

A Pill is Not Only a Pill: The Social Meaning of the Elderly's Daily Medications

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Previous studies have shown that the use of polypharmacy among the elderly has been increasing and has become the cause of health risks for the elderly, including higher incidences of adverse drug reactions, increases in sensitivity to drug-drug interactions and a lower total quality of life. In addition, the use of polypharmacy has become a prominent cause of the increase of unnecessary national health costs. This study aims to understand the meaning of drug taking behaviour in the daily life of elderly patients with a focus on their perceptions of the matter. Ethnography and content analysis have been used in this study with the results showing that elderly patients not only use their medications as pharmacological substances but also in a sense involving social meaning. This meaning regards (1) the obligation of elderly users to be good patients, (2) the prerogative of having rights as citizens of the kingdom, and (3) the context of maintaining relationships in health care services, communities, and families. These social meanings of medicines, which were constructed through social discourse, health policies, and socio-cultural systems, could cause the use of polypharmacy in elderly people.

Key words: *Social meaning of medications, Polypharmacy, Elderly, South of Thailand.*

Introduction

One of the most significant challenges that Thai people and the global society are facing is dealing with the health issues of the elderly. The overlap between the concept of ageing and illness seems impossible to deny. The representative image of the elderly does not differ from the image of being a patient who is responsible for their own illness through receiving help



from others, getting cooperative treatment and seeking medical services by themselves (Gabe, Bury, & Elston, 2004). Together with the influence of medicalisation, a large amount of medication or polypharmacy is brought into the context of life and becomes the primary choice for dealing with the health problems of the elderly. Many previous studies reflected that the situation regarding drug use among the elderly tends to increase (Linjakumpu et al., 2002; Veehof, Meyboom-de Jong, & Haaijer-Ruskamp, 2000). The use of polypharmacy is an important cause for the elderly to be at a higher risk of drug related incidents or drug related problem (DRP), higher risk of increased sensitivity to adverse drug-induced side effects, higher risk of drug interactions and drug poisoning or even a higher risk of improper use of medicines that affect the safety and quality of life among the elderly. In addition, polypharmacy use among the elderly causes social problems. More specifically, it is a cause of unnecessary health expenditure (Lee et al., 2013; Leelakanok, Holcombe, Lund, Gu, & Schweizer, 2017; Linjakumpu et al., 2002; Monegat, Sermet, & Rococo, 2014; Pichayapaiboon & Bua-Khwan, 2016).

Using medical and economic perspectives as a framework for determining measures and methods for managing medication use was not as successful as expect in the past. For example, treatment under Directly Observed Treatment (DOT programs) involved forcing the patient to take medication instead of encouraging the continuous use of the drug to achieve the maximum effectiveness. Home visiting programs found faults and monitored the lives of patients, instead of aiming to understand patients' lives. The latter leads to medication design according to their life context. Health policies, such as the Universal Coverage scheme, are standard government health welfare and civil servant medical benefit programs that provide free medical services (with conditions) for government officers. They are seen as involving patient classification that causes inequality and deprivation of access to medicines among the lower classes instead of encouraging the effective use of drugs and promoting reasonable use of drugs.

Social perspectives could be a solution to promote the understanding of this phenomenon more thoroughly. Prasertsuk and Wattananamkul (2011) and van der Geest and Whyte (1988) argue that the use of medication actually relates to the social and cultural context of users. The process of deciding whether drug use is the determination of the appropriateness of drug use cannot pertain to knowledge from other contexts. It does not explain the abundance of prior knowledge. Therefore, the way to understand the behaviour of drug use is that it should be holistically studied in terms of culture, history, and other contexts. The Helman (1981) report is an interesting piece of research that has revealed the social view of the use of medication. He argues that we should not attempt to describe behaviour patterns or definitions based on medical concepts but try to understand and interpret the patterns and definitions from an emic point of view. Thereupon, we will find the reasons behind patients'

drug use behaviour and that this behaviour is more complex and relates to the context of each patient.

The rural south of Thailand is the research setting of this study due to not only the changing of the elderly's living contexts (which are related to globalisation), the existence of medical pluralism, and the complexity of public and private drug distribution systems, but also the small amount of previous studies about medication use among the elderly. This makes this area of research more interesting and challenging in terms of evidence of new information in the field of medical anthropology. It includes knowledge of the culture of medication use among the elderly, knowledge of drug systems in the rural south of Thailand, and knowledge of structural systems to determine drug use behaviour in the elderly. This leads to the formulation of effective drug use policies in both the elderly and society.

