Euphemisms in Medical Jargon

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Abstract

The aim of this paper is to offer a brief insight in the field of euphemisms in the English language from different points of view. First of all, I have represented some basic definitions and terms related to euphemisms according to some relevant linguistic research studies. Since I was exploring medical euphemisms, the explanation of some basic principles of medical communication has also been included in my work. Based on the relevant sources a brief overview of the factors which play an important role in medical communication has been included. While trying to define the role and importance of euphemisms in medical communication the use of euphemisms in some specific medical situations and diagnoses such as heart failure, cancer and some other mortal diseases in general has been studied. I have taken into consideration relevant research works on the opinions of medical workers and the patients on the use of euphemisms and medical communication. The representation of Warren´s model of euphemism has also been incorporated in this paper and the corpus of the paper has been analyzed according to her principles. Finally, I have come to the conclusion that euphemism, despite being a linguistic unit, and their usage are significantly influenced by many extra-linguistic factors.

Key words: euphemism, doublespeak, medical communication, linguistic factors, extra-linguistic factors

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Introduction

Nowadays euphemisms are an integral part of the everyday communication. According to the definition ″a euphemism is traditionally regarded as the replacement of an unpleasant or offensive signifier by another that functions as a 'veil' thrown over the signified″. (Portero Muñoz, 2011: 137). Although at first glance it may seem that euphemisms provoke an ambiguous and dishonest communication, a number of research studies on euphemisms prove the opposite. The use of euphemisms is a sign of very well developed communication skills. Euphemisms are usually used in the situations which demand the avoidance of some unpleasant effect and a certain degree of thoughtfulness and correctness connected with the encounters between people. Just as everything else, euphemisms are beneficial as long as they are not overused. In fact, they are essential and inevitable for a successful communication in the 21st century. Therefore, I want to show that they can be researched in many different ways, both purely linguistically, and also non-linguistically. In my research paper I want also to show that euphemisms are just a small part of something more complex, which is called medical communication. The first chapter of my paper offers an insight in the viewpoints of some relevant authors referring to euphemisms and doublespeak. The second chapter will be dealing with the basic extra-linguistic features of a successful medical communication and some common mistakes which the doctor should avoid. The third chapter of my work introduces the most desirable linguistic tools for a successful medical communication. The following chapter deals with the role and importance of euphemisms in terms of medical communication. In the next three I will be dealing with euphemisms related to specific diagnoses such as heart failure, cancer and the medical communication about a terminal illness in general. I will introduce both the opinions of the doctors and of the patients. The last two chapters of my paper will be dealing with euphemisms from a linguistic point of view. It will be a representation of Warren´s model of euphemism and the corpus analysis according to her principles.

Basic viewpoints and categorizations referring to euphemisms and euphemisation

Some authors even regard euphemisms as a means to improve the image of the society in general to an extent:

> For instance, euphemisms used to talk about people who suffer from various handicaps may have led to the increasing level of acceptance of "the handicapped" by society. Recently, there has been a trend to include "children with special needs" in mainstream education, rather than educating them separately. Nevertheless, it is difficult to prove that such approach has really contributed to changing the image of "the handicapped citizens" for the better. By making the word "crippled" politically incorrect or even taboo, the society creates a better image of itself; however, the individuals may find this hypocritical, feeling no real difference between "the blind" and "the visually challenged" (Šebková, 2012: 11).

As some authors suggest, the range of reasons for euphemizing is very broad: ″They range from fear and superstition, being polite and kind, avoiding embarrassment, playful ways to exclude

others from understanding what is being discussed, to white lies and manipulation ″ (Walker 12) Some authors, furthermore, make certain distinctions between euphemisms and divide them into particular groups:

> The "**instinctive**" group may include avoiding religious terminology and swearwords (e.g. replacing "oh my god" with "oh my gosh" or "hell" with "heck"), careful choice of words when not wanting to hurt or offend someone (e.g. "pass away" instead of "die" when talking about a beloved relative), avoiding embarrassment when mentioning body parts and functions (like when someone announces "going to the little boys room" rather than "taking a piss"), which is closely related to the topic independent of time, place or culture – sex (the creativity with which people refer to coital activity is stunning), followed by more recent political correctness (e.g. calling the "blind" people "visually challenged"), which could be perceived as a transition between the two groups. The widely criticized political double-speak would then belong to the "**strategic"** group(Šebková, 2012: 12).

