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The nature of medical truth and cognitive personal activity

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Abstract

The present article analyzes the interdisciplinary aspect of the nature of medical truth at the empirical and theoretical levels of scientific research. The idea of the criteria for this truth is associated with the peculiarities of the cognitive structures of consciousness and the functional characteristics of the synthetic complexity of their components from biochemical to psychocultural. This space as phenomenology considers the terminology and meanings used in the field of logical construction, and appear in medical practice as an immateriale factor in communicative culture. The factor has an emotional-energy load that affects the temporal psychological status of the individual. It is shown that cognitive-energetic proportions of speech perception determine cultural belonging of an individual and its disposition to a private medical

truth combining potency of scientific and non-scientific impact. Secondary truth is active within the bounds a particular social pool and capable of transformation into scientific truth empirically manifested in medicine and physiology. Local closure of constructs combining function and structure, physiology and morphology in formation of neurodynamic connections is considered. The integrative referent of primary truth is the external world, the integrative referent of secondary truth is the internal world of the doctor and the patient as a special combination of individual, and socially subjective principles. The truth as the purpose of medical cognition is attributively expressed in non-numerical mathematical measures and defined as the product of ambivalently directed subject-subject relationships.

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Keywords

Person, truth, practice, medical truth, primary and secondary truth, doctor, patient, world, subject, object.

Introduction

Comprehension the nature of medical (physiological) truth and solving the problem of its criteria in an interdisciplinary aspect [Gagaev, 2004] are connected with knowledge of the features of the formation of cognitive structures of consciousness. Their functional characteristics, derived from the synthetic complexity of their constituents – biochemical, physical, psychosocial and psychocultural – arouse interest both in the nature of substrate [ibid., 20], itself and in the nature of verbal expression and expression. Words, concepts and terms are not physiologically (psychologically) homogeneous. Some of the terms, in addition to the semantic or cognitive load, carry an emotional and energy load that affects the temporal psychological status of the individual. The inducing content of the term is ambiguous and is determined by the physiological and cultural-typical status of the individual. Modification of the psychophysiological state of a person also reflects a change in the functional state of information processing mechanisms in the central nervous system. The latter is accompanied by the transformation of algorithms and structures of the nervous system that take part in the processing of information, which excludes the possibility of standardizing these processes.

The nature of cognitive activity can be investigated at three levels: 1) descriptions (fixation of observations of the integral picture of the phenomenon), 2) classification (determination of the internal structure of the phenomenon, object, process), 3) dynamic study of the phenomenon as a complex developing system. In socio-humanitarian and natural science knowledge, there is a paradigm turn to research on carriers of social interaction and their functional mechanisms. In this case, the interest in the toolkit of formal logic is obvious. The tools of formal logic, proclaiming the task of objectifying truth, do not actually contain means of eliminating a "specific psychophysiological" subject, which can manifest itself in logical constructions and beyond. This defines the range of problems that fall within the scope of logical construction. The latter eventually turns into a "thing in itself" or into a form of

locally closed art. In addition (in relation to intralogical constructions), the inducing term has two different referents, one of which is in the outer and the other in the inner world.

Main contents

The high relevance of the concept of "truth" leads to the fact that it is used extralogically and excessively often in various tautological contexts. An example of this is the corresponding interpretation of truth as the correspondence of knowledge of reality [Chikin, 1990, 11]. The ability of the components of the language to evoke a completely clearly phenomenologically manifesting "response" (psychological, physiological, pathophysiological) of one of the segments of the world has, in our opinion, significant medical and philosophical potential. An example of this is the terminological romanization of the modern language of classical medicine, which allows you to simultaneously eliminate, in relation to the patient, the cognitive component of the term and activate its energetic impact by including it in the continuum of the "therapeutic field." In this regard, one can recall the recipe of the neurologist Sharko, which consisted only of water, but written in Latin [Tsaregorodtsev, 1966, 256]. The task of this work is not to improve logic, and therefore in the future we will use the term truth in the traditional plan.

