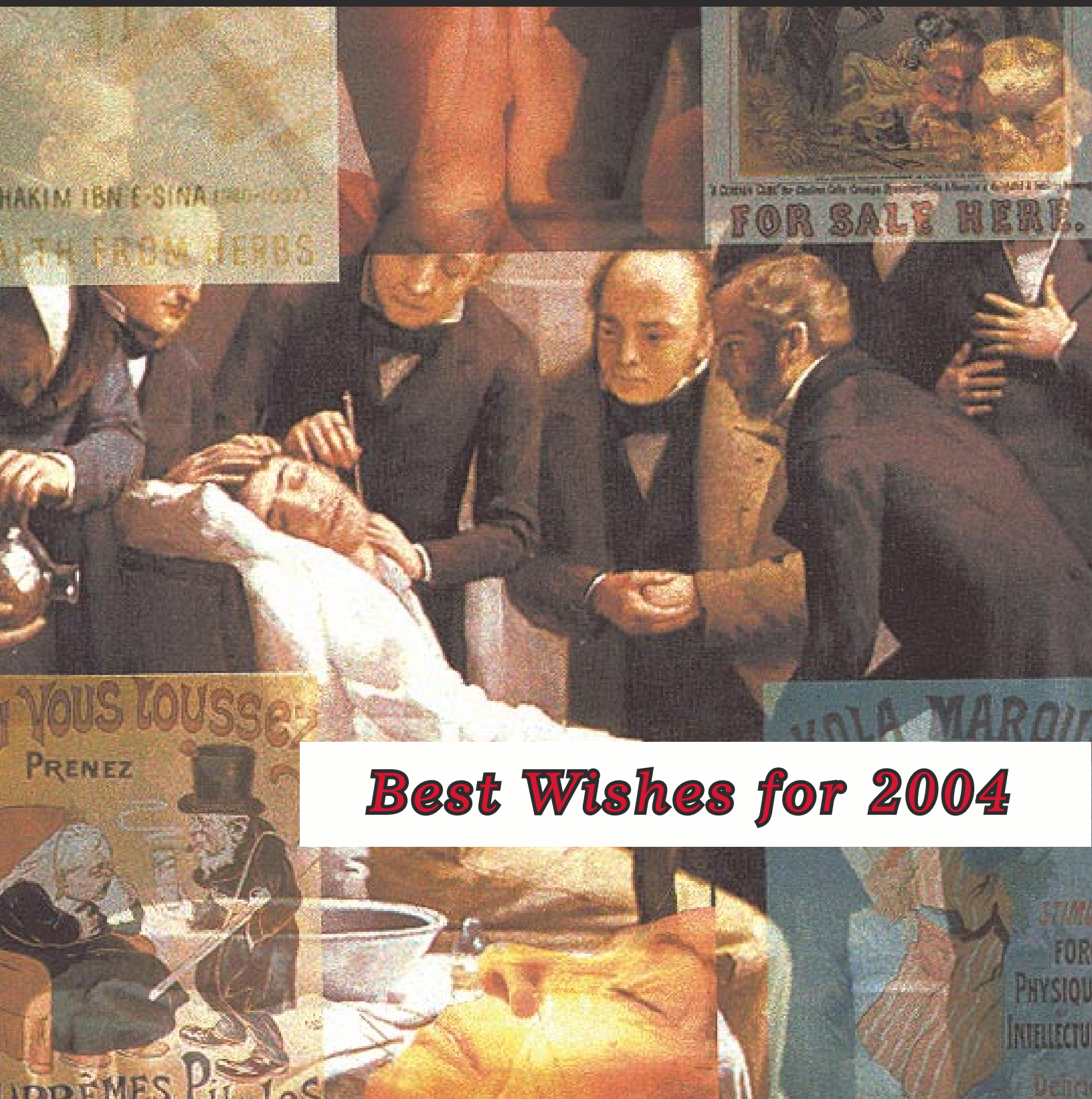
Winter 2003-2004

ata CADUCEUS

A publication of the Medical Division of the American Translators Association



Best Wishes for 2004

Caduceus

January 2004

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

Editorial Staff
Diane Howard
Elena Sgarbossa, M.D.
Astrid Kaesser
Joan Wallace
Vero Albin
(rest "under construction")

Proofreaders
Esther Diaz
Maria Rosdolsky

Art Director
Maritza Cosano
Coral Springs, Florida
mcosano@bellsouth.net

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

FROM THE EDITOR

Things have happened awfully fast! The Division's Annual Conference activities and the editorial change over have taken up all of my time and attention. It is a matter of record, I am pleased to inform you, that our efforts in Phoenix were very well received. As you read I am making arrangements for this year's conference in Toronto.

Caduceus, in its new format, is still "under construction" in various parts, including the selection of a newsletter staff that can help me create the best product we are capable of. I need you to come forth and offer your skills, be they editing, proofreading, fresh design or layout ideas, articles, small contributions or regular features, how to present medical information that is useful to the membership and whatever interesting enhancements you can suggest after going over this issue.

If your first impression is a positive one, just think what we could do if we all pull together in a common effort.

Holly Mikkelson has strengthened our view that we must seek ways to express our linguistic diversity. Keep in mind that we are not a specific language division, but a professional specialty division represented by many languages, with English as our common language.

This has been a rapid growth period for our division. Your ideas and participation are not only welcome but necessary to insure we stay on course.

Rafael

FROM THE ADMINISTRATOR

I hope the New Year has been good to all of you so far. November 2003 marked our first time participating in the ATA Annual Conference and I am happy to report that it was a huge success. Our Day of Medicine sessions were stimulating, well organized and well worth the effort.

We also had our elections in Phoenix and I am proud to be serving the division as the Administrator with Rafael Rivera as the Assistant Administrator. Everyone has put forth a great deal of effort to bring this division together. I would like to thank everyone who graciously volunteered throughout the year and during the conference. I personally would like to thank Marla O'Neil, our past Assistant Administrator, and Naomi Moraes, our past Editor, for making it all happen. We could not have done it without you.

In addition to continuing with the publication of our great newsletter, we look forward to achieving the following goals: building a website, organizing sessions for the Toronto Annual Conference, and putting a program in place to support education for our colleagues and ourselves. We are all motivated about the prospects for 2004 and with a continued effort on everyone's part we can increase our network, build a strong platform on which we can all grow and learn, and most certainly enhance our career opportunities. I know we have talented and creative members, do not be shy. Those of you with hidden web design talent now is the time to come forward, we need you.

If you like to provide your assistance with any of these efforts or if you have any new input on ideas, please contact me at 954 252 4529 or at creole_md@yahoo.com.

Sincerely,
Martine Dougé

FLATA Congratulates the Medical Division

FLATA--the Florida Chapter of ATA-- congratulates the new Medical Division on being officially established so soon after initiating its activities early last year. The energy invested by its acting administrators, newsletter editorial staff and contributors have been rewarded with an early well-deserved approval.

We are particularly proud to see that some of the members of our own Florida Chapter--Martine Douge, Rafael Rivera, and Vice President, Gloria Nichols--are actively involved in the rapid progress of the new ATA Medical Division. Other groups within ATA wishing to form a new division or local chapter, should derive encouragement from the successful launching of the Medical Division. Our warmest congratulations!

Giovanna Lester
President, FLATA--ATA Florida Chapter

ATA Division Committee...

would like to congratulate the **Medical Division** on their very successful first year! We look forward to working with the Medical Division throughout 2004 as we plan for **ATA's 45th Annual Conference** in Toronto, Canada.

The Medical Division acknowledges the following donors and their representatives who graciously supplied their products for raffling during our 2003 annual meeting.

- Beetext, Canada - Benoit Desjardins -<benoit@beetext.com>
- Dawn Sign Press - Joe Seifrid - <joes@dawnsign.com>
- Lingo Systems - Jeff Woods - <jeffw@lingosys.com>
- Schreiber Publishers - Morry Schreiber - <SPbooks@aol.com>
- Trados Corp. - Mike Kidd - <mikek@trados.com>
- WordFinder Software International AB - Ola Persson - <ola@wordfinder.com>

FIU Congratulates our Medical Division

The Section of Translation and Interpretation of the Department of Modern Languages at Florida International University congratulates the Medical Division of the American Translators Association. We are particularly pleased to see our colleague Dr. Rafael A. Rivera as part of the leadership of the Medical Division's efforts.

Many Thanks, MARY!!

The Medical Division greatly appreciates the constant help and advise of our ATA Liaison, Mary David.

IMPRESSIONS FROM PHOENIX

A Member's Commentary

Let me start by saying that I found the first Medical Division meeting at the ATA Conference in Phoenix to be one of the most memorable, invigorating and rewarding events I have attended over the years. It was a great pleasure to meet and chat with colleagues who help thousands of sick and less privileged people to be heard and understood.

Also, I am pleased to write a short note about the presentation given by Dr. Rafael A. Rivera. I think we are very fortunate to have an MD amongst us who has been on both sides of the barricades and who is so generous with his experience, and so eloquent. The presentation 'End of Life - the Rise of Palliative Medicine: Issues and Terminology', drew a huge crowd. End of life is a very sensitive issue and many people prefer not to even think about it. We, as interpreters, often find ourselves involved in this very delicate situation and have to serve not only as interpreters, but also as an information resource and a grief counselor. We have to be well informed, maintain our professionalism and our own sanity in order to help the dying person go with dignity, help the family and friends cope with the experience, and act in accordance with the wishes of their loved one.

This presentation, along with an excellent handout, provided a wealth of information about important medical, legal, linguistic and even spiritual issues that we have to deal with. Dr. Rivera's breath of experience and his presentation style was both educational and motivational. He took us on that very difficult journey, made us pause and think about the end of life, made us feel the anguish, learn and become better equipped to handle ourselves the next time we have to deal with the experience.

Hope to see you all again in Toronto!

P. Elana Pick, Ph.D.
ATA-certified from English into Russian

An Invitation from Holly Mikkelson

The ATA Medical Division has more than tripled its membership in the few months since it was founded: In December 2002 there were 142 members, and as of October 2003 there were 525! A quick glance at the roster reveals that our members translate and interpret in a wide variety of languages. What this means is that we have a tremendous diversity of expertise in our ranks. This issue of the newsletter has a lot of material about Spanish medical terms and related concepts, thanks to our editor Dr. Rafael A. Rivera, but in the next issue we'd like to see a lot more languages represented. If you'd like to contribute a dictionary review, a glossary, an article about health care practices and beliefs in your culture, medical terminology in your language, or anything else you think our readers would be interested in, by all means send it in. We want this newsletter to reflect the rich mosaic that is our membership.

