The treatise №2 from series "*About ontological and epistemological grounds of modern medicine and physiology*"[1]

THESES ABOUT MAIN ONTOLOGICAL AND EPISTEMOLOGICAL DOCTRINE OF CLINICAL MEDICINE IN 21st CENTURY

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Abstract

This small treatise is short introduction to main ontological and epistemological problem of the modern clinical medicine, interpreted here as a practical science; namely it is introduction to a problem of *individuation* (*individualization*) *of doctoring*. I will offer special treatises with more detail interpretation, a substantiation, and my version of the decision of this problem a little while later.

Keywords: "*clinical medicine*"; "*technological doctrine*"; "*individual nature of patient*"; "*individuation doctrine*"; "*individuation of doctoring*"; "*addressing of doctoring*" (*or* "*selectivity of doctoring*").

Резюме

Этот небольшой трактат представляет собой краткое введение в главную онтологическую и эпистемологическую проблему современной клинической медицины, интерпретируемой здесь как практическая наука - введение в проблему *индивидуации (индивидуализация) врачевания*. Несколько позже я предложу специальные трактаты с более детализированной интерпретацией, обоснованием и моей версией решения этой проблемы.

Ключевые слова: *клиническая медицина*; *технологическая доктрина*; *индивидуальная природа больного; доктрина индивидуации; индивидуация врачевания*.

Prologue

The modern science historically starts in that time when knowledge practice initiates separating from priestly practices, and becomes independent of these. Social circumstances favorable for it have arisen in the Ancient Greece by the end of first half of 1st millenium BC, and a physiophilosophical movement here was originated at that time. Various physiophilosophical schools have tried to find final reasons of the natural phenomena underlying a natural variety of actual and latent properties and relations of things. The epistemological skepticism formulated by sophists and based on physiphylosophy of Heraclitus, becomes result of opposition between schools: the knowledge of the nature of things of infinitely changeable world is impossible. The ethics of Socrates has accepted reaching of the well-being of the person as the purpose of knowledge. Schools of professional doctoring on this background have started to consider medicine as a science and a iatrotechnics (doctoring art) which are based on certain physiophilosophical knowledge. First of all thanks to Koss Physicians School the epistemology of a medical science has been formulated. This epistemology has identified knowledge of health status of the patient not as the knowledge of its nature exactly, but as knowledge of real possibilities to provide with medical aid the individual nature of each patient. Since then medicine has started developing actually on two basic epistemological traditions - on *empiricism* and *rationalism*. But always in real circumstances each physician thinks both as rationalist and as empiricist. A marginal version of empiricism considers sensual experience as a source of knowledge and assumes that content of knowledge is

[1] Earlier the treatise №1 has been published (See: *Kutlumuratov A.B., Kutlumuratov C.B.* "About an intuition primacy in the clinical medicine" / viXra submission 1604.0206). In this work, in particular, a demarcation between natural and practical sciences regarding significance of logical thinking and intuition of a researcher for these was performed.

either sensual experience or the description of this experience. A marginal version of rationalism adheres to a position according to which any knowledge is based on some aprioristic principles, and from these we can deduce new knowledge. However, a physician thinks and treats patients in situations which are very far from such extreme cases.

After Bacon and Descartes "syncretic" (logical-empirical) method of thinking has been established in the European natural sciences as the basic one. Medicine has started to develop under a mark of dominating of rationalism over empiricism and represent an organism as a complicated natural *"mechanism"*. It is supposed that in the foreseeable future the knowledge of this "mechanism" will allow to operate all processes of vital-activity of an organism of the sick/healthy person in interests of his/her health. In 19th century and in the beginning of 20th century this domination has been embodied in developing of pharmaceutical industry, and this has unrecognizably changed an arsenal of conservative treatment of illnesses of the person and has expanded possibilities for surgical interventions. By the end of 20th century and the beginning of 21st one this domination was embodied in a rapid progress of the medical technical equipment and a technological arsenal of conservative (non-invasive) and invasive treatment. Besides a pharmaceutical arsenal the modern clinical medicine has wide technical possibilities. Presence of these two technological arsenals in modern medicine does not guarantee adequate application of ones in each clinical case yet, but this presence refreshes a problem of this adequacy on new epistemological level. There is a deep chasm between variety of technological possibilities on the one hand and adequacy of a choice of schemes of doctoring (according to the requirement of individual approach to medical interventions in each clinical case) on the other hand. Only the attending physician is able to fill this gap beneficially for health of each patient.

