

**Speaking in Tongues:  
Latinos, Medical Interpreting and Translation  
Issues in Somerville**

An Oral History Project  
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Urban Borderlands  
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## Preface

Regular and reliable medical attention is essential for everyone—regardless of citizenship status. Although not many think that their neighbor’s health is their concern, every individual’s health affects a whole community’s health outcomes. At the same time, individual health is closely linked to community health, which in turn is affected by collective behaviors, attitudes, and beliefs of all those who live in a community.<sup>1</sup> From this perspective, the idea of public health addresses the organized efforts of a society to protect, promote, and restore health from within the complex interaction of forces that link the individual to the collective and begin make up organized systems human health. “[Public health] is the combination of science, skills, and beliefs that is directed to the maintenance and improvement of the health of all the people through collective or social actions.”<sup>2</sup> It is through close study of the existing networks of public health care and open dialogue with community residents that the limitations, successes and continuing movements for reform can be studied, and understood.

One of the services and organizations directly serving Somerville’s multi-cultural and multilingual public health needs is the Cambridge Health Alliance (CHA). The CHA is a regional health care system comprised of three hospitals, more than 20 primary care practices, the Cambridge Public Health Department, as well as Network Health, a statewide Medicaid health plan. The CHA was created on July 1, 1996 with the merger of the Cambridge Hospital and Somerville Hospital, and expanded in July 2001 with the addition of Whidden Memorial Hospital in Everett.<sup>3</sup> The CHA’s primary goal is to

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<sup>1</sup> The Well Being of Somerville 2002 Annual Report. Printed by the Cambridge Health Alliance. Page 2.

<sup>2</sup> M. Martinez. Interview. Somerville, Massachusetts. October 16, 2004.

<sup>3</sup> Cambridge Health Alliance: CHA. 2003. “Cambridge Health Alliance.” 15 October 2004  
<<http://www.challiance.org/Default.htm>>.

provide equal and dependable medical services for all their patients, many of whom are recent immigrants from countries ranging throughout Central and South America to East Asia.

One of the most progressive aspects of the CHA is their translation services which serves CHA's diverse ethnic patient population. Translation is the meeting point of different cultures, and introduces nations and people to various perspectives on their path to modernization and intellectual advancement. The goal of translation is to establish a relationship of equivalence between the source and the target audience so that they both communicate an identical message, while taking into account any number of constraints. These constraints include the context, the rules of grammar of the source of language, its writing conventions, and its specific idioms. Within the constellation of CHA services a distinction is made between 1) translations: which consists of transferring ideas expressed in writing from one language to another, and 2) interpreting: which consists of transferring ideas expressed orally, or by use of gestures, from one language to another. Both of these practices are essential to the daily function of clinics and hospitals alike, especially in areas as culturally diverse as Somerville. The skilled provision of these translation services can be seen as an ethical commitment to the delivery of quality health care.

The translation process, whether it is for translation or interpretation, can be divided into two distinct steps: decoding the meaning of the source text and re-encoding the meaning in a specific desired language. To decode the meaning of the text the translator must first identify its component 'translation units', which are considered segments of the text, and which may be a word, phrase or one or more sentence, which is

to be treated as a cognitive unit. Behind this seemingly simple procedure lies a complex cognitive operation. To decode the complete meaning of a sentence, the translator must methodically interpret each piece and generate a phrase or word with an equivalent meaning. This process requires thorough knowledge of the grammar, semantics, syntax, idioms, as well as the culture of its speakers. Often a translators' knowledge of the target language is most important, and needs to be deeper than their knowledge of the source language. For this reason many translators are native speakers in one or both of the languages that they translate.

The medical translation services available for the Latino population in Somerville were the main topic of our research. However, it is impossible to study populations and health care without looking at the social and cultural contexts affecting access to reliable health care. This research project includes interviews and oral histories from 21 Somerville residents. The interviews range from discussions with CHA administrators who told us about the practices, rules, and regulations of the translation and interpretation services, to conversations with immigrants who talked to us about their personal experiences with these medical translational services. We cover both “upstream” and “downstream” stories and sources so as to see a more objective and whole perspective of the translational services in Somerville. The interviews are incorporated into themed chapters, to establish a more realistic context and hear in first-person from people knowledgeable in the field.

Hopefully our work can be used in the future for further research in the medical and translational field in Somerville. The hardest thing to overcome during our research was the voluminous amounts of information we obtained, and the decision as to what to

include in this report. The precise focus of this paper therefore became the medical translation and interpretation services offered by the Cambridge Health Alliance, as well as the history and current issues with translation and interpretation in the City of Somerville. However, this very scope of our research often limited our ability to address other important public health issues and their community affects such as infections and vaccinations.

In this project the contact with the CHA and the methodology of semi-structured interviews with local residents and health service workers can be seen as groundwork for further study; perhaps in the future others can pick-up where we left off and add to our research on further translation and interpretation services in Somerville and surrounding communities.

## Biographies



*From left: Julia Goldberg Diana Esteves Joanne Flores Leah Rogers*

**Diana Esteves** is a sophomore at Somerville High School. She was born in Puerto Rico, and lived in Pennsylvania before coming to Somerville, where she lives with her family. She enjoyed working on this project because she was able to participate in interviews with her family members and hear stories they hadn't shared. Through the project she learned about the differences in health care in Somerville as compared with in countries like El Salvador, Mexico and Puerto Rico.

**Joanne Flores** is a freshman at Somerville High School. She was born in Cambridge in 1990. She lives in Somerville with her mother, an immigrant from El Salvador, and three siblings. She enjoyed learning about the work of interpreters in the medical setting. In the interviews in which she participated, she learned how different the life of a young person in El Salvador can be from her own here in the US.

**Julia Goldberg** Julia Sarah Goldberg is a sophomore at Tufts University majoring in Community Health and Spanish with a minor in Latino Studies. She is an Active Citizen and Public Service Scholar. Her scholar's project is based in Somerville, and addresses public health issues of the immigrant community.



Julia has worked on public health issues in the Dominican Republic and Brazil. During the summer of 2004 Julia interned with The Way of the Heart: The Promatora Institute in Nogales, Arizona and Nogales, Sonora, Mexico. She helped open a free public health clinic in Sonora, teaching classes on nutrition and cardiovascular health, and helped change the menus of local restaurants in Nogales to offer more heart-healthy options. In the future, Julia hopes to continue her work with the health care of immigrant populations.

**Leah Rogers** is a Tufts University senior majoring in International Relations, with a minor in Latin American Studies. She was born and raised in the Boston area but had little connection to the Latino community here while growing up. After high school, she spent a semester learning Spanish in Costa Rica, and it was there that her



love for Latino culture was born. The themes of equality and justice have been prominent throughout her academic career, particularly with regard to ethnicity and basic human rights like access to health care. She has been interested in translation services since 2001, when she worked as an interpreter for the Lynn Community Health Center. She has truly enjoyed meeting the people she and Julia interviewed for this project, and she is grateful to them for their candidness and their contributions to what she hopes will be a greater awareness of the obstacles and possible solutions to health care access for the Somerville Latino community.

## **Introduction**

The City of Somerville, Massachusetts is a tangible confluence of cultures that has formed one of the most unique and diverse communities in the United States. As you walk down Broadway Avenue, one of the main roads through the heart of down-town Somerville, salsa and Latin beats come streaming out of cars stopped at red lights. In Somerville the names of businesses are in a different language on every other block, and the hours of operation are written in three languages. Walking through the city, you can hear fragments of sentences called out in a multitude of accents. Of the 77,478 residents in Somerville, 22,727 were born in a foreign country.<sup>4</sup> In an environment like this, it is important to find a way to facilitate communication between disparate ethnic and racial groups. Translation services are needed to make new immigrants feel they are a part of the larger, established community.

Upon entering the waiting room at the Central Street Clinic in Somerville, different voices penetrate the air, asking the same types of questions in three different languages: “¿Como puedo ayudarle, Señora?” (How can I help you Mad’am?) “¿Voce naõ pode a quarta feira?” (You can’t make it Wednesday?) “So would you like to see Dr. Cohen instead?” The cultural competency of the clinic is astounding; it is seen in the multilingual secretaries handling the numerous languages spoken by the immigrant populations who use the clinic, and in the posters on HIV and AIDS prevention translated into three languages on the wall in the waiting room. The clinic seems to operate in a perpetual state of simultaneous translation.

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<sup>4</sup> The Well Being of Somerville 2002 Annual Report. Printed by the Cambridge Health Alliance. Page 5.

The availability of translation services, both written and spoken, at the clinic allows people of diverse backgrounds equal access to quality medical care. This project allowed us to view the residents' accounts of their health care experiences in the context of specific services provided by the Cambridge Health Alliance, which we learned about through interviews with administrators involved with translation services.

Working in conjunction with Concilio Hispano's AHORA project, we and the other eight Tufts students in the Urban Borderlands class were matched with high school student partners who helped us make our first contacts for interviews. Not only did the high school students serve as voices from the community, they helped us get a better feel for Somerville than we could achieve in our isolation on the hill. Various professionals from Somerville and the surrounding areas came to speak with the Tufts students and our high school partners about issues facing the Latino population in Somerville. In the end, the Urban Borderland projects were a collaborative effort between the students who dug beneath the surface of Somerville in an attempt to understand and appreciate the community and its struggles, and the Somerville residents and professionals who provided information and insights that formed the core of the final projects.

## **Methodology**

Our research method was based entirely on recorded first-hand interviews and oral histories we conducted. We have both served as medical translators in the past, and so we were able to connect well with many of our narrators who were working or had worked as interpreters. Our familiarity with the topic was a great advantage as we knew the basic requirements of the job and had a good idea of what sorts of questions to ask during the interviews. During the course of the project we conducted 21 interviews in private homes and in clinics around Somerville. The interviews typically lasted 45 minutes to an hour and were conducted in Spanish (5), Portuguese (1) or in English (15), depending on the preference and the ability level of the person being interviewed. We grouped the narrators into three distinct categories – community organizers, immigrants, and medical professionals – in order to provide conceptual coherence to the interviews.

The atmosphere of the interviews was generally informal and conversational, despite the awkwardness of having a tape recorder present. The narrators were very open and shared their stories without hesitation. We began by asking for basic biographical information, and the responses led to more specific questions about the narrators' knowledge of or experiences with the translation services in Somerville. The legal status of some of the narrators became apparent during the interviews, but we avoided discussing it explicitly unless the narrator was the first to broach the subject. Our high school partners set up initial interviews for us with their family members, and we used various academic and local resources to find other contacts to interview about the more technical aspects of our research.

## **Research Limitations**

Throughout the investigative process of this project, we realized that the depth of our research and analysis had a number of limitations; namely, our inexperience with conducting interviews, our own and the narrators' reservations about using a tape recorder during conversations, weekly deadlines for interview reports, and problems coordinating our four schedules with the busy schedules of our potential narrators. While our high school student partners were released from school mid-afternoon, our own classes sometimes lasted until after 8pm, making it very difficult to schedule interviews at times when all members of the group could attend. Although we were persistent with phone calls and emails, many contacts waited days before returning our calls, and some never responded. Our most obvious hurdle was the amount of time we were given to complete this research process; in a mere 14 weeks, it was difficult to both understand and document the breadth and depth of the translation issue in Somerville. Our project should therefore be considered a preliminary analysis; there is great scope for more focused research in this area in the future.