Highlights from the Annual Meeting of the Medical Division (MD)

Division Administrator, Ms Martine Dougé presided over our first meeting of attendees to the annual conference, mostly a group of unknowns to each other among the current 531 members strong division. Bylaws were approved. The editor of our successful newsletter, Naomi de Moraes, received a round of applause having since returned to college passing the editorial baton to our Assistant Administrator, Dr. Rafael A. Rivera, to whom we owe this present issue. Dr. Rivera also organized a series of medical division sponsored presentations called a ***Day of Medicine,*** all of which were very well received. Ms Joan Wallace addressed our growing listserv and clarified questions regarding membership and use of our list. Joan has since become our listserv moderator. By a show of hands we learned that our division represents a wide range of languages including Haitian Creole, most Europeans, Slavic and Arabic. Ms Lydia Stone, editor of Slav File, invited members to join in an empirical study of cultural and linguistic circumstances in healthcare situations. An exchange of medical resources - glossaries, dictionaries and websites useful in medical translation and interpretation – took place among members. Liability insurance for freelance translators was the final topic before closure. Attractive embroidered polo shirts were available for purchase by Division members.

Caduceus... What's In A Name?

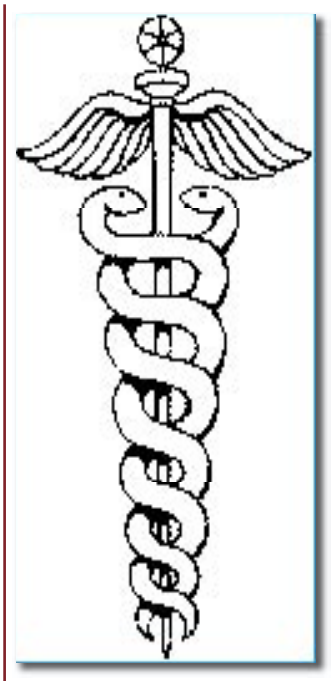
If you've ever been to a hospital or flipped through a phone book looking for a physician, you've probably seen the image: two serpents criss-crossed around a staff topped by a knob and flanked by wings; it has been the symbol of American medicine for over a hundred years.

Rod of Aesculapius – single snake

Serpent symbols intertwined, alone or over a staff, have appeared since antiquity related to fertility, wisdom, healing—even under circumstances of punishment and redemption. Biblical writings, for example, describe the vicissitudes of the exodus en route to the Red Sea, with an encounter with serpents. Moses pleads and is given a divine prescription. He makes a bronze serpent, mounts it on a pole... "and whenever anyone who had been bitten looked at the bronze serpent, he recovered."

According to Greek mythological legend, the configuration of our present symbol goes back to a similar staff carried by the god Hermes, the 'winged' messenger of all gods, given to him by Apollo, the god of healing. His Roman equivalent was Mercury, also a symbol for truce, neutrality and non-combatant status.

The staff of Hermes symbol has moved throughout history as representative for the postal service, ambassadorial status and commerce. In the 16th - 17th centuries, printers also adopted Hermes, since he was messenger to the gods, as a symbolic deliverer of information—the divine communicator. In the 19th century, a medical publisher used the symbol prominently in medical tests, thereby rekindling the association to medicine and healing. Finally, in 1902, the US Army Medical Corps adopted it as their insignia, strengthening forever the symbolism in America.



Staff of Hermes – double snake

There is another very similar medical symbol to the Staff of Hermes, the same image but with only one snake—the Rod of Aesculapius.

Aesculapius was a demi-god, a living, breathing Greek physician, son of the god Apollo, for whom there are well preserved temples in Greece. Medical cults to Aesculapius followed after his death. Centuries later, Hippocrates, the Father of Medicine, also revered Aesculapius, who did carry a simple stick, like a branch of a tree, that believed to have been used in his medical ministrations.

The historical connection to Aesculapius as physician is more direct so that his symbol—the Rod of Aesculapius, a single snake around a stick—is consider the symbol of the medical profession, as seen in the emble American Medical Associ

PITFALLS & CAVEATS

By Elena Sgarbossa, MD

In this section we will present and discuss medical terms or phrases that may be of interest to translators because of their novel, misleading, or multiple meanings. We invite readers to send in their questions and contributions!

Glossary of abbreviations

A common stumbling block is that of abbreviations, which are not always spelled out in the source text. While medical abbreviations can sometimes be found online or in dictionary lists, lists are often incomplete. Or, if an abbreviation's several meanings are located, how does one decide which is the most appropriate for the context?

If you usually translate Oncology material, for example, and have ever wondered whether "AML" stands for *angiomyolipoma* or for *acute myeloblastic leukemia*, or whether "BM" is *bone marrow* or *brain metastases*, you are certainly not alone.

Here we offer the first part of a glossary of medical abbreviations. We hope you will find it helpful.

ACE

- **angiotensin converting enzyme**, the enzyme that catalyzes the conversion of angiotensin I to angiotensin II. Angiotensin II is a natural and potent vasconstrictor that can contribute to some patients' hypertension. Often, the abbreviation "ACE" precedes "inhibitor", as in "ACE-inhibitor", which is the name of a class of drugs used to treat hypertension.
- **acute coronary event**. This is a relatively recent term, used mostly in Cardiology to refer to cardiac events such as acute myocardial infarction or sudden cardiac death.

AML

- **angiomyolipoma**: a rare tumor of soft tissue involving the kidneys, liver and other organs.
- **anterior mitral leaflet**: one of the two mitral valve cusps, also called aortic leaflet or cusp, which faces the posterior mitral leaflet. The mitral valve is one of the two atrio-ventircular valves separating the ventricles (lower heart chambers) from the atria (upper heart chambers).
- **anatomical medullary locking**: is a term describing a type of femoral prostheses used in hip replacement.
- **acute myeloblastic leukemia**. The abbreviation AML can indeed refer to acute monocytic / myelocytic / myeloblastic / myelogenous / or myeloid leukemia. These are all variants of granulocytic leukemias and are sometimes used synonymously.
- The abbreviation "AML" can also be found within texts discussing DNA or genetics, in which "AML" may still allude to "acute myeloblastic leukemia", such as in:
    - binding sites / transcription factors (AML-1; AML-2)
    - cloned cell lines expressing monoclonal antibodies (AML-3)
- **affinity macro-ligand** refers to an oligonucleotide that binds to a specific DNA site, and is used in gen therapy or research.

Acknowledgment: We thank Dr. Steven Sherman, MD, for the insight he provided about the AML family of abbreviations.

BAT

- **basophil activation test:** an in-vitro technique to detect allergy
- **best available technology**: an expression used in waste disposal technology
- **blood alcohol test**
- **body attitude test:** a questionnaire for the assessment of patients with eating disorders

BBB

- **blood-brain barrier**: a specialized system of capillary cells that, while allowing the passage of nutrients to the brain, it protects it from harmful substances in the bloodstream. With this meaning, "BBB" may appear in contexts related to Neurology or Neurosurgery, patients with neurological problems, or descriptions of medications and their ability to cross –or be halted by- the BBB.
- **bundle branch block**: a problem in the heart's conduction system. "BBB" may appear in the report of an electrocardiogram (ECG), in the patient's history, or in Cardiology scientific articles.

BM

- **bowel movement**: bowel movement (referring to elimination of feces, not to the peristaltic movement of the bowel which is "intestinal motility") may appear as "BM" in medical records, in scientific articles on Internal Medicine, Surgery, or Gastroenterology, and in medication descriptions.
- **bone marrow**: the organ that generates new blood cells, found inside many bones. Bone marrow may appear as "BM" in medical records (often followed by the word "biopsy") or in scientific articles, usually on Hematology, Oncology, or medications.
- **bone matrix**: an histological component of the bone, made of hydroxyapatite crystals and collagen fibers. The bone matrix arrangement is the basis for the different structure of the spongy bone versus the compact bone. It is not unusual for some medical articles to contain both terms, *bone marrow* and *bone matrix.*
- **brain metastases**: cancerous cells spread from a distant organ to the brain.
- **basement (or basal) membrane:** a normal membrane that underlies epithelium and separates it from deeper tissues. May appear in scientific articles on a number of subjects.
- **basilar membrane**: the most important structure in the cochlea (inner ear). Found in ENT or Audiology articles and medical reports.
- **black male or men**: in descriptions of patient demographics
- **body mass:** in descriptions of patient demographics (including test reports), in obesity / nutrition articles, and in medication descriptions. Often seen as "BMI", body mass index.
- **buccal mucosa**: the mucous membrane that lines the mouth.

BMD

- **bone mineral density**: a measure of osteoporosis
- **benchmark dose**: a dose method proposed as an alternative to the no-observed-adverse-effect level (NOAEL) approach for assessing noncancer risks associated with hazardous compounds
- **bipolar mood disorder:** manic-depressive disorder

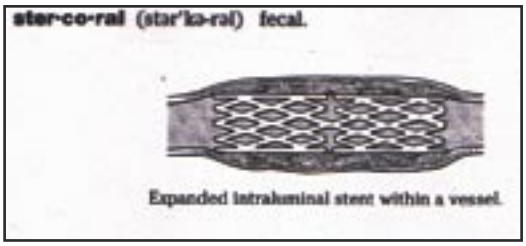
About the Author:

Dr. Elena Sgarbossa is a cardiologist, medical writer, translator and member of the Editorial Board of Caduceus. This column will be a regular feature. Division members and readers are welcome to contribute.

Words About Words and Related Words

Our Glossarium features terms in English, but in their fefinitions we may also include Spanish terms or terms in other languages that are common sources of confusion during translation.

1.
stent .. catheter, plastic tube, which is inserted or implanted into a tubular structure in the body i.e., bood vessel, ureter, biliary duct, urethra, in order to relieve obstruction and or maintain patency (keep the opening) of the hollow structure after the obstruction is relieved. Coronary artery blockages are opened by means of an angioplasty, *angioplastía* - a ballooned catheter is expanded in the midst of the obstructing material squeezing it against the wall of the coronary artery. Relief of obstruction is then maintained by the intravascular placement of a tubular stent at the angioplasty site. Current stents, *implantes o mallas expansibles,* are tubular expansile meshes which spring upon release by the operator and are often coated with a variety of substances.



The suggestion by Navarro[1] of *"prótesis endovascular"*, as an appropriate Spanish translation for stent, is used commonly in medical documents. Be aware that a prótesis (*prosthesis*) is really an artificial substitute for a body part such as an arm, leg, eye, tooth – so that only replacing a segment of a coronary or other blood vessel with a segment from another blood vessel, or an artificial could truly be considered a true prosthesis.

At the English colloquial level, it appears that the use of 'stent' or its spanglicized version estent or estén appears to serve the spoken purpose.