Purposes

I formulate the main "technological" doctrine of clinical medicine, the doctrine which determines "technology" *of physician's* thinking, or *an individuation doctrine of doctoring*. I also aspire to characterise essence of this main doctrine, and to show, that any variants of an epistemology of the clinical medicine interpreted here as a *practical science* (a science of doctoring) are based on this doctrine which physicians use almost unconsciously, actually spontaneously. In particular, I shortly analyze three basic epistemological doctrines of technological development of clinical medicine in 21st century, which tries to solve the main problem, an *individuation* problem *(or an individualization problem) of each patient's doctoring* with aid of these; I also aspire to characterize essence of this main problem.

Principal theses

Three basic technological doctrines

The clinical medicine - a science of doctoring, which investigates the nature of health of the human being, and also ways to protecting health if the human being is healthy, and to restoring health if the human being is sick, and operates in interests of health of each patient. Hence, this area of a science is based on idea of an individuation according to which always for any two individuals in reality it is possible to find a sign distinguishing these from each other. And spatial and time distinctive signs between individuals are final. Even if we do not know any properties and relations inherent to individuals, the fact that two individuals co-exist in space and time allows to assert, that they are not identical to each other. Distinctions between individuals regarding ones' properties and relations supplements this primary distinction regarding space-time; individuals co-exist with each other in one world, maintaining and advancing own individuality. The individual nature of each living thing detects itself in actual and potentially infinite variety of its properties and relations, and by this way expresses current coexistence of that living thing with an external world.

If we will dart a glance at evolution of medicine within the past 150-200 years, then we can find, that this evolution is result of development of following three basic technological doctrines.

1. *Traditional (rationalistic) doctrine*. This doctrine assumes, that each physician applies own abilities to diagnostics and iatrotechnics, in other words, abilities to detection and the analysis of signs of illnesses, during medical examination, clinical research of patients and medical procedures, and to acceptance of adequate decisions during doctoring of each patient. A physician establishes

the diagnosis of health status of the patient and assumes a "mechanism" of his/her disease; the physician deduces from this assumption ways of elimination of diseases' causes, and medical appointments necessary to patient; the realisation of these appointments should result by recovery of health of the patient. For example, doctoring can involve a method of the surgical treatment stipulating operational traumas with various level of burden for the patient, which are able to affect the further destiny of the patient quite seriously. Various kinds of conservative therapy also are not ideal from the point of view of ones' influence on health status of patients. Nowadays this doctrine is almost entirely based on traditions of epistemology of "organismic" medicine, which are assuming knowledge of anatomical-physiological "mechanisms" of organism survivability. In other words, it is supposed that physicians adhere to rationalistic *approaches* to doctoring only in a context of this tradition. During long time the medicine was developing conservative therapy and the traditional surgery of open access to a seat of organism's damage on the basis of this doctrine. This doctrine gradually starts to pale into insignificance, yet keeping a worthy place in modern medicine. This doctrine keeps great value when medical aid is granted in absence or under lack of technical and laboratory diagnostic resources, and, hence, when results of doctoring depend very much on ability of the physician to clinical thinking.

