

Attitudes and Issues in Treating Latino Patients With Type 2 Diabetes: Views of Healthcare Providers

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The purpose of this study was to explore the concerns of Latino patients with Type 2 diabetes. Focus groups were conducted with healthcare practitioners to chart their perceptions of the issues faced by their Latino patients. One group consisted of professionals working among Mexican American clients in an inner-city clinic; another group was held at an inner-city hospital serving mostly Puerto Rican Americans; and a third group involved providers practicing with more affluent, suburban Mexican Americans. Practitioners agreed that communication with patients was hindered by low reading levels, lack of proficiency in English, and an excessive respect for physicians. Emotional barriers to adequate treatment were often more important than financial concerns, even among low-income patients. Fear of insulin therapy was expressed in Hispanic communities, and folk remedies were commonly used. Because family needs were considered most important, adhering to a treatment regimen might be viewed as self-indulgent. Yet families provided valuable reinforcement and emotional support. Important questions facing Latinos with diabetes were effectively identified using focus groups of healthcare providers.

Type 2 diabetes is a major health problem among Hispanic Americans, yet the impact of culture and migration on diabetes treatment has not been fully examined.^{1,2} An estimated 1.3 million Latino adults are affected, and the diabetes mortality rate is twice the rate for non-Hispanic whites.^{1,4} Because of the chronic nature of diabetes and the critical role of the educated patient in treatment management, an understanding of the interface between providers and patients is essential for effective medical care. A strong ethnic identity may interfere with the delivery of satisfactory levels of care, but may also contribute positively to patients' coping strategies. Clinical, behavioral, intellectual, and social variables are all of critical importance in determining whether Latino patients have the necessary skills to address the demands of living with diabetes.

The attitudes and beliefs of physicians and other healthcare workers also have a strong influence on the adequacy of diabetes treatment.³ The educational approach and emotional tone adopted by practitioners are important determinants of patient adherence to the behavioral changes necessary for living successfully with Type 2 diabetes. These factors may be even more important among migrants with values and social norms that differ from those of the majority culture. Furthermore, practitioners working daily with community members may be able to provide valuable insights into the challenges faced specifically by Latino patients in their attempts to adhere to a treatment regimen.

Methods

This project comprised the qualitative component of a study from the Midwest Latino Health Research, Training, and Policy Center at the University of Illinois with the purpose of examining the current status of diabetes treatment among Latinos in Chicago; a patient survey was conducted concurrently.⁴ The goal of the overall study was to collect information on the impact of patient and provider characteristics that influence the health outcomes of Latino patients with

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1. Scope of the problem
 - a. About what percent of your diabetic patients are Hispanic?
 - b. Is there a high prevalence of diabetes among your Latino patients compared with other ethnic groups?
 - c. Is there more diabetes among those who are newly arrived (Spanish speaking) or those who have been in Chicago a long time (more English speakers)?
 - d. In general, do you have more Latino patients who have complications than patients of other ethnic groups? Does diabetes onset seem to occur earlier among Latinos?
2. Patient factors in compliance
 - a. Do you often find patients who deny they have diabetes altogether, who feel hopeless (that diabetes is a death sentence)? Are these attitudes more frequent among your Latino patients than among others?
 - b. Are the number of adherent patients different than among non-Hispanic patients?
 - c. Can you point to any cultural factors that affect adherence (for example, diet, attitudes toward authority figures, language barriers, financial considerations)?
 - d. How are educational interventions received? Do diabetes classes seem to improve adherence among Latino patients? What are the characteristics of a successful education program among Latinos?
 - e. What is the role of folk medicine (home remedies, herbalism) in treating Latino diabetes patients?
3. Provider factors
 - a. Do you feel comfortable treating most of the diabetic patients you see? Are you familiar with the national guidelines for diabetes care?
 - b. Are you able to follow the guidelines given the financial status of the patients, and insurance and institutional constraints?
 - c. Do you feel that excellent diabetes care, according to the national guidelines, is possible in the Latino community of Chicago?
 - d. What approach do you see as the most successful, in your experience, in improving patient adherence (for example, education, enlisting family members, putting the patient on a rigid schedule)?
 - e. Do you generally use a different approach with your Latino patients than with others?
4. Recommendations and general comments
 - a. Do you have any recommendations or suggestions regarding Latinos with diabetes?
 - b. What other aspects of diabetes in the Latino community should we be studying?

