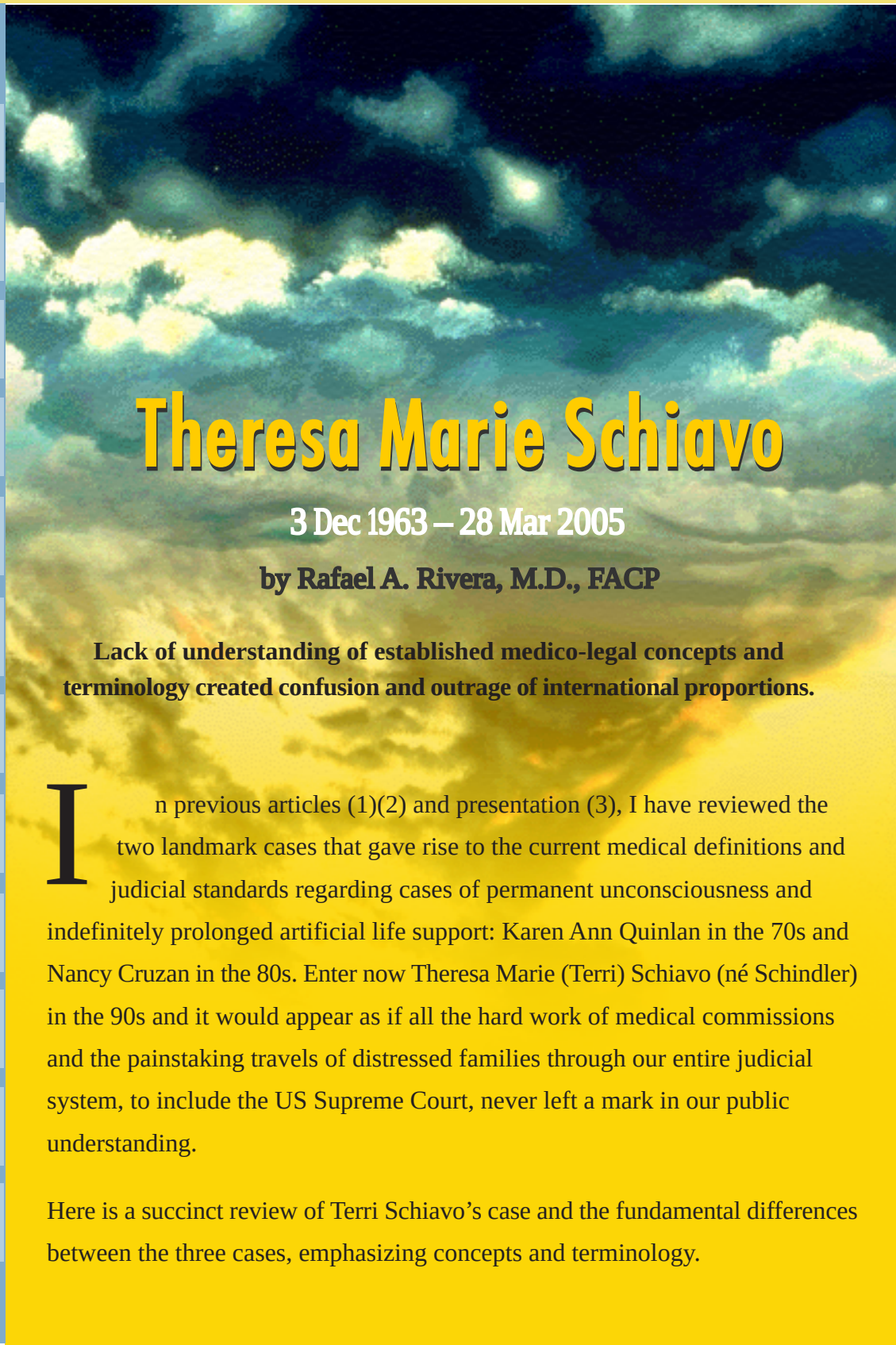
Caduceus
A Publication of the Medical Division of the American Translators Association
Summer 2005

CONTENT



Theresa Marie Schiavo

3 Dec 1963 – 28 Mar 2005

by Rafael A. Rivera, M.D., FACP

Lack of understanding of established medico-legal concepts and terminology created confusion and outrage of international proportions.

In previous articles (1)(2) and presentation (3), I have reviewed the two landmark cases that gave rise to the current medical definitions and judicial standards regarding cases of permanent unconsciousness and indefinitely prolonged artificial life support: Karen Ann Quinlan in the 70s and Nancy Cruzan in the 80s. Enter now Theresa Marie (Terri) Schiavo (né Schindler) in the 90s and it would appear as if all the hard work of medical commissions and the painstaking travels of distressed families through our entire judicial system, to include the US Supreme Court, never left a mark in our public understanding.

Here is a succinct review of Terri Schiavo's case and the fundamental differences between the three cases, emphasizing concepts and terminology.

The medical evidence:

On February 25 1990, Terri Schiavo, then age 27, collapsed at home. At the time the rescue squad personnel arrived she was in cardiac arrest (her heart had stopped). Following the delivery of seven consecutive electrical shocks a normal cardiac rhythm was restored. Upon arrival at the hospital she was in a state of coma associated with a serum potassium level of 2.0 (normal = 3.5-5), low enough to cause cardiac arrest. There was no evidence of trauma to the head or any other findings on physical examination or subsequent laboratory testing to explain her persistent coma. It is impossible to tell precisely how long she was deprived of oxygen to her brain; however, it appears that it was longer than the critical 4-6 minutes before irreparable brain damage occurs. The patient remained in a state of permanent unconsciousness until her death 15 years later.

The most important entry in the medical history of Terri Schiavo was a history of bulimia, an eating disorder, a binge-purge habit used primarily by women for weight control. This practice can lower the person's serum potassium which in this case was low enough to explain her cardiac arrest that led to the oxygen deprivation to her brain which induced her lifetime of unconsciousness. A malpractice suit was brought against the medical sources that were treating her bulimia based on a lack of close supervision of her ongoing bulimic habit, which could have discovered the dangerously low potassium level. Experts on eating disorders have raised to public attention the life-threatening risks of this common weight control practice.

The court testimony of medical experts who had examined Terri Schiavo and her medical records was that her medical condition was consistent with what is known since the Quinlan case as a Persistent Vegetative State (PVS) (4). Essentially, PVS represents a lifeless body not yet entirely dead. It is a state of permanent unconsciousness in which the patient remains alive due to the continued presence of electrical activity in the lower parts of their brain, technically known as thalamus and brain stem. Lower brain functions, those referred to as "vegetative", i.e., breathing, swallowing, etc., are still functioning as they usually do in the normal individual, under his level of awareness, while at sleep. The remaining upper brain functions, those referred to as "cognitive" or "sentient" i.e., awareness, recognition, reasoning, affective responses, are all lost due to extensive brain damage. Terri Schiavo's brain scans had already shown massive loss of cerebral tissue in the whole upper area of her brain, technically known as the cortical mantle, degenerative changes in the adjacent tissues and replacement of the area by cerebrospinal fluid as is expected in such cases in order to keep intracranial pressure within the limits of normality.

The most recent addition to the terminology of the PVS is that of a Minimally Conscious Vegetative State (MCVS) (5). This diagnosis is possible only when it can be determined - after repeated careful clinical observations at the bedside of interactions between the patient and her environment - that the patient indeed "recognizes" and "responds" to particular stimuli, like faces and sounds, etc., albeit in a primitive manner. This possibility was mentioned by a consultant of the State of Florida who had not examined Terri Schiavo as rigorously as required before rendering such an opinion.

A complete autopsy was performed and national experts were consulted. The findings were consistent with the clinical diagnosis of a Persistent Vegetative State. The extent of brain damage was massive and irreversible, no amount or type of therapy would have made any difference. Further, the amount of brain deterioration had left her blind. There was no evidence of trauma or abuse. The actual technical cause of death was, as expected, marked dehydration, not starvation.

Legal issues:

During 7 of the last 15 years of Terri Schiavo's life, a legal battle took place in a Florida courtroom that would in time move through our entire judicial system, to include the US Supreme Court – as did the two previous cases – repeatedly. The essential points of divergence rested on the following legal issues:

❒ **Guardianship and substituted judgment**: In the two previous cases, Quinlan and Cruzan, the parents, acting as legal guardians under the doctrine of substituted judgment advocated, in full accord, for the ***removal*** – not the continuation – of their loved ones from artificial life support, which at the time could be construed as assisted homicide. In the Schiavo case, a bitter family feud centered around the wish of her parents, on one side, to keep the patient artificially supported indefinitely and the husband, her court appointed guardian and decision maker on the other side, acting upon the orally expressed wishes of her wife during life, advocating just the opposite.

❒ **Advance directives**: The legal instruments known as a **living will** and a **medical power of attorney / healthcare proxy determination** for medical decision making – all of which fall

under the rubric of advance directives – were not known during the Quinlan or Cruzan time frame. This came about a result of US Supreme Court ruling during Cruzan *v*. Missouri wherein the high court recognized for the first time **the right to refuse treatment** as a constitutional right which should be expressed *ante facto* by means of properly drafted advanced directives. Terri Schiavo did not draft a living will during life. In the absence of written advanced directives court testimony of a spouse, family, close friends and guardians serve the legal purpose of delivering wishes expressed during life. These testimonies are usually challenged, as they were in this case, only unsuccessfully, as hearsay assertions.

❒ **Withdrawing or continuing life-prolonging medical treatments**: In the absence of previously written or clearly voiced wishes, the decision will rest on the family or the patient's legal representative, thus the importance of living wills and proxy determinations. Physicians honor the patient's previously expressed wishes, though they seem to be the last ones to give up hope (6). Courts throughout the land have addressed and ruled differently on this issue, yet some general principles have emerged. First, mentally competent patients have the right to refuse medical treatment even at the risk of death. Whatever wishes the person has previously indicated regarding administration or withholding of life sustaining treatments – which includes food and water – in the event of permanent unconsciousness the courts will respect, so long as they are "clearly and convincingly expressed". The opinion expressed during life by Karen Ann Quinlan during a formal Catholic high school discussion to the effect that she would not want to be kept alive on a ventilator moved the court to sanction the removal of her ventilator. Courts are more prone to favor removal of a ventilator than the withdrawal of artificial feeding. The former is viewed as more "heroic" or "extraordinary" than artificial feeding.

The influence of the media, the government and organized religion:

The Quinlan and Cruzan cases traversed the judicial system for 10 and 8 years, respectively, with only sporadic attention from the media and without interventions by interested groups or public demonstrations. Equally quiescent was the Schiavo case throughout its many years of judicial processing to include the US Supreme Court.

However, things changed dramatically when it came time to carry out the judicial order to remove Terri Schiavo's feeding gastrostomy tube. Central to the drama were the figures of her parents pleading for the life of her daughter to be spared and begging to have their daughter transferred to their personal care. On the other side of this real life stage was the legal representative of the patient's husband, her legal guardian, explaining to the public the realities of US law precisely crafted to deal with this most unfortunate medico-legal setting, all of which had been meticulously followed.

Television cameras on location outside the patient's hospice kept the world on a 24/7 repetitive stream of information. Right-to-life groups, members of religious orders and groups coming from near and far accumulated on hospice grounds as the police maintained order. The presence of international press members made it a matter of worldwide concern. Appearances by legal and medical experts were noticeably few, certainly not enough and repetitive enough for the public to gain a reasonable understanding of the medico-legal issues.

In an unprecedented move in US history the Schiavo case brought forth much criticized (7) political activism from the State of Florida, the Congress of the United States and the White House, all of which sought, through the swift drafting of new laws, to exercise jurisdiction over what the judicial system had accomplished up to the moment. This brought about judicial reviews from State and Circuit courts all the way to the Supreme Court on four different occasions. In every instance original rulings were upheld

The feeding tube was finally removed and the patient expired two weeks later as expected.

