

Book report: me medicine vs. we medicine



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Introduction

“ Is personalised medicine replacing public healthcare in ways that are harmful to us?” This is the main question that Donna Dickenson poses in her book *Me Medicine vs. We Medicine: Reclaiming biotechnology for the common good*.

By *Me Medicine* the author means personalized medicine, in which the healthcare with medical decisions, practices, and products is tailored to the individual patient. Opposed to what she calls *we medicine* as a “ one size fits all” approach (Dickenson, 2013).

In her profound and well written book, Donna Dickenson uses evidence from academic as well as from popular sources to give an overall perspective. This combined with her easy style of writing makes this book accessible to readers beyond a specific academic field.

I therefore recommend this book not just to the decision makers in the healthcare but to everyone who looks for a critical introduction to cord blood collection, direct-to-consumer genetic tests (DTC), genetics and enhancement. The book is also useful for individuals who are susceptible to advertisements and will be tempted to buy expensive DTC generic tests.

Challenge of Me Medicine

In the recent decade, there is an increasing tendency toward personalized medicine. Based on new biotechnologies as direct-to-consumer genetic testing or neurocognitive enhancement, personalized medicine, what the author calls “ *Me medicine*”, gets more popular. In contrast public health

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programs such as childhood vaccinations are met by global resistance. In the opinion of the author this is not a good development. Her main question throughout the book is “ How can we balance the role of the individual and the communal in healthcare and our civic life”.

In some cases, these new biotechnologies have shown positive results. Yet in others they have produced negligible or even negative results. This means that not just science is responsible for the increasing popularity of Me Medicine, but other more important factors play a role.

For this the author examines in her analysis the economic and political factors connected with the rise of Me Medicine and explores how, over time, this approach to our health might damage our individual and collective well-being.

Using the latest findings from leading scientists, social scientists, and political analysts, she looks critically at four possible explanations. These are: a sense of threat to our health, narcissism and decline in public-spiritedness, corporate interests backed up by neoliberal government policy, and the near-sacredness of autonomy and choice in our thinking.

Threat, includes many factors such as the idea that genetic and environmental causes of disease act at an individual level and thus require a personalised response, or the idea that individualised resources are safer than communal resources such as public blood banks, and finally a more general sense that public health provisions are under threat from economic cutbacks and cannot be relied upon for the future.

Narcissistic culture , is mainly based on two existing works Twenge and Campbell's The Narcissism Epidemic(2009) and Robert Putman's Bowling Alone(2000).

Corporate interests under neo-liberal capitalism, explains the well documented entanglement of capital and (bio)science as detailed by Dumit (2003), Rajan (2006) Waldby & Mitchell (2006) and Mirowski (2011) among others.

Sacredness of personal choice and individualism is about autonomy in contemporary medical ethics and bioethics of today.

In four case studies, she investigates the influence of these four possible explanations. These case studies are; Direct to Consumer genetic testing (DTC), Pharmacogenetics (tailoring drug treatments to specific genotypes), the banking of cord blood for future use and enhancement technologies (using treatment to be “ better than I am” physically, cognitively or emotionally).

These studies provides startling examples as: Personalized cancer treatments are often seen as the cure for cancer. While this works for some individuals, they work only on “ stupid” cancers, those with only one genetic mutation. Unfortunately because only a small fraction of human cancers fit this profile, personalized cancer treatments has little benefit to the masses.

Several courts have ruled that families who contribute their genetic samples to doctors, hospitals and corporations in hopes of promoting a cure for a

familial disease will lose control of the results, the subsequent treatments and any profits generated.

Another example is the scientific research for the benefits of DTC genetic testing. These tests proved to be so unreliable and of minimal use that 13 states in America prohibit sale of these tests and 12 more allow only certain tests under a doctor's oversight. In reality simple gathering of family illness history information is considerably more helpful in predicting future illness than the genetic testing available in 2013.

