“Nothing to Fool Around With”: Seniors’ Experiences with Medications

by

Britt Vegsund
B.A., Dalhousie University, 2007

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of the Requirements for the Degree of

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Supervisory Committee

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Abstract

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With little research documenting elderly medication users’ beliefs and attitudes towards medication, the purpose of this study is to document how seniors experience medication use within the context of their daily lives. The study population was comprised of female and male seniors aged 65 and over who were recruited from the Parksville – Qualicum Beach and Nanaimo communities of eastern Vancouver Island, British Columbia. The findings of this research suggest that for seniors, medication use is a complex and emotionally charged experience. It is an experience filled with contradictions, in which seniors are forced to negotiate between diverse realms of information concerning medications, from the directives they receive from health care professionals, to the signals they receive from their bodies. It is an experience in which powerful conceptions of medications as prolongers of life often trump an individual’s overwhelming desire to stop taking those medications. This research is intended to expand our understandings of the perceptions, attitudes, and beliefs that inform Canadian seniors’ medication use practices. Furthermore, findings from this thesis will contribute to a collaborative investigation of seniors’ experiences with medication designed to address the increasing number of adverse drug reactions experienced by the elderly.
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Dedication

This thesis is dedicated to the many seniors whose experiences and insights appear in pages that follow. My one hope is that their voices are heard and resound with those who read this thesis.
Chapter 1: Introduction

“What about the old people?
“They are the strongest of all, for they have lived longer than all of us, and they have wisdom.” (Lawrence Hill 2007)

Canada’s population is aging. By the year 2016, the number of seniors aged 85 and over is expected to more than double the 1993 numbers (Public Health Agency of Canada (PHAC) 1996). These figures are concerning given that medication use, particularly multiple medication use, is most prevalent amongst the very old (Ibid.). Today the number of medications prescribed to, and taken by seniors has increased significantly (Rollason and Vogt 2003) as the number of seniors living longer with chronic and multiple illnesses increases (Stephenson 2007). Adverse drug reactions (ADRs) in the elderly are a dangerous result of increased and multiple prescription drug usage (Rollason and Vogt 2003). ADRs can result when: 1) medication is not taken as prescribed, 2) prescription medication is combined with over-the-counter (OTC) drugs, alcohol, or other prescription drugs, 3) medications that are inappropriate for a senior’s health requirements are prescribed, and 4) multiple medication interaction results from inappropriate prescribing (PHAC 2007: 3). It has been estimated that in the United States of America one in four hospital admissions of the elderly are the direct result of medication problems and prescription drug interactions (Today’s Senior 2008). Furthermore, in Canada, “between 19% and 28% of hospital admissions for patients over 50 years of age occur as a result of medication problems, and 60% of these admissions are attributed to adverse reactions to medications” (PHAC 1996: 12).
Attempts to address ADRs and other unwanted effects of increased and multiple prescription drug use in seniors have focused on health care practices, but have not investigated the implications of seniors’ attitudes and beliefs towards medication. In order to adequately address ADRs among the elderly, I suggest that researchers must first engage with the seniors who use them, so that we may arrive at a clearer understanding of the consequences of their beliefs and attitudes towards medication on their prescription and over-the-counter drug use practices.

This thesis research was conducted under the umbrella of a larger study entitled “A Pilot Study of Seniors’ Experiences with Medication” that is the result of a collaborative effort between a group of health care professionals from the Vancouver Island Health Authority (VIHA) (Roseanne Beuthin and Marilyn Bater), the University of Victoria’s Centre on Aging (Elaine Gallagher), a professor of nursing from Vancouver Island University (Ann Holroyd), a University of Victoria professor of anthropology and environmental studies and Centre on Aging Research Associate (Peter Stephenson), and myself (a graduate student in anthropology). The study was created as a response to the high number of documented ADRs experienced by seniors in Canada. It is hoped that the results from this thesis, as well as reports written by co-researchers from the team will be used to inform the creation of a larger study that will further investigate the nature of Canadian seniors’ experiences with medications and, we hope, a public health intervention to reduce them. The final goal of these projects is the creation of an effective, and culturally and age-appropriate education campaign concerning safe medication use for seniors.
The more specific purpose of this thesis is to document how seniors actually experience multiple medication use in their daily lives. It explores the attitudes and beliefs towards medication of a group of middle class, elderly citizens who live on Vancouver Island in the communities of Parksville - Qualicum Beach and Nanaimo. Broadly speaking, this thesis intends to answer questions about seniors’ experiences with and attitudes towards medication. Specific research questions include:

1. How do seniors conceptualize and understand medications within their own terms?
2. What are some of the consequences of these conceptualizations for daily life?
3. What are the perceived negative and positive effects of medication use?
4. What are the recognized consequences of these effects?
5. What are some of the main factors that inform seniors’ decisions concerning their medications?

The seniors who participated in this research generously offered their time to teach us about their experiences with medication. Our conversations with these individuals quickly availed us of the complex nature of their experiences with, and attitudes towards medication.

Before continuing, I would like to offer a quick note on the term medication as I use it in this thesis. From the study’s inception and during the data collection phase, research team members systematically differentiated between prescription and over the counter medications (including vitamins and dietary supplements). We set out to discover if participants conceptualized easily attainable and relatively inexpensive OTC medications differently than their prescription counterparts. We quickly learned that they did. Interestingly, it turned out to be prescription medications for chronic illness that
participants spoke about most in descriptions of their daily experiences with multiple medication use. Furthermore, the casual manner in which participants spoke about OTC medications and their informal attitude towards them, availed researchers of the fact that participants did not define OTC drugs as medication in the same manner as they defined prescription medications. The consequences of this will be discussed in Chapter 4.

Therefore, unless otherwise specified, the term medication in this thesis refers to those prescribed by a biomedical professional and obtained through a licensed pharmacy. Participants lived either independently in the community or semi-independently in residential care homes. They were all competent individuals; none suffered from forms of age-related dementia or had debilitating brain injuries.

This thesis documents the contradictory nature of participants’ attitudes towards their medications. Furthermore, it discusses participants’ perceptions of what medications are, how they work inside the body, and their perceived capabilities. Within this thesis, the term perception refers to the manner in which participants defined medication within their own subjective categories and terms. Anthropologists conventionally label this type of perspective as the ‘emic’ perspective, which refers to the description of phenomena as understood and experienced by persons within a particular cultural or societal group (Spiers 2000: 716). Therefore, this research documents the consequences of these emic perceptions for seniors who take medications as part of a maintenance regime to treat chronic illness and conditions, over long periods. It also discusses the physiological, social, and emotional repercussions of medication use for the seniors who participated in this study, as well as the manner in which they made decisions concerning their medications.
The following pages reveal the complex and emotionally charged world in which seniors take medication. It is a world filled with contradictions, in which individuals are forced to negotiate between diverse realms of information concerning medications, from the directives they receive from health care professionals, to the signals they receive from their bodies. It often seems to be a world in which powerful conceptions of medications as prolongers of life supersede an individual’s overwhelming desire to stop taking medications, or at least reduce the quantity of medications they regularly consume.

Currently, there are few studies within health research, medical anthropology, and other social sciences that have investigated how seniors actually understand and practice medication use. Qualitative research from disciplines within the social and health sciences that have focused on seniors’ attitudes and beliefs towards medication have primarily focused on the extent to which elderly medication users can be said to comply with directives of their health care providers. Not only is the dualistic framework of compliance too simple to adequately explore and describe the complexities of seniors’ experiences with medication, it is also replete with negative connotations of “control, domination, obedience, poor communication and incompetence outside of medicine” (Smith and Stephenson 2007: 2). Therefore, this thesis aims to create a space for the voices of participants to sound clear and to document their own experiences with medication in a descriptive and non-evaluative manner that does not pre-ordain their resistance towards some drug regimes as a kind of disobedience or failure, which is precisely what terms like compliance convey.

Following this introductory chapter, this thesis is organized into the following sections. Chapter 2 contains a literature review outlining the studies and papers from
academic disciplines as diverse as medical anthropology, nursing, sociology, and psychology that have guided this research from its inception to completion. Chapter 3 includes a description of the methodology for this research. It outlines in detail the research design, objectives of the study, and the steps taken along the way. Chapters 4 and 5 present the results of the study. Chapter 4 includes a description of participants’ level of knowledge concerning medications and documents their perceptions of what medications are, and how they function. Chapter 5 documents the negative physical, social and emotional effects of medication use, as reported by participants, and then outlines their own attempts to mitigate these negative effects. It also discusses participants’ recommendations for how to improve seniors’ experiences with medication. Chapters 6 through 8 contain a multi-part discussion of the results presented in Chapters 4 and 5. These chapters engage with the medical anthropological and other medication related frameworks presented in the literature review to discuss the results specific to this research. Finally, Chapter 9 addresses both the contributions and limitations of this research and provides some concluding remarks on the insights arising from this research.

The epigraph speaks to the wisdom of the elderly. The elders who participated in this research had much to teach about their experience of taking multiple medications. Their stories were revealing, inspiring, and oftentimes heart breaking. Participants were very knowledgeable about the effects of medication use on their lives and the lives of their loved-ones. This thesis aims to present their wisdom.
Chapter 2: Literature Review

Introduction

While seniors in Canada account for only 12 percent of the population, they account for almost 40 percent of pharmaceutical prescriptions filled (Barat et al. 2000). Many elderly people are prescribed multiple medications to treat multiple illnesses (Rollason and Vogt 2003). Furthermore, many seniors use OTC medications daily for conditions associated with old age, such as analgesics for chronic pain (Amoako et al. 2003). Research has shown that the incidence of adverse drug reactions increases with the number of drugs taken (Rollason and Vogt 2003), and that seniors are the members of society most likely to be admitted to hospital as a consequence of an adverse drug reaction (Heininger-Rothbucher et al. 2001, Patel and Zed 2002, Zed et al. 2008). In this chapter, I explore the range of literature that has examined seniors’ medication use from both inside and outside the commonly employed discourse of compliance favoured in allopathic medicine. I also discuss studies that have explored the medication related experience not of seniors, but of people of different ages who use prescription medications to treat various chronic illnesses and medical conditions, from diabetes and asthma to epilepsy and anxiety. Finally, I discuss medical anthropological examinations of illness experience. The anthropological perspective provided by these texts contributes to the relatively small body of literature that has examined seniors’ medication experiences outside of the discourse of compliance by providing a nuanced and in-depth view of the phenomena that shape seniors’ beliefs towards medication.
Medical Anthropological Approaches to Health Beliefs and Practices

Studies within medical anthropology have long focused on health beliefs and practices in various cultural contexts. Early work in this subject area discusses how the practices of medicine and healing are social processes, and how beliefs and responses to disease are cultural constructions (Rivers 1924, Ackerknecht 1971). Another body of literature in medical anthropology considers the beliefs and practices of non-biomedical health practitioners and care receivers. Some of this work has focused on shamanism (Joralemon 1993, Brown 1988), while more recently some have investigated the beliefs and practices of participants involved in alternative therapies (Harwood 1977, Trotter and Chavira 1981, Snow 1993, Brown 1997), and the health beliefs and practices of minority populations in the United States (O’Conner 1995).

Another more contemporary area of study in medical anthropology has focused on patients’ beliefs about, and responses to particular life crises and events that occur within a medical setting. In this context, much research has discussed organ donation and transplantation (Joralemon 2003, Lock 1995, Sharp 1995, Fox and Swazey 1974, 1992, Ben-David 2005), pregnancy (Mitchell 2001), childbirth (Davis-Floyd 1993), and amniocentesis (Rapp 1999). Some medical anthropologists have explored the health practices and beliefs of biomedical professionals (Taylor 1988, Kleinman 1988, Galanti 1991, Singer 1987, Fitzgerald et al. 2005), while others have examined the health beliefs and behaviours that older adults believe are important within the context of particular diseases and chronic conditions. For example, anthropological methods have been used to examine beliefs about cancer (Mathews, Lannin and Mitchell 1994), arthritis (Gray 1983), urinary incontinence (Mitteness and Barker 1995), and general health promoting
behaviours (Arcury, Quandt and Bell 2001). How multiple chronic conditions associated with ‘frailty’ in the very old may limit social connections to others and are differently reported by men and women as feelings of independence, or dependence has also been closely examined (Stephenson, Wolfe, Coughlan, and Koehn 1999).

Medical anthropological studies that have focused specifically on prescription medication have examined peoples’ experience of taking medications for asthma (Snadden and Bell Brown 1992, Adams, Phil and Jones 1997) and diabetes (Ferzacca 2000). These studies provide insight into the manner in which people come to accept the use of drugs for diabetes and asthma and touch upon the social identities associated with the use of prescription medications used to treat these diseases. Snadden and Bell Brown’s exploration of experiences related to asthma medication also illustrates the manner in which users of asthma medications equated taking the medication with taking control over the disease’s debilitating symptoms (1992). There do not appear to be any studies (other than clinical trials) associated with the use of non-prescription, over-the-counter medications by any age group, other than those that tally the economic aspects of their widespread use. Despite this extensive range of medical anthropological studies related to the health beliefs and practices of individuals in a variety of contexts, there is a lack of work that focuses specifically on the beliefs and practices of elderly people who participate within the world of biomedicine as patients, particularly their attitudes and beliefs towards medication in general.
The Extent and Limitations of Compliance Studies

Outside of medical anthropology, research focused specifically on the attitudes and beliefs of the elderly towards medication use has been completed in the health and social sciences fields. However, the majority of this work has centred around what is termed compliance – or the extent to which elderly patients who use multiple medications adhere to the prescription demands of their health practitioner (Lorenc and Branthwaite 1993, Belcher, Fried, Agostini and Tinetti 2006). However, as Smith and Stephenson (2007) have illustrated, the concepts of compliance and non-compliance form a discourse that is laden with negative connotations of “control, domination, obedience, poor communication and incompetence outside of medicine … but continue to be used within the medical professions” in an uncritical manner (2).

Studies that have examined patients’ beliefs towards medication use within the discourse of compliance have focused on the patients’ ambivalences towards medication (Townsend, Hunt, and Wyke 2003), and view “non-compliance” as a product of the desire of patients to control their symptoms within the context of their daily lives (Hunt et al. 1989). Other studies that have focused specifically on the causes of non-compliance in elderly patients have demonstrated that it is related to the complexity of a drug program (or regime), the type of prescriber, the patient’s knowledge of the purpose of the drug (Lau et al. 1996), and their perceptions of both the efficacy of a particular medication, and of their own ability to adhere properly to a drug regimen (Chia et al. 2006). Other studies have compared rates of compliance amongst young patients and elderly patients. These studies often reflect a bias towards viewing the elderly as
incompetent, and characteristically do not take into consideration the sheer number of prescription medications they may take (Lorenc and Branthwaite 1993).

**Qualitative Studies Particular to Seniors’ Experiences with Medication**

Notwithstanding the extensive body of research discussed above, to date there exists only a small number of studies from within the health and social sciences that focus specifically on the beliefs and attitudes of seniors towards medication, the manner in which seniors understand medication, and how they perceive their medication use experiences outside of the discourse of compliance.

In 1999, Deborah Wendt published a PhD dissertation (Wendt 1999) concerning the manner in which seniors manage medications at home. While Wendt’s qualitative study was similar to my research in design, her findings were uninformative with respect to insights into how seniors actually experience medication use, and how they may understand medication itself. Wendt’s examination does not critically analyze older adults’ experiences with medication so much as describe it as a means of supporting her two-staged grounded theory entitled “the Routine Integration Process” (1999). The potential benefit of Wendt’s account of seniors’ medication experiences is that it stands to expand our knowledge of how seniors manage their medications in the home setting. However, a more critical engagement with her data may have presented a more nuanced understanding of seniors’ experiences with medication.

Mirza (2006) has completed the most extensive and relevant doctoral research related to seniors’ medication use. Mirza demonstrates the complexity of elderly
peoples’ decisions concerning medication practices. In his dissertation, he documents the dynamic nature of “medication taking behaviour” (Mirza 2006: 102). Mirza’s study provides a window into the complex nature of seniors’ attitudes and beliefs towards medication, and helps debunk the notion that seniors are obedient and passive patients. By doing so, Mirza has provided the necessary foundation for this research project, which investigates the beliefs and practices of seniors towards medication use in their everyday lives. Another theme identified by Mirza that corresponds well with my own work is that seniors are actively engaged in decision-making processes concerning whether or not to follow prescription drug regimens.

While there are many points of accordance between Mirza’s study and this research, our two studies diverge on the matter of questions of quality and quantity of life amongst seniors who take medication. Mirza reports that seniors who suffer chronic and multiple illnesses often appear to choose quality of life over quantity of life in their decisions about drug use. In contrast, this research demonstrates that seniors often chose quantity of life over quality of life when deciding to continue taking medications that cause negative side effects. Their understanding that medications for chronic illness possess the ability to prolong life influences this decision. By examining the emic categories and perceptions with which participants understand medication, this study extends Mirza’s documentation of the dynamic nature of seniors’ medication experiences, and provides a description of a greater diversity of understandings of medication use amongst seniors.
Other Medication Experiences: From Epilepsy to Benzodiazepines

Due to the dearth of literature specifically pertinent to the medication beliefs of seniors within the field of medical anthropology, it was necessary to expand the parameters of this literature review to other social groups and disciplines. Research conducted within various fields of social sciences, including sociology and psychology has explored the experiences of women who take medications to treat metabolic disorders (Hunt et al. 1989) as well as persons of both genders who take anti-psychotic medications (Carrick et al. 2004, Gabe and Lipshitz-Phillips 1982), medications to treat epilepsy (Conrad 1985), and medications for chronic illness in general (Shoemaker and Ramalho de Oliveira 2008). While not specific to elderly persons, this body of literature has provided insight into the medication beliefs, perceptions, and practices of the seniors who participated in this research. There was much thematic crossover between these studies. This relatively small body of literature emphasized four significant findings about peoples’ experiences with medications: 1) that contradictory understandings of medications comprise a significant portion of peoples’ medication experiences (Shoemaker and Ramalho de Oliveira 2008, Gabe and Lipshitz-Phillips 1982, Carrick et al. 2004); 2) that medication users negotiate between the negative and positive effects of their medications (Carrick et al. 2004); 3) that medication users sometimes express strong feelings of antipathy towards their medications (Gabe and Lipshitz-Phillips 1982); (4) that peoples’ decisions concerning medications are often characterized by attempts to regain control over both the negative effects of illness symptoms and medication side effects (Shoemaker and Ramalho de Oliveira 2008, Conrad 1985). These thematic
overlaps support Shoemaker and Ramalho de Oliveira’s suggestion that there may exist a common experience of taking medications for chronic illness and conditions that “transcends the specificity of diseases and medications” (2008: 87). Furthermore, these studies provide an analytical framework that is not centered on notions of compliance but instead describes decisions regarding medication use as reasoned actions, both of which are notions that correspond well with the findings and framework of this research.