Public reaction:

In the absence of an informed and balanced view of the case, the general public was left to respond in an emotional way to what was indeed a heart-wrenching spectacle. It was said by those vigorously opposed to the removal of life support that she was being starved to death, that she was being denied even water, that she was not receiving enough pain medication to relieve her suffering. Her status was equated to that of a conscious person deliberately deprived of food and water. Outraged demonstrators brought food and bottled water to the premises and tried to force their way into the hospice. Protesters flooded Florida abuse hot line using words such as "crucifixion", "torture" and "starvation". Religious television figure, Pat Robertson called the removal of the feeding tube "judicial murder" while House majority leader Tom DeLay described it as an "act of medical terrorism."(8) The Vatican quoted the opinion of Pope John Paul II to the effect that food and water in a case like this are not medical issues and should, therefore, be allowed. Such a pronouncement was immediately criticized by the medical community. Indeed, everything that is done or not done for any PVS patient is a medical issue. Finally the Head of the Vatican's Pontifical Council for Justice and Peace reiterated in a written statement his condemnation of the Schiavo case as: ".. the killing of this woman in one of the most cruel ways, through hunger and thirst" (9).

In reality, the opinion of medical experts (4) is that PVS patients do not experience thirst or hunger or pain, or similar sensations because they lack the central nervous system connections that are necessary for that to occur. In effect, the credible suspicion that any of these are present, if confirmed, indicates that the diagnosis of PVS has been wrongly made.

The hallmark of PVS is chronic wakefulness without awareness:

Such unconscious wakefulness can be accompanied by spontaneous eye openings, the utterance of unintelligible, instinctive sounds such as grunts or screams or even brief smiles as well as sporadic movements of facial muscles. Despite a possible "alert demeanor", observation and examination fail to demonstrate coherent speech, comprehension of words or a capacity to initiate or make purposeful movements. Since neither visual or auditory signals require upper brain integrity to stimulate brief orienting reflexes, some vegetative patients may turn the head or dart the eyes towards a noise or moving object. However, PVS patients neither fix their gaze upon or constantly follow moving objects with the eyes, nor do they show other than startle responses to loud stimuli.

More about PVS

- Prevalence of PVS:
  Number of cases at any given time in the US is estimated as: 10, 000 to 25, 000

- Causes of PVS:
  a) trauma, severe head injury – 40%
  b) hypoxia (oxygen deprivation) – 40%
  c) miscellaneous causes (acute brain diseases, stroke, poisonings, hypoglycemia) – 20%

- Recovery from PVS:
  Unheard of after several years. No documented case after 15 years.
  A case of PVS due to hypoxic – ischemic encephalopathy (lack of oxygen or circulation to the brain) for more than 3 months is considered permanent

Source: -- Medscape Medical News

The necessity of a drafting a living will and talking about your wishes with your family and friends has become clear to the American public (10). It has also started a national debate about the rights of incapacitated people in general, specifically how to proceed at the end of life if there are no specific instructions left. This is also a matter of great concern for hospitals that must continue to provide very expensive, long-term artificial life support care often without hope of reimbursement or mechanism for decision making about a final disposition.
(World Medical Association)

Clinical Features of PVS

- No evidence of awareness of self or environment
- No evidence of sustained, reproducible, purposeful or voluntary behavioral responses to visual, auditory, tactile or noxious stimuli
- No evidence of language comprehension or expression
- Intermittent wakefulness
- Sufficiently preserved lower brain autonomic functions to permit survival and nursing care
- Bowel and bladder incontinence
- Variably preserved cranial nerves and spinal reflexes.

Source: American Academy of Neurology
www. medscape.com/view article/502272

References:

1. Rivera, R.A., Asuntos de vida o muerte. Intercambios (Newsletter of ATA Spanish Language Division) Agosto, 200
2. Rivera, R.A., Matters of Life and Death, The ATA Chronicle, August 2004
3. Rivera, R.A., End of Life – The Rise of Palliative Medicine. ATA Annual conference, 2003. Phoenix, AZ
4. Persistent Vegetative State and the Decision to Withdraw or Withhold Life Support. Joint Report of the Council on Ethical and Judicial Affairs and the Council on Scientific Affairs. American Medical Association. JAMA 1990:263(3):426-43. This document is quite comprehensive and has an extensive bibliography. It can be accessed at
5. Medscape Medical News.
6. On Dying in America. Annual Report. The Robert Wood Johnson Foundation.
   P.O. Box 2316, Princeton, New Jersey 08543
7. New York Times editorial, March 19, 2005
8. TIME magazine. April 4, 2005
9. The Florida Catholic, Miami edition, May 27, 2005
10. South Florida Sun-Sentinel, March 26, 2005
11. Multiple internet sources:
12. www.nybooks.com/articles/18050 this is a non-medical comprehensive review of the Schiavo case by noted author Joan Didion for the New York Review of Books.

A brief English-Spanish glossary of the pertinent terms is now presented. Readers are invited to look up the August 2004 issue of The Chronicle for a more comprehensive End of Life glossary.

End of Life Glossary (English < > Spanish)

advance directives: instrucciones/ directrices / disposiciones // adelantadas // por adelantado // instrucciones en caso de incapacidad // instrucciones sobre mi tratamiento en caso de incapacidad

attorney / proxy for health care: apoderado legal / representante // para la atención médica / cuidados medicos

brain death: muerte cerebral…/////…el cese de **toda** función cerebral determinada por un trazado electroencefalográfico (**EEG**). Cuando no hay actividad eléctrica en la corteza cerebral (funciones cognitivas), el paciente en estado vegetativo persistente se considera *legalmente vivo* ; sólo cuando también se pierde actividad eléctrica en el area medular (responsable de reflejos primitivos, funciones vegetativas, e.g., toser, tragar, respirar etc.) se considera que la persona ha incurrido una muerte cerebral i.e., una muerte total. **Whole Brain Death (WBD)** (*Presidential Commission1983)*

bulimia: bulimia

cardiac arrest: paro cardiaco, cese total de funcionamiento cardiaco

clear and convincing evidence: prueba clara y convincente

coma: coma // pérdida de conocimiento y capacidad de responder a estímulos **(**unconsciouness and unresponsiveness**)**. Causas multiples.

death: muerte // cese de todas las funciones vitales del cuerpo incluso toda actividad cerebral (definición oficial). Para própositos medicos o legales existen varias clases o categorias de muerte

durable power of attorney for health care: poder notarial duradero para la atención médica / cuidados medicos.

health care surrogate/proxy/agent: representante / sustituto /suplente /subrogado /agente para atención médica

hospice: hospicio…// en los EE.UU hospicio no es el nombre dado a un lugar, sino un concepto de cuidados paliativos para pacientes en estado terminal y sus familiares hasta el fin de vida. Los cuidados se ofrecen en cualquier entorno, preferiblemente el hogar o domicilio primario, aunque también el hospital, residencias de cuidado custodial, cuidados ambulatorios, hasta las prisiones; en suma, dondequiera. Hospicio es una preparación multidimensional para la muerte.

living will: testamento vital / última declaración voluntaria en vida/declaraciónde voluntad en vida / disposición ante notario para no prolongar la vida en caso de enfermedad terminal. Testamento vital es la frase con mayor vigencia en los, EE.UU, Puerto Rico, México.

minimal conscious vegetative state (MCVS): estado vegetativo con conciencia minima (see text).

palliative care: cuidados paliativos // intervenciones provistas por un equipo diverso (médicos, enfermeras, personal religioso y social) destinadas al alivio sintomático sin intención de curar o alterar el curso de la enfermedad. Se ha creado recientemente una nueva rama de la medicina llamada Medicina Paliativa.

palliative medicine: medicina paliativa…, ibid *palliative care*… y además incluye interés en las areas de pediatría y geriatría con atención al contexto cultural del paciente

persistent vegetative state (PVS): estado vegetativo persistente (EVP) // un estado de coma profundo y sostenido causado por daño cerebral extenso atribuible a múltiples causas; las más comunes son el traumatismo craneano (accidentes , armas de fuego) y la combinación de isquemia (pobre circulación) y anoxia (falta de oxígeno).

patient self-determination act: ley sobre la auto-determinación del paciente.

right to refuse medical treatment: derecho al rechazo de tratamientos médicos // un derecho constitucional bajo dictamen de la Corte Suprema de los EE.UU.

substituted-judgement doctrine: doctrina jurídica sobre juicio sustituto // significa que una persona, usualmente un miembro de la familia, asume la capacidad de otra persona para ejercer juicio acerca de un asunto sobre/para el cual la otra ha perdido su capacidad

By Elena Sgarbosa, M.D.

Typos (overt and covert)

In my pre-translator times, I remember a day when I had just arrived from Argentina to Bologna, Italy, as a visiting physician in the Dipartimento di Cardiologia. My Italian, while still inadequate to fully understand some regional accents, was good enough to understand any written materials –or so I thought. In the outpatient clinic's hallway there was a sign with instructions regarding patients without medical insurance. In the sign's text, one word was strange to me: *pamento*. So I asked about it. One of the cardiologists explained it: she said, with a dismissing gesture, that *pamento* was an error for "pagamento" (payment). Of course. Now that she mentioned it…

Similarly, during translation, an unrecognized term in the source text may infuse us with doubt. Is the word…. a legitimate term, but new to us?…a neologism?…or a misspelling? Sometimes a definition for the foreign term may indeed be found through some research or peer consultation.

The following examples represent "real life" peer questions and answers posed on online lists or forums by translators.

A translator working with an Italian medical text requested online help from peers with the term ***loide***. The term appear in the legend for a figure of the upper airways and indicated a structure close to the soft palate and lingual muscles. The term *loide* was quickly identified by another translator as the word "Ioide" written with a capital "i" (the lowercase "l" and the uppercase "I" look the same when using the font "arial" in Word). "Ioide" in English is *hyoid [bone]*, the bone below the tongue which provides insertion to lingual muscles.

Another translator was working with a Spanish document that cited the patient's own words, including the term ***bricia.*** The patient was on hemodialysis (a chronic treatment that requires an arteriovenous fistula). He was quoted saying "Actualmente tengo una fístula tipo *bricia* en el antebrazo derecho, la cual es la vía que aún conservo para el tratamiento." (I currently have a *bricia*-type fistula in my right forearm, which I the line I keep for my treatment)". The translator requested help with the term *bricia. Bricia* here was a misnomer for *Brescia*, a proper name. The fistula technique was developed by Drs. Brescia and Cimino, and their procedure is commonly called *fístula de Brescia.*

Another translator working with a Spanish document was unsure about the word ***reinoide*s**, which appeared in the phrase "Congreso sobre la terapéutica y el uso de *reinoides.*" (Congress/scientific meeting on therapy and uses of *reinoids*".). The online consultation was answered by a peer who offered the opinion "*reinoids* is probably exactly the term", and posted a number of web links to sites discussing "reinoids". She also indicated that the term referred to derivatives of retinoic acid and Vitamin A. This is correct; the word "reinoids", however, is not. It is misspelled in Google. The Spanish word is "retinoides", which translates into English as "retinoids" (a group of substances used in treatment of acne and wrinkle prevention, such as retinoic acid).

In less fortunate occasions, the translator may not even suspect that a typo or transcription error is present. This is because the misspelled term has become another logical word. For example, in a Neurology record, "the patient had difficulty talking" becomes "the patient had difficulty walking". Such "covert typos" can only be detected by having a thorough understanding of both one's source language, one's working field, and the specific context.

By Elena Sgarbosa, M.D.

The Spanish word "clave" means "key" or "code." ***Clave*** appeared on a Spanish medical invoice, listed as "*Clave* con ext. 10 cm 1 vía 2870." Here, "ext." is "extensión" (extension). The translator working with the invoice asked for help with *clave*. A colleague suggested "code"; another offered "rod", explaining (with a reference to the DRAE) that a *clave* is a rod-shaped percussion instrument consisting of two sticks. In the medical bill in question, however, *clave* was most likely a misspelling for "llave" or clamp –e.g, a roller clamp or an on-off clamp. (The extension, in turn, would refer to a 10 cm tube that prolongs the IV line). "Clamp" was the term accepted by the translator.

