated events, we alternate turns in talking with our co-participants. Turn-by-turn, we swap places between being a listener and a speaker, with the interpreter in the middle relaying the messages. In this process, conversational partners give each other signals expressing their intentions: a person speaking at a certain moment may indicate that they have finished their turn by making this verbally explicit, for example, by asking a question, and/or nonverbally, by gazing at the next speaker. On the contrary, they may also express the wish to continue the turn by deliberately avoiding eye contact, hesitating, prolonging the pronunciation of a word, and so on.

The fact that we combine different verbal and nonverbal modalities or resources in our communication is also referred to as multimodality (e.g., Mondada, 2016; Stivers & Sidnell, 2005). Resources are "meaningful facial expressions, gestures, body postures, head movements, words, grammatical constructions, and prosodic contours" (Stivers & Sidnell, 2005, p. 2). In addition, finding the right moment to take or yield a turn is also essential in smooth turn transitions. By providing each other the right signals at the right moment and by

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monitoring these, we attempt to minimize pauses in between our turns and avoid talking at the same time.

Whereas this close cooperation in turn alignment is already a complex multimodal process in non-mediated communication, in interpreting, it becomes even more intricate since the interpreter is in the middle of the exchanges. They must continuously monitor the primary participants' signals in order to achieve smooth transitions from one speaker to the next (Davitti, 2019).

Next, I will discuss how this becomes relevant to remote interpreting by looking into some of the technical characteristics of the different configurations and their impact on communication.

Limited view

As Due and Licoppe (2021, p. 6) argue, how participants can respond to each other depends on the affordances and constraints of the communication medium they use. An important feature of remote interpreting is the limited or lacking view of each other and the impossibility of establishing direct eye contact. Next to that, in video-mediated interpreting, the view that participants have of each other is reduced to the size of a computer screen, showing only the participant's head and upper part of the body. In addition, mutual eye contact between participants is impossible, since we tend to look at the screen while talking and listening, and not at the webcam. At the same time, the medium does create an "illusion of mutual gaze" (Bohannon et al., 2012, p. 3). All of this renders the use of gaze less efficient as a means of handing over the turn and may result in several people talking at the same time. Overlapping talk can become particularly disturbing in video-mediated interpreting, since it can cause a disruption in sound quality and render a part of what has been said inaudible to the other side (De Boe, 2021, 2024).

In telephone interpreting, obviously, there is no image at all. Here, the lack of view creates longer pauses in between the turns, since participants seem to want to make sure that another person's turn is finished before starting a new one. Another inconvenience is that, when a turn by the health care provider or patient is becoming very long (and therefore more cognitively demanding for the interpreter), the interpreter cannot make any visible signals to indicate their willingness to start interpreting. The longer duration of the pauses in between turns and the increased turn-length also lead to a greater dissatisfaction among the participants, who often feel detached from the communication when the language they do not understand is spoken.

Delay

According to Pöchhacker (2016, p. 149), the visual access provided by video-mediated interpreting does promote better coordination compared with telephone interpreting, but also leads to additional issues. For example, even with highly sophisticated equipment, a delay in the transfer of sound and image is inherent in video conferencing technology. This makes a precise timing of responses difficult, and non-verbal or paralinguistic signs such as breathing in, saying "uhm" or taking a short pause become less effective to indicate a listener's wish to start speaking (Hansen, 2020; Hansen & Svennevig, 2021).

Especially when combined with direct technical issues such as compromised sound quality, delay may lead to communication breakdown and difficulties to repair this. For example, in my research on video remote interpreting, the direct verbal and nonverbal reactions between the healthcare provider and the patient, such as mutual laughter, disturbed the sound quality on the side of the interpreter, causing misunderstanding that took some time to be resolved because of the delay between the two locations. At the same time, the healthcare provider and the patient seemed hardly aware of the effect of their exchanges, as they themselves were not troubled by the sound quality.

Participant distribution

The situation described above is also linked to the distribution of the participants: both in video remote interpreting and telephone interpreting, the healthcare provider and the patient are physically together in a location, for example, in a hospital, whereas the interpreter joins in from a remote location. This implies that the two primary participants have full access to each other's multimodal behavior, while the interpreter is at a disadvantaged position, since they have only limited access to the other participants' multimodal resources (Spinolo et al., 2018). It happens that mutual understanding between healthcare provider and patient has already been established by simple head nods or other ways of showing agreement, while the interpreter has no way of monitoring this and may lag behind.