Focus group guidelines.

diabetes. The focus group approach was selected because it is well-suited to the goal of identifying key areas of concern regarding Latino patients with diabetes; formal statistical analyses would be inappropriate for these qualitative data.

Three focus groups were held with health professionals from Chicago-area primary care facilities to ascertain their perceptions of various issues related to the treatment of Latinos with Type 2 diabetes. These discussions concentrated on provider views and perceptions of how their patients cope, on identifying barriers to care, and on provider attitudes toward specific Latino cultural practices.

Outpatient clinics were chosen in three distinct neighborhoods of the Chicago area with large concentrations of Latino residents. An attempt was made to account for the cultural and socioeconomic diversity of the Latino community. To this end, one focus group was conducted among providers (physicians, nurses, and health educators) working at a clinic that served a predominantly inner-city Mexican American population of lower socioeconomic status (SES); another group was conducted at an inner-city hospital that served a large number of impoverished Puerto Rican Americans; and the third focus group was conducted among providers affiliated with a suburban hospital that served some-

what more affluent low- to middle-class Mexican Americans. The majority of patients at both inner-city sites were Latino (>90%), according to the estimates of the focus group participants. The providers from the suburban site stated that they were primarily seeing Mexican Americans who were working in the nearby factories; these patients comprised about 25% of their overall patient population.

The plan was to explore issues that could be identified by health workers as being of particular importance to their patients and to discover the culturally specific techniques being used to treat Latinos with Type 2 diabetes. A series of open-ended questions was prepared by the research staff and incorporated into a set of guidelines for discussion (see the Figure). These questions were used by the group leaders but not given to participants. The guidelines were used in all three focus groups to ensure consistency in coverage of topics. Attention was focused on patients' behavior and any particular problems encountered in working with Latinos, especially regarding adherence and patient education. The discussion was structured to address four categories of questions: the extent of the problem; demographic and cultural factors in patient adherence; training, culture, practice type, and other factors that affect healthcare provider behavior;

Characteristics of Focus Group Participants by Practice Site

Characteristics	Urban MA*	Urban PR [†]	Suburban
Number of participants	5	10	9
Number of females	3	8	3
Ethnicity			
Mexican American	4	2	1
Puerto Rican	0	3	0
Other Hispanic	0	0	3
Non-Hispanic	1	5	5
Professional Training			
Physicians	2	2	6
Registered nurses	0	6	1
Other	3	2	2
Unable to speak Spanish	0	1	4

*MA=Mexican American.

[†]PR=Puerto Rican.

and the recommendations and general comments of the participants.

Approximately 12 primary care staff members (physicians, certified diabetes educators, nurses, dietitians, and physical therapists) were invited to attend the focus group session at each institution. Invitations were extended 2 weeks prior to the scheduled meeting date by the staff liaison. The meetings were timed to coincide with a breakfast or lunch break to make them convenient to attend and lasted 60 to 75 minutes. A light meal but no monetary incentive was offered. Sessions were conducted cooperatively by at least 2 of the 3 investigators who were experienced in the focus group technique (AG, RBL, JM). A research assistant from the Center attended each session to collect demographic information from each participant and to take handwritten notes. The meetings were audiotaped and later transcribed for analysis. Results of the meetings were summarized individually by members of the diabetes research team. These summaries were later discussed by the research team as a group, then synthesized, and the primary findings were agreed upon.

Focus groups were conducted between July 20 and August 2, 1994. There were 24 healthcare providers who attended overall (range=5 to 10 per session); 14 were women (see the Table). Thirteen of the 24 participants described themselves as of Latino ethnicity; 3 of these individuals were neither Puerto Rican nor Mexican American. Non-Hispanic whites and Asian Americans comprised the remainder of the participants; there were no African Americans. Ten of the healthcare providers were physicians and 7 were nurses, of whom 4 were certified diabetes educators. Only 20% of the participants expressed a lack of competence in speaking Spanish, and the majority of those worked primarily with outpatients. A selection bias was probably introduced because no attempt was made to recruit a representative sample of all healthcare providers working with Latinos in Chicago. In fact, based on where they practiced and the lack of payment for attending the sessions, the focus group participants were likely to be those healthcare providers with a deep commitment to the Latino community. Thus, the insights and

opinions of the healthcare providers in the current study may not be representative of all of their colleagues.