2. *Macro-technological doctrine*. In the process of development of medical methods and a pharmaceutical industry (on basis of biomedicine) the arsenal of tools of laboratory diagnostics and medicalization of patients has been considerably enriched. The claim to provide physicians with tools and means of laboratory researches was as a result established; this allowed to increase entirety of diagnostics of diseases to understand ones' "mechanisms" and accordingly to enhance an addressing (selectivity) of treatment effects. Experts nowadays work to reduce or even in general to avoid necessity for applying a scalpel. The technics of the minimal surgical interventions (for example, laparoscopic operations), which are allowing to avoid the troubles connected with traumas of open surgical access to internal organs, reduce time of operation and the postsurgical rehabilitation period, to provide the best viability and quality of a life of the patient, has been developed. In oncology these methods sometimes allow to avoid a laparotomy and expand application not only of palliative operations, but also radical programs of radiotherapy and complex treatment (for example, a brachytherapy). This doctrine allows improving medical interventions and reducing consequences of these interventions, taking into account natural "mechanisms" functioning in an organism of a patient.

3. *Micro-technological doctrine*. At the end of 20th century, in the process of development of a science and the technical equipment, the requirement to selective treatment of patients has been more and more increased. In parallel with it the tendency to radical intervention into anatomy and physiology of an organism of the sick person for the purpose of artificial support in him of vital processes has been increased.

Experts believe that bioengineering and medical Nanotechnology will become basic technological doctrines of 21st century's medicine and these will allow treating most different pathological statuses. For example, a key problem on a pathway to reaching of these aims is the creation of special medical Nano-robots - of Nano-vehicles for diagnostics and repair of damages at cellular level.

These achievements of Nano-medicine will become accessible in 25-50 years. Laboratories on the chip will allow to carry out many difficult analyses very quickly and to receive results that are extremely necessary in critical situations for a patient. For example, study of blood structure; identification of consanguinity of a person by means of DNA; detection of poisonous substances; cleaning up of water and air; disinfection of clothes and of special coverings.

Nano-therapy will include an injection of Nano-robots into a human body for the further analysis of a situation and decision-making with regard to a method of treatment. Physicians will operate Nano-robots, receiving the information from these. Thus, this doctrine actually is based on idea according to which the microsigns allow to separate a pathology from health. It is supposed, for example, that «the physics of microscopic distances» will allow the physician to influence

natural molecular "mechanisms" of person's body functions directly for the purpose of treatment of patients.

Natural "mechanism" and essence of doctoring

All three listed technological doctrines are versions of the rationalistic epistemology of modern clinical medicine which is interpreted as a science based on theoretical (logic) generalizations of empirical data. Such generalizations underlie of our knowledge about natural "mechanisms" and causes of health or illnesses of the person. This knowledge is not knowledge of the nature of concrete patient, but this knowledge characterises his/her status ("mechanisms" of the status) as an element of a certain class of statuses (a class of "mechanisms" of a status). However, a physician aspires to reach recovery of each patient's health. Meanwhile each patient is the infinitely complicated, unique natural "mechanism" which cannot be reduced to any classes of natural "mechanisms". Therefore the knowledge of classes of natural "mechanisms" does not guarantee of adequacy of intervention into a status of the concrete patient. Hence, in an ideal all trajectory of doctoring actually is the process of *an individuation* of all available medical knowledge regarding of interests of each concrete patient. *The clinical medicine as a science of doctoring is a practical science about an individuation of available knowledge about nature of person in a sick or healthy status, for the good of each patient; and just the attending physician conducts this individuation completely.* From here follows, that all achievements of modern clinical medicine are based not only on the described three doctrines. Actually these achievements would be impossible without each attending physician's individualising clinical thinking. *Only* an attending physician provides the adequacy, and, hence, selective efficiency of application of available technologies and knowledge about human nature, subjecting these to individuation during clinical research and doctoring of each patient. However, this "only" is very significant.

