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МІНІСТЕРСТВО ОСВІТИ І НАУКИ УКРАЇНИ
ЗАПОРІЗЬКИЙ ДЕРЖАВНИЙ МЕДИКО-ФАРМАЦЕВТИЧНИЙ УНІВЕРСИТЕТ

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ЗМІСТ

СЕКЦІЯ 1. ФІЛОСОФІЯ МЕДИЦИНИ – ІНТЕЛЕКТУАЛЬНО-НАУКОВИЙ ПРОЕКТ XXI СТ.: ТЕОРЕТИКО-МЕТОДОЛОГІЧНІ АСПЕКТИ

радикальний виклик картезіанській моделі філософії медицини, що прагне локалізувати травму в межах індивідуального організму (*Körper*). Трансгенераційна травма, натомість, розкриває тілесність як **живе тіло (***Leib***)**, в якому історія, насильство і пам'ять співіснують у формі болю, тривоги, тілесної напруги та вразливості.

Біополітичній видимості етичної нейтральності медицина протиставляє етику турботи як форму опору логістичній асиметрії вразливості, за якої тіло втрачає свою «живу» природу. У війні медицина може постати як інструмент біополітичного контролю, так і як етична практика захисту тілесної правди у формі турботи. Саме війна змушує медицину розглядати травму не лише як патологію, а як свідчення насильства; бачити тіло як носій достовірних цінностей; а також протистояти фейкам і дезінформації як формам насильства над життям.

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LOGOS WITHOUT POLIS: LANGUAGE, UNCERTAINTY, AND THE PARADOX OF PATIENT-CENTERED MEDICINE

Maryna S. Demianiuk,
Assistant, Department of Medical and Surgical Oncology,
Educational and Scientific Institute of Postgraduate Education,
Zaporizhzhia State Medical and Pharmaceutical University

The paradox of patient-centered medicine does not stem from insufficient empathy. It emerges in the language through which medicine is practiced.

Clinical reasoning unfolds within a grammar that resists certainty. It moves through probabilities, margins, statistical shadows, and provisional scenarios without final guarantees. Expressions such as "likely," "based on current evidence," "at this stage," or "it remains uncertain" do not signal weakness; they mark epistemic discipline. Medicine, as a knowledge practice, depends on this conditional mode.

Clinical institutions, however, function differently. They are not designed to sustain uncertainty. Administrative demands, legal accountability, and symbolic expectations privilege clarity and decisiveness. What is required in practice is not complexity but closure, not because truth is simple, but because simplicity is operationally manageable.

A structural tension emerges here.

Physicians are required to translate – not merely from technical terminology into lay language, but from one epistemic order into another. The provisional language of science must be converted into the performative language of confidence. This conversion occurs in real time, without revision, without hesitation, and without reflective distance.

The issue is not simplification but displacement. The very language that enables professional reasoning is gradually excluded from the space of practice.

Under these conditions, questions become liabilities. They slow decisions; delay reads as uncertainty; uncertainty is recoded as incompetence. What appears to be a communication problem is, in fact, a structural intolerance of philosophical reasoning within clinical space.

Patient-centered medicine presupposes a subject capable of sustained, complex judgment. Yet the same system that invokes this ideal erodes the conditions that make such judgment possible: tolerance for uncertainty, time for reflection, linguistic latitude, and protection for intellectual risk. In doing so, it undermines the epistemic subject it claims to empower.

Within this configuration, the physician shifts from being a scientific agent to functioning as an operational interface. Decisions pass through them, but authority and protection do not. The resulting decline in quality is structural rather than motivational.

The tension becomes clearer through a philosophical parallel. Imagine a philosopher approached not with a question but with a demand for immediate output – an answer understandable without effort, context, or preparation. Responsibility for misunderstanding is assigned entirely to the speaker. Such a demand would be recognized as conceptually incoherent. It collapses the distinction between knowledge and service.

What philosophy would identify as a category error has become routine in clinical practice.

Physicians are expected to master specialized conceptual language, continuously translate it into simplified form, assume responsibility for the consequences of that translation, and bear moral blame for any residual misunderstanding. They may think in complex terms, but they are discouraged from speaking in the language that sustains such thought. Their logos is tolerated internally but not institutionally legitimized.

This enforced translation is not merely communicative labor; it operates as a form of epistemic coercion. When a subject is repeatedly required to abandon the language in which reasoning unfolds, intellectual development contracts. Thought reduced to instruction gradually becomes instruction alone.