The specificity of medical-physiological truth, in our opinion, is that it is humanomeric, inseparable from the subjective component, which is a complex derivative of the natural-biological, social and individual components [Pesotskaya, 1996, 10]. In this sense, this is confirmed by all science as human-centered [Nalimov, 2013, 278] in essence. Moreover, the subjective component is inherent in both the "object" of truth and the subject of its perception. The patient and the disease (health) can act as the object of truth. A doctor and a patient can also act as subjects of perception of truth. Thus, the subject of truth is deployed in the main "object-subject pairs" of the patient - the doctor, the disease - the patient and the disease - the patient - the doctor. A doctor is a component of a specific medical school or direction, from which he draws subjective forms of ideas about pathological and physiological reality. From here, the object-subject chain of deployment of medical and physiological truth will have the form: "disease – patient – doctor – direction of medicine" [Pesotskaya, 2017, 160].

With regard to the peculiarities of physiological problems and medicine as a pragmatic field of activity, the most adequate, in our opinion, is one of the directions of the classical concept of truth, formulated as follows: "Truth Is Experimental Confirmability" [Chikin, 1990, 11]. This approach dates back to the ideas of K. Marx that the question of the substantive truth of human thinking cannot be resolved within the framework of thinking itself. Marx believed: "In practice, a person must prove truth, that is, reality and power... his thinking. There is a purely scholastic question about the validity or invalidity of thinking isolated from practice" [Marx, Engels, 1955, pp. 1-2].

Various subjective manifestations of the psychosomatic picture of iatrogenic diseases in different cultural and historical types depend on the tradition in which the formation of the concept of truth took place, on the fulfillment of regulatory prescriptions. This indicates that the "physiological" truth can be not only primary, but also secondary, and its both hypostases are able to manifest themselves objectively. The initial mechanisms of the formation of secondary reality are due to faith, then faith-knowledge, however, real manifestations of secondary truth arise as a result of the act of self-authorization. Secondary truth arises as a reality sanctioned by us. The act of sanction gives rise to truth (both as a real set of objective processes, and as a correspondence of these processes to manifestations of investigative activity), at least in the physiological space of the body and is of key importance. Secondary truth is the "active," productive force that "governs" reality. If the primary truth can be seen

as a correspondence of the thought of reality, then the secondary truth unconditionally acts as an act of coercive correspondence of the reality of thought.

The act of authorization, in technological terms, is social. The corresponding social pool and individual act as the object and subject of secondary truth. The technology of the formation of truth is due to the transformation of individual thought into "social." In this regard, it is appropriate to return to the thought of K. Marx [Marx, 1955, 422]: "the theory becomes a material force as soon as it takes possession of the masses". Secondary truth is active within its social pool, losing it within another pool. The cognitive content of truth and the form of its phenomenological manifestations in different pools can be different.

In a functional, paragonoseological (in relation to such a gnoseology, which, knowing, simultaneously changes reality, being fundamentally not self-equivalent) relation, secondary truth can be divided into three components: question, answer, reaction. The commonality of various secondary truths of this class lies in the question, while the pluralistic answer acts as a conductor of reality and a non-cognitive element of truth. If we consider truth as an algorithm of universality and uniqueness of the world, then only the question acts as a component of the epistemological essence of truth, and the non-specific activity of the answer only fixes the truth of the question posed. It confirms the act of its "contact" with substantive truth, which has physiological representation in the body, realized at the level of the mechanisms of secondary reduction of consciousness.

The primary truth is not actually revealed. None of the manifestations of physiological life can’t be considered as an indisputable manifestation of primary truth. The isolation of primary and secondary truth is practically important for medicine, which led to the development of methods for separating the components of primary and secondary truth. Technologically, in medicine, the primary truth is "extracted" using the placebo method. But, methodologically, there is no guarantee that it reveals exactly the primary truth, and not the deeper strata of secondary truth. At the same time, medicine as a form of practical activity little needs subtle philosophical definitions and is satisfied with the criteria in the form of "before" and "after" (conversation or other form of this informational impact on the patient).