A threat to efficient communication?

The extent to which these technology-induced challenges actually become a threat to effective communication depends on a number of factors, an important one being the participants' behavior in the interaction. As Pittarello (2012) points out, the ways in which participants organize interaction in terms of turn-taking and communication exchanges contribute to the success or failure of the interaction. The same way that the various clinical contexts require different interpreting strategies (Hsieh, 2023), the different configurations for remote interpreting require adaptation of communicative responses.

However, it is not simply the interpreter who needs to be more flexible, coordinative, proactive, and assertive. All participants need to cooperate and become more aware of the responsibilities they carry in the communication process. This means that they not only have to adapt their behavior to the communication medium, but also to working with an interpreter in the first place. Some research (e.g., Pöchhacker & Klammer, 2024) even emphasizes the responsibility of service providers for communication management.

In remote interpreting, effective communication may be at risk when participants are not sufficiently aware of the particular constraints of the medium they use, or of the specific communication needs of the interpreter. As we have seen, the issues that arise are often linked to participants' behavior: when the health care provider and patient act too spontaneously, their talk or laughter may disturb the sound quality and have in impact on the coordination, or when they take extended turns to talk, the interpreter has more difficulties to intervene, so the risk of cognitive overload will increase. All of this will affect efficient communication.

Strategies at macro, meso and micro level

This brings us to some concrete strategies that can be employed at different levels. At a macro level, it is obvious that the improvement of technological conditions for remote interpreting and clear standards of practice would provide a more solid base for high-quality communication and care. Next to that, at the meso level, both interpreter and medical education should promote the interprofessional communication skills of their trainees and awareness for each other's communication needs. An important step at this level is taken by interpreting agencies that offer dedicated courses for practitioners and users of (remote) interpreting services. The outcomes at these levels will positively influence communication at the micro level, that is, the actual exchanges between healthcare provider, interpreter, and patient. This, in turn, will create more favorable working conditions for interpreters and contribute to better care.

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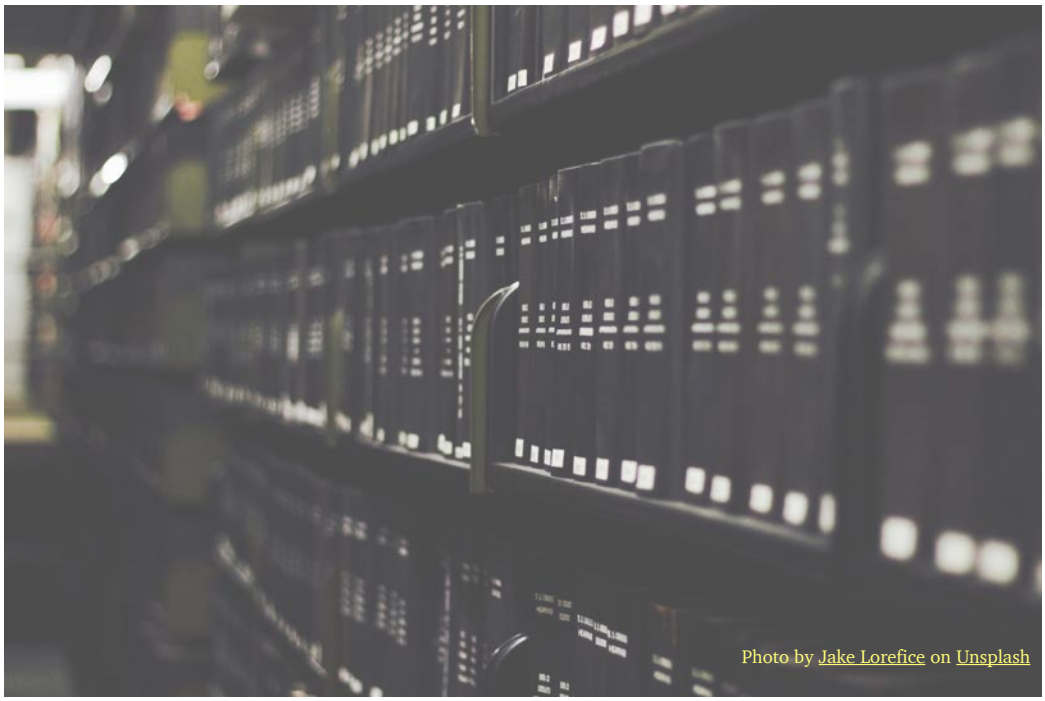

