Awareness of Hypertension and Diabetes in the Hispanic Community

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Major barriers to awareness and control of hypertension and diabetes in Hispanic Americans include poor language comprehension, poor physician–patient communication, cultural differences, low educational level, and lack of health insurance. To better communicate the concerns about the risk factors for cardiovascular disease, physicians could use patient-education materials that include illustrations, familiarize themselves with their Hispanic patients and their preferences regarding communication (eg, formality, close proximity, appropriately used touch), and advocate government action to make health insurance more affordable. An increase in Spanish-speaking physicians would help alleviate some of the confusion that Hispanic patients experience in their interactions with health care providers. **(*Clinical Cornerstone*. 2004;6[3]:7–15)** **Copyright © 2004 Excerpta Medica.**

INTRODUCTION

People of Hispanic origin constitute the largest and fastest-growing ethnic minority in the United States, having increased from 14.5 million in 1980 to 37.4 million in 2002.[1] Hypertension and diabetes mellitus are the 2 major modifiable risk factors for cardiovascular disease (CVD) in the Hispanic population. Although the prevalence of hypertension in the Hispanic American population is slightly lower than that in the general US population, the prevalence of other CVD risk factors (eg, obesity, sedentary lifestyle) is higher.[2] In particular, the prevalence of diabetes is high among Mexican Americans, who constitute 65% of Hispanics in the United States. Metabolic risk factors for CVD (eg, hyperinsulinemia, insulin resistance) play a causative role in the hypertension associated with type 2 diabetes. Cardiovascular risk in Hispanic Americans is related to suboptimal control of blood pressure and metabolic risk factors.[3,4] Data from various studies indicate that the health status of the Hispanic population is below that of non-Hispanic white Americans. Hispanics are more likely to become diabetic, be obese, less likely to get vaccinated, and less likely to see a doctor on a regular basis than non-Hispanic white Americans.

> **KEY POINT**
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> **Hypertension and diabetes mellitus are the 2 major modifiable risk factors for cardiovascular disease in the Hispanic population.**

There are many heterogeneous subgroups within the Hispanic American community. Although Mexican Americans remain the largest subpopulation, the number of people from other Hispanic countries, including Puerto Rico, the Dominican Republic, and Cuba, more than doubled in the United States between 1980 and 2002.[5] These groups display dif-

ferences in the prevalence of CVD and its risk factors. For example, Hispanics from the Dominican Republic and Cuba have a lower prevalence of diabetes than do Mexican Americans,[6] and those from Puerto Rico have mortality rates from myocardial infarction and other types of ischemic heart disease that exceed those in other Hispanic subgroups.[7]

KEY POINT

Compounding the increased prevalence of CVD and its risk factors in Hispanic Americans are demographic and cultural barriers that could prevent Hispanic patients from fully understanding the risk of hypertension and diabetes.

Compounding the increased prevalence of CVD and its risk factors in Hispanic Americans are demographic and cultural barriers that could prevent Hispanic patients from fully understanding the risk of hypertension and diabetes. These barriers also may make it difficult for physicians to detect risk factors for CVD and for patients to comply with treatment.[8,9] The majority of Hispanics in the United States are of lower socioeconomic status, younger, and less well educated than the non-Hispanic white majority. In addition, some of their values and beliefs (eg, in traditional medicine) differ from those of the non-Hispanic US community. These differences may erect barriers to awareness of hypertension and diabetes, which physicians often misinterpret as noncompliance.[8]

Hispanic Americans have higher rates of diabetes and its complications than do non-Hispanic whites.[9,10] The risk for hypertension-related morbidity and mortality in Hispanics falls between that in blacks (who are at highest risk) and that in whites.[11] Hispanic Americans also are at great risk for stroke and cardiovascular events. Despite their increased risk, Hispanics have not been well represented in clinical trials of antihypertensive agents, resulting in limited evidence-based therapies and scant clinical data to help guide their therapy. There is also debate regarding the role of ethnicity in the pathogenesis of hypertension and response to antihypertensive pharmacotherapy.[12,13] Relatively few studies have focused on the prevalence and outcomes of hypertension in the Hispanic community. However, it has been noted that although the rate of death from CVD is declining in the United States, it is declining less rapidly in Hispanics than in blacks, Asians, and non-Hispanic whites.[11] Also, Hispanic American men are less likely than non-Hispanic white or black men to have their blood pressure diagnosed, treated, or controlled.