Can secondary truth act as an object of science research, that is, can its components transform into scientific truth? This question should be answered in the affirmative. In the present pharmacology is actively investigating such phenomenological manifestations of secondary truth as the effect of packaging, the nature of annotation, price, manufacturer's rating and other parameters on the biological effectiveness of drugs. The influence of these factors is subject to registration, quantitative and qualitative assessment by the same standard methods of pharmacology as the components of what traditionally refers to the banal manifestations of "objective" truth. This empirical circumstance allows us to disagree with the opinion about the inconsistency of scientific truth to the products of faith [Chikin,1990, 62].

Note that in general, the biological effects of faith are psychophysiological in nature and have a more pronounced phenomenological manifestation than the corresponding products of knowledge. The effects of faith affect the processes of illness and recovery, changing the objective parameters of the functioning of the body, and so on. Knowledge is more phenomenologically in passive physiological respect. In addition, not knowledge, but the rejection of additional knowledge, the canonization of the thesarius in the form of faith or ideology (in a certain sense, delusion) acts as a source of cognitive activity related to truth.

There is the ability of truth to produce physiological reality, secondary to thoughts, and, if this key property is fixed in psychotherapeutic models, this ability is relevant in working with the basics of human motivation.

In the psychotherapeutic tradition, for a holistic idea of the truth in the present, the understanding of the relationship between faith and knowledge is not fully reationalized. On the part of intelligence, the analysis of physiological truth uses an assessment of the state of "higher forms of equilibrium of cognitive structuring" in a new model of adaptive intelligence [Katkov, 2021]. Neural support of the activity of individual consciousness and increasing its adaptive conditions in the aspect of truth formation and cognitive activity has been studied as a process of building a "global neural workspace" [Dean, 2018], as well as symbolic and geometric [Reimann et al., 2017]. This means the systemic influence of the substrate biological framework on cognitive structuring and on the structures of adaptive intelligence key to studying the role of truth in the construction of transformative and design mechanisms of human ontos.

In the neurodynamic characteristic of the working brain, the morphological structure and physiological function close and coincide. There is a combination of physiology and morphology; function and structure are combined into "constructs." This association is based not only on the dependence of the function on the structure, but also on the fact that the connections formed in the process of functioning are postponed in the structure, that the formation of the structure itself is due to the function [Rubinstein, 2022, 265].

So, according to a substrate approach to the research of a multi-level organization of a personality, the process of selective perception of reality and its assessment depends on the processing of information by neurons and their algebraic topology [Luczak et al., 2015, 745-755]. After that, the consciousness of the subject enters objective reality into the system of its own conceptual thinking and cognitive action, into the system of value thinking and worldview. The reworking of information organized in this way, neurobiological architectonics and activism contribute to the design and correction of truth on the substrate.

The physiological world is the field of real coexistence of what neo-Kantianism means as a world of existence and a world of dignity [Gaidenko, 1992, 20], therefore, one who is able to confidently and persistently assert his dignity has metaphysical power over the body and personality, which at all times has found its practical embodiment in specific methods of treating diseases and activating society.

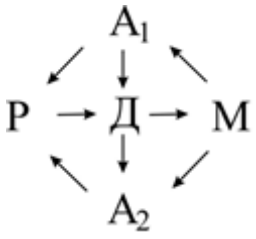
From the point of view of the topological model proposed by physics, it can be assumed that beliefs and ideologies as one-order manifestations of public consciousness represent a variant of fundamentally closed structures occupying a certain "volume" and "coordinates" (configuration) of topological "space," which give rise to their ability to topological and teleological determination of reality. At the end of the last century, in scientific constructions, such a topological space was assumed as a worker for understanding functional psychological mechanisms [Akchurin, 1992, 29]. At the same time, it is faith or delusion that are the only possible mechanisms for "closing" the process of cognition and the corresponding structure of knowledge that is fundamentally opened (and therefore productively inactive in itself (outside of substantive activity) [Palyushev, 1992, 75]. From this point of view, faith or delusion is the necessary and functionally most active component of the dynamically unfolding truth. In our opinion, one of the methodological grounds for the study of the present process and its mechanisms is the design approach in philosophical ontology. The approach provides the widest possible interpretation for any theoretical and design activity for the qualitative processing of information ontogenetically encoded in neurons [Florencia Iacaruso et al., 2017]. In this row is reflection as intellectual and as a professional medical activity to establish the truth.

