

Chapter 8 Culture and pharmacology: drugs, alcohol and tobacco

CASE STUDIES

Case study: placebo effect in angina pectoris

Benson and McCallie¹⁹ in 1979 reviewed the effectiveness of various types of therapy for angina pectoris. Many of these had been tried, only to be abandoned later on. They included heart muscle extract, various hormones, X-irradiation, anticoagulants, monoamine oxidase inhibitors, thyroidectomies, radioactive iodine, sympathectomies and many other treatments. When each of these had been introduced, their proponents (or 'enthusiasts') had reported remarkable successes in their initial trials of treatment. Most of these non-blind or single-blind trials failed to control the strong placebo effect evoked by the investigators' expectations of success. Later, when more controlled trials were done by 'sceptics' (more sceptical investigators who operate under circumstances that minimize the placebo effect), the therapy was found to be no better than inert, control placebos. Quantitatively, there was a consistent pattern of a 70–90 per cent success reported initially by the enthusiasts, which was reduced in the sceptics trial to 30–40 per cent baseline placebo effectiveness. This 30 per cent, as already mentioned, is the usual proportion of placebo types in a group, or the degree of placebo effect from any drug or procedure.

Benson and McCallie analysed the results of five erstwhile treatments for angina pectoris, all of which 'are now believed to have no specific physiologic efficacy, yet at one time all were found to be effective and were used extensively'. These were the xanthines, khellin, vitamin E, ligation of the internal mammary artery, and implantation of this artery. Vitamin E, for example,

was introduced as a therapy for angina in 1946. Initial enthusiastic reports noted that 90 per cent of 84 patients benefited from several months' treatment with it. Over the years, several more trials were carried out which found a gradually reduced level of effectiveness. By the 1970s, controlled trials were showing it to be no better than placebo pills. That is, 'the discrepancy between the results of advocates and sceptics may be attributed, in part, to the greater degree of placebo effect evoked by the enthusiasts'. More than 80 per cent of patients initially reported subjective improvement in symptoms, from any of these five treatments. There were also objective improvements, such as increased exercise tolerance, reduced nitroglycerin usage and improved electrocardiograph results. In some cases these lasted up to 1 year.

The authors pointed out that 'the placebo effect will most likely persist as long as the psychologic context in which it was evoked remains unchanged. Patient and physician belief in the efficacy of the therapy and a continuously strong physician–patient relation should maintain the effects for long periods'. This can even occur in the presence of angiographically verified coronary artery disease. They also point out that the history of angina treatments demonstrates that the advent of a 'new' procedure may impair the effectiveness of an old one, and that the expectation of better results transfers the placebo effect to the new procedure. In conclusion, they quote Trousseau's remark that: 'You should treat as many patients as possible with the new drugs while they still have the power to heal'.

Case study: addict subculture in Lexington, Kentucky, USA

The power and nature of an addict subculture was studied in 1974 by Freeland and Rosensteel⁴⁵ at the Clinical Research Center in Lexington, Kentucky. They found that self-defined groups, such as narcotic addicts, 'tend to justify their own way of life by stereotyping the behaviour of others in a negative fashion'. The power of culturally based stereotypes to influence a person's life and perceptions depends on how committed the person is to that way of life. In the case of the narcotic addicts, this commitment was intense and all-embracing. Their cultural (or rather subcultural) belief system embodied a strong we–they dichotomy. 'They' were the 'squares', whose lives were seen as being boring,

passive, hypocritical, fear-ridden and subordinate. This negative picture contrasted with their own idealized self-image as 'hustlers' – a hustler being 'an active, dominant, capable, self-motivated person who is highly aware of his surroundings and in control of them'. They saw themselves as living 'the fast life'; a hustler first and an addict second. Hustlers were seen as having a specialized type of knowledge about the world that 'maximizes one's abilities as a predator'. In the researchers' view, the maintenance of this we–they dichotomy, and the stereotypes of 'square' and 'hustler', tend to minimize the impact of any therapeutic or rehabilitative programmes directed towards the addicts.

As a strategy to overcome this situation, they organized lengthy discussions on these stereotypes between the addict

group and a group of 'squares'. The aim was to reduce the addicts' tendency to stereotype by reducing their ethnocentrism – that is, by providing them with alternative ways of seeing the world, derived from other groups. The 'squares' included medical staff and students, as well as others from churches and schools. Both groups were encouraged to discuss the stereotypes of the others, and to examine how these stereotypes affected their interactions. The addicts were also shown

films of other societies, and it was pointed out that stereotyping was a universal human feature, although it could be dangerous and inhibit communication. The outcome of this process was to convince the addict group that they could modify their lifestyle 'without being doomed to a life of subservience, boredom, inactivity, and passivity'. This was a major step in their rehabilitation into everyday life. It was also helpful in enhancing rapport between addict patients and medical staff.

Case study: 'crack' cocaine subculture in Spanish Harlem, New York City, USA

Bourgois⁴⁶ in the late 1980s studied the violent street culture of 'crack' cocaine dealers and their clients in Spanish Harlem, New York City. He described the bleak lives of the residents of this poor, inner-city area, many of them Puerto Ricans, and the role played by the underground economy of drug dealing, distribution and consumption within the community. He pointed out that in order to understand the origins of this violent and crime-ridden drug subculture, larger social issues, such as the 'objective, structural desperation of a population without a viable economy, and facing systematic barriers of ethnic discrimination and ideological marginalization' cannot be ignored.