**Examining Pregnancy and the Three Bodies**

Medical anthropological literature pertaining to the manner in which pregnant women (Browner and Press 1996, Root and Browner 2001) and lactose intolerant women (Kingfisher and Millard 1998) make decisions concerning their bodies provides insight into the manner in which the elderly participants in this study made decisions concerning their medications. This literature offers comprehensive definitions of the two sources of knowledge that pregnant women rely upon in their decision-making processes concerning their bodies. The first, “authoritative” or “biomedical knowledge”, refers to the medical norms and directives they receive from medical professionals (Root and Browner 2001). The second, “embodied” or “subjugated knowledge”, refers to the experiential knowledge that women learn through their bodily experiences of pregnancy (Root and Browner 2001, Browner and Press 1996). This literature demonstrates the manner in which pregnant women negotiate between these two realms of knowledge when making decisions concerning their bodies. Furthermore, Root and Browner (2001) provide a framework for considering the influences and reasons behind the medication related
decisions made by participants in this research that analytically exceeds dualistic notions of compliance.

Nancy Sheper-Hughes and Margaret Lock’s framework for analysis called “The Three Bodies” (1987) provides a useful and widely accepted approach for considering participants’ attitudes and beliefs towards medication use. This framework consists of three notions of the body: “the individual body, the social body, and the body politic”. The individual body refers to the lived experience of the body-self or the individual’s sense of self as an embodied entity (Schepers-Hughes and Lock 1987: 7). The social body refers to the “representational uses of the body as a natural symbol with which to think about nature, society, and culture” (Ibid.), while the body politic refers to the regulation, surveillance and control of bodies (Ibid.). Although ubiquitous within the field of medical anthropology, this framework is a useful analytical tool for this research; and, it is not widely used outside of anthropology. Firstly, the individual body is useful for considering the manner in which elderly participants conceptualize the nature of their bodies and the manner in which their medications function within their bodies as mechanisms of control. Secondly, the social body provides a tool for considering the ways in which participants conceptualize their inclusion within a community of medicated seniors. Finally, the body politic helps us to interpret the manner in which participants understand the broad social ramifications of the regulatory effects of medication use. While the three bodies framework is a useful tool for considering the medication related experience and beliefs of participants in this research, caution needs to be exercised towards its fragmentary structure. After all, there is but one body in which all of this activity is actually going on, and the embodied experience of individuals
encompasses political and social realms simultaneously. This observation has great import when we wish to establish an ethnographic description of how seniors experience medication in daily life in a way that is not fragmented by analytical categories.

The Medicalization of Aging

Related to Scheper-Hughes and Lock’s notion of the body politic is the concept of medicalization. Medicalization has been defined as the process through which “non medical problems become defined and treated as medical problems” (Conrad 1992: 209). Sociological literature concerning the medicalization of aging illuminates some of the phenomena associated with seniors’ experiences and beliefs about medication. Estes and Binney (1989) argue that the medicalization of aging has caused the public to perceive aging negatively as a period of “inevitable decline, disease, and irreversible decay” (594). In his investigation of veterans’ experiences with diabetic medications, Ferzacca reported on the remarkable extent to which his participants had internalized negative representations of aging as pathological (2000: 36). He suggests, “Representations of aging as pathological certainly coincide with a changing body and the sense of self” (Ferzacca 2000: 37, emphasis in the original). The implication of this suggestion is that as people age they begin to associate the bodily changes they experience with their understanding of aging as pathological, which in turn informs their sense of self. In other words, their sense of self is informed in part by the negative cultural attitudes and understandings of what it means to grow old. Similarly, Becker and Kaufman suggest that negative cultural attitudes and beliefs towards old age affect health policies related to
seniors care and posit that they “play a key role in shaping interpretations of illness for both patients and physicians” (1995: 168). They note that little is known about how these negative cultural attitudes and beliefs affect seniors managing an uncertain illness trajectory following a stroke. Following from Becker and Kaufman and Ferzacca’s lead, I suggest that little is also known about how these negative attitudes towards aging affect seniors’ beliefs towards medication use. Examining notions of the medicalization of aging and its associated negative perceptions of aging provides further insight into seniors’ beliefs about the purpose, function, and effects of medication use.

However, recent aging studies have begun to question the rubric of loss and decline that has dominated contemporary theories of aging. Janice Graham and Peter Stephenson’s edited volume “Contesting Aging and Loss” (2010) demonstrates the many ways in which older adults from a variety of geographical locations and socio-economic positions contest the notion of aging as a process of inherent decline and loss. Graham and Stephenson suggest that in contesting loss, older adults question, negotiate, confront, adapt, and surmount the challenges of aging (2010: XV). The narratives woven in this volume from the experiences of elders in countries ranging from the Netherlands, to South Africa and Canada create an image of older adults as capable actors who are able and willing to meet the challenges of the aging process, as opposed to being passive recipients of a process of slow decline. The insights found in Graham and Stephenson’s volume highlight a dualistic element of seniors’ experiences with prescription medications. On the one hand, they seem to conceptualize their need for medication as the product of the functional decline of their bodies, while on the other, they take steps to
confront that physical decline and ensure that it does not come to dominate their daily life.

Lawrence Kirmayer (1992) has discussed how peoples’ illness experience is often articulated through metaphors that are both grounded in, and constrained by bodily experience and social interaction (323). According to Kirmayer, people use metaphors to describe the sensations they feel as they navigate their way through illness. While Kirmayer’s discussion refers to peoples’ use of metaphor to describe their illness experience within the context of patient-physician interaction, it provides an interesting perspective for considering how seniors conceptualize the functioning of their medications.

A paper co-authored by members of the research team responsible for the larger study of which this thesis is a part and soon to be published in the *Canadian Journal of Nursing Research*, reports on seniors’ use of metaphor to describe their daily experiences with medications to treat multiple illnesses (Beuthin, Holroyd, Stephenson and Vegsund, *in press*). The paper describes how the community-dwelling seniors who participated in our larger research project used metaphor to describe their experiences of taking multiple medications to treat multiple illnesses. We suggest that much insight can be gained from listening closely to what seniors communicate through their use of metaphor to describe their experience of using medications on a daily basis. Analysis of participants’ metaphoric language in this context revealed the manner in which participants’ medication experience was characterized by deep ambivalence about taking medications, in which seniors often used metaphors of “hope” and of “being shackled” simultaneously to describe their medication experience. The use of several
other metaphorical language by seniors was also reported, including descriptions of
doctors as authority, metaphorical language about not having “a voice” and not being
“heard”, and metaphors of medication as personifications of states of being. The authors
suggest that by developing awareness to this use of metaphor, and metaphorical language,
health care providers and researchers can better “enter into interpretive understanding of
the dilemmas which may exist for this vulnerable group” (Beuthin, Holroyd, Stephenson

**Conclusions**

The literature sourced from a variety of academic fields reveals that little research
has focused specifically on elderly persons’ beliefs towards their medication outside of
the discourse of compliance. This lack of research demonstrates the need for more
extensive work in this area. Studies that have focused on elderly patients’ compliance
with medical directives may be useful for evaluative purposes, but they ignore seniors as
persons with agency, and may actually view its exercise as a negative outcome. In
support of this, Mirza has stated, “measures of compliance and adherence cannot account
for intentions or the actual medication behaviour of patients” (2006: 31). The findings
that emerge from a critical review of literature from the fields of medical anthropology,
sociology, psychology, and the health sciences described above yield some insights about
seniors’ experiences with, and beliefs towards medication. However, they are, with very
few exceptions, not explicitly studies of medication experiences as described by seniors
talking about their daily lives. This research aims to address the lack of research related
to elderly peoples’ daily experiences with medication. Finally, the multi-disciplinary
nature of the literature discussed above is reflective of the inter-disciplinary composition
of the research team involved in conducting the larger study from which this research is
drawn.
Chapter 3: Methods

Research Team and Methodology

This research is the outcome of a unique collaboration between a group of researchers and health care professionals including; Roseanne Beuthin, MScN and Marilyn Bater, MD from the Vancouver Island Health Authority (VIHA), Ann Holroyd, RN, PhD from Vancouver Island University, Elaine Gallagher, PhD (formerly) director of the Centre on Aging, University of Victoria, Peter Stephenson, PhD from the Department of Anthropology and School of Environmental Studies at the University of Victoria and Centre on Aging Research Associate, and myself, a graduate student in the MA program in anthropology. The research was funded by a combination of grants from the British Columbia Network on Aging Research (BCNAR is a funded research network of the Michael Smith Foundation), and VIHA. Community partners involved in this research included the Oceanside Seniors’ Advisory Network located in Parksville, B.C. The institutional partners were the aforementioned, University of Victoria, Vancouver Island University, and VIHA.

Several team members originally proposed the need for this research based on the documented rise in the incidence of adverse drug reactions experienced by elderly medication users. From an anthropological perspective, the main purpose of this study reflects the long-standing tenets of Sol Tax’s action anthropology. According to Tax, action anthropology is an academic endeavour in which a researcher has “two coordinate goals - he wants to help a group of people to solve a problem, and he wants to learn
something in the process” (Tax 1975: 515, emphasis in the original). In this spirit, it is hoped that the findings of this research and subsequent studies will be used to guide the creation of a health promotion project geared at encouraging safe medication use amongst seniors, and reducing the incidences of adverse drug reactions experienced by elderly Canadians.

I was invited to join the research team after they had created a preliminary list of interview questions comprised of themes established through literature reviews and the Principal Investigator (Peter Stephenson) had conducted interviews with 5 interlocutors who were seniors over the age of 65 who took at least one prescription medication from the Victoria area. At this time, I contributed further questions to the preliminary list based on a review of pertinent anthropological literature that I had completed. This list of questions was used by both Anne Holroyd, and myself during data collection. I worked closely with the team throughout data collection and analysis until we had completed a representative coding scheme of all transcripts. Following this, I engaged with the coded data on my own to arrive at my personal interpretations of the team’s data.

The research team employed an approach to qualitative research sometimes called Rapid Ethnographic Assessment (REA), the purpose of which is to gather essential ethnographic data from a very specific population in a relatively rapid manner. REA is a “methodological approach that is intended to maximize the strengths of the anthropological, open-ended approach to data-gathering, in a manner that permits data to be utilized in multi-staged research” (Bentley et al. 1988: 108). REA seeks to make ethnographic data available to researchers in a prompt fashion through the expedient use of traditional ethnographic research methodologies such as in-depth key-informant
interviews. REA approaches are used in interdisciplinary projects developed to design health intervention programmes (Bentley et al. 1988: 107). While REA is not a perfect replacement for traditional ethnographic approaches that include participant observation and spending extended periods of time in a chosen community, a well-planned and executed research design employing REA guidelines can provide important information about attitudes and approaches to health care services (Ibid.). Furthermore, REA is often a necessary response to budgetary constraints and programmatic time limitations (Ibid.). Given this research’s status as a pilot study, the research team did indeed face both time and budgetary constraints and for this reason, we chose to employ an REA approach. However, within our REA approach we employed principles of the ethnographic interview, therefore ensuring that we were able to learn as much as possible and collect as much insightful data as we could within the limited time we had during our data collection phase.

The advantage of using a REA approach in this research is that it permitted multiple perspectives and ensured that we completed our data collection relatively quickly. The task of interviewing participants was shared between Ann Holroyd and myself over a three-week period. Arguably, because we shared the interview schedule evenly, the same amount of data collection would have taken twice as long if undertaken by one researcher. This was advantageous for our research team, as we were working with elderly, ill individuals. By conducting data analysis in a rapid fashion, we were able to ensure that participants did not exit the study midstream due to illness, rapid changes in health, or loss of availability. Furthermore, as we have different academic and practical backgrounds (she a professor of nursing with years of practical nursing
experience, and myself a graduate student with no experience within a health care setting), we approached the interview process with different perspectives. However, we worked together closely to analyze the data. This ensured that both perspectives were included in the coding scheme, which we co-developed after discussions with the rest of the research team. Conducting ethnographic interviews and employing analysis techniques inspired by grounded theory within the research’s REA approach permitted the research team to move into subsequent analytical steps in a timely manner and with the assurance that the data we collected was representative of the study population’s experiences with medication, as well as the combined expertise of the research team.

The specific methodology that the research team employed within our REA approach was applied ethnography. Through this method, researchers attempt to discover the meanings of peoples’ behaviours, beliefs, and perspectives within the context of the social and cultural worlds they live in (Chambers 2000). Furthermore, it is “inquiry intentionally developed within a context of decision making and directed toward the interests of one or more clients” (Denzin and Lincoln 2000: 641). In a rather antiquated yet accurate description inherited from Malinowski’s perspective on the purpose of ethnography, Spradley explains that the essential goal of ethnography is to “understand another way of life from the native point of view” (1979: 3). Thus the goal of this thesis is to understand and describe the daily experience of medication use from the emic or insiders’ perspective as drawn from interviews with a group of volunteer seniors identified as regular users of at least one prescription medication.

In order to enter the medication related world of participants in a timely and efficient manner, the research team designed a semi-structured, in-depth interview plan
based on some of the principles of the ethnographic interview (Spradley 1979, Fontana and Frey 2000). Ethnographic interviews encourage the transmission of cultural information based on principles designed to help create an atmosphere of trust and comfort between researchers and participants. These principles include choosing an appropriate interview environment, developing rapport between the researcher and participant, and the use of descriptive questions to encourage participants to describe experiences within the context of their daily lives (Westby 1990: 106). We chose to conduct our interviews in a community centre where the majority of our participants regularly attended social events, or in participants’ homes depending on their preference. These were familiar environments in which participants felt at ease, thus ensuring their comfort in participation in the research. During my time in the community, I was invited to attend various social events with several participants, including a tour of a new long term care facility and dinners. These events allowed me to become friendly and develop rapport with several participants. To further establish rapport with participants I held lengthy telephone conversations with them prior to our interview to answer any questions and address any concerns that they had about the study. I also provided refreshments during our interviews, and arranged the interview space in such a way to encourage friendly and casual interaction. I established friendly rapport with staff at the community centre, who were very helpful and excited about the research. This warm relationship also helped participants to feel comfortable and at ease when they arrived at the centre for their interviews. According to Spradley, “language is the primary means of transmitting culture”, and “both tacit and explicit culture are revealed through speech, both in casual comments and in lengthy interviews” (1979: 9). Interview questions were descriptive;
they focused on asking participants to describe their actual experiences with medications through examples in a comprehensive manner. The fact that these questions probed various aspects of participants’ daily medication related experiences availed the researchers of the opportunity to arrive at a comprehensive understanding of their beliefs and attitudes towards their medications, the categories they used to conceptualize what medications are, and the manner in which medications influenced their daily lives. The research team’s decision to employ this fairly descriptive and discursive methodology represents our attempt to learn about, and make explicit seniors’ understandings of medications as they conceptualize them within their own terminology and beliefs.

**Participant Recruitment**

We recruited participants from the towns of Parksville and Qualicum Beach, as well as the larger city of Nanaimo, which are all communities located on the eastern coast of Vancouver Island. We chose to conduct research in this area because of the high proportion of elderly people who live there. The number of seniors who are 65 years of age and older in the area is twice as high as the rest of British Columbia and Canada (Don Hunter Consulting 2006). Qualicum Beach in particular has the highest 65 and older population in British Columbia, and one of the lowest proportions of young children (Ibid.). The area is a desirable for retirees because of the gentle climate, the services and activities available that cater to the needs of seniors, and the large number of older adults living there. There are many parks, golf courses, opportunities for fishing and other outdoor activities, and health care facilities in the region. While the city of Nanaimo is
more urban than the communities of Parksville and Qualicum Beach, all are considered middle class communities. While median household incomes in the area are close the British Columbia average, approximately 75 percent of residents in the area own their homes and live on investment income, free of mortgage costs (Ibid.).

Inclusion criteria for the study dictated that participants needed to be aged 65 years or older, took at least one prescription medication, and were able to participate fluently in an English language interview. Eleven women were recruited, five of which were aged between 65 and 74, and 6 of which were aged 75 and older. Ten men were recruited, six of which were aged between 65 and 74, and 4 of which were aged 75 and older. All research participants were of Western European descent, and were either first or second-generation Canadian citizens. Participants shared similar occupational backgrounds – the majority had worked in professions such as Teaching, Engineering, Health Care, and the Military. Others had run successful businesses servicing the needs of the community. Within the broader context of Canadian society, participants would all be labelled middle class and were able to maintain a high quality of life in a relatively affluent community. The majority had spent most of their lives in the region.

Recruitment was completed with the assistance of the Oceanside Seniors Advisory Network who placed an electronic notice of the study on their website, and paper notices in a community centre in Parksville called Society of Organized Services (SOS). I was invited to attend a meeting of the seniors’ support group at the SOS as a guest speaker. At this meeting, I discussed the increasing incidence of adverse drug reactions amongst the elderly population in Canada, and the need for this research. Many attendees were very enthusiastic about participating, and I was able to recruit half of the
participants that day. Ann Holroyd recruited participants with the assistance of the Nanaimo Lifeline program, an organization that provides assistance for medically at risk individuals in the central Vancouver Island area.

Following their original statement of interest in participation, potential participants were contacted by telephone to confirm their eligibility. Researchers answered any questions that they had concerning their participation during that conversation. Once a potential interview subject’s interest and eligibility was confirmed, an interview was arranged. Volunteers were provided the opportunity to participate in an interview at the SOS building in Parksville, in their homes, or in another location of their choosing.
Data Collection

Approximately 40 percent of participants chose to come to the SOS, while the other 60 percent preferred to meet with researchers in their homes. Participants were welcome to bring a family member or friend for support. Prior to the commencement of the interview, participants were provided with information sheets and consent forms. Participants were informed that they could withdraw their participation at any point before, during, or following their interview. At that time, the researchers also asked participants if they could contact them via telephone to clarify any ambiguities and questions they had during the data analysis process.

As discussed above, interviews were semi-structured and lasted from 45 to 120 minutes. Interviews began with a discussion of the participant’s life, including their educational and occupational background as well as their medical history. Within this discussion, participants often discussed their childhood and other occurrences of personal significance, such as family history and important medical events. Following this discussion, interviews moved into specific questions concerning the nature of participants’ experiences with, and attitudes towards both prescription and OTC medications, including dietary supplements and vitamins.

Data Analysis

All interviews were recorded using a digital voice recorder, then transferred to a computer and transcribed verbatim. Using a technique informed by grounded theory
(Glaser and Strauss 1967), content analysis was conducted upon the transcripts. Immersion into the data was completed through multiple readings of several transcripts. Themes are constructs that researchers identify before, during, and after data collection. They are emergent in character and are derived from multiple sources including; literature reviews and previous research, the characteristics of the phenomenon studied (such as the concepts, behaviours, terminology and phrases used by research participants during interviews), researchers’ values and personal experience with the subject matter, and professionally agreed upon definitions (Powell and Renner 2003, Bernard and Ryan 2012). A coding scheme comprised of the major theme categories that were included in the interview questions, and themes that emerged during interviews and their associated sub-themes was created after Ann Holroyd and I reviewed and coded each line of these transcripts. This analysis technique provided researchers the opportunity to unveil not only participants’ explicit beliefs and attitudes towards medication, but also the tacit perceptions of medications embedded within their descriptions of the manner in which medications function.

