

"Strong Medicine":

Cambodian Views of Medicine and Medical Compliance

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OBJECTIVE: To identify important determinants of noncompliance among Cambodian refugees.

DESIGN: Open-ended interviews.

SETTING: University-affiliated ambulatory care clinic in an inner-city hospital.

PARTICIPANTS: Thirty adult Cambodian refugees (15 men and 15 women) who were regular utilizers of a refugee clinic.

MEASUREMENTS AND MAIN RESULTS: Sixty-seven percent of the participants described being noncompliant with at least one of their medications. Four common causes of noncompliance were identified: 1) misunderstanding the intent of the medication; 2) side effects; 3) concern about the effect of medication on "internal strength"; and 4) Cambodian ideas about pharmacokinetics.

CONCLUSIONS: Noncompliance was commonly reported by the Cambodian respondents. Noncompliance was both intentional and unintentional; the unintended noncompliance derived from patients' attempting to comply with therapy according to Cambodian ideas about the body and Western medication. This article suggests clinical approaches to enhance compliance with prescribed regimens among recent Cambodian immigrants and refugees.

KEY WORDS: Cambodians; noncompliance; cultural barriers; health beliefs.

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Patients, providers, and health systems all lose when clinical encounters result in poor communication and failed therapy. Although the causes are numerous, the term "noncompliance" is generally used to denote that a patient has not taken medications as prescribed.^{1, 2} Inadequate instruction, confusion, inability to pay, apathy, attempts to self-prescribe according to experience, intentional abuse, and other often unrecognized reasons can all lead to noncompliance.³⁻¹⁰ Features of medical therapy associated with patient noncompliance include treatment necessitating behavioral change, long-term therapy, type of medication, and real

or perceived side effects.¹¹⁻¹⁴ Patient characteristics such as social isolation and significant cultural differences also have been associated with a higher risk of treatment failure.¹⁵⁻²¹ Cultural factors shaping compliance deserve special attention because physicians and medical systems may be able to anticipate and address key cultural issues that have a predictable influence on compliance with medical therapy.

Exploration of both intentional and unintentional reasons for noncompliance may be important to identify strategies to improve communication and treatment outcomes. This is especially true for clinicians caring for the growing numbers of foreign-born, non-English-speaking patients entering the United States health system who require translations of treatment plans into diverse linguistic and cultural contexts. For example, Lee et al.²² found that 33% of Southeast Asian patients had discontinued a prescribed medication, and 75% were taking at least one medication at an incorrect dose. Buchwald et al.²³ reported that 58% of the Southeast Asian patients used traditional health practices in addition to Western pharmaceuticals with reportedly good success. Given that culture commonly shapes compliance, and that the potential for noncompliance among Southeast Asian refugees is significant, we used ethnographic interviews to explore attitudes toward medication. In particular, the reasons, both intentional and unintentional, underlying noncompliant behavior were discussed with Cambodian patients who were regular utilizers of a refugee clinic.

BACKGROUND

Following the social upheaval in Cambodia in 1975, more than 140,000 Cambodians settled in the United States.^{18, 21} Nearly 2 million Cambodians who survived the massacres, torture, and forced labor of the Khmer Rouge fled to Thailand where they waited in refugee camps, often for years, before repatriation. Only a small portion of this large number were resettled in the West. Often professionals and intellectuals not killed by the Pol Pot regime resettled in France, while farmers, laborers, and merchants relocated to the United States. As a consequence, Cambodian refugees using American clinics have had minimal exposure to Western health practices prior to their arrival in the United States.^{21, 24, 25}

Cambodia is a largely agrarian society, the most recent estimates suggest that before the revolutionary period 87% of Cambodians lived in rural or semirural

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Table 1
Types of Noncompliant Behaviors