The Spanish word ***riega*** is a conjugation of the verb "regar", which means "to water", "to irrigate" or "to supply [blood to]". A poorly written Spanish medical record included the curious impersonal verb ***se riega***. The sentence was *Fue vista el día 21 por el servicio de MI; RX de tórax y analítica, a lo cual se riega la paciente* . . .(i.e., [She] was seen on the 21st by Internal Medicine; chest X ray and bloodwork, to which the patient "se riega"). The translator working with this text posted an online peer consultation asking "How do you translate *se riega* here?"

One colleague suggested that *riega* was probably a typo for "ruega." The sentence must have read –the colleague reasoned- "se ruega a la paciente que..." (i.e., the patient is kindly asked/requested to...). The most plausible explanation, however, is that "riega" was a typo for "niega": *a lo cual se niega la paciente*, i.e., "which the patient refuses" (or, rephrasing: "the patient declined the tests ordered by IM, including Rx...").

A translator working with a Spanish radiological report posted an online peer consultation regarding the English rendition of ***senos costo frenéticos libres.*** The word "senos" in this context translates as "sinuses" or "recesses". "Costo" alludes to the ribs, and remains "costo" in English. "Libres" is "free" or "clear". As for *frenéticos*, it means "frenetic" or "frantic", a term which does not belong in a radiology report. The Spanish term, correctly spelled, was "senos costo *frénicos* libres," which translates as "clear costodiaphragmatic recesses / costophrenic sinuses."

In many fields, including Medicine, foreign words and expressions have been incorporated into other languages. Those foreign terms' meaning and spelling also need to be known to translators. A translator working with an Italian document requested help with the term ***winning respiratorio*** (i.e., "respiratory winning") as it appeared in the sentence *I parametri vitali hanno consentito al paziente di eseguire un buon winning respiratorio* (i.e., "respiratory parameters have allowed [the patient to follow] a good *respiratory winning* "). Here, "winning" is a misspelling for "weaning" and it refers to "ventilator weaning" or "weaning from respiratory support".

These excerpts from peer consultations illustrate how typographical errors in a source text can seriously blur meaning and become stumbling blocks.

Ideally, medical translators must strive to understand the source language to the point of not being misled by typographical errors. When in doubt, it is imperative to conduct terminology research. "Googling" a word in the languages in which Google is available and obtaining many website samples which include the queried word, however, does not guarantee that the word is correctly spelled. If in Google one enters, for example, "bussiness", Google will return well over 1 million results. Yet at the same time, Google will ask "Did you mean: *business*" (no pun intended), which should be enough to alert the user to the original misspelling.

Note: All the online consultation examples in this article represent true instances of questions and answers by medical translators. The specific URL for each example is available by request to the author at Elena@TranslatingMedicine.net.

By Leon McMorrow.

Translation in Medicine's "Sister Sciences"

Veterinary medicine and dentistry have a long history running parallel to clinical medicine. Veterinary medical texts go back to 221 B.C. in China, with references to "horse priests" (healers) dating back to 1766 B.C. In the Greco-Roman tradition, the treatment of horses was also discussed. These had become keystones of military and economic power.

Dentistry was part of medicine in the ancient Middle East and dental treatment initially involved medication and not surgery. As the profession began to specialize, dentistry and surgery split off *very gradually* – overlapping professions were very common until recent centuries. Today, however, the lines between doctor and dentist are clearly defined in the popular and professional mind.

Will we see a "veterinary translator" and "dental translator" emerge as distinct professions from the "medical translator"? It probably all depends on the market. Money flows created the recent boom in medical translation, and could do so again for the sister clinical sciences.

My experience with veterinary medicine has been totally limited to pharmaceuticals, where many drugs are similar in class to those in human medicine. Since clinical trials are not mandatory for animal medications in the same way or to the same extent as for humans, one of the major sources of translator income is not yet matched in veterinary translation.

Dentistry, however, seems to be moving toward greater globalization, not so much as a scientific or clinical trend toward collaboration or standardization, but rather as a result of more intense marketing of restorative/cosmetic dentistry and prostheses. Remarkably esthetic dental restorations (crowns, bridges, veneers, implants) are now becoming the norm, driven by rapid improvements in restorative materials and techniques. Acrylics, ceramics, silicones, and metal alloys are fashioned into natural-looking restorations by dental technicians operating in highly efficient, often computerized dental laboratories. CAD-CAM dentistry has arrived in most Western countries. The expenses associated with modern cosmetic dentistry of course are very high, thus driving the market. Is there room for the translator to participate in this business flow?

A qualified *yes*. There is a market. Multilingual catalogs, websites, and journals for restorative and cosmetic materials, instruments, and procedures are common and need dental translators. International conferences and training courses need interpreters. The flip side of the coin is that training resources in dental translation, including courses and aids, are sparse but

clients routinely require high levels of performance. For example, I have a Reuter-Reuter *Dictionary of Dentistry* (G-E, E-G, Georg Thieme, 1999) but compared to their outstanding *Dictionary of Medicine*, this book is a 'flop' for the modern dental translator needing help with prosthodontics, implantology, and restorative dentistry – the authors avoided these technical/surgical fields almost entirely. The reason may be that the language of prosthodontics and restorations is borrowed from ceramics, metallurgy, mechanics, physics, and chemistry, fields now left to the dental technicians. (Just as medical dictionaries seem to totally ignore medical technology as an allied science and leave it to the bioengineers.) Many materials and technology patents exist in these fields and require translation. If the translator or interpreter has the stomach to work gradually and persistently into these "hot" fields of dentistry, the effort will eventually pay off, but you must endure many hours of Google searches in the interim. A good printed source for all areas of dentistry was Stedman's DENTISTRY WORDS (1993), which is now reissued under the title SURGERY/ENT/DENTISTRY WORDS (latest edition 2005).

Does Surgery Get a "Bad Rap" from Bilingual/Multilingual Medical Dictionaries?

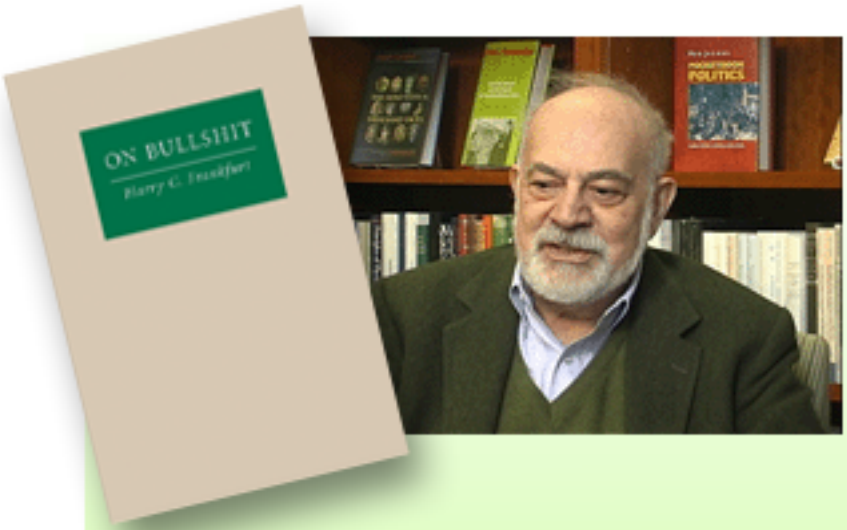
One of the most difficult translation fields may be surgery, not because of the basic sciences or techniques (multiple surgical texts and manuals exist) but because both bilingual and monolingual dictionaries seem to ignore the basic *tools* of surgery, the instrument set. Where can I find dictionary entries and ideally drawings of reamers, cutters, burrs, rasps, surgical drills, saws, retractors, dissectors, rongeurs, elevators, holders, hooks, picks, forceps, curettes, surgical needles, punches, irrigators, mobilizers? Editors may include one or other but not all. This is not helpful when we get down to details, since translators are not at home in such technical fields. (Tip: take a test of your knowledge of surgical instruments at a surgeon's delightful personal website:

There is a market. Multilingual catalogs, websites, and journals for restorative and cosmetic materials, instruments, and procedures are common and need dental translators.

entusa.com/instrument). I once researched the English-Italian-English offerings for surgical "pick" and "hook" and found that the closest coverage in dictionaries was uncino = pick or hook. These are different tools in the surgeon's (or dentist's) kit, since a pick never has a full curve to form a partial loop, while a hook does. So a compromise was found through discussion with the particular client – 'hook' = uncino, and 'pick' = piccolo uncino. It was a "patch" since we did not have time to visit the marketplace.

Are there any good resources the translator can turn to? The Internet has helped, since some manufacturer sites now have different language versions for the user and we can compare these. Going a step further, it is now possible to get multilingual catalogues with parallel entries from surgical instrument manufacturers and these can be very valuable if the entries have been checked by local distributors or dealers for accuracy. Alas, sometimes the catalogue (produced by a translator) uses one term for an instrument, while the local sales people use a different term, but that is a constant problem we all live with. It is very difficult to keep up with the 'sales talk' or 'shop talk' of a particular industry and sometimes tears are shed because of poor localization. Language is never tied down very tightly in real life.

Erratum: In the previous issue of Caduceus the name of author Leon McMorrow appeared followed by the post-nominal initials M.D. Dr McMorrow has called to our attention that he is not a Doctor of Medicine but a Doctor of Medical Anthropology. We regret the mistake and offer our apologies. Ed.



By Harry G. Frankfurt
Princeton University Press
ISBN 0-691-12294-6

"One of the most salient features of our culture is that there is so much bullshit. Everyone knows this. But we take the situation for granted. Most people are rather confident of their ability to recognize bullshit and to avoid being taken in by it. So the phenomenon has not aroused much deliberate concern, nor attracted much sustained inquiry.

In consequence, we have no clear understanding of what bullshit is, why there is so much of it, or what functions it serves. And we lack a conscientiously developed appreciation of what it means to us. In other words we have no theory. I propose to begin the development of a theoretical understanding of bullshit, mainly providing some tentative and exploratory theoretical analysis"

The above two paragraphs is the beginning of one of the shortest and fastest bestselling books in recent history. In just 67 small pages, Dr. Harry G. Frankfurt, Professor of Philosophy Emeritus at Princeton University and one of the most influential moral philosophers of our time, puts together a succinct but poignant review of what bullshit is, or might be, depending… The essential element, all reviewers of the book or the subject agree, is to give proper answer to the question: What is bullshit? Professor Frankfurt's immediate conclusion is that bullshit is defined not so much by the end product as by the process by which it is created – 'which is to express a blinding insight', says one magazine commentator. Frankfurt's own trajectory starts by looking for previous similar endeavors that lead him to Max Black's book, The Prevalence of Humbug in which the phrase "deceptive misrepresentation" seems to capture a close but softer approximation of humbug to bullshit. The deception, in either case, is deliberate, not inadvertent.

"Short of lying" is another attribute that is carefully dissected out in a way that makes you realize that the subject is in the hands of a master craftsman of words and thinking.

