THE POSTHUMAN PATIENTHOOD AND CRITICAL CARE

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Abstract

In the statistical terms, Illness is defined as the standard deviation from the general condition. Patient hood in the traditional understanding refers to the state of being, to the subject of illness and care. Where, patient is an autonomous embodied subject having dignity, autonomy and endures cure. Critical medicine and post human condition destabilizes this idea. The perspectives of medicine and humanism become saturated in a hybrid model of technologically advanced and co operated models. Post humanism highlights how critical care redefines patient hood. It is then, defined in the terms of variations and monitoring. Critical care becomes relational and algorithmic in nature which only focuses on Absolute cure by the extension of all available means.

"The Post Human Patient hood and Critical Care" discusses the position of illness subjects as an extended reality of medical gaze to an algorithmic patient hood where care is focused through statistical modeling and predictive analytics and has a complex ethical structure. "Post human patient" henceforth is interpreted more from a hybrid state of being rather than organic stature. . So this article would generally discuss how Critical care is not simply interpersonal approach but output based which focuses on absolute cure, which is the re authoring of what it means to be a patient when technology and human life are inseparably entangled.

Keywords: *Care, Cure, critical illness, control, dignity, autonomy, post humanism*

Abstract

"Since times immemorial the regulative idea *of restitutio ad integrum*, reinstatement of human wholeness or intactness, has dominated medicine. Currently, the idea of restoring the normal functions of the human body still plays a central role. However, another notion has recently entered the medical limelight as well. Beyond merely reinstating the original physical and mental states of the patients, physicians are currently increasingly envisaging the improvement of the traits of perfectly healthy persons. Thus, the *restitutio ad integrum* doctrine is gradually being forced to share its status in present-day medicine with *the transformatio ad optimum* idea, reshaping persons who are already in good physical shape to further improve certain characteristics. This phenomenon is commonly called enhancement" (Gordijn &Chadwick, 2010).

The above quoted text is from *Medical Enhancement and Posthumanity* in which the idea of *restitutio ad integrum,* the classical patienthood which has the immediate reformation and signaling shift to Human wholeness. *restitutio ad integrum,* works in the framework of care, cure and restoration, returning to baseline shifts to *transformatio ad optimum*, which is the posthhuman patient hood which works in the framework of optimization. This shift apart from the changing clinical practices has broader revisions in the concept of patient hood.

Taking into the account of inclusive clinical practices, I must say Posthuman Patienthood sits at the intersection of critical medical humanities, critical posthumanism and critical care.

Before we discuss post human Patienthood i must address personalized physiological medicine and its necessity.

Personalized physiological medicine is the product of, the understanding of the heterogeneous nature of patients. It arises from the limitations of conventional medicine which fits for all and works in a general framework which is based on population average. It understands that traditional medicine ignores the inter individual variability which has Innumerable treatment outcomes and adverse effects and acknowledges that every patient exhibits unique physiological and genetic profile as it "seeks to tailor care to the unique biological profile of the critically ill patient" (Ince, 2017) is about precision care in critical setting.

Through that we come into 'patienthood' which is, always in a flux where the line between person and patient is very thin, which is manifested by disease is not a static event but interaction with one's environment (Cassell ,1986a) which means the concept of disease is inseparable, from the concept of the person who has the disease. In this light Physician's need for to be technically competent and upright intensifies. As far as the art of medicine was concerned the physician's moral character was regarded essential. Their function was not to merely cure people but to care for. But in practice this went a radical transformation and now operates in a transactional level as Cassell, again suggests that it is not merely about diagnosis but understanding as the relationship between physician and patient is changing from a covenant to a contract (Cassell, 1986b).

Care, operating at transactional level happens because of the clinical overemphasize of Cure. it is evident through Beeson's concern with the balance of clinical practice and scientific research "Is the tail wagging the dog" (Beeson,1986) which, re orients priorities of medicine and Eisenberg who argues "that biological repair was given importance while undervaluing care" (Eisenberg, 1977) .with the perception that illness should not only be considered as a biological - physical malfunction or what we call as the standard deviation from the normal - it should be considered as the disruption of life as well as social relations. Physician's role therefore shifts from mere treatment to recognition of suffering as " patients feel they have gotten better sooner for having consulted a practitioner certified as possessing special prerogatives in sanctioning illnesses and arcane skills in restoring health" (p.236) In spite of this hyper dominance, bio medical reductionism strips medicine from its obligations by the very "success of medicine, or at least the publicity about scientific advances and new cures, has had the effect of increasing demands for its services. Not so long ago, hospitals were viewed as places to die rather than as places where miracles could be worked. But this has in turn effected changes in health-care-delivery patterns: increased size breeds bureaucratization and impersonality. While these features of American society may be tolerated, however reluctantly, in certain other areas, they are particularly resented in so intimate and personal a matter as illness'' (p.238).

Through this, we come into the realization that there is change in care delivery patterns, Patienthood therefore becomes a paradox of prevention and efficiency. This is evident through Skovdal's demonstration of PrEP Users, which is - Pre exposure prophylaxis In this

view we should read personalization, prevention and efficiency together. This study essentially discusses the duality of patienthood, where PrEp users are negative and at the same time they are argueably healthy, but they are administratively patients. Because of changed care delivery pattern "they may feel 'at risk' or judged socially and morally because of the medicalization of prevention" (Skovdal, 2025).