This study aims to understand the meaning of medicine in daily life from the view of the elderly that will determine how a large amount of medication exists in the lives of the elderly in the present society.

Methodology

Study population and Sample: Criterion and purposive sampling were applied in this study. Inclusion criteria for key-participants are the elderly who (1) are aged 60 and over; (2) are living in communities 2, 4, 6, and 8 in the Thaiburi sub-district, Thasala district, Nakhon Si Thammarat province, Thailand; (3) were experiencing at least one of three chronic diseases including: high blood pressure, Diabetes Mellitus, and Hyperlipidemia; (4) and take more than one type of medication daily. In addition, the elderly's peers were interviewed when interesting topics were considered. Overall, the 74 participants were divided into 2 groups; 31 elderly key-participants and 43 peers (including 28 family members, 6 neighbours, 5 Medical personnel, and 4 community leaders).

Data collection: This study is based on fieldwork conducted in the Thaiburi community from February to September 2019, with the application of ethnography methodology. An in-depth interview was held with each of the participants to determine their knowledge of their prescribed medication (the use and purpose thereof). All conversations were recorded and transcribed.

Data Analysis: Transcribed data was interpreted and validated through a triangulation technique. After that, the data was analysed using the content analysis technique (coding, classifying and statement analysing, with verification of a conclusion). The descriptive data was collected and managed by licensed software (MS Word and MS Excel). The participants'



characteristics were described. A descriptive statistic was used for characteristic data, such as, numbers, percentages, and means.

This study has been approved by the Committee for Research Ethics (Social Sciences), Mahidol University, No. 2019/014 (B2), dated 5 February 2019.

Results

The average age of the 31 key-participants was 72.8 years old. Most were female, working in agriculture, and were registered in the Universal health coverage scheme (UC). The average amount of diseases was 2.29 per person. The largest number of underlying disease was High blood pressure (29/31). This was followed by Hyperlipidemia (19/31), and Diabetes Mellitus (13/31), respectively. In addition, the study found that older adults had chronic illnesses including laboured breathing due to asthma (4), pain (3), dizziness (1), kidney stones (1), and cataracts (1). The average amount of medication that the elderly usually used was 8.67 items per person and 92.6 percent of these were prescription drugs.

Table 1: Demographic of key-participants

Demographic	number (person)	percentage (n=31)
Age (average 72.8 years)		
60-69	9	29.03
70-79	18	58.06
80-89	4	12.91
Gender		
Female	23	74.19
Male	8	25.81
Career		
Farmer	20	64.52
Merchant	4	12.90
Retired	3	9.68
No working	3	9.68
Folk Medicines	1	3.22
Medical Welfare		
Universal Health Coverage	27	87.10
Civil Servants Medical Benefits	4	12.90
Number of illnesses/Underlying diseases (Average 2.29 diseases)		
1	8	25.81
2	8	25.81
3	13	41.93
>3	2	6.45
Number of medication items (Average 8.67 items)		
2-4	4	12.91
5-9	11	35.48
>9	16	51.61

The results showed that the elderly participants normally took polypharmacy daily. To convey their sentiments toward the medication, they referred to the amount as “too much medicine”. The participants were complacent toward the large amount of medication not only as part of the pharmacological expectation, but also within a social context. The social meanings of taking medication are (1) the obligation of the elderly users to be good patients; (2) the prerogative of having rights as citizens of the kingdom; and (3) the context of maintaining the relationship in health care services, communities, and families as follows:

1. In terms of the obligation of the elderly users to be good patients, the results showed that all the participants were accepted without questioning their sickness. After they become



elderly, they automatically become a patient. His/her illness is normally related to fragility from old age. The role of medication is not only for treatment but also to represent that they are obligated to be good patients and well-behaved geriatrics:

“I am an elderly person and it is normal to be a patient. There is no other way. I do not want to be a burden to anyone. I should go to see doctor and take these pills by myself. I know, I am an elder but if I want to be an effective elder I should not only sit or lie. I must try to take care of myself” (Participant No. 19, Male, 84 years old).

Moreover, 27 participants reported that after they had attended a medication checking program, provided by the local government, they became elderly patients. They were sick and needed medication. They agreed to what doctors told them, accepted it as qualified medical advice and could not reject or question the advice. However, they reflected that the use of medication made them more feel safe and valuable. For example, participant no. 19, who was male and 84 years old, said,

“Taking too many pills make me bored however I need to take it because I would like to stay longer with my family. I would like to see them grow up. Moreover, I believe that my life can benefit my family and other people.”