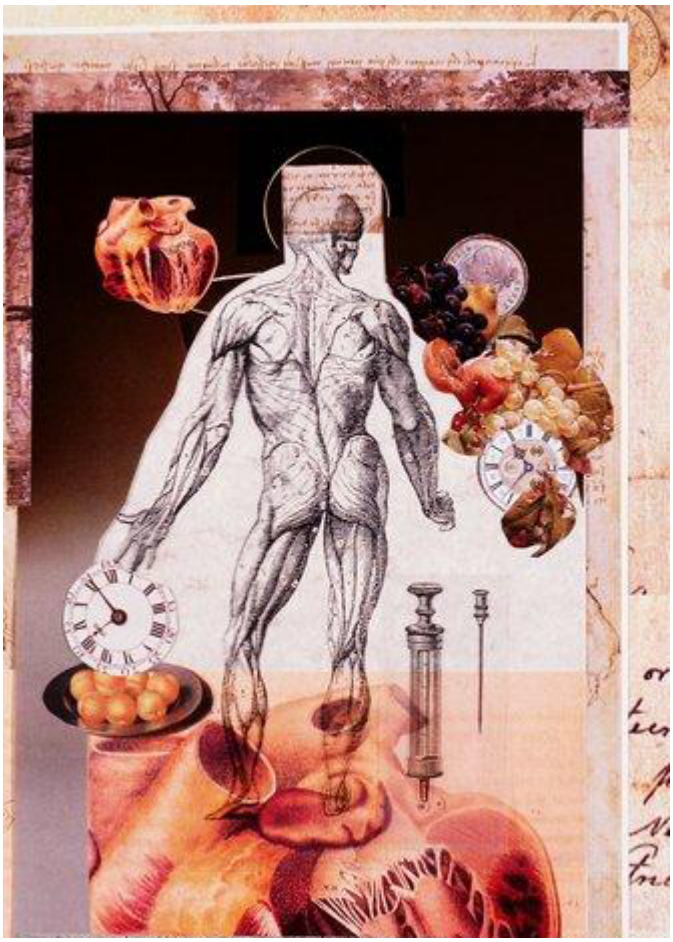
His take on what a "bull session" is, as defined in the OED (Oxford English Dictionary) is particularly masterful. "The very term *bull session*, he says, is, indeed, quite probably a sanitized version of *bullshit session*. The worlds of advertising, public relations and, most certainly, politics are, in the words of the author: "replete with instances of bullshit so unmitigated that they can serve among the most indisputable and classic paradigms of the concept". Is there truth in advertising? is a saying we all know well. And then there is the contemporary concept of "spinning" - the deliberate presentation of an issue in a way that is advantageous to a person or an organization, usually for political purposes.

Is there really more bullshit now than ever before is really impossible to say, but it looks like we are swimming in it because there is so much communication of all kinds in our time, but, says the author, " the proportion that is actually bullshit may not have increased". And it certainly appears to any reader of this book that we all do a bit or a bunch of it, more than we would ever admit to.

By John H. Dirckx, MD.

TERMINOLOGIA ANATOMICA

STRICTLY A CLASSICAL TONGUE



Terminologia Anatomica (*TA*), the current version of international anatomical nomenclature, was approved in 1997 by the International Federation of Associations of Anatomists (IFAA) and published[1] the following year. Although based on the sixth edition (1989) of *Nomina Anatomica* (*NA*), the new system embodied enough innovations to justify fully the change of name. *TA* was quickly adopted in all countries where *NA* had formerly been in general use.

Like its earliest predecessor, the *Basle Nomina Anatomica* (*BNA*) of 1895, *TA* consists of lists of Latin words and phrases displaying rigorous internal consistency and arranged systematically in hierarchies or cascades to reflect structural relationships. Unlike previous systems, *TA* includes one or more English equivalents for each Latin term. This has led to what I consider a grave misunderstanding of the intentions of the Federative Committee on Anatomical Terminology (FCAT), the compilers of the system.

Elsewhere[2,3] I have discussed the hopeless muddle created by those who prepared the Latin index of *TA* and have drawn attention to the inadvisability of retaining Latin, which few have learned and scarcely anyone knows well, as the official international language of anatomy. Before *TA* was published, many observers predicted that English would replace Latin in the next revision of anatomical nomenclature.

Some, apparently interpreting the inclusion of English equivalents in *TA* as a first step in that direction, have mistakenly assumed that the English terms possess the same authority as the Latin. Speakers of English commenting on deficiencies of *TA* in the technical literature[4,5,6] have referred exclusively to the English terms. In a paper discussing the semantic configuration of *TA* and the feasibility of its incorporation into computer programs, Rosse[7] examined only the English vocabulary.

Rickard et al.[8], in integrating *TA* into their Foundational Model of Anatomy (FMA), used both Latin and English terms but clearly considered the English equivalents the basic nomenclature: "Latin terms are treated in an identical manner to English terms." English-language atlases of human anatomy[9,10] and the University of Michigan Visible Human Project (UMVHP), which are claimed to incorporate *TA*, contain only the English equivalents. The 27th edition of *Stedman's Medical Dictionary*[11] (2000) places the initials *TA* in brackets after the English equivalents as well as after the Latin terms that actually make up *TA*.

This issue is far from being purely academic. If I post a sign saying "No Parking—Police Order," I have created the appearance of an official directive that, considered purely from the viewpoint of public awareness, possesses as much legal force as if the police had in fact posted the sign. In the same way, using only English terminology in a published work purporting to comply with *TA* or placing the letters [TA] after an English anatomical term in a reference work becomes in effect a statement that the English terms have the official endorsement of FCAT whether or not that is true. I propose to show that it is not true. The Preface to *TA* states: "The terms are laid out in three columns, with each Latin term accompanied by a term in current usage

in English-speaking countries.... [By way of clarification, the first of the three columns contains a unique numerical identifier for each structure named in Latin (second column) and in English (third column).] Only the Latin list of terms should be used as the basis for creating lists of equivalent terms in other languages. English equivalents are given in this list as English is spoken in many countries. It is not the basis for terminology in other languages."

Nowhere is any kind of official status claimed for the English terms. The reason given for their inclusion, that English is spoken in many countries, would hardly be a full statement of the position if FCAT had meant to place the English terms on an equal footing with the Latin ones. Nor, if the English terms enjoyed the same degree of official approval as the Latin ones, would it be necessary or even reasonable to direct that only the Latin list of terms should be used as the basis for creating lists of equivalent terms in other languages.

The Secretary General of FCAT, Liberato Di Dio, stated in an editorial[12] published in 2000 that the newly approved Latin terms of *TA* were "accompanied not by an English translation but by 'equivalent' terms in English for the guidance of those who have never learned Latin or who don't remember it." In a footnote he further observed that the English versions of the terms had been "prepared by groups of English-speaking anatomists to settle such doubts as might naturally arise and to forestall disputes among the various national groups that speak English." These remarks certainly lend no support to the idea that the English terms in *TA* have any official status.

In numerous instances throughout *TA*, the choice of an English term diverges sharply from what would be expected if FCAT had intended to make the English equivalents part of official nomenclature. The statement quoted above from the Preface, to the effect that each Latin term is accompanied by a term in current usage in English-speaking countries, is misleading. Certainly one or more English terms are provided for each *structure* named in the Latin list. But in some cases where two or more Latin alternatives are approved, only a single English equivalent is given (e.g., *commissura posterior; commissura epithalamica/posterior commissure*), while in other cases two or more English names may be applied to a structure for which only one Latin term is official (e.g., *ostium ileale/ileal orifice; orifice of ileal papilla*).

Careful analysis of the English list shows that many of the terms in it are not even synonyms of the Latin, much less translations in the strict sense. English *roof* and *floor* (*of cranial cavity*) are listed as equivalents respectively for *paries superior* (literally 'upper wall') and *paries inferior* ('lower wall'). The English equivalents given for *substantia corticalis* and *substantia compacta* are not *cortical substance* and *compact substance* but rather *cortical bone* and *compact bone*. For *corpus adiposum buccae*, *TA* gives *buccal fat pad* as an English equivalent instead of the verbatim translation, *fat body of cheek*.

The numbering system used in Latin for naming the digits (*digitus secundus [II]*, *digitus tertius [III]*) is duplicated in English for the toes (*second toe [II]*, *third toe [III]*) but not for the fingers. The equivalent given for *digitus secundus* (*manus*) is *index finger*, and that given for *digitus tertius* is *middle finger*. Presumably these choices are intended to avoid the ambiguity resulting from the widespread practice among speakers of English of counting the index finger as the first finger.

" Only the Latin list of terms should be used as the basis for creating lists of equivalent terms in other languages. English equivalents are given in this list as English is spoken in many countries "

The English list fails repeatedly to match the meticulous organization and internal consistency that characterize the Latin system. The standard English terms *oval window* and *round window* are offered as equivalents for Latin *fenestra vestibuli* and *fenestra cochleae* respectively although, being semantically vague and unsystematic, they lack the precision of the Latin. Both Latin *labium* and *labrum* are rendered *lip*, while *crista* is sometimes rendered *crest* and sometimes *ridge*. *Face*, *facet*, and *surface* variously correspond to Latin *facies* ; *eminence*, *tuber*, and *tuberosity* to *tuber*. More subtly, the well-established English *central tendon* corresponds to *centrum tendineum* (*diaphragmatis*), literally

'tendinous center'—anatomically the same thing but conceptually and grammatically quite different.

In each of these examples the semantic disparity can be explained by the fact that a more faithful translation of the Latin would have yielded a new, unfamiliar, or perhaps ambiguous English counterpart. Virtually every English equivalent published in *TA* is a standard component of the current nomenclature of human anatomy. (In sharp contrast, according to some sources *TA* contains about 1000 Latin terms that did not appear in the last edition of *NA*.) Surely it is evident that the compilers of the English list created none of the terms in that list, but simply drew them from the existing nomenclature of anatomy already fully familiar to speakers of English.

If you look up Conradi's disease in a medical dictionary, you will find it "defined" as chondrodysplasia punctata. If you look up the amino acid tyrosine in *The Merck Index*, you will find it "defined" as _-amino-*p*-hydroxyhydrocinnamic acid. If you look up poison ivy in the English index of a botany key, you will find it "defined" as *Toxicodendron radicans*.

A moment's reflection should make it clear that these reference works do not thereby endorse or ratify the non-systematic, trivial, or provincial names in question, but only employ them as indispensable markers or signposts to the more formal terms, proceeding from the familiar or known to the unknown.

In constructing *Terminologia Anatomica*, the Federative Committee on Anatomical Terminology selected and ratified a body of Latin nomenclature. A list of equivalent English terms was then drafted by a subcommittee. I have shown that the decisions of that subcommittee were driven not by the goal of rendering the official Latin verbatim, much less of preserving its strict uniformity and internal harmony, but rather of making the most perspicuous and unambiguous choices from among English terms already in general use.

My purpose has been to correct the erroneous belief that the English terms published with *TA* have some kind of official status corresponding to that of the Latin. A major piece of evidence in support of that position is that the English vocabulary accompanying *TA* does not translate the Latin list verbatim and thus fails to reproduce the valuable organizational patterns built into the Latin system. But although, in that respect, it falls short of an ideal English anatomical nomenclature, it may be the next best thing.

Wherever the English vocabulary diverges from the official Latin, the reason is almost always that a verbatim rendering would have required the creation of a new English word or phrase. In that light, the English list emerges as a carefully selected index or register of standard, fully established, and unequivocal English anatomical terminology—certainly a valuable resource for medical writers, translators, and editors.

References

1. Federative Committee on Anatomical Terminology (FCAT): Terminologia Anatomica. International Anatomical Terminology. Stuttgart: Georg Thieme Verlag, 1998.

2. Dirckx J: [Book review] Federative Committee on Anatomical Terminology: Terminologia Anatomica. Terminology 1998/1999;5(2):279-283.

3. Dirckx J: [Book review] Federative Committee on Anatomical Terminology: Terminologia Anatomica. JAMA 2000;283(11):1485-1486.

4. Mirilas P, Skandalakis JE: Benign anatomical mistakes: the correct anatomical term for the recurrent laryngeal nerve. Am Surg 2002;68(1):95-97.

5. Mirilas P, Skandalakis JE: Benign anatomical mistakes: right and left coronary ligaments. Am Surg 2002;68(9):832-835.

6. Mirilas P, Siatitsas Y, Skandalakis JE: Benign anatomical mistakes: inferior pulmonary ligament. Am Surg 2002;68(10):922-926.