Which, takes us to the necessity of understanding Human nature in patienthood. The observation becomes significant, when "medicine becomes more technologically advanced and specialized, the risk of detachment grows exponentially. Increased medical gaze reduces patients into clinical problems" (Wailoo, 2022). Critical care gets into action irrespective of time and resources when there arises a clinical problem. It is an inclusive view which validates the argument where care extends beyond human relations as Cassell suggests.

In Such extension "Care detaches from being merely a relation among humans and becomes involved in a wider, more radical political ecology" (Parikka, 2019, 450). When I say care only happens through networking it directly attributes care practices, which are technologically infrastructured and resourcefully entangled, which has a complex power – political structure.

I said that the Posthuman Patient sits at the intersection of the triad. Patient therefore "the reimagination and rehabilitation of the conception of the patient, must begin with a more robust, holistic understanding of the individual that extends beyond the physical markers of disease to account for the 'whole person,' an entity composed of idiosyncratic biological, genetic, emotional, psychological, social, and cultural aspects, and possessing highly subjective experiences of disease"(Stock, 2013, p.3) is not simply a passive recipient of care but also a source for negotiation of knowledge.

Critical Medical Humanities is "always concerned about the application of medicine and position of the patient who receives care, in spite of latitudinal concept of health and tailored bio medical framework" (Braidotti & Oostveen, 2024). "It always gives us the problem who should be saved first" (Hwang, 2023), which is the site where medical practice faces crisis.

As far as Critical Postuhumanism is concerned "There is always a need of human in post human plurality .The encounter with the non human disrupts the human subject's sense of mastery. Human must act without the comfort of fully knowing what envelopes him" (Mentz, 2019), here that non human is technology which essentially means, the posthuman experience demands a new posture less detached from control or representation.. Critical care is the site for the disruption for the human subject "this stage is no longer a space for purely human presence but rather a site where technologies, bodies and environment co produce meaning" (Remshardt, 2010).

We saw the transition from Patienthood to Posthuman Patienthood. It is in the matrix of inclusive care practices. As Sobchack observes "medicine seeks to reestablish "the body's previous and privileged wholeness'" some bodies never will be - or never have been - whole,' in this sense, whether due to amputation, paralysis, cognitive impairment, developmental disability, psychological disorder, or any other 'abnormal' bodily state (Sobchack, 2006, p22). The wholeness of human subject can happen only through the intervention of personalized clinical practices and technological assemblage.

Specifically I would say, that constructed reality through critical care practices. Of course, if raises the ethical concerns and question of agency but they are set aside and needs to be addressed separately. My point is that, only in this Matrix, the question of human rises again. To be precise, in the spectrum of illness, the human meaning can only be extracted, is by tracing the posthuman patienthood. This should be explained with a tangible example.

The post human patienthood, in practice can be found in the event of critical care. The ICU is the tangible site for it, which is constructed through continuous clinical monitoring, technological devices and assemblage and transformed patient identity. Horton argues that ICU is a site of necessity. It is the interface between medical decision making and exceptional circumstances. "that admission should take place only where the patient 'has a reversible acute condition and is and is appropriate for advanced intervention' but not where the patient's 'co- morbidity and poor physiological reserve make the prospect of significant and sustained recovery minimal " (Horton, 2025, p.148) this observation, from Hospital's direction given to regulate Care , which demonstrates the legitimacy of receiving emergency care which mainly discusses the availability, efficacy and potential outcome emergency care. Patient now becomes no longer only a subject of care.

In spite of being a technological construction posthuman patienthood now has a legal assemblage. It now becomes more, less autonomous human subject. Now we know that ICU is the concrete site where care is task oriented which it prioritizes physiological parameters over subject patient experiences. But at the same time it is the site for humanization. Apart from the material- complex forms of Care, there should exist acknowledgement from clinicians, care givers and family, where human is not lost in the circuit of care but it is re configured as Basile observes that "clinicians need to detach themselves enough to be able to perform invasive procedures, and the recognition of the patient as a human with sensitivity to pain. Humanization, too, may also be associated with outcomes such as improved communication and decreased psychologic morbidity among patients. Because the impact of dehumanization and humanization may be significant, it is imperative to understand how ICU patients are dehumanized and humanized and to understand the root causes associated with such behaviors"(Basile et.al., 2021).

This takes us back to Nayar who argues that posthumanism is not a rejection of humanity but an expansion of what counts as human. "Posthumanism is not about the end of human but about rethinking the human in relational, distributed and non anthropocentric terms" (Nayar, 2014). Here I should say, the patient in the ICU is in such relational construction only where the life is sustained , and the reorientation of human meaning comes through external human intervention as part of the inclusive care practices, where human is never erased.

Hence we'll come to the agreement "thinking about care through the lens of posthumanism arguably brings it to the forefront of medical considerations as the relationality of care lends itself to a posthuman perspective" and only through "Bringing a posthuman perspective to the medical humanities can therefore change the emphasis of what we consider medicine to be" (McFarlane, 2024).

To conclude I must say posthuman patienthood is always defined in network of relations. It is the web of clinicians and critical care practices and facilitated by technology and devices. This is mediated for optimization of health and restores the human wholeness.

Posthuman patienthood is not in a permanent flux, because physiological state is time variant. When critical care is successfully removed there will be no patient. Posthuman patienthood makes patient 'person' 'again', becomes a reconfigured rather than a rejected human subject.

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