Results

In general, most of the areas listed in the guidelines (see the Figure) were addressed, although patient and provider factors were inextricably linked during the actual discussions. Therefore, specific topics that were seen as being of importance to patients, providers, or the patient-provider interaction are presented together.

Scope of the Problem The groups agreed that diabetes among Latinos was a major problem in their communities. One of the inner-city groups estimated that about 20% of the patients seen at the clinic had diabetes, and the majority were women. Gestational diabetes was common. A number of young Latino men at one of the inner-city clinics were not considered by practitioners to truly have diabetes because their disease was secondary to alcoholic pancreatitis. A larger proportion of suburban Latino patients were men, perhaps because they had medical insurance through their employers. In contrast, inner-city clinic patients paid out of pocket using a sliding scale of fees or were on public insurance.

Barriers to Care Members of one focus group observed no difference in adherence between Latinos who had been in the US for a long time and those who were recent immigrants. The other two groups, however, felt that patients who had been in the US for a longer period or had the support of an acculturated family member were more likely to adhere to treatment.

Communication barriers, financial/legal problems, and cultural barriers were seen as factors that prevent Latinos from getting any care or adequate care. After specific probing by the facilitators, providers at two of the three sites indicated that communication was more of a concern than economics. It was difficult to convince patients to follow a prescribed diet, particularly when the plan conflicted with the use of traditional folk remedies. The need to elicit

information about alternative treatments also was seen as problematic; in the words of one physician, "If you don't ask, you don't know."

Communication Several aspects of communication were identified as potentially difficult: communication between provider and patients, between patients and their families, and the language barrier. All three discussion groups recognized that while education was critical to adequate patient management, there was a dearth of appropriate educational materials for this patient population. Material that was available in Spanish did not account for the different idiomatic expressions of the various Hispanic cultures. Illustrated materials both in English and Spanish were needed for those with poor reading skills. An interesting observation in two of the discussion groups was a marked disagreement between doctors and educators on the availability of diabetes material in Spanish. In these two groups the physicians felt that a lack of such materials was a major problem, while the educators asserted that some educational literature was available in Spanish. Clearly, lack of communication between physicians and health educators was an additional factor to be addressed.

Legal and Financial Issues Patients who lacked proper US visas or work permits, who were in the process of obtaining legal residency status, or who were of low SES often were fearful of accepting assistance from government agencies, even though insulin and supplies could be obtained from local sources. One educator told of a patient whose immigration case was in the process of being reviewed, and who was afraid that revealing her chronic illness by requesting government assistance to obtain supplies would jeopardize her chances of gaining US citizenship. A strong feeling of pride and self-reliance (*dignidad*) also may have prevented families from accepting free medicine. According to providers from one of the inner-city clinics, it was common among patients to believe that services provided free of charge would eventually have to be paid for, even if years later.

Cultural Factors in Adherence In all three focus groups a discussion of the importance of knowing the language and culture of the patients led directly to the issue of how to deal with folk remedies. Participants said that their patients would admit to resorting to alternative practices. The use of aloe (*sávilas*) and cactus (*nopalitos*) or herbs was mentioned in all three groups. Garlic was another popular remedy. Inner-city providers concurred with the suggestion that allowing patients to continue with alternative therapies was a means of getting them to adhere more readily to prescribed medical therapies. In contrast, two doctors and one educator in the suburban focus group expressed concern that folk remedies were being used by their patients in place of standard medical therapies. Substitution of folk remedies was a particular difficulty in patients who did not show dramatic improvement in health status; it also was linked to financial constraints.

Participants in both the Puerto Rican and the Mexican American inner-city sites commented on the almost reverential attitude their patients had for doctors. The credibility of

nurses and dietitians was enhanced, they believed, by a close association with the patient's physician. However, excessive respect for medical personnel, particularly among first-generation patients, prevented them from asking questions or clarifying medical instructions; according to one physician, "they nod yes out of politeness."