7. Rosse C: Clin Anat (US) 2001;14(2):120-133.

8. Rickard K et al.: Problems and solutions with integrating terminologies into evolving knowledge bases, in Fieschi M et al., eds.: MEDINFO 2004. Amsterdam: IOS Press, 2004

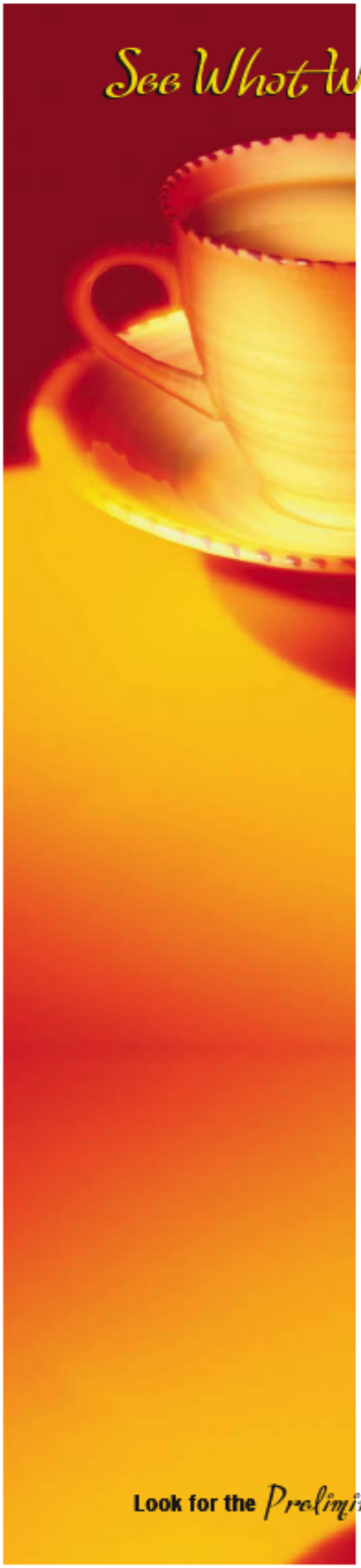
9. Köpf-Maier P, ed.: Wolf-Heidegger's Atlas of Human Anatomy, 6th ed. (2 vols.) Basel: S Karger, 2005

10. Platzer W: Color Atlas of Human Anatomy, vol. 1. Locomotor System. 5th revised and enlarged English edition. Stuttgart, New York: Thieme; 2004.

11. Pugh MB: Stedman's Medical Dictionary, 27th edition. Baltimore: Lippincott Williams & Wilkins, 2000.

12. Di Dio, L: [Editorial] Lançamento oficial da Terminologia Anatomica em São Paulo: um marco histórico para a medicina brasileira Rev Assoc Med Bras 2000;46(3):191-193. Original in Portuguese; author's translation.

John H. Dirckx, MD, retired in 2003 after 35 years as director of the student health center at the University of Dayton (Ohio). He has written numerous articles on the language, literature, and history of medicine, as well as books and articles on clinical medicine for medical transcriptionists.



See What We've Got Brewin' in... SEATTLE

ata 46th Annual Conference

of the American Translators Association

The Westin Seattle | Seattle, Washington | November 9-12, 2005

Features

Over **150 educational sessions** that cover topics in a variety of languages and specialties, **offering something for everyone**

A **multitude of networking events** that allow you to connect with over 1,200 translators and interpreters from throughout the U.S. and around the world

Opportunities to **promote your services** and interview with language services companies **at the Job Marketplace**

An **exhibit hall** that brings companies together for you to see the latest software, publications, and products available that **fit your unique needs**

Register

Look for the **Conference Registration Form** with the **July issue** of *The ATA Chronicle* to take advantage of special **Early-Bird rates**, available **until September 10**.

Join ATA to register at the discounted ATA Member rate. For an application, contact ATA or **join online at www.atanet.org/membapp.htm**.

Don't miss this **opportunity to network**, meet newcomers and seasoned professionals, **market yourself and your skills, reunite with friends** and colleagues, **and have fun!**

Hotel

The Westin Seattle is located in downtown Seattle, 15 miles from the Seattle-Tacoma International Airport and within walking distance to Pike Place Market and the Space Needle.

Special Room Rates for ATA Conference Attendees (exclusive of tax)
Single: $175 | Double: $185

Take advantage of this special rate, **available only until October 19**.
Call **(800) WESTIN-1** (937-8461) and tell them you're attending the ATA Conference.

The Westin Seattle, 1900 Fifth Avenue, Seattle, Washington 98101
Phone: (206) 728-1000, Fax: (206) 728-2007; **www.westin.com/seattle**

Look for the *Preliminary Program* and *Registration Form* with *The Chronicle* in July!

By Gilberto Lacchia, M.D.

Roche Lexikon Medizin Online

The new 5th edition online: an outstanding resource for English-German medical translators

The Roche Lexikon Medizin is a very useful German-English medical dictionary. The main item and definitions are in German, but an English translation is added.

Some Internet sites already offered a free access to the 4th edition (1998) (e.g. http://www.gesundheit.de/roche/). A new edition of the lexicon has been issued by the end of 2003 and both the book and the CD-ROM are available from the publisher site (http://www.elsevier-deutschland.de/titel/3-437-15180-0).

The 5th edition is also freely accessible on the Internet (http://www.tk-online.de/rochelexikon/). Compared with the old online editions, it offers more research options and features. This new edition contains more than 140,000 searchable entries, 60,000 English entries and 2,200 pictures, tables and multimedia files.

The search engine is a new one. The query words can be in German or English and, differently from the old online editions, in case of incorrect spelling or inexistent terms the software will suggest other related entries (listed by concordance in descending order; try e.g. the wrong term cesarian).

Truncation is supported: the search engine will automatically search all the words beginning with a group of letters (e.g. cardio, bacil, ku). The asterisk (*) may be used as a jolly character to search for items beginning with or containing a group of letters (e.g. ku*ung, ja*operation, *syndrom). Other jolly characters or the boolean search seem not to be supported.

The item page has almost the same structure as the old editions:

- Item
- Synonyms
- Clickable icons (Pictures / Multimedia files / Tables)
- English translation
- Definition (in German)
- Related Item(s) (Verwandte Themen)
- Related External Links (Ausgewählte Internet-Seiten)

The *Related External* Links is a new feature: these links point to related German (mainly) or English authoritative sites. However, they are subject to the unpredictability of Internet URLs, and broken links are not unusual (e.g. almost all the links pointing to the Cochrane Review Groups are broken; a comprehensive list of these groups can be found at (http://www.cochrane.de/deutsch/ccgroup.htm).
In the definition text, the blue underlined words that are also entry terms work as hyperlinks jumping directly to the related term. Words that are not hyperlinked can be selected and dragged and dropped with the mouse into the query box.

This edition contains some multimedia files, such as audio files identified by a loudspeaker icon (see e.g. Herzgeräusch systolisches).

A new excellent feature are the anatomic tables (anatomische Bildtafeln) . Based on the “Sobotta Atlas of Human Anatomy” by R. Putz and R. Pabst (21st edition, 2001), the thirty-two tables illustrate the main anatomic zones of the human body together with the standard Latin anatomic terminology. The small green squares are hyperlinks that, when clicked, allow to highlight the anatomic term. Likewise, by clicking a term on the right, the corresponding square on the picture will change color and display the name of that part. See, for example, the eye (http://www.tk-online.de/rochelexikon/pics/s02566.000-1.html) or the heart (http://www.tk-online.de/rochelexikon/pics/s15733.000-1.html) table. In the definition page, a related anatomic table is identified by a pointing finger icon (see e.g. Auge).

Medstract

The flow of new biological information is so voluminous that it is virtually impossible to keep up-to-date in the field. Thousands of articles appear on a monthly basis. A particular example of the problem is the sequencing effort of the Genome project and individual investigators in the field of genetics, whose efforts are rapidly expanding the sequence databases. Medstract – short for medical information extraction – is a collaborative project between computational linguists at Brandeis University and biologists at Tufts University School of Medicine, supported by the National Library of Medicine, whose goal is to apply recent advances in computational linguistics and text analysis data in order to extract information from Medline with special emphasis on the biological literature. This allows rapid access to relevant worldwide information on individual genes and proteins.

Does it matter if an interpreter uses the first versus the third person?

By Zarita Araujo-Lane, LICSW
Edited by Vonessa Phillips

In the late 70's, when I started interpreting at a Boston area hospital, I was so worried about my fluency in the English language and about understanding medical terminology that the concept of using the first person never came to mind.

For many years, I used the third person with both the patient and the provider. In fact, if someone had questioned it, I would likely have reacted defensively. I can imagine that my answer would have not been very different than most answers I hear today from my students, "but the patient and the doctor will get confused with the first person, especially patients with lower education levels. They'll think that I'm the doctor and not the interpreter". This fear is not totally unfounded.

Once, an interpreter that freelanced for my company took an assignment for which we later received a Critical Incident Report from the provider. The report stated that the interpreter was biased throughout the psychological assessment of a child because she kept making personal statements and giving her opinions. A serious accusation, indeed!

After interviewing both the interpreter and the provider, I realized that in fact this provider had arrived late to the meeting with the child, mother and co-therapist and had subsequently missed the interpreter's explanation to the group regarding the use of the first person. Even after we uncovered the misunderstanding, there remained certain distrust resulting in the interpreter's decision to never again work for the provider in question.

This episode made me justify my old habit of using the third person in my interpretation. I felt comfortable, no one was watching me, and patients and providers seemed happy with my services. At this point I was already familiar with the MMIA Standards of Practice, which encourage the usage of the first person, but as long as I was not missing the medical information I felt good about my interpretation style. I have also heard in several presentations by well-respected interpreters that it does not make a difference if the interpreter uses the first or the third person. To them, what matters is that the interpreter is accurate with the content of the message being voiced.

With a quiet desire to prove to myself that I was right about the usage of the third person, I began to ask students in my community and college-level interpreting classes to interview patients, providers and interpreters on any interpreting-related topic and to document the interviews in essay papers. When students asked for suggestions on picking a topic, I would often advise them to explore the use of the first and third person.

To my surprise, the papers revealed that providers and patients seem to feel that sessions go faster and communication is clearest

when the interpreter uses the first person. Now, this information does not have any statistical relevancy, but it made me rethink my old ways of interpreting. So I started to use the first person for most of the sessions I interpreted in, and the third person only when I felt that I needed some emotional distance from a "loaded" situation.

Now, when I teach first-person interpretation, I try to illustrate situations in which the third person might be appropriate. But I do encourage students to try to stick with the first person. In this, I often encounter resistance from students who feel that they have found in the third person a style that works.

So we start with a "blind" role-play. I give no instructions regarding use of the first or third person. But what normally happens is that students with a prior knowledge of the Standards of Practice will unconsciously use the first person when the patient is speaking and the third person when is the provider speaking. This is an interesting approach and attempt to compromise, but it makes me question if all this switching back and forth has less to do with what is "best" for the patient, and more to do with our own issues with authority.

So in the second class role-play exercise, I ask a student who has never interpreted as a professional to interpret, and I request that this student do so in the first person. Like magic, the professional interpreters who had so resisted the idea of using the first person are able to see themselves in the "mirror" of another interpreter. Soon I begin to hear, "yes it does make a difference", "the doctor and patient seem more attentive to each other" and "the session goes faster".

Some interpreters experience a type of transference with providers. They feel they do not have the right to voice a voice of authority. So they distance themselves from this authority by using the third person (i.e. "the doctor says you might need surgery"). My concern is that through this transference, we create counter transference for our patients, building a silent alliance that in many ways robs the clinician from the chance to develop a personal relationship with the patient. Our internal voices and our insecurities prevent us from accurately representing the voices of the other parties to the triadic encounter.

We are the only professional group that I know of that does not receive guidance in dealing with our intrapsychiques. Psychiatrists, medical doctors, nurses, social workers and other direct care professionals all have some kind of ongoing one-on-one or peer supervision, often in the form of team meetings or Grand Rounds.