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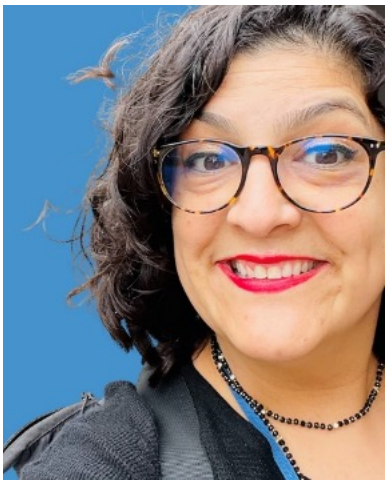
HEALTHCARE LITERACY IN INTERPRETING

DR. GLORIA RIVERA



Dr. Gloria Rivera is an English/Spanish translator, certified court interpreter in California, and medical interpreter with both CMI and CHI certifications. She is a physician who practiced medicine in her native Peru prior to moving to the U.S. She uses her medical background and experience as a translator and interpreter to develop and teach culturally competent webinars for Blue Urpi. You can also find her at www.facebook.com/groups/MedicalCrew a Facebook Group

I have been an English/Spanish interpreter for quite a long time but, to date, the most complex issues I have had to deal with are not related to medical terminology, but to cultural misunderstandings. I find these situations fascinating, as even though both the patient and the provider are deeply involved in this "cultural entanglement," neither of them is aware of the dance they are participating in.

Even if there is an interpreter facilitating the encounter and eliminating language discordance, the interaction between a patient and a provider can turn into a game of telephone if both are not familiar with their cultural and biomedical language differences. In my experience, this usually happens because both the patient and the provider come to this encounter with their own cultural expectations and assumptions. The English-speaking provider approaches the medical encounter expecting a Spanish-speaking patient who has an average level of healthcare literacy, enjoys medical insurance coverage, exercises patient autonomy, and has a good grasp of the US healthcare system.

One of the most important concepts I have learned and used with providers when noticing a "cultural entanglement" is healthcare literacy. The U.S. Department of Health and Human Services and the Institute of Medicine, define healthcare or medical literacy as the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make good health decisions. According to results from the 2003 National Assessment of Adult Literacy (NAAL), Hispanic adults had **the lowest average health literacy** among all racial/ethnic groups. But how does this look during an interpreting session?

A medicine resident asked a limited-English proficient (LEP) patient who came to the emergency department, to describe his pain. As most LEP patients, he was not familiar with pain descriptors, such as dull, tender, or achy, and replied "¿Dolor? Bueno, me duele, es un dolor… doloroso" [Pain? Well, it hurts, it is a painful pain]. In fact, another LEP patient with a UTI once replied to "Do you have any pain when you urinate?" with "No me duele. Me quema." [No, it does

not hurt, it burns]. The resident looked at me confused as, to her, burning was a type of pain, but to the patient it was a completely different symptom and not a pain descriptor.

Every time I interpret "on a scale from 1 to 10, with 10 being the worst possible pain, how do you rate your pain?" I know I will get a weird look because Latino patients are used to "me molesta, me duele un poco, me duele muchísimo" [experience discomfort, mild, moderate, and intense pain] to describe how intense their pain is. Some patients have said "No tengo dolor. Tengo una molestia." [I don't have pain. I have a discomfort]. When the provider explores when this discomfort started, it is after the patient got injured. Ever since I noticed this, I take "me molesta" [I have a discomfort] as 1-3 on the pain scale.

Fever and over-the-counter medication are another topic that baffles English-speaking providers. For example, a mother brought her child to the emergency department because "he had a fever for the past three days." When asked about how high the temperature was, the mother said that she "did not measure it because she did not have a thermometer." The mother just touched the child's forehead, and it was warm. To the question "Did you give him anything for the fever?" The mother gave him either Tylenol or ibuprofen just once, a couple of days prior, and complained about the medication not working as "la fiebre volvió" [the fever returned]. In other cases, mom gives the medication on the right schedule, but uses a dose for an 8 kg baby to a 23 kg child and complains of it not working.