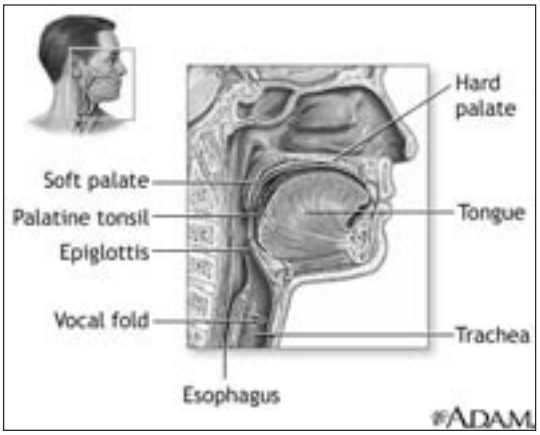
2.
splint .. (*férula*) (*ferrule*) not to be confused with stent, is a protective appliance used to hold body parts in position. Simply tying an ordinary tongue depressor next to an injured finger is an act of splinting or immobilizing to prevent further injury.

Splints: (A) Denis Browne splint; (B) Taylor splint; (C) Thomas knee splint.

3.
sling— *cabestrillo* not to be confused with splint is a bandage or suspensory support of a structure (as in arm sling)

4. **intern** .. time-honored medical word, no longer in favor by the American Medical Association, is now known as PGY-1 = first postgraduate (medical training) year. Originally French and spelled interne, referred to one confined to a certain geographic limitation .. as would be the case with a neophyte physician confined to the hospital for a whole year.

5. **palate** .. recently discussed in an internet forum when 'roof of the mouth' came up as a subject. *Cielo* or *techo de la boca* and *paladar*, all correct, were mentioned. Palate / *paladar* more correctly is the entire separation between the oral cavity and the sinus cavities. It has two parts: the hard palate, the bony portion more closely associated with the



roof of the mouth and closer to the mouth which is the one we burn when hot food comes in .. *"me quemé la boca"*. The soft portion lies further back without bony 'roof' ' on top, it ends at the uvula (*úvula palatina* o *"campanilla"*).

The word palate has been extended, figuratively, to mean "taste" (*gusto, degustar, probar*)- a difference is made between what is palatable and unpalatable. The Latin *pala*, same in Spanish, means shovel or spade, is applicable to this area which moves the food into our throats and gullets. Palatine, the adjective, refers to what belongs to the palate.. as in, guess what, palatine tonsils – the ones at either side of the entrance to the throat when we look at the mirror.

6. **tonsil ..** is a small, rounded mass of tissue, especially lymphoid, which, in the throat, has a protective function. We have four of them in close proximity, the palatine ones (*amígdalas*), the ones commonly removed, and the pharyngeal ones called adenoids (*adenoides*), not necessarily removed simultaneously. The adjective for tonsil is tonsilar and, not surprising, amygdaline.. However, amygdala (watch the y), Latin for almond, stands for an almond shaped structure. It is carried into English anatomy as a most important structure in the brain which integrates sensory and cognitive information to make emotional sense out of our experiences.

7. **a Freudian slip ..** A recent medical forum consult referred to the Spanish to English translation of a psychological "*acto fallido*". It turns out that "*acto fallido*" translates literally to "faulty achievement", which then gives rises to **parapraxis**, an English psychiatric term which is equivalent for the German one used by Freud – *Feblleistung* – in his book, Psychopathology of Daily Life (*La Psicopatología de la Vida Cotidiana*). 'Faulty achievement' occurs when we mean to do one thing and do another, whether it be to speak, to hear, to think, or to act. It looks like the only recognizable residual psychological faulty achievement in our present daily American life is the "**slip of the tongue**", when we, innocently and unintentionally, say something different from what we meant to say. And, of course, if the slip has a sexual connotation then, for sure, it is a **Freudian slip**. It is a slip (*desliz / fallo del habla*) because, said Freud, it slipped through our tight intrapsychic defenses which otherwise would have prevented us from saying 'that' or saying it 'that way'.

Readers are invited to send in contributions in any language combined with English.

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

LTC—long term care insurance—the latest insurance industry "offering," is the topic that interests me today.

A euphemism for nursing home insurance, LTC is the insurance industry's answer to the rise in costs of nursing home care. An industry known for its readiness to answer to public needs it can also create a need where the reality of obtaining, maintaining and eventually using your insurance benefits is, at least, far different from what it appears to be at first glance.

The marketing strategy is to suggest that long term care costs are likely to wipe out your life savings in short order leading to catastrophic consequences. Whatever the amount of money saved you have, or expect to have, should serve as a point of reference to consider the amount of coverage you should obtain. While some published estimates for a yearly average of nursing home expenses are indeed impressively high, most studies find the cost to be considerably lower. Furthermore, protection afforded by Medicaid laws provides lifetime nursing home services coverage should you run out of money.

Consider some other facts. Two thirds of all men and one third of all women age 65 and over will never spend a day in a nursing home facility. More than half of all nursing home stays are less than 6 months. The average stay of those who enter a healthcare care facility of this type is about 18-20 months. Only 7-8% of nursing home residents will stay longer than 3 years. At the other end of the issue, when LTC benefits are paid they are usually far below the actual cost of care. When the exclusions and limits of said policies are figured in, the policy performance of these instruments is quite poor. Further, as is true of other kinds of insurance, the mayority of policies lapse before any benefits are ever payed. Please note that between acute hospital and nursing home care there are a number of intermediate facilities such as skilled nursing care and rehabilitative units of various types. In addition, the present panorama of elder care contains a variety of assisted living residential facilities that attend quite well to the daily personal needs of the aged with varying degrees of functionality.

If actual professional nursing care and its derivatives is required, the availability and breath of home health care services – durable medical equipment (DME) and experienced nurses that visit as often as ordered by a physician – solves the majority of problems. Included here are: a hospital bed or a wheel chair, oxygen equipment delivery, infusion punps - really, any kind of durable medical equipment. Nurses take care of: administration of medications via all routes, the placement and care of intravenous and intraarterial lines, care of wounds, checking vital signs, examining the patients – just about anything a nurse would do in a hospital. Blood drawing and urine collections for laboratory examinations and mobile x-rays are also available. Nurses report to a physician telephonically and keep a written record of care. All of this done in a more homely setting than a hospital or typical nursing home, without the threat of nosocomial (hospital acquired) infections or life threatening pharmacy medication errors (over 50,00 cases per year). And, most important for our discusion, this kind of care is undeniable by Medicare and other forms of healthcare insurance. Having had actual experience with the final years of four loved ones in their 90s, I am an advocate of assisted living. That, I believe, is where the long term financial help should go.

"When the exclusions and limits of said policies are figured in, the policy performance of these instruments is quite poor."

INTERPRETERS AT WORK

Finding your "center" is not always easy for a medical interpreter! A lawsuit is today a realistic possibility.

By Zarita Araújo-Lane, LICSW and Vonessa Phillips

During training sessions, we remind interpreters of the need to avoid "becoming" a patient or a provider while interpreting. We ask them to be transparent and impartial. Interpreters are also asked to strive for accuracy and completeness thus acting as effective language mediators between patient and provider.

At a cognitive level, most trained interpreters agree with and understand the logic of acting as facilitators of communication between patients and providers. However, in the heat of a session, interpreters are often challenged by the unconscious awakening of personal feelings. Something in the provider words or behavior unexpectedly triggers in the interpreter an immediate automatic reaction and he or she stops being a mediator or facilitator, and for a quick second acts as a provider.

The following case illustrates well how for two fleeting moments, a qualified interpreter, who has attended multiple interpreter training programs, lost her center, a misstep which resulted in a threat of legal action.

A patient who had lost some fingers while operating a machine was being seen by a surgeon in a follow-up consult to remove stitches. Halfway into the session, the surgeon stepped out of the examining room to check on another matter, and the interpreter stayed with the patient. While alone in the examining room, the patient began to cry over the loss of her fingers. She asked if the interpreter would give her a plastic bag, so that she, the patient, would not have to look at her hand. The interpreter replied that she, as an interpreter, could not supply a bag. The patient continued to cry, and the interpreter reassured her that the surgeon would return promptly

Later, while the stitches were being removed, the patient became very loud, and her sobbing could be heard throughout the clinic. The interpreter, in a spirit of helpfulness and worried about the other patients in the clinic, quickly asked the emotional patient to please calm down. Some time after the session, the patient's lawyer called the agency responsible for interpreter services to inform it of pending legal action. The patient had accused the interpreter of suggesting that the injuries were the patient's own fault.

The interpreter denied making any such comment to the patient. When asked by the contracting agency if she had had private communication or side conversations with the patient, she revealed that indeed she had stayed alone with the patient in the exam room when the provider stepped out.

In the course of the interview, it became evident that the interpreter had been accurate and complete in her representation of the patient and provider's voices. How, then, did she err? By adding her own voice! The one additional comment, "please calm down", which she believed was for the good of everyone, set in motion a chain of events that could potentially cost this interpreter her job.

While trying to figure out what motivated the patient to make a formal complaint, the interpreter and her supervisor thoroughly reviewed the case and came up with the following guidelines to be observed in all interpreting sessions:

Interpreters should never stay alone in examining rooms with patients.
Interpreters should not be owners of a patient's decisions. When the patient asked for a bag to cover her fingers, the interpreter should have given her the option of either waiting for the provider or having the interpreter go find the provider. Instead, the interpreter had said, " I can't give you a bag. I am only here to interpret for you and the doctor."

Interpreters should not interfere when patients cry, no matter how much noise they make.
This is the provider's job, not the interpreter's! However, if the crying interferes with the

ability to hear either the provider or the patient, the interpreter may gently inform both parties, "I'm sorry, the interpreter can not hear."

Conclusions:
There is no doubt that this patient truly believes the interpreter blamed her for causing her own injuries. On the other hand, the interpreter did not actually state that the patient was at fault. However, the interpreter's two moments of weakness gave cause to the misunderstanding.

The first moment of weakness occurred when the patient asked for a bag. The interpreter, although right to not supply the bag, responded to the request in a formal manner. This may have been perceived by the patient as cold-heartedness. So, when denying a request for action, interpreters need to be both caring and diplomatic. In addition, a request should never stop with an interpreter's refusal to comply. All requests for action need to be related back to the provider so that he or she can make an informed decision. In this case, a more appropriate response would have been: "I am so sorry I can not provide you with a bag, I would not want to harm you. Would you like me to call the provider right away or can you wait until he gets back?"

The second moment of weakness was when the interpreter's unconscious feelings towards how patients should behave in gave rise to her impulsive request for the patient to calm down. In this case, the interpreter acted as if she was a provider, and by imposing her values on the patient, she lost both her center and her transparency. This misguided action broke trust between the interpreter and the patient causing irreparable damage to the triadic encounter.

As the interpreter and her supervisor discussed the allegations, they took time to discuss background information such as immigration history. Both the interpreter and the patient had come to the United States as refugees, likely enduring terrible losses. What had helped the interpreter to survive wartime and immigration trauma was self-control. But for the patient, the loss of her fingers was just too much to bear, emotionally and physically. At that moment, self-control and decorum were the last things on her mind.

Interpreters realize that there are times when they must decline an action or refuse a request. It is noteworthy that not only patients, but also providers, place unreasonable demands on interpreters.