Hispanics are thought to be leading the current diabetic epidemic, and many Hispanics have undetected diabetes.[14] Because the combination of stroke and diabetes is strongly associated with high 5-year mortality in some Hispanic subgroups,[15] it is not surprising that stroke is the third leading cause of death in Hispanics aged >65 years.[16] Thus, early detection and control of diabetes are crucial to preventing morbidity and mortality in this population.

SCREENING FOR DIABETES AND HYPERTENSION

The American Diabetes Association (ADA) recommends that high-risk patients (ie, Hispanic Americans and other ethnic minority groups having a first- and/or second-degree relative with type 2 diabetes) be screened for diabetes at the age of 45 years. The ADA also recommends screening for patients with signs of insulin resistance, including hypertension. These recommendations are particularly important in the Hispanic population, many of whom are at high risk for type 2 diabetes and have high rates of associated hypertension, dyslipidemia, and obesity.[16,17]

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The criteria for optimal management of diabetes include glycosylated hemoglobin (A1C) concentration <7%, blood pressure <130/80 mm Hg, and low-

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density lipoprotein cholesterol level <100 mg/dL.[18] Two small studies have shown that Hispanics consistently fail to meet these goals.[18,19] This concept is important because a 1% decrease in A1C and a 10–mm Hg decrease in systolic blood pressure in patients with diabetes and hypertension have been associated with reductions in diabetes-related mortality of 21% and 15%, respectively, as well as significant decreases in the risks for myocardial infarction and stroke.[20,21]

Barriers to Awareness and Compliance in Hispanic Patients

Language and communication barriers may decrease awareness and compliance in Hispanic patients with hypertension and/or diabetes. Effective physician–patient communication is essential to the diagnosis and management of hypertension and diabetes in these patients.

Patient Language Difficulties

The most common barrier to effective physician–patient communication is language. Although most Hispanic Americans report being bilingual, 77% speak primarily Spanish, and many millions speak only Spanish. In addition, as more Spanish-speaking immigrants arrive in the United States and settle in large Spanish-speaking communities, Hispanic Americans may be likely to retain Spanish as their primary language. Because the availability of Spanish media is increasing, the need to understand English is decreasing. A wealth of information in the literature supports the observation that most non–English-speaking patients receive medical advice without the benefit of an interpreter; thus, they may have only a poor understanding of the health issues confronting them.[22–24] In these patients, there is a clear potential for misdiagnosis, medical errors, poor compliance, patient dissatisfaction and/or mistrust, increased stress, and poor outcomes.[25–27] These patients tend to show poor compliance with prescribed treatment regimens, to receive a poor quality of care, and to be dissatisfied with that care.[27]

Morales et al[28] conducted a controlled study in which 3 groups of patients were asked to rate their degree of satisfaction with the information supplied by their health care providers during a medical interview. These investigators found that patients whose primary language was Spanish but who spoke some English were least satisfied with the information provided, followed by patients whose primary language was English but who spoke some Spanish. Predictably, non-Hispanic white patients who spoke only English were most satisfied with the information they received.

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Poor Communication Skills by Physicians

Physician–patient communication is a key factor in disseminating information about hypertension and diabetes and their risks. Poor communication skills on the part of the physician have been shown to be a barrier to treatment compliance. Compliance is less likely if a patient does not clearly understand the message the physician is trying to communicate.[24,29] Indeed, effective physician–patient communication is reflected in improved health care outcomes.[30]

Some Basics of Communication Skills with Hispanic Patients

Medical students, residents, and physicians should improve their ability to communicate effectively with Hispanic patients with regard to verbal and nonverbal communication. Tone of voice is important, as is the degree of formality used. Spanish distinguishes between formal and informal modes of address that

do not exist in English; these distinctions can be reproduced to a certain extent in the way the health care provider addresses the patient. Americans tend to be more informal on first meetings, whereas Hispanics tend to address people by their last names on the first encounter to show respect. For example, in Spanish, initial contact is generally more formal than in English. Use of "Mr." or "Mrs./Ms." rather than first names to address patients conveys respect.