Having a wide choice of the diversified means of treatment of one illness, we get into serious uncertainty when we wish to treat the concrete patient on the basis of knowledge of "mechanisms" of his/her disease. Any effective ways of doctoring includes some number of procedures and application of some medical remedies. However, hopes to determine precisely individual mechanism of disease of each patient by diagnostic tests are illusory. Any hopes, that a physician can select accidentally a combination which is the most suitable one individually for each patient among astronomical number of probable combinations from various schemes, sequences and doses of medical agents, are illusory also. The number of these combinations becomes astronomically big even if the number of such agents, from which a physician can constitute these combinations, is a small. For example, at the scheme of treatment which includes only 10 components (10 agents) - procedures, medicines, modes, application schemes, etc. - the number of such variants will constitutes *10!=362880*. We cannot know for certain which of these variants is the most suitable one for *the* certain patient in a present clinical situation. Furthermore, each physician implies tens of such agents (procedures, schemes, modes and drugs), but he/she should choose these by proving suitable variants for each clinical case. Only an individuation which an attending physician conducts during doctoring allows to eliminate the uncertainty created by expanded applying of a rationalistic epistemology in clinical medicine.

Individuation doctrine (individualizing doctrine)

The modern official medicine does not take into account the fundamental ontological difference between a real state of health of the patient and the individualising description by physicians of his/her current state (the difference between the current unhealthy individual nature of the patient and the diagnosis of his/her state). *However, each physician uses such gap in each clinical case in practice.* It is considered that a diagnosis expresses a real status of the patient. But actually each diagnosis is only a conception, an abstract description of the status of the patient with aid of rationalistic knowledge of the nature of this status (of its “mechanism”); it even is not approximate copy of this status in professional consciousness of the physician. The diagnosis allows the physician to log on into the “reference system” of the process of a morbid individuation of patient's nature mentally. And now, if the diagnosis is adequate, physician's task is to pass into "reference system" of healthy individuation of the patient together with him/her. Each practical

physician always operated before and operates nowadays (irrespective of as far as he/she understands it) in frameworks of this strategy we can name *strategy of an individuation of doctoring*. *The individuation of doctoring* of each patient was before and is now the basic doctrine of the medicine considered as a science of doctoring. But physicians and researchers do not attach importance to this fact still.

Three basic technological doctrines, described above, we can consider as components of this main doctrine in a modern variant of its interpretation. *An individuation of doctoring is the strategic doctrine of the clinical medicine* interpreted *as a science of doctoring*. Evolution of individuation technologies of doctoring always took place - and still takes place - only within the practice of doctoring, by way of the spontaneous adaptation of physician's thinking to demand of rationalistical knowledge of the "mechanisms" of health and illnesses of a person. In other words, when the modern physician uses knowledge of these "mechanisms" he/she spontaneously (intuitively) adapts it for technology of individuation he/she develop during all his/her professional practice. However, there is no certain special practice of scientific development of technologies of an individuation of this process (the process of doctoring), and there never was such practice: actually each physician develops own doctrine of an individuation of doctoring. And usually each physician creates own doctrine, adapting own intellection to working with certain collective of physicians.

Previous to present time about an "individual approach" to doctoring many authors had spoken and many authors often speak about it nowadays. But what precisely it is implied under the term "individual approach" in modern official rationalistic medicine? We can tell about it undoubtedly only the following: this term is not relating to quite spontaneously current process of individuation of doctoring.

When the modern scientists speaks about «an individual approach to each patient», usually by it mean aspiration to estimate the health status of the concrete patient by means of the data of diagnostic researches, clinical monitoring and knowledge of classes of the physiological "mechanisms". In this case the physician solves a routine problem: he/she relates these registered indicators of a status of the patient with a certain class of status of an "averaged" human body. It is not a question about a status of the patient as about expression of natural process of an individuation of his/her nature. The real effect of doctoring depends on adequacy of such estimations and decisions, which were accepted by the physician concerning this patient during all process of doctoring. The concept "an individuation of doctoring" expresses the fact, that the physician is involved into a flow of a natural individuation of a nature of a patient by his/her thoughts and actions, and this flow is process of patient's ontogenesis. The doctor as if dares to be involved mentally into a flow of a painful individuation of the nature of the patient, and then tries to redirect this flow into a channel of a healthy natural individuation with the aid of his/her professional knowledge, experience and intuition.