In this case, the surgeon left the interpreter alone with the patient. It is common for providers, nurses, and other medical staff to specifically ask an interpreter to stay alone with a patient "to keep the patient company" or "to explain this form". In this case the interpreter did not want to be rude to the physician nor leave the patient alone to feel isolated . So she consented to stay alone with the patient, and by so doing, risked potential legal action. Patient and interpreter alone – whatever happens becomes a classic case of "she said/she said". No witnesses to support either side!

Cross Cultural Communications Systems (CCCS, Inc.) has created the image of a butterfly; where the interpreter at the body, or center, is ever busy managing the provider and patient's at the wings. With this image, we have attempted to artfully represent the dynamics and intricacies of the triadic encounter. And we want you to remember that if even one party to the encounter is neglected, the interpretation will not fly!

Bibliography:
Across Cultures Newsletter. 1998. January. Pages 3 – 5. Washington: CCHCP

Araújo, Z. 1996. Portuguese Families. Ethnicity & Family Therapy, Second Edition,
pp. 583 - 594.

Battle, M. General Guidelines for Providers in Cross-Cultural Settings. Pages 44 – 50. Massachusetss General Hospital, Boston Massachusetts

Bonder, B., Martin, L., Miracle, A. 2002. Culture in Clinical Care. New Jersey: Slack Inc.

Additional bibliography available upon request.

A little bit of everything!

Two major diseases redefined...

1. Hypertension: Under the old guidelines published in 1997, your blood pressure (BP) was considered normal if the systolic (the top one) was under 140 and the diastolic (the bottom one) was under 90 i.e., 140/90. The Joint National Committee on Prevention Detection, Evaluation and Treatment of High Blood Pressure (JNC 7 for short) now defines normal, meaning optimal or healthy, as a BP under 120/80. A systolic between 120-139 or a diastolic between 80-89 is called ***pre-hypertension***. See below.

New Blood Pressure Categories

	Systolic BP	Diastolic BP
Normal (optimal)	**less than 120**	**and less than 80**
Pre-hypertension	**120-139**	**or 80-89**
Stage 1 hypertension	**140-159**	**or 90-99**
Stage 1 hypertension	**160 or higher**	**or 100 or higher**

As confusing as it might seem the term "high blood pressure" covers any blood pressure above 120/80, while hypertension refers to pressures of 140/90 and above. (Harvard Heart Letter, August 2003)

2. Diabetes: Previously, there were two major kinds of diabetes – the **juvenile** also known as **Type 1** and the **adult onset** or **maturity onset - Type 11** varieties – obviously defined by age of onset of the disease. The juvenile variety is more difficult to control, prone to manifest itself earlier and with more severe organ-specific complications of diabetes. The adult variety, in general, is a less dramatic, more controllable illness which permits a near normal life with a slower, though variable, advent of complications.

Normal
FBS below a 100mg/dL
GTL below 140mg/dL

Prediabetes
FBS is at least 100 but less than 125 mg/dL
GTT is at least 140 but less than 200mg/dL

Diabetes
FBS is 126mg/dL or higher

The classic symptoms of diabetes

Frequent urination	Unusual hunger
Blurred vision	Unexplained weight loss
Increased thirst	Sores that don't heal
Unusual fatigue	

The basic diagnostic tests for diabetes are: a **fasting blood sugar (FBS)** (nothing by mouth for 10-12 hr) and **a glucose tolerance test (GTT)** (your body handles a standardized sugar drink in which the expected rise in blood sugar is promptly brought down to acceptable levels in response to the body's production and use of the hormone insulin).

Number of Americans having a heart attack this very minute – 3

Cholesterol mud slinging: Have you heard the bad apellatives for the killer within, the 'arterial fungus among us'? How about: deadly waxy build up, arterial apatite, heart clogger, coronary crud, vascular barnacles, blood mud – just a few of the bad names. Can you add any?

Number of Americans who die in hospitals – 70%

Better sex not yet OTC: The FDA approval of Viagra (sildenafil citrate) tablets in 1998 and the injectable Caverject (Alprostadil) did spell relief for many men, doing away with the problematic penile implants. The world of 'erectile dysfunction' – having moved into the urologists offices from the psychologists domain of 'impotence' – has now spread to general practitioners and family physicians. Stay tuned – there's a lot more to come, pharmaceutically speaking. Various over-the-counter supplements that promise "to spice your life", "rekindle desire", "improve performance" or "enhance the body's own natural sexual health" have no scientific or even popular support.

The number one condiment in the world is – ketchup.

The Basic Four
Four out of five people who develop heart disease have at least one of these major risk factors: high blood pressure, high cholesterol, diabetes or smoking.

ByRafael A. Rivera, M.D., FACP

Part III Allopathic – Alternative Integration

Third in a series that examines the US healthcare delivery system with emphasis on pertinent terminology.

A group of coronary heart disease (CHD) patients , some after already having had bypass surgery, meet three times a week for a year long preventive – rehabilitative program structured by well know cardiologist and medical writer, Dr. Dean Ornish. The drill includes diet, exercise, yoga, meditation and a support group type of interaction. Pre and post evaluations, including sophisticated radioactive PET scan imaging of the heart show that such a program can, in fact, clean coronary arteries even those with advanced blockages. (*JAMA*. 1998; 280:2001-2007) "Well, that's all well and good", says the American Heart Association, "but we can't endorse such a program because those patients that can not follow such a rigorous diet… will feel guilty which makes their CHD (Coronary Heart Disease) even worse." Think about that.

"Cancer patients turn to Eastern healing arts", reads the title of a comprehensive article on a large, well known South Florida city newspaper. Diet, meditation, acupuncture, tai chi and qigong are all mainstream therapy for an oncology population of patients —all the cancer specialists caring for the participating patients are well aware of and endorse all of these additional complementary measures.

The December 2, 2002 issue cover of Newsweek magazine features: *"The Science of Alternative Medicine" – Depression Treatments, Acupuncture & Herbs, Natural HRT (hormone replacement therapy). Plus Insights From Harvard Med School*. The article is a comprehensive lay review of the current status of this subject. The January 20, 2003 Special Issue of TIME magazine goes into the mind-body connection topic. And, finally, the most recent August 4, 2003 Time magazine cover features *The Science of Meditation*. A comprehensive historical review and extraordinary radioactive imaging of the brain before and after meditation showing dramatic beneficial changes.

The reports come from everywhere and it isn't all recent. Dr. Robert Benson – cardiologist and autor of the books: The Relaxation Response, Beyond The Relaxation Response and The Faith Factor– had already demonstrated the salutary effects of transcendental meditation on the cardiovascular system back in 1967. Progressively, other well known physician-authors associated with the best known American medical schools have led the charge towards the integration of modern medicine and all of these traditional approaches that bring benefits to those who practice them on a regular basis. 'Disease-centered' long standing allopathic approaches have been combined with a 'patient- centered' orientation to create a wholesome integration called "holistic medicine". Medical students are now introduced to this complementary approach early on.

"The "medicalization of life" is a subject of recent times found in lay and medical writings. Smoking, drinking, obesity, gambling, even shyness, are all considered medical diagnoses when they reach disturbing or disabling levels."

One of the most sobering discoveries, for patients and doctors, is that there are few illnesses that physicians can, in fact, cure – that is to say, eliminate altogether –, perhaps some common infectious problem, results of trauma, or conditions amenable to surgery.

The daily practice of general medicine consists of what is called 'disease management' – a life long approach to keep in check the disabling conditions and eventual killers in our society: coronary heart disease, hypertension, diabetes, chronic pulmonary disease, depresion, cancer, rheumatic problems. A *life*-long

approach must now include *life-* enhancing, *life-*improving activities that have proven salutary efects though they are not considered 'medical' in nature. This is where the word "wellness" fits perfectly. This is really what patients are looking for when they seek out 'alternative' practitioners – a steady state of well being.

The "medicalization of life" is a subject of recent times found in lay and medical writings. Smoking, drinking, obesity, gambling, even shyness, are all considered medical diagnoses when they reach disturbing or disabling levels. We all visit doctors when we don't feel well, don't sleep well, feel tired, not feel up to par, feel stressed out. We don't really think we are sick but, "Hey, it could be something". At his end, the physician who listens to a patient's complaints must, of necessity, think 'medically'. His mind is crunching various 'medical' diagnostic possibities as the 'medical ' history unfolds. Examinations and tests will follow to round out the evaluation . An actual diagnosis rarely comes about. Symptom relief without need for a diagnosis is the best outcome. The worried person is well and yet does not feel well. He now joins the ranks of the "worried well ", the "check-up crowd". Enter the world of stress management: yoga, meditation, tai chi, physical exercise routines of all kinds. Add therapeutic massage, spinal manipulations and acupuncture to the mix and a lot of doctors would lighten their load and the managed care industry would love it. Since most of these activities are done in groups where there is camaraderie, new friends to be made and old stories to be shared, a new healthy frontier is ahead.

Another toxic effect of showing up at the doctor's office too often, perhaps for minor things, is the creation of a medical record that, this day and age, is likely to be looked at by a lot of people looking for evidence of "pre-existing conditions". A cursory note like: Dx. Anxiety, probably job related. Rx. Valium 5mg bid (twice a day), prn (as needed) can cause a lot of real anxiety when you are denied some form of insurance because your medical record "showed something..". It happens quite often. And, of course, comes as a surprise that can send you on a distressing chase trying to find out what is it that is wrong with you that you didn't even know about. In case you weren't aware of it, insurance companies have a repository organization of medical information about you that is shared among all of them. Should you apply and be denied coverage by one insurance company that information is also available to the others.

Next issue: The Nursing Profession – Moving forward during hard times

JOIN US!

We sincerely hope you are enjoying our new formatted newsletter. We believe it can provide all readers with ideas for their own participation. Short contributions can appear in columns we intend to repeat as our regular features, like Pitfalls and Caveats, Glossarium, Bits-Pieces-Facts and Figures, History of Medicine and, most certainly, Resources – what readers consider useful in their daily work.

Anecdotes and personal vignettes are also welcome. Otherwise, let us know of a possible regular column of your own creation. We need to hear from those who work in research, chemistry, pharmacy, as well as humor and the business side.

English is our basic newsletter language. Spanish runs a large second within the membership. However, we strongly encourage articles that mix English with other languages representative of our diversity. Frases Médicas de la Calle is a response to the need of medical interpreters dealing with large Latino communities.
Do join us.

--The Editorial Board

Pay Attention!