The criterion of truth in medicine, as a practical form of activity, in our opinion, is the actual practice in the form of compliance with the predictable and achievable results of therapeutic effects. The subject of truth in practical medicine can be formulated in the form of a formula: "I can cure a

given patient," which has been the official form of initiation of an act of treatment since the days of ancient Sumerian medicine. At the same time, the logical structure of truth will be different in relation to scientific and non-scientific schools of medicine (methods of therapeutic influence). The scientific and medical truth is presented as the correspondence of three referents – the initial state of the patient – A1, the final state of the patient – A2 and the ability of specific methods of treatment (D) to ensure the transformation of the A1 into A2, due to the additional internal correspondence between the state of the A1 and the method of treatment. D is a form of representation of the world (M) in the act of treatment.

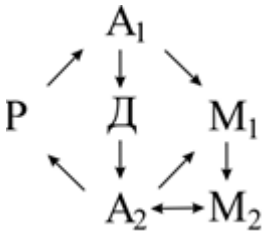
Scientific truth is located and operates in the field of primary reality and is knowledge itself, that is, a form of correspondence of representations of reality, and the world is its integrative referent. So, in qualitative terms, the scheme will have the following form:

P^{H} - true if



Non-scientific medical truth is constructive, and its referent is the personality of the doctor, capable of ensuring a purposeful transformation of the world.

P^{BH} - non-scientific truth if

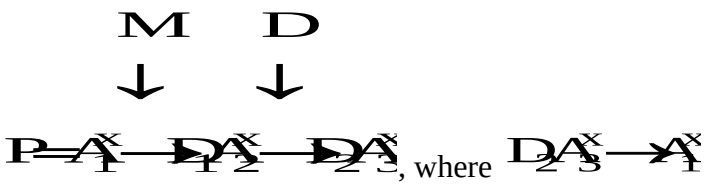


The logical structure of medical-practical truth (real medicine combining the potences of scientific and non-scientific impact) will look like a statement – P is the truth if it corresponds to W in the equation: if you apply exposure D to a patient A in state F, then with probability L, it will go to state W, where W will strive for A. The equation does not contain a single standardized member. The components of equations A, F and W are fundamentally indeterminate because they are given through a finite number of parameters. D consists of two components: a) physical exposure (drug or other, the effect of which corresponds to the primary truth); b) a psychogenic treatment effect that cannot be privately assessed (secondary truth effect) [Slesarev, 2000; Pesotskaya, 2017, 164].

Components A, F and W may be expressed as deviations D and L as uncertainty component A or F. In doing so,

$$\begin{array}{c} D \\ \downarrow \\ P = DA^{x}_{2} \rightarrow DA^{x}_{3} \end{array}, \text{ where } DA^{x}_{3} \rightarrow A^{x}_{1}$$

If the pathogenic factor M that caused the disease is known, the equation takes the form:



Considering the process of developing the disease and recovery as an irreversible movement of the dissipative structure through a sequence of bifurcations, the essence of the treatment process, and therefore the medical truth, is to find such a D that would level out the disease-causing effect of M (fluctuation) and cause recovery, as a return to the old one, if the point of bifurcation, in the process of developing the disease, was not overcome. Or (in the case of an already overcome bifurcation point) finding such a D, which, by forming a new fluctuation, would bring the initial state of the body as close as possible to the original one. Thus, medical truth, in the process of configuring reality, that is, becoming truth, must have two functionally different tools. The first of them should have the ability to "exacerbate" the fluctuation (therapeutic fluctuation of the body), that is, to work in the pre-bifurcation period, affecting the primary reality, "disturbing," "shocking" it. The second instrument must have the ability to "control" fluctuation, tilting its development towards the most acceptable bifurcation.