Both analysts (Holroyd and Vegsund) independently agreed that saturation, or the point during analysis of thematic categories at which no new information can be found to expand a researcher’s understanding of those categories (Creswell 2007: 240) occurred by the sixth transcript. At this point, no new categories were added to the coding scheme. Saturation at this point was reasonable given the fact that all participants were of similar cultural and socioeconomic background and had spent the majority of their lives in the same geographical location (the south coast of British Columbia) (Carrick et al. 2004). Furthermore, the fact that many of the participants lived in the same community,
participated in social events together, and knew each other as acquaintances and friends meant that as researchers we were able to access a commonly held set of beliefs, a factor that helps explain how we reached saturation when we did. All data was coded and managed using NVIVO 8 software. Pseudonyms are used in this thesis to protect the identity of participants.
Chapter 4: Seniors’ Understandings of Medication

Introduction

In Chapter 4, based on interpretations of our interviews, I provide detailed descriptions of participants’ perceptions of medication. This chapter illustrates the complex and often contradictory nature of participants’ understandings of medication, while detailing the experiences with medications that were common among all study participants. I begin by examining the lack of knowledge that participants exhibited about their medication and the documented reasons for this phenomenon. I also describe participants’ understanding that medications are mechanisms of internal control and some of the repercussions of this conceptualization. The elders of this community have much to teach us about their experiences with medication and the factors that influence their medication use practices. I hope that their voices ring clear in the chapters that follow.

Defining Medication

In the early stages of this research, the term medication was employed to refer to both prescription and OTC medications. The reason for this was that the research team wanted to investigate seniors’ broad experiences with medications based on the recognition that adverse drug reactions can be the product of the interaction not just between prescription medications, but also between OTC and naturopathic remedies as well. Interview questions were designed to encourage participants to separately discuss
their experiences with their prescription medications as well as the OTC drugs and remedies that they took regularly.

Questions that addressed medication-sharing practices revealed a difference in participants’ attitudes towards prescription and non-prescription medications. The majority of participants responded with an adamant “no” to questioning about whether they had shared their prescription medications with other people. They explained that they would be too concerned about the negative consequences of sharing, and would worry that they could induce an adverse drug reaction in another person by giving them an inappropriate medication. They explained that because they did not have extensive, or in some cases, any knowledge of how their medications worked, they were afraid of how a shared prescription medication could harm another person. Only 30 percent of participants hypothetically explored the idea of sharing a prescription medication with another person. However, they specified they would only do so with a person who took exactly the same medications in the exact same dosages as they did themselves. This demonstrates participants’ awareness of the possibility of adverse drug reactions and the care with which they handled their prescription medications.

Conversely, many participants described sharing OTC medications with other people, acetaminophen and ibuprofen being two of the commonly cited examples. When asked to elaborate on why they would not share a prescription medication, and would more readily share an OTC medication such as Tylenol, it became clear that many participants felt that these OTC medications were less significant and serious than prescription medications. Interestingly, not one participant expressed any concern that an OTC pain medication might negatively interact with another person’s medications. This
reveals a conceptual divide between prescription and OTC medications common amongst participants. While participants clearly defined prescription drugs as “medication”, OTC remedies were not. However, it was prescription medications for chronic illnesses that participants discussed in detail, and for this reason, they are the focus of this thesis. As specified in the introductory chapter, unless otherwise identified, the term medication in this thesis refers only to prescription medications that treat chronic illnesses and conditions.

However, it is important to recognize that some of the most dangerous ADRs are often the result of interactions between prescription and OTC medications, and that sharing OTC medications has potentially disastrous consequences. Commonly occurring ADRs include; internal bleeding (especially gastrointestinal bleeding), incontinence, diarrhea, loss of energy, dizziness, mood changes, confusion, memory problems (Stephenson 2009), and seizures (Coleman 2004). The frequency with which these types of ADRs lead to hospitalization and death in countries with advanced medical care systems is startling. Studies of ADRs in Canada and the United States have shown that 19 to 28 percent of hospital admissions for patients over 50 years of age occur because of medication problems (Tamblyn et al. 1994, Col et al. 1990). In Australia, it is estimated that 138,000 people require hospitalization each year due to an ADR (Roughead and Lexchin 2006). Furthermore, studies have shown that the majority of patients in long-term care facilities experience ADRs, some of which are deadly (Cooper 1996). A study out of Liverpool University has suggested that ADRs account for 5700 deaths per year on admission to hospital in Britain (Shepherd 2005) and, in the United States, it is estimated that ADRs are the fifth most common cause of death after heart disease, cancer, stroke,
and lung disease (Motl et al. 2004). Perhaps the most startling figure of all comes from an American study that estimates that more than 100,000 deaths annually can be attributed to serious ADRs in that country (Lazarou et al. 1998). Any public education campaign concerning ADRs should consider these figures and potentially focus on informing seniors about the potential hazards of combining OTC medications, vitamins and supplements with prescription medications. Efforts should also be made to educate seniors about the hazards associated with sharing any medication with another person, either prescription or OTC. Furthermore, it is incumbent on health care professionals and those associated with public education efforts to enforce the notion that while easy to attain, OTC remedies are still medications, and as such, are as potentially dangerous as their prescription counterparts are. In particular, the two classes of medications interact with each other.

**Seniors’ Knowledge of Medication**

A discussion of the knowledge that study participants exhibited concerning their medication serves as a point of departure for this chapter. This starting point is crucial because it provides a launching pad for exploring the understandings of medication that shape seniors’ medication related decisions and actions. Furthermore, it allows us to explore the processes through which seniors arrive at their particular perceptions of what medications are, how they work, and the effects that medications have on their bodies and lives.
The data reveals that all of the individuals who participated in this research possessed only limited knowledge of how their medications worked. Amongst participants, three categories of limited knowledge about medication existed. First, there were persons who possessed some knowledge of the actions that medications took within the body, the specific health condition that a medication addressed (such as heart arrhythmia), or the particular body part targeted by particular medications. Persons in this category represented approximately 25 percent of the study group. Second, were those persons whose knowledge of medication was limited solely to an understanding of the body part or medical condition targeted by a particular medication. Approximately 50 percent of participants exhibited this level of knowledge. Third, were those who had little to no knowledge of either the anatomy or condition targeted by a medication, or the manner in which a medication acted. Approximately 25 percent of participants possessed this very limited level of knowledge. These three categories represent a range of knowledge levels in which individuals grouped within the first category possessed the most knowledge concerning medication, and those in the final category possessed the least amount of knowledge about their medication. It is also important to note that in some cases individuals exhibited a greater understanding and familiarity with a particular medication over the other medications they took.

As an example of category one, when asked about how Prilosec worked (which is the trade name of a medication called “omeprazole”, used to treat symptoms of gastroesophageal reflux disease), Polly responded: “Yes, it calms down the production of acid in the stomach”. Polly was able to articulate the condition that warranted her taking Prilosec, and the manner in which this particular medication helped her condition by
restricting the creation of acid in her stomach. She attributed her high level of knowledge about medication to the fact that she had been taking them for so long. She was diagnosed in her forties with a rare form of psychiatric illness and had suffered digestion problems for many years.

The seniors in category two are exemplified by the response of Mica, a 75-year-old retired banker, who described why she takes Synthroid (a pharmaceutical drug generically called “levothyroxine sodium” that reduces the symptoms of low thyroid hormone) and Dixirit (a pharmaceutical medication generically called “clonidine” that treats vascular fluctuations associated with migraines and menstrual hot flashes). She said, “Synthroid is for the thyroid gland, and the Dixirit is for the hot flashes.” Similarly, Bridgette, a 65-year-old woman who dedicated much of her time to community activities and who had suffered from status epilepsy since her adolescent years, placed an emphasis on what her medications were for and not what they actually did. She explained, “I take Tegretol (trade name)… for the epilepsy … Fosamax (trade name) for osteoporosis once a week.” Answers like these were common throughout our interviews and provide insight into the fact that many participants possessed only a vague idea of the reason why they had been prescribed and took particular medications. These participants had little knowledge of how those medications actually worked to address their health concerns.

Category three participants possessed little to no knowledge about the medication that they took regularly. When asked, the majority of these individuals were not able to provide any information concerning why they took certain medications or the symptom or disorder those medications addressed. The following excerpt of an interview with Belinda, a 68-year-old woman with hypertension, demonstrates this complete lack of
Belinda was able to name with confidence the medications she took, however she had no understanding of how they worked,

R: “How do you think your medications work inside your body?”
B: “No idea, I really don’t know.”
R: “Do you have any sort of theory? What it does?”
B: “I have not got a clue.”

This kind of response was very common amongst research participants. Mary, a 79-year-old uterine cancer survivor who maintained a very positive outlook on life and volunteered frequently within the community, did not have any knowledge of how her medications worked. Of them, she said, “I don’t know how my medications work. I just know that they work.” In this statement, Mary alludes to her embodied sense of knowledge that her medications were working. She took her medications regularly and could physically sense that they performed some kind of beneficial action within her body, but she was not able to provide any other information concerning the mechanics of how they worked.

Quite often participants described the functioning and effects of their medications via physical or embodied sensations. It was through an embodied sense of wellness that participants derived the knowledge that their medications were addressing their health concerns and chronic illness. Furthermore, several participants reported knowing that something was going wrong due to an embodied sense of not being well that they experienced after they took certain medications. This phenomenon will be explored further in the following chapter. It was through these physical, embodied sensations that all participants discerned both the positive and negative effects of their medications.
The above discussion illustrates the range of knowledge that the seniors who participated in this study had about their medication. At best, some participants were able to explain why they consumed particular medications regularly and how those medications functioned. However, the vast majority of participants had little to absolutely no understanding of how their medications worked, and in some cases why they took them in the first place. With such a high level of constrained knowledge, the prevention of ADR’s can be seen as a challenge that centres on the importance of communicating a sense of what medications actually do. That challenge falls squarely upon the medical profession as a far too frequently neglected responsibility.

**The Situated Domains of Knowledge: Experts and Others**

Regardless of how much or how little knowledge participants had concerning medication, they all placed their personal understanding of medication within a dualistic context of expert knowledge versus layperson knowledge. For the seniors who participated in this study, comprehensive and technical knowledge of the physiological processes induced by medications was seen to be the responsibility of physicians and other health care professionals, not of those who actually consumed the medications.

While some seniors were content to leave this technical understanding in the hands of the trained professionals that administered their health care (a point to which I will return shortly), others sensed that their physicians withheld information pertaining to the mechanics of their medications. In a very animated and frustrated tone, Bridgette described how her doctor had never explained to her how her medications worked.
“Never, and that’s not me forgetting. Nobody has ever said ‘this opens and does this, and this is absorbed by’. No never.”

Belinda echoed this frustration. While describing her general experience in the doctor’s office, she said, “… they don’t seem to tell you anything”. While several participants expressed frustration that their physicians seemed to purposely withhold information, others did report feeling that their physicians were reliable sources of information about medication, and that their doctors provided informative responses to their medication related questions.

Thirty percent of participants reported having forgotten what their doctors had taught them about their medications. These individuals tended to blame their forgetting on their aging mind, or the circumstances of their visit to the doctor. Ignatius was a 65-year-old with an extensive history of cardiovascular disease. In recent decades, he had suffered several strokes and heart attacks. He frequently volunteered for medical studies related to heart health. Ignatius reported how one time his doctor disclosed important information to him about his medications while he was still under the influence of antihistamines. “At the end of the procedure they tell me all this stuff that I’m supposed to know and I don’t remember a thing they tell me because I’m so dopey because I have so much Benedryl in me.”

However, despite the feelings of frustration described above, the vast majority of participants in this study appeared to be content with their own personal (albeit limited) understanding of their medications. For these individuals, the technical information about medication was irrelevant to their needs so long as they could sense that their medication was working or, in their words, was “doing what it is supposed to do”. This
sentiment was often associated with an embodied sense of wellness, a phenomenon exemplified in the following passage from Brian, a 69-year-old ex-smoker with a family history of hypertension. In this passage, Brian responded to a question concerning his efforts to learn more about his medications. He replied, “I haven’t. I’m an ignorance is bliss kind of guy. As long as I feel good and can keep going.”

This propensity to not want to know more about medication was tied not only to an embodied sense of wellness produced by medications; it was also strongly linked to a feeling of hopeful gratitude towards those drugs. Primarily, study participants were grateful that medications that addressed their health concerns existed. This gratitude was enmeshed with a sense of hope; hope that the medications they were taking functioned the way they were supposed to. The following passages illustrate this sense of hopeful gratitude towards medication. According to Bridgette, “You take them [medications] with water and hope for the best. I don’t think about it.” An 83-year-old woman named Debbie, who suffered from arthritis and underwent hip-replacement surgery in 2000, expressed a similar sentiment. She did not want to be bothered by thinking about her medications, and was happy to continue taking them so long as they appeared to work. She said, “I guess I don’t want to think about it. I just want it to work.” A statement made by Madge, a 77-year-old retired nurse, illustrates the relationship between many participants’ lack of desire to have knowledge of how their medications work, and their quasi-religious sense of faith that their medications would aid, not injure, their bodies. She explained,

“Well I hope that they all know what they are supposed to do. I take them in the morning and think ‘oh my god, I hope you guys know what you’re doing down there …’”
Jack, an 85-year-old war veteran, provided insight into the sense of hopeful gratitude that corresponded with participants’ lack of desire to know any more than absolutely necessary about the mechanics of medication. He explained,

“I have done a lot of slaughtering, but I haven’t seen the insides of a human being. I know what my doctor has explained to me and I don’t waste time thinking about it. I haven’t got much time left. It’s all on the way out now. So I have to enjoy what time I have left.”

This passage demonstrates a perception that knowledge of medication is tied to an ability to see inside the human body. Since Jack and the other participants of this research did not have this ability, they were content to leave this knowledge in the hands of the people who are capable of doing this - their health care professionals. Jack and others, who perceived that their lives were coming to an end, did not wish to dedicate extensive periods of time learning about the mechanics of their medications. They left that knowledge in the hands of those they entrusted with their medical care and focused on other important matters in their lives.

Tied to this sense of hopeful gratitude was participants’ opinion that they really were not any better off knowing how their medications worked. For many participants, it was more important to trust their medications would do what they were supposed to do, than to develop an extensive knowledge base about them. In response to a question concerning how she would go about gathering more information about her medications, Bridgette responded,

“I can’t see wanting to know that. I’m not a scientist, I wouldn’t understand what he was saying if he was talking his language. I just have to trust. Am I going to be any better knowing how it works? No.”
These quotations reveal that many participants perceived that a conceptual division exists between the medication-related knowledge that trained medical professionals and laypeople possess. Professional knowledge was linked to an ability to see and clearly understand human anatomy and the physiological effects of medication. Participants who did not have this kind of technical knowledge and familiarity with medication came to trust and have faith that their medications would have a positive effect on their bodies and would “do what they were supposed to.”

However, approximately 50 percent of participants did report making efforts to research and educate themselves about their medications. This number demonstrates that while they were generally content to not have extensive, technical knowledge about their pills, these individuals did seek out professional assistance when they had questions concerning their medications. Interestingly, all of the individuals quoted above as saying that they preferred to not know about their medications reported speaking to health care professionals about their medications. The individuals within this group felt that despite having the power to prescribe medications, doctors were not reliable sources of information because their training was broader in scope than pharmacists, and they were not as easy to see due to the need to book an appointment to visit them. These individuals reported that they received medication information from pharmacists, community health nurses, and even community centre programmers. Participants felt that these professionals were more reliable, and easier to access than family doctors or specialists. Approximately 30 percent of participants also considered print information about medications to be educational and convenient reference sources. This print information included the literature inserts that accompany prescription medications, the
British Columbia Health Guide, and Pharmacopeia. Fifty percent of participants reported consulting Internet websites for medication information.

Participants also drew from social sources of information about particular medications. Social sources included advice and suggestions made by family members (particularly spouses), friends, and community members.

The following section moves into a discussion of the understandings of medication that were common amongst the seniors of the communities who participated in this study. Participants’ understandings of medication were grounded in the scenario described above in which many of them were generally not taught about their medications by medical professionals, nor were they generally interested in educating themselves so long as they sensed that their medications worked.

**Seniors’ Understandings of Medication: Malfunctioning Bodies that Require Mechanisms of Control**

This section explores participants’ understandings of medication as they described them within their own terms and categories. I obtained this information by conducting a close read of the manner in which study participants described medications within the context of our broader conversation about their daily experience with them. For the vast majority of study participants, the physiological effects of aging were perceived as malfunctions; the idea being that as the body aged, particular anatomical functions stopped working as they once did. This notion of internal malfunction was central to participants’ understandings of medication. The following discussion will demonstrate the manner in which participants understood medication to be a substance invested with
the ability to keep these internal malfunctions under control. The ultimate effect of this understanding was that participants perceived medications to have the ability to prolong human life. I will begin by exploring participants’ descriptions of their elderly bodies and associated notions of malfunction. I will then focus on discussions of medications as mechanisms of control that keep malfunctioning bodily processes in check. The section closes with an investigation of the manner in which medications were understood by participants to prolong human life.

The majority of participants described increased medication use as an inherent characteristic of aging. The manner in which they described their bodies, as functional entities, was also central to their conceptualization of medication and how it might or might not work. There was a perception common among the majority of participants that due to the development of an age-related chronic illness such as adult onset diabetes, hypertension, or high cholesterol, some function of their body had begun to malfunction and was no longer able to perform properly. Belinda described her body as being “out of whack” due to age. Berny explained, “I think that you are more likely to have medications as you get older because as your different body parts age, they don’t work as well”. Finally, Polly explained that as people age, their “bodies get fouled-up in one way or another”.

Medications were understood by participants to aid and address the chronic illnesses they had developed with age. For example, according to Polly, medications were the medium through which seniors were able to “curtail the effects” of aging. Therefore, the understood purpose of medication was to control and regulate the bodily malfunctions that had developed over time. The following passages from participants
who suffered from cardiovascular disease and diabetes clearly demonstrate these corresponding notions of flawed bodily functions and control.

Holly, a 66-year-old woman who was diagnosed with adult onset diabetes at the age of 58, clearly illustrated the notion of malfunction and control discussed by many participants. In discussion about her diabetes and the medication she took for it, Holly explained, “The insulin is not being properly secreted in my body so therefore the medication is what is keeping that under control.” Debbie described the anti-depressant generically called “imipramine” that she took in similar terms. When asked how “imipramine” functioned, she responded, “… it has something to do with the bloodstream, it affects it, so that something goes into your brain and regulates it.” Finally, Gord, a 78-year-old retired builder who maintained excellent health his entire life and was taken by surprise when he needed to have a double by-pass surgery in 2006, described his cardiovascular disease medications in similar terms. He explained, “… they must be able to control your system, the fluidity of your blood and up to a point your heart beat.”

Frequently, participants described not only the malfunctioning of a specific body part or function as the result of a chronic illness, but rather a general sense that they experienced of being out of control which their medications were able to address. Polly, who took “lorazepam”, (a generic benzodiazepine used to treat anxiety disorders), illustrated this notion of an embodied sense of losing control,

“When I do get slightly hypo-manic I can take one, and it will calm me down. I can take half a tablet and it will bring me back down enough to realize that I was getting out of control.”
For a final reflection on this notion of a malfunctioning body that is no longer under control, I return to Holly. In discussion about her diabetes medication, she explained,

“You just have to take the medication in order to control it. Actually diabetes doesn’t seem like a serious thing until you hear about it – they call it the silent killer and those types of things. But until you’re out of control, I really don’t think about it.”