Have you ever watched kids
On a merry-go-round?
Or listened to the rain
Slapping on the ground?
Ever followed a butterfly's erratic flight?
Or gazed at the sun into the fading night

You better slow down
Don't dance so fast
Time is short
The music won't last

Do you run through each day on the fly?
When you ask, How are you?
Do you hear the reply?
When the day is done
Do you lie in your bed
With the next hundred chores
Running through your head

You better slow down
Don't dance so fast
Time is short

Ever told your child
We'll do it tomorrow
And in haste
Not see his sorrow
Ever lost touch,
Let a good frienship die
Cause you never had the time
To call and say, "Hi"

You better slow down
Don't dance so fast
Time is short
The music won't last

When you run so fast to get somewhere
You miss half of the fun of getting there
When you worry and hurry through your day
It's like an opened gift.. thrown away
Life is not a race. Do it slower
Hear the music Before the dance is over

– Written by a terminally-ill teenager

LISTSERV ETIQUETTE

Simple Rules to Keep the List Effective

As our list becomes busier, it is good to keep in mind a series of steps that will eliminate confusion, need for additional messages requesting clarity and similar unnecessary interventions. The following is a compilation of opinions and suggestions received from our members so far. Additional suggestions or modifications will be appreciated.

Listserve of the ATA Medical Division
http://groups.yahoo.com/group/ATAMedDiv/
Not a subscriber yet? To join, please contact
Mary David at mary@atanet.org

• SUBJECT LINE
- use TERM, followed by language pair abbreviated, followed by the word or. phrase. For example: TERM: En<>Spa.. IV pressor therapy.. This is an absolute requirement if we want to do a search in archives for specific subjects
- Do not write "used to be" when using a previous message. Just erase and do as suggested.

• CONTEXT
- always helpful, if not absolutely necessary. Say something about what it is about, or give the complete sentence or paragraph. Anticipate what others may need to know to help.

• PREVIOUS MESSAGES
- don't forget to delete anything and everything that's not pertinent but it's still floating around, including Yahoo trivia.

• SIGNATURE
- this is a tough one. Keep it short and compact, avoid several telephone numbers and addresses and quotes from the masters.

• JOKES
- consensus seems to be against them, at least the full story. Some decent levity in our commentaries is tolerable.

Thanks to Joan Wallace and Helge Gunther who have volunteered to act as facilitator and co-facilitator for our list. Members' participation is appreciated, observations and ideas are welcome.

EYEGLASSES

Can you see the difference?

Dictionaries won't help.

A recent poll among member's of the Spanish Language Division's Internet forum Espalista in answer to the question: what is / are the most often used Spanish words in order of preference as a translation of "eyeglasses – those intended to correct refractive errors and visual problems, not sunglasses or telescopic sights – yielded the following:

Argentina ..……...anteojos, lentes,
Colombia …… gafas, anteojos
Costa Rica ……. anteojos
Cuba ……... espejuelos
Ecuador ……. anteojos, gafas
El Salvador ……. lentes
España ……gafas o lentes
Mexico ……... lentes y anteojos
Paraguay .. ……...anteojos
Perú ……. anteojos y lentes
Puerto Rico .. ….. espejuelos
Rep. Domicana ... lentes y espejuelos
Uruguay …….. lentes
Venezuela.....lentes

First Choice:

anteojos=5
lentes=5
espejuelos=5
gafas=2

In Cuba and PR, *gafas* are sunglasses and *anteojos* are binoculars. In Paraguay, *lentes* are mostly sunglasses.

The Various Forms of Professional Recognition

A confusing set of words often used interchangeably

• **certification** .. there is usually a test involved. Found competent by means of a test, as in: federally certified interpreters, Board certified physicians, ATA certified member. Usually applies to individuals, with some exceptions, like Medicare - certified which, most likely, should be Medicare - approved, since there is no recognized testing mechanism by Medicare of individual providers or organizations.

• **accreditation** .. usually involves and evaluation, not just a test, by an independent organization. Applies to organizations, institutions, programs. Hospitals are accredited by the Joint Commission of Accreditation of Health Care Organizations (JCAHO).. or, "the Dept. of Radiology at Memorial Hospital was accredited by the American Academy of Radiology (ACR).." or, "the Dept of Pathology lost it's American College of Pathology (ACP) accreditation.."

• **qualification** .. variously understood. Usually refers to a person who has met all the requirements for some form of recognition, ex. Board certification, but has not yet taken the certification test - also known as "eligibility". "Professionally qualified" is also used when a person is a member in good standing of a recognized association or has worked for a distinguished organization such as, for example, the United Nations, Depts. of State or Defense. It is also a simple colloquialism indicating a known level of experience or expertise - "She is well qualified for this job."

• **registration** .. as applies to the "registered" professionals. Registered: Nurse, Dietitian, Pharmacist, Physical Therapist, Occupational Therapist, others. These professionals all have in common: 1) a university degree, 2) a supervised practice experience and 3) a national licensing certification. In a generic fashion, registration simply means the person's name appears in a certain registry or listing.

• **licensure** .. a State-specific legal requirement. Essentially, a permission to practice your profession, trade or line of work in a particular State. Upon moving to another State you are required to secure that State's licensure. No matter what your professional status is as regards any of the above mentioned forms of recognition, you must also be licensed. "He is a licensed physician" only means the doctor has a State license to practice in said State. Licensure in Spanish is *permiso* o *licencia*, not *licenciatura* which is the equivalent of a Bachelor's (or higher graduate) degree in Spain and most of Latin America.

"No matter what the professional status... you still need to be licensed."

• **approval** .. term included in this list only because quite often interpreters show a business card that reads "Approved by XXX" – a local or State organization. It has no standard meaning other than perhaps to show recognition or give access to the bearer by the issuing organization

Reprinted with permission
Rafael A. Rivera, M.D.
Medical Seminar 2003
Florida Chapter - ATA

BOOK REVIEW

The House of God

By Sam Shem

> “... it’s the breeding ground for our classic detached compassion that becomes less and less detached and more compassionate as we move along.”

The most successful best seller in the history of Medicine. The ultimate medical irreverence. The bible of Hippocratic profanity. The House of God, now in its 25th year of publication, continues to be a must for anybody who is, was, or could ever be interested in a medical career. Sam Shem – pen name for Dr, Steve Bergman, a Rhodes scholar and physician member of the faculty at Harvard Medical School – tells it like it was, and is, during the postgraduate years of medical training, even in the sacred halls of the premiere medical training institution of the premiere medical school of our country.

Much has been written of this masterpiece. The comment I like best is: “Does for the practice of Medicine what Catch-22 did for the practice of warfare.” I say: multiply MASH a hundred times in irreverence and intensity to get a real idea of what survival of the medically fittest could ever be. I know. I lived through it.

All the disrespectful mockery of the ‘medical glossary’, comments and acronyms contained in The House have survived through the years. For example, “turf”, as in “get rid of”, has reached the U.S. congress where anti-turfing laws have been enacted. Turf the GOMER, (or GOMERE for a female), as in Get Out of My Emergency Room. The very first law of The House is: Gomers don’t die. The second law: Gomers go to ground, but only after going around and around. And then there was the LOL in NAD .. a little old lady in no acute distress. You weren’t worth very much if you selected an NPC – no patient care – specialty, like ‘gas’ for anesthesiology, or “skin” for dermatology or “eye” for opththalmology. A POGIE, in my own intern days, was a “Poor Old Guy In Eloise”, a little town near Detroit with a huge old folks residential facility that provided us a steady stream of medical sustenance stored in geriatric containers. The House is really about survival in the midst of life and death and exhaustion. Like a good well timed joke in a combat foxhole, it can lift depression if only for 10 seconds to live another hour. It’s the irrational modus vivendi of the physician-in-training days, it’s the cerebral regulator of keen attention span or the doze-alert rhythm that creates endurance. Learned defense mechanisms that veteran residents teach intern recruits. Believe it or not, it’s the breeding ground for our classic detached compassion that becomes less and less detached and more compassionate as we move along.

Every serious endeavor in life needs a release mechanism. A bishop friend tells me the best jokes were told by brilliant seminarians. Old Army Chaplains are a lot of fun during the worst conditions. I remember the “Chap” in my paratrooper days who came to every single jump class with the groaning admonition: “ ‘Legs’ (the worst insult call for all other soldiers who don’t jump out of perfectly good airplanes), when you get up there and a cold blast of air hits you face you’re gonn’a feel like you wann’a to talk to Him. Well, do all the talking you need to down here, He can’t hear you through the roar. Good luck, men.” With a smile he was the first one out in every class. As the distinguished graduate of my class we later jumped together. It was an honor. Making clinical rounds with your physician mentors is always an honor. Rounding or practicing with your trade with best in any human endeavor is always an honor.

Life is about memories. The House will go on forever. It’s the stuff that will always brings a smile to any caring physician with a silver head.

In the next issue:
Stiff – The Curious Life of Cadavers by Mary Roach

WHAT'S A "DRINK"?

One or two a day keeps the doctor away.

It is now a matter of medical record that 1-2 'drinks' of alcohol a day can have a proven salutary effect, particularly regarding coronary heart disease. The incidence of heart attacks in the totally abstemious population is higher than in controlled social drinkers. And so, it always comes down to: "Well, what is the definition of a 'drink'?" The referenced author uses a biblical writing where one can find early examples such as, Proverbs 31.6, ".. give strong drink to him who is perishing and wine to him whose life is bitter". The Theological Wordbook of the Old Testament actually carries one of the oldest definitions of the 'strong drink' as: "…most likely not liquor, there is no evidence of distilled liquor in ancient times, ... just barley beer and alcoholic beverages prepared from grain or fruit. No mention of unit of measurement, of course. Likely is that a mouthful or whatever amount could be swallowed in one pass was a 'drink'.

Today, we highly recommend Russ Rowlett's Dictionary of Units of Measurements, University of North Carolina at Chapel Hill as the reference source of choice on this subject. It defines (medical) drink as: a unit measuring the alcohol content of beverages, used in describing the medical effects of alcohol.

(Ref: www.unc.edu/~rowlett/units/dictO.html)

> "..give strong drink to him who is perishing and wine to him whose life is bitter."

U.S. physicians consider one drink equal to:

- 0.5 U.S. fluid ounces of alcohol
- in metric equivalent would be 15 milliliters (= cubic centimeters = cm^3 = cc).
- In U.S. fluid units, (the bartender's guide) one 'drink' corresponds to:
  - –about 4 ounces (= a wineglass) of wine at about 11% alcohol, or
  - –1.25 ounces (= a shot) of whiskey, or any hard liquor, at 40% alcohol = 80% proof)
  - – one 12 oz beer, at 4% alcohol)
- a glass of wine
- a shot of liquor
- a 12 oz beer

What is a Teetotaler, you ask? – one who totally abstains from alcohol, a person who practices teetotalism, and is a teetotal person. Do you know the origin of the word teetotaler? A common understanding is that it refers to the person who "totally drinks tea".

As far back as the 1800s "tee-totally" was an emphatic form of "totally". It is the result of duplication - a lexical phenomenon where the initial letter of a word was repeated for emphasis. Most sources agree that the first application of teetotal to drinking was in a speech by Richard Turner, a member of the British Temperance Society, in 1833, in which he urged everyone to abstain tee-totally from all forms of alcohol.