Providers usually prescribe medications using generic names instead of brand names, as recommended. A Latino patient who was scheduled for a surgery was informed during the pre-surgical appointment to stop taking ibuprofen 10 days before his surgery. Unfortunately, the morning of the procedure, when asked if he took any over-the-counter medication, the patient said that he had taken Advil. The procedure was canceled since ibuprofen is discontinued before surgery to minimize the risk of bleeding. This lack of knowledge that ibuprofen is the active compound in Advil caused the delay of a much-needed treatment.

In all the examples mentioned previously, the commonality was that the provider seemed confused as the answer received from the LEP patient did not fit their cultural expectations. This is because most providers, whether American or foreign, trained in the U.S., are taught to interact with an American patient who owns a thermometer, knows the difference between dull and sharp pain, knows that ibuprofen is also Advil, that Tylenol should be administered every six hours, and that the dose is weight dependent.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These real-life examples of low healthcare literacy demonstrate the issues that may arise due to a provider's lack of familiarity with the LEP patient's culture. As interpreters, knowing the concept of healthcare literacy, and how it may negatively impact an encounter, helps us be better prepared to manage the flow of an exchange between a patient and provider. It also increases the patient's trust in the provider, treatment compliance, and patient satisfaction.

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20 YEARS OF ATA'S MEDICAL DIVISION (2020–2023): WORDS FROM OUR FORMER AND CURRENT ADMINISTRATORS

The Fall 2023 issue of *Caduceus* featured interviews with past administrators to mark the 20th anniversary of the establishment of the division. We continue with this issue with a few more interviews with both former and current administrators.

We hope you enjoy learning about the journeys of these individuals and are inspired by their dedication to the field of interpretation and translation, and their commitment to ATA.

Interview with Jorge U. Ungo

What was on your mind when you decided to join the team and be part of the creation of the Medical Division? What did you hope to share with members?

I remember being in a meeting room with a few dozen other people to discuss the creation of a medical division. There was a great deal of excitement but when it came time for volunteers, very few hands were raised. Being relatively new to the industry but with experience volunteering on other boards, I thought, "why not?" and went for it. I was excited to be a part of something from the very beginning and work with a new group of colleagues to get something new off the ground.

How has the Medical Division changed over the years as you moved through new responsibilities in your career?

I can't believe it's been 20 years since that first meeting! I am amazed to see how much the Medical Division has grown and have always been impressed with the content shared in *Caduceus*.

As you may know, the Spring 2023 issue of our newsletter included an article about dealing with stress. What does mental health mean to you?

To me, mental health is… health. I believe that our minds are capable of affecting us in so many ways, so mental health is incredibly important to maintaining our overall health.

What is the biggest challenge you have overcome in regard to your mental health?

Finding balance in life has been my biggest challenge. Being the type of person who dives into the deep end of anything, it does often lead to feeling overwhelmed. Learning to slow down, pace myself, and sometimes say "no," have been valuable lessons that have helped me make time for myself to breathe and regain energy.

For over two decades, Jorge U. Ungo (he/him) supported healthcare organizations in their efforts to deliver compassionate, culturally competent, and patient-centered care to their diverse patient population. During this time, he served as a board member on the National Council on Interpreting in Health Care (NCIHC), president of the Texas Association of Healthcare Interpreters and Translators (TAHIT) and a commissioner on the Certification Commission of Healthcare Interpreters (CCHI). In 2015, Jorge was recognized by the Texas Association of Healthcare Interpreters and Translators as the Texas Star in Language Access, and, in 2019, he was recognized by the National Council on Interpreting in Health Care as a Language Access Champion. Today, he serves as the language access advocate for CCHI. Born in El Salvador and raised in a bilingual, bicultural home in Texas, Jorge is passionate about uplifting marginalized communities and being a vocal ally for the underserved.