## Chapter 1: Linguistic Diversity

### Importance of Cultural and Linguistic Awareness

With each passing year more health care providers are recognizing the challenges inherent in caring for patients from diverse linguistic and cultural backgrounds. Health care professionals must have a basic understanding of the impact of language on the delivery of health care in order to provide services that efficiently and effectively meet the needs of both the medical institution and the diverse patient population.<sup>5</sup>

Linguistic and cultural diversity is an inescapable element of modern American society. According to the United States 2000 Census, 11.1 percent of the total U.S. population is foreign-born. A total of 17.9 percent of the population speaks a language other than English at home.<sup>6</sup> Spanish is spoken in 10.7 percent of American homes, while an additional 3.8 percent of the American population speaks another Indo-European language. Other Asian and Pacific Island languages are spoken by 2.7 percent of Americans. In some states, the percentage of those speaking another language other than English at home is significantly higher than the national average - 39.5 percent in California, 36.5 percent in New Mexico, and 31.2 percent in Texas.<sup>7</sup>

The challenge of learning and mastering a new language is significant. Basic language proficiency often takes years to achieve, and even then familiarity with medical terminology and concepts may still be absent. Lack of basic reading and writing skills in a person's native language hinders the ability to learn a new language. In times of

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<sup>5</sup> Diversity Rx. "About Us." 27 November, 2004. <http://www.diversityrx.org/HTML/ESLANG.htm>

<sup>6</sup> US Census 2000. 2000. "Somerville, Massachusetts." 4 December 2004. <http://somervillema.areacconnect.com/statistics.htm>.

<sup>7</sup> US Census 2000. 2000. "Quick Facts" 8 December, 2004. <http://quickfacts.census.gov/qfd/index.html>.

significant stress or emotional trauma, as when dealing with an acute illness or injury, even individuals with years of experience speaking English may revert to their "mother tongue."

Health care facilities in almost every large U.S. city, and many suburban and rural areas as well, now serve diverse patient populations. Even though most health care providers want to offer non-English speakers the same attention and quality of care as they would to any other patient, patients with limited English proficiency can encounter obstacles at every turn. Patients may delay making an appointment because of the difficulty communicating over the telephone while their health problem becomes more severe, requiring more expensive or invasive treatment later. Misunderstandings about the time, date, and location of appointments are more likely to occur if the patient does not understand English. Even when patients arrive at the medical facility on time, they may be late for appointments because of difficulty communicating with registration staff.<sup>8</sup>

For the non-English speaker, a medical examination and interview conducted in English present almost unlimited opportunities for confusion and potentially serious misunderstandings. A complete and accurate medical history is crucial for a correct diagnosis, and thus is indispensable for providing quality health care to patients. Sophisticated technology and diagnostic procedures cannot be substitutes for clear patient-provider communication. In addition, miscommunication can result in unnecessary or inaccurate tests. When medical tests are necessary, if the patient is not given instructions in a language he can understand, he may not be adequately physically or psychologically prepared to undergo these frightening and sometimes painful

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<sup>8</sup> M. Pienasola. Interview. Somerville, Massachusetts. November 22, 2004.

procedures. Likewise, if patients are to comply with a treatment plan, they must have a clear understanding of what is required of them.<sup>9</sup>

. If the medical provider does not speak the language of the patient, interpreting and translation services are absolutely crucial. The key factor in all cross-cultural patient/provider relationships is communication, not only through gestures, facial expressions, and spoken discourse but also with the nuances supplied by translators and interpreters who are attuned to the subtleties of language and expression. Since expressions vary by social contexts and local communities, quality interpretation and translation is often achieved through familiarity with these subtle differences. The need for interpreting and translation services in medical settings varies on a state to state basis. In Massachusetts at the Cambridge Health Alliance (CHA), the main health care provider for more than 230 communities in the Cambridge/Somerville area, 51 percent of visits are with patients from linguistic minorities.<sup>10</sup> This linguistic diversity and its effect on the methods of supplying health care is of paramount importance to determining how to effectively care for non-English speaking patients. What is more, despite certain national legal regulations there is a wide variation in the quality and breadth of translation services available. This stems partly from the complex nature of the task itself. Nevertheless it is clearly possible to provide consistent, high quality, coherent translation and interpreting services in the medical sector and, we argue, in the government sector as well.

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<sup>9</sup> Ibid.

<sup>10</sup> Cambridge Health Alliance: CHA. 2003. "Cambridge Health Alliance." 15 October 2004 <<http://www.challiance.org/Default.htm>>.

## **Health Care Options for Immigrants in Somerville: Background**

### **The Population in Somerville**

The unmistakable mix of cultures and ethnic groups living in Somerville, Massachusetts, is represented on the city's official website. There, visitors are welcomed in four different languages: English, Creole, Spanish and Portuguese.<sup>11</sup> Nearly 82,000 people live within Somerville's 4.3 square miles.<sup>12</sup> Located between the Charles and Mystic Rivers, Somerville has a rich history. It served as a key military position during the American Revolution, offering protection for Prospect Hill, which held important military fortifications. During the 19<sup>th</sup> century, Somerville was also an important crossroads between the various canals and railroad routes nearby.

Somerville is a community made up of blue-collar residents, young professionals and immigrants. There are large populations of artists and college students because of the location of Tufts University and the city's proximity to Cambridge and Boston. There are 22,727 foreign born residents living in Somerville; about 29.3% of the total population.<sup>13</sup> Adding to this mix are many residents who are second and third generation Americans of Italian, Irish and Portuguese descent.

Somerville was the destination of two distinct waves of immigrants. The first wave, beginning in the late 1970s and lasting through the early 1980s, included mainly Portuguese, Azorean, Cape Verdean, and Haitian immigrants. The second wave of immigration to Somerville began in the late 1990s and has continued to the present; it includes many Central Americans (the majority from El Salvador), East Asians and

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<sup>11</sup> Area Connect LLC. 2000. "Somerville Population and Demographics." 6 November 2003 <<http://somervillema.areaconnect.com/statistics.htm>>.

<sup>12</sup> Ibid.

<sup>13</sup> The Well Being of Somerville 2002 Annual Report. Printed by the Cambridge Health Alliance. Page 5.

Brazilians. Somerville residents speak more than 50 different languages.<sup>14</sup> Approximately ten percent of the population in Somerville is Latin or Hispanic, while 72 percent of the population is Caucasian.<sup>15</sup> Between 1990 and 2000, the white population in Somerville declined (-13%) while the black (15%), Asian (44%), and Hispanic/Latino (31%) population increased.<sup>16</sup> Compared to the State of Massachusetts, Somerville has a lower percentage of children (18% vs. 26%) and seniors (10% vs. 14%) and both age cohorts declined in numbers between 1990 and 2000, while the population aged 25-64 increased.<sup>17</sup>

The number of immigrants in Somerville has increased by 25% in the last ten years, according to census data.<sup>18</sup> Due to the high levels of undocumented immigrants living throughout Somerville, the true number of immigrants is even higher than recorded. Some of the interviews included in this report touch on the problems and benefits of the illegal immigrant population in Somerville. Somerville's median household income, \$46,315, was below the state average of \$50,500.<sup>19</sup> There were also more residents in Somerville living below the poverty status.<sup>20</sup> While it is important to note that Latinos have the highest rate of poverty in the U.S, our research did not focus specifically on the resource-poor Latino communities in Somerville.<sup>21</sup> While it has been convincingly demonstrated elsewhere that the financially disadvantaged are at a greater

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<sup>14</sup> The Well Being of Somerville 2002 Annual Report. Printed by the Cambridge Health Alliance. Page 5.

<sup>15</sup> Area Connect LLC. 2000. "Somerville Population and Demographics." 6 November 2003 <<http://somervillema.areaconnect.com/statistics.htm>>.

<sup>16</sup> US Census 2000. 2000. "Somerville, Massachusetts." 4 December 2004. <<http://somervillema.areaconnect.com/statistics.htm>>.

<sup>17</sup> Ibid.

<sup>18</sup> Ibid.

<sup>19</sup> Ibid.

<sup>20</sup> (12% compared to 9% for the whole state of Massachusetts) US Census 2000. 2000. "Somerville, Massachusetts." 4 December 2004. <<http://somervillema.areaconnect.com/statistics.htm>>.

<sup>21</sup> Kim Krisberg. "Work on eliminating disparities far from over," *The Nation's Health*, April 2003, p. 1, 26.

risk for poor health, there is little written about the impact of translation services on immigrant health.<sup>22</sup>

Somerville is currently the most densely populated city in New England, with 18,453 residents per square mile and an average of 33 persons per square acre.<sup>23</sup> This demographic contributes to many problems in ensuring that public programs are made equally available to everyone. For many immigrants, the idea of governmentally funded free health care is unfathomable. A total of 80% of men in Somerville and 86% of women in Somerville had health care coverage, as compared to 89% of men and 94% of women in the state of Massachusetts (includes enrollment in Free Care as health coverage).<sup>24</sup> Only 15% of men and 11% of women in Somerville had delays in getting care due to lack of money or translation services at the clinic or hospitals.<sup>25</sup>

Many immigrants are afraid to sign up for Free Care (federally funded health care in the State of Massachusetts) due to fear of deportation from their documentation status. However, the hardest obstacle for many immigrants in receiving health care is overcoming the language barrier. Upon arrival in Somerville, an immigrant typically learns of health care options through word of mouth. Without health care providers who speak one's own language and clinics that can provide information in one's own language, the health care process is severely impeded.<sup>26</sup>

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<sup>22</sup> Eliot Fishman, *The Devolution Revolution: Running in Place* (New York: The Century Foundation Press, 2002), p. 25.

<sup>23</sup> Area Connect LLC. 2000. "Somerville Population and Demographics." 6 November 2003 <<http://somervillema.areaconnect.com/statistics.htm>>.

<sup>24</sup> *The Well Being of Somerville 2000 Annual Report*. Printed by the Cambridge Health Alliance.

<sup>25</sup> *Ibid.*

<sup>26</sup> N. Salazar. Interview. Somerville, Massachusetts. December 3, 2004.

## **Chapter 2: The Perspective of the Community**

### **Linguistic Diversity and its Effects on Public Health Outcomes**

A wide variety of immigrants, health care professionals and community organizers in Somerville were interviewed during this field research-based research project, in order for us to obtain a full understanding of the linguistic diversity here and the effect that medical interpretation and translation services have on public health outcomes. There was some overlap between the two groups; all of the interpreters and some of the community organizers we interviewed were immigrants. These were perhaps the most useful interviews, because these individuals had been on both the receiving end and the providing end of multilingual health care services, and so their sense of the issues involved had a depth that the other narrators were not as able to supply.