In medicine itself, there was an idea of therapy as a two-sided process with a complex multi-contour interweaving of mutual reflections [Pesotskaya, 2017, 139], with power and responsibility with all their constituents [Maleychuk, 2022, 158-159]. It exists in the form of knowledge of the persistent pathological levels of homeostasis and the pathological systems underlying the disease chronization process. Destabilizing these systems acts as a necessary prerequisite for the cure process.

From the point of view of the idea that medical truth, in the process of its formation, requires the presence "within" itself of a mechanism for shocking primary reality, one can imagine the school-determined "delusion" of the doctor and the patient's faith in recovery as a tool for creating fluctuation, as the initial element of any targeted action. From this point of view, the periodic change of dominant paradigms in medicine, while coexisting a variety of its directions with different worldviews, can be considered as a prerequisite for the ability to transform reality (patient). A combination of various areas of medicine that ensure the process of cross-sectional mutual transformation is to be considered as a single methane direction of medicine.

Conclusion

1. The classical concept of truth in the form: "Truth is experimental confirmability" gravitates to the ideas of K. Marx about practice, as a criterion of truth, considering the continuity of the objective and subjective component of the object and subject of knowledge. The concept is the most adequate in relation to medical and physiological problems.

2. A person is an inextricable unity of objective and subjective, therefore, medical-physiological truth, being a product of socially determined, ambivalently directed subject-subject relations, cannot be absolutely objective.

3. Psychophysiological (medical) truth is active, it acts not only as an act of conformity of thoughts of reality (primary truth), but also generates it, acting as an act of compulsory correspondence of reality of thought (secondary truth).

4. Elements of secondary truth in medicine and physiology have a clear empirical manifestation. The needs of the practice led to the development of specific scientific methods of separation and the research of elements of primary and secondary truth in medicine.

5. The integrative referent of primary truth is the external (in relation to the doctor) world, the integrative referent of secondary truth is the "inner world" of the doctor and the patient as a special kind of combination of individual, and socio-subjective principles.

6. Secondary physiological truth is cognitive-energetic, by the mechanism of interaction with a human. Cognitive-energetic proportions of speech perception are one of the factors determining the cultural and typical belonging of an individual and his disposition to a given (private) medical (physiological) truth.

The integration of the obtained results into psychologically adapted worldview concepts, adequate to the modern Russian mentality, contributes to solving the problems of society, in which treatment becomes a paradigm of human existence. And since philosophy is the most flexible of all theoretical forms of scientific rationality, the optimal theoretical model of the philosophical support of modern medicine and its meta-theoretical basis are constructed in conjunction with it.

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Природа медицинской истины и когнитивная активность личности

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Аннотация

В настоящей статье на эмпирическом и теоретическом уровнях научного исследования анализируется междисциплинарный аспект природы медицинской истины. Представление о критериях этой истины связывается с особенностями когнитивных структур сознания и функциональных характеристик синтетической сложности их составляющих от биохимических до психокультурных. В этом пространстве рассматриваются терминология и смыслы, применяемые в сфере логического конструирования, и выступающие в медицинской практике как нематериальный фактор коммуникативной культуры. Фактор носит эмоционально-энергетическую нагрузку, влияющую на темпоральный психологический статус индивида. Показано, что когнитивно-энергийные пропорции восприятия речи определяют культурную принадлежность индивидуума и его диспозицию к частной медицинской истине, совмещающей потенции научного и вненаучного воздействия.

Вторичная истина активна в пределах конкретного социального пула и способна к трансформации в научную истину, эмпирически проявленную в медицине и физиологии. Рассмотрена локальная замкнутость конструктов, объединяющих функцию и структуру, физиологию и морфологию при образовании нейродинамических связей. Интегративным референтом первичной истины является внешний мир, интегративным референтом вторичной истины – внутренний мир врача и больного как особая совокупность индивидуально-, и социально-субъективного начал. Истина как цель медицинского познания атрибутивно выражена в нечисловых математических показателях и определена как продукт амбивалентно направленных субъект-субъектных отношений.

Для цитирования в научных исследованиях

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Ключевые слова

Человек, истина, практика, медицинская истина, первичная и вторичная истина, врач, пациент, мир, субъект, объект.

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