(Ref. The Mail Archive, www.mail-archive.com)

TO ERR IS HUMAN

by Elena B. Sgarbossa, MD

"*To Err Is Human: Building a Safer Health System"* is a compelling book on medical errors in the US. This book, however, sheds little light on one source of potential errors: that of linguistic barriers. For 19 million people with limited English proficiency, communicating with their physicians is a challenge. Yet among health care providers there is a generalized impression that non-English fluent patients (including children) are well served by both professional and ad-hoc medical interpreters. To test this belief, medical interpretation should be evaluated not through post-hoc surveys to the parties involved but by videotaping, then analyzing actual interpretation sessions in medical centers. This is precisely what a group of physicians and nurses set out to do.

The investigators collected data on 13 patient- (or parent)- pediatrician interactions mediated by Spanish interpreters. (1) Professional hospital interpreters were present in 6 encounters, while ad-hoc interpreters manned the other 7. All sessions were videotaped and transcribed. The analysis of the data revealed that medical interpretation errors were common. A disturbingly common error was omission (52%), with the interpreter failing to transmit information from or to the patient (or parent). Other errors included false fluency (16%), substitution (13%), editorialization (10%), and addition (8%).

A sobering fact was that of all errors detected, as many as 63% could have clinical consequences for the children. Such errors included omitting questions about medication allergies; omitting specific instructions on treatment; adding that hydrocortisone cream must be applied to the entire body (instead of the face); instructing a mother not to answer personal questions; omitting that a stool swab had already been taken; and instructing a mother to put amoxicillin in both ears (instead of one) for treatment of otitis.

The investigators concluded that given the frequency (and potential impact) of errors in medical interpretation, it would be advisable to rely exclusively on services by professional interpreters. (An analysis of errors according to the interpreter's qualifications - ad hoc vs professional- however, was not performed).

When Silence is Golden

In a second study the same investigators recently re-examined the material from all 13 encounters. (2) The transcripts were divided into segments of dialogue in a single language plus any translation of that dialogue. Of all the segments where translation was expected, 66% were translated with substantial errors or omissions -or not translated at all. Unexpectedly, in 30% of segments the interpreter engaged in speech unrelated to interpretation -either with the health care provider (assuming the patient's role) or with the patient (assuming the provider's role). This behavior was labeled by the investigators "role exchange." A striking finding from the study was that role exchange was inversely related to the quality of the interpreter's job. The more time spent in role exchange, the poorer the interpretation.

Those of us who have ever provided medical interpretation have often felt tempted to offer - beyond good language renditions- some pertinent "off the record" comments. This, we know now, is not advisable. Engaging in speech behaviors other than interpreting is associated with a higher rate of interpretation errors –many of which can have adverse consequences for patients.

To err is human, but to learn from error is (almost) divine.

Bibliography:

1- Flores G, Laws MB, Mayo SJ, Zuckerman B, Abreu M, Medina L, Hardt EJ. Errors in medical interpretation and their potential clinical consequences in pediatric encounters. Pediatrics 2003;111:6-14.

2- Laws MB, Heckscher R, Mayo SJ, Li W, Wilson IB. A new method for evaluating the quality of medical interpretation. Med Care 2004;42:71-80.

FRASES MEDICAS DE LA CALLE

A ver lo que se cuece en los pasillos …

1. **intoxicación ..** "Está intoxicado..". This simple phrase by a family member who thought the confused and incoherent patient was drunk led the treatment team astray from an aggressive pursuit of a stroke in progress, and ended up in a 90 million dollar lawsuit to a known hospital in South Florida. Intoxication / intoxicación leads us to think of contact with / being under the influence of a toxic substance received through ingestion, injection, inhalation or skin contact. Borracho, ahumado, ajumado, metido en palos/ en tragos are just but a few of the many colloquial regionalisms to describe being drunk or drunkenness. Blood alcohol levels do not necessary relate closely to the manifest symptoms since tolerance is always an unknown factor.

2. **envenenado / envenenamiento .. poisoned /** poisoning, is a related situation to intoxicado. It is not often related to actual poisoning, as the word may imply, but to the suspected ill effects of some food or drink with usual attendant gastrointestinal symptoms i.e., general malaise, nausea, vomiting, diarrhea. A clinical history, particularly the proper taking of prescribed medications, is as good as it gets to sort out the connection and seriousness of these situations.

3. **las 'direcciones'..** the Sig. part of the prescriptions or directions, how to take the medication, instrucciones, has also created serious problems "Take every 2-4 hours" mistaken for "every 24 hours" .. "two to four" and "twenty four", said hurriedly, can certainly be misheard. Once a day and once (number eleven) al día was a serious mistake, used as an example in a well-known television medical program.

4. **resquemor ..** meaning chest pain associated with a burning sensation coming up from the stomach to the chest, is the equivalent of heartburn – also known as agrieras, agruras, acidez related to gastroesophageal reflux, reflujo gastroesofágico. Normalmente, el resquemor es lo opuesto al amor, el odio. En nuestro caso es posible que la sensación de quemar o quemazón, burning, se ha aumentado mediante el uso del prefijo res'.. The initials GERD, by the way, mean gastroesophageal reflux disease.

5. **estresado ..** stressed out. Contrary to first impressions, estrés, estresante, and the verb form estresar are all included in the Diccionario de la Real Academia.

6. **agudo ..** is not used in the usual medical sense of acute – of recent or sudden onset. But rather as the equivalent of sharp or severe or intense. Dolor agudo, fuerte, intenso..

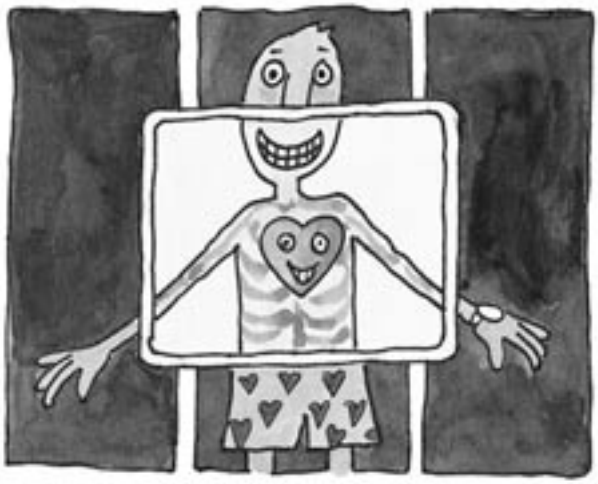
7. **tener bilis ..** bilis is bile. Having 'too much of it' can be the alleged cause of problems, particularly in two areas – the gastrointestinal (GI) and the 'emotional' tracts. If your GI symptoms include vomiting wherein yellowish bile is recognizable – bilious vomiting – , then the cause is too much of it. Somehow, bile is also related to anger. So that a short-tempered, short-fused, easy to anger person is said to have too much bile.

8. **ojo, tener ojo, el mal de ojo ..** no Spanish medical colloquialism list is complete without the allusion to ojo, meaning eye, specifically the "evil eye". Evil eye is a universal traditionalism wherein envy – the root of all evil, – is also what gives rise to all sorts of evil-related maladies or injuries = causes the 'eye' on another person – particularly vulnerable children. Fear of 'the eye' also gives rise to a wide assortment of customs and devices used as protection against the ravages of the envious evil eye. One of the most widely used customs used to protect newborn children against 'the eye' in Latin American countries is the use of bracelets, for newborn boys, and earrings for newborn girls. Thereafter, there is no limit as to what could be ascribed as due to or protective against the evil eye, for children or adults. In another occasion we will deal with entire topic.

Gracias a nuestro colega Roberto Guzmán por sus contribuciones a esta columna.

MANAGED CARE HUMOR

VITAL INFORMATION YOU SIMPLY MUST HAVE ...
TO HELP YOU CHOOSE WISELY YOUR NEXT HEATH PLAN



Q What does HMO stand for?

A. This is actually a variation of the phrase, "Hey, Moe." Its roots go back to a concept pioneered by Moe of the Three Stooges who discovered that a patient could be made to forget about the pain in his foot if he was poked hard enough in the eyes.

Q. I just joined an HMO. How difficult will it be to choose the doctor I want?
A. Just slightly more than choosing you parents. Your insurer will provide a book listing all the doctors in the plan. Doctors basically fall into two categories: those who are no longer accepting patients and those who will see you but are no longer participating in the plan. But don't worry, the remaining doctor who is still in the plan and accepting new patients has an office just a half-day's drive and his credentials from a Third World Country Medical School are currently being translated into English. This will take time.

Q. Do all the diagnostic services need pre-certification?
A. No, only those you need.

Q. Can I get coverage for my pre-existing conditions?
A. Certainly, as long as they don't require treatment.

Q. What happens if I want to try alternative forms of treatment?
A. You'll need to find alternative forms of payment.

Q. My pharmacy plan only covers generic drugs, but I need the name brand. I tried the generic medication, but it gave me a stomach ache. What should I do?
A. Poke yourself hard in the eye.

Q. What about if I am away from home and get sick?
A. You really shouldn't do that.

Q. I think I need a specialist, but my doctor insists he can handle my problem. Can a general practitioner really perform a 3-button-holes gall bladder removal in his office?
A. Hard to say, but considering that all you are risking is the $15 co-payment, there's no harm in giving it a shot.

Smiling
More
Increases
Life
Expectancy

WHAT'S UP, (TODAY!) DOC?

Keeping up with scientific advances can often be confusing, sometimes downright contradictory.

Contrary to what the scientific community could have ever suspected, the Atkins diet is today definitely in! Which means that proteins ands fats are more in than ever while carbs are out – if weight loss is the primary aim. Carbs is what makes you fat, today (very complicated hormonal biochemistry). So instead of a baked potato you fill up with veggies next to the sirloin and you're good to go.