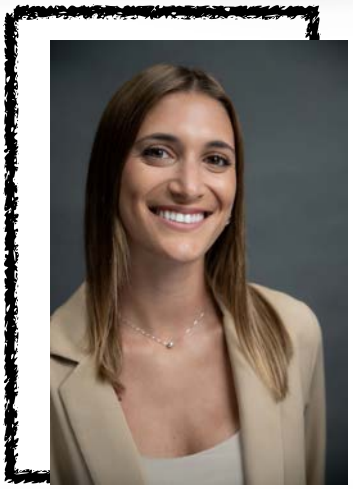
Interview with Maria Paula Plazas

What was on your mind when you decided to join the team? What did you hope to share with members?

I wanted to join the team to contribute in some way to our profession. When I first joined, I oversaw the division's social media, and I hoped to bring more information about our division as well as resources to our members through new channels.

What was one idea that you think inspired you to start?

I wanted to volunteer and get involved within the translation industry and, since I specialized in medical translation, I thought ATA's Medical Division was a good place to start.



How has the Medical Division changed over the years as you moved through new responsibilities in your career?

I believe we have improved the services we offer and have added some more, such as networking events and MED Talks, which are our new free webinar series. We also have more presence on social media, with the idea of reaching younger members as well. Finally, our Leadership Council has more members, and everyone is in charge of a different task.

The Spring 2023 newsletter included an article about dealing with stress. What does mental health mean to you?

I believe mental health is as important as our physical health. We need to take care of both to be able to work, be productive, and contribute to our communities.

What values are important to you when you think about the evolution of ATA's Medical Division?

I think teamwork is one of the most important values. Everything we have done within the Medical Division Leadership Council to better serve our members has been done as a team, with help from different Leadership Council members. Everyone within our Leadership Council plays a key role and adds value to the work we do. We decide everything as a team and we all help when we need to do more complex tasks, such as organizing our Annual Dinner at ATA's conference.

What has been your favorite job at the Medical Division? What has been your least favorite? What has been the most rewarding and what the most challenging so far?

I have enjoyed everything I have done within the division. I started taking care of our social media four years ago, and then I also helped with networking events. Later, I became assistant administrator for a two-year term and now I am the administrator of the division for another two-year term. Every single task and position have helped me learn and grow within our division. I think my favorite job is organizing events for our members. It is very rewarding to see that our members enjoy them and are willing to join us for more events. The most challenging part was becoming assistant administrator because I had to learn a lot about the division's overall functioning, but it was great to work with more experienced colleagues who helped me and gave me advice.

Is there anything we haven't covered that you would like to say? What is one final thought that you want to leave our readers with?

If you have never attended a Medical Division networking event, MED Talk, or Annual Dinner, I highly recommend you do this. This is your opportunity to connect with like-minded colleagues and to know who is behind the Medical Division. I also suggest you check our website, https://ata-md.org/, which is updated regularly and has a lot of resources I am sure you will find useful.

Meet the Assistant Administrator – Sara Greenlee

Sara recently began her role as assistant administrator and has been part of the division's Leadership Council since 2022. We posed some of the questions above from the Medical Division 20th anniversary interviews of former admins, and below are Sara's responses so you can get to know a bit more about her.

Leadership was barely in my 15-year plan when Yasha Saebi tapped me to join the Medical Division Leadership Council in 2022, but I decided to run with it and see where it would lead. I have always been conscious of the good fortune I have had and the privileges that I have been afforded, and I decided early in my career that when I could, I would pay it forward. Now seems like the perfect time to deliver on that promise. In the course of my career and travels, I have met a lot of bright, dedicated, and incredibly talented interpreters, many of whom are right here in the Medical Division. My philosophy in taking on the role of assistant administrator is that I find my success in your success. For me, this is a position of service aiming to support translators and interpreters in their roles and elevate them in their careers. To this end, what's mine is yours: all my knowledge, connections, resources, and efforts are at your disposal. I am excited to see us all grow together and make the coming year the best one yet!

Interview with Yasha Saebi

Yasha Saebi is the most recent former administrator and served two consecutive two-year terms (2020-2023) as administrator and a partial term as assistant administrator in 2019.

What was on your mind when you decided to join the team? What did you hope to share with members?

In my case, it was jumping in at a moment of crisis and doing my best to help when needed. I was not elected as assistant administrator; instead, I received a phone call from the Medical Division administrator at the time. Marisa and I knew each other and had met at several conferences. She asked if I could become the assistant administrator and explained that the Medical Division assistant at the time had to resign at midterm, and that was the second assistant who resigned during Marisa's term. The division desperately needed help. Despite a very tight schedule with completing a certificate program at Georgetown University, I accepted the position and offered my help. I could not say no at a time of crisis, to what I consider to be "my" division. I love the Medical Division.