William Lutz has established the following definition of doublespeak:

> "[it] is language that pretends to communicate but really does not. It is language that makes the bad seem good, the negative appear positive, the unpleasant appear attractive or at least tolerable. Doublespeak is language that avoids or shifts responsibility, language that is at variance with its real or purported meaning. It is language that conceals or prevents thought; rather than extending thought, doublespeak limits it" (Lutz, 2012: 30).

When it comes to the process of euphemizing he exclaims that it depends on certain conditions:

> ″Although Lutz ("The World of" 348) admits that euphemisms may be considered doublespeak, he makes it clear that euphemizing itself is a positive thing, as long as the speaker's intentions to use euphemisms are honest, i.e. concern for someone's feelings, or respect for a recognized cultural or social taboo″ (Lutz, 2012: 31).

Therefore he advocates no clear and strict attitude towards the use of euphemisms, but expresses his opinion briefly and clearly : ″ It is the real purpose of using euphemisms which makes all the difference. Lutz ("The World of" 349) puts it simply: "When a euphemism is used to deceive, it becomes doublespeak."″(Šebková, 2012: 31).

The complexity of medical communication and some extra-linguistic factors which play an important role in it

The perception of a euphemism as a tool of deception is not applicable to every aspect of human life and communication. Euphemisms may be deceptive in terms of political or military jargon,

but medical communication is too complex to make any conclusions too soon, without taking into consideration both linguistic and non-linguistic parts of it. Medical communication happens on many different levels, for example, between the doctor and his or her colleagues, between the doctor and the family members of a patient, and most importantly, between the doctor and the patient. Some research works have proven that medical communication is complex not only because it includes so many people and the use of delicate language, but also because it is hugely influenced by many non-linguistic factors which are closely related to a successful communication, in particular between the doctor and the patient. As some authors suggest the perception of a patient in the 21st century has changed significantly: ″In the 21st century, the patient is not treated as an object of therapy, but as a participant in it″ (Tacheva, 2013: 604).

Such an attitude has led to the increase in consciousness about the importance of medical ethics and correctness. Therefore, much research has been conducted on both linguistic and extra-linguistic aspects of medical communication. Violeta Tacheva has listed the basic sociolinguistic factors of medical communication as follows:

- conciseness: precision and economy of expression without excessive detail
- concentration: on events and facts, objectivity
- compliance: with specific addressee; positive language, politeness
- clarity: easy to understand, logical emphasis, short, familiar, conversational words are used to construct effective and understandable messages, arrangement of numbers and figures in a table
- courtesy: tact and delicacy; appropriate vocabulary
- correctness: appropriate style, spelling, ambiguous jargon is avoided, as are discriminatory or patronizing expressions, sexism and discrimination (Tacheva, 2013: 604).

Furthermore, according to the basic principles of medical ethics, the medical personnel are expected to show empathy, concern and responsibility.

The influence of the way the doctors communicate on the treatment outcome is very significant. Therefore it is very important to bear in mind some extra-linguistic tasks which determine the success of the communication and which are listed below:

- Giving information on appropriate and accessible language for a given patient’s health, disease and corresponding complications, planned treatment and risks, diagnostic and therapeutic alternatives, participating experts, price.
- calming the patient and adjusting his/her mood by:

– overcoming fear and anxiety,

– removal of pain and fear

• Instilling hope, confidence in success, a favorable outcome of treatment, reliable rehabilitation

• Deterring the patient's wrong idea, concepts of disease, dominant in his/her mind because of "*Think sick, get sick*"

• Formation of a picture of the disease in the patient

• Avoiding ambiguity, incompleteness and equivocation in his/her speech

• sharing (concealed from the patient) the truth about his/her illness, depending on the situation in terminal conditions (imminent death)

• showing interest in the patient as a person.

• The implementation of these communication tasks is the most important prerequisite for successful treatment – a strong link between patient and doctor. This relationship becomes a key to the patient's heart and establishes a long-term partnership (Tacheva, 2013: 606).

Furthermore, a successful medical communication is a challenge which includes some very important things to avoid:

• Interruption of the patient's story;

• Inadequate language - complicated or ambiguous, using medical jargon;

• Manner of speaking: too fast, unclear articulation;

• tone and content;

• Not questioning the patient at all;

• Not listening carefully to the patient;

• Uncontrolled body language

• Gender, social and cultural differences;

• Human factors: personal preferences and attitudes, failures, stress and fatigue of the staff (Tacheva, 2013. 607).