General conceptions of "mechanisms" of illnesses cannot really characterise a current status of the concrete patient, as its nature is absolutely unique. Each physician forms technology of doctoring of each patient during his/her doctoring only, and the physician involves *eclectically* for this purpose the many various facts from various areas of medical scientific knowledge. And then physician, guided by the main doctrine (*doctrine of individuation*), involves gradually into the process of doctoring the rational (non-eclectic) knowledge he/she has. Physician selects various fragments of medical knowledge, conjugates these fragments with these data, and thus constitutes representation about *the preliminary diagnosis*, a status of the patient. A preliminary diagnosis bears many accidentals and inexactness. But the further physician observations during process of doctoring allow to specify and form gradually representation about *the clinical diagnosis* directly influencing a choice of character and sizes of medical interventions. A physician forms *the* final *diagnosis* when doctoring is coming to the end: he/she can put forward the proved conception about the nature of illness of each patient only after exhaustion of all the process of his/her doctoring when all the significant clinical symptoms of disease are already extinguished. Thus, the health status of each patient can be estimated as much as possible adequately only when process of his/her doctoring will be finished. Hence, an individuation of patient's status cannot is reduced to certain

standards, for example, such as *ICD-10* or *ICD-11*.[2] These and other standards are only used by each physician during a clinical individuation of a status of each patient as reference points in clinical thinking.

The main doctrine exists *de facto*, and it influences behavior of physicians, but physicians not always have a clear comprehension of this fact. (We regularly make a banal mistake: we believe, that our intellection is completely conscious process). This doctrine is not interesting properly to a modern science. This is caused by rationalistic biases of modern official medicine on the one hand, and by social and economic imperatives which are involved into a life of a modern market civilisation on the other hand; and both these circumstances do not motivate interest to this doctrine. But mainly skilled physicians follow this doctrine to the extent practicable from the point of view of ethical professional considerations only. Within this doctrine the problem of clinical medicine is reduced to the task of the adequate control by a current individual status of an organism of the patient during all doctoring process. The physician as if aspires to involve himself/herself mentally into a stream of a painful individuation of the nature of the patient, and then to deduce this stream onto a trajectory of a healthy individuation, using a professional knowledge, experience and intuition. A suitable metaphor: the pilot conducts a vessel on the unfamiliar river with aid of Sailing Directions, and the pilot also orients himself/herself with respect to a local terrain, relying on own knowledge, professional experience and intuition. Similarly so-called classes of "mechanisms" of disease of the patient are performing only auxiliary function of "catalytic agent" during real process of treating; and by this a consciousness of the physician becomes involved in process of a clinical individualization of patient's status, an individuation of doctoring. Thus, there are no questions of finding of illness' "mechanism" at patient in process of doctoring, though the official medicine it supposes just.

The concept of "mechanism" is not identical to concept of «an organism status», which is used by the official medicine, armed with multivariate statistics and the theory of probability (for example, within practice of "evidential medicine"). The official medicine equalizes these concepts, considering the individual nature of a patient as the countable individual natural "mechanism" providing course of physiological processes in its organism. The inaccuracy of such approach becomes obvious as soon as we will address to professional behaviour of physicians. The physician does not try to touch mentally all logically probable variants of an estimation of a current status of a patient, and chooses specific ones, taking into consideration own experience and trusting own intuition. During process of doctoring a physician detects characteristic individual indicators of a status of each patient. But the physician do not touch all possible individual variations of ones. And the physician makes the conclusion, leaning on own experience and knowledge, and leaning on an experience and an knowledge of colleagues (medical consultation, or *consilium*). However, the official medical science develops on the basis of an implicit assumption as if the knowledge of "mechanisms" underlies medical thinking. Despite this opposition physicians operate quite effectively. The single explanation of this efficiency is that a physician actually does not treat a patient, but helps his/her nature to restore a healthy flow of an individuation. The recovering is result of "work" of patient's individual nature itself.