The 21 interviews conducted with community organizers, immigrants, and medical professionals covered a wide range of topics, themes and ideas. From within these groups, patterns, commonalities, and differences emerged. For example, the issue of the lack of medical translation services and how this can lead to a city-wide decrease in public health outcomes was mentioned and discussed in all of the interviews. Many of the community organizers reflected on the lack of adequate city interpretation and translation services and the way political decisions impact the delivery of public health services. Many of the immigrants interviewed made reference to the differences between the health care services of their country of origin and those of Somerville. Every medical professional interviewed described their background, how they began working in interpretation and translation services at the Cambridge Health Alliance, what their job entailed, and how their job allowed them to connect to the immigrant Latino community

in Somerville. Although all of the oral histories recorded included some type of background on the narrator, personal stories of arrival to Somerville and motivations for emigration figured centrally in every interview conducted with immigrants, and set this group of interviews apart from the other two.

Perhaps the single greatest similarity among the interviews was the way in which every individual reflected on the cultural heterogeneity of the City of Somerville. Every narrator mentioned the collective feel of many cultures living so closely together and how the city was an exciting and intriguing place to live. Some of the narrators had recommendations for other policymakers or immigrants in the community. Although not everyone was able to come up with a constructive or cohesive idea on how to remove intransigent barriers to the provision of interpretation and translation services in local and medical settings, all narrators agreed that looking at the issue from different vantage points was the only way to get a clear picture of local conditions and achieve meaningful change.

**Marty Martinez:  
Somerville Politics and Public Health Outcomes**

The health care system of Cambridge, Massachusetts far exceeds that of most cities in North America. Through the Cambridge Health Alliance, Cambridge and Somerville have access to advanced medical technology, some of the best-trained doctors in the world, the best facilities, and an



*Marty Martinez*

administration that pursues progressive goals.<sup>27</sup> Because the cities of Cambridge and Somerville have welcomed refugees and immigrants formally since the Sanctuary Movement in the 1970s, the population of these cities is culturally diverse and politically aware.<sup>28</sup> However, the problem of addressing health care and major public health issues is underlined by the diverse community and the separation between the new immigrants and the old residents in Somerville.

According to an interview conducted with a local Somerville politician, Marty Martinez:

We will continue to have an ‘out group’ until the power shifts to people who reflect those ideas. Since the demographics shifted in Somerville drastically over the past 20 years, the ‘old blood’ is being mixed with the ‘new blood’ immigrants and the old blood Somerville residents do not feel as though it is their responsibility to look after and care for the new immigrants into Somerville. They feel as though it is not their obligation to supply those who do not speak English good health care. They only feel a personal responsibility to themselves and the ‘old families’ in Somerville...the bottom line is that public health has to affect the right people before public health issues are attended to.<sup>29</sup>

Once public health affects the “right” people – typically, those with money and political influence – public health changes will start to be made in Somerville. Martinez discussed the idea of public health in general terms and how it is important for a community to recognize that public health should be a high priority in a community since it is something that affects everyone, not only the individual.

Mr. Martinez went on to say,

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<sup>27</sup> Casey Rosholt. The Latino Oral History Project: Health Care for Latinos in Cambridge, Massachusetts. 2003. Pages 3-4.

<sup>28</sup> A. Pirie. Interview. Somerville, Massachusetts. November 22, 2004.

<sup>29</sup> M. Martinez. Interview. Somerville, Massachusetts. October 16, 2004.

...the number one thing we ignore is public health...Somerville is now taking positive steps to recognize public health issues, and to go about health issues from a more well-rounded perspective—as shown through the appointment of Noreen Burke as the new Health Director for the city of Somerville. She not only comes from a more grassroots background, she understands the public health model, and can make serious changes in the ‘upstream’ world of polity makers...since Noreen used to work as the Human Rights Director which helps her to see and issues from various angles.<sup>30</sup>

The groups and organizations, both elected and volunteer, that work with Somerville immigrants must be more representative of the population at large. Martinez said that Somerville has an “ugly step-sister relationship with Cambridge.”<sup>31</sup> Not only does Cambridge municipal government have more representation from the minority populations living in Cambridge, but they have higher expectations for public health and access to health care. The higher expectations stem from the fact that those in governing positions in Cambridge are supportive of the populations they are representing. They have had African-American representation as well as Latino representation so that those populations and communities feel more connected and represented. People in Somerville are not as empowered as Cambridge residents and are hesitant to “do all the same things” they have done in Cambridge in Somerville.<sup>32</sup> Martinez argues that Somerville is a perfect example of the way politics can get in the way of public health. He said, “There is a clear correlation between smoking and the effects of second hand smoke as a public health issue, yet the politics kept the mayor from passing the smoking ban in restaurants for years.”<sup>33</sup>

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<sup>30</sup> Ibid.

<sup>31</sup> Ibid.

<sup>32</sup> Ibid.

<sup>33</sup> Ibid.

Martinez agreed that a lack of language skills can be a barrier to receiving good medical health care. He pointed out that, “The Cambridge Health Alliance does a great job serving the immigrants to who know how to get in contact with the medical services available to them—but those who don’t know what is available are those who are suffering.”<sup>34</sup> For Martinez, public health empowerment is a key piece that is missing from Somerville government and politics. Martinez feels that the community must want to empower themselves in order to make organizations that support immigrants create a better and more public health orientated community. The absence of this desire stems from the more established residents’ lack of a sense of responsibility toward the immigrants in their community; they consider themselves to be separate populations, without realizing that poor health care for one group can have an abundance of consequences for the entire community. Poor health leads to decreased daily productivity, increased work absences due to illness, higher health care costs later in life and shorter life spans in general. All of these consequences directly affect the economy and the finances of the entire city. Perhaps the older Somerville population resents the new waves of immigrants because they are seen as public charges; with equal access to health care and other services, their presence would further enrich the city as earlier immigrant waves have in the past. It is not until Somerville has Latino political representation that public health issues can be addressed more seriously. Without more organizations like CAAS (Community Action Agency of Somerville) and the SCC (Somerville Community Corporation) to help empower the community and immigrants, the same circular arguments concerning public health and who is to blame for sub-standard health outcomes will continue into the future. As Martinez said, “We will

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<sup>34</sup> Ibid.

continue to have an ‘out group’ until the power shifts to people who reflect those ideas,” and if the community wants to change, public health issues need to be addressed today and not left to the winds of political change.<sup>35</sup>

### **Nelson Salazar: Immigrant Translation and Interpretation Options**

Nelson Salazar, the Executive Director of the Welcome Project in Somerville, a non-profit organization that provides affordable housing in Somerville, is extensively



*The Welcome Project*

involved with the immigrant community and the barriers they face in obtaining proper health care. Through his involvement with the Welcome Project,

Salazar is familiar with the resources available to immigrants needing interpreting and translation services both in and beyond the health care sector. As an immigrant who did not speak English before coming to the United States, Salazar is able to clearly understand the frustration immigrants have when they need a translator or interpreter in a medical or non-medical setting.

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<sup>35</sup> Ibid.

Salazar described the translation and interpretation services available through the Welcome Project and other non-profit organizations that work with the immigrant populations in Somerville. He was also aware of the informal interpreting services offered by various members of the community who have extensive



*Nelson Salazar*

contact with the non-English speakers. Salazar clarified the differences between the multiple types of immigrants who need translation and interpretation help. “It’s the older community like Cubans, and Portuguese who are more highly educated. Now in the Somerville area there is a large Haitian population and many Latinos who were field laborers and peasants who were not exposed to formal education and fled their countries.”<sup>36</sup> Salazar stated that it is this variety in the socio-economic status of immigrants that creates the need for different types of interpretation and translation services. Dr. Pieter Cohen, a Family Practitioner at the Central Street Clinic in Somerville, also noted the differences between Latin American and Central American immigrants. Since Dr. Cohen speaks Portuguese, his patients consist primarily of Brazilians.

“...the majority of my patients are highly trained professionals...but they were just trained in Brazil...that’s the major difference between the patients I see and other Latinos from...say El Salvador, that are seen here at the Clinic, the Brazilians are highly educated since they were from a higher social-class in Brazil than other Latino immigrants...”<sup>37</sup>

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<sup>36</sup> N. Salazar. Interview. Somerville, Massachusetts. December 3, 2004.

<sup>37</sup> P. Cohen. Interview. Somerville, Massachusetts. December 3, 2004.

All of the flyers from the Welcome Project are written in English, Spanish, Haitian Creole, and Portuguese. The Welcome Project offers verbal translation support when immigrants receive documents in the mail that they do not understand. Salazar stated that there is no official translation or interpreting service offered by the city, and that it is only through organizations such as the Welcome Project, the Massachusetts Alliance of Portuguese Speakers (MAPS), and Concilio Hispano that translation is provided. Salazar primarily has bilingual and bicultural staff members at the Welcome Project so that immigrants seeking guidance can feel comfortable and more easily communicate their needs. Salazar has found that more women come to him seeking



*An immigrant mother and child at the Welcome Project*

medical advice than do men. What is more, in most cases it is not until immigrants inquire about health care to the Welcome Project, family members, or friends that they learn of the medical services available to them in their community.

“If [the immigrants] are illegal they think that there is no way that the U.S. is going to want to cover their medical needs. I mean... why would they? But they can get health insurance,

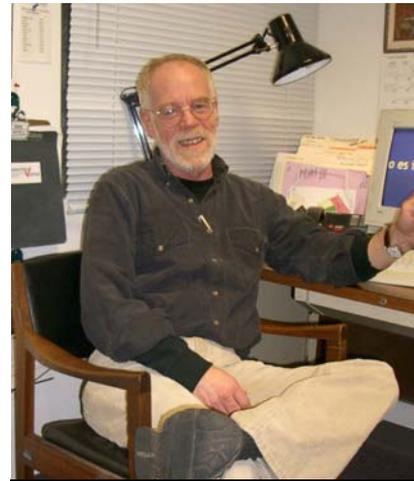
Free Care or Mass Health and get all the health attention they need.”<sup>38</sup> Salazar then described a dual gap in the access to health care services—one defined along sharp gender lines and the other by degrees of patient agency or the individual perception of one’s own ability to seek out medical services.

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<sup>38</sup> Ibid.

## **Alex Pirie: The Present and Future of Translation/Interpretation Services**

Alex Pirie works with the Somerville Community Corporation (SCC), one of the few community-based advocacy groups in Somerville. Pirie is a community activist, and is very informed about many aspects of Somerville community issues ranging from ‘bed bugs’ to low-income housing. As did the other community organizers interviewed, Pirie noted the lack of translation services available for immigrants in Somerville. He



*Alex Pirie*

stated that, “other than the services offered at the Cambridge Health Alliance, there is not much available in terms of translation and interpreting services for immigrants.”<sup>39</sup> Pirie brought up an important fact:

“The city of Somerville has since around 1998 had a stipend for an interpreter– for a bilingual person who passes a kind of interview test. The stipend isn’t officially labeled as such, but at least \$10,000 a year is available...the only problem is that over half the people who qualify are bilingual in Italian, and Italian is not in high demand for interpreting. If you’re bilingual and you pass the test and you’re a Somerville public employee, you automatically get \$500 a year added to your pay check because you’re supposedly always on call to be sent to a location to interpret.”<sup>40</sup>

Pirie lauded the translation services at the CHA, but he communicated a kind of general cynicism about the quality of translation provided in Somerville more broadly.