However self-destructive their lives, Bourgois did not see the drug dealers as propelled by an 'irrational cultural logic distinct from that of mainstream USA'. On the contrary, although completely excluded from the mainstream economy and society, many of their values are ultimately derived from it. The participants in the underground crack economy are frantically pursuing their own, distorted version of the American dream. As in conventional society, their ambitions include rapid upward economic mobility, the respect of their peers and the accumulation of flashy consumer objects.

Faced with the prospects of unemployment, low wages and discrimination in the outside world, some of the residents of Spanish Harlem have chosen to become aggressive, self-employed private entrepreneurs – like Papito, who owns a 'string of crack franchises' run by street sellers. People like him are, wrote Bourgois, 'the ultimate rugged individualists braving an unpredictable frontier where fortune, fame and destruction are all just around the corner'. Much of the crack economy is run on conventional business lines, with a recognizable hierarchy of bosses, wholesalers, messengers and street salesmen (who have to meet sales quotas set by their bosses). However, the entire crack economy is based on violence and a culture of terror and, ultimately, on self-destructiveness. Dealers have to be tough and violent enough to intimidate competitors, impress their clients and cement partnerships with other dealers. As a result, homicides, woundings, robberies and high rates of crack addiction are common in the community.

Despite their violent, and ultimately doomed lifestyle, Bourgois emphasized that for these marginalized inner-city young men, employment (or even better, self-employment) in the underground crack economy 'accords a sense of autonomy, self-dignity and an opportunity for extraordinary rapid short-term upward mobility'.

Case study: social uses of alcohol in two pubs in Cambridgeshire, UK

Hunt and Satterlee⁷⁰ in 1986 described the different social uses of alcohol in two pubs in a village in Cambridgeshire. One pub, 'The Griffin', was frequented mainly by newcomers to the village, who were predominantly upwardly mobile and middle-class, and about one-third of them were women. Here alcohol was a way of creating and sustaining new relationships, especially by the ritual of 'round buying', which involved taking turns to buy drinks for as many as 20 people in the group. Much of their bonhomie spilled over into social events in one

another's homes, either before or after visiting the pub. In contrast, the clientele of 'The Three Barrels' were predominantly male, mainly working-class and middle-aged. Most of them had been born in the village, lived nearby, had known one another for many years and were often related to one another. In this ambience, 'round buying' was rare and unnecessary, since group cohesion was already maintained by a shared history, shared kinship and shared neighbourhood. In each pub, therefore, the same form of alcohol had a different meaning, and played a different social role in maintaining the cohesion of the group of drinkers.

Case study: distribution of Western pharmaceuticals in South Cameroon

In 1988 van der Geest⁹³ described the formal and informal distribution of pharmaceuticals in an area of South Cameroon. In the formal sector, medicines are provided without charge by state-run hospitals and health centres and issued by hospital pharmacies. Private non-profit institutions – usually church-run hospitals, health centres and primary-care projects – also prescribe medicines, but charge for them. In addition, private commercial pharmacies (of which there were 76 in the whole country) sell large numbers of these medications over the counter and without prescriptions. In general, these pharmacies are only situated in urban areas, since the pharmacists 'are entrepreneurs who only settle in areas with a high purchasing power'. They are highly profitable, with a high turnover; in 1978, the value of medicines distributed by this commercial sector was 50 per cent greater than those distributed by the entire public sector. Parallel to these officially sanctioned outlets, there is an enormous informal sector of pharmaceutical distribution in South Cameroon. It consists of many hundreds of people who sell pre-packaged medications to the public, in towns and villages throughout the country. These include:

- shopkeepers, who sell medicines as well as general provisions (in one town there were 75 general stores that also sold at least one or two types of medicine)
- market vendors, who sell these drugs along-side their other products
- hawkers, who travel from village to village during the cocoa harvest season, selling medicines as well as other articles
- traders who specialize in selling medicines, and who carry a much larger assortment than the other groups
- the personnel of medical institutions who illegally sell medicines that should be provided to patients free of charge (van der Geest estimated that up to 30 per cent of state-supplied medicines do not reach patients, but are sold privately by the health workers themselves).

The informal retail trade therefore obtains many of its drugs from the formal sector. While some are smuggled across the border from Niger, most are bought from pharmacists or hospital personnel, indicating how closely interwoven are the formal and informal sectors. In one example of this inter-relationship Van der Geest describes how, in one hospital, because patients had to wait a long time before seeing a doctor, they sometimes bought their medications (such as analgesics) while they were waiting from a medicine vendor who had set up his stand in the hospital grounds right next to the polyclinic.

In all, Van der Geest found 70 different drugs circulating in the informal sector, especially analgesics (13 types), antibiotics (12 types), cough and cold remedies, laxatives, vitamins, worm remedies, remedies for anaemia and antimalarials. He pointed out that while this sector does have advantages – for example, making drugs available locally at prices lower than at pharmacies – it can also be very detrimental to health. Despite this, it would be impractical to try to dissolve the informal sector, since this would deprive much of the population of their only source of modern medicines. Therefore, the aim should be to reduce the importation of drugs, thereby excluding dangerous or useless drugs from this sector, as well as improving the knowledge of vendors and clients as to the proper use of medicines.