Physicians should try to avoid the common mistake of treating non–English-speaking adults like children because of their poor command of the language. Technical talk can be insulting to patients who are inarticulate in English. Furthermore, Hispanics tend to be more comfortable discussing their personal lives and families, whereas non-Hispanics tend to be more reserved about such issues. For optimal communication, health care providers should get to know their Hispanic patients well, including their lifestyles and preferences. Another consideration is that Hispanics generally prefer physical closeness and express themselves through touch. As familiarity develops, the physician–patient relationship can be reinforced by the appropriate use of touch, a technique that must be learned.

In inner-city clinics, it is not unusual for some nurse practitioners to speak both in Spanish and English, but there is a dearth of bilingual physicians. Perhaps more physician training programs could emphasize multicultural communication as part of their curriculum.

KEY POINT

Patients who are best acculturated tend to be more treatment compliant than those who are less well acculturated.

Cultural Differences in Patients' Attitudes to Health Care

Cultural barriers also result in differences in attitudes toward health care between Hispanics and non-Hispanics in the United States. Evidence of these differences was provided in a study by Pachter and Weller,[31] who assessed the degree to which immigrants from Puerto Rico had become assimilated to the American way of life. These investigators found that patients who are best acculturated tend to be more treatment compliant than those who are less well acculturated.

Cultural misconceptions can act as barriers in the care of Hispanic patients.[32] For example, the likelihood of a successful outcome is greater if a patient believes that diabetes and/or hypertension require lifelong treatment, than if a patient believes that the disease is episodic or appears only when the patient is under stress. Hispanic patients may have opinions about these diseases that are very different from those of non-Hispanic patients. Such opinions often are derived from a belief in traditional medicine, which is particularly common in elderly Hispanics and those who recently arrived in the United States These beliefs constitute a barrier to the acceptance of the major health risk posed by hypertension and diabetes. For example, traditional Hispanic medicine is based on the principle that disease is caused by an imbalance between hot and cold. Hypertension is believed to be a "hot" illness, caused by anger or fear; thus, its treatment consists of remedies that are "cold," such as bananas and lemon juice. Also popular are teas of passionflower, linden, and sapodilla. Diabetes mellitus is also considered a "hot" illness that requires the use of cactus, aloe vera juice, or bitter gourd. Some of the therapies believed to be effective in the management of diabetes, such as sage tea, may be harmful if taken long term.

Given the prevalence of the belief in traditional medicine, perhaps it is not surprising that some Hispanic patients may be distrustful of the efficacy of modern pharmaceuticals or be fearful of the possible adverse-effect profiles of drugs prescribed by American physicians. These concerns may translate into poor compliance with prescribed treatment or a reluctance to visit a US-trained physician.

Low Educational Level

An estimated 40 to 44 million adults in the United States have a low level of education. Many Hispanic patients have difficulty understanding English and therefore poorly comprehend documents written in English.[33] Among Hispanics 25 years and older, 27.3% have less than a 9th grade education. The National Adult Literacy Survey reported that 25% of Hispanics reported that they were fluent only in Spanish and

6% were literate in both Spanish and English. These patients are almost twice as likely as those with adequate skills in reading English to report poor health, less likely to understand written instructions about their medication, and more likely to have trouble finding their way to and around a physician's office. Furthermore, many feel ashamed of their inability to read.[34]

The results of a study on the views and preferences regarding diabetes education of Hispanics with a low level of education[35] should be required reading for all physicians caring for Hispanic patients with diabetes. In that study, 2 native Spanish speakers conducted interviews with non–English-speaking, urban Hispanic Americans with type 2 diabetes from Caribbean and Central American countries. Although the number of patients was small, the focus groups were detailed. A key finding was that participants expressed a preference for a diabetes-education program that used illustrations to convey principles.[35]

Lack of Health Insurance

Because many Hispanic patients are of low socioeconomic status, they are frequently unable to obtain and/or pay for long-term health care. This is particularly true of patients with hypertension and/or diabetes, for whom treatment is lifelong. Many Hispanics live in inner cities and are more likely to be underinsured or uninsured than non-Hispanic whites. The increase in uninsured Hispanic individuals between 1989 and 1996 was 36.4%.[36] A 1999 analysis of data from the Third National Health and Nutrition Examination Survey found that Hispanics had lower rates of health insurance (77%) than blacks or non-Hispanic whites (93% and 95%, respectively). In addition, lack of prescription drug coverage may mean that patients are unable to afford physician-recommended medications. For all the stated reasons, many Hispanics may fail to seek medical care.[37] Major barriers to awareness and control of hypertension and diabetes in the Hispanic population include poor comprehension of language, poor physician communication skills, cultural differences, poor patient literacy, and lack of health care coverage.