Even though the participants were bothered with taking large amounts of medication, they admitted to taking polypharmacy until a doctor told them to stop:

“I am a patient so I should not insubordinate. If I do not take these medicines, I do not know how to do. When I have medicines, I feel like have doctor beside me. Whatever doctors recommend, I should do. I rely on doctors, should not insubordinate to them” (Participant No. 21, female, 76 years old).

2. In terms of the prerogative of having rights as a citizens of the kingdom, participants in this study were registered in 2 types of government welfare systems. Firstly, most of them (27/31) were in the Universal Coverage program (UC). It is a standard package that allows Thais to access government health services with no co-pay. In the past, service clients had to pay 30 baht at the hospital they attended and all in this program received a yellow card to identify their conditions, giving it the nickname of the “gold card”. Secondly, 4 participants are in a civil servant medical benefit program. This program was designed to provide free medical services (with conditions) for government officers and their families including their parents, spouses, and children.

Sixteen participants indicated that their medication is evidence of their medical rights from the government. These benefit programs influenced the patient population regarding access to

both medication services and medication. Even though it will affect society's health care costs, it depends on the willingness of both service providers and service recipients. Participant number 4 (female, 73 years old) informed that she had heart disease and other health problems including pain, insomnia, dizziness, and flatulence. Although those symptoms are not serious, they made her uncomfortable. She often went to see the doctor and asked for medication in the government hospital where she was registered because she did not need to pay for her medical services. At the same time, she did not want to wait for her illness to dissipate naturally. Similarly, a quote from participant number 24 (female, 64 years old) was as follows:

“When I do not have serious symptoms such as pain or cold, I prefer to go to see the doctor at the government primary hospital rather than going to buy medicines at a drugstore. In my opinion, they will give me the same medication. Moreover, it is free. At the government hospital, I do not pay for my pills.”

3. In terms of the context of maintaining relationships in health care services, communities, and families, at least 8 participants mentioned that they took large amounts of medication not only for treatment but also for keeping a good relationship between them and their doctor. These supporting quotes elaborate on this:

“When I was sick I went to see the doctor. Then, he gave me some medications. If I do not take the medicines, I do not know how to tell him later. I am afraid that he does not love me, does not sympathise with me, and no longer take care of me again” (Participant No. 12, male, 72 years old).

“I want to stop taking these pills but I am afraid my doctor will complain” (Participant No. 8, female, 63 years old).

In addition, the results showed that a set of large amounts of prescribed medications were used as a reflection of doctors' expertise. Participant number 2 (male, 79 years old) mentioned that

“My doctor gave me a set of 6 medications for my dizziness. When I told him I have dizziness, he did not prescribe only dizziness pills but he gave me a pill for blocking my nerve, my brain, and all sources of it. He gave large amounts of pills to cover all my sickness and I do not want to stop taking them. Unlike another doctor, who did not give medicines to cover my sickness, he only gave 1 or 2 items which cannot cover all sources. When I took his medicines, it was only 2 hours after that and I had a headache again. It is not the same as the pill my doctor prescribed, his pills are perfect for me. He is so smart, his pills are so great, I love to take his medications.”

Similarly, participant number 24 (female, 64 years old) explained her medication use habits and compared the medical prescription of her doctor with another doctor:

“I do not know what happened, last time, I went to see my doctor but I did not see him at the chronic disease clinic. I must go to the general department to meet another doctor. He did not give me all of the medication that I had received before. I do not know another doctor could choose to change my medication, but I need it. In my opinion, this doctor might not be a specialist for my illness, so he could not prescribe that pill for me.”

The reduced list of medications after the follow-up had not been understood as an improvement regarding the illness but was misinterpreted as a lack of expertise on the doctor’s side. Ultimately, this resulted in a search or request for more medications from their preferred doctor or place.

The meaning of medication use in terms of keeping a good relationship between elderly users and their peers reveals the existence of medical pluralism in the community. Fifteen participants accepted that prescribed medicine is very important in their daily lives. However, due to the unsuccessfulness of treatment, they have tried to find new options or combinations of products. This could be why patients take daily doses of polypharmacy. Furthermore, they did not consider if their products were registered as medications or not. These products could be categorised into 4 types: dietary supplements (5/15), traditional medicines (6/15), herbal medicines (7/15), and magic medications from shamans (2/15). Moreover, participants believed in the effectiveness of the medications and cultural practices/medications to treat their illnesses. For example, having Thai massages (2/15), having bamboo sticky rice as part of a ritual on Makha Bhucha Day (an important religious day for Buddhists) (3/15), having Yaku rice as part of a ritual on Hare Phar Khun That Day (an annual tradition for taking a monk’s cloth to cover the pagoda) (2/15), and having local desserts on the Tenth Month festival or Ching Pret festival (festivals in October to make merit for dead ancestors) (2/15).