Even though a list of bilingual interpreters for general city translation exists in City Hall, the number of residents in Somerville aware of and using this service is quite

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<sup>39</sup> A. Pirie. Interview. Somerville, Massachusetts. November 22, 2004.

<sup>40</sup> Ibid.

low. The city wide “Language Line” phone service at City Hall allows city workers to use phone interpreters at any given time. Pirie was the only narrator that even knew that the Language Line existed in City Hall. Pirie said that, “If someone who doesn’t speak English needs an interpreter at, say, City Hall to register to vote, there doesn’t seem to be anyone available to help them...no one knows about the Language Line service. Immigrants are forced to depend on the mercy of strangers because there’s nothing structural in place.”<sup>41</sup> Pirie thinks it is important for Somerville to avoid having bilingual children translate for families in medical settings. It is inappropriate for the children to translate for their families because children do not know all of the medical terminology and may not be objective, and their presence can be a violation of patient-doctor confidentiality. Here, Pirie positions translation as part of an ethical commitment to health care—a series of services that cannot be left passively to children of immigrants but that should be a product of a community that values high quality health care for even the most disadvantaged members of society.

Pirie noted that the translation services in Somerville have not significantly changed in the city over the past thirty years. The first wave of immigrants came to Somerville in the early 1980s fleeing political strife and chaos in their home countries. The need for translation was acknowledged by city officials and although few changes were enacted, an annual stipend for bilingual interpreters was created in the budget. Pirie with irony did note that, “[the city of Somerville] has clearly lost sight of the original mission if they’re “still paying Italian speakers to provide a service that no one needs.”<sup>42</sup>

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<sup>41</sup> Ibid.

<sup>42</sup> Ibid.

Currently Pirie is working on a program teaching bilingual Somerville teens to use their natural language talent as a source of income and overall benefit for the community. After the Teen Summit in 2000, three teenagers from *Jóvenes Latinos* (a CAAS teen tobacco and alcohol peer leadership program) served on the Immigrant Service Providers Group steering committee as full members, trying to come up with an idea of providing better language services throughout Somerville. Pirie and the committee proposed a course for bilingual teens on how to become “interpreter aids.” Andy Klatt, a professional interpreter in Somerville, taught many of the classes to the bilingual teens. After completing the course and passing a certification test Somerville teens began interpreting in various capacities all over Somerville.



Pirie was also the Head Coordinator of the Immigrant Community Health Fair that took place in Somerville on November, 13<sup>th</sup>, 2004. More than 80 adults from the immigrant community received medical tests, health information, vaccinations, and a delicious international lunch.<sup>43</sup> In an article from the Somerville Journal, Pirie wrote about the Immigrant Health Fair:

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<sup>43</sup> Alex Pirie. “Immigrant health boosted at fair”. Somerville Journal. Thursday, November 18<sup>th</sup>, 2004.

“A unique feature of this health fair was the participation of 16 young people from the Portuguese, Haitian Creole, Spanish and Chinese language communities who worked throughout the day as interpreter aides, greeters and survey conductors. Some of them attended a small interpreter skills class conducted by Somerville resident Andy Klatt, and all of them brought the special energy and enthusiasm of youth to our event.”<sup>44</sup>

Despite the bilingual teens’ new contribution to the available interpreting services, Somerville’s non-profit organizations are still struggling to find interpreters. Official city-wide meetings are legally required to have interpreters present but interpretation services are usually not provided unless, as Pirie says, “someone makes a big fuss about it.”<sup>45</sup> Community Action Agency of Somerville (CAAS), owns a set of radio interpreter headsets, but Pirie reported that the headsets do not work well. CAAS also offers full-time interpreter services for non-medical needs, because hiring professional interpreters is expensive (interpreters can cost up to a few hundred dollars for a few hours) and therefore unrealistic for immigrants to use in Somerville.<sup>46</sup>

Pirie feels as though the money appropriated for interpreting in Somerville should be allocated and distributed in a more logical and deliberate way. In the future, he suggests that there be a more comprehensive inventory of what is available in terms of interpreter services—what works, what does not work, and what is missing from interpretation services in Somerville. “Once we know the needs of the community—we can better fill them.”<sup>47</sup> Like Marty Martinez, Pirie mentioned how local city politics gets in the way of translation laws and money to be passed. “The money is there, it is now only a question of will. The priorities of the city are weird. Somerville has a strong

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<sup>44</sup> Ibid.

<sup>45</sup> A. Pirie. Interview. Somerville, Massachusetts. November 22, 2004.

<sup>46</sup> Ibid.

<sup>47</sup> Ibid.

mayor, who is elected every two years...but basically that means that one-half of governing and one and one-half years of campaigning—so very little gets done really.”<sup>48</sup>

Pirie imagines the possibility of a structural coherence for all of Somerville’s translation services that could withstand the turbulent political shifts and bureaucratic transition periods.

Community organizers like Alex Pirie who are making an active change in Somerville are examples of the few who are thinking creatively about how to engage community members, specifically young teens, to serve as catalysts pushing for change and community cooperation. Through programs like the teen language empowerment program, improvements will be made in Somerville for translation and interpretation outside of the medical setting.

### **Eugene Brune: Health Care Advocacy and Past Translation/Interpretation Options**

In contrast to Alex Pirie’s cynical view on city politics, Eugene Brune, a former mayor of Somerville, felt that during his term as mayor he accomplished many initiatives for the betterment of Somerville. Today, Brune is the Registrar of Deeds to Southern Middlesex County. He was the mayor of Somerville from 1980-1990, and the Alderman of the City of Somerville from 1971-1977. He also served as the Chairman of the Board of Health in Somerville from 1969-1970. He is a Trustee of the Cambridge Health Alliance, and currently serves on the Board of Trustees for the East Somerville Clinic. When he was the Mayor of Somerville, he initiated the first free flu shot clinic and eye disease clinic.

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<sup>48</sup> Ibid.

Brune was mentioned in many of the other interviews we conducted as a mayor who represented his constituency by backing local health grass-root movements. When the East Somerville Health Center (ESHHC), founded by a few Somerville women (“founding mothers”) in 1969, was in danger of being closed due to Fire Marshall regulations, Brune “saved” the clinic by renting a new building to the leaders of the Clinic for just one dollar per year.

In the early 1970s, around the same time of all the first wave of immigrants came to Somerville, the East Somerville Committee for Action (ESCA) was formed by about twelve politically active and liberal-minded women. The ESCA splintered into several groups, addressing themes ranging from health to environmental issues. One of the subordinate groups formed by the ESCA was a group of neighborhood mothers established the East Somerville Health Committee. Barbara Cassesso, the sister of Mary Cassesso, one of the founding mothers of the clinic, said that,

When I was about 30, I joined the East Somerville Committee for Action (ESCA), formed by women in reaction to the destruction of Boston and Cambridge communities as a result of development; in order to build a better community in East Somerville...the group had a huge impact on my life...although I didn’t work with the set-up of the clinic, I know Mary loved it, and loved how the community was using it as a family health center.<sup>49</sup>

Cassesso said that the ESCA, with grants from Permanent Charities and the Hyams Foundation, opened the doors to the East Somerville Health Center on July 2, 1970, with Somerville Hospital as the back-up hospital. In 1971, the clinic moved locations and in 1977, due to various expansions to the health care options available in the clinic, it moved to the East Somerville Community School. Mayor Lester Ralph donated space in the school for the clinic to meet the fire codes. In its last and final

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<sup>49</sup> B. Cassesso. Interview. Somerville, Massachusetts. October 22, 2004.

move, Mayor Brune provided the space at Cross Street for the clinic, where it is still housed today. In September of 1988, a new state-of-the-art clinic was opened at Cross Street when the Cambridge Health Alliance started to get involved with the East Somerville clinic, as well as other satellite health clinics all over Somerville. Brune added that,

The only health care option available to Somerville residents at the time was the Somerville Hospital....and the East Somerville Clinic was non-existent until the late 70s, and became fully functioning in the early 80's...what happened was that the clinic was going to be shut-down due to the high space rental prices, over-crowding in the clinical space, so I rented it to Mary Casseso for a down payment of \$1 a year at the current location on 49 Cross Street.<sup>50</sup>

Brune mentioned that there were various translation services available when he was Mayor. Translators worked throughout the school system and any time someone needed an interpreter, they would simply call a city hotline and speak with an interpreter by phone. Although this service is no longer available, Brune believes it was a system that worked well. During the 1980s, the schools also made an effort to have people who spoke Haitian Creole, Spanish, Portuguese and English on staff so that the school could communicate with the immigrant population without having to employ independent interpreters.

Today, as a Trustee of the CHA, and as a member of the Board at the East Somerville Clinic, Brune is privy to promises made by the CHA to the East Somerville Clinic. "I believe that the Alliance will follow through on their promises...they promised grants and funds to renovate the clinic to keep up the reputation and quality of care."<sup>51</sup>

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<sup>50</sup> E. Brune. Interview. Cambridge, Massachusetts. November 29, 2004.

<sup>51</sup> Ibid.

Brune was the mayor during the time the CHA was formed. He therefore has insight into the way the CHA was received in Somerville and its reputation today.

The Somerville Hospital decided to merge with the Health Alliance in Cambridge since the demographics in Cambridge and in Somerville were ethnically similar...but during the 80's the Alliance did not have such a good reputation, since some of the doctors were not all certified—but the nurses received great reviews.<sup>52</sup>

Although he acted only in the field of public service in terms of health care, Brune showed sensitivity to the way that individuals relate to publicly administered entities. Through his experience as a public servant he provides an example of how such a perspective can be employed to make the small changes and attitude adjustments often necessary to provide a decent system of public health. Brune understands the value of clinics and hospitals that receive “great reviews,” draw patients into schools and clinics, and keep patients returning to clinics for continuity of care.

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<sup>52</sup> Ibid.

### **Chapter 3: the Somerville Immigrant's Perspective**

To gain a better perspective on translation and interpretation services in Somerville, we conducted interviews with immigrants from many different backgrounds. Old and new immigrants were interviewed to give us a better picture of the services available to immigrants today as compared with what was available thirty years ago. Old immigrants were broadly defined as those who moved to Somerville in the first wave of immigration in the late 1970s to the early 1980s, while the new immigrants were those who came in the second wave of immigration to Somerville in the 1990s to today.

#### **Mr. Cabral: Medical Translation and Interpretation Services in the Past**

We met Mr. Cabral during a house-call with Dr. Cohen during our last series of field interviews. Mr. Cabral is an 80-year old Azorean immigrant who came to Boston in 1972 at the age of 84, and he currently receives his medical care at the Central Street Clinic. He immigrated to the United States with his wife and ten children. Only one of his eleven children was born in the United States. During the course of the interview, we asked Mr. Cabral about the community of Somerville and the translation services available to him when he arrived with the first wave of immigrants.