In her thorough analysis, Dickenson explores how, this paradigm shift in how we approach our health, might damage our individual and collective well-being. Historically, the measures of “ We Medicine,” such as vaccination and investment in public-health infrastructure, have radically extended our life spans, and Dickenson argues we've lost sight of that truth in our enthusiasm for “ Me Medicine.” It will come as no surprise that based on her research Dickenson concludes that ‘ we medicine’ is more promising for the improvement of the health of populations than ‘ me medicine’. Also that the most important driver of ‘ me medicine’ developments is neoliberal capitalism and corporate interest and not science.

Competitors: Personalized Medicine, biomedicine and information technology

Potential competitors of the ideas of Donna Dickinson might be the pharmaceutical firms, personal genetic firms, private companies for storing cord blood and governmental organisations.

Pharmaceutical firms who are facing patent expiry on blockbuster drugs, need to find a new business model: the nice for the personalized drugs. This way they can create new products and claiming new patents.

Personal genetic firms trying to pursue a strategy of accumulating genetic and lifestyle data and claiming valuable patents.

Private companies for collecting and storing cord blood, want to increase their income by promoting private cord blood banking.

Finally governmental organizations. For example, the UK government announced that it would offer private companies a subsidy from a £300 million fund to encourage investment in its personalized medicine initiative, Genomics England. Last year the US administration increased the National Institutes of Health budget for personalized medicine, while cutting the budget for the Centers for Disease Control and Prevention's Office of Public Health Genomics by 90 per cent. Politicians are not inclined to admit they have made a mistake by investing large amounts of money in medical developments that proved to be contra productive.

Societal and scientific relevance

The critical way the author describes four hypotheses in different contexts situated by technology in the cultural and political context, shows the societal and scientific relevance of the book.

The societal relevance is pointed out by the examples that large funds are made available for personalized medicine while at the same time budget is cut for parts of the we medicine. This way social and economic inequality will

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increase. Another example for the increase of social and economic inequality is that Gene-specific drugs will probably be very expensive because of the small market for these drugs. Only the wealthy people will profit from such a drug. Dickinson also raises the question that because of the higher cost of me medicine there is a change that health systems find themselves denying some patients treatment. Finally there is evidence from surveys that the public dislike both the term stratified medicine and the idea behind it of classifying individuals into subgroups.

Therefore this book has great social relevance.

The scientific evidence the author used, is also very relevant in these times. These evidences, especially evidence of advances in biotechnology shows that the promises of me medicine can't still be met. For example, that personalized cancer treatments are only helpful for some individuals, and have little benefit to the masses. Thus the question remains as to whether and when such techniques will have large-scale applicability. Another example is the unreliability of DTC genetic testing. The simple gathering of family illness history information is much more helpful in predicting future illness.

The important thing is that Dickinson used very up-to-date scientific research from a range of domains including sociology, ethics, philosophy, law and biomedicine.

Lessons learned

This book provides new insights in looking at the current paradigm shift from public health programs to personalized medicine. Dickinson makes it very clear that this shift can't be explained only by advances in biomedical science. She also points out the advantages and disadvantages from such a paradigm shift

Dickenson created a clear and coherent story through the same build-up of scientific evidence, used by the four hypotheses at the end and the context in which they are situated.

She makes her audience think about which kind of medical treatment is the best not only from biomedical point of view but also from other points of view as sociology, ethics, philosophy, and law. I think Dickinson presented the information well and unbiased. She explained the subject very clear to me.

Before reading the book, I didn't give the subject me versus we medicine much thought.

Now I think that governments should be very careful in deciding which forms of personalized medicine are supported. So that healthcare remains for the common good and not just for a happy few.

The subtitle of this book " Reclaiming biotechnology for the common good" points out that me medicine isn't a bad development in itself, but that that decision makers and public as well should be aware of the disadvantages of me medicine and try to minimize those.

This book is written in an easy style and looks at the different issues from a broad perspective.

I would recommend this book to decision makers in governments and public health organization as well to workers in the health sector and fellow students.

My only critical point is that the part about ‘reclaiming biotechnology for the common good’ is very small. Furthermore, the book ends with a call to ‘reclaim the commons’ of biotechnology through promoting the public general resources, but the strategies of how to reach these are missing. What is your choice, We Medicine or Me Medicine?

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