The lists above prove the complexity and importance of the medical communication. Furthermore, here are some common mistakes and goals which come along the way of a successful medical communication:

> Doctors tend to underestimate patients' desire for information and to misperceive the process of information giving. The transmission of information is related to characteristics of patients (sex, education, social class, and prognosis), doctors (social-class background, income, and perception of patients' desire for information), and the clinical situation (number of patients examined). Nowadays people are more educated

> and competent and therefore more concerned about their health. today people not only eat, do sport and live healthily, but they care a lot more about prevention and treatment in case of illness (Tacheva, 2013: 60).

It is important to bear this in mind and to ensure understanding: ″A doctor or practitioner who is a good communicator has the ability to share information in terms his/her patients can understand. It is OK to use medspeak and complicated terms, but they should be accompanied by an explanation at the same time ″ (Tacheva, 2013: 610).

This analysis of medical communication may seem extensive and insignificant, but the research have shown that the appropriate strategy plays a very significant role in medical communication since the doctors usually work in very complex circumstances and have to be not only medical workers, but also psychologists and sociologists at a time:

> What does the right language in medicine mean? Above all, it is a premise of verbal contact - analysis of the individual patient and selecting the appropriate language register with its relevant characteristics. Firstly, this includes a special selection of vocabulary in conversation with severe, terminally ill or very old patients, use of diminutives in conversation with children, avoiding unacceptable words associated with parts of the human body, abortion, fertilization, pregnancy and birth by a particular ethnicity religion as Muslims, Hindus and others. secondly, right and appropriate language includes other communication techniques as well such as avoiding judgmental and negative language, answering the patient's questions, assessing the patient's understanding, summarizing the encounter, asking for agreement to fill in the patient summary form, encouragement of patients to share their thoughts, feelings, emotions, worries (Tacheva, 2013: 61).

The most preferable linguistic tools in medical communication

After having taken a look at extra-linguistic features of medical communication we should finally consider the most important features, techniques and goals of the verbal tools and linguistic aspects of the medical communication. Some specific linguistic techniques and tools which are related to medical communication are:

> **Deliberate, targeted selection of positive vocabulary.** It has been shown that positive words with semantic feature set actively stimulate the competitive spirit of the addressee or diplomatically prevent unwanted negative reaction. It is very important for medical communications whose primary purpose is to promote patient's good health and self-esteem. Everyone in critical health condition would rather hear words like**:** *heal, recover, get better, improve, relieve, alleviate, help, success, good results, positive, beneficial, a significant improvement, recuperate, stabilize…* instead of their antonyms with negative charge. Many studies and polls show the benefits of using exactly those words because

they are associated with the positive aspect of life. conscious selection and frequent use of words with positive charge transform the ordinary language into language of hope with therapeutic effect.

Deliberate avoidance of morphological and lexical units, explicit or hidden negative character and negative semantics: *no, never, nowhere, nothing, impossible, pain, hopeless, unfortunately, a problem, bad, negative, anxiety, danger, worsen, deteriorate, aggravate, exacerbate,* or terminology prefixes such as: *anti-, un-, de-, dis-, a-* Psychological studies show that every patient feels an additional burden and stress even when only a negative form is used, despite the positive meaning such as "*No problem", "No metastases in other organs."* This can be explained with the fact that in critical, especially in life-threatening situations, the first signal system is activated and more limited perception of the message takes place mainly in the form, not content. so from a psychological perspective it is questionable whether phrases with negative vocabulary are perceived as positive messages even though their overall meaning is positive (Tacheva, 2013: 612).

Editing and restructuring bad news expressed by words and phrases with negative connotations by replacing them with synonymous positive ones. It is important to replace words and phrases such as *hopeless, metastases, problem, failure, poor performance, injury, long term treatment, death, died, terminal disease* with expressions that do not provoke feelings of fear, anxiety and hopelessness. Many patients seem to be able to maintain a sense of hope despite acknowledging the terminal nature of their illness. Patients and caregivers mostly preferred honest and accurate information, provided with empathy and understanding (Tacheva, 2013: 613).