The habitual taking of medication of people in their communities, specifically in cases of self-medication, was provided by traditional and popular sectors in the medical system. According to an interview with participant number 2 (male, 79 years old), he posed his opinion of the connection between medications and social relationships in his community. He used dietary supplements named Puk (vegetable) Baan (local). These are soft, black capsules labelled “Vegetable Pills”. The participant indicated that he used these pills with his prescription medications. He mentioned that his friend from a coffee shop took them and got well. Then, his friend suggested them to him and convinced him thereof. Even though he was aware of the possible negative side effects, he tried them because he felt obliged to do so, so as to comply with his friend’s good intentions. Similarly, participant number 21 (female, 76

years old) explained that she used Bee Propolis pills because her friend recommended them and she was afraid of offending her friend:

“She told me this Bee Propolis pill could treat so many diseases. She is my old friend. She used it and suggested I buy it. She said that she would like me to get well too. Yes, I bought it because I was afraid of offending her. It is not wrong; I just want to try and I believe that she really has the best intentions. She does not lie. There is no reason to refuse her.”

The use of medication was a way that the elderly and family members expressed their love and tried to maintain good relationships in their households. Children were being dutiful to their parents or elderly members in families. The children did not live with their parents, or they lived together but did not have much time to take care of them. They often bought and sent medicines or health products to their parents at home, which is a traditional form of recognition in Thai culture. This practice is not only due to polypharmacy use, but also leads to cases of unreasonable medication use in the elderly:

“My daughter has been living in Krabi province. She does not come visit me often. So, she bought this medicine to prevent Colorectal cancer. She sent it by Kerry (a courier service). I am willing to use these because it is from my daughter. When I have taken them all, I tell her and she will send me more or sometimes I do not tell her, she takes it upon herself to send it to me” (Participant No. 8, female, 63 years old).

“Doctors do not give me medicines. So, I bought it for my mother from the drugstore. My mother was sick. We went to see the doctor with hope to receive some pills. The doctor told us bluntly that my mother has osteoporosis. My mom and I had been waiting for his prescription but he did not mention it. In my opinion, he is a miserly doctor. In the hospital we cannot pay for pills, but if I do not need a prescription, I am willing to pay for it in the drugstore. I want my mother to recover from her pain. I will try to do everything for her” (Daughter in law of participant No. 10, female, 65 years old).

Discussion

In looking at the phenomenal use of polypharmacy in the daily life of the elderly with the concept of Critical Medical Anthropology (CMA), it shows complexity and multiple levels of power in the medical system. Medication uses were determined by the social role of users. Medications or health products that were manufactured as a symbol of medicines were not only pharmacological substances that were effective in treating, alleviating, or preventing diseases and illnesses, but also vehicles of ideology that communicated the social aspects of users' bodies (Baer, Singer, & Susser, 2003; Kelly, 2013; Waring, Latif, Boyd, Barber, &

Elliott, 2016). On the other hand, the experiences of medication use also created self-reflection in users (Adams, Todorova, Guzzardo, & Falcon, 2015).

This study revealed interesting definitions that can be divided into three themes: (1) the obligation of elderly users to be good patients; (2) the prerogative of having rights as a citizen of the kingdom; and (3) the context of maintaining relationships in health care services, communities, and families. These are consistent with the studies of Prasertsuk and Wattananamkul (2011), Clarke and Bennett (2013), and Gibson (2016) in terms of embodying illness causality and responsibility. They are used to indicate opinions and social classes. In addition, they clearly show the influence of the economy, politics and cultural systems that are dynamic in modern society.

Modern society falls in the trap of globalisation and medicalisation. As subjects of social discourse, they have the power to determine both people's thoughts and behaviours. The elderly, in this modern society, exist in two main states: being elderly and being patients. The role of the elderly in modern society is focused on an active ageing discourse, which is interpreted as elderly people needing to be involved in health, security, and participation with their family and society. Thus, the image of elderly people in this era has been reflected in the terms of people with healthy bodies with the ability to do daily activities and have a career to support themselves (Thanakwang, Isaramalai, & Hattakit, 2014). Although the results did not find that families or communities expected the elderly to work, in the context of rural poverty, almost all of the elderly participants indicated that they still did not want to burden their children. Therefore, most elderly people still work in agriculture, which not only creates income to support themselves but to support their children in their own family as well.