From this perspective, contemporary medicine occupies a position philosophy would refuse. It continues to operate while weakening the conditions for its own logos.

Here the Aristotelian notion of the polis becomes structurally instructive. For Aristotle, the polis is the condition of possibility for rational life. Outside it, the human being becomes either more than human or less – not by moral judgment, but because the shared space that sustains logos is absent.

When physicians lose a stable linguistic and institutional space capable of sustaining reasoning, they enter a structurally unstable condition. This condition is transitional by nature; it cannot endure indefinitely.

The Promethean figure illuminates this instability – not as heroism, but as diagnosis. Knowledge carried outside a sustaining community exposes its bearer to structural vulnerability. Logos without polis cannot stabilize itself.

Two trajectories follow. One is functional reduction: reasoning narrows into procedural compliance, language collapses into protocol, and judgment becomes automation. The other is exit: the search for another space in which knowledge is institutionally sustained – whether in research communities, alternative systems, other countries, or beyond clinical medicine altogether.

In this context, scientific community is not a luxury but a necessity. It becomes the remaining polis – a space where complexity is not treated as aggression, where speech in one's own language does not require apology, and where participation in thought is expected rather than disruptive.

A final complication remains. The clinician approaching burnout may no longer recognize this alternative. Immersed in a routine of compensating for systemic disorientation, the memory of an adequate intellectual environment fades. The crisis is therefore not merely individual. A subject deprived of polis cannot restore it alone.

The paradox of patient-centered medicine, then, lies not in insufficient compassion but in the erosion of the linguistic and institutional conditions that make genuine clinical reasoning possible. A system may continue to simulate care. It cannot indefinitely retain those for whom logos is not ornamental, but existential.

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HEALTH-PRESERVING BEHAVIOR IN THE CONTEXT OF CONSUMER SOCIETY: PHILOSOPHICAL AND SOCIAL ASPECTS

Dobryden Oxana,
PhD in social philosophy, associate professor,
the department of Language training and Humanities,
Dnipro State Medical University

Risk factors for human health are invariably socially and culturally conditioned. Even when addressing the relationship between environmental indicators such as water, air, and soil pollution and health outcomes, human activity and agency remain at the core of these processes. In this sense, the human factor is an irreducible element. In the case of culture, the connection with health preservation is even more evident, as demonstrated by numerous studies conducted within this research field.

Unfortunately, scientific conclusions reached within the medico-biological and socio-humanitarian disciplines remain insufficiently integrated. As a result of this epistemological fragmentation, we observe traditional medical approaches that, in most cases, remain closed to the influence of non-medical knowledge. For medicine, anatomical and morphological characteristics of norm and pathology consistently remain a priority. At the same time, the influence of an individual's worldview orientations on health is taken into account only fragmentarily. In situations requiring urgent medical assistance, it would indeed be inappropriate to emphasize the importance of socio-humanitarian knowledge – this is beyond doubt. However, in the context of preventive measures undertaken by healthcare institutions and educational activities carried out by the mass media, such a lack of interdisciplinary synergy represents not merely an informational gap, but a large-scale problem that significantly complicates effective health-preserving strategies.

At the same time, an important and positive aspect in the accumulation of knowledge about health lies in the fact that the multifaceted consideration of this problem within philosophical and sociological literature expands the research horizon. This expansion occurs not only in terms of analytical depth and the development of a systemic vision of reality, but also in the context of searching for productive strategies to counteract risks arising from socially conditioned causes.

Naturally, humanity's encounter with risks to physical and spiritual health is not a novel phenomenon. However, the contemporary stage of consumption is separated from historical patterns not only by time, but also by the quality and quantity of what is consumed. Today, the functioning of consumer mechanisms is predominantly driven by artificially constructed desires and needs. When such desires remain unsatisfied, they are capable of leading individuals into destructive psychological and emotional states. For this reason, it is timely and necessary to address the challenges posed by consumer society to human health.

Health-preserving behavior functions as a key indicator of how personal and social markers of well-being interact within consumer society. This form of behavior becomes especially significant in conditions where health is increasingly shaped by external social influences.

The components of health-preserving behavior include attitudes toward one's own health, adherence to a daily routine of activity and rest, healthy nutrition regimes, engagement in medical-preventive practices, and the maintenance of emotional balance. Thus, health-preserving behavior constitutes a complex of cognitive, motivational, volitional, emotional, and physical markers. It is precisely these individual markers that become targets for the mass media and other agents of