HEALTH CARE INITIATIVES

A number of associations and pharmaceutical companies have established partnerships and programs to foster awareness of hypertension and diabetes and to improve compliance with therapies for these diseases in the community as a whole. All of these programs have specific components directed toward the Hispanic community.

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Take Action for Healthy Blood Pressure Consumer Awareness Program

The American Society of Hypertension Inc. has partnered with Novartis Pharmaceuticals Corporation to develop the Take Action for Healthy Blood Pressure Consumer Awareness Program (http://www.healthybp.com), the principal focus of which is to increase awareness, detection, and treatment of hypertension using goals recommended by the National Institutes of Health (NIH) and the National High Blood Pressure Education Program. It offers participants a free 30-day trial of 1 of 3 antihypertensive drugs and guarantees that if the patient fails to attain the blood pressure goal set by the physician, out-of-pocket prescription costs will be refunded to the patient. The program also provides the patient with a free ambulatory blood pressure monitor to use at home.

American Diabetes Alert and Make the Link! Diabetes, Heart Disease and Stroke

The ADA, in association with the Elizabeth Knight Fund, supports an awareness program, American Diabetes Alert (http://www.diabetes.org/community programs-andlocalevents/americandiabetesalert.jsp) that aims to help identify the millions of Americans with undiagnosed diabetes.

The ADA and the American College of Cardiology have launched a multiyear initiative to help people with diabetes and health care professionals under-

stand the association between diabetes and CVD. The program, called Make the Link! Diabetes, Heart Disease and Stroke, focuses on reducing diabetic patients' risk factors for CVD by generating awareness and providing tools to facilitate a constructive patient–physician dialogue. Supporters of the program include the manufacturers of drugs used in diabetes management—AstraZeneca Pharmaceuticals LP, Bristol-Myers Squibb Company, Eli Lilly & Company, GlaxoSmithKline, Merck & Co., Inc., Novartis Pharmaceuticals, and Pfizer Inc.

Be Smart About Your Heart: Control the ABCs of Diabetes

The National Diabetes Education Program is a partnership between the NIH, the Centers for Disease Control and Prevention, and >200 public and private organizations with the aim of preventing and controlling diabetes. Among its awareness programs highlighting the link between diabetes and CVD is Be Smart About Your Heart: Control the ABCs of Diabetes (http://www.ndep.nih.gov/diabetes/pubs/BeSmart_broch_Eng.pdf). This campaign includes fact sheets specifically tailored for the Hispanic community, as well as Spanish-language public service announcements on radio and television. The campaign focuses on the management of diabetes through monitoring of A1C, blood pressure, and cholesterol.

Clear Health Communication Initiative—2003–2004

The American Medical Association Foundation and Pfizer Inc. have launched the Clear Health Communication Initiative—2003–2004 (http://www.pfizerhealthliteracy.com), which aims to raise physicians' awareness and understanding of the importance of patient education and to develop tools to improve physician–patient communication. This program is based on the premise that pictures, diagrams, and videotapes help communicate health care information to patients, especially those with a low level of education. Currently, most patient-education materials are written at the 10th- to 12th-grade reading level. However, many patients cannot comprehend information written at a reading level higher than 5th grade. It is hoped that this initiative will provide useful patient-education materials for the Hispanic community.

Robert Wood Johnson Foundation

The Robert Wood Johnson Foundation (http://www.rwjf.org) has established a national program, Hablamos Juntos, to develop and evaluate language technologies for use in emerging Hispanic health care markets across the country.

CONCLUSIONS

The growing Hispanic community and their associated modifiable risk factors for CVD continue to present difficult health care challenges. Cultural, language, and economic barriers make treatment of this patient population difficult. There are a growing number of associations and pharmaceutical companies that have established programs to raise awareness of hypertension and diabetes; however, they do not address key concerns such as disparities in health insurance for the economically disadvantaged, many of whom are unemployed or have low-paying jobs that do not provide health insurance. Action at the level of the federal government is a way to solve this problem. Alternatively, individual states might become involved in an attempt to make health care more affordable to the general population. A large increase in the number of Spanish-speaking physicians and/or Hispanic American physicians would help alleviate some of the confusion that Hispanic patients experience in their interactions with health care providers. Providing patient information materials in both Spanish and English would help the physician provide take-home lessons. Using illustrations, graphics, and electronic media to communicate important issues could increase awareness of hypertension and compliance with treatment regimens.