Because of their ability to control malfunctioning body parts and processes, participants ultimately understood medications to possess the ability to prolong life. Many participants felt that their medication was one of the largest contributing factors to their longevity (other factors included lifestyle, technological advances and genetics). However, medications were understood to be the key player keeping elderly and chronically ill people alive. According to many participants, medications were able to accomplish this feat because of the manner in which they regulated and controlled bodily processes that had ceased to work the way they once had.

The following indicative words and phrases were repeated throughout our conversations with all participants about their medications, “my medications keep me alive”, “it keeps me going”, “drugs keep people alive”, and “medications prolong life”. These words imply that without medications, participants felt that their lives would have ended at a much earlier point in time.

Many participants welcomed the life-extending ability of medication. These people expressed gratitude that their medications had given the gift of life following the onset of a life-threatening chronic illness. In the case of Bridgette, the 65-year-old woman with status epilepsy, her medication had provided her with functionality and a life.

1. This was exemplified by Mica, who said, “But do we live longer now because of medication, or do we live longer because of our lifestyle? And about all that technology we have on the market now, - to make our life easier – like we don’t have to go and get water anymore, everything is right there at hand”.
that her disease had threatened to take from her since her adolescent years. The following quotation demonstrates her positive perception of medication. This passage is Bridgette’s response to a question I posed about the positive effects of *Frisium*, (the trade name for a benzodiazepine generically called “clobazam” used to treat seizure disorders).

She explained,

“For the most part it made me able to live a productive life. I was able to work, and if it had been my mother’s time, I would have died.”

Bridgette recognized that without her medication, at best, she would not have had the opportunities she had for work, and at worst, her disease would have killed her at a much earlier stage in her life.

For Brian, were it not for his hypertension medications, he felt he would not have survived following the open-heart surgery he underwent several years prior to our interview. He was very grateful that his medications allowed him to spend more time with his family and friends. When asked if he would be alive without his medications Brian responded,

“I don’t think I would be. Seven years ago, I was 62 and I could have died having open-heart surgery, and since then I think it keeps me going. My grandparents, they didn’t have the advantage of that – you stroke out and die.”

These thoughts from Brian and Bridgette highlight the manner in which several participants often compared their lives to that of their elders who did not have access to the same medications and medical technologies. While there were some participants who felt that the combination of a healthy lifestyle and “good genetics” were responsible for their family’s history of longevity, more felt that the reason they were personally living so long was that they had medications to keep their dysfunctional body systems and
chronic diseases in check. This was particularly true for participants who suffered from cardiovascular diseases.

However, the perceived ability of medication to keep a person alive was not always thought to be beneficial by all participants. In the case of persons who suffered from diseases such as terminal cancer, the fact that medication kept a person alive was thought by some to only prolong a person’s suffering. Dan was a 65-year-old who suffered from diabetes and emphysema, but maintained a positive attitude despite his health challenges. To emphasize his understanding that medication can cause suffering by prolonging an intolerable life, Dan described the situation of his brother-in-law who had been diagnosed with stomach cancer. He explained,

“A perfect example is my wife’s brother. He’s dying from stomach cancer and he’s fighting like hell and he knows he’s going to die because it’s inoperable cancer in his stomach. And he is still fighting it and they’re putting him on all these drugs and what not to ease the pain and get rid of the nausea and all this type of stuff. To me all it’s really doing is prolonging things.”

In the context of a debilitating terminal disease, medication’s ability to prolong life had negative connotations for many study participants. As Dan illustrates, there are few benefits to keeping a person alive if it means prolonged suffering. When medications were thought to only be able to provide an extremely ill person with a very poor quality of life, their ability to keep a person alive was much more negatively received. Dan emphasized the perceived life-prolonging quality of medications, pointing out that not every senior he knew welcomed this aspect of the use of medications to treat chronic illness,

“Without the medications we’d be dead a long time ago. And that is causing problems on its own, because people are living too long now – longer than they want to in a lot of cases”.
The quotations employed in this discussion highlight the contextual aspect of medication’s perceived ability to keep a person alive. Medication’s ability to maintain life was welcomed so long as it provided functionality and relief from the symptoms of a chronic illness. However, if a person had become so ill that medication could not positively address the symptoms of a chronic illness and greatly improve their quality of life, then it was thought only to prolong suffering. Many of our participants’ experiences with medications were characterized by these kinds of qualifications and contradictions, which were evident in observations they made about others and themselves. The first section of the following chapter will continue to explore participants’ contradictory perceptions of medication.
Chapter 5: Serious Substances with Significant Effects

“I am very grateful that there is the knowledge and medications to help with the various ailments, diseases, pain, remedies and control medications. They are helpful, but they can be harmful.” (Bridgette)

Introduction

Chapter 5 begins by exploring participants’ contradictory understandings of and ambivalent feelings towards medications. It examines participants’ perceptions that medications were simultaneously helpful and harmful. The chapter describes in detail how participants felt that while medications help increase a chronically ill person’s functionality, they also produce significant negative effects that can decrease the quality of an individual’s daily life. The reported negative physical, social, and emotional effects of medication use will be examined, as well as their ramifications for the participants of this study. The first portion of the chapter closes with an examination of the manner in which these negative effects, coupled with participants’ understanding that medications were very serious mediated many of their decisions concerning medication. The second portion of the chapter addresses the actions taken by participants to mitigate the negative effects of their daily medication regimens. The chapter closes with a discussion of participants’ recommendations for how to improve the quality of life of seniors who regularly take multiple medications.

For the most part, participants felt that medications were very serious. Madge aptly described this when she declared during our conversation that, “Medication is nothing to fool around with”.

During participant interviews, questions concerning
whether or not individuals altered the dosages of medication on their own, commonly elicited remarks about the seriousness of medication. This seriousness stemmed from participants’ understanding that medications can be dangerous and cause harm when not taken properly. The majority of participants accompanied their comments about the inherent danger of medications with remarks that they would not alter their medication regime without the advice of their doctor.

In the following excerpt, Bill, an ex-miner who suffered from industry-related respiratory problems since retirement, discussed the idea of medication as dangerous.

R: “You don’t tend to do things without the advice of a physician?”
Bill: “No, because some of those drugs have been pretty dangerous and we don’t mess with danger.”

Fred, a 76-year-old retired electrician with hypertension and high cholesterol, echoed this conception of medication as potentially dangerous. In a discussion about the fact that he would not alter his heart medication dosages without the consent of his doctor, Fred elaborated,

“I would not do it myself … because I don’t know what the effect might be. I know a lot of medication can be dangerous. With blood pressure it can be very dangerous if you cut it off right away.”

Both of the above passages demonstrate the propensity amongst participants to adhere to the medical directives of physicians based on their understanding that medications can be dangerous when not taken properly. These passages also show participants’ awareness that their personal lack of knowledge of medications could lead them to make medication related decisions that might cause more harm than good. Here we find another manifestation of the contradictory meaning of medication for participants
that I began to discuss in the previous chapter. While on the one hand they felt gratitude that their medications addressed their health concerns and provided them with functionality, on the other hand they were aware that when taken improperly, certain medications could be harmful and could possibly endanger their lives.

The negative effects of medication use

Participants’ conceptualization of medication as something serious and potentially dangerous was grounded in their negative experiences with medications. More than just physical side effects, participants reported suffering both social and emotional effects from extensive medication use. Social effects, for example, could include not being able to join others for lunch, entertain, or to drive, or travel longer distances, or even to go for a walk. In the following pages, I will explore these negative effects and the ramifications that they had for the participants of this study.

When asked to describe their negative experiences with medication, participants most often began with a discussion of the negative physical effects caused by the medications they took. The negative side effects commonly discussed by participants included stomach pain, constipation and other bowel-related issues, weight gain, lethargy, and cognitive impairment such as the inability to concentrate. While approximately 60 percent of participants attributed side effects to one particular medication, roughly 25 percent of participants considered the side effects they suffered to be the product of negative interactions between the different medications they consumed regularly.
In the following passage Bernie, a retired medical researcher, attributed the stomach pain she often experienced to be the product of a negative interaction between two prescription medications that she took regularly for the seizure disorder and acid reflux she suffered. She explained,

“Sometimes I have pains, sort of an upset stomach from it … It might be a combination of having the Losec (trade name) with the Tegretol.”

Madge was also aware that medications could adversely react and cause negative physical effects. In the following passage, she described the bloating she regularly experienced as the negative interaction between the many different medications she took in the morning. She explained,

“Well … I take so many at one time like after breakfast. When I’m finished having breakfast, I can tell, like all medications don’t work together. I feel bloated after that.”

Finally, Dan who experienced several negative physical reactions to different medications offered advice on how to avoid adverse drug interactions. He explained,

“Make sure your doctor is aware of everything you’re taking so that you don’t get unexpected side effects from mixing them because that can be a problem too.”

While a relatively small proportion of participants attributed the negative side effects they suffered to the interaction of different medications, approximately 60 percent of participants were aware of the possibility that their medications could adversely react with one another. However, another way to look at this is to point out that a rather startling 40% had no idea that this was the case. Furthermore, consider that as noted in Chapter 4, not one participant expressed concern that sharing an OTC medication such as ibuprofen and acetaminophen could cause a harmful adverse drug reaction in another
person. While some participants, such as Bernie and Madge chose to put up with the negative physical sensations caused by such interactions, others (such as Dan) took precautions to ensure that they did not take medications that negatively interacted.

The majority of participants discussed more than just the negative physical effects they experienced from their medications. Throughout our interviews, it became very clear that many participants suffered both socially and emotionally because of the medications that they took regularly. I believe that this is one of the greatest insights to be learned from this research as it could have significant impact on future research and policy creation geared towards the promotion of healthy aging.

Interestingly, when asked how medications made them feel, many participants discussed the feeling of relief and security that accompanied the process of taking a medication that addressed their health concerns. However, several participants adamantly responded that they experienced no emotions towards taking their medications. In the words of Bridgette,

“You mean taking my daily dosage? No, you just take it. It’s like having a drink of water. You just have to take those pills to make sure things are regulated.”

However, further discussions with research participants demonstrated that taking medication was emotionally significant and did have a heavy social and emotional toll on the seniors who took several different drugs daily.

As mentioned above, several participants stated that the high dosages they took of certain medications impaired their cognitive abilities. While these participants characterized the more distinctly physical effects of medication (such as bloating) as difficult to cope with, these negative cognitive effects had dire social consequences for
some. Bill’s wife claimed that her husband suffered from a “lack of direction, and lack of concentration because of his medications”. Brian described how his hypertension medication generically called “ramipril” made him “really lethargic and not thinking clearly”. The quality of these participants’ social lives was negatively affected by the fact that their medications compromised their ability to concentrate and think clearly.

These descriptions reflect what Bridgette addressed in an essay she wrote about the over medication of seniors that she prepared for this study\(^2\). Bridgette was not asked to prepare this essay, she wrote it of her own accord, and provided me with it during our interview. In this essay, Bridgette discussed how medication dosages become too strong as the human body ages. In her opinion, what may have once been an acceptable amount of a particular medication becomes too much as a person’s body declines in health and vitality. She described how overly medicated persons lose cognitive functioning and become confused. She wrote,

> “People not just seniors often take several medications a day, several various times per drug, per day -2,3,4 times a day, every 6 hours, once a week, once a month, with food, no food for a half hour, no grapefruit, with a sip of water, with a full glass of water, and the list goes on. It is no wonder that seniors, that anyone, experience memory problems (NOT dementia / Alzheimer’s) or have become “confused”. Anyone who is over medicated will experience a change in behaviour / mood / appetite. Seniors eat less food, drink less water less often, exercise less, walks are shorter, socialize less often for most, BUT we are (often) on the same dosages. This has to play havoc on our systems (emphasis in the original).”

What Bridgette wrote in her essay was very much reflected in the lived-experiences of other participants. These participants described feeling that their medication regimes were very complicated and that the process of taking pills had come

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\(^2\) Bridgette’s essay can be found in its entirety in Appendix A.
to dominate their daily lives. Bill described how his medication regime had come to take over his daily life and dictated how he spent his days. He said, “I am getting bombarded with medication.” Similarly, Molly, an 82-year-old woman with congestive heart failure and advanced osteoporosis described her medication regime as a process that was “taking over [her] life and was not what [she] should be doing.” Dan expressed his frustration with the fact that the logistics of his wife’s medication regime complicated their family’s ability to eat meals and travel,

“It can be a real nuisance trying to time different medications, not so much for me but for my wife. She has about 16 different medications that she has to figure out head-wise. It can screw things around in terms of meals and traveling and what not. You take one suitcase with pills in it.”

In their most drastic manifestation, these complicated and extensive medication regimes caused many participants to lose their ambition to pursue activities that they enjoyed, such as socializing and cooking. The socially constraining aspect of medication use was clearly described by Ignatius. “Some days, maybe it’s the days I really want to go out and do stuff, I have a real desire to get out there and do something, and then you look at this whole tray of bottles and go ‘oh crap’.” Bridgette also described feeling that heavy medication use could constrain seniors’ ability to pursue desired activities. She said,

“I’ve seen these 85-year-old ladies at the church, at the seniors’ centre – they’re all saying they only had a sandwich last night. It’s not that they can’t make a dinner – there is just no will to make it. And why? Because they’re likely overdosed on medication, they might not be at the zombie stage but it sure is affecting them, ambition-wise.”

These narratives illustrate how the negative effects of medication were far more extensive than merely the negative physical sensations associated with side effects.
Clearly, the seniors in this study perceived that medication use had the ability to negatively alter the social fabric of elderly peoples’ lives. In addition to Bridgette’s observation that many seniors lose their ambition and become socially reclusive because of the effects that medications have on their cognitive functioning, the logistics of self-administering many different medications were cumbersome enough that several participants were discouraged from pursuing the activities they enjoyed. These activities included socializing, cooking meals, and going out in public.

The constrained reality caused by extensive medication use had a heavy emotional toll on several participants. Gord and Bridgette, who were both highly critical of the over-prescription and over-use of pharmaceutical medications amongst the elderly population, discussed these emotional effects. In a passage that illustrates the intense emotions that many participants felt towards their medications, Gord also provides insight into the heavy emotional toll that having to take medications to treat a chronic illness had had on him. Gord underwent heart by-pass surgery in 2006. His need for the surgery came unexpectedly and Gord was completely shocked by its occurrence. He described the surprise he felt when told that he needed such extensive surgery only one day after taking a long bike ride, “The previous day I had been on my bike with a group and we had put down 17 miles, and the next day they want to operate on my heart.” Immediately following the operation, Gord thought that he would only need to take medications temporarily. However, he quickly learned that he would have to continue taking medications to maintain the health of his heart for the rest of his life. It took some time for Gord to accept the fact that medications would become a part of his daily life. He said,
“Now I am finally convinced that I have to live with this for the rest of my life. Which is worthwhile but on the other hand it gives you a negative feeling that you are, well almost your masculine pride is gone up in smoke because now you’re dependent on one of those little pills, day after day. So, whereas you still had this feeling that although you are retired you are quite with it, but now you are more or less, demoted to the other part of the population that has had this experience already for years.”

For Gord the need to take medication to control the functioning of his heart represented a loss of his physical autonomy. He felt demoralized that he had become dependent on something external to keep his body alive, and in doing so, had become like all the other seemingly misfortunate people who already had a need for medication.

Bridgette also expressed feeling the sense of lost pride that characterized Gord’s experience of medication. In her essay, she discussed the emotional pain caused by the negative effects of medication that all people suffer. She also alluded to the dualistic nature of her feelings towards medication use.

“When medications are taken correctly they can be most beneficial & life saving. Too much medications, too heavy a dose can & does more harm than good. Our pride is hurt when we can no longer do what we once did. I speak for the young, the adult, & the senior. The person who is toxic on a medication, & sees double (often nauseating), stomps the foot down when walking, reels from one side to another – walking with the appearance of being drunk, is not very happy. We are crying / upset on the inside.”

In the above passages both Bridgette and Gord expose the distressing side of medication use amongst elderly people. Many participants in this study were very upset by their need to take medications to address their health issues and chronic illness, and to ultimately stay alive. These accounts demonstrate how the negative effects of medication use amongst participants were not limited to unpleasant physical sensations, but also included negative social and emotional effects. Furthermore, many felt that the intensity
and complexity of their medication regimes had the ability to cause emotional harm by restricting their daily possibilities and altering the social fabric and enjoyment of their lives.

**The Consequences of Medication’s Negative Effects**

Due to the multifaceted and numerous negative effects of medication described by participants, the vast majority of them reported conducting some manner of cost-benefit analysis for each medication they took. These participants reported weighing the negative effects of a particular medication against its perceived benefits. The results of these personal analyses are telling.

A small minority of participants reported feeling that the negative effects of their medications outweighed the benefits. In discussing the negative effects she experienced from her medications Madge explained,

“Well I always say that the side effects are always worse than the cure from the medication. Because they all have side effects, and it’s the side effects that sometimes do more harm than the medication does good.”

While a small number of participants echoed Madge’s position, it certainly represented the minority. In fact, the majority of participants demonstrated a willingness to cope with the negative effects of their medications so long as they felt that their medications were working to address their health needs and the symptoms of their chronic illness. Nearly all participants expressed an acceptance of the negative effects of their medications in light of the benefits they provided.

Interestingly, close analysis of the data has revealed a very insightful contradiction that emphasizes just how often participants were willing to cope with the
negative physical, social, and emotional effects of their medications. I return to Madge, the participant quoted above as believing that the negative effects of her medications outweighed the benefits they provided. In the following passage, she demonstrates a willingness to put up with the unplanned weight-loss that she experienced because of a nasal inhalant pain medication she took daily.

“I’m going to keep taking it if it’s going to help, and that’s not the worst of it because I’m losing weight and I wanted to lose weight. But I’m losing more than I want.”

Despite Madge’s expressed belief that medications can be more harmful than helpful, she clearly expressed a willingness to cope with the negative effects of one particular medication that she took.

The following passage from Ignatius illustrates the heavy psychological burden of taking medications that he experienced, and the extent to which he was willing to cope with the negative effects that medications had on his life. Ignatius is the participant quoted earlier who discussed how the scheduling and sheer amount of medications that he took every day to treat congestive heart failure often dissuaded him from leaving his house and attending to activities that he enjoyed such as walking. In the following passage, he describes all his medications as an anchor that keeps him grounded in one place. This metaphor is very appropriate considering that he suffered from a lack of mobility due to the numerous medications he took daily.

“Well you take them and you know that you’re going to have this anchor. So there are days when you think, maybe to hell with them, I just won’t take them. I do know people, who have done that, people with heart problems, and they are still alive but they’ve gone downhill. And I just as soon not go downhill. I’m happier dragging the anchor and being able to go around the park than not taking
the medications and 6 months later not being able to go around the park, even though you might feel better for a few months."

