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EUPHEMISM AND DYSPHEMISM IN MEDICAL DISCOURSE: THEORETICAL BOUNDARIES, CLASSIFICATION CRITERIA, AND PRAGMATIC FUNCTIONS

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Abstract. This article examines euphemism and dysphemism in medical discourse as strategies of naming illness, risk, disability, and death. It clarifies theoretical boundaries, proposes classification criteria, and identifies pragmatic functions in doctor-patient, institutional, and public health communication.

Keywords: medical discourse, euphemism, dysphemism, pathology, pragmatics, terminology, doctor-patient communication.

Introduction. Medical discourse is a highly sensitive sphere because names of diseases and conditions do not merely denote clinical facts; they also shape fear, trust, stigma, and responsibility. Turaev's study of pathological terminology shows that disease names are part of the linguistic worldview and that the choice of a term is important in professional medical communication. Therefore, euphemism and dysphemism should be analysed not as decorative expressions, but as pragmatic instruments that regulate relations between doctor, patient, institution, and society. The aim of this article is to define the theoretical boundaries between euphemism and dysphemism, establish classification criteria, and describe their main pragmatic functions in medical discourse.

Materials and Methods. The study uses qualitative discourse-pragmatic analysis. The material consists of typical communicative situations in medicine: diagnosis explanation, prognosis, discussion of disability, death notification, institutional documentation, and public health messages. The theoretical basis includes research on pathological terminology, euphemism and dysphemism, and politeness theory. The units were classified according to five criteria: semantic direction, degree of emotional evaluation, communicative setting, participant roles, and institutional purpose. The analysis is conceptual and interpretative; it does not claim corpus frequency, but identifies recurrent functional patterns.

Results. The first result concerns theoretical boundaries. A euphemism mitigates medically or socially difficult content; a dysphemism intensifies negative evaluation, fear, blame, or social distance. The boundary is contextual rather than purely lexical. For example, "a serious condition" may function as a euphemism when it softens a threatening diagnosis, whereas "a hopeless patient" is dysphemistic because it reduces the person to a negative prognosis. The same technical term may be neutral in a case report but frightening in a consultation if it is not explained.

The second result is a classification model. By semantic domain, euphemisms and dysphemisms in medical discourse can be divided into five groups: disease and diagnosis, bodily processes, disability and mental health, death and prognosis, and patient behaviour. By form, they appear as lexical substitution ("passed away" for "died"), periphrasis ("life-limiting illness"), metaphor ("battle with cancer"),

abbreviation, technical terminology, or colloquial negative labelling. By pragmatic orientation, euphemisms can be protective, ethical, confidentiality-based, or educational; dysphemisms can be stigmatizing, alarmist, coercive, or emotionally expressive.

The third result shows that euphemism is not always positive and dysphemism is not always useless. Euphemism can protect the patient's emotional state and preserve face in difficult interaction, which is consistent with politeness theory. However, excessive mitigation may obscure risk and weaken informed consent. Dysphemism may create urgency in public health campaigns, but in doctor-patient communication it often produces shame, fear, or mistrust.[1]

Discussion. Turaev's distinction between scientific and folk disease names is especially useful for understanding euphemism and dysphemism in Uzbek and Russian medical discourse. Scientific terms tend to support precision and institutional authority, while folk names often rely on visible symptoms, metaphor, or everyday experience. This difference explains why a doctor must balance clinical accuracy with cultural intelligibility. A term that is formally correct may still fail pragmatically if it increases panic or is perceived as humiliating.[2]

From a pragmatic point of view, euphemism performs four main functions: emotional cushioning, politeness, maintenance of therapeutic trust, and adaptation of expert knowledge to the patient's worldview. Dysphemism performs opposite or marked functions: intensification of risk, expression of negative judgement, stigmatization, and sometimes mobilization. In ethical medical communication, neither strategy should replace truthfulness. The most appropriate model is calibrated naming: the clinician gives accurate information, explains technical terms in plain language, avoids stigmatizing labels, and uses mitigation only when it helps comprehension and dignity.

Conclusion. Euphemism and dysphemism in medical discourse are pragmatic mechanisms of naming illness, risk, death, and patient status. Their theoretical boundary depends on contextual effect: mitigation produces euphemism, while pejorative intensification produces dysphemism. Classification should consider semantic domain, linguistic form, communicative setting, and pragmatic function. The analysis confirms that terminology in medicine is never purely technical; it also organizes social meaning, emotional response, and professional responsibility.

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[1] Brown & Levinson, 1987.
[2] Turaev, 2026, pp. 108–115.