A physician can have really adequate knowledge about "mechanism" of illness of the patient only after its clinical signs are already extinguished. The knowledge about "mechanisms" of diseases which was collected by medical science can be applied by a physician only as first "touchstone" during doctoring of each patient. But also any decisions accepted by a physician during doctoring are "trials". A physician is able to control damages caused at a patient by medical actions only, and a physician can aspire to reduce these damages in order to maximise the final effect of doctoring. The knowledge about "mechanisms" poorly help to individualise treatment, but it helps to explain why a physician has chosen this or that decision. Such an explanation can be only verisimilar, but it poorly reflects a real clinical situation. It is easier for a physician to explain his/her actions with helping of knowledge of "mechanisms" rather than really explain why he/she

[2] "ICD" - "International Classification of Diseases".

operated just so, but not differently, and why his/her actions were clinically effective, ineffective or noneffective. Any lawful acquittal of professional actions of a physician is based on the logic analysis of motives of these actions and of medical knowledge which a physician uses, i.e. on rationalistic considerations.

Individuation of doctoring express an essence of the science "clinical medicine"; hence, we can't do without an individuation doctrine in a context of this discipline. This fact enters rather specific pragmatical restrictions into medical epistemology: an individuation of doctoring converts the clinical medicine to *a practical science*, the science of doctoring. But medicine usually is interpreted as the area of natural sciences based on a rationalistic epistemology. Representation of the patient's health status as the reference to some class of "mechanisms" is bounded epistemologically because in real practice in each clinical case each physician actually creates *de novo* representation about individual "mechanism" of patient's status, its specificity, and a configuration of the causality involved in maintenance of this status. The content of this representation is supervised by a doctor, whose thinking is constantly guided by a current state of the patient, current clinical signs of its illness. For example, even if all existing projects of Nano-medicine will be implemented, we can't do without an individuation doctrine; vice-versa, it even more will strengthen requirements to development of a doctrine of individuation. Development of Nanomedicine can affect only tactics of doctoring (just as it occurs at the development of the rationalistical doctrine and the macrotechnical doctrine), but nanotechnologies cannot cancel a strategy of an individuation. The individualization doctrine evolves, remaining «a skeletal support» of all the clinical medicine, uniting all technological doctrines into a common system, and legalizing an existence of these. When we develop a doctrine of individuation we develop the pragmatical essence of a medicine and humanistic traditions of this discipline for the good of each patient.

Conclusion

We can reduce the concept of modern clinical medicine to following three basic technological doctrines - to traditional (rationalistic), macrotechnical, and microtechnical one. These doctrines are evolving on grounds of a logic-empiric epistemology of natural sciences. But a doctrine of individuation develops during many centuries in frameworks of the social practice of doctoring in the process of adaptation of a professional physicians' thinking to circumstances accompanying this practice. This doctrine develops on the basis of an evolution of physicians' intuitive thinking only, hence, within their individual practice. This doctrine evolves only within the specificity of experience, knowledge, and schemes of mobilisation of each physician's professional intuition. But the scientific developing of this doctrine is not ensured in modern medicine, for example, it is not ensured by practice of evidential medicine. Actually each physician develops own individuation doctrine of doctoring. This doctrine cannot be replaced with other ones, and it serves as a "skeleton» of all other technological doctrines of the medicine. Scientific development of this doctrine in accordance with problems of an our time, in my opinion, should be considered one of the main tasks of an epistemology of modern clinical medicine. This task is even the most important among such tasks. The decision of this task would allow to have provided a significant breakthrough in an evolution of the clinical medicine, having strengthened an ability of physicians to applying of different technological possibilities of the modern medicine in maximal accordance with the nature of each clinical case.