Ignatius was an avid walker who had always enjoyed exercising. While he felt that a short walk around the park was less satisfying than the long walks he used to take prior to the onset of his heart failure, he acknowledged that at least his medications allowed him to do that. In his discussion, he compared his life to that of his friends who had stopped taking their medications in order to mitigate their negative effects. However, Ignatius realized that if he did as they had done, within a short amount of time he too would not have had the ability to take even a short walk around the park. He chose to cope with his medications’ ability to anchor him to a limited existence and live a longer (but limited) life, than to stop his medications and live a shorter but less restricted life. He realized that his medications provided him with a particular quantity of life rather than quality of life, and he chose the former over the latter. Furthermore, Ignatius’ perception that his medications provided him with a longer, albeit limited, life is another manifestation of the understanding common amongst participants that medications possess the power to prolong human life.

Furthermore, Ignatius’ description of his medication regime as an anchor provides insight into how much participants were willing to cope with the negative effects of their medications because of their perceived ability to keep a chronically ill body functioning and alive. Ignatius’ claim that he would rather “drag the anchor” of his medication was an expression of personal agency. It implies that he actively made an effort to cope with the effects of his medication by pulling them alongside him as he navigated his way through life, rather than letting them take complete hold of his life and fasten him to a
place where medications and their negative effects could dominate every aspect of his life. I will return to a discussion of similar mitigating actions later. Furthermore, Ignatius’ use of his medication as an anchor illustrates Beuthin et al.’s contention that the seniors who participated in the larger study of which this thesis is a part, frequently viewed their medications as having elements of imprisonment (in press: 10).

The above passage from Ignatius alludes to the proclivity common amongst the majority of our participants to express a strong desire to stop taking medications in order to mitigate their negative effects. Participants discussed how they constantly questioned the necessity of all the medications they were prescribed. The following passage taken from my interview with Mica provides an example of the doubt and questioning that formed a part of participants’ experiences with medications. It also provides an example of the fear of dying that participants felt might result if they did actually stop taking their medications. Of this Mica said,

“T’m just wondering if it is really necessary for me to be taking all those medications … because if I was to go off those medications, what would happen to me? Maybe I don’t ever want to know what’s going to happen if I stop. So I go along with my doctor.”

Much like Mica, the majority of seniors who participated in this research described how they constantly questioned the need for all the medications prescribed to them, and expressed a strong desire to stop taking all their medications because of their associated negative effects. However, just as the above quotation from Mica has illustrated, participants were afraid to stop taking their medications because they did not have the knowledge of what would occur inside their body if they did. This relates back to my earlier discussion of participants’ understanding that medications work by keeping
malfunctioning body systems under control. Mica understood that if a person were to stop taking medications, the bodily functions that had been regulated by medications might cease to be regulated. The ultimate result of this, and a very frightening one for the seniors in this study, was death – the possible occurrence of which Mica did not want to find out. This is not to say that all research participants had a fear of death. In fact, several expressed a readiness for their lives to end. An example is Maddie who felt that her life had run its full course, and after years of fulfillment, and with no remaining family members she was ready to die. In this case, Maddie’s fear was not of dying itself, but the manner in which she might die once she stopped taking her medications.

Aware of the possible outcome of a death that included a prolonged period of uncontrolled bodily functions, participants deferred to their physician’s knowledge of medication and followed their directives. Participants’ lack of knowledge of the potential result of stopping medications was ultimately tied to the fact that physicians and other health care providers were perceived to withhold information concerning medications. Here it is also important to remember that the seniors who participated in this study had at best very rudimentary knowledge of how their medications worked, and at a minimum, a blind faith and hope that their medications worked the way they were supposed to.

However, participants’ lack of knowledge was not the only factor that kept them from stopping their medications. As both Ignatius and Mica explained above, it was medications’ perceived ability to extend life that was the strongest factor that influenced participants’ decision to continue taking medications - despite the negative physical, social, and emotional effects that they caused. Therefore, just as many participants in this study demonstrated a willingness to defer to the authority of their physician, they were
also willing to defer to the authority they understood their medications to possess - an authority grounded in its ability to keep malfunctioning bodies functioning and alive.

So far, I have written much about the physical, social, and emotional ramifications of polypharmacy in elderly Canadians, (the practice of using multiple medications concurrently), as well as participants’ understandings of medication as something invested with the authority to prolong human life. I would be remiss to not discuss the decisions and actions taken by participants to mitigate some of the negative effects of their medications. The following section discusses these mitigating decisions and actions. It also explores the recommendations made by our participants for how Canadian health care providers could work to decrease the incidence of over medication in seniors.

Mitigating Measures and Recommendations

The previous section demonstrated that despite the negative effects that participants suffered because of certain medications, most were not willing to stop taking medications that they understood had the ability to extend the life of their dysfunctional and chronically ill body, although some had considered doing so. However, not all participants chose to put up with all of the negative effects they experienced. In some cases, participants took action to mitigate certain negative effects associated with particular medications and make their lives more tolerable within the context of needing medications to manage a chronic illness. These actions included: 1) altering and skipping dosages of pharmaceutical medications without the consent of a physician, 2) seeking
alternative treatments when medical treatments caused unpleasant side effects, and 3) advocating on behalf of other seniors who appeared to be overly medicated.

This section will further highlight the contradictory nature of participants’ experiences with medication, showing that while on the one hand, they were willing to cope with some of the negative effects of medication; on the other, they took steps to mitigate their extent. My intention here is to discuss the actions taken by seniors outside of the dualistic context of compliance and to demonstrate the complex, idiosyncratic context in which participants made decisions concerning their medications.

As discussed in the previous section, many participants reported not altering their medication dosages because they did not know enough about their medications and they felt that doing so could cause physical harm. They described medications as potentially dangerous when not taken properly. However, several participants did report adjusting their medication dosages without their doctor’s knowledge. These individuals were willing to take their health matters into their own hands because they felt that the directives of their physicians caused negative effects and proved to be inadequate in some manner. Jack, the 85-year-old war veteran who had a very limited history of medication use, was one of these people. Shortly after having been prescribed “pantoprozole”, (the generic name of a proton pump inhibitor used to treat stomach ulcers and gastroesophageal reflux disease) for indigestion, he doubled his dosage from one tablet in the morning, to one tablet in the morning and a second tablet in the afternoon. His reason for doing so was that by the end of the day his heartburn had increased to a level of serious discomfort. He explained,
“So I just doubled the dose and then I told the doctor. And he said ‘well, it’s
double what you’re supposed to have, but if it’s working for you than why should
we stop? It’s not doing any harm’. So I was my own doctor for a while.”

By taking double the amount of medication prescribed by his doctor, he was able to take
control over the heartburn symptoms that were negatively affecting him. Jack’s decision
to counteract his doctor’s orders was more strongly mediated by his negative bodily
sensations than by the perceived authority of his doctor. Interestingly, in this scenario
Jack referred to himself as his own doctor - the person with the authority to alter his
medication regime. Jack’s self-identification as his own doctor helped enable him to
justify his decision to double his dosage.

Brian was another participant who took steps to mitigate the negative effects of a
particular medication. He decided to stop taking a medication generically called
“diltiazem” that treats hypertension because of the negative effect it was having on his
cognitive functioning. He described the sense of relief that he felt once he had stopped
taking the medication,

“And I was just out of it, I couldn’t even think straight. I made an appointment to
see him [the doctor], but I stopped taking it before I went.”

Brian later followed up with his physician and was prescribed another medication to
address his hypertension. However, unlike those who were willing to put up with the
negative effects of particular medications, he counteracted the negative effects of
“diltiazem” by both ceasing to take it and informing his doctor of his decision to do so.

Brian’s physician subsequently prescribed another medication to treat his hypertension.

Other examples of participants who took action to mitigate the negative effects of
their medications include Molly and Gord. Molly was the 82-year-old woman introduced
earlier who suffered from congestive heart failure and advanced osteoporosis. She was prescribed a generic diuretic called “furosemide” to relieve the swelling in her leg associated with congestive heart failure. The unfortunate side effect of this medication is that it caused her to urinate frequently. On days when Molly planned to spend time out of her home, such as Sunday when her son would take her for her weekly grocery trip, she delayed taking her “furosemide” until she returned home. Doing this allowed her to enjoy the limited amount of time that she spent with her son without the discomfort and inconvenience of having to constantly find a place to urinate. Molly’s decision to counteract the directives of her physician was mediated by social forces. Since her medication negatively affected her ability to spend unfettered time with her son, she chose to manipulate her medication schedule, as opposed to allowing it to negatively affect her time with family.

Gord suffered from debilitating diarrhea as a product of the heart medications he was prescribed following his by-pass surgery. After months of complaining to his family doctor and receiving no help, and upon the encouragement of his wife, he turned to the assistance of a naturopathic doctor. This doctor prescribed him a stomach toner made from extracts of ginseng and astragalus. Within six weeks of taking it, Gord’s bowel movements returned to normal. His decision to seek the assistance of a naturopathic doctor was mediated by three factors: the discomfort and health risks of continuous diarrhea, his allopathic physician’s inability to properly assist him with this trouble, and his wife’s advice to seek a non-biomedical treatment.

The above examples demonstrate that participants’ medication related decisions that countered the order of their physicians (or in the case of Gord, to pursue alternative
therapy) were grounded in experiential reasoning. For these individuals, the negative effects caused by particular medications were debilitating enough that they took proactive steps to reduce them. Analyses undertaken within the discourse of compliance would label the above-described actions as non-compliant because they counter the directives of medical professionals. However, examining the broader context within which these individuals consumed medication provides the opportunity to begin to understand the reasoning that supported their decisions. Such a perspective allows us to see this less as a form of disobedience than as a form of adaptation, or even resistance based on a logic of self-preservation. All of these decisions demonstrate acts of conviction in which participants willingly took steps to counteract the negative effects of particular medications that they did not want to stop taking altogether. Participants’ unwillingness to stop taking these medications was based on both their acknowledgement that the drugs addressed the symptoms of their chronic illness, and their perception that they were ultimately keeping them alive.

Given the prevalence of seniors in the Parksville-Qualicum Beach and Nanaimo area that experienced negative affects from medication use, many participants felt compelled to advocate for change. Participants who spoke on behalf of themselves and the other overly medicated seniors they had encountered within their community made a number of recommendations for how to decrease the incidence of over medication amongst the elderly. These recommendations reveal that many participants were members of a well-informed, highly observant community of people who were interested in improving the lot of seniors who are required to take several medications to address the symptoms of chronic illness.
This seemingly contradicts my earlier discussion of how participants had very limited knowledge of the physiological processes induced by their medications. As discussed earlier, many participants did acknowledge that they did not have technical knowledge of medication, and some even confided that they were not interested in learning it, so long as they felt that their medications were working properly. However, the subsequent documentation of the negative effects of medication that participants experienced, and the mitigating actions they took to reduce their suffering, demonstrated that they were indeed experts in the daily experience of multiple medication use. It follows to suggest that while they did not necessarily have technical medical expertise, they did possess an expertise that was grounded in experiential knowledge. As participants confided during interviews, they did not know much about the technical details of medications, but they certainly knew well how it affected their lives, and the lives of those in their community. It is exactly this lived experience and experiential knowledge of medication use amongst elderly Canadians that this research seeks to document.

Several participants discussed the need and importance for seniors to have a person to advocate on their behalf during visits to the doctor. According to the wife of one study participant, the grown children of seniors were the most suitable persons to undertake this duty. She explained that this is due to the decrease in cognitive functioning that accompanies aging,

“Unfortunately the cognitive powers of an older person are going … you almost need a child, not a child, my child, your grown child to go in and be an advocate. I’m still okay, but you really need somebody there to question.”
However, several participants explained that many elderly members of their community did not have a younger family member or another person to advocate on their behalf during their visits to the doctor. These individuals described how they tried to empower those seniors who lacked the support of an advocate to inform their doctors about the complications and problems they experienced with their medications. But, as will be demonstrated in the following passage, this proved to be an extremely difficult task given the fact that many elderly seniors deferred completely to their doctor’s authority and decisions and did not want to “make waves” with their physician.

Bridgette discussed how many of the seniors who she knew from her community did not tell their doctors about the problems they experienced with their medications.

“But I know that there are a lot of older people who have reactions or they’re feeling worse and they don’t want to report it … they know sometimes that it is the medication … but it’s like pulling hen’s teeth.”

Bridgette explained that the reason for this phenomena was that as seniors age they lose their conviction to take care of themselves. While this is clearly not the case for all of the participants discussed above, Bridgette explained this within the context of her own life. When asked if she would inform her doctor if she experienced problems with her medications, Bridgette replied,

“Oh I would, he’d know. But will I feel that ability 10 years from now? I don’t know. Because the will starts to decrease as you get older”.

Given the confounding factors of some seniors’ loss of conviction, their deference to the authority of medical professionals, and the loss of cognitive functioning due to aging that many suffer, several participants acknowledged that advocacy was a very important
component of efforts to reduce the amount of medication complications and adverse drug reactions experienced by seniors in their community.

Furthermore, approximately 30 percent of participants discussed the need for routine and mandatory blood testing as a tool to prevent the occurrence of adverse drug reactions amongst seniors who take multiple medications. The following passage is an extract from Bridgette’s essay concerning over medication in Canadian seniors. In this passage, she alludes to the propensity of medical professionals to delay blood testing until adverse drug reactions have already occurred and to treat the negative effects of one medication with more medication, something that was discussed by many of our participants.

“As a layperson, I strongly believe mandatory blood tests at specified intervals should be enacted. If one is on some medications (i.e. “warfarin” (generic name) a blood test is done each week, in one particular case I know of. Various meds are checked at various times, I presume. The damage is done if doctors wait until we lay in the emergency to run the blood tests. We are treated & given MORE medication to correct the problem. They adjust the medication after the problem, instead of catching the problem before the problem is a problem” (emphasis in the original).

Like Bridgette, it was common for participants to recommend mandatory blood testing while discussing the fact that the Canadian Health Care system does not practice preventative medicine. All of these conversations were couched within a framework of cost. Bernie believed that blood testing was not mandatory because of its inherent expense,

“I’m actually more for preventative medicine. Sometimes in the beginning it costs a little more … but I think the doctors are told to cut back on the lab tests because they are very costly”.
However, participants who discussed prevention did acknowledge that efforts to reduce costs up front by cutting preventative measures such as blood testing only result in heftier costs down the road. I return to Bridgette’s essay,

“If the government’s Care Plan won’t pay for all the blood tests of medications at specified intervals, they will & do pay later as we lay in the emergency ward with various maladies. The aging process is not the only culprit making seniors ill (emphasis in the original).”

In this passage, Bridgette expresses her belief that while medications can be very beneficial, when not kept in check by preventative measures, they can be as harmful as chronic illness itself. This belief corresponds with the statistic that shows that 12 percent of patients admitted to the emergency room at Vancouver General Hospital are due to medication related complications, not because of pre-existing illnesses.

Several participants also discussed the need for physicians to perform on-going evaluations of elderly patients’ medication regimes. Many participants felt that their doctors were more inclined to increase, and not decrease the amount of medication they took. They described frequently encountering a sort of domino effect in which their physicians prescribed a new medication to counteract the negative effects of another. While describing the story of his elderly mother-in-law, Brian discussed this domino effect.

“My wife’s mother had open-heart surgery years ago and every time she’d go to the doctor they kept increasing and increasing her medication and to the point where – one time they admitted her to the hospital and they thought she was simple because she’d been dosed so much. She was in the hospital 4 or 5 days – they took her off all the medications, straightened her out and she was fine. And then back to the doctor and it slowly started again – we saw it happen a couple of times.”

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Brian went on to discuss the need for more frequent and complete reviews of elderly patients’ medication regimes to ensure that incidences like his mother-in-law’s would decrease\(^4\).

Many participants’ experientially based knowledge of multiple medication use led them to conclude that preventative measures should be enacted in order to both increase the quality of life of seniors who take multiple medications, and decrease the number of adverse drug reactions experienced by elderly persons. For these participants, frequent and mandatory blood testing, medication reviews and advocacy all represented actions that could positively influence elderly Canadians’ experiences of multiple medication use.

**Conclusions**

Through an examination of participants’ knowledge and perceptions of medication, as well as the negative effects of medication and the actions taken by participants to mitigate them, Chapters 4 and 5 have discussed the complex and sometimes contradictory nature of seniors’ experiences with medication. While participants thought that medications were helpful, they also understood that they could be potentially harmful. This is the dilemma facing many elderly Canadians who require

\(^4\) Interestingly, in the years since this research began, the province of Nova Scotia has initiated a medication review program for seniors who take multiple medications to treat co-morbidities. The goal of the program is to reduce drug waste, work with elderly patients and other health care providers to optimize a patient’s medication therapy, and to reduce medication related problems (Pharmacy Association of N.S. 2011). In the program seniors arrange to meet with a pharmacist who conducts a complete review of their medications and discusses lifestyle choices that affect their health. The pharmacist identifies any unnecessary and redundant medications and submits these findings in a report to the seniors’ physician. According to one pharmacist that I spoke with in October of 2010, the program has permitted pharmacists in the province to eliminate 30 to 40 percent of some seniors’ medication regimes.
multiple medications to treat co-morbidities. While they may feel a sense of gratitude and relief that medications exist that are able to treat the symptoms of their different health conditions and chronic illnesses, they are well aware of the negative effects of medication use and the harm that these effects can have on their quality of life. However, medications’ perceived ability to keep an elderly, malfunctioning body alive factored strongly in participants’ experiences with medication. Because of this, medication use becomes a tricky negotiation between quantity of life and quality of life, where often quality of life is sacrificed in the name of living longer. Not taking medications to treat particular conditions was a very tempting idea for the participants of this study because they felt it would translate to living without the unpleasant negative effects of particular medications. However, it also meant living for a much shorter period with the uncertainty of what might happen in the absence of the regulating influence of medications that control malfunctioning body processes. Ultimately, all participants respected their medications’ perceived ability to keep them alive, while finding small ways of coping with the negative effects that accompany the gift of a longer life.

Framing this interpretation outside the widespread medical terminology of ‘compliance’ allows us to better understand the competing alternatives that medication represents as a departure from normative bodily experience: it changes things, and whether this is always for the better, is not always clear and very context dependant.
Chapter 6: Discussing the Three Bodies Framework

Introduction

This chapter re-engages with Nancy Scheper-Hughes and Margaret Lock’s “Three Bodies” (1987) framework to discuss participants’ conceptualizations of medications as mechanisms of control that possess the ability to regulate dysfunctional body parts and systems. The chapter begins by relating Scheper-Hughes and Lock’s concept of the individual body specifically to this research. It moves on to discuss their notion of the social body and concludes by examining the application of Scheper-Hughes and Lock’s concept of the body politic to the medication experiences of study participants. Throughout this chapter, references to other pertinent studies and texts will be made to deepen the discussion of participants’ understandings of medications as mechanisms of control.

Individual Body

According to Scheper-Hughes and Lock, the individual body refers to the “lived-experience of the body-self or the individual’s sense of self as an embodied entity” (1987: 7). In this research, questions that addressed participants’ understandings of how their medications worked inside of their bodies elicited responses that demonstrated the extent to which they had come to understand their elderly bodies as entities made of anatomical parts and systems that no longer function properly. For example, some participants with
diabetes described how their bodies were no longer able to secrete insulin properly.