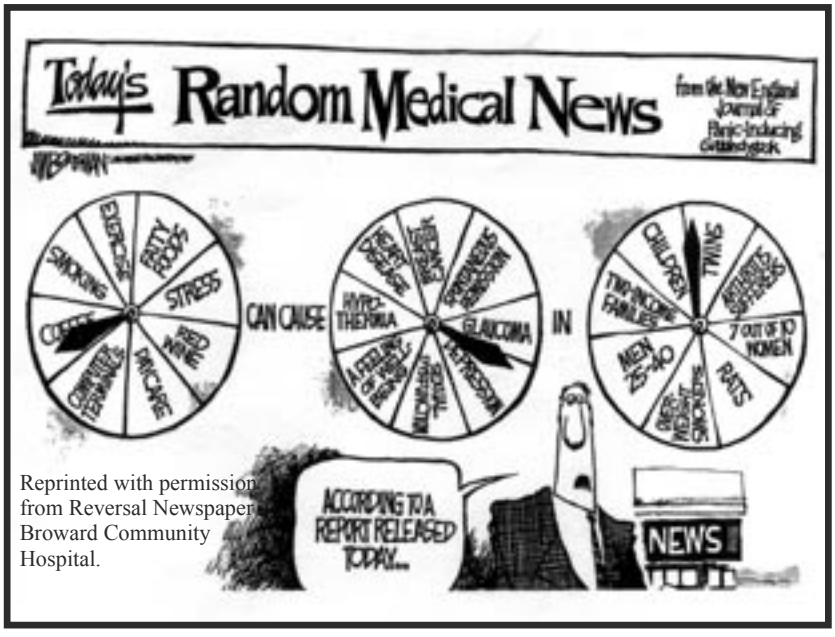
Remember the days when a high fiber diet was definitely out for the folks with diverticulosis. Many vegetable elements such as corn and tomato seed deemed ominous enough to get into those colonic pockets. Well, it's not the corn or the tomato seeds that get into the pockets, we now know, but the degree of muscular spasm within the bowel wall that creates the pockets to begin with. A high fiber intake is now in to maintain steady intra-colonic pressure.

Remember when hormonal replacement therapy (HRT) for menopausal and postmenopausal women was an absolute in, just for the asking. Now, it's an absolute out unless you sweat your partner out of bed (severe hot flashes) or can't stand yourself (mood swings) at any time. HRT for men, however, is gaining momentum.

Talking about in or out - Viagra is still sometimes in, sometimes out but still around. And it's in for women too. Around the corner, a new "weekender" Viagra-like wonder – Levitra - that lasts three days.

Testosterone in gel form or patches has gained FDA approval. Though it is difficult to gauge scientifically any health benefit from testosterone replacement, those who try it report renewed energy and improved gains from strength training – such as greater mobility, and ability to get in and out of wheelchairs which turns into lesser risks for falls and broken hips.

The color of health is definitely red. Lycopene – a powerful antioxidant found in tomatoes – is what makes them red, so ketchup and pizza are on the plus side. Resveratrol, another antioxidant substance most commonly found in red wine, is getting the thumbs up for the goodness attributed to red wine. The original thought of red wine over other colored grapes has dissipated. Really, any "drink" of customary size –wine, beer, hard liquor, even plain colorless ethyl alcohol has been shown to have a salutary effect, if you keep it down to 1-2 per day. (See What's a Drink?, page 20.)



Reprinted with permission from Reversal Newspaper Broward Community Hospital.

Online Resources for Medical Translators

An excellent start for our regular Resources feature.

by Rebecca Davis

Ten years ago, I used to spend days in the library searching for resources, hunting for journal articles, dedicating hours to finding accessible with a click of the mouse. I would like to take this opportunity to introduce to our readers to the wealth of information available out there, ways to access it, and how to exploit it, particularly for those of us doing medical translations.. With the Internet information explosion a term which may have taken hours to find is now accessible with a few clicks of the mouse.

Dictionaries Online

• http://www.granddictionnaire.com **: maintained by the Office *québécois de la langue française*, is always my preferred first general choice as a French <> English translator. This resource is only useful if you're translating French into English, however. For other languages, it's best to ask other translators who work in your particular language pair. Or you may try,**

• http://www.webbsnet.com/translation/multi.html

Search Engines

For highly specific technical terms or prases which you are unlikely to find in general dictionaries the answer lies in modern search engines.

Let's assume that you are translating an article on "self-expanding metal stents" (see Glossarium, page X). Things are progressing swimmingly until you encounter a stent-related term that you've never seen before. If the term is not in any of the dictionaries on your desk, where do you go from here? The next step is to look for a web page in your target language, describing the same stent procedure. Such a page will probably contain the term you're looking for, if you define your search correctly. This is where you need good search skills and a good search engine.A search engine allows you to search millions of web pages to find ones containing the word or words you're interested in. It does this by storing information about every web page it knows in a local database. This database is constantly updated and new pages are being added all the time. When you ask a search engine for web pages about "stent", it will return a list of links to all the pages it knows that contain the word "stent".

In my work the most valuable search engine is www.google.com. It is the best there is, in my opinion. It's simple and clean, plus it offers a very up-to-date database to include in your search.

Click "Preferences" on the Google home page, and next click the "Search only for pages written in these languages" (check box). Be sure to click the "Save Preferences" button before going back to the Google search.)

In my work the most valuable search engine is www.google.com. It is the best there is, in my opinion. It's simple and clean, plus it offers a very up-to-date database to include in your search.

There are two main kinds of searches: searching for pages containing words in any order, not necessarily next to each other, and searches containing words in a specific order. For example, to find articles on self-expanding metal stents in Google, if you type "expanding metal stents" in quotes, only web pages containing those words in sequence will be found. If

you type the same words without quotes, you will see a longer list of web pages, containing the same three words, but not necessarily next to each other or in the same order.

To narrow the search further, find another term you do know that seems to occur frequently with the unknown term, and add this known term to your search. This will find pages that are more likely to cover the specific topic you're looking for. Be sure to include any accents or special characters if your language uses them.

For example, if you need to translate "stent à élution de sirolimus CYPHER" into English, the word CYPHER is a brand name and will probably be the same in the target language. The best search would be "CYPHER" and "stent"; the resulting hits indicate that the proper translation for this is "CYPHER sirolimus-eluting stent". You will notice in the list of hits returned by Google that the phrase often has the word "coronary" preceding the word "stent". Is this the preferred term, you wonder? A search of the exact phrase in quotes, with and without the word "coronary", shows that Google finds 400 hits without the word coronary, and about 400 hits with the word coronary. Either phrasing seems to be correct. Sometimes you will find that one phrasing has tens of thousands of hits, and the other only a few hundred. In such cases, as long as each phrasing has the exact same meaning, use the more common one.

A word of warning: if the wording is written by a non-native speaker, the source may have incorrect terms. I try to use web pages written by natives of the target language country. If it's a page maintained by a Boston Hospital and you're translating into American English, the term should be OK, but check the name of the author if possible. The link to the web page, called its URL (or Universal Resource Locator), may also indicate in which country the web site is located. For example, if the URL ends in suffixes such as: .ch, .fr, or .jp – these stand for Switzerland, France, or Japan as the source countries involved. For a list of suffixes and the corresponding countries, check out this comprehensive site of multinational domains – http://www.computeruser.com/resources/dictionary/noframes/nf.domains.html.

Sometimes you just can't find a page containing the term you need. In this case, move on to step three: find a page that has the term in the source language. Those of us translating into English have an advantage here, as web pages in foreign languages sometimes contain English text providing clues to the unknown term. You can try adding the word "English" to your search, in an attempt to find web pages containing links to an English translation. Otherwise, you'll need to browse the web pages you find, looking for more detailed descriptions of the unknown term.

Mailing Lists

Suppose all the above steps fail. In that case, there are other translators out there who communicate on a daily basis via the Internet who may be able to help. Colleagues tell me Lantra is a good place to post terminology questions, although I must confess I have never used this well known site**:** **http://www.geocities.com/Athens/7110/lantra.htm**
Another useful multilingual medical site is the one available to ATA – Medical Division Members only - **http://groups.yahoo.com/group/ATA_MedDiv/**, for information on how to join the Medical Division contact Mary David at mary@atanet.org

Useful Web sites for the medical translator:

http://www.ncbi.nlm.nih.gov/PubMed/
PubMed is the National Library of Medicine's searchable database of millions of journal articles. It allows you to search by author, title, and keyword. The article abstracts often contain the term you're looking for. Very useful. Note that search results with a blank document icon to the left of them do not have an abstract. Look for document icons with horizontal lines drawn on them.

http://www.hon.ch/MedHunt/MedHunt.html
MedHunt is an interesting tool provided by Health on the Net. It returns a list of web sites, ranked by relevance, that relate to the terms you are interested in.

www.ProZ.com
ProZ.com is a great website for translators. It is not exclusively devoted to Medicine but translators post daily questions and answers in the fields of Medicine, Health Care, Pharmacology, Science, Chemistry, and Biology. There are also many discussion Forums.

http://ep.espacenet.com/
This is the European Patent Office database search tool. A useful, one of a kind data site for finding terms related to newer procedures and devices.

www.onelook.com
Onelook Dictionary Search. It will return links to all online dictionaries containing the search term. The hits are divided into general, medical, science, and technical dictionaries of various kinds.

http://allserv.rug.ac.be/~rvdstich/eugloss/language.html
Multilingual glossaries of medical terms.

www.stedmans.com
Stedman's online. This currently will tell you your term doesn't exist in the dictionary if you search by typing the word, but you can still access your term by clicking the correct letters of the alphabet listed below the "Search" box.

cancerweb.ncl.ac.uk/omd/
Online Medical Dictionary.

http://www.medterms.com/script/main/hp.asp
Medterms.com Medical Dictionary.

http://www.mercksource.com/pp/us/cns/cns_hl_dorlands.jsp?pg=/pp/us/common/dorlands/dorland/dmd_a-b_00.htm
Dorland's Illustrated Medical Dictionary.
You can also use this page to search the entire site, which returns information found in the Merck Manual (although it's the home edition) on your search term.

www.whonamedit.com
Whonamedit defines medical eponyms and gives a bio of the person concerned. This is useful for verifying a procedure that may not be named after the same person in different countries.

http://www.mtdesk.com/alpha.shtml
Definitions of newer drugs/medical equipment/procedures, with links to other medical, scientific and technical areas.

Good resources for French/English translators:

www.granddictionnaire.com
French-English dictionary maintained by the Office Québécois de la Langue Française.

www.termium.com
This is an excellent online database, but is only available for a monthly fee of $25. A 7 day free trial period is available.

Author's note: Everyone has favorite web sites for finding information. If you have a link you think others should know about, please email it to me and I'll collate the responses in future articles of our newsletter.

Editorial note: Members and readers, take note of Rebecca's offer to continue her participation in our regular Resources feature. She will gather your preferred sites as you submit them for future publication. If you prefer, put together an article dedicated to resources appropriate to a particular subject or area of interest.

Please note that as per recent ATA resolution British spelling is considered unacceptable in ATA exams.

GLOSSARY OF TERMS USED IN CLINICAL RESEARCH

By Astrid Kaeser

Clinical research has become increasingly regulated over the last twenty years. This glossary provides a summary of frequently used terms and abbreviations. It is based on information published by Health Canada and the Appendix of the article "A Primer on Drug Development" published by Mary Anne Foote and Theresa K. Neumann in the AMWA Journal, Volume 18, Number 2, 2003. I would herewith like to express my thanks both to Mary Anne and the AMWA editorial staff for permitting me to reprint part of this article.

ADME—Absorption, distribution, metabolism and excretion of a drug compound.

ADMISSION CRITERIA—Criteria used to select the target population for a particular clinical trial. All studies must have both a list of inclusion criteria and exclusion criteria which patients have to meet to be eligible for the study.