Mr. Cabral focused much of his commentary on the differences in medical care he received in Portugal and in the care he now receives in Somerville. For example, he spoke about medications differing from country to country and said that the availability of doctors and nurses in the U.S. is much better than in Portugal. When he first arrived to Somerville he used the Cambridge Hospital, but after a bad experience with a doctor there, whom Mr. Cabral thought was prescribing too many medications, he switched to

the Central Street Clinic, where he continues to receive care today. Mr. Cabral always had a translator available to him at medical visit. “I always had a translator for me...that was never a problem...even back then...I was always well cared for...and even now I love seeing Dr. Cohen because he speaks Portuguese and I can understand him and all the translators well...”<sup>53</sup>

It is important not to overlook Mr. Cabral’s comfort with the linguistic capabilities of his doctors and the translation team more generally as an important factor

not only in the perception but the provision of quality health care services. While we do not suggest that doctors must befriend their patients in order to provide care or to improve community health indicators, it is undeniable that patients have



*Mr. and Mrs. Cabral and Maria Terra, interpreter*

great trust for the providers that with whom they can communicate well. Further epidemiologically-based research might explore how personal loyalties to clinics as a result of the clinics’ multilingual services might directly impact public health outcomes.

### **Eva Hernandez-Morales: Emergency Room Translation and Interpretation Services**

Two years ago, Eva Hernandez-Morales emigrated from San Juan, Puerto Rico to Somerville. She was born in Xalapa, Mexico, orphaned at a very young age, and taken

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<sup>53</sup> J. Cabral. Interview. Somerville, Massachusetts. December 3, 2004.

under the wing of the Catholic Church. Mrs. Hernandez-Morales said that the health care in America is much better than in both Puerto Rico and Mexico. She believes that the superior medical care found in the United States is due to the fact that Americans have better technology. She had her children in two different Latin American countries, and even between Mexico and Puerto Rico, she noticed a difference in the quality of health care. “In any country you go—you’ll find a difference.”<sup>54</sup> When she arrived in the United States, she was amazed at the number of available options for health care.

Shortly after she arrived in Somerville, Mrs. Hernandez-Morales remembers using interpreting services when her son fell off his bike and received stitches at the Somerville Hospital. Since it is a legal regulation for all hospital emergency rooms in Massachusetts to have full-time medical interpretation services, Mrs. Hernandez-Morales and her son were well attended, and had no problem accessing medical care.

We walked right in...and they attended to us...I was first asked by a nurse or some kind of intake woman if I needed a translator in English, I didn’t understand her. Since Alinson is bi-lingual and understood her, he answered the nurse, and we were given a Spanish-English medical interpreter for our visit to the ER...<sup>55</sup>

### **Violeta Ganas: Translation and Interpretation in Pre-natal care and Birthing**

Violeta Ganas is a 22-year-old mother of an eight-month old son who was born at Cambridge Hospital. Ganas was born in Mexico City, and is a violinist. She wanted a better life for her then-unborn son, so she came to the United States. Ganas speaks with the passion and wisdom of someone much older than 22 years when discussing her professional goals and experiences as a young non-English speaking immigrant mother.

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<sup>54</sup> E. Hernandez-Morales. Interview. Somerville, Massachusetts. October 1, 2004.

<sup>55</sup> Ibid.

Upon her arrival to the United States, Ganas received pre-natal services at Somerville Hospital. She was amazed at the ease of obtaining quality health care, particularly as a pregnant woman. In Mexico a person must have documentation in order to obtain health insurance but in the United States Ganas immediately received Free Care, Mass Health, Healthy Start, and WIC, all without having to provide documentation on her immigration status.

During the interview Violeta said that every medical service she received was provided with appropriate interpretation and translation services. Ganas participated in 10-20 hours of free “birth class” from Cambridge Hospital over the last two months of her pregnancy, and she was amazed at how much more parenting information is available for expecting mothers in the U.S. than in Mexico. “That is typical for Mexico...you have to pay for everything - even down to the saline drip they put into your arm. Childbirth is not even discussed in common conversation...there you have no real access to doctors but here I could use a mid-wife and doctor...”<sup>56</sup> Even though Ganas was in labor for only two hours, she was not permitted to leave the hospital for three days. Throughout her experience, bilingual staff or interpreters were present; communication was never a problem for Ganas.

All three of the immigrants interviewed received their health care from the Cambridge Health Alliance. These immigrants had no complaints about interpretation and translation services provided by the CHA. In fact, all of the immigrants were grateful and spoke very highly of the health care they received from their providers and interpreters at the clinics and hospitals. It is the CHA’s “commitment to provide anyone

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<sup>56</sup> V. Ganas. Interview. Somerville, Massachusetts. October 15, 2004.

with an interpreter 24/7 no matter what language they speak”<sup>57</sup> that makes the Alliance so well respected in Somerville. The policies and the mission statement of the CHA was echoed in the voices of the patients that we interviewed; through our contact with local immigrants we could sense the way that the Alliance’s dedication to clear communication resonates with all of those that come into contact with the CHA.

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<sup>57</sup> L. Saint-Louis. Somerville, Massachusetts. December 3, 2004.

## Chapter 4: The Cambridge Health Alliance

### Overview of the Cambridge Health Alliance

The Cambridge Health Alliance is an award-winning regional healthcare system with patients of all ages residing in Cambridge, Somerville, and Boston’s Metro-North region. The system includes Somerville Hospital, Cambridge Hospital, Whidden Memorial Hospital in Everett, at least 20 smaller primary care clinics, the Cambridge Department of Public Health, and Network Health, a state-wide managed Medicaid insurance plan. The Alliance combines public health, clinical care, academics and research, and offers a broad range of services from obstetrics to surgery to mental health. The Cambridge Health Alliance has earned its excellent reputation for innovative healthcare and community contributions – the Alliance is frequently described as a model toward which other healthcare systems should aspire. The Alliance has received numerous awards; most notably for our purposes, it has been recognized by the National Association of Public Hospitals and Health Systems for its Cultural and Linguistic Competency.<sup>58</sup>

In order to understand the history of the Alliance and the evolution of its role in the community, we spoke with Linda Cundiff, the Senior Director of Community Affairs for the Alliance. Linda is also the president of the board of directors for Concilio Hispano, and her



*Linda Cundiff*

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<sup>58</sup> [http://www.challiance.org/about\\_ii/index.htm](http://www.challiance.org/about_ii/index.htm)

involvement with issues facing both the Latino community and the Somerville community as a whole made her a valuable resource for us.

The Alliance was formed in 1996 by the merger of the Somerville and Cambridge hospitals, and expanded to include Whidden Memorial Hospital in 2001. Each of these hospitals was founded around the turn of the last century, and thus they have long histories of serving their respective communities. The oldest of these institutions is Somerville Hospital, which was founded in 1891, followed by Whidden Memorial Hospital in 1897, and finally the Cambridge Hospital in 1917. Over the years, these hospitals have seen many changes – in medical practices, in technology, and in the health care industry as a whole. They have also faced financial hardship and potential bankruptcy. At the time of the original merger Somerville Hospital, a private non-profit hospital, was struggling to stay afloat, and the creation of the Alliance saved it from having to close due to lack of funding.<sup>59</sup>

In 1996, Cambridge Hospital was a public hospital owned by the city. It had a charismatic leader who was politically savvy and very well-connected, and he was able to obtain substantial federal and state funding for the hospital, as well as better reimbursement for FreeCare. This financial “cushion” enabled the hospital to offer improved services to the poor and uninsured, becoming what is known as a “safety net hospital.” With the formation of the Alliance later in 1996, Cambridge Hospital was able to create a unified health care system where every hospital, department and clinic could operate under the same consistent standards of practice, hold the same mission of improving the health of its communities, and provide the same quality of care.

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<sup>59</sup> Linda Cundiff, Somerville, 11/18/04



The city of Cambridge has always had progressive leadership dedicated to public health, as well as access to a much broader tax base than does Somerville due to its extremely high property values and its large biotechnology industry, and so it is not as dependent on local state aid. Somerville has historically been a poorer, working class community with fairly traditional leadership; it lacks a strong business base and thus is heavily dependent on property taxes. Because of its more secure financial position, Cambridge is able to give the Alliance six million dollars per year, while the city of Somerville provides nothing. Ms. Cundiff spoke of the resentment the Somerville community seems to feel toward Cambridge because of its position of advantage; some feel that it would be more appropriate for Cambridge to resent Somerville for its

dependency. Nevertheless, the unification of the cities' health care systems makes sense; many of the populations overlap, and the cities face many of the same social issues.

The consistency in standards of practice and quality of care has earned the Alliance an excellent reputation, and this reputation has attracted significant numbers of patients from well beyond the primary service area.<sup>60</sup> Over half the patients of the Alliance reside in the primary service area, but a significant portion of the uninsured patients live outside the region. In 2002, the more than 40,000 uninsured patients from 234 communities in Massachusetts sought health care from the Alliance.<sup>61</sup> On one of its websites, the Alliance states that “our commitment to care for all patients, regardless of ability to pay, has resulted in our designation as a disproportionate share hospital. This means that a disproportionate number of Alliance patients are uninsured or have only public health insurance (Medicaid or Medicare).”<sup>62</sup> About 23.7% of the Alliance's inpatient volume, 3950 discharges, is for uninsured patients. The data is even more striking with outpatient services: 41.9% of the outpatient service volume, more than 200,000 visits, is for uninsured patients.<sup>63</sup>

The site goes on to explain that:

Many patients are drawn to our services to overcome barriers to health care (financial barriers for the uninsured or under-insured, cultural and linguistic barriers for non-English speakers). These uninsured patients are primarily adults, many of whom are short-term unemployed or of working low-income families without access to employer based insurance or categorically ineligible for MassHealth. In 2000, approximately 51% of Alliance patient visits were made by linguistic minorities.<sup>64</sup>

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<sup>60</sup> The primary service area consists of the cities of Cambridge, Somerville, Everett, Malden, Chelsea, Revere, and Winthrop.

<sup>61</sup> [http://www.challiance.org/iao/who\\_we\\_serve.htm](http://www.challiance.org/iao/who_we_serve.htm)

<sup>62</sup> Ibid.

<sup>63</sup> Ibid.

<sup>64</sup> Ibid.

The Cambridge Health Alliance's commitment to serving the uninsured, people of lower income, and recent immigrants has earned it a reputation that has traveled beyond Massachusetts borders. Many of the doctors, interpreters, and Somerville residents with whom we spoke said that they knew of, had treated, or were related to immigrants living as far away as Florida who received their health care from the Alliance because they trusted its service. Above all, what earns this loyalty is the quality of translation and interpreting services provided by the Alliance.