Similarly, some participants with congestive heart failure explained that their hearts were not able to beat and pump blood, as they were once able to do.

The fact that participants associated the increased dysfunction of their bodies with aging was evident in the manner in which they described several of their body parts and systems as anatomical entities that were no longer able to function as they were once able to, and were supposed to do. Recall Polly who described how bodies become “fouled-up in one way or another” as they age. Alternatively, consider Berny, who explained that as different body parts age, they cease to work as well. The manner in which participants described their aging bodies in terms of functional loss supports Ferzacca’s (2000) contention that amongst elderly, male American war veterans, aging is considered pathological. Furthermore, the nature of participants’ descriptions of their malfunctioning, elderly bodies correlates well with Becker and Kaufman’s discussion of how in U.S. society “the aging process is thought to consist of losses: physiological, functional, personal, and social” (1995: 167).

However, according to several participants, particular medications were able to address the dysfunctional body systems that existed in their bodies. Building on the examples provided above, medications for hypertension and arrhythmia were thought by some participants to ensure that an individual’s dysfunctional heart continued to pump blood with the correct pressure and at a constant rhythm. Similarly, several participants felt that medications for diabetes ensured that the correct levels of insulin were maintained within the circulatory system. By addressing the malfunctions that participants understood were occurring inside their bodies, they felt that medications
were able to restore and maintain a state of proper functioning and control. Because of their ability to regulate internal dysfunctions such as those described above, medications appeared to represent some form of external control mechanism, which after having been digested, worked to regulate and exert control within the elderly bodies of participants.

Participants felt that their medications’ ability to regulate dysfunctional body parts and systems ultimately translated to an ability to keep their elderly and chronically ill bodies alive. Consider Fred, who explained that he just simply had to take medications if he wanted to live any longer than he already had. Furthermore, consider Mica who discussed how every elderly person she knew took some kind of medication and that was the reason why they had all lived as long as they had. Participants expressed a recognition that if left alone, their dysfunctional bodies would cease to work altogether. This was evident in the manner in which many individuals compared their lives against the lives of their parents and grandparents saying such things as, “given my condition, if I had lived in my grandmother’s time and did not have access to the same medications I currently have, I wouldn’t be alive”.

In light of Scheper-Hughes and Lock’s definition of the individual body as “the lived-experience of the body-self or the individual’s sense of self as an embodied entity” (1987: 7) and the above discussion, it becomes clear that participants experienced their own bodies as both elderly and controlled, as well as ineffectively regulated by itself. They perceived their body as elderly, in the sense that they contained dysfunctional parts and systems, but also controlled, in the sense that the medications they took worked to regulate those dysfunctional aspects of their anatomy. Many participants expressed feeling a sense of frustration that their bodies had developed a need for medication to
maintain an internally regulated state. This phenomenon is remarkable in light of Graham and Stephenson’s (2010) suggestion that elderly people in different cultural contexts contest the inevitability and notion of decay common to aging narratives in different ways. Building on Graham and Stephenson, the manner in which participants had come to understand their bodies as entities that required regulation by medication is an example of the many ways in which elderly people dispute, negotiate, and sometimes accept the notion of decay and its inevitability that prevails in narratives of aging. In this instance, participants’ conceptualizations of their bodies, which were often fraught with feelings of frustration, as entities made up of parts and processes that had undergone a loss of functionality was central to their understanding of their need for medication.

**Social Body**

Scheper-Hughes and Lock’s concept of the social body refers to “the representational uses of the body as a natural symbol with which to think about nature, society, and culture” (Scheper-Hughes and Lock 1987: 7). This concept contributes to our understanding of participants’ conceptualization of medication by helping us to consider the manner in which they situated their personal experiences of medication as mechanisms of control within the context of the broader community in which they lived.

There appeared to be recognition amongst many participants that a community of elderly people existed in society whose bodies contained dysfunctional systems that required regulation by medication. For these participants, their inclusion in this community was predicated on their personal requirement for medications to treat their
own chronic illness. Gord’s description of how he had become “demoted to the other part of the population that [had] had this experience already for years” after he was prescribed medication that he would require in perpetuity is a productive example of this phenomenon. Shoemaker and Ramalho de Oliveira (2008) reported similar findings in their study of the meaning of medications for patients of all ages. In their discussion of the “meaningful encounter” that comprised a portion of the medication experience, Shoemaker and Ramalho de Oliveira explained how patients who needed to take chronic medication described feeling that they had become part of a group of people who took medications because they were older (2008: 88). While Gord did not specifically state that the community of people to which he had been demoted was elderly, given that we know that participants associated medications with aging, the implication of his statement was that he had joined a community of medicated persons made up primarily of elderly individuals.

Furthermore, in Bridgette’s discussion of the over medication of elderly people, she spoke as a representative of this collective group of people who she felt suffered the consequences of the over prescription of medications by health care professionals. The negative effects she described included physical impairment, lack of motivation, and social exclusion. In this discussion she used the personal pronoun “we” to indicate her inclusion in this community, as in “we are crying on the inside”. Bridgette’s essay provides us with the opportunity to question our assumptions about elderly members of Canadian society and the manner in which they live their daily lives. She invites us to explore the possibility that the quiet, reclusive life that she felt many of the elderly people in her community lived might have been strongly influenced by heavy medication use
and was not simply the status-quo for people of that demographic. Bridgette’s observations on this community of medicated, elderly individuals certainly warrant further academic investigation. A potential place to begin such a study would be to investigate further the connections between medication use and lifestyle choices as experienced by Canadian seniors.

**The Body Politic**

Medicalization is the process through which non-medical problems become defined in medical terms. According to Peter Conrad (1992), it “consists of defining a problem in medical terms, using medical language to describe a problem, adopting a medical framework to understand a problem, or using medical intervention to ‘treat’ it” (211). Conrad classifies the medicalization of aging along with other “natural life processes” that have been medicalized including PMS, childbirth and death (1992: 213). Estes and Binney (1989) assert that the medicalization of aging focuses on the treatment and management of diseases of the elderly from the perspective of medical practice. Scheper-Hughes and Lock define their concept of the body politic as “the regulation, surveillance and control of bodies” (1987: 7). The medicalization of aging is therefore a productive concept for considering how Scheper-Hughes and Lock’s body politic applies to participants’ understanding of medications as mechanisms of control. Arguably, by turning the process of aging and the health conditions that develop because of an individual’s genetic predisposition and a lifetime of particular lifestyle choices into a problem that can be addressed by medical practices and technologies, the medicalization of aging has worked to create a new type of human body, the dysfunctional and
chronically ill, yet controlled body that participants reported having because of their medications.

As discussed earlier in this chapter, the manner in which participants described how their medications were able to control the parts and systems of their body that had become dysfunctional, demonstrated their understanding that their bodies were being internally regulated and controlled by an external source. The image that results when we combine participants’ descriptions of these dysfunctional, yet controlled bodies with their discussion of the community of persons who share this experience is one of a collective of elderly individuals who are intentionally being kept alive by medications that treat the symptoms of chronic illness. While many participants were grateful that their bodies were subject to internal control via medication use, they also appeared to feel that their controlled body existed in relation to notions they held about their “natural” body - a body that once had the ability to function properly without the regulatory effects of medications, but now required medication due to the process of aging. Many participants couched this understanding within a chronological context: they were keenly aware that if they had been alive during their parents’ and grandparents’ eras, they would not have had the same chance to continue living due to the lack of medications to address chronic illness. Herein lies another contradiction in seniors’ experiences with medications: while many participants felt upset by the fact that their body could not maintain a state of natural internal regulation, and many longed to stop taking their medications and return their body to a state of “nature”, they also recognized the impossibility of doing so. While the notion of a natural body, as one that is able to function efficiently without the regulatory abilities of medications, appeared to be
idealized by participants in the study, they also recognized and accepted their need to consume medication due to the fact that the process of aging had altered their body’s ability to regulate itself.

This powerful image leads to many questions. Primarily, why has the medical apparatus targeted the physiological effects of aging as problems that can be solved by medical technologies and medication? This is not a question that can be answered here; it extends far beyond the parameters of this research. However, the negative experiences that some participants had because of particular medications’ ability to prolong life certainly emphasizes the need to ask such questions. Especially considering that one very elderly participant described how she had lived much longer that she ultimately wanted to, a phenomenon that she attributed to her medications’ ability to regulate the dysfunctional components of her body. This particular individual was Maddie, an 86-year-old woman who suffered from amongst other conditions, type-2 diabetes, congestive heart failure, and atrial fibrillation. Maddie was frustrated by her medications’ ability to keep her body functioning and expressed a readiness to die because with her family and friends having all passed away, she did not have anything that she wanted to live for any longer. She welcomed death and wished to stop taking her medications. Nevertheless, like so many other participants who wished to stop taking their medications due to the negative effects they caused, she was afraid to stop because she did not know what would happen to her body if she did. Since no medical professional had ever told Maddie and these individuals about the functions that their medications performed inside their bodies, they did not have the technical knowledge to understand the physiological events that would occur if they stopped. For Maddie and these other participants medications
represented control; without medication, their body would be unregulated, and could possibly become out of control. Therefore, although Maddie welcomed the end of her life, her fear of having an unregulated body ensured that she continued taking her medications.

In his examination of American clinical practice, medical anthropologist Byron Good asserts that the fact that more American health care dollars are spent on the last few weeks of life, as opposed to the first few weeks of life demonstrates the intensity of North American society’s “commitment and technological capacity for extending life” (1994: 87). This commitment directly affected the participants of this study. Both those who were grateful that their medications possessed the ability to keep them alive longer and those who no longer felt gratitude towards this ability, continued to take their medication because of a fear of allowing their dysfunctional bodies to become out of control. For Maddie, who was ready to end her life, the fear was not of death itself, but of the manner in which she might die without the regulatory effects of medication.

As discussed earlier, the gratitude of those participants who appreciated their medications’ life-prolonging qualities was tempered by the fact that the same medications that worked to keep them alive also had many negative effects on their lives. This phenomenon corresponds well with Estes and Binney’s contention that the medical premise inherent to the medicalization of aging “supports the extension of life at all costs … yet it has not been able to extend that life with quality or reasonable costs in ways that are desirable or practical (1989: 595). Consider Ignatius, who was frustrated and disheartened by the sight of his medications every day. He told the story of his friend who had quit taking all of his medications because of the negative effects they caused.
Ignatius explained that his friend lived well and free from negative effects for only a brief period before his health drastically spiralled downhill. This experience encouraged Ignatius to continue taking his medications despite the fact that they inhibited his ability to exercise, and therefore reduced the quality of his life. Alternatively, consider Gord, who continued taking his heart medications despite the fact that they negatively affected his digestive system and represented his demotion to a less healthy and more elderly demographic. Like many other participants in the study, Ignatius and Gord chose the medicated, predictably controlled (albeit dysfunctional) body that their medications produced, over the unpredictable, dysfunctional bodies they otherwise had. When confronted with the decision to stop taking medications to mitigate their negative effects and possibly increase the quality of their daily lives or to stay on medications in order to live a longer yet negatively affected life, all participants chose the latter option over the former.

Interestingly, these results oppose Mirza’s (2006) recent examination of the medication related decisions of elderly Canadian patients. While the goal and results of Mirza’s study were very similar to this research, our discussions diverge on the application of the concepts of quality and quantity of life to our research results. In his application of the “theory of reasoned action” (Fishbein and Ajzen 1975), Mirza suggests that when making decisions about their medications, the participants in his study weighed the risks and benefits of behaviours that would lead to an outcome (108). He writes,

“This outcome was typically based on the reasoned decision to choose quality of life, by modifying or discontinuing the use of medications, over the use of a medication that would prolong life but with unwanted side-effects or burden on their bodies” (Mirza 2006: 108).
While the results of this research do indeed support Mirza’s specific contention that seniors modify and sometimes discontinue the use of medications that cause unwanted side effects, they do not support his suggestion that seniors generally choose quality of life over quantity of life when considering their medications. A significant number of participants in this research reported that despite the negative effects of specific medications, they chose to continue taking those particular pills because they understood that those medications were keeping their bodies alive. This deliberate decision to cope with the negative physical, social, and emotional affects of medication use provides insight into the immense power and authority that participants understood medications to possess, the power to maintain life in the face of probable death. By addressing and treating the health conditions and chronic illnesses that are the cumulative result of a lifetime of making particular choices and the natural process of aging, the medicalization of aging has created an elderly body that relies on medication for its continued existence.

For a final reflection on the body politic of the use of medication to treat the symptoms of chronic illness and ultimately create a human body that lives longer, I return to Byron Good. He writes,

“Sickness, death, and finitude are found in the corpse, the human body. And salvation, or at least some partial representation of it, is present in the technical efficacy of medicine” (Good 1994: 86).

Participants’ understanding that medications were mechanisms that could regulate dysfunctional body parts, systems, and processes supports Good’s assertion. Within the context of the mortal body of the seniors who shared their experiences of medication in this study, Good’s equation of medicine with salvation (by which he implies not strictly
medication, but the medical apparatus) is easy to conceptualize. In their experiences of chronic illness, participants were confronted with their mortality. Medications that could control dysfunctional systems represented some form of salvation because of their perceived ability to extend human life and keep mortality at bay. The concept of salvation via medications’ perceived ability to prolong life is productive for considering the fact that participants chose to continue taking medications despite the negative effects that they caused. In this context, the negative physical, social, and emotional effects that accompanied medication use become unwanted, yet tolerable nuisances associated with the gift of a longer life that medications provided.

Furthermore, this concept of salvation through medication also assists with a possible interpretation of the reverential attitude many participants expressed towards their medications. Within this context, it is not surprising that so many participants expressed faith and hope that the medications they took would beneficially address their health concerns (as evident in expressions such as “I take them by guess or by God” and “I just have to have faith that they will do what they’re supposed to do”). Their faith was grounded in a hope that their medications would control not only the dysfunctional components of their bodies, but also that the medications would not manifest their malevolent side and cause harmful effects.

The concept of salvation via medications’ ability to prolong life is also arguably rooted in participants’ lack of knowledge about the physiological processes induced by the medications they took. As reported in Chapter 4, both the fact that physicians failed to explain to participants how their medications actually worked, and that some participants had forgotten for various reasons, could contribute to the reverential attitudes
that the majority of participants expressed towards their medication. Examining the processes and institutionalized practices through which medication comes to be understood as a source of salvation could be an insightful area for future research into seniors’ understandings of medication.

Concluding Remarks

This discussion has engaged with Scheper-Hughes and Lock’s Three Bodies framework to explore how the conception of medications as mechanisms of control, and prolongers of life was arguably the most influential force that guided participants’ medication related decisions. It was a powerful conceptualization that permeated all of their medication related experiences and informed the decisions participants made concerning how to administer their daily medications and cope with their negative effects. Furthermore, while Scheper-Hughes and Lock’s segmented framework is productive for the purposes of discussing the results of this research, it is crucial to recognize and acknowledge that participants’ experiences of medication were much more holistic in nature. The three distinct categories of analysis presented above (the individual body, the social body, and the body politic) were combined within participants’ daily experience of medication use. While Scheper-Hughes and Lock create a useful set of analytical distinctions, it is crucial to realize that as ‘lived experience’ they are not separate: they are experienced simultaneously and often, in a contradictory way. The nature of the contradictions constitutes embodiment.
Chapter 7: The Contradictory Nature of Seniors’ Medication Use

In a commentary section included in a *Medical Anthropology Quarterly* edition discussing contemporary analyses of the biomedical practice of organ transplantation, Margaret Lock invites her reader to contemplate the dualistic nature of biomedical technologies. She writes that “we have been warned about the Shiva-like character of invasive biomedical technologies: potential creators of happiness but, at the same time, destroyers of society as we know it …” (Lock 1995: 391). While Lock’s position may seem extreme, it is appropriate considering the invasive and extreme nature of the act of replacing a person’s diseased organ with another functioning organ. The parallels between the contradictions she sees in the practice of organ transplantation and the contradictory nature of participants’ experiences with, and perceptions of medication are strong. This chapter engages with studies of peoples’ dualistic understandings of medication to explore the contradictory nature of participants’ understanding that medications were simultaneously helpful and harmful. This literature provides several distinct perspectives for considering the manner in which all participants found themselves negotiating between the positive and negative effects of their medications and their associated perceptions that medications were simultaneously helpful and harmful.

In a recent analysis of multi-aged persons’ experiences of medication, Shoemaker and Ramalho de Oliveira describe both the expected pharmacological benefits of medications, as well as the unanticipated adverse effects that patients experience as part of the bodily effects of medication use (2008: 89). Similar to the results of this research,
the authors explain that for persons with a debilitating illness, medications were understood to be able to provide relief. However, just as participants in this research reported experiencing negative effects from medication use, Shoemaker and Ramalho de Oliveira reported, “medications can cause negative bodily sequelae that are part of a patient’s medication experience” (Ibid.: 89). In order to address the contradictory nature of their participants’ experiences of medication as substances that simultaneously help and hinder, they suggested “the bodily effects of medications … [were] revealed as the experience of a magic elixir and trade offs” (Shoemaker and Ramalho de Oliveira 2008: 89).

Shoemaker and Ramalho de Oliveira’s use of the term magic elixir to describe the beneficial effects of medication experienced by their participants corresponds well with the results of this research, which have shown that medications provided relief and functionality for those participants suffering from the debilitating effects of chronic illness. Furthermore, magic elixir is a particularly appropriate term to apply to this research because the majority of participants in this study reported that they did not know how their medications functioned. In some cases, participants explained that they did not want or need to possess such knowledge. Many described how their health care providers had not taught them about their medications. Others explained that the information was too complicated for them to comprehend, and that they had other priorities given their age and the limited amount of time they felt they had left to live. These individuals preferred to remain unknowledgeable and to let information about the functioning of their medications remain in the hands of trained medical professionals.
However, as Shoemaker and Ramahlo de Oliveira suggest, medications were not only perceived as magic elixirs, but “magic elixirs with significant trade-offs” (2008: 89). Herein lays the contradictory nature of medications for the participants of this research; the very medications that mysteriously treated the symptoms of their chronic illness and provided them with functionality and relief, were also the substances that caused the negative and unpleasant physical, social, and emotional effects they described suffering. In this contradiction, we find a mild manifestation of Lock’s comments of how biomedical technologies have the ability to provide happiness, yet destroy society, as we know it (Lock 1995: 391). The participants in this research live in a society in which life expectancy has increased significantly. However, this increased longevity is not without its consequences. Elderly Canadians may be living longer, but as demonstrated by participants, they do so with the heavy task of coping with the unpleasant, and oftentimes debilitating adverse effects of medications. As this research has shown, many are also living with the emotional burden of relying on medications to maintain functionality, and the complicated task of managing an intense drug regime on a daily basis.