My proposal to interpreters is that we begin to research this area. What type of support systems can we develop locally and how can these be tied in to a nationwide network? Of course, one shoe may not fit us all, perhaps due to specific cultural or linguistic challenges, but the closer we as a group pay attention to our internal voices the better listeners…in fact, the better interpreters we will become on our path to professional excellence!

Any other meanings to PVS?

Worldwide attention to the case of Terri Schiavo has brought the initials PVS to everybody's attention. There are other established meanings to PVS, medical and non-medical, some of which existed long before Persistent Vegetative State was introduced in the 1970s. Here are some:

- Programmed Ventricular Stimulation
- Pigmented Villonodular Synovitis
- Psychological Vulnerability Scale
- Plummer-Vinson Syndrome
- Post Vaccinial Surveillance
- Plexus Visualization Score
- Pulmonary Vein Stenosis
- Peritoneal Venous Shunt
- Partner Violence Study
- Pig Veterinary Society
- Proxy Voter Services
- Pubo-Vaginal Sling
- Polyvinyl Sponge

The Role of the EMEA in the European Union

By Gilberto Lacchia, M.D.

A side effect is “a consequence other than the one(s) for which an agent or measure is used” (Dorland’s Medical Dictionary). Usually side effects are undesired responses to a medicine, the so-called adverse drug reactions (ADRs) or adverse reactions. The Summary of Product Characteristics (SPC) for prescribers and the package information leaflet (PIL) for patients list the known ADRs related to a particular drug. Adverse reactions are highly variable among patients. Many patients will get no side effects and, when this happens, in most circumstances the benefit-risk ratio of the medicine to that individual is still positive. Rarely a serious adverse drug reaction (SADR) may occur: this results in death or is life-threatening or leads to hospital admission or a disability (e.g. blindness, deafness). Adverse reactions linked to a birth defect are considered serious irrespective of the severity of the birth problem.

Before marketing, drugs are extensively tested in animals and in clinical trials in humans. These tests tell much about the drug's efficacy but for several reasons relatively little about safety (). Economical reasons make impracticable a thorough search of all possible adverse effects: such research would make new drugs too expensive. Therefore an organization for detecting and monitoring ADRs after marketing has an important role, especially in the first marketing period.

Table - Limitations of most clinical trials in highlighting a drug's safety (Stricker BH, Psaty BM., Detection, verification, and quantification of adverse drug reactions. BMJ. 2004;329:44-7)

Homogeneous populations	Most trials assess relatively healthy patients with only one disease and mostly exclude specific groups such as pregnant women, children, and elderly people
Sample size	Small sample size (up to 1000 patients) reduces the chance of finding rare adverse reactions
Limited duration	Trials of short duration preclude the discovery of long-term outcomes such as cancer
Inability to predict the real world	Drug interactions can be substantial in a population as patients may take drugs concomitantly, a condition that can almost never be predicted from clinical trials

The word pharmacovigilance has its origins in the Greek 'Pharmaco' (medicine) and the Latin 'Vigilantia' (vigilance, watchfulness): it refers to the process of monitoring, evaluating and improving the safety of medicines in use, by pharmaceutical companies, government agencies and healthcare professionals. The scope of pharmacovigilance is the detection, assessment, understanding and prevention of ADRs or other product-related problems.

The term pharmacovigilance has been used since the late 1970s by a group of French pharmacologists and toxicologists and is still most widely used in non-English and European texts: in the Anglo-Saxon texts the preferred term is post-marketing surveillance. "Pharmacovigilance" is still not present in the MeSH thesaurus although with a PubMed search one finds 850+ hits for post-marketing (or postmarketing) surveillance and almost 800 for pharmacovigilance.

To identify new ADRs pharmacovigilance produces an early signal, defined as a request of attention triggered by any possible source (e.g. clinical trials, spontaneous reporting) about the possible association between a drug and an adverse reaction.

The signal leads to a series of events:

a) hypothesis for the possible cause-effect relationship

b) evaluation of the available data to confirm or refute this hypothesis

c) verification, evaluation and explanation of the signal

d) decisions and information

Pharmacovigilance usually uses different approaches (table 2) to elicit signals by observing a single patient or populations of patients.

Pharmacovigilance has four major goals:

1

As quick as possible identification of new ADRs

2

Improvement and spreading of information about suspect or known ADRs

3

Evaluation of the advantages of a drug in comparison with other drugs or therapies

4

Communication of information to improve clinical practice

Table - Pharmacovigilance methods (adapted from Meyboom RHB, et al. Principles of signal detection in pharmacovigilance. Drug Saf, 16: 355-365, 1997)

Analytic non-experimental approach	Voluntary reporting Intensive monitoring Record linkage Case-control studies Cohort studies Morbidity/mortality data banks
Analytic experimental approach	

Voluntary reporting

This is the most important approach in ADRs detection. Adverse effects could not be easily detected without professional observers. Case reports are among the most important tools for observational research. In a country such as the United Kingdom, with about 60 million inhabitants, a 1% cumulative exposure to a drug would mean 600,000 people using yearly the drug at any time during that year. A rare adverse effect with an incidence of 1 in 10,000 might be detected in such a population making it easily recognised. For instance, recognition of phocomelia due to thalidomide should have been easy but because of the unfamiliarity with drug safety problems it took then several years to identify a causal relation. Detection of non-specific ADRs is more difficult. Similarly, it may be difficult to detect an adverse effect that is indistinguishable from the disease being treated. For example, arrhythmia as an adverse effect of antiarrhythmics, a kind of ADR that may therefore remain unnoticed.

Voluntary reporting can be related to medical literature or monitoring centres. Medical literature is probably the most effective system for initial detection of ADRs. Case reports are detailed, assessed for quality and usually independent from commercial incentives. Not all published case reports represent true ADRs as there is always the possibility of false positive signals. Despite this, medical literature is a highly efficient system for new ADRs and often recognizes rare events and people at high risk.

When substantial numbers of reports are available, comparing the proportion of reports of an adverse effect with similar drugs may provide strong signals (e.g. rhabdomyolysis associated with cerivastatin).

Usually many of such reports are needed to produce a signal, depending on the event severity and on the quality of information submitted. However, a single good quality report with a positive drug rechallenge may sometimes produce a strong signal (e.g. phocomelia caused by thalidomide, halothane hepatitis, chloramphenicol-induced neutropenia or practolol-induced oculomucocutaneous syndrome).

Monitoring centres are the national ADR monitoring centres and the WHO Collaborating Centre for International Drug Monitoring. In 1968 the WHO set up the “Programme for International Drug Monitoring” to monitor ADRs and identify those ADRs not identifiable during clinical trials because of their rarity. Within the programme, individual case reports of suspected adverse drug reactions are collected and stored in a common database: it now contains over 3 million case reports. In each of the countries joining in the program, the government has designated a national centre for pharmacovigilance. Today this system of voluntary organized spontaneous reporting is followed by more than 70 nations.

In some countries (e.g. UK, Italy) healthcare professionals such as physicians or pharmacists must compulsively fill in an ADR form (yellow card scheme) and send it to health authorities. Healthcare professionals should not ask themselves whether a drug is associated or not to an observed ADR: they are asked only to report it. The purpose of the system is to gather many reports and produce alarm signals by evaluating different sources. Physicians should above all report ADRs from recently marketed drugs, serious ADRs, ADRs that could represent late effects of drugs, congenital defects and all those ADRs following vaccine administration.

MedWatch it the FDA's pharmacovigilance programme. Through MedWatch, a voluntary programme, health professionals report serious adverse reactions and problems related to drugs, biologics, medical devices, dietary supplements, cosmetics, and infant formulas.

These systems may be applied to a whole population of patients undergoing a drug treatment. It is not easy to identify ADRs not already suspected or known and reporting relies on the motivation of healthcare professionals to report ADRs. It is

influenced by the kind and severity of the ADR and it suffers from the so-called under-reporting (from 90% to 98% of cases in different studies). It is therefore impossible to know the real number (incidence, prevalence) of ADR cases. As a result, organized spontaneous reporting underestimates the risk associated with drug treatments. Nevertheless, this system has proved to be a valuable information source about ADRs: by merging reported data with prescription data is possible to estimate ADR incidence. It represents a useful system to monitor ADRs in different countries, to validate ADRs and to assess the risk-benefit ratio for a drug.

Intensive monitoring

The Boston Collaborative Drug Surveillance Programme is a typical intensive monitoring programme: ADRs are systematically recorded in a database. It is possible to produce statistics about the incidence of ADRs, but not to discover new ADRs.

Record linkage

With record linkage the information from two independent sources is integrated. Records from the two sources about the same individual are matched in such a way that they may then be treated as a single record for that individual. For pharmacovigilance purposes different registries and databases are linked: general practice disease registries, prescription registries, hospital disease registries, hospital prescription registries.

Prescription Event Monitoring (PEM), used by the English National Health Service, is a form of post-marketing surveillance of new drugs which prompts all doctors using new drugs to report the events which follow their use. Its aim is to examine the safety of new drugs intended for widespread use in primary care. The English Prescription Pricing Authority (PPA) provides the PEM database with details of prescriptions written by English general practitioners for the new drugs monitored by PEM. This forms the 'exposed' group (denominator). After enough time (usually six months), the physicians should report any event occurring among patients with the prescription and this information forms the outcome data (numerator). From these data is possible to estimate the incidence.

Cohort studies

A population of patients taking a certain drug is followed in time and the adverse events recorded. These studies are costly and there is not a control group for comparison.

Case-control studies

They are retrospective studies used to compare the adverse reactions of patients taking a drug with those that do not take it.

Morbidity and mortality data banks

Registries and databases recording deaths and congenital defects are linked to drug use registries: this method delivers important information about drug use risk.

European Agency for the Evaluation of Medicinal Products

The European Agency for the Evaluation of Medicinal Products (EMEA) was born in London on 22 July 1993. At the same time two new European drug authorising procedures were introduced: the centralised procedure and the mutual recognition procedure. The Agency harmonizes the existing scientific resources of the Member States to evaluate and supervise medicinal products for both human and veterinary use throughout the European Union. The EMEA promotes public health by providing health care professionals and users with the same information throughout the European Union in all official EU languages: medicinal products have the same name, labelling and package leaflets for all users and the same indications and product information. A second important role of EMEA is the continuous monitoring of medicines across the EU.

A Management Board made up of 34 members supervises EMEA activity, with two representatives from each Member State, from the European Parliament and from the European Commission. Two scientific committees are responsible for issuing EMEA's opinions on questions about the evaluation of medicinal products: the Committee for Proprietary Medicinal Products (CPMP) and the Committee for Veterinary Medicinal Products (CVMP). Each committee is made up of 30 members chosen by the Member States.

Centralized procedure: it is compulsory for all medicinal products produced with biotechnology and is optional for other innovative new medicines. Applications are made directly to the EMEA and are evaluated by one of the scientific committees. The EMEA has 210 days to perform the evaluation, but this period may be interrupted if the committee needs further information from an applicant. Based on the EMEAs opinion, the European Commission has 90 days to decide about granting a marketing authorisation. A Community marketing authorisation is valid throughout the European Union and usually it lasts 5 years.

Mutual recognition: this procedure is based on the principle of mutual recognition of national authorisations between Member States and applies to most conventional medicines. Under the procedure a marketing authorisation granted by one Member State is extended to one or more other Member States selected by the applicant. If another Member State does not recognize the original marketing authorisation, the points in dispute are referred to the EMEA for arbitration. The opinion of the EMEA is then enforced by a decision of the European Commission.

EudraVigilance

EudraVigilance is a central computer database created by the EMEA in December 2001. It contains adverse reaction reports to medicines licensed across the EU. Such reports are issued by the EU regulatory agencies and by pharmaceutical companies.