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Dialogue Box

EDITORIAL BOARD

You indicated that very few studies on hypertension have looked specifically at the Hispanic patient. Are plans in the works to organize a Hispanic American working group for hypertension similar to the one that exists for African Americans?

ARANDA

That's the next step—organizing a group that represents Hispanics and the issues they face regarding hypertension and diabetes. One of the objectives of this group would be to develop specific guidelines for the Hispanic patient.

EDITORIAL BOARD

Why have so few Hispanic patients participated in the large clinical trials that have been published?

ARANDA

To get a significant number of Hispanic patients into clinical trials, you need to enlist the participation of Hispanic doctors in Hispanic communities, not only in South Florida but also in Chicago, New York, Texas, and California. These doctors tend not to be associated with the academic centers that generally participate in large clinical trials. Thus, the challenge involves not so much the direct recruitment of Hispanic patients into clinical trials, but more so the recruitment of Hispanic doctors as principle investigators who will then recruit this subset of patients.

EDITORIAL BOARD

Why is it important for Hispanic physicians to be involved at that level?

ARANDA

It is clear that the message about hypertension and the importance of early detection and treatment is not reaching the Hispanic community. It is my belief that the lack of representation of Hispanic patients in clinical trials, which stems, at least in part, from Hispanic physicians not being involved, is a factor in the message failing to be disseminated. What works in getting this information to non-Hispanic patients will not necessarily work for Hispanic patients; until cultural barriers are adequately scrutinized, optimal control of hypertension in these patients will continue to be an elusive goal.

EDITORIAL BOARD

How important a role does the Latino cultural concept of "fatalismo" play in hindering the treatment of hypertension in the Hispanic patient?

ARANDA

It is a factor that needs to be considered. This concept dates back to very old traditions which conveyed the message that once you got sick, you lived out your days and "what will be, will be."

EDITORIAL BOARD

How do you effectively address it? Is it more a male than female phenomenon?

ARANDA

I take the same approach with both sexes. As you treat more and more Hispanics, you find that you not only treat the patient, in some ways you also are treating the spouse. I frequently try to put them together in a room so that the same speech I give to the husband, the wife also hears, which allows her to apply it to her condition as well. I try to get the message across that if you receive treatment with the appropriate drugs, any notion of fatalism simply doesn't apply. I emphasize to both that we've made a lot of progress from the days when fatalism might have applied, and that with treatment, we can assure them a good quality of life for many years.

EDITORIAL BOARD

Are you saying that you routinely enlist the wife to help reduce the "fatalismo" barrier in the male?

Dialogue Box

ARANDA

Yes. The female spouse controls the situation in the Hispanic family—from the male receiving the medication, to making a follow-up appointment, to watching his diet and telling the physician what dietary rules he has broken or what medicines he has forgotten to take or didn't want to take. It all revolves around the wife.

EDITORIAL BOARD

So a way of dealing with this cultural issue, at least in the male, is to not make an appointment unless you make an appointment with the spouse.

ARANDA

Either a spouse or the daughter. I generally do not like to see a Hispanic male patient alone. In the interest of fostering awareness and compliance with treatment, I also want the participation of the wife or daughter. In fact, I like having as many family members present as possible, because they will all look at each other and reinforce what's being said. Such a family approach not only helps the patient, but also serves to make family members more knowledgeable about the health problem as it might apply to themselves, either currently or possibly in the future.

EDITORIAL BOARD

What role does Catholicism play in the management of the Hispanic patient with hypertension?

ARANDA

At least in the minds of patients, it plays a role. If Catholicism is brought up, you should respect and acknowledge it, and, when appropriate, use it to help them cope with their condition as well as reinforce compliance and what they need to do to reduce their risk factors and improve clinical outcomes.

EDITORIAL BOARD

Do you usually bring up Catholicism or does the patient?

ARANDA

As a physician I don't mention it; usually patients will. For example, they might say that under the power of God and Jesus, I hope that you know what you are doing and that you are prescribing me the right medicine. This is frequently expressed in the clinic.