## **Multilingual Interpreting and Translation Services at the Cambridge Health Alliance**

The patients of the CHA are extremely diverse; more than half the patients do not speak English as their primary language, and over thirty languages are used regularly within the Alliance.<sup>65</sup> In order to properly serve its multicultural population, the Alliance has implemented an overarching strategy of multiculturalism that has impacted its hiring practices as well as its treatment of patients. Because it is such a large system, the Alliance has been able to build a very organized and cohesive structure for delivering interpreting services. The CHA created the Immigrant Health Improvement Program in 1995 in order to address the needs of its immigrant patients. The main goals of this program are to:

- Increase access to health care
- Expand cultural competency training for providers and staff
- Improve language and ethnicity data to help the Alliance plan for better service delivery for its patients
- Monitor community health
- Conduct community surveys that focus on immigrant health
- Address public policy to improve immigrant health<sup>66</sup>

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<sup>65</sup> <http://www.challiance.org/commconn/multilingual.htm>

<sup>66</sup> <http://www.challiance.org/commconn/immigranthealth.htm>

The hiring policy of the Alliance gives preference to bilingual and bicultural applicants and once hired, employees have access to language classes and diversity training. English language classes are also available for the many CHA employees who have not yet mastered the language. Dalia Rosas, one of the immigrants we interviewed, works as a cook at the Somerville Hospital, though she was trained as a psychologist in Mexico. For her, the biggest barrier to finding a better job is her lack of English proficiency, but the Alliance is paying for her to take English classes, and she hopes that with this training she will be able to earn a degree in psychology that will enable her to be licensed to practice in the US. She is grateful for the opportunity to study English, but notes that the classes are only offered to those who qualify – she was vague on the requirements – and who have time to attend classes. Many immigrants work multiple jobs and have children to care for, and they are simply unable to make the shorter-term sacrifices necessary to glean the many long-term rewards that would come from being able to speak English.

For their patients, the Alliance provides professional interpreters and written translation services, and has a separate department for each. Their more recently hired interpreters have undergone extensive training, and every interpreter has taken a challenging exam with both oral and written components. The hospitals and most of the smaller clinics have full-time interpreters on staff in at least one of the most common languages of Spanish, Portuguese and Haitian Creole, and each of the hospitals has a dispatcher who places the on-call and per-diem interpreters in necessary locations; interpreters are available on call in every language needed. In addition, the Alliance has

created an in-network phone interpreting service. With this service, if an interpreter for a particular language is needed and no one is available at that location, an interpreter working at another CHA location can interpret through a speakerphone system set up in each exam room. The Alliance is also experimenting with video interpreting, and has conducted studies that suggest that speakerphone and video interpreting may be effective tools for reducing costs and increasing the efficiency with which these services are provided.

### **Methods of Interpreting**

If there is no interpreter available to interpret during the visit, there is an Alliance-wide phone service available. With this technology, interpreters at one clinic are able to translate via speakerphone in another location, eliminating the delays that often arise when on-call interpreters must drive to the appointment. Phone interpreting is cost-effective and extremely efficient, as it minimizes the need for full-time interpreters to be hired in locations where demand is lower. If no CHA interpreter is available, providers use the Language Line, a national phone interpreting service that offers over 150 languages. The CHA pays a fee of \$50 a month for the service. Depending on the rarity of the language, the dollar amount and rate per minute may change as well. Many of the translators on the Language Line work from their homes.

In the Testing New Technologies in Medical Interpreting report published by the Alliance in 2003, various methods of interpreting are evaluated and discussed. When using remote translation methods such as phone and video interpreting, technical difficulties occur frequently. On speakerphone interpreting, the report states the following:

We received many comments that telephone interpreting worked well for cases that were not extremely complex or multi-dimensional, and for short appointments. One physician said that it works well for basic, uncomplicated appointments, where it is not as important for the interpreter to read the visual cues.... Speakerphone interpreting did not work well when the telephone was far away from the patient and/or provider. It also did not work well when there was a lot going on in the room (such as when a test or a procedure was being done on the patient, and there were multiple people and/or lots of equipment noise in the room). When the patient or provider could not project his or her voice, the interpreter had difficulty hearing them. Also, interpreters commented that it was hard to follow appointments when more time was spent on examination or procedures, while less time was spent on speaking. Some interpreters had difficulty telling who was who, and when they should interpret, when multiple people were in the room (especially when there were multiple family members with similar sounding voices). Others did not find this so much of a problem... Telephone interpreting does not allow for visual cues, which made it harder to follow the conversation, and perhaps to pick up on cultural cues. One interpreter commented that she would compensate for missing the visual information by listening very carefully and being more explicit in her descriptions. A physician said that she found herself having to describe exactly what she and the patient were doing, so that the interpreter had more context as to what was going on in the appointment. In general, participants seemed to find telephone interpreting fast and efficient.<sup>67</sup>

Some of the interpreters who participated in the study found that the absence of the interpreter as a physical presence in the exam room allowed for better interaction between the patient and the doctor. Nevertheless, providers missed the advice they usually received from interpreters on cultural differences as well as the interpreters' help in communicating with the patients' family members.<sup>68</sup> According to the study, the majority of patients preferred speakerphone interpreting to the traditional face-to-face method because of the efficiency and the privacy it allowed.<sup>69</sup> In contrast with the findings of the report, the majority of the practicing medical interpreters we spoke with

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<sup>67</sup> Loretta Saint-Louis, PhD, et al. *Testing New Technologies in Medical Interpreting*. Cambridge: Cambridge Health Alliance, June 2003; 35-36.

<sup>68</sup> Ibid, 36.

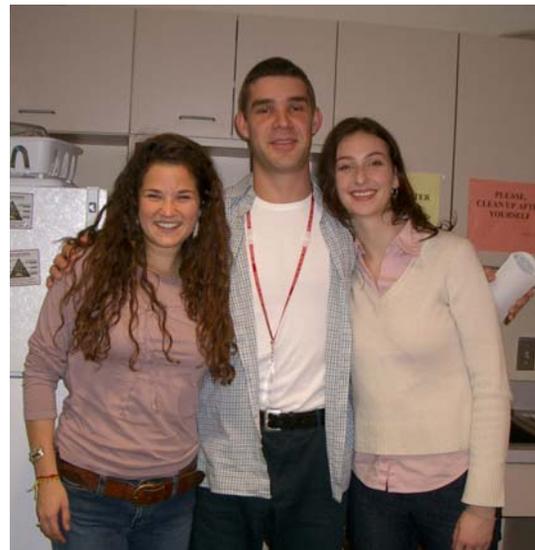
<sup>69</sup> Ibid.

greatly preferred in-person interpreting and were anxious about the potential turn toward less personal technologies in the future.<sup>70</sup>

Video conferencing may be the next step for interpreting services at the CHA. The technology is being tested to see if the interpreters, doctors and patients can read the visual cues and communicate effectively through video. The study found that video conferencing offered the benefits of in-person interpreting while increasing the efficiency of the interpretation. If privacy is a factor, the camera can be covered temporarily. There were occasional instances where patients were uncomfortable in front of the camera or misunderstood the technology and were afraid of being videotaped. “One provider said that he had a couple of patients who persisted in looking at the TV throughout the entire appointment, and that he felt uncomfortable because he was not able to make eye contact with [the interpreter].”<sup>71</sup> Nevertheless, younger and more educated patients handled the



*Maria Terra*



*Julia Goldberg, Marcos “Vinicios”  
Pienasola, Leah Rogers*

<sup>70</sup> Marcos Pienasola, Somerville, 11/22/04; Maria Terra, Somerville, 12/3/04. Carol Miranda (Somerville, 12/6/04) had no particular preference.

<sup>71</sup> Loretta Saint-Louis, PhD, et al, 40.

camera well.<sup>72</sup>

Much boils down to the personal preferences of the patients, interpreters and providers and the level of intimacy they wish to achieve during a medical visit. We spoke with three practicing medical interpreters – Marcos “Vinicios” Pienasola, Maria Terra, and Carol Miranda. These interpreters are all aware of the responsibility they hold and are extremely dedicated to their patients. During their interviews, Ms. Terra and Ms. Miranda spoke of the role of the interpreter as a patient advocate. Because immigrants, particularly recent arrivals, are generally unaware of the resources available to them, they turn to interpreters for help with non-medical interpreting and translation issues. Furthermore, the interpreter is the only participant in the medical visit who has a true sense of perspective, gained through multilingualism and multiculturalism and a familiarity with medical terminology and regional variances in phraseology. The interpreter is also less constrained with regard to scheduling and often is able to spend time speaking with the patient without the doctor present.

With this perspective, an interpreter may notice things that the doctor cannot. Aida Corredor, a multilingual parent liaison at the Somerville Parent Information Center and a former medical interpreter, related a moving story during her interview. Once when she was translating, a Latino woman was brought into the hospital for a headache. During the exam it came to light that she had taken



*Aida Corredor*

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<sup>72</sup> Ibid, 39.

excessive amounts of aspirin to quell the headache. The doctor failed to inquire further about the patient's actions but for Ms. Corredor this was a red flag. Once the doctor had left the room, Ms. Corredor was able to speak with the patient and determine that she had in fact attempted suicide via overdose in order to escape an abusive relationship. She then was able to counsel the woman about her situation and provide her with resources where she could seek assistance.<sup>73</sup> If she had been interpreting over the phone or through video conferencing, it is unlikely this situation would have been addressed, because as opposed to in-person interpreting, with remote methods the interpreter's time with the patient lasts only as long as the doctor's visit.

### **The Multilingual Interpreting Department**

Loretta Saint-Louis is the Director of the Multilingual Interpreting Department at the Cambridge Health Alliance. Dr. Saint-Louis is a native Midwesterner, but her mother's parents had been missionaries and so her family was worldlier than is perhaps typical for Ohio. She has had extensive professional and personal contact with the



*Loretta Saint-Louis*

Haitian population in both the US and Haiti since college. She took her current job in 1993 partly because she felt she could address the cultural disparities in health care she had observed while working at the Haitian Mental Health Clinic. When we interviewed Dr. Saint-Louis for this project, she explained to us both the structure of the Alliance's translation and interpreting departments and the

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<sup>73</sup> Aida Corredor, Somerville, 10/22/04

reasons she is so committed to language services. During her work as a translator at the Haitian clinic, Dr. Saint-Louis observed a few medical crises that made her realize both the absolute necessity for interpreting services and the tragedies that can occur when such services are not readily available.

The Cambridge Health Alliance was the first hospital in the state to develop on-call translation services in the 1970s. The US Department of Health and Human Services had no requirements for translation services until 1989. In 1993, the recently-formed Massachusetts Medical Interpretation Association (MMIA) had begun to develop guidelines for the provision of quality interpreting services. Saint-Louis feels that the professionals working on the issue at that time “grew up together” in a sense; they were all working on improving a situation that until that point hadn’t been thoroughly discussed. Dr. Saint-Louis stated that the interpreter services at the Alliance did not change as a result of new legislation; rather, the laws gave the CHA leverage against those who did not agree with the importance of translation services. The administrators at the Alliance seem to think of translation legislation as a sort of “lower bound.” Dr. Saint-Louis argues that the role of an interpreter is not only to effectively communicate the language and the culture, but also to serve as a patient advocate. Ten states currently can be reimbursed for interpreter costs; Massachusetts is not one of the ten.<sup>74</sup> Nevertheless, the Alliance resists using funding constraints as an excuse for limitations in the availability of translation services and quality care for all.

