WHO WILL BE THE LAST HUMAN? OR, ARE WE EVEN STILL HUMAN?

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“A well person is a patient who has not been completely worked up,’ – a resident’s answer to the question, ‘What is a well person?’”

“Well people are disappearing. . . . After that, I began to look more carefully. I have not met a completely well person in months. At this rate, well people will vanish.”

With these words, Clifton Meador, a Tennessee physician, opens his satirical clinical encounter with the “The Last Well Person.” The protagonist of Meador’s account is a middle-aged former stockbroker turned professor who retires to devote his life to maintaining his health through an obsessive regimen of preventative care and testing. Regular checkups could find nothing medically wrong with him, but he was the last person for whom this was true. Norton Hadler echoed Meador’s essay a decade later while exploring the rise of medicalization—a cultural shift to interpret and treat everything, particularly nonmedical problems, from a medical perspective and the subsequent dangers of overtreatment that result from such a perspective.3

In our age of Viagra and the proliferation of Prozac and Ritalin, once commonly accepted descriptors of “average” and “normal” have become fluid placeholders given to the fickle whims of cultural values in a new type of arms race in therapeutic medicine. With prenatal genetic testing (PGT) becoming routine in obstetric medicine, species variation among our human brethren is being narrowed with ruthlessly systematic precision. Our intolerance of genetic diversity and variance in capabilities has led to what has been referred to by some as the “new eugenics.” These increasingly perfectionist interpretations of ideal humanity are leading to devastating tragedies around the globe whether through sex selective abortions or the extermination of prenatal life not deemed “fit enough” to survive.6

As societal advancement has been reduced to categories of technical “progress,” humans as Homo faber (“man the maker”) and the tools we create are no longer clearly distinguishable from one another, for we, like society itself, have become a machine of sorts.6 This transformation may not yet be one that is physical, but it is one in which our condition as physical beings has been reduced to medical diagnostics and therapeutic correction. This is no more evident than in the cultural shift from receiving children as gifts to pursuing the child of choice, children made through our own intention and eventually through our own design. A pursuit that will culminate in the actions of procreative beneficence and reproto genetics,7 creating perfect babies in the quest for the betterment of their future and our own personal happiness.6 Humanity becomes means to ends just like everything else. Sadly, that there has been such minimal resistance to this shift no longer comes as a surprise.

In our contemporary society there is no longer a place for imperfection or for inefficiency, as our technology disposes us toward goals in which it excels (e.g., standardization and efficiency). Medicine likewise disposes us to interpret nonmedical qualities or conditions in terms of pathology. Shyness and introversion, sadness and melancholy are all quickly becoming intolerable pathologies requiring therapeutic intervention. While medical and technological capability advance at breath-taking speed, a shift is occurring in which we must ask a new set of ethical questions. Some of these advances offer the means to alter the very nature of the human species and to challenge our traditional notions of what it means to be human.

Are disease and disorders, or even human finitude, realities that can be tolerated when the march of technological and medical progress push us beyond our reflection of ethics and values? Human imperfections and limitations have no currency, no value; they are merely technical hurdles to be overcome through technology, pathologies that medicine must fix in our endlessly flawed biology on the way to a “better than well” future. As our understanding of health has changed with the rise of medicalization, we increasingly interpret our humanity in these technical terms. Medicine has shifted from care and comfort to diagnostics and therapeutic technique,
believe it is important to engage in this conversation, but inspiring robust Christian bioethical reflection in the public health arena eludes us.

We intend to broaden the theological and bioethical conversation about what it means to care for our neighbor. Will you join us?

ontological mechanization that ushers in nothing more than merely complex biological machines. When this shift is compounded with the pervasiveness of objectification and the rise of commodification, the importance of our theological anthropology should be readily apparent, for a catastrophic shift in our cultural anthropology is in process.

Here is where our title for this reflection gains significance. In a clear challenge to those of us who struggle with living life constantly plugged-in, Katherine Hayles has provocatively written that some of us are already more “posthuman” than we care to admit, based on the nature of our technological use.”

‘Hayles writes, “the construction of the posthuman does not require the subject to be a literal cyborg. Whether or not interventions have been made on the body, new models of subjectivity emerging from such fields as cognitive science and artificial life come closer to encompassing what Homo sapiens counts as posthuman.” The point should be clear. Long before physical transformation occurs, we will have become posthuman, and more importantly, we will have embraced the posthuman. As we proceed boldly into the era of medicalization, into the rise of personalized medicine, into human enhancement beyond perfectionism, I wonder. Who will be the last human? Or, perhaps more appropriately, are we even still human? And, will we know when we no longer are?”

1 51. Minutes available on the center’s website at http://www.cbhd.org/content/beyond-perfectionism-0. 15, no. 1&2 (2008): 5. Also available on the center’s website at http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3300621/


3 42. Ibid.


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