ADVERSE DRUG REACTION (ADR)—Any undesirable adverse event (see below) occurring during a study, which has been assessed, and where a causal relationship to the investigational product (s) has been established.

ADVERSE DRUG EVENT (AE)—Any undesirable experience occurring during a clinical trial, whether or not considered to be related to the investigational product(s). All adverse events must be reported to the respective regulatory agency (agencies).

AMENDMENT—A document describing changes or additions to an existing clinical trial protocol.

BASELINE—Measurements that are taken at the beginning of a clinical trial to serve as reference for subsequent measurements or observations.

BIAS—A point of view that prevents impartial judgment on issues relating to the subject of that point of view. In clinical trials, this is controlled by blinding and randomization.

BIOAVAILABILITY—Studies performed with different formulations of a drug to identify if the blood levels, the time course of these blood levels and the elimination of the drug from the body are the same or different between the formulations.

BIOEQUIVALENCE—A bioavailability study using the same drug manufactured by two different companies (or different processes) to prove that the bioavailability of the drugs is (bio) equivalent.

BIOLOGIC LICENSE APPLICATION (BLA)—Original submission to obtain a license for marketing of a biologic agent in the USA.

CARRYOVER EFFECT—Any effect of a drug which lasts beyond the period of treatment.

CASE REPORT/RECORD FORM (CRF)—The forms specifically designed for each protocol to collect the data on each subject enrolled in a clinical trial.

CLINICAL HOLD—Ruling by the FDA that some part of the Investigational new Drug (IND) submission (investigator's brochure and/or clinical protocol and/or informed consent) is inadequate and must be resolved before the study can start.

CLINICAL PROTOCOL—Specific set(s) of goals and procedures that define what will happen in a trial.

CLINICAL STUDY AGREEMENT—See CONTRACT

CLINICAL STUDY REPORT (CSR)—Summary of the clinical and statistical findings of a given protocol.

CLINICAL TRIAL APPLICATION (CTA)—Term used to describe the process in the European Union that allows for testing of drugs in healthy volunteers or patients before the start of a clinical trial. Whether or not a CTA is required differs from country to country.

CLINICAL TRIAL EXEMPTION (CTX)—Allows for testing of drugs in patients in the United Kingdom. A CTX is usually not needed to test a drug in healthy volunteers

CO-INVESTIGATOR—A physician or qualified individual who assists the Principal Investigator (PI) with the clinical trial.

COMMON TECHNICAL DOCUMENT (CTD)—New global marketing application that takes the place of the regional marketing authorization application (MAA) and New Drug Application (NDA).

CONCOMITANT MEDICATION—Any medication taken by a patient, in addition to the study medication.

CONTRACT—A document signed by the investigator(s) and the sponsor(s) that delineates agreements on liability and financial issues as well as on delegation/distribution of responsibilities. Must be signed prior to the clinical trial.

CONTROLLED CLINICAL TRIAL—A study design that compares the investigational product(s) with either placebo or with another treatment known to be effective against the disease.

CROSS-OVER DESIGN—A study design that has each patient in two or more treatments in a specified order.

DECLARATION OF HELSINKI—The Declaration of Helsinki is the international standard for the protection of subject's rights.

DOSE-RANGING STUDIES—A study designed to evaluate the effect and/or safety of different doses of an investigational product.

DOUBLE-BLIND—Neither the patient nor the investigator knows which treatment the patient is receiving.

DROP OUT—A subject who does not complete the protocol requirements of a clinical trial.

ELIGIBLE PATIENT—A subject who meets the inclusion and exclusion criteria.

ERB—Ethics Research Board, see IRB.

EVALUABLE PATIENT—A subject who has satisfied all of the protocol requirements.

EXCLUSION CRITERIA—A set of criteria, any of which would exclude the patient from participating in a clinical trial.

FOOD AND DRUG ADMINISTRATION (FDA)—Agency of the Unites States federal government that is responsible for the safety of foods, drugs, and medical devices.

GOOD CLINICAL PRACTICE (GCP)—A standard by which clinical trials are designed, implemented and reported.

INCLUSION CRITERIA—The criteria which, if fulfilled, will make a patient eligible to participate in a clinical trial.

INDEPENDENT ETHICS COMMITTEE (IEC)—See below: IRB

INFORMED CONSENT (IC)—Agreement to participate in a trial that is given after a potential participant

has reviewed all available information about the treatment including an explanation of potential benefits, risks, inconveniences, other treatment options as well as his/her rights and responsibilities.

INSTITUTIONAL REVIEW BOARD (IRB)—Independent body in the US consisting of medical professionals and non-medical members, whose responsibility it is to verify that the study is conducted in a way that the safety and human rights of the subjects are protected.

Designations in other countries include ERB, REB, and IEC (see above and below).

INTERNATIONAL CONFERENCE ON HARMONIZATION (ICH)—Unique project that brings together the regulatory authorities of Europe, Japan, and the United States and experts from the pharmaceutical industry to discuss scientific and technical aspects of product registration. The purpose is to make recommendations on ways to achieve greater harmonization in the interpretation and application of technical guidelines and requirements for product registration to reduce or obviate the need to duplicate the testing carried out during the research and development of new medicines and to allow for a more economical use of human, animal, and material resources while maintaining safeguards on quality, safety, and efficacy, and regulatory obligations to protect public health.

INVESTIGATIONAL NEW DRUG APPLICATION (IND)—Allows for the testing of drugs in humans (healthy volunteers and patients) in the United States.

INVESTIGATOR—Physician or otherwise qualified individual conducting a clinical trial.

INVESTIGATOR'S (DRUG) BROCHURE (I[D]B)—Collection of all relevant up-to date information known on the investigational product including chemical, pharmaceutical, and toxicological data as well as the from earlier clinical studies, if available. The IB is the basis for an investigator to decide to participate in a trial.

MARKETING AUTHORIZATION APPLICATION—Original submission to gain marketing approval in the European Union. The information must contain chemical, pharmaceutical, biological and clinical data.

MAXIMUM TOLERATED DOSE (MTD)—The highest dose that can be administered without unacceptable side effects.

MONITOR—A person who monitors and reports on the progress of a clinical trial and verifies the data.

MULTICENTER TRIAL—A clinical trial that is conducted according to a single protocol at more than one investigational site by more than one investigator.

NEW DRUG APPLICATION (NDA)—Original submission to gain marketing approval in the United States.

NO OBSERVABLE EFFECT LEVEL (NOEL)—Dose of an experimental drug given to animals that does not produce an observable toxicity.

OPEN-LABEL STUDY—Both the investigator and the subject know the treatment schedules, drug and doses.

PHASE I STUDY—Initial evaluation of a drug in man to determine the safety and tolerance. Usually conducted in healthy volunteers. Exceptions exist for drugs, which cannot be safely administered in healthy volunteers e.g. anti-cancer drugs.

PHASE II STUDY—Initial evaluation of a drug in patients to determine whether a drug has the intended activity.

PHASE III STUDY—Large scale studies to gain experience about the efficacy and its profile of side effects. Usually, designed as randomized controlled trials comparing an existing treatment to the investigational product.

PHASE IV STUDIES—Also called Post Marketing Surveillance (PMS) studies to gain wider experience with the drug to support new claims for indications and obtain further information when comparing it to other marketed drugs.

PLACEBO—Dummy medication, which looks, feels, smells and tastes identical to the active drug.

PIVOTAL STUDY—A study that is rigorously monitored and provides fundamental data on efficacy and safety to regulatory authorities. Studies not meeting GCP and intensive monitoring criteria may be considered "supportive studies" by the FDA and cannot be used to support efficacy claims, while safety data will be accepted.

PROSPECTIVE STUDY—Patients are recruited according to criteria, which are laid down in a protocol before the start of the trial. Most clinical trials today are prospective.

RANDOMIZATION—Process that reduces the likelihood of bias by assigning subjects to treatment groups by chance alone (randomly).

RESEARCH ETHICS BOARD (REB)—See above INSTITUTIONAL REVIEW BOARD

SAFETY MONITORING COMMITTEE—Independent committee, composed of community representatives and clinical research experts, that reviews data while a clinical trial is in progress to ensure that participants are not exposed to undue risk. A safety monitoring committee may recommend that a trial be stopped if there are safety concerns or if the trial objectives have been achieved.

SERIOUS ADVERSE EVENT (SAE)—Any adverse event that is fatal, life-threatening, disabling or which results in in-patient hospitalization or a prolongation of in-patient hospitalization. Congenital anomaly and occurrence of malignancy are always considered SAEs.

SITE—Place where a clinical trial is conducted

SOURCE DATA—Records of original observations or activities including medical charts, laboratory reports, physician's/nurse's notes or recordings from instruments such as EEG, X-ray films etc.

STATISTICAL SIGNIFICANCE—The probability that any outcome of a study occurred by chance alone. The level of significance depends on the number of subjects and the magnitude of differences observed.

SUBJECT—A human being (patient or healthy volunteer) participating in a clinical trial.

UNEXPECTED ADVERSE EVENT—Adverse event, which has previously not been reported (in nature, severity or incidence).

WASHOUT PERIOD—Period between two active treatments in order to remove all traces of the first drug and to obviate carryover effects before the second drug is administered.

Editorial note: This excellent glossary is open to translation into any language. Astrid will do the German version. French, Spanish, Portuguese, Italian - any other languages are welcome. Volunteer members please step forward. The final product will be published separately - all participants will be duly credited - once all versions are collated. A multilingual glossary of this kind would be a convincing step towards our goal of

Next issue...

- Pain – the Fifth Vital Sign
- The Nursing Profession
- Heart Talk – The Status of the Statins
- Interview
- Regular features
  - Pitfalls and Caveats
  - Glossarium
- Your contributions – less than 2000 words, sent to bukrak@bellsouth net

MARK YOUR CALENDAR NOW!

Toronto, Ontario, Canada
October 13-16, 2004

ATA Annual Conference

Lutheran Medical Center

Lutheran Medical Center is looking to expand its pool of **freelance translators**

Spanish, Arabic, and Chinese (preferably Cantonese speakers) are of particular interest to us.
Experience with underserved populations is a plus.

Please contact Irja Estrella, Cultural Initiatives Coordinator, Lutheran Medical Center, Brooklyn, NY iestrella@lmcmc.com

Support your Division!

FOR SALE

Attractive polo shirts embroidered with the Medical Division logo in the front and the ATA logo on the sleeve. Get one along with a Medical Division bookmark.

For only $25

Send check or money order to:
ATA – HQ
ATTN: Mary David
225 Reinkers Lane, Suite 590
Alexandria, VA 22314

Would you like others to know about you?

Space is available in Caduceus

Full page $150
Half page ..... $ 75
Single column ..... $ 65
Business cards ..... $ 25

Send check or money order to
ATA – HQ
ATTN: Mary David
225 Reinkers Lane, Suite 590
Alexandria, VA 22314