However, it is important to note that the negative effects of medication use did not as heavily affect the quality of life of some participants. For some, the positive effects of certain medications outweighed their accompanying negative effects. However, in the experience of those participants who suffered from significant negative effects of medication use, we are offered a glimpse of the intensity of the trade-offs (to use Shoemaker and Ramahlo de Oliveira’s term) that accompany medications’ ability to maintain functionality and prolong life. Consider Ignatius, who described feeling an intense loss of ambition each morning when he saw his medication jars lined up on the
kitchen table. Alternatively, consider an extreme example, like Maddie, for whom the life-prolonging effects of medications for cardiovascular disease had become negative effects: she felt prepared to pass away, yet could not because of her medications’ regulatory effect on her heart. In cases like these, we also find another manifestation of Lock’s assertion that biomedical technologies have the ability to provide happiness, yet destroy society, as we know it. Cases like Ignatius and Maddie demonstrate how the use of medications has significantly decreased some elderly individuals’ quality of life. Yes, these individuals have lived longer, but with a reduced quality of life and in some cases without the ability to choose how they live and when they die. Maddie’s case in particular is crucial for considering the manner in which medications have the ability to destroy society, as we know it. Her medications’ ability to keep her body alive had co-opted any chance she had in choosing the manner in which her life ends. She was emotionally distraught over this, and felt disempowered in her ability to make decisions concerning her body. In this case, we see how the use of medications to treat chronic illness in the elderly has destroyed many elderly peoples’ ability to affect influence over their own bodies. This phenomenon highlights the need for future anthropological research to investigate important questions surrounding the maintenance of quality of life and quantity of life in the medical treatment of elderly, chronically ill persons.

Shoemaker and Ramalho de Oliveira’s notion of medication as a magical elixir is also productive for discussing the reverential attitude that many participants expressed towards their medications. This reverence was tied to the fact that participants had little to no understanding of the physiological workings of their medications. It was also tied to their contradictory perception of medications as helpful yet harmful substances. It was
evident in the manner in which some participants discussed their medications with a quasi-religious faith and hope that once ingested; their medications would manifest their benevolent side and positively address the symptoms of their chronic illness, and not their malevolent side and cause negative side effects. This attitude was particularly evident in Madge’s statement that after she takes her morning medication, she thinks to herself, “I sure hope you know what you’re doing down there”.

Carrick et al.’s (2004) examination of peoples’ experiences of the negative side effects of antipsychotic medications is insightful for considering the manner in which participants weighed both the negative and positive effects of their medications to treat chronic illness. Carrick et al. explain that a person’s decision to take an anti-psychotic medication is based on how they “weigh up the costs and benefits of the medication, not simply in terms of symptom reduction but the combined level of distress caused by those symptoms and/or by side effects (2004: 30). These results correspond with those of this research and highlight an important aspect of participants’ experiences with the contradictory nature of their medications as substances that are simultaneously helpful and harmful. They reported constantly needing to measure the positive effects of a particular medication against its negative effects. In addition, as Carrick et al. suggest, people often measure the negative effects of a particular medication in conjunction with the negative bodily sensations they experience which are associated with the symptoms of chronic illness. Consider Madge who explained that, “the side effects … sometimes do more harm than the medication does good”. Furthermore, for some participants in this study, this balancing act of weighing the two sides of medication use was further
complicated by their awareness of the fact that certain medications could negatively interact with each other.

A sociological study of middle-aged female experiences of taking benzodiazepines to treat anxiety provides another perspective for considering participants’ contradictory perceptions of medication and the associated process of weighing the benefits and negative effects of particular medications. The authors of this study, Gabe and Lipshitz-Phillips sorted their participants into three categories: high users, intermittent users, and non-users (Gabe and Lipshitz-Phillips 1982: 202). High users had received a minimum of ten prescriptions for benzodiazepines in at least five of the previous ten years, intermittent users received between one and eight prescriptions over less than five of the previous ten years, and non-users had not been prescribed benzodiazepines over the previous ten years (Ibid.: 202). They reported that all participants expressed “a strong antipathy to using drugs of any kind” and expressed ideas about taking drugs that the authors described as “an anti-drug culture” (Ibid.: 203). This culture was based on their participants’ fears and worries of developing a dependence on the medication, a commonly cited negative effect of psychotropic drugs (Ibid.: 203). The authors also described differences in the attitudes of the three groups. Non-users emphasized how medications were likely to cause harm because they were “unnatural” (Ibid.: 204). High users described feeling a sense of hopelessness about the benefits of their medications, but also conceded that they did sometimes help and reported that they took what the doctor had prescribed to them (Ibid.: 204). Intermittent users, who used benzodiazepines in an on-and-off manner, seemed to use the medication in a more discriminating manner (Ibid.: 204). However, participants, especially those
classed as high-users, were able to reconcile their fears and worries about their medications by recognizing that the benzodiazepines that treated the symptoms of their anxiety also worked to improve their daily functionality (Gabe and Lipshitz-Phillips 1982: 205). A confounding issue with benzodiazepines is a set of side effects, which include some serious memory problems and confusion, which can serve to increase anxiety, and lead to even stronger prescriptions. For an aging person, in particular, this nightmare scenario can easily be mistaken either by the patient or by a health care professional as early symptoms of Alzheimer's disease—for which there is no clinical test. Any individual with a history of use of a specific and highly problematic medication such as benzodiazepines could easily develop extremely negative associations with medications in general.

The notion of an anti-drug culture as discussed by Gabe and Lipshitz-Phillips is productive for considering the cautious attitudes that many participants exhibited towards their medications. Arguably, a similar anti-drug culture existed amongst the seniors who participated in this research. It was founded in their perception that medications were very serious and sometimes harmful. It was evident in the fact that many participants constantly questioned the necessity of their medications and expressed a strong desire to stop taking them in order completely mitigate their negative effects. Furthermore, several participants expressed concern that they had become dependent on certain medications to maintain their functionality. While some participants in this research were similar to those in Gabe and Lipshitz-Phillips study in that they were able to reconcile their concerns about their medications’ negative effects with the fact that those same medications addressed their health concerns and increased their functionality, others were
not. Several others reported that the main reason they continued taking a medication was that health professionals had told them that they required it, and they were simply afraid of the consequences of stopping. Arguably, the fear driving this decision was based on their lack of knowledge of both the physiological functioning of particular medications and the consequences associated with not taking them. In these cases, participants were not necessarily involved in a negotiation of the perceived benefits of their medications and their associated negative effects, but rather a process of resignation in which they felt that they simply required medication to treat the symptoms of their chronic illness and to keep their bodies alive. They felt they had no other choice. For these participants, medications’ negative effects were an unavoidable and necessary component of their medication experience.

This research’s departure from Gabe and Lipshitz-Phillip’s findings highlights the need for future examinations of the true intent behind elderly persons’ decisions to continue taking medications that they understand to be sometimes unnecessary and potentially harmful. Furthermore, given the heavy emotional toll that medication use has been demonstrated to have on the seniors involved in this research, it could be insightful to study the emotional ramifications for the elderly of coping with the need to regularly consume a substance that they perceive to be at once dangerous and beneficial.

The above discussion highlights the complex terrain that participants negotiated in their experiences of the contradictory nature of medications. Furthermore, despite the fact that several participants commented that medications “are just medications, you just take them”, their discussion of the complex negotiating process they undertook when considering the positive and negative effects of their daily pills demonstrates the fallacy
of this comment. The complexity of participants’ experiences with medications was also
evident in their need to reconcile their requirement to take medications to address chronic
illness with the fact that those same medications could also produce harmful side effects
that reduced the quality of their daily lives.
Chapter 8: Mitigating Decisions

The previous discussion chapters have demonstrated that all participants chose to continue taking medications that they understood possessed the ability to keep their elderly, dysfunctional bodies alive, even if they did cause negative physical, social, and emotional effects. This particular decision was ubiquitous amongst the seniors who participated in this research. However, analyzing participants’ medication experiences from the perspective of their other drug-related decisions permits a nuanced and detailed discussion of the ways in which some of them did take steps to mitigate the negative effects of particular medications. This chapter discusses those attempts. It focuses on participants’ decisions to skip medication doses, seek alternative treatments and therapies, and even in some cases, to stop taking a particular medication that caused an unwanted negative effect. These decisions represent participants’ attempts to make their lives more comfortable while continuing to take medications that they understood were keeping their bodies functioning and alive.

This chapter engages with a relatively small, but rich body of medical anthropological literature pertaining to the manner in which pregnant women make decisions concerning their bodies (Browner and Press 1996, Root and Browner 2001). The analytical framework provided by this literature is productive for a discussion of participants’ mitigating decisions because it provides the opportunity to avoid conducting a compliance analysis which views a person’s medication decisions in a simplistic and dualistic manner in which one is said to either comply with a medical professional’s
Root and Browner (2001) propose that as opposed to simple compliance or non-compliance with biomedical norms surrounding pregnancy, the health-related decisions of pregnant women are complex acts that result from their negotiation between two bodies of knowledge. The first they term “biomedical” or “authoritative knowledge” which includes the directives and information provided by medical professionals. The second they refer to as “experiential” or “subjugated knowledge” which consists of the knowledge that women have based on their own embodied experience of pregnancy (2001). While pregnancy may seem vastly different from the health concerns of the elderly participants in this research, the model of negotiating terrains of knowledge that this body of literature provides is germane to the mitigating, medication related decisions of participants.

Root and Browner define authoritative knowledge as the “practices that are conveyed to pregnant women through their health providers or other media, which produce and accrue their authority by virtue of their scientific medical origins (Root and Browner 2001: 197). Within the context of this research, participants’ sources of authoritative knowledge included the biomedical information about medications that they received from their physicians and pharmacists, as well as the literature inserts that accompanied their prescriptions, the internet, and other publications such as Pharmacopeia.

Root and Browner define subjugated knowledge as the “practices that do not depend for their credibility or authority on biomedical endorsements; their power to influence prenatal practices is a function primarily of the resonance they have with pregnant women’s needs and experiences, especially those which biomedicine cannot or
does not directly address (Root and Browner 2001: 198). This sort of experiential knowledge relies on women’s sensory experience of their bodies; something the authors claim is subjugated by biomedicine though the lack of recognition of the seriousness of individuals’ sensory experiences (Root and Browner 2001: 202). Related is Browner and Press’s notion of embodied knowledge, which they define as, “the subjective knowledge derived from a woman’s perceptions of her body and its natural processes as they change throughout a pregnancy’s course” (1996: 142). Furthermore, Root and Press describe how the women they researched used phenomenological indicators as diagnostic criteria (Ibid.). In other words, women interpreted physiological occurrences such as breast enlargement and food cravings as signs of pregnancy (1996: 142). Transferring these ideas to the context of this research, the phenomenological indicators that participants drew upon when making decisions to mitigate the negative effects of particular medications included; the negative feelings associated with side-effects such as frequent urination, nausea, irregular bowel movements, and the general sense of “not being well” that participants described feeling. Therefore, for the purposes of this discussion, building on Root and Press (1996), the embodied, experiential knowledge of the elderly medication users in this study was derived from their perceptions of their body and its processes as they changed with the use of particular medications.

Shoemaker and Ramalho de Oliveira (2008) discuss a similar notion of experiential knowledge that contributes to our conceptualization of the embodied and experiential knowledge that influenced participants’ decisions to take mitigating actions against particular medications. In their study of the medication experience of persons of all ages, they describe a series of stages through which people pass in their medication
experience (Shoemaker and Ramalho de Oliveira 2008). The final stage they label as “exerting control”, which follows after a person has first encountered the meaning of a medication, questioned it, has realized the physical effects of medication, and come to understand how medications have become a part of their daily life (2008: 90).

Shoemaker and Ramalho de Oliveira describe this phenomenon of “exerting control” as the point at which their participants “discovered creative ways to manage their medications and exert control over them; in part because they were now knowledgeable” (2008: 90). According to the authors, at this stage medication users have developed a base of knowledge built on their own experiences with the medications that they take (2008: 90). In their own words, “Participants have their own method of learning pharmacology – through experience. They know their bodies and perceive the changes produced by medications” (2008: 90). Shoemaker and Ramalho de Oliveira’s description of this particular stage in a person’s medication experience highlights the experiential nature of peoples’ knowledge of how medications affect their bodies. It also corresponds well with the manner in which participants described their personal understanding of how the medications they took affected their bodies.

**A Spectrum of Actions and Possibilities**

Before continuing, it is important to recognize the difficulty of arguing the mutual exclusivity of participants’ authoritative and embodied, experiential knowledge of medication use. Interplay between the two must have surely existed. Certainly, the realm of biomedical knowledge that participants experienced through visits to the doctor,
consults with the pharmacist, and technical literature influenced the manner in which they understood their bodies. Root and Browner’s discussion (2001) of the embedded nature of women’s knowledge of pregnancy supports this contention. They describe “how difficult it is to isolate the biomedical within pregnant women’s practices and reasoning …” (Root and Browner 2001: 205).

Due to the confounded nature of women’s knowledge of their pregnant bodies, Root and Browner contend that to categorically label one action as “authoritative and the other subjugated is not only disingenuous, it diverts attention from the more important point, that practices are functions of diverse relations with oneself and others, as well as texts” (2001: 206). They provide a spectrum comprised of different levels of resistance and compliance to biomedical norms for analysing the nature of pregnant women’s decisions (Root and Browner 2001: 208). The extreme outside points of this spectrum are absolute compliance and open resistance. Minimal compliance, centre of spectrum, and understated resistance comprise the middle of the spectrum from left to right (Ibid.). Building from this spectrum, but employing the term acceptance rather than compliance, because it better recognizes the ability of individuals to willingly receive information and make informed choices, a spectrum for considering the decisions and actions that participants took to mitigate the negative effects of their medications looks as follows:

Absolute Acceptance … Minimal Acceptance … Centre of Spectrum … Understated Resistance … Open Resistance

This spectrum is productive because it does not categorically label certain individuals’ medication related decisions as simple acts of compliance or resistance. Furthermore, it provides the opportunity to explore the fact that certain participants did not necessarily
only resist, or only accept the biomedical norms, information, and directives for medication use that they received when it came to making medication related decisions. Finally, it allows us to consider the sources of knowledge (biomedical or experiential, embodied) that a participant may have drawn upon when deciding to undertake a particular mitigating action.

Participants’ medication related decisions often appeared to conflict with each other. Frequently, a participant would describe having taking an action that appeared to be very accepting of biomedical norms, as exemplified in the commonly cited decision to continue taking medications despite their associated negative effects. On the other hand, the same individual would also describe decisions they had made concerning a particular medication that appeared to be openly resistant to biomedical directives and knowledge. Consider Gord. During my interview with him, Gord often expressed a total dislike and resistance to biomedical practices that relied heavily on the prescription of pharmaceutical medications to address chronic illness. He was highly sceptical of the true intentions behind the prescribing of medications to elderly patients, claiming that pharmaceutical companies stood to profit from the practice. When his doctor failed to successfully address the negative effects he was suffering from his medications for cardiovascular disease, Gord sought the advice of a naturopath and began taking an herbal remedy to treat the bowel irregularity that his medications caused. On the Root and Browner inspired spectrum for analyzing the nature of participants’ medication related decisions, Gord’s action could be charted towards the right, or resistant side. On the other hand, Gord continued taking his cardiovascular medications as prescribed by his physician, and was loathe to skip even one dosage out of a fear that his heart would cease
to be regulated without medication. This action could be charted closer to the left or acceptant side of the spectrum. In a case like this, exploring the intentions behind Gord’s medication use decisions helps to illuminate why he lived with such a seeming contradiction. On the one hand, he chose to continue taking his medications because of his understanding that those medications worked to keep his body alive. On the other hand, his embodied knowledge, based on his experience of negative physical sensations (bowel irregularity) influenced his decision to seek alternative therapy.

Approximately 25 percent of participants chose to skip or delay taking a dosage of a particular medication whose side effects negatively affected their daily life. Consider Molly, who on Sundays when her son took her out shopping, deliberately chose to delay taking her morning dosage of “furosemide”. Her decision to delay that particular dosage of the diuretic was deliberate and based on her experiential and embodied understanding that the medication caused her to urinate frequently, something that impeded her ability to enjoy her weekly visit with her son. Mirza (2006) refers to seniors’ decisions to skip or delay medications as “drug holidays” (84). He describes them as a “rational response” to the fact that “while the effects on quality of life of some drugs were not necessarily discussed in the clinical setting, the effects of the therapy (on quality of life) were nonetheless experienced by the patient in the personal setting” (Mirza 2006: 84). As suggested by Shoemaker and de Oliveira (2008), Molly’s decision to delay taking “furosemide” represented an attempt to exert control over a medication that she knew negatively affected her body and social life. Here again is another example of a medication related decision that health care professionals might label non-compliant because it purposely countered the directives provided for the medication.
However, on the Root and Browner inspired spectrum, this action might be charted somewhere near the center. In Molly’s decision to delay taking the diuretic we find a decision based on embodied, experiential knowledge that is partially resistant to the biomedical directives associated with that particular medication. However, in her decision to delay, but not completely skip taking this medication, we find her acceptance of the biomedical directive that she required the diuretic to treat the water retention she experienced. In both the case of Molly and Gord, we find an example of the underlying complexity of participants’ decisions to mitigate the negative effects of their medications.

Other participants chose to acknowledge and place more trust in their experiential understanding of how a particular medication affected their body. Some reported having altered or discontinued dosages of certain prescription medications based on their experience of negative body sensations. Consider the decisions of Brian and Jack: Brian chose to stop taking a medication to treat hypertension; Jack chose to increase his dosage of a medication to treat chronic acid reflux. These two men made decisions based more on their experiential knowledge of how a particular medication affected their body. This resulted in actions that could be plotted more towards the right or resistant side of the spectrum, than the acceptant or left side. Brian chose to discontinue taking his hypertension medication because it negatively affected his cognitive functioning. He described feeling dopey and “not with it” when he took the medication. Conversely, Jack increased his dosage of “pantaprozole” to twice the amount recommended by his physician when he was experiencing excruciating heartburn. Both of these men reported their medication decision to their physician, who in turn acknowledged the validity of each man’s decisions. In Brian’s case, his doctor prescribed a different medication for
hypertension that produced less negative effects on Brian’s body. Jack’s doctor followed his lead and increased his prescription for “pantaprozoze”. By doing this the doctor allowed Jack’s experiential knowledge to take precedence over his own professional understanding of appropriate dosages of “pantaprozoze” for a patient with physical characteristics similar to Jack. In general, both of these men took their medications as prescribed and expressed having a healthy relationship with their family doctor. While they may have contradicted the original directives of their physician, Brian and Jack both made decisions concerning their medications that were well reasoned and logical choices grounded in their own experiences. Labelling decisions such as these as non-compliant while failing to look at the context in which they were made does not acknowledge the validity of each man’s experiential knowledge of their medication, and the important role this knowledge plays as a determinate in their medication use habits.