The CHA has both full-time staff interpreters and on-call per-diem interpreters. The main languages offered are Spanish, Portuguese and Haitian-Creole. Other languages that full-time staff interpreters speak include Hindi, Bengali, Vietnamese and various

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<sup>74</sup> L. Saint-Louis. Somerville, Massachusetts. December 3, 2004.

dialects within those languages; the Chinese and Russian interpreters are only part-time. Almost all of the interpreters are bicultural and therefore native speakers of the language. Per-diem translators speak Albanian, Greek and various other languages that are not needed as often. Although there are also per-diem translators for the three main languages, they are usually used at night or at moments when the need for interpreters is unusually high. There is a central office for Somerville and one for Cambridge; there, a dispatcher schedules interpreters to be on call according to their availability, and contacts them when they are needed. This greatly eases the process of locating an interpreter for a particular appointment.

Interpreting as a profession has been gaining popularity and respect over the last decade. Before the most recent two immigrant waves to Somerville, when formal interpreters were available they tended to be volunteers. No formal standards had been established, and there were no guidelines for health care facilities providing these services. Most translators lacked any formal training for medical terminology or the practice of translation; their language skills alone gave them the credentials to work in medical translation. Often they had to pass a test to prove their abilities, but the tests varied system to system, and there was little to distinguish these interpreters from any other multilingual person. Indeed, the interpreters we spoke with began their professions before such training was expected or even widely available. Some took classes on medical terminology for their own benefit, but this was not particularly encouraged by the hospitals where they worked.

Now, many local colleges offer full programs for budding medical interpreters. Cambridge College offers an Interpreting Training program which was modeled after the

program at Northern Essex Community College. The program consists of six courses that can be taken alone for a certificate in interpreting, or counted toward a degree. An interpreter can take the class and earn the certificate whether or not she is a full-time student. Bunker Hill Community College still offers a class on medical terminology (which some of our narrators have taken), and interpreter training programs are sprouting up all over the country.

All the new interpreters at the Cambridge Health Alliance must pass a test, which includes oral and written sections and is by all accounts much more difficult than earlier versions. Marcos Pienasola sometimes assists in administering the test, and he has noticed that new interpreters tend to be almost *too* trained; they are very formal, and often they are so focused on *translating* what is said word for word that they forget to *interpret* the meaning of what is said and convey it effectively.<sup>75</sup> Still, the fact that formal training is available and that the standards are high is encouraging. We are not alone in hoping that in the coming years, standardized curriculums and testing will be developed so that the quality of interpreting services across the country will be more consistent.

### **The Written Translation Department**

Donald Wood serves as the Director of the Written Translation Department at the Cambridge Health Alliance. Of American parentage, he spent the first 22 years of his life in Brazil. His father was a pilot, and so he traveled and lived all over the world while growing up. Mr. Wood speaks English, Portuguese,



*Donald Wood*

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<sup>75</sup> Marcos Pienasola, Somerville, 11/22/04

French, and some Italian and Spanish. He has worked as an interpreter, primarily performing simultaneous consecutive interpreting. He found the Alliance almost accidentally; he once fell ill and was taken, unconscious, to one of the Alliance hospitals. He was so impressed with the care he received that he worked as the written translation coordinator for free. Since 2000, he has been working at the CHA full time.

Written translation is a more complex endeavor than commonly thought. The procedure involves many steps and requires the attention of many individuals. Mr. Wood receives requests for documents to be translated from departments of the Alliance and also from outside sources. His first act is to review the request and to see if there may be a similar document that has already been translated. If of the 2,300 translated documents no acceptable document is on file, he then contracts the job out to the translators who perform these translations through an online form. One translator in the network translates the document; another proofreads it. Then Mr. Wood evaluated the finished document before it is returned to the requesting party. Thus each document is seen by at least three people. It is important not only to translate a document but also to determine its readability. If a document reads at a 9<sup>th</sup> grade level and the target audience is a group of immigrants with little formal education, the information will not be received. Special software (Déjà Vu) has been developed to evaluate the readability of translated documents. In general, the documents prepared for the Alliance are designed to read at a 6<sup>th</sup> grade level.

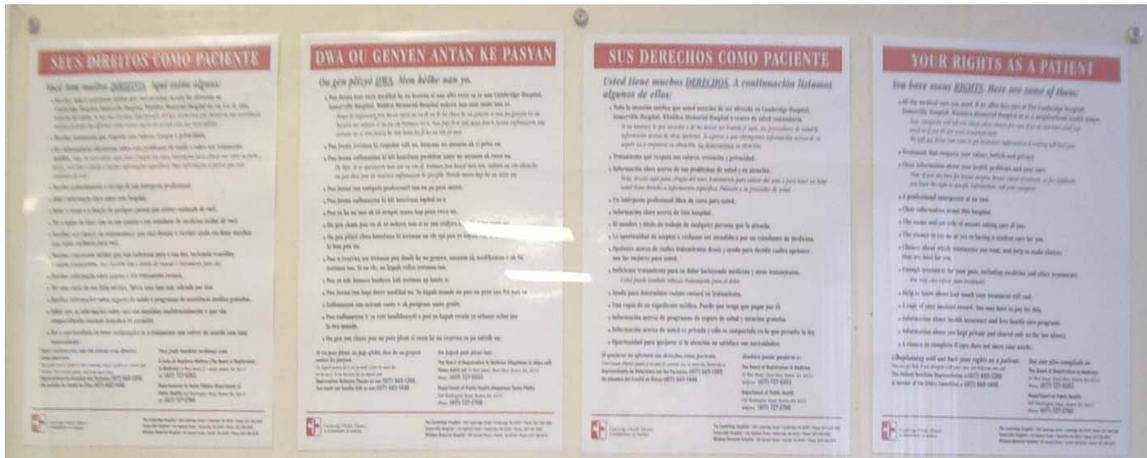
Each year the Written Translation Department translates about 500,000 words.<sup>76</sup> Some of the translators also work for the Alliance as interpreters; others are independent interpreters or bilingual people who enjoy the flexibility that comes from being able to

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<sup>76</sup> Donald Wood, Somerville, 12/3/04

work from home. Most are from Massachusetts, but some work from as far away as California. None works from outside the country, due to complications with payments and communication. All of the translators have been tested by completing a mock document. Mr. Wood has noticed that the best translators are not always those who have the highest credentials.

Written translation costs much less than person-to-person translation. As Wood explained, “We are, by and large, a cost center. It’s a good thing if we go over budget!”<sup>77</sup> In the future, he would like to see a higher demand for translated documents, as well as a better system for cataloguing completed translations so that they may be more easily located. He believes the CHA’s medical translation and interpreting system should serve as a model for other hospitals and health care systems across the nation.



## Critiques and Compliments of the CHA Multilingual Interpreting and Translation Services

The Cambridge Health Alliance’s multilingual interpreting services have undoubtedly served as a model to be emulated. The Alliance has made an investment in

<sup>77</sup> Ibid.

the health of the community as a whole, and has worked to serve its patients well regardless of their national origin, English proficiency or ability to pay. The formalized structure of the interpreting services has allowed non-English speakers to expect quality and efficiency in treatment from their providers. Beyond this, the dedication and quality of character in every staff member we have met is to be lauded. Administrators, physicians and interpreters took hours out of their extremely hectic schedules to speak with us, freely sharing their information and observations in order to heighten awareness of the needs of the immigrant community. Dr. Cohen and Sr. Cabral granted us the invaluable opportunity to observe a house-call and interact with the patient through an interpreter – their openness and generosity is tremendous. Every interpreter we spoke with recounted their frequent interactions with patients that extended beyond the medical examination. These interpreters are highly invested in the well-being of the patients they serve; they translate letters and documents, ask after the well-being of family members, and help guide new immigrants to needed resources, and through these actions the interpreters earn their trust, no small feat in what is typically an intimidating environment. These interpreters are Somerville’s “welcoming committee” in a sense; they serve as the bridge between the familiar and the unknown.

Nevertheless, there is more to be done. Despite reports by the CHA to the contrary, almost all the interpreters we spoke with raised concerns about the potential increase in speakerphone interpreting. They seemed to feel that face to face interaction was an essential part of effective communication, that it helped them as interpreters to be able to observe cultural and linguistic differences in person, and that it helped the patients to feel more at ease in the exam room. Carol Miranda at the East Somerville Health Center described the inconsistency with which interpreters are needed; some days there are

too many Spanish-speaking patients for the number of available interpreters, while on other days an interpreter may not be needed at all. She also spoke about the issues of availability and punctuality. Particularly with low-frequency languages, appointments must often be made according to the interpreter's schedule, rather than that of the patient. On-call interpreters are often paid for their time even when they arrive too late at the appointment to provide any service.

Another suggestion that arose in interviews was for improved interaction between the CHA and various non-profit organizations working to address the needs of the immigrant population. Often newcomers, particularly those with little English ability, are simply unaware of the resources and services available to them, and so they turn to interpreters when others would be better able to help them, or they miss out entirely. Miranda suggested that a clothing drive or similar event held at the clinic, properly advertised, would be an excellent opportunity for community organizations to conduct outreach to immigrant residents. Finally, it goes without saying that increased funding is necessary. East Somerville Health Center, for example, is limited in how well it can serve the needs of its patients by its small size, and is in desperate need of renovation. The clinic also used to have a person on staff that would assist patients filling out Medicaid and Mass Health paperwork in their own languages. Due to budget cuts that position has been eliminated, but the task remains, and so other members of the staff have absorbed the responsibility. The Alliance has demonstrated its ability and its dedication to improving the health of the community, particularly the minority population. Its programs are well organized, its mission well defined, and more money would undoubtedly be put to good use.

## Chapter 5: Medical Translation and Interpreting Nation-Wide

The United States is growing ever more ethnically and racially diverse, and the need for interpreting and translation services will only continue to rise. Title VI of the Civil Rights Act of 1964<sup>78</sup> requires all entities that receive federal money to ensure that non-English speakers have adequate access to the services provided.<sup>79</sup> But until recently, there were no formal standards for the provision of medical interpreter services. This has contributed to the inconsistency with which medical translation and interpreter services are provided across the country.

### National Laws

In March of 2001, the Office of Minority Health at the US Department of Health and Human Services published its final report on National Standards for Culturally and Linguistically Appropriate Services in Health Care. The fruits of several years of labor for many individuals were the following fourteen standards:

- *Standard 1. Health care organizations should ensure that patients/consumers receive from all staff members effective, understandable, and respectful care that is provided in a manner compatible with their cultural health beliefs and practices and preferred language.*<sup>80</sup>
- *Standard 2. Health care organizations should implement strategies to recruit, retain, and promote at all levels of the organization a diverse staff and leadership that are representative of the demographic characteristics of the service area.*<sup>81</sup>
- *Standard 3. Health care organizations should ensure that staff at all levels and across all disciplines receive ongoing education and training in culturally and linguistically appropriate service delivery.*<sup>82</sup>

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<sup>78</sup> 42 U.S.C. §2000d, 45 C.F.R. §80.1 et seq.

<sup>79</sup> 65 Fed. Reg. 52762-52774, August 30, 2000, found at [www.hhs.gov/ocr/lep](http://www.hhs.gov/ocr/lep)

<sup>80</sup> Office of Minority Health. *National Standards for Culturally and Linguistically Appropriate Services in Health Care: Final Report*. Washington, DC: US Department of Health and Human Services, March 2001; 7.