The purpose of EudraVigilance is to support the public health of EU citizens by collecting safety information on medicines and making this available for scientific assessment. This assessment is carried out by regulatory authorities in the EU that constantly supervise and monitor the correct use of medicines in all EU countries. Companies that market the medicine have access to the information about their own medicines. In this way they can have a complete picture on what is currently reported in terms of safety and provide prescribers and patients with up-to-date information. Health professionals or patients do not yet have access to this database, but this is planned for the next few years.

Pharmacovigilance has been extended to clinical trials too: for all clinical trials starting in the European community from May 1st 2004 onwards, sponsors need to obtain a EUDRACT number from the European clinical trials database (EUDRACT). Sponsors of clinical trials conducted in the EU shall also ensure that all relevant information about suspected serious unexpected adverse reactions (SUSARs) are recorded and reported to the competent authorities in all the Member States concerned and to the Ethics Committees. Commercial and non-commercial sponsors of clinical trials are also allowed to report electronically SUSARs occurring during clinical trials. All SUSARs occurring in the EU shall be sent electronically to the EudraVigilance clinical trials module. EudraVigilance contains two reporting modules:

- EudraVigilance Post-Authorisation module (EVPM) designed for post-authorisation individual case safety reports (ICSRs)
- EudraVigilance Clinical Trial module (EVCTM) designed for pre-authorisation SUSARs

Reporting of suspected serious adverse reactions involves health care professionals, regulators, marketing authorisation holders and relates to the reporting of reactions, occurring both within and outside the EU, for all medicinal products approved in the EU itself. The number of suspected serious adverse reaction reports yearly managed at Community level is estimated at 320,000. Therefore the system is moving away from a paper based reporting organization towards electronic transmission of pharmacovigilance information.

References

A.Caputi - La farmacovigilanza (Italian)
http://www.farmacovigilanza.org/corsi/caputi/all.htm

Stricker BH, Psaty BM., Detection, verification, and quantification of adverse drug reactions. BMJ. 2004 329:44-7.
http://bmj.bmjjournals.com/cgi/content/full/329/7456/44

EudraVigilance FAQs
http://eudravigilance.emea.eu.int/human/Q&A.asp

WHO Programme for International Drug Monitoring
http://www.who-umc.org/whoprog.html

Human Product Information Templates (EMEA)
http://www.emea.eu.int/htms/human/qrd/qrdtemplate.htm

Pharmacovigilance Terms Definitions
(Uppsala WHO Monitoring Center)
http://www.who-umc.org/defs.html

Glossary of Terms and Acronyms (Medicines and Healthcare products Regulatory Agency)
http://medicines.mhra.gov.uk/pilot/app1.htm

Caduceus
A Publication of the Medical Division of ATA

By Rafael A. Rivera, M.D., FACP

Words about words and related words

"little people" is a general term given to people of abnormally short stature. The medical term is dwarfism, which includes persons of an unusually short stature with or without any number of associated abnormalities. Midget is the most common synonym for dwarf. Pigmy refers correctly only to particular breeds of African and Asian dwarfs but is also used imprecisely for other dwarfs. The Little People of America (LPA) http://www.lpaonline.org/index.html , a non-profit organization that provides support and information for people of short stature and their families, is the most comprehensive resource to obtain any information, medical or otherwise, about dwarfism.

"live autopsy" means collecting forensic evidence from a live person, not performing an autopsy in front of a live audience

incest from the Latin *incestus*, meaning unchaste. Correctly, refers to sexual behavior between persons who are closely related genetically. Practically speaking, though, it often is used to include genetically unrelated family members.

attending physician the member of the medical staff of a healthcare organization (usually a hospital) who is responsible for all the medical and legal aspects of a patient admitted under his care while hospitalized. Such a physician may or may not have an antecedent medical relation with the patient who may have been admitted through an emergency room without a physician of record. The patient may also be referred for admission by his private physician who does not have admitting privileges to the particular hospital and is, therefore, unable to care for the patient, or is referred for admission by a public healthcare organization. It is the **in-patient status** of the person under his care that determines the **attending physician status** of the doctor in charge (who attends) of his medical care.

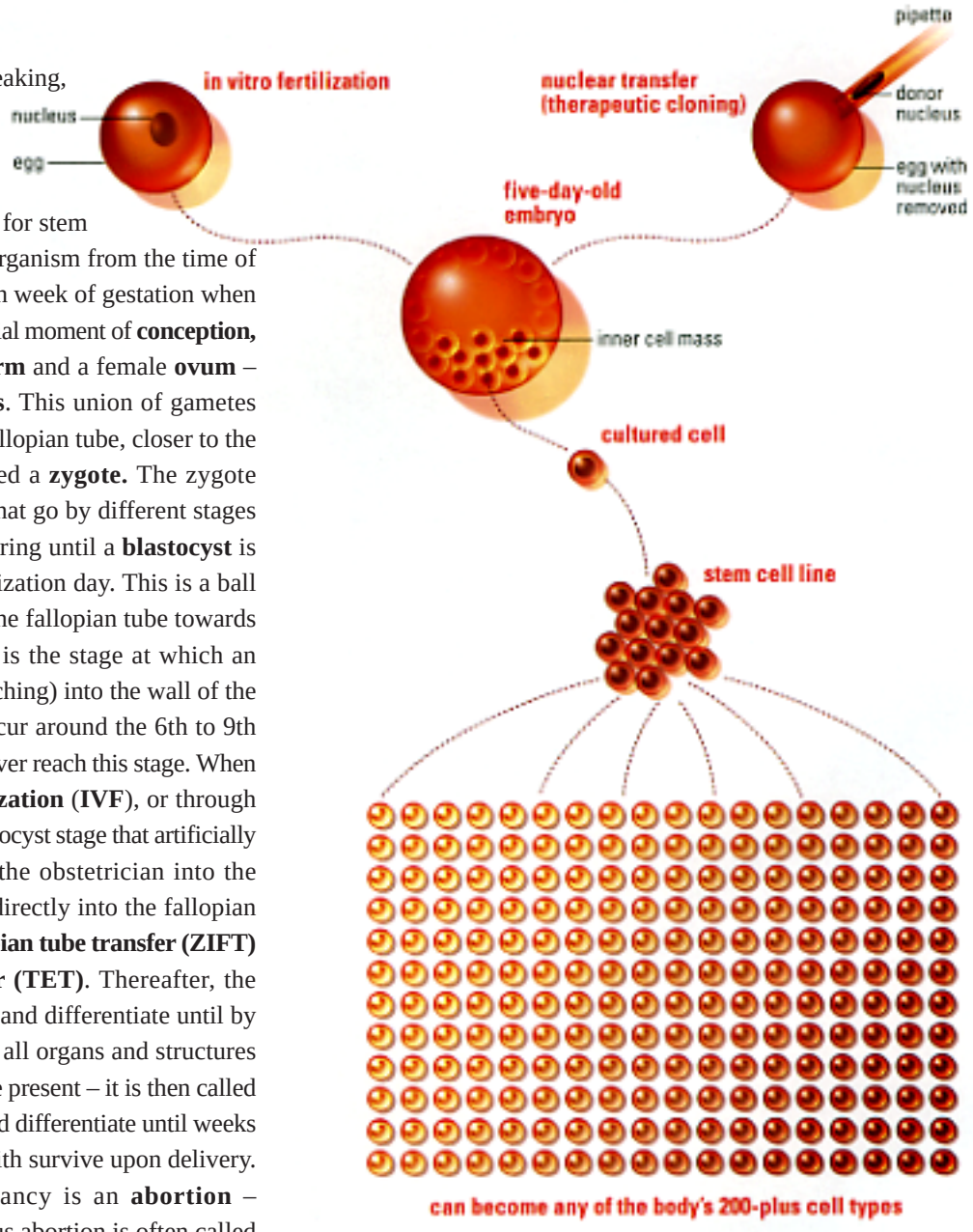
verbal autopsy the word autopsy is often used to indicate any investigate process or diligent scrutiny for many purposes other than the usual pathological dissection of a cadaver in search of the cause(s) of death. A verbal autopsy refers to the use of structured interviews and study of available relevant records in a particular population or community in order to ascertain the cause(s) of a particular fatal event. The methodology is useful in underdeveloped countries where information and access to medical sources is scarce. Suitable situations for verbal autopsy investigations would be the cause of HIV-related deaths, pregnancy-related deaths, or the cause of death in newborn babies.

Minute Clinic refers to medical services rendered promptly in a variety of settings without the usual delays. Shopping malls, pharmacies, university campus, large organizations have a full time, experienced Certified Nurse Practitioner available to see and prescribe, on a walk-in basis, for patients with common ailments such as pink eye, sore throat, sinus infection, ear infection, flu, skin conditions of recent onset, poison ivy, tick bites, screenings for cholesterol, pregnancy and the like. The practice is growing nationwide.

Human Development Terminology

From gametes to adults with embryos and stem cells in between

EMBRYO: an **embryo**, generally speaking, is the earliest developmental stage of plants and animals. A **human embryo**, as defined by the official National Institutes of Health resource for stem cell research, refers to a developing organism from the time of **fertilization** until the end of the eighth week of gestation when it becomes a **fetus**. Fertilization, the initial moment of **conception,** is the coming together of a male **sperm** and a female **ovum** – also called male and female **gametes**. This union of gametes takes place in the distal portion of a fallopian tube, closer to the ovary. The fertilized egg cell is called a **zygote.** The zygote undergoes rapid cell division cycles that go by different stages whose names are not worth remembering until a **blastocyst** is formed by around the fifth post-fertilization day. This is a ball of about 150 cells as it moves down the fallopian tube towards the uterus. Importantly, a blastocyst is the stage at which an embryo is capable of implanting (attaching) into the wall of the uterus, a critical event which will occur around the 6th to 9th day. Approximately 55% of zygotes never reach this stage. When pregnancy occurs via **in–vitro fertilization** (**IVF**), or through **artificial insemination,** it is at the blastocyst stage that artificially created embryos are transferred by the obstetrician into the uterus. Zygotes can also be injected directly into the fallopian tubes - referred to as **zygote intrafallopian tube transfer (ZIFT)** or simply as **tubal embryo transfer (TET)**. Thereafter, the embryo continues to divide, lengthen and differentiate until by the end of the 8th week of pregnancy all organs and structures normally found in a newborn infant are present – it is then called a **fetus.** The fetus continues to grow and differentiate until weeks 29 to 39 when most healthy fetuses with survive upon delivery. A premature termination of pregnancy is an **abortion** – spontaneous or induced. A spontaneous abortion is often called a **miscarriage.**



Source: National Geographic Magazine.

STEM CELL – a **stem cell**, simply speaking, is a cell that has the capacity to become a wide variety of other cell types, it is pluripotent. There are three sources of stem cells.

a. Human embryonic stem cells, stem cells from developing human embryos, have said capacity to give rise to every kind of human tissue. Scientists have now developed the technique to isolate and grow cultures of human embryonic stem cells,

let's say from frozen blastocysts, that are then separated into specific subpopulations of human cells i.e., heart muscle, bone marrow, kidney and others. These cells multiply tirelessly in laboratory dishes offering a self-replenishing supply from which to grow replacement tissue for use in a wide variety of diseases, from diabetes, to Alzheimer's to feeble heart muscle, to damaged spinal cords and other medical problems. This technology could replace the need for organ transplantation and the problem of immune-system reactions could be eliminated through genetic manipulations to make stem cells universally compatible. Stem cell banks like today's blood banks would be a matter of time.

b. Umbilical cord blood is a well-known rich source of stem cells. The cord blood registry, which claims to be the oldest and largest umbilical cord blood bank of its kind, says it has more than 300,000 samples of stored cord blood for possible future use by the child or adult who was once attached to that cord. Cord blood deposits can be made by any parent to the nearest cord blood public bank that uses them as a source of stem cells for anyone who needs them.

c. Adult stem cells are stem cells found in all adult human tissues, most notably bone marrow and testicles. Approximately 200 billion red blood cells, for example, are produced daily in an adult human from hemopoietic stem cells. Adult stem cells are not considered as plentiful, easy to isolate, harvest and purify as the embryonic variety. Nevertheless, their usefulness is under investigation worldwide, For example, stem cells extracted from the bone marrow of South Korean patients with strokes and injected into their damaged tissues were reported to have remedial effects in 64 of 74 such patients. Adult bone marrow stem cells injected into heart arteries are believed to improve cardiac function in cases of heart attack or heart failure. In various studies, leukemia patients treated with stem cells from bone marrow and umbilical cord blood have emerged free of disease; donor blood stem cells have reduced certain lymphomas, pancreatic and ovarian cancer in some patients. In human trials, joint pain lessened temporarily in patients with rheumatoid arthritis, and some then responded better to standard drug therapies (6).