Epilogue

Thus, *an individuation doctrine of a doctoring* is the fundamental conception, used intuitively by each physician to control an adequacy of his/her clinical thinking regarding each clinical case. The epistemology of clinical medicine - as the epistemology of a practical science of doctoring - can be developing actually just on this main doctrine. But each collective of physicians evolves this doctrine spontaneously in the course of adaptation of physicians' thinking to circumstances in which they conduct doctoring of each patient. Each physician follows this doctrine involuntarily when he/she applies own experience, knowledge and mental abilities for maintenance of an adequate understanding of a status of each patient. Specificity of medical practice forces a physician to think

about an individuation of treatment of each patient. However, I emphasize, the process of an individuation of doctoring is conducted spontaneously and goes only under an attending physician's control; actually each physician develops own individuation doctrine of doctoring. It is partly caused by positions of managers of medical practice and experts of health care, who take into consideration mainly administrative possibilities and circumstances influencing profits of medical business. But the medical community have interests to the development of an individuation of a doctoring, and this corresponds also to interests of patients. Hence, managers and experts of public health services also extracts benefits from this doctrine. In addition, in my opinion, “the Semmelweis effect”[3] should weaken if the process of an individuation doctrine evolution will be conducted by scientific means, but not spontaneously. Also the success depends on the political power (certainly, if the power has interest to increase of an efficiency of public health services). Anyway, the political power can take into consideration interest of a medical society in the development of an epistemology of individuation of doctoring and motivate on this direction an official science and managers of public health services. Welcoming the doctrine of an individuation of doctoring as object of priority attention of a modern science the official medicine and Public health services could open new possibilities to motivate physicians to build-up of professional abilities, and this will beneficially influence upon efficiency of all forms of medical assistance. I believe our expectations from new technological breakthroughs in modern medicine will be legitimate if we will focus our efforts not only at a rationalistic epistemology of three basic technological doctrine. Now the understanding and perfection of statuses and circumstances determinIng the effectiveness of physician's intuitive thinking also is very importantly for us.

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К читателю

Трактатом «Theses about main ontological and epistemological doctrine of clinical medicine in 21st century» я продолжаю публикацию цикла работ об эпистемологических и онтологических основаниях *медицины* и *физиологии* как интимно связанных между собой *практических наук* и о *природе клинического (врачебного) мышления.* Данный цикл представляет собой результат переработки *второй книги* трилогии «Физическое тело человека», завершенной мной в конце 1999 гг., но оставшейся неопубликованной (как и написанная годом позже третья книга этой трилогии) в силу обстоятельств, не зависевших от меня. В 1997 году в свет вышла лишь первая книга трилогии*, посвященная *введению* в самые общие вопросы философской антропологии, философии науки, формулировке общей (психосоматической, или - психофизической) модели (онтологии и эпистемологии) медицины, в частности, эвристике клинической онкологии. Книга была написана в форме лекции, как свободное размышление о человеческой природе, ее эволюции, социальной истории науки и, в частности, клинической медицины. Основную ее тему выражает вопрос - «Может ли клятва *Гиппократа* иметь естественнонаучную основу?», поставленный в самом начале предисловия. Главная ее цель – указать на общие ориентиры для поиска ответа на него. Вторая книга по замыслу должна была развить эту тему в контексте прагматических идеалов медицины, превращающих ее в специфическую естественную науку - *практическую*. Настоящий цикл создан на основе черновиков второй книги трилогии, переработанных с учетом литературы, которая стала доступной в последние два десятилетия и, так или иначе, затрагивает эту тему.

Причины, побудившие к решению публиковать данный цикл в электронном архиве *viXra.org*, вполне соответствуют политике данного архива. Укажу только на две из них.

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* *Бекчан А.* (*Кутлумуратов А.Б.*) Физическое тело человека (или непрочитанные лекции о полноте человеческой природы).- Ташкент: Изд-во им. Абу-Али Ибн-Сино.- 1997.- 312с. (“Атабек Бекчан”, а в латинской транскрипции “Atabek Bekchan” – не псевдоним, а личное имя, соответствующее традициям личного именования, свойственным культурам Центральной Азии, Кавказа, сходным, впрочем, и с таковыми многих культур Восточной и Западной Европы; ряд моих работ опубликованы под этим именем).