Behavior	Number of Patients (%)
Decreasing dose	1 (3%)
Dosing "as needed"	8 (27%)
Discontinuing medication	5 (17%)
Being unaware of medication prescribed	8 (27%)
Increasing dose	9 (30%)
Using nonprescribed medication	11 (37%)
Two or more noncompliant behaviors	12 (40%)

areas.²⁶ In Cambodia, biomedicine is available only in urban and regional centers, and traditional health practices are the usual form of medical care.^{16, 18, 21} Allopathic medical care is often crisis-oriented, and used primarily after initial attempts at herbal medicines, home remedies, or ritual healing have failed.²⁷ This is particularly true in rural Cambodia, where medical attention is sought first from family members, who may suggest herbal supplements or dietary changes, or who may perform dermabrasive techniques such as therapeutic coining, pinching, cupping, or massage.²⁴⁻²⁷ If symptoms are not relieved at home, families often seek the advice of a *Kru Khmer* ("traditional healer"), who specializes in traditional remedies and rituals.²⁸ In larger towns, Western and herbal medicines are available in stores without prescription. Cambodians are accustomed to choosing the combination of treatments they wish from these diverse sources. The lack of familiarity with Western medicine among most Cambodians is reflected by the fact that a single word, *p bhett*, refers to a physician, a nurse, a specialist, a surgeon, or the clinic.

The names of Cambodian illnesses have historically reflected the symptoms, or underlying causes. For example, *khaut leoung*, or "yellow illness," is named for the associated jaundice. Illness can result from disturbance of a normally harmonious state of health by natural and supernatural forces operating simultaneously on different levels. Karma, or the repercussion of past actions during previous incarnations, can predispose one to illness or health. In addition, malevolent people (oracles, shamans, witches) or spiritual beings (gods, demons, ancestral ghosts, and spirits) can influence health. Natural forces, such as the bodily humors of "wind," "heat," and "cold," and changes in climate, food, or familial discord also can produce illness.^{16, 18}

METHODS

The Refugee Clinic is located at Harborview Medical Center, one of four major teaching hospitals affiliated with the University of Washington. The clinic was established in 1982 to meet the expanding needs of a rapidly growing Southeast Asian refugee population. It now

serves 13 distinct communities from Africa and Asia, with more than 5,000 annual visits. Cambodian refugees are the largest single ethnic group, comprising 60% of the clinic visits.

A convenience sample of 30 adult Cambodian refugees living in Seattle who had established care at the Refugee Clinic were recruited to participate in the study. In 1990, 15 men and 15 women gave verbal consent to be interviewed and to have their medical records reviewed. The interviews focused on a general discussion of medical problems and the use of oral medications. To explore the reasoning behind pill-taking behavior, we used open-ended semistructured interviews lasting one and a half to two hours. Medical procedures, intravenous or intramuscular injections, and therapeutic behavioral and dietary changes were not targeted topics of discussion. All interviews were conducted by one of us (JS) at the patients' convenience in their homes. The interviewer was not aware of the patient's medical conditions, medications, or nature and extent of medical care at the time of the home visit. Three professional bilingual and bicultural medical interpreters alternated to interpret the sessions using phrase-by-phrase interpretation. Each interview was audiotaped, and later the English portions were transcribed for careful review and content analysis. The content analysis focused on reported pill-taking behaviors, the rationale for these behaviors, and personal and cultural reasons for complying, modifying, or discontinuing therapy. Chart reviews were conducted at the end of the study to obtain medical diagnoses and treatment intentions. Compliance with the advice of Refugee Clinic health care providers was established by comparing prescribed treatment regimens with behaviors reported by the participants.

RESULTS

Participant Characteristics

The average age of the participants was 50 years (range 26 to 76). The sample was therefore representative of those refugees who had grown up in Cambodia before the revolutionary period. All participants were from rural areas and had received minimal formal education. Seventy-seven percent were Buddhist; the remainder gave no religious affiliation. These refugees had waited an average of 4.8 years (range 2 to 8) in a country of first asylum after leaving Cambodia and before resettlement, and had lived an average of 9.1 years (range 4 to 13) in the United States. The former occupations of the sample were: 17 (57%) farmers, three (10%) merchants, two (7%) military personnel, three (10%) manual laborers, one (3%) student, one (3%) homemaker, and five (20%) participants who gave no occupation. One individual, in addition to working as a farmer, was a *Kru Khmer* (traditional healer). All the patients were currently unemployed and receiving public assistance, which paid for medical care and medications.