References:

1. http://en.wikipedia.org/wiki/Embryo
2. www.ncfmc.com/comterm
3. www.lifebankUSA.com
4. www.marchofdimes.com/professionals/681_1160.asp
5. www.keepmedia.com/pubs/AFP/2005/06/09/887284
6. National Geographic Magazine, July 2005

The Medical Division will be well represented during the Annual Conference in Seattle.
Here is a listing of Seminars, Presentations and our Annual Meeting as we to publication withis issue.

J	Pre-Conf Seminar Emphasizing the Medical in Medical Interpretation *Rafael A. Rivera, M.D.*
MED-1	Moving from Cure to Care: The Challenges of Palliative Medicine at End of Life *Richard S. Lane, M.D.*
MED-2	Epilepsy: History and Terminology *Maria Rosdolsky*
MED-3	The Anomalies of Mental Health Interpreting *David Cardona and Janet M. Erickson-Johnson*
MED-4	Words and Values: Factors Affecting Translation of Patient-centered Medical Documents *Elena N. Levintova*
MED-5	Instrument Development for LEP Individuals: Cultural Competence Considerations *Alejandra E. Koval*
MED-6	Tool Box for the Medical Translator *Alain Cote*
MED-7	Medical Liability Reform *Santiago Neme and Marcela D. Pinilla*
MED-8	Symbiotic Interaction within Medical Interpreting *Janet M. Erickson-Johnson*
MED-9	Medical Division Annual Meeting *Martine Dougé*
MED-10	Requesting Clarification in the Triadic Encounter *Zarita Araújo-Lane and Vonessa A. Phillips*
MED-11	Credentialing Healthcare Interpreters in California: A Step Toward Certification *Tom M Riley and Cynthia E. Roat*
MED-12	The Multilingual World of American Healthcare: Challenges and Opportunities *Catherine W. Ingold, Angela A. Kurtz, and Carol J. Patrie*

Access to health care means access to language interpreters.

By Roberto Anson

Community Health Centers (CHC) are all about access - access which is not possible without the presence of trained language interpreters. CHCs are at the forefront in the delivery of primary health care benefiting low-income, uninsured and at-risk people in urban and rural multi-language communities The rapid growth of Limited English Speaking (LEP) populations, migrant workers, immigrants and refugees has fostered a corresponding increase in the number of medical interpreters within CHCs. Other sources of medical care are grappling with crafting how best to adapt to changing local needs.

Like the weaving of a small textile cloth, six threads run through this piece: a focus on trained language interpreters, a summary of the interpreter's role, an overview of key interpreter competencies, a snapshot of cultural connections, a link between language/cultural proficiency and quality of care, and a list of interpreter resources.

Interpreters cannot interpret what they do not understand. Similarly, patients cannot fully act on information they can not grasp. The link between these two statements underscores the importance of interpreter competencies and quality training.

The complexity of the triadic encounter unfolds by understanding the roles of the three key people involved: patient, practitioner and proficient interpreter. Patients report symptoms, practitioners diagnose and treat while interpreters serve as a 'voice' and not a 'filter'. The primary interpreter competencies involves the six Ps: Positioning, Person (1st instead of 3rd person tense), Proficiency, Professionalism (including ethics) and Pre and Post triadic encounter introductions and self-assessment.

The six Ps of interpreter competencies

a. Positioning
b. Person (tense)
c. Proficiency
d. Professionalism
e. Pre-session introduction / instructions
f. Post encounter assessment

When conducting cultural training to health care staff in the city of Baltimore, I usually summarize some key aspects of Latino culture by referring to the five Fs: family, friends, faith, food, and festivities. These areas of attention, while not unique to Latino/Hispanic cultures, do provide opportunities for "interaction" and "connection" among these diverse populations, both culturally and linguistically.

Because cultural beliefs influence the maintenance of health as well as the onset, progression and outcomes of disease, a medical interpreter's effectiveness is greatly influenced by his understanding of intra-cultural and cross-cultural traditions. Culture and communication are as inseparable as a fish from water. Professional growth and learning occur in each encounter. Effective medical language interpreting links quality care and communication.

"Cultural DNA", as I call it, is the process of internalizing and externalizing an understanding of the deeply imprinted beliefs of the people served. Language and culture are all about nuances.

Access to health care means access to language interpreters.

RESOURCES

1.Cross Cultural Health Care Program (CCHCP) Training programs and resources, best practices, advocacy and policy. "Bridging the Gap" (BTG) is an outstanding 40 hour training program in medical interpreting. www.xculture.org (206.860.0329)

2.www.diversityrx.org A variety of cross-cultural and language training resources.

3."Using Bilingual Staff Members as Interpreters," (8 rules for interpreters) Javier F. Sevilla Matrir, MD and Deanna R. Willis, MD, Family Practice Management Journal, American Academy of Family Practice, July-August 2004 www.aafp.org/fpm (1.800.274.2237)

4."Communication is a Quality of Care Issue", National Alliance for Hispanic Health, 2005; 5 pages (strategies to provide services to LEP patients, skills for competent interpreting and excellent examples of financial benefits of interpreters.) www.hispanichealth.org 202.387.500

5."Cultural Health Assessment", Mosby's paper-back pocket guide series, edited by Carolyn Erickson D'Avanzo and Elaine M. L. Geissler, St. Louis, MO. 3rd edition. (Cultural, ethnic and health profiles from over 180 countries presented in a quick-reference format. A quick-reference format for practitioners, interpreters and students). ISBN # 0-323-01858-0 www.elsevierhealth.com

6.University of Michigan's Program for Multicultural Health. Cultural resources and tools for health care professionals. The section on "Bi-weekly multicultural health generalizations" summarizes multicultural and health beliefs from dozens of nations. www.med.umich.edu/

7.Plastic laminated Clini-cards in different languages. Example: "La Historia Clinica Modelo" by A. Arturo Rodriguez, MD (RODRAM Corp., SA de CV Mexico, D.F., Mexico) 2002 Edition (ISBN # 968-6277-64-1) www.ScyMed.com

8.Plastic laminated bilingual cards (3"X 7") "Spanish – English Translator"2002 MIS, Inc., 25 Horseshoe Lane, Stamford, CT 06903 Medical Information Systems, Inc. www.medicalinfosystems.com

9.Pocket tri-color tabbed language phrasebooks in various languages. Example: "Speedy Spanish for Medical Personnel"; ISBN # 0-9602838-6-2 (3 1/2 "X 5 1/2 ") $4.95 each (plus shipping), Baja Books, Box 4151, Santa Barbara, CA 93140 1.800.962.4028 www.speedylanguage.com

Roberto Anson is a Spanish Medical Interpreter at a Community Health Center in Baltimore, MD. He formerly served in that capacity at the National Institutes of Health (NIH) Clinical Center in Bethesda, MD
He can be reached at : culturerus@verizon.net

A ver qué se cuece en los pasillos...

Por Roberto Guzmán

ACHUCHARSE En el lenguaje familiar sirve para señalar que una persona sufre de escalofríos. También designa a la persona que contrae la enfermedad llamada "chucho" que es el paludismo. En última instancia con ella la persona expresa que está asustada/achuchada.

AGALLONES Es palabra del género masculino. Es la parotiditis o "paperas", inflamación de las glándulas salivales. El vocablo consta en algunos diccionarios. Fue recogida en el Pequeño Larousse.

AGRIOR Es palabra del género masculino. Es la acidez del estómago. Además de "tener agrior", otros equivalentes para síntomas relacionados a la acidez estomacal son agruras o hervederas

CURSIADERA Es voz femenina. Es la diarrea. De esta voz descienden "cursiento, ta, con funciones de adjetivo para referirse a la persona que "tiene flujos" o diarrea. El "curso" se refiere anatómicamente al ano-recto. Mover el intestino se le dice "dar del curso" o "dar del cuerpo"

CHAGÁSICO Es vocablo masculino. Se designa con él al individuo que tiene la enfermedad de Chagas o Chagas-Cruz.

ESCUPIDA El género se deduce de la terminación. Es el escupitajo.

GANGOSEO Es verbo gangosear es intransitivo. Corresponde al verbo más conocido ganguear. Se define con el verbo la forma de hablar de algunas personas que lo hacen con resonancia nasal producida por algún defecto en los conductos de la nariz.

LATENTE Es adjetivo que se emplea para describir el dolor. Describe lo que es vivo, intenso y persistente, también la sensación de latidos / pulsaciones, en inglés a "throbbing sensation or pain".

LIVIANO, NA Es un adjetivo que destaca el tipo de alimento que es de fácil digestión.

MANCHA Es una especie de carbunclo de tipo contagioso.

OJEADURA Voz femenina. También la aojadura, o el aojo. Es la acción o el efecto de aojar que es el hacer o echar mal de ojo.

OLLA Es la cavidad natural que existe entre la garganta y la parte superior del esternón. Se usa tanto para animales como en los humanos.

Roberto Guzman es un lingüista que se desempeña como interprete médico en el Jackson Memorial Hospital, hospital principal de enseñanza de la Facultad de Medicina de la Universidad de Miami. Además del español trabaja en francés, criollo haitiano y portugués

Caduceus
A Publication of the Medical Division of ATA

SUMMER 2005

Caduceus is a quarterly publication of the Medical Division of the American translators Association, a non-profit organization dedicated to promoting the recognition of translating and interpreting as professions.

Editor
Rafael A. Rivera, M.D.,FACP
bukrak@bellsouth.net

Assistant Editor
Elena Sgarbossa, M.D.

Editorial Staff
Gilberto Lacchia, M.D.

Proofreaders
Diane Howard
Ester Diaz
Maria Rosdolsky

Design by
GrafMarc.com
albertom@grafmarc.com
[954] 298-3051

Please send all correspondence and contributions to:
bukrak@bellsouth.net

The Schiavo case captured world attention and merits a lead position in Caduceus. The article is a comprehensive review of the case and the medico-legal concepts and terminology involved in it which created so much confusion, plus a comparison with other landmark cases. Dr. Elena Sgarbossa, our Assistant Editor, takes us for a stroll through the landscape of typos during her early experiences in Italy. Leon Mc Morrow continues his Translator Clinic series visiting our “sister services”, dentistry and veterinary medicine, which hopefully will generate the interest of others in offering their contributions from a variety of perspectives. We have obtained a contribution from Dr. John Dirckx, a learned physician with vast experience in terminology and nomenclature who gives us a perspective of current anatomical nomenclature. Roberto Anson returns with a real world perspective of Community Health Services and a comprehensive list of resources worthy of note by medical interpreters.

Known contributors Gilberto Lacchia, Zarita Araujo, Vonessa Phillips and Roberto Guzman round up this issue with their continued excellent work.

This Summer issue represents an invitation to all to join us in Seattle during the forthcoming Annual Conference where, once again, our Medical Division will be very well represented. Also, we will be holding elections this year. Hope to see you there.

Salud.

Rafael

Instructions to Authors

Submissions for publications must be sent electronically in Word format. The deadline for submissions for the Fall-Winter issue of Caduceus is 15 Dec 2005.

Caduceus carefully reviews its content in order to eliminate any textual errors. Nevertheless, we apologize for any errors in grammar, punctuation, typography and the like which may inadvertently appear on our pages.