The results from these in-depth interviews also revealed the influence of the political economy, noticeably linked to the burden of occupation among the elderly. The southern rural area, especially this research field, was a lowland area. In the past, it consisted of almost entirely rice fields. Currently, those rice fields have been changed into rubber plantations. The rice farmers' lifestyles have changed to planters' lifestyles. Eighty-six percent of elderly participants reflected that falling prices of rice and ineffective government policies were the main factors causing them to face career changes. Although the government had a policy to support the community, including improving irrigation systems to improve suitability for rice cultivation, it did not help the improvement of the farmers' overall well-being. A study by Jermittiparsert (2013) interestingly criticised that, in the current context, globalisation has been the power of the world rice market here. It was influenced by the economy and the price of domestic paddies more than the actual cost of production. Therefore, it was not surprising that the price intervention policy of the government could not solve the problem as efficiently as expected.

In addition, society has established the preconception of being a good patient, according to the sick role of the elderly, who must cooperate with the treatment (Gabe et al., 2004). The results of this study are consistent with the studies of Clarke and Bennett (2013) and Das, Angeli, Krumeich, and van Schayck (2018). They describe that self-care behaviours, which include the use of prescription medicines, searching for over the counter medicines, and health seeking behaviour, are the result of moral responsibility arising from discourse and social-cultural norms. However, the obvious difference is that Thai society, specifically in rural areas, values elderly patients' roles as passive participants rather than active participants. Family members and medical personnel in the study area reflected that the expectations of elderly patients' roles in their care involved wanting the elderly to comply to and strictly follow rules rather than to be curious, dare to ask questions or participate in the decision-making process.

The use of large amounts of medication, as a basic right of citizens, is one of the empirical phenomena of drug provision under the ruse of being a health product. Access to medicines has become the norm, determining whether the government is potentially caring for the equal health of people or not (Bell & Figert, 2012). From the people's perspectives, medication use is like exercising one's rights. There were some participants, who were family members of some elderly, reflecting that drug use is the empirical right of a taxpayer. Going to the hospital and taking medication home is the only way for them to have evidence of what they spent at the medical practitioner. On the other hand, going to the hospital and not getting any prescriptions from a doctor made them feel like they were being taken advantage of. "A doctor begrudges a pill" is used to describe their feeling of unfairness that occurs in the medical service system.

While the elderly themselves see medication use as a right, the overlap with rural conditions and poverty (as well as having to live alone) has been the cause of frequent dependence on health benefits. The situation of self-paying for medication or medication use to show social status within metropolitan cities (Prasertsuk & Wattananamkul, 2011) is still not evident. Instead, it is still common to see elderly patients waiting patiently to receive services at public hospitals and facilities. The words "go to ask for... do not pay money" and "have a doctor prescribed... because it can be reimbursed" are words that clearly reflected the view of the health system in the area. People thought that having rights and exercising their rights were expected. This is consistent with the information and critiques of Srisukho (2014) and TDRI (2014). They described that the government welfare system was a mechanism to support smooth and effective public health care, to reduce public health costs, and to promote the development of primary health facilities. At the same time, the government welfare system also created a new awareness of health. People tended to use services from hospitals more than self-care. In addition to the existence of drugs decreasing the illness threshold

(Nichter, 1996), the existence of government welfare rights decreased the endurance of illnesses, causing increased seeking and taking of medication.

The relationship system is one cultural system that occurs in society, including in the medical service system. Echoes of “fear of doctors scolding” “fear of doctors not treating” indicated the powerlessness in negotiation with both the disease and the medical service system. A doctor has the power in terms of drug selection and prescription, also the power to control patients to take the medication that they prescribed. The elderly is dependent and drug use is a way to express compliance within this power relationship. Qureshi and Collazos (2011) explained that one obstacle or problem of creating the Therapeutic relationship or the transfer to alliance in the medical service system is the cultural difference between medical personnel and patients, specifically the factors related to the role such as gender, age, or even a title showing the expertise of a doctor. It was therefore not surprising that the participants in this study would use medications to convey different levels of power relations between themselves and their doctors.