Reasons for Noncompliance

One hundred twenty-one illnesses were identified by chart review, an average of four illnesses per patient. There were five acute and 116 chronic complaints. Only nine of the chronic conditions were asymptomatic illnesses such as hypertension or hyperlipidemia. Patients were prescribed an average of 2.7 medications each, and were no more or less compliant with medications for symptomatic vs asymptomatic illnesses. People were selectively noncompliant because all the respondents found at least one of their medications helpful for the reason prescribed. Although several people had more than one noncompliant behavior (Table 1), many of them were simultaneously compliant with other medications in their regimens. Three patients did not know the purpose of at least one of their medications, but were compliant nonetheless. Noncompliant behavior with at least one medication was reported by 20 (67%) respondents. The four major reasons for noncompliance were: 1) misunderstandings, 2) side effects, 3) concern about the effect of Western medication on "internal strength," and 4) Cambodian ideas about pharmacokinetics.

1. Misunderstandings

Eleven (37%) patients thought at least one of their medications was intended for a purpose other than that for which it was prescribed (Table 2). Of these 11, seven discontinued their medications and six used them on an as-needed basis. This response is exemplified by a man who was prescribed ranitidine for gastritis but discontinued the medication because it did not relieve his musculoskeletal pains. Four individuals (13%) believed that one of their medications was not effective and subsequently discontinued its use. Five patients (17%) understood the indications for their medications but also believed they could be used for other purposes (Table 2).

2. Side Effects

Side effects, both well described and idiosyncratic, were reported by 19 (63%) respondents as a reason for decreasing dosages ($n = 15$), or discontinuing medications altogether ($n = 4$).

3. Effect of Medication on "Internal Strength"

People reported regulating their intake of medication because of their concern that Western drugs were "strong medicine" (*thnam klaing*) and might interfere with the body's "internal strength" (*kamlaang*), also translated as "energy." This exchange reflects this opinion:

Patient: *Its like if I feel like I don't have the internal strength (kamlaang), then I'm not gonna take the medicine.*

Table 2
Nonformulary Patient Uses for Prescribed Medications

Medication	Use
Imipramine	Strawberry allergy; chest pain
Tetracycline	Sore throat
Trimethoprim/sulfa	Chest pain
Nitroglycerin	Dizziness
Mexiletine	Leg pain
Atenolol/triamterene	Weight gain; back pain; stomachache
Theo-dur	Rapid heart beats
Ranitidine	Muscular pains
Cimetidine	Constipation
Famotidine	Headache
Tolectin	Weakness; body shakes
Folate	Insomnia

Interviewer: *And what, what would happen if you did take the medicine when you didn't have energy or strength?*

Patient: *I never, if I, like I feel like I have a severe dizziness, then I have to not take it. But after I have a little bit to eat, like rice soup, stuff like that, and give some strength, then I take the medicine. . . its like if you have low internal strength (kamlaang), then you take the medicine, then it's you're gonna have even less internal strength (aah kamlaang).*

Interviewer: *Is there the same problem with Cambodian medicine?*

Patient: *Cambodian medicine is okay. If you don't have strength then you can take it, it's fine. But I'm afraid of Western medicine because Western medicine, it's more strong.*

Thirteen people (43%) reported that if a person was ill and the body has low "internal strength," a "strong medicine" can further aggravate the situation.

When I feel really weak, I stopped taking my pills . . . afraid something happen when I takes the medicine but I didn't know the effect.

I'm afraid . . . my stomach has problems, if I put all the medicines together, probably something will fight in (my) stomach . . . the medicine is strong, so if a person is already weak (aah kamlaang) and he takes the medicine, a person probably becomes weaker.

4. Cambodian Ideas about Pharmacokinetics

Twenty-two of the 30 participants (85%) stated they feared taking two different medications at the same time because of a possible "reaction" or detrimental effect on a person's "internal strength." "Reaction" was described in several instances as a chemical event occurring in the stomach between the pills that produces ill effects on the body. One woman observed that a decrease in "internal strength" results in vomiting, decreased activity and ability to perform daily functions, weakness, dizziness, fevers, and body tremors.