**Desiring Control or Shared Care**

This discussion will now return to the issue of peoples’ desire to exert control over their medication as reported by Shoemaker and Ramalho de Oliveira (2008) and mentioned earlier in this chapter. Similarly, in his study of the reasons guiding seniors’ medication related decisions, Mirza (2006) reports that the participants in his research expressed a desire to exert control over the medications they took (2006: 107). To address this phenomenon, he applied reactance theory (Fogarty 1997) and suggested that “patients react to the authority of the physician and attempt to (re)gain (sic) or maintain control over their own health care” (Mirza 2006: 107). The actions of altering, skipping, and stopping doses of particular medications discussed above can be interpreted as acts of
reactance to both the effects of particular medications, and in some cases (particularly Gord) to the perceived authority of the physician who prescribed that medication. However, they do not necessarily indicate that participants sought complete autonomy or control over their health care through the use of medication. Consider that the majority of participants who reported taking these actions also explained that they usually told their doctors about their decision to do so. Furthermore, consider that many participants in this research discussed the need for better and more frequent monitoring of elderly persons’ medication levels via routine and mandatory blood testing. This illustrates many participants’ recognition that medical professionals, with their education and access to technology, have the ability to see and understand the physiological processes produced by medications. In this case, there appears to be recognition on the part of participants that health maintenance through medication use is a process that cannot be practiced safely without the assistance of trained medical professionals.

While participants expressed a desire to maintain their autonomy and play a dominant role in their health care, as demonstrated in their attempts to mitigate the negative effects produced by their medications, they did not desire total or complete autonomy. It appears that participants desired more of a measure of autonomy or partial form of control over their healthcare when it came to the management of their medications. Participants’ desire for routine monitoring of medication levels presents an interesting conundrum for the Root and Browner inspired spectrum. On the one hand, it represents a strong recognition of their own embodied and experiential knowledge that medications can be harmful, and on the other, it represents an acceptance and even an
endorsement of the biomedical knowledge and expertise needed to ensure safe medication use.

This phenomenon suggests that further anthropological research to investigate the notion of elderly patients as partners and well-informed contributors within a health care setting could prove useful in acknowledging the well-reasoned and experientially informed decisions that elderly people make concerning their medications. Such a partnership would presumably require health care providers to recognize the validity of seniors’ experiential and embodied knowledge of medications and their ability to contribute to the partnership. Furthermore, it would require the acknowledgement from health care professionals of the complexity of seniors’ medication related decisions and a forfeiture of well-entrenched notions of compliance. This notion of partnership and shared decision-making in the health care setting provides an intriguing answer to academic and applied efforts to increase the safety and effectiveness of elderly peoples’ medication use. The following section explores some of the philosophical underpinnings necessary to realize this notion of partnerships within allopathic treatments and management of age-related chronic illness.

**A Partnership between Experts**

The fact that a high number of adverse drug reactions occur amongst elderly medication users cannot be denied. The evidence is in the statistics that show the significant number of seniors admitted to hospital due to drug-related problems and adverse drug reactions (Patel and Zed 2002, Zed et al. 2008, PHAC 1996). However, academic attempts to address this phenomenon that have focused on documenting
peoples’ compliance with medical directives have not improved the situation, and they have also failed to recognize the complexity of seniors’ medication related decisions. As this research has shown, these decisions are too nuanced and complex to be categorized simply as compliance or non-compliance. They need to be examined within their own context and within the context of the deeper understandings that seniors have about what medications are, what they can achieve, and how they affect (positively and negatively) the lives of elderly individuals.

This research is propelled by the contention that we have a lot to learn from the elders whose valuable knowledge about medications is founded in years of experience with the complexities of medication use. Shoemaker and Ramalho de Oliveira allude to the need for medical practitioners to recognize the complexity and idiosyncratic nature of each person’s experiences with medication. They write,

“Since medications are among the most common options in the treatment and mitigation of diseases, it is essential for health care practitioners to acknowledge an individual’s medication experience in order to positively influence patients’ medication-taking behaviours. Patients’ decisions, which at first appear irrational, might be seen as intelligent when a practitioner understands a patient’s unique medication experience” (Shoemaker and Ramalho de Oliveira 2008: 90).

Similarly, Deegan and Drake suggest that the model of shared decision-making that is inherent to contemporary evidence-based approaches to the management of long-term illness provides the opportunity to recognize the complexity of peoples’ medication related decisions, their right to actively participate in the management of their illness through medication, and their expertise in the effects of medication use. They write,

“Using medication is an active process that involves complex decision making and a chance to work through decisional conflicts. It requires a partnership between two experts: the client and the practitioner. Shared decision making embraces current science, individual experiences, the client’s right to autonomy,
informed decision making, the practitioner’s expertise, and the dyad’s skill in forming an alliance” (Deegan and Drake 2006: 1638).

Deegan and Drake’s conceptualization of shared decision-making encourages recognition of the complexity of peoples’ medication related decisions, as illustrated in participants’ decisions to mitigate the negative effects of particular medications. It also supports the notion of patients as informed partners within the health-care setting.

This chapter has demonstrated the complex nature of both the source of knowledge that participants drew upon when making decisions to mitigate the negative effects of their medications, and the diverse nature of those decisions. Neither simply acceptant, nor completely resistant to biomedical directives for medication use, all of the decisions discussed above were made based on a participant’s negotiation between their bodily experience of the effects of a particular drug, and their understanding of the biomedical norms and directives pertaining to that medication.

Theoretically, a model of shared decision-making between health care providers and medication users could provide the foundation for improved medication use experiences for elderly Canadians. In a setting in which health care professionals seek to understand the intentions behind seniors’ medication related decisions, and recognize the validity of those decisions as the product of a medication user’s experiential knowledge and expertise, elderly persons may feel encouraged to more openly share their experiences with, and perspectives of certain medications with their health care providers. While the majority of examples discussed in this chapter were seniors who felt they could discuss their mitigating decisions with their physicians, the majority of the study population reported not wanting to “make waves” with their doctors and therefore
continued to take medications that negatively effected their lives without reporting those effects. Perhaps in a more open and supportive environment, physicians would provide more technical information about medications with elderly medication users. This sharing of information could ensure that seniors develop a more thorough understanding of the functioning of the medications they take. By de-mystifying medications’ abilities, seniors may feel more empowered to talk with their physician about the negative effects they experience, as opposed to suffering quietly under the exaggerated understanding that those medications keep their elderly body alive.
Chapter 9: Conclusions

The goal of this research has been to document how Canadian seniors experience multiple medication use in their daily lives. It has achieved this by examining the emic perspective of medication experience of a group of elderly medication users from the Parksville - Qualicum Beach and Nanaimo communities of Vancouver Island. By tapping into this emic perspective, this research has explored participants’ attitudes towards medication, as well as their deep-rooted perceptions of what medications are, and the manner in which they function. It has shown that the consequences of these perceptions are significant in that they influence seniors’ medication related decisions and actions. Furthermore, it has described both the positive and negative effects that participants attributed to their medications, and their attempts to mitigate the unwanted negative effects that accompanied the use of certain medications.

Contributions and Limitations

This research contributes to recent qualitative investigations that seek to document seniors’ experience with medications outside of the framework of compliance. It expands upon Mirza’s (2006) study of the decision-making processes of elderly medication users. The research presented in this thesis contributes to, and is the product of a collaborative study entitled “A Pilot Study of Seniors’ Experiences with Medications” led by principle investigator Ann Holroyd of Vancouver Island University. The collaborative nature of this larger project ensured that multiple professional and academic perspectives were incorporated into the research design. Without the team
effort of the five academic researchers and health care professionals who participated in this larger project, this thesis would be much narrower in scope. With this in mind, this thesis represents my personal interpretation of the larger project’s analyzed data and is not representative of the whole research team’s perspective. Papers and reports published by multiple team members will incorporate broader academic and professional perspectives.

This research has focused on the medication related experiences of a small and relatively homogenous group of individuals. All the participants in this research were of Western European descent and were either first or second-generation Canadian citizens. Future research into seniors’ experiences with medication should investigate the medication related experiences of seniors of different ethnicities, who have moved to Canada from countries and communities in which the biomedical model of health care does not predominate. Furthermore, subsequent qualitative studies of seniors’ experiences of daily medication use could benefit from an increased study population and from the opportunity for researchers to spend greater lengths of time with participants and in their community. These limitations will be addressed by the following stages of research expanding on the “Pilot Study of Seniors’ Experiences with Medication”.

Conclusions

This research has demonstrated the complex nature of elderly Canadians’ experiences with medication. Not only do seniors rely on multiple sources of knowledge for information about their medications, they have to negotiate between the signals their bodies give them about how their medications positively and negatively affect them, and
the biomedical directives they have been given for safe medication use. Seniors also have complex conceptualizations of what medications are and how they work. They are generally not provided with the technical details of the physiological effects of their drugs, yet they perceive that their medications regulate their aged and dysfunctional body systems and processes. The ultimate manifestation of this conceptualization is that they understand medication to have the powerful ability to keep their aged and chronically ill bodies alive. The consequence of this common understanding is that many seniors continue to take medications that cause negative physical, social, and emotional effects. In the words of Bridgette, these elders “don’t want to make waves” with their physician, so they continue to live with the negative effects despite the fact that their quality of life has been reduced by daily and often extensive medication use. The powerful conceptualization that medications prolong life ensured that the seniors who participated in this research found themselves negotiating between questions of quality of life and quantity of life when managing their pills. For the most part, participants in this study expressed a willingness to compromise the quality of their life in order to obtain the greater quantity of life produced by their medications to treat chronic illness.

Seniors’ medication use is also characterized by their need to negotiate complex contradictions. The very medications that provide relief and functionality also produce unpleasant and sometimes debilitating negative effects. They face this contradiction each time they take a pill. Furthermore, for participants, the need to take medications to control internal malfunctions was considered an inevitable part of the process of aging. However, the understanding that their bodies were being controlled by an external source resulted in participants’ feelings of alienation from their own bodies. And, while feelings
of being alienated from one’s own body, is a part of many peoples’ experiences of illness, having it become an inescapable part of aging denies aging as a normal process. Many participants felt that by taking medications they had lost the ability to exert control over, and perform acts of agency related to their body, which resulted in a powerful sense of social alienation. This had heavy emotional consequences on how participants lived, and on the quality of their daily lives. This thesis has shown that seniors’ medication use is very different from a participant’s suggestion that medications are “just medications – you just take them”. It is a complex negotiation between seniors’ powerful conceptualizations of medications’ abilities, the lived experience of how those medications actually affect their physical body and social and emotional life, as well as the directives and prescribed norms for how those medications are supposed to be taken.

Adverse drug reactions are the dangerous and frequently fatal product of the over-prescription and over-use of medications amongst the elderly population in this country. Indeed, it is the fifth leading cause of death in North America (Stephenson 2009). They are also a significant burden on our already stressed health-care system. In response to this, health care providers and researchers need to further investigate the complexity behind the seemingly simple act of taking medication. We need to acknowledge elderly peoples’ expertise with medication use, an expertise that is grounded in years of experience with the effects produced by particular medications.

Medications are created to address physical symptoms associated with illness. From the perspective of biomedicine, they are prescribed to address those symptoms within patients’ specific organs and body systems. However, from the perspective of medication users, those medications work on bodies that include social and even political
aspects of the self. As the elders who participated in this research have demonstrated, medication use affects change in not only their physical bodies, but sometimes has disheartening consequences on the social, emotional, and political aspects of seniors’ lives. Those effects often cause seniors to make medication related decisions that do not correspond with the directives of doctors and other health care professionals, which are constrained by their intense focus on the physical changes induced by medication use.

Evidently, medications are not experienced in the same manner in which they are prescribed, which creates a set of potential problems around how illness is managed in elderly people. Health care professionals’ efforts to address the widespread problem of ADRs and to understand seniors’ medication use habits have focused so intensely on users’ rates of compliance that they have failed to examine the complex physical, social, and political consequences that seniors negotiate in their experiences with medications. Within this setting, seniors are discouraged from trusting their own experiences with medications and communicating them to their health care professionals. This scenario makes the prevention of ADRs extremely difficult to confront.

The anthropological perspective on the effects of medication use on seniors’ lives presented in this thesis provides researchers with a more detailed and nuanced account of what it means to be a senior who has been prescribed and who takes multiple medications to treat co-morbidities. From this perspective, we view the affected senior from a more holistic perspective that does not disqualify the social and emotional consequences that inform seniors’ management of their medications. This perspective allows researchers to examine the effects of medication use at the point where seniors’ multiple experiences of their bodies intersect, a body that is not purely a physical entity, but one with social,
emotional, and political ties to the people, places and institutions that inform their sense of self.

In order to succeed, efforts to confront and reduce the high rates of ADRs that occur amongst the elderly population need to expand their focus and consider the broad effects of use that participants have taught us about in this research. This expanded focus might encourage open communication between health care practitioners and elderly medication users. Perhaps an effective place to begin would be to follow participants’ advice and instigate a program of medication reviews to remove redundancies in seniors’ medication regimes, such as the Nova Scotian program discussed in a footnote in Chapter 5. Within this setting, elderly medication users would be invited to describe in detail the reasons behind their medication related decisions, which would be considered as a key determinant in their medication management. By taking such a step, all parties involved in seniors’ medication use may begin to open the lines of communication between health care providers and elderly medication users, ultimately paving the way towards safer medication use for the treatment of chronic illnesses amongst the elderly.
Bibliography


ROUSE, CAROLYN. 2004. "If she's a vegetable, we'll be her garden": Embodiment, transcendence, and citations of competing cultural metaphors in the case of a dying child. *American Ethnologist* 31:514-29.


Appendix A
Essay Written by Study Participant Bridgette

August 15, 2008

Recap

Mandatory Blood Testing / too many pills / dosages are too strong – because eating less affects the absorption & we are not as active / medications should not cost us as much / side effects / we don’t want to “make waves”

Too many pills for various ailments are prescribed to seniors. Barring temporary medications, ie antibiotics, etc., the well-intentioned doctor leaves you on that / those dose(s), often without doing a blood test(s) to verify the levels of medications & that the medications are being taken as prescribed and that no problems are arising.

It is only when we become ill, fall and break bones, become unsteady, experience vision problems (seeing double), experience unpleasant side effects, and end up in the hospital, that the blood works are done and the problem(s) are discovered. Perhaps we become toxic on a given medication. I speak from personal experience.

People not just seniors often take several medications a day, several various times per drug, per day -2,3,4 times a day, every 6 hours, once a week, once a month, with food, no food for a half hour, no grapefruit, with a sip of water, with a full glass of water, and the list goes on. It is no wonder that seniors, that anyone, experience memory problems (NOT dementia / Alzheimer’s) or have become “confused”. Anyone who is over medicated will experience a change in behaviour / mood / appetite.

Seniors eat less food, drink less water less often, exercise less, walks are shorter, socialize less often for most, BUT we are (often) on the same dosages. This has to play havoc on our systems. The absorption level changes with the diet change.

Bubble packs are a great invention for some people. Some arthritic hands have problems trying to get into the meds.

I am very grateful that there is the knowledge & medications to help with the various ailments, diseases, pain, remedies & control medications. They are helpful, but they can be harmful.
As a lay person, I strongly believe mandatory blood tests at specified intervals should be enacted. If one is on some medications (i.e. warfarin) a blood test is done each week, in one particular case I know of. Various meds are checked at various times, I presume. The damage is done if doctors wait until we lay in the emergency to run the blood tests. We are treated & given MORE medication to correct the problem. They adjust the medication after the problem, instead of catching the problem before the problem is a problem.

When medications are taken correctly they can be most beneficial & life saving. Too much medications, too heavy a dose can & does more harm than good. Our pride is hurt when we can no longer do what we once did. I speak for the young, the adult, & the senior. The person who is toxic on a medication, & sees double (often nauseating), stomps the foot down when walking, reels from one side to another – walking with the appearance of being drunk, is not very happy. We are crying / upset on the inside. We don’t want to be a bother, so, unless someone intervenes on our behalf, we remain quiet & don’t voice our opinions – “after all, the doctor is a good man, is well-educated & knows more & what is best.”

The care plan is better than no plan. But it could be & should be improved. The Medicare Plan in Quebec, as of 1998, paid 100% less the dispensing fee. The fee was the only cost to the patient.

It costs dearly to be sick & to be elderly. Many of us worry about the cost of medications. Second opinions are a must if we have any doubts about the treatment – but the older we get the less we want to “make waves”.

If the government’s Care Plan won’t pay for all the blood tests of medications at specified intervals, they will & do pay later as we lay in the emergency ward with various maladies\(^*\). The aging process is not the only culprit making seniors ill.

\(^*\) stygmus (or something like it)

\(^*\) preventable
Appendix B
Interview Questions

1. Tell me a little about yourself (educational and occupational background). Just a short sketch not a complete life history! It would be especially helpful if we had some idea of your medical history.

2. What prescription medications do you take? (Study participants will be asked to bring a list of medications that they take).

3. As you look at the sheet in front of you, can you tell me about any non-prescription items that you take; this includes such things as herbal teas or over-the-counter items like Ibuprofen or antacids, medicinal teas, and topical creams and patches.

4. Please tell me a bit more about your overall experience with medication use:
   a. What would you describe as some of your more positive experiences with prescription medications?
   b. … with non-prescription medications?
   c. What would you describe as some of your more negative experiences with prescription medications?
   d. … with non-prescription medications?
   e. Has your experience with (a) particular medication(s) changed over time from when you first began taking the medication?

5. You have just told us about your experience with medication use. We would like you to elaborate on how you believe your medication(s) actually work to address your health issue(s)?
   a. For example, has any health professional ever explained how the medication you are taking actually works?
   b. How would you go about finding out more about how your medication(s) work?
   c. Can you tell me how you think any of the non-prescription medications or other alternative therapies might work?
   d. What words might you use to describe how taking medication makes you feel?

6. Have you ever adjusted your medication dose after consulting with your doctor?
7. Was there ever a time when you decided on your own to adjust the dose or the frequency of your prescribed medication(s)?
   a. Did you tell your doctor or any other health professional about this?
   b. Did specific body sensations associated with the medication(s) play a role in your decision? Can you describe them?
   c. Did you decide to do this based on information about your medication gained from reading, or newspapers, TV, friends or some other source?
   d. How did you feel about adjusting your dose? Were you relieved, anxious?
   e. If you have not, do you think you ever would do something like this without advice?

8. Was there ever a time when you decided not to fill your medication prescription?
   a. Can you tell me about what motivated you in making the decision not to fill a particular prescription? (Probe, if necessary: were there sensations associated with the medication that played a role in this?)
   b. Did you inform anyone else—for example a son or daughter or a friend—that you had not filled the prescription?

9. How confident do you feel about expressing your health related needs to the physician?

10. Do you discuss your medication use with any other health professionals? If so, who?
    a. (If you do) How confident do you feel about that?
    b. (If not) who would you likely talk with about medication if you did discuss it with someone other than your doctor?

11. Other than your physician (or other health professionals), what are some of the ways you might gain information about your prescription medication(s)?

12. Considering what you receive your medication for...
    a. Do you believe that taking medication is a part of aging / growing older?
    b. Do you believe that taking more medications is generally better for your health?
    c. Do you believe that less medication is better for your health?
    d. What factors do you think are most important concerning dosage levels of medications?
13. How do you think your medication(s) work(s) inside your body?

14. Have you ever had the experience of sharing your medication with another person? What was this experience like?

15. Is there anything else that you would like to say about your experiences with prescription or non-prescription medication that we have not discussed?