<sup>81</sup> *Ibid*, 8.

<sup>82</sup> *Ibid*, 9.

- *Standard 4. Health care organizations must offer and provide language assistance services, including bilingual staff and interpreter services, at no cost to each patient/consumer with limited English proficiency.*<sup>83</sup>
- *Standard 5. Health care organizations must provide to patients/consumers in their preferred language both verbal offers and written notices informing them of their right to receive language assistance services.*<sup>84</sup>
- *Standard 6. Health care organizations must assure the competence of language assistance provided to limited English proficient patients/consumers by interpreters and bilingual staff. Family and friends should not be used to provide interpretation services (except on request by the patient/consumer).*<sup>85</sup>
- *Standard 7. Health care organizations must make available easily understood patient-related materials and post signage in the languages of the commonly encountered groups and/or groups represented in the service area.*<sup>86</sup>
- *Standard 8. Health care organizations should develop, implement, and promote a written strategic plan that outlines clear goals, policies, operational plans, and management accountability/oversight mechanisms to provide culturally and linguistically appropriate services.*<sup>87</sup>
- *Standard 9. Health care organizations should conduct initial and ongoing organizational self-assessments of CLAS-related activities and are encouraged to integrate cultural and linguistic competence-related measures into their internal audits, performance improvement programs, patient satisfaction assessments, and outcomes-based evaluations.*<sup>88</sup>
- *Standard 10. Health care organizations should ensure that data on the individual patient's/consumer's race, ethnicity, and spoken and written language are collected in health records, integrated into the organization's management information systems, and periodically updated.*<sup>89</sup>
- *Standard 11. Health care organizations should maintain a current demographic, cultural, and epidemiological profile of the community as well as a needs assessment to accurately plan for and implement services that respond to the cultural and linguistic characteristics of the service area.*<sup>90</sup>
- *Standard 12. Health care organizations should develop participatory, collaborative partnerships with communities and utilize a variety of formal and informal mechanisms*

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<sup>83</sup> Ibid, 10.

<sup>84</sup> Ibid, 11.

<sup>85</sup> Ibid, 12.

<sup>86</sup> Ibid, 13.

<sup>87</sup> Ibid, 14.

<sup>88</sup> Ibid, 15.

<sup>89</sup> Ibid, 16.

<sup>90</sup> Ibid, 17.

*to facilitate community and patient/consumer involvement in designing and implementing CLAS-related activities.*<sup>91</sup>

- *Standard 13. Health care organizations should ensure that conflict and grievance resolution processes are culturally and linguistically sensitive and capable of identifying, preventing, and resolving cross-cultural conflicts or complaints by patients/consumers.*<sup>92</sup>
- *Standard 14. Health care organizations are encouraged to regularly make available to the public information about their progress and successful innovations in implementing the CLAS standards and to provide public notice in their communities about the availability of this information.*<sup>93</sup>

The standards are further categorized as follows: Standards 4-7 are current federal requirements for all recipients of federal funds; Standards 1-3 and 8-13 are recommended by the Office for Minority Health for adoption as federal mandates; Standard 14 is suggested for voluntary adoption by health care organizations.<sup>94</sup>

Hopefully their recommendations will be implemented; a cohesive national policy for the provision of medical interpreting services would generate the consistency now so lacking in interpreting services across the country. And if these standards could be imposed on organizations in other sectors of society, such as municipalities, the results could be extraordinary. With truly equal access to government resources, civic engagement, and complete information with which to make informed decisions, immigrants could become truly integrated in American society. They would learn English because of their desire to advance financially. But the civil and political rights that are explicit in the rhetoric of American society would be genuinely upheld in its practices.

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<sup>91</sup> Ibid, 18.

<sup>92</sup> Ibid, 19.

<sup>93</sup> Ibid, 20.

<sup>94</sup> Ibid, 28-29.

## State Laws

In June of 2001, the Massachusetts Department of Public Health released regulations governing hospital emergency room interpreter services.<sup>95</sup> This event trailed the enactment of Chapter 66 of the Acts of 2000, “An Act Requiring Competent Interpreter Services in the Delivery of Certain Acute Health Services.”<sup>96</sup> The regulations, which were accompanied by a document to clarify them, include the following:<sup>97</sup>

- Hospitals must designate a coordinator of interpreter services with overall responsibility for the operation of the program.
- Hospitals must provide notices and signage informing persons coming to the emergency department of their right to interpreter services.
- Hospitals must conduct an annual language needs assessment in their service areas.
- Hospitals must assure that interpreters have received appropriate training in the skills and ethics of interpreting.
- Hospitals must refrain from encouraging the use of family members for interpreting, and are prohibited from using minor children.

A major issue with regard to state laws is the difficulty in enforcing them. State initiatives are drastically under-funded as it is, and so enforcement of these laws would likely become each city’s responsibility. As Somerville cannot afford to employ quality full-time municipal interpreters, it is unlikely the city would find it productive to police health care systems.

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<sup>95</sup> 105 CMR 130.1100 et Seq.

<sup>96</sup> “Hospital Interpreter Services Update: Regulations and Best Practices,” in Communicable Disease Update, Newsletter of the Bureau of Communicable Disease Control, Massachusetts Department of Public Health. Vol.9, No.3, Fall 2001;1,6. [<http://www.mass.gov/dph/cdc/update/cd1001.pdf>]

<sup>97</sup> Division of Health Care Quality circular letter (DHCQ 01-07-414); The regulations and best practice recommendations can be found on the MDPH website [[www.state.ma.us/dph/bhqm/licregs.htm](http://www.state.ma.us/dph/bhqm/licregs.htm)]

## **Interpreters in Somerville: How the City Serves its Non-English Speaking Residents**

The interpreter services that the Cambridge Health Alliance provides to the residents of Somerville remain by far the most comprehensive and complete services available. Non-profit community organizations like Concilio Hispano and CAAS provide interpreter services for a reasonable fee, but residents must be aware of this resource in order to take advantage of it, and even the small fee may be prohibitive for new immigrants with extremely limited means.

The city of Somerville has budgeted several thousand dollars for interpreting. Every qualified bilingual municipal employee is eligible for a 500-dollar annual bonus in exchange for being listed as “on-call” to interpret should the need arise in any of the city departments. However, there does not appear to be a formalized structure for placing these interpreters, and so the immigrant community’s needs are not being adequately served. Furthermore, the languages of the interpreters available are not sufficiently reflective of the languages spoken by non-English speaking residents. The money is available, but there is clearly a need for it to be more appropriately distributed and for the efficacy of the services to be evaluated.<sup>98</sup>

Yanelly Molina, another Urban Borderlands student, in her research on Latino civic engagement, called the Elections Department at City Hall to inquire whether there were translators at polling stations. The response was that City Hall as a whole has none. On a visit to City Hall, Ms. Molina observed a Latina woman struggling to communicate with the city clerk because she was unable to speak English. And City Hall’s answering

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<sup>98</sup> Alex Pirie, Somerville, 11/21/04

service is entirely in English.<sup>99</sup> With no one in the municipal offices employed to provide interpreter services, immigrants must rely on strangers, friends and family members to perform the most basic civic functions. This seriously impedes civic participation and encourages isolationism among immigrant communities.

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<sup>99</sup> Yanelly Molina, personal correspondence with Julia Goldberg, Fall 2004

## **Conclusion**

### **Common Themes**

Somerville has attracted Latin American immigrants for decades; the city's hospitality was made official with its establishment as a Sanctuary City for refugees in 1985. The large immigrant population makes the city an attractive destination for immigrants even now, but the gentrification of the city and the rising cost of housing are forcing poorer immigrants to move to less expensive communities further from the Boston area. Somerville's homepage welcomes residents in English, Haitian Creole, Spanish and Portuguese, but none of the other pages on the site are available in any language other than English; making these sites available in other common languages would undoubtedly make new residents feel more welcome, not to mention make the city's resources and services more accessible. The awareness of the need for improved interpreter services in the city exists; the next step is to take action.

The Cambridge Health Alliance has offered interpreter and translation services since the influx of Portuguese and Latin American immigrants that began in the 1980s. It has made a concerted effort to address their needs and improve their health in a way that serves both the immigrant community and the larger community as a whole. While certain aspects of their services are limited by funding constraints and the need for greater efficiency, as a whole the Alliance is to be commended for its efforts and its achievements, and the city and other organizations that serve immigrant communities should look to the Alliance as a model to emulate. If the dedication of CHA employees could be reproduced in other areas, we would undoubtedly observe greater integration

and involvement of immigrants in the city, and their contributions would benefit the Somerville community in innumerable ways.

### **Further Lines of Research**

Several issues have arisen during the course of our research that deserve further investigation. First and foremost, there must be an active examination of the availability of quality interpreter services for the city of Somerville. It seems clear that the funding available is not being properly allocated, and that there is a need for an organized and official structure for placing interpreters where they are most needed. The city would do well to try to emulate the structure of services provided by the Cambridge Health Alliance.

Another issue that deserves further attention is the absence of simple means of communication between non-English speaking residents and the city government. Should one of these residents seek services at City Hall, for example, and not receive assistance in his or her preferred language, there is little recourse available. Therefore, the lack of complaints may seem to indicate that the needs of immigrants are more adequately met than they are in reality. A well-publicized website or complaint form in a variety of languages would facilitate the monitoring of residents' satisfaction with available interpreter services. Perhaps a form could be created for all municipal departments, where employees can document each time a resident came to seek information or services and was in need of an interpreter, as well as how this need was addressed. This would allow for a standardized and more thorough analysis of the efficacy of existing services.

Outreach and communication between non-profit community organizations and the populations they serve could stand to be improved; it is wonderful that so many resources are available, but many immigrants are unaware of them. Clearly, public funding and grant money will never be sufficient, but increased funding would serve the needs of these organizations and the Cambridge Health Alliance as well.

## **Acknowledgements**

We would like to acknowledge all of those who collaborated with us, juggling their demanding schedules, multiple jobs and heavy familial responsibilities to make this project possible. Each and every person we met through this project was remarkable; their courage, their passion, their dedication, their patience and their optimism is truly inspiring. We want to thank Alex Pirie for his continued advice, contacts and contributions to our research. We thank Marty Martinez, Loretta Saint-Louis, Donald Wood, Linda Cundiff, and Noreen Burke for giving us the facts and background we needed to focus our project, and Barbara Cassesso for showing us an unrivaled passion for Somerville, liberal values, and civic and political engagement.

We are grateful to our immigrant narrators for welcoming us into their homes, sharing the details of their immigration experiences and being candid in their evaluation of the care they have received here. We thank the providers and interpreters, who did everything they could to help us understand translating and interpreting, the difference between the two, and their impact on health care outcomes. All of the narrators provided a valuable perspective on translation and interpretation services in Somerville. To our classmates and Professor Pacini, thank you for your contributions, advice, and patience. To our families: thanks for the edits and above all your support. And to our readers, we thank you in advance for your interest and attention. Any mistakes herein are our own, and we welcome any feedback you may have. We hope that the conclusions of this work will be taken into consideration by policymakers and practitioners, and that our overall impact is positive.

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