A mutually trusting relationship between the provider and the patient was seen as a way of enhancing the chances of adherence. Personalizing the relationship (*personalismo*) was identified several times as a strategy that was particularly important when working with Latinos. Providers felt that they should consider the needs of their patients rather than telling them what to do. For example, one suburban physician stated, "Latinos work two jobs, 12 hours a day. They have no time for exercise."

An interesting aspect of *personalismo* was mentioned by one of the suburban physicians who was a member of a large practice. He stated, "Families come as groups," and he stressed the importance of treating family members, who may not themselves have insurance or the financial resources to pay out of pocket, as a way to maintain a close relationship with his patients. He expressed sympathy for those physicians in small or solo practices who might not be able to absorb the expense of treating nonpaying patients.

The role of the family was seen as both positive, in providing emotional support for the patient, and negative, patients, particularly women, often balked at changing family eating patterns to accommodate their diabetes. Because a common attitude was that the woman's needs were secondary to the good of her family, expenditures for diabetes medications and supplies were considered less important than other family necessities.

Accepting diabetes as a serious disease was often a problem. Participants described the fatalistic belief that the disease was a judgement from God, and that with faith God would provide a cure (*Diós me ayudará*). Moreover, unless a patient felt ill, there was no perception of a need to see the doctor. One diabetes educator stated that patients would first try folk remedies, and only when complications set in would they visit the doctor. When asked further whether this attitude was related to mistrust of hospitals, the participants in one of the inner-city sessions hypothesized that the main reason was financial, since home remedies were generally less expensive. For men, there was a concern over job loss related to ill health. Several practitioners agreed with the statement, "Changing lifestyles for our patients is near to impossible."

Providers also felt that the recommendations and stories of friends and family members with diabetes strongly influenced their patients. These *comadre* stories were seen as particularly problematic with respect to insulin treatment. People who took insulin were invariably seen as more debilitated than those who used pills or diet therapy alone. Further, patients resisted increasing their insulin dosage based on the fear that even more serious illness or complications could result. Both inner-city and suburban providers felt that in general, financial barriers to insulin treatment were actually less significant than the fear of insulin use itself.

Provider Recommendations: Strategies to Improve Health Care for Latinos With Diabetes

Focus group participants responded creatively when asked what they thought should be done to improve diabetes care in the community. No far-reaching solutions such as healthcare reform or immigration reform were mentioned. Instead, the focus was on a practical, incremental approach. Getting the family involved was mentioned as a successful strategy in two of the groups. The suburban group concentrated on language-related tools and having available Spanish-speaking staff. Diabetes educators in all three sites expressed a need for more bilingual personnel, while physicians felt that having additional dietary information in Spanish would be most useful. Low-literacy materials were seen as a critical need. Both the suburban group and one of the city groups felt that the ability to send a health worker into patients' homes would enhance adherence to treatment. One group wanted to see doctors involved in prescribing diabetes education, because "the patients pay more attention to the doctors than to the dietitians." Physician participants in two of the groups acknowledged not having devoted sufficient time to health education.

Conclusions

Qualitative techniques have been used infrequently to explore health issues among Latinos,⁷ and just one study has specifically addressed diabetes in this patient population.⁸ Although patients rather than practitioners were involved in that study, the conclusions regarding Latinos' fatalism about diabetes, their fear of insulin, and the priority of the family over the individual reflect the findings reported in this current study. The use of folk remedies also was a common theme.

Healthcare providers agreed that there was almost an excessive respect for physicians, which was thought to possibly interfere with communications between practitioners and patients. Low-literacy educational materials, particularly those in Spanish, were an essential tool but difficult to obtain. Focus group participants reported that, in many cases, emotional barriers and cultural beliefs were more important to patient adherence than financial barriers, even among low-income, urban residents. There was a widespread fear of insulin therapy in the Latino communities of Chicago, despite the diversity of ethnic backgrounds that were represented. Similar to patients of other ethnic backgrounds, many Latinos do not take diabetes seriously until late in its course. The advice and stories of friends and family were highly valued, and folk remedies were used extensively. The needs of the family came before individual concerns, although families provided valuable reinforcement and emotional support to those with diabetes.