Kind of having a feeling that one hour makes it better than shorter, otherwise all the medicine might melt and go into the body and might be gone in a period of one hour. (35-year-old farmer)

It is interesting to note that several people indicated they would take medications at the same time if their providers specifically approved such a regimen. One woman took antihypertensive medications concurrently because they were "similar." She also believed that one could take two traditional medicines at the same time because both are liquids and do not need to dissolve. Another individual explained that medications must match the type of illness. For instance, Tylenol had the same "strength" as her headache and therefore adequately managed her pain. Medications weaker than the ailment would be unlikely to result in relief. Similarly, if a therapy were too strong, the condition would worsen.

The idea that, in some cases, higher dosages yield faster results was reported by seven respondents (23%) who increased dosages on their own, often with the expressed disapproval of the health care provider.

I took two tablets a day and it got better and I wanted to make it quicker and get results sooner, so I began taking three a day. (61-year-old farmer)

I thought it would be more helpful, more easily cured, earlier. . . . The reason I take two instead of one is because I tried it and if it is okay, if one was okay, try two to see if it was more helpful faster. (53-year-old male laborer)

Use of Traditional Medicines

Although 25 (83%) of the 30 study participants reported using traditional medications in Cambodia, none currently used traditional medicines, primarily because they were not available. Eleven (37%) stated that they would try traditional medicines if accessible, though several said they would continue concurrent use of Western medications. Almost half the respondents (47%) stated they would not utilize traditional medicines for the following reasons: bitter taste, no confidence in their effectiveness, preferred using Western medication exclusively, feared improper preparation of the medicines, and no knowledge of how to administer it. One of the subjects, a practicing *Kru Khmer*, expressed reluctance to use his own herbal medicines, explaining that he is currently testing the effectiveness of Western medications.

DISCUSSION

Sixty-seven percent of the participants in this study were noncompliant with prescribed medications. While lack of efficacy, misunderstandings, and adverse side effects can result in noncompliance regardless of cultural background, our respondents explained medication use in terms of Cambodian views of the body and

Table 3
Suggestions to Enhance Compliance with Medications

At initiation of therapy
Avoid complicated regimens and multiple doses
Inquire about concerns regarding potency of Western medication
Address concerns that dose and frequency are written for Americans accustomed to Western medication
Reassure patient that prescription is written with a Cambodian patient in mind
Reassure patient that prescription is the right strength for the symptoms and illness
Reassure patient that certain medications can mix together without difficulty
Have patient repeat purpose, strength, and frequency of dosing for each medication
Acknowledge possibility of side effects and an acceptable course of action (e.g., clinic call system)
Acknowledge that simultaneous use of Cambodian therapies may be helpful but that Western medications should be taken concurrently
During follow-up
In nonthreatening manner, solicit dosing routines to establish regimen
Inquire whether medications helped
Inquire whether medication is too "strong" or too "hot"
Inquire about effect on patient's "internal strength" and about side effects
Inquire whether patient has discovered other uses for the medication
Inquire about the use of other medications, or prescriptions received from other physicians
Address each symptom and side effect systematically
If noncompliance is reported, acknowledge reasoning, and negotiate change in regimen or medication

pharmacokinetics. None of the respondents explicitly referred to previously described terms such as "hot" or "cold" forces, "wind," or "karma," although they alluded to these underlying concepts of harmony through their concern with improper balance of body energies and the strength of medications. Due to their ingredients and method of manufacture, Western pharmaceuticals generally were considered "strong" (*klaing*) medicine that should be used with caution, especially when a person was ill or had decreased "internal strength" (*aah kam-laang*). This was particularly true when subjects discussed taking multiple Western medicines simultaneously.