What are the qualities that are important for a Medical Division?

It is important for members to be passionate about their career and their association, and care about the future of this profession. Medical interpreters save lives. I take this job seriously, and I wanted the Medical Division leadership positions to be filled with the most passionate experts in this field to improve the division and offer the best service to ATA members.

How has the Medical Division changed over the years as you moved through new responsibilities in your career?

I believe it has continuously improved. It is in the best place it has ever been and will continue to be better and better every day. There is no doubt that the Medical Division has had very good years in the past, however, there have been some ups and downs and I happened to come on board at a time that could not be defined as the best year of the division. After I was elected to the MD, I realized that the division's newsletter had not been published for 18 months! I started working hard, and within a few months of being elected administrator, we resumed publishing *Caduceus* with a new editorial team.

One of my other goals was to bring diversity to the Medical Division leadership team, and I managed to do so.

Another objective was to bring unity and team spirit to the division leadership council and do my best to unite the team to improve the division so we could serve our members better. I am so proud that I managed to bring together a team of experts from the field who love each other and are working together in the best possible way. The current Medical Division Leadership Council members are the definition of a true team.

In the spring 2023 newsletter, there was an article about dealing with stress. What does mental health mean to you?

Interpreters' mental health is a topic that I am personally very interested in and feel obligated to work on, not only for the Medical Division members but for all medical interpreters. Medical interpreters go through a lot of stress without getting appropriate support. Medical interpreters are members of the medical team who do not receive mental health support. Most often they are left to deal with their mental health on their own, and that is not fair. I personally went through a lot during the pandemic. I witnessed losing patients to COVID while they were alone and family members could not be with them, so the last people they talked to were interpreters and the medical team. That is not easy to deal with, and I did not have the proper support to deal with this kind of experience until the pandemic.

What is the biggest challenge you have overcome in regard to your mental health?

I am finally managing to separate the feelings that I develop for the patients from my daily life. I still have a long way to go. But I am getting better at separating my daily work life from my personal life. I have learned to not think about what happened during a particular interpretation and separate it from my daily personal life.

What values are important to you when you think about the evolution of ATA's Medical Division?

Diversity. I would love for all of us to get together to bring more minority language translators into the division and Leadership Council. I would love to encourage more minority language translators to join the Medical Division.

What was your favorite job at the Medical Division? And what was your least favorite part?

I loved everything about the Medical Division, and everything I did, I always did with passion. I enjoyed the quarterly meeting with the leadership team. I love hearing from the Medical Division members through surveys and during our networking events. I also enjoyed connecting with all Medical Division members through the Letter from the Administrator in the division newsletter. The annual conferences were the most rewarding for me because these are where we see the result of the year's work, and the annual meeting with our members is when we do our annual reports and talk to our members about our achievements throughout that year. The annual meetings were the best moments for our team and the proud moments for me and all of us because of the great teamwork and achievements. I am so happy and proud that I managed to recruit the best in the field and gather a team of experts to help me to rebuild our division. My least favorite part was to see a leadership council member leaving the division, because I loved them all.

What was the most challenging during your time?

During the first few months of starting as administrator, there was a lack of proper documents and passwords from previous leadership members. As a result, the logins for the different platforms were not readily available. We had to work hard to access our social media and rebuild some of them. Not having easy access to these tools should no longer be an issue for future administrators. Before I left, I made sure there was a folder with all the division's data to share with the incoming administrators.

Is there anything we have not covered that you would like to say? And what is one final thought you want to leave our readers with?

I want to encourage ATA members to join the Medical Division and contribute in any shape and form they can. Even if they are partially specialized as a medical translator or interpreter, we would love to have them as part of the team. Please join associations and divisions of your choice and share your expertise to help improve the industry. I want to encourage ATA Medical Division members to step up and join the leadership team or nominating committees. Please consider volunteering and playing a role in your own association. I also encourage ATA's Board to continue showing appreciation for the volunteers and create more incentives.

Caduceus Team

Silvia Villacampa | Luz Miranda Valencia | Gabriela Penrod | Andreea Boscor