Во-первых, в соответствии с этой политикой архив не требует *предварительной научной экспертизы* публикуемых в нем работ. Такая экспертиза иногда нецелесообразна: существует много причин, по которым не всегда можно найти рецензента, способного адекватно оценить работу, особенно если та затрагивает трудные вопросы философии науки и междисциплинарную сферу, где зыбкость оснований познания слишком очевидна. Дать же экспертную оценку работе, уже *опубликованной*, ничто и никому не мешает. В этом - преимущество данного архива перед рецензируемыми изданиями, и я нахожу его соответствующим моральному праву автора не ставить публикацию своего труда в зависимость от *рецензии*, которая, к сожалению, слишком часто носит *формальный* характер.

Во-вторых, *архив сохраняет за авторами право на публикацию работ в рецензируемых изданиях*[**], заинтересованных в сотрудничестве с авторами, опираясь на непредвзятые отзывы. Что касается меня, то за 40 лет научной карьеры я привык работать в рамках требований к публикациям, выдвигаемых рецензируемыми изданиями. Поэтому, обращаясь к услугам данного архива, я не исключаю и сотрудничества с такими изданиями, если у тех возникнет желание издать трактаты данного цикла.

Ранее в *viXra.org* был опубликован трактат «О примате интуиции в науке врачевания»[***] (на русском языке), написанный на основе тех же черновиков, который следует считать первым трактатом данного цикла. Опыт опубликования этого трактата в данном архиве и подвел меня к мысли создать цикл трактатов на основе черновиков второй книги трилогии “Физическое тело человека”. Первый трактат был опубликован в соавторстве, но в *остальных трактатах цикла* соавторов не будет. Принадлежность публикуемого трактата одному циклу всякий раз будет указываться в заголовках. Последовательность, с которой я планирую публиковать трактаты цикла, не обязательно будет соответствовать последовательности изложения соответствующих разделов второй книге моей трилогии. Каждый трактат я стремлюсь оформить как самостоятельную научную статью. Базовые идеи, разумеется, будут в них повторяться в разных ракурсах, объединяя их в тематически единый цикл, которому, полагаю, вполне подходит общее название цикла - «Онтологические и эпистемологические основания современной медицины и физиологии».

Все трактаты я планирую публиковать на английском языке[****], имея в виду, что большинство моих читателей проживают в дальнем зарубежье, но буду стремиться снабжать каждый трактат полным параллельным текстом на русском и узбекском языках (правда, не сразу, что допускается правилами для авторов, публикующих свои работы в данном архиве).

Цикл я адресую главным образом философам и методологам медицины, преподавателям медицинских кафедр - клиницистам и специалистам по биомедицине. Хочется верить, что его читателем будут и *опытные врачи*, сумевшие с годами практики развить склонность к научным обобщениям, или сохранившие ее, если та была свойственна им в молодые годы. Я имею в виду профессионалов, стремящихся научно осмыслить свой опыт, чтобы передать его *молодым коллегам* и *целеустремленным студентам*, надеющимся стать опытными врачами. Речь, таким образом, идет о потенциально огромной читательской аудитории, являющей той интеллектуальной силой, которая в любой стране мира прямо заинтересована в росте качества врачебного обслуживания населения. И именно на эту силу в конечном итоге и опираются политики, менеджеры и эксперты здравоохранения.

Вторая книга трилогии «Физическое тело человека» (следовательно, весь данный цикл) я *посвящаю памяти друга – Татьяны Алексеевны Головиной*.

Кутлумуратов Атабек Бекчанович (Атабек Бекчан)

[**] См. http://vixra.org/submit (проверено 27.01.2020).

[***] Кутлумуратов А.Б., Кутлумуратов С.Б. О примате интуиции в науке врачевания. (*Kutlumuratov A.B., Kutlumuratov C.B.* “About an intuition primacy in the clinical medicine”) - viXra submission 1604.0206.

[****] Первый трактат (viXra submission 1604.0206) будет переведен на английский, как только мне удастся выделить на это время.