In spite of this, there was a trend showing that the participants were compliant with the power of a doctor’s knowledge without questioning or them to circumvent conflicts. Similar to the research of Holroyd, Vegsund, Stephenson, and Beuthin (2012), it was found that the relationship between doctors and patients influenced the medication use experience. Patients were more likely to believe in a doctor’s authority as a result of varied knowledge. At the same time, doctors “not listening” and “not having time” caused physical suffering due to side effects and the misuse of medication, as well as psychological distress caused by anxiety and frustration with medication use (Rimando, 2013; Rosbach & Andersen, 2017).

This study also revealed that, in addition to the context of the multicultural society of the southern region influencing various ways to take care of people's health (Sangmanee, 2017; Somsap & Ingathawornwong, 2014), the kinship system of the southern people in rural areas also affected health care methods, specifically the use of large amounts of medication. The “filial piety drug” phenomenon was created by social construction no differently than the definition of illness than Conrad and Barker (2010) described. Some illnesses are not properly understood but are understood through social responses. A society will determine whether an illness is offensive or unacceptable and whether it is light or severe, which leads to dissimilar management methods.

The filial piety drug phenomenon is also a clear reflection of the relationship between drug use and family relationships in modern society. Family structures have been changing from extended families to nuclear families or skipped generations. The proportion of the elderly living alone or living with other elderly people has increased. This has become an important factor that makes the elderly in modern society more fragile (Grøn, 2016; Vapattanowong,

2019). However, there are still some people who are embedded with the norms of caring offspring. Drug purchasing, drug delivery, and drug use were created to engage the existence of norms and social relations.

Offspring often assume the necessity of medication due to the deterioration of the elderly's health, together with the capitalist family relationships that identify care with gifts when they meet family. The elderly also create filial piety medication use through communicating their own illnesses to grandchildren.

At the community level, filial piety drug use is constructed from a discourse of gratitude that has become a social norm. The neighbour of participant number 8 clearly reflected that after knowing the drug and supplement purchasing behaviour of a female member in the family (her mother), she was proud and happy to be recognised as a woman who left home but still cared for her mother. Dutiful children are considered to be children who are grateful to their parents, whereas society expects those who play the role of offspring to be responsible for raising, helping or caring of their parents. Buying and sending medications or supplements to parents when they are ill is considered a good way to show that they are still performing their duties as society expects. In addition, the public relations of the pharmaceutical industry have had an influence on constructing the definition of filial piety drug use. Medicines and products advertising in the media have not only had the power to stimulate buying, but they have also had the power to create new traditions or cultures (Eaves, 2015; Nichter, 1996; Nichter & Vuckovic, 1994; Nor, Yap, Liew, & Rajah, 2014). These include the culture of using natural products instead of synthetic substances as well as the culture of showing love through the colour, appearance and meaning of extracts in the product, etc. It was therefore not surprising to see a picture of carrying a gift basket including birds' nests, bottles of calcium, bottles of chlorophyll granules, or a gift set of healthy vitamins as a souvenir for the elderly in place of snacks or food like in the past.

The results of this study clearly showed many of the factors affecting drug use among the elderly in rural areas, specifically in this research area. Besides factors of age, education levels, medical services, and access to drug distribution sources (Ruangritchankul, 2018), the social meaning of medication use (which was constructed through discourse, health policies, and socio-cultural systems), could cause the use of polypharmacy in the elderly people as well.

Conclusion

This study is part of research on "Subjectivity and polypharmacy using behaviour among the elderly in the rural south of Thailand: A case study of the Thaiburi community in Thasala district, Nakhon Si Thammarat Province". The study attempted to reveal the perspectives on



medication use in the daily life of the users. Although it cannot be used to refer to the general elderly population, it helps to reveal the underlying meaning behind medication use behaviours. Medication is not just an object of treating, alleviating, or preventing diseases and illnesses, but a vehicle of ideology for the elderly to play a role in society. This ideology was constructed from the influence of politics in the form of a health policy. The discourse of power has been embedded to such an extent that the people recognise it as their duty, both as patients and elderly within the unique social and cultural systems of each area.

This study will be useful in terms of a more comprehensive understanding of the medication use behaviours of the elderly. It will also understand the rationalities and conditions in life that cause different uses of medication. In addition, it will be useful for future research in terms of expanding knowledge about the subjective and medication use behaviours of elderly people as well as in terms of creating new knowledge about medicines and the elderly in the current medical system's context. This will lead to the establishment of balanced health care policies and medication use both in terms of the effectiveness of drug treatment and the good quality of life of the elderly who are subjected to polypharmacy.



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