The focus group technique proved to be an effective method for identifying important questions from the perspective of physicians and diabetes educators working with Latinos with diabetes. Fortunately, the participants in the current study were highly motivated and committed to the community, and articulately expressed what they felt to be the concerns of their patients. Again, the participants were not randomly selected and may not have been representative of all healthcare providers working with Latinos in Chicago. A number of issues emerged which were common to patients

without regard to ethnicity, such as denial, resistance to changing dietary habits, and lack of exercise. Other concerns, such as the level of acculturation to the North American lifestyle, English language skills, immigration status, and insurance eligibility, may be specifically relevant to treating patients from Latino backgrounds.

Recommendations

Although this paper presents broad generalizations about a heterogeneous cultural group, considering typical Latino attitudes and beliefs may assist practitioners in tailoring diabetes educational interventions. For example, an awareness of the clients' views of the importance of family can be useful in a discussion about adhering to dietary guidelines; knowing that clients are likely to use folk remedies can be useful in designing appropriate educational materials about pharmacologic therapy. In practice, it is often helpful to acknowledge, and ultimately work around, deeply rooted cultural practices rather than attempt to contradict them directly. Financial and legal barriers may be equally difficult to surmount for entirely different reasons. Nonetheless, recognizing the day-to-day hurdles encountered by their Latino diabetes patients will enable health educators to set realistic goals. The content of these focus group discussions hopefully will provide the context for formulating a more detailed, quantitative examination of patient attitudes and barriers to adherence, which in turn will assist in improving diabetes health care among Latinos.

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Budget Justification: 12-Month Budget

Personnel

1. The Principal Investigator (Aida L. Giachello, Ph.D.) will serve as Project Director. Dr. Giachello serves as the overall administrator for the Center 50% of the time for the first 3 months followed by 35% for the following 9 months. This person is responsible for meeting the Center's goals and objectives in all areas: Training & Technical Assistance, information dissemination and for overseeing the operations particularly regarding project activities. Dr. Giachello is a medical sociologist, and also has a master's degree in Social Work (Policy and Management). She has more than 23 years of experience in conducting health behavioral research Latino and other racial and ethnic populations in Midwest. Dr. Giachello also has vast experience in planning and implementing local, regional and national conferences and workshops, and also has excellent linkages with the minority communities, researchers, and services providers.
 2. The Co-Principal Investigator, NAME, in addition to co-convening the Planning Groups help identify Advisory Board members and Trainers. He will assist in the design of training curriculum, review the training packages, and training sessions. Name will assist in the provision of technical assistance to health care providers and community-based partnerships.
 3. The Technical Coordinator (Jose Arrom, MA), will be responsible for the technical content of the training packages, translation of the training package, and selecting additional support materials. He will develop and implement an evaluation plan of the training courses. Evaluation results will be used to up-dating the training modules.
 4. Medical Specialist, MD. He/She will be available to provide medical expertise, verify and clarify medical terminology in the most accurate format. Name will oversee medical aspects of training package and training courses.
 5. Nutritionist will be available to provide dietary importance and nutritional expertise and will engage in information dissemination to trainers and consultants.
 6. Trainers will form part to the team which designs training package, training curriculum and conducts training course. Trainers will assist in the development and editing of a Spanish version of training package and conduct evaluation technical assistance.
 7. Program Manager (Coordinator) will be the day to day person who will coordinate trainers, consultants, advisory board members and health care providers. Name will be responsible to assist trainers with materials and courses, advisory board member with agenda, travel, and meeting preparations.
 8. The Project Assistant Manager, will be available on a day to day basis to assist the Project Manager with all administrative issues such as travel arrangement, meeting minutes, preparing correspondence, and personnel agendas.
 9. Secretary will provide clerical support to Institute staff, including answering calls, copying, mailing, faxing, filing, as well as other services.
- A.
- B. Consultants:
1. Trainers (5)
 2. Consultants
 3. Advisory Board Members
 4. Scholarship recipients (50)

Supplies/Printing

14.