Concern about the strength and number of Western medicines have been reported by others working in Asia. For example, Schultz²⁵ and De Lay and Faust¹⁷ found that Southeast Asian patients considered Western medications to be "too strong" and "too hot" and consequently often decreased dosages. This is not unique to Cambodia or Southeast Asia. In Pakistan, Mull et al.,²⁹ studying compliance among leprosy patients, found that patients lowered their doses of medicine when they thought it was too "strong" or "hot." While Pakistani

concepts of health and illness reflect Unani, not Cambodian, humoral theory, the general concern about the strength of Western medication may be common where potent pharmaceuticals are introduced in areas that historically relied on relatively milder herbal therapies.

In our study, patients reduced dosages, discontinued therapy, or waited a significant amount of time between taking medications. Although these efforts were meant to improve the efficacy of the medication or prevent adverse outcomes, the effect of these behaviors on therapeutic efficacy can be negative. Similar concerns may have prompted 16 of 19 (68%) Lao, Vietnamese, and Cambodian patients receiving isoniazid chemoprophylaxis for tuberculosis in Seattle to discontinue therapy.³⁰

Among Cambodians, health is a symptom-free state of internal balance.³¹ Since symptoms are evidence of disease and signal the need for an intervention, their disappearance can be considered a return to health. Hence, the notion that medication must be continued in the absence of symptoms is often incomprehensible. The goal of treatment is a cure; once balance is restored, medication is no longer needed. Since Cambodians often concurrently receive treatments from diverse sources and may stop or modify therapies according to their symptoms, providers caring for these patients must specifically address the need to continue medications in the face of asymptomatic illnesses. Control of medications may be difficult because in Cambodia, people self-prescribe herbal medicines and/or Western pharmaceuticals, which are widely available for virtually any ailment or symptom.²³ People who have experienced prolonged periods of powerlessness may be very reluctant to give up the little remaining control they have in their lives, in this case, their ability to choose type and duration of medications. For cultural and recent historical reasons, people may publically acquiesce to higher authority, while privately exercising their independence.

One objective of this study was to distinguish non-compliance from culturally conceived compliance. While the outcomes of failed therapy from intentional misuse and miscommunication may be the same, understanding the underlying motivations is necessary to shape the intervention. As demonstrated in this study, there is intended noncompliance because of side effects, presumed inefficacy, or failure to obtain medications. We also observed examples of unintended noncompliance, such as individuals' making considerable efforts to comply with therapy, but in a manner consistent with their underlying understanding of how their medicines and the body work. These cultural predispositions to pill taking constitute the unintended noncompliance that is culturally informed and predictable and that can be addressed systematically. Providers who frequently care for Cambodians should anticipate that patients may adjust their medications in accordance with culturally congruent ideas of health and illness. Those familiar with

Cambodian views of Western therapies will be able to provide better care by proactive discussions with patients regarding the use of medications (Table 3).

This study has a number of limitations. The repetitive and narrative nature of ethnographic interviews enhances the validity of the data, but limits the data's generalizability, in this case to the unemployed Cambodian adults on public assistance utilizing this refugee clinic. Consequently, we do not know whether this group is representative of more acculturated Cambodian patients, or Cambodians resettled in other states. The interviews are not comprehensive, and many factors affecting compliance remain unexplored. Finally, we suspect that noncompliance may have been underreported, given the Cambodian aversion to disagreement and confrontation.

In conclusion, two-thirds of our Cambodian patients were noncompliant with their medications. The reasons given ranged from side effects to completely misunderstanding the purpose of the drug. Many of these patients made attempts to comply with therapy according to Cambodian notions about the body and medications. Although Cambodians may be intentionally non-compliant because of disagreements with diagnosis or cost, the number of treatment failures resulting from unintentional noncompliance may be reduced if providers are familiar with Cambodian ideas about pill taking. Knowledge about culturally derived medical beliefs should be used in developing programs to address noncompliance among Cambodians and other non-English-speaking peoples.

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REFLECTIONS

It is our duty to remember at all times and anew that medicine is not only a science, but also the art of letting our own individuality interact with the individuality of the patient. —ALBERT SCHWEITZER (1875–1965), Franco-German medical missionary, philosopher, and theologian