Grammar tools

• use of future tense, e.g. *You will feel better; Soon you will feel the effects! Everything will be alright!*

• use of 1st person plural to identify the medical staff with the patient such as: *Today we are better, right?* (Tacheva, 2013: 616)

The role of euphemisms in medical communication

And the last tool of the medical communication which the author of the research points out are euphemisms. For her, euphemisms represent the highest level of verbal, social and emotional intelligence in medical communication. She explains the importance of using euphemisms in medical communication in the following way:

Euphemisms – the highest form of lexical diplomacy in medicine Euphemisms are the highest form of lexical diplomacy in medicine because they are more affordable, decent synonyms of and substitutes for unwanted or inappropriate words for a particular situation. The use of euphemisms is determined by psychological factors, but in healthcare they acquire moral and social characteristics. Euphemisms are necessary for communication with terminally ill adults in hospices and children who suffer from an incurable disease. These patients show specific hypersensitivity due to their condition and age. The consciously chosen language contributes substantially to the achievement of optimal results in diagnosis and treatment. In modern medical practice, mastering the correct use of euphemisms is no longer a sign of good breeding and medical

> professionalism, but a legal requirement. In healthcare euphemisms play a special role - they describe and present realities, concepts and facts that cause negative emotions. Euphemisms are used to name stressful medical pathology, and to deliver bad news in a descriptive and acceptable way, e.g. information about cancer, poor prognosis, reporting the death of a patient to his/her relatives. today it is unacceptable to use direct language to achieve a communicative purpose. Our experience and research has proven that this is a new linguistic phenomenon which should be described as medical euphemisation unlike traditional ethno cultural euphemisation. For example, out of all synonymous phrases referring to ***death*** only the ones in bold are appropriate in a medical context: *died*, ***passed away, passed, passed on, is gone***, (Tacheva, 2013: 615-616).

Euphemisms and heart failure

The fact that there are more or less preferable euphemisms opens up the space for a more profound discussion about these linguistic structures. As a part of language, they can of course, be regarded from the exclusively linguistic point of view. But, the fact that they are used to convey unpleasant things pleasantly while communicating opens up the space to regard euphemisms from some different points of view and to take a look at them as a linguistic phenomenon that has a great impact on human consciousness about certain unpleasant situations. This particularly refers to medical communication and medical euphemisms. Many research have been conducted on the way euphemisms are used by the doctors and the way the patients perceive the use of euphemisms.

For example, the aim of one of the studies was to discover which euphemisms the doctors use and prefer instead of the term ″heart failure″. The results of the study showed the following:

> The results showed that the most commonly used euphemism was ‘‘you have fluid on your lungs as your heart is not pumping hard enough’’, followed by ‘‘your heart is a bit weaker than it used to be’’ and ‘‘your heart is not pumping properly’’. The least popular term was ‘‘left ventricular dysfunction’’. Paired *t*-tests were used to assess whether the euphemisms were more or less likely to be used than the term heart failure. The GPs were significantly more likely to use the following euphemisms than the term heart failure ($p < 0.001$): You have fluid on your lungs as your heart is not pumping hard enough; Your heart is a bit weaker than it used to be; Your heart is not pumping properly; Your heart is not working efficiently; Your heart, which is a pump, is not working as well as it should, causing back pressure on the lungs. The GPs were equally as likely to use the following euphemisms as the term heart failure ($p > 0.05$): Your heart is not as strong as it used to be; Heart strain. Finally, the GPs were significantly more likely to tell the patient that she had heart failure than use the following euphemisms ($p < 0.01$): Your heart is not strong enough, You have left ventricular dysfunction (Tayler and Ogden, 2004: 323).

The outcomes of the study concerning patients´ beliefs about the illness and the use of euphemisms may be marked as expected and as a very strong argument for using euphemisms:

> The results showed that the term 'heart failure' made patients believe that the illness had more serious consequences, would be more variable over time and would last for longer then when the same symptoms were labeled using the euphemism. In addition, 'heart failure' made them more anxious and depressed (Tayler and Ogden, 2005: 325).

Euphemisms and cancer patients

Some other more serious diseases provoke some different expectations among the patients´. The research concerning communication with cancer patients offer a surprising insight when it comes to communication about cancer. First of all, since cancer is one of the most serious diseases, some experts have tried to describe the main factors of coping with such diseases in a following way:

> Cohen and Lazarus described five main adaptive functions of coping with illness: (1) to reduce harmful environmental conditions and enhance prospects of recovery; (2) to tolerate or adjust to negative events and realities; (3) to maintain a positive self-image; (4) to maintain emotional equilibrium; (5) to continue satisfying relationships with others. The desire, especially in younger patients, for more information and greater involvement in treatment decisions, suggests that the maintenance of a sense of personal control over one's life is also an important function (Dunn et al., 1993: 990).

In some further research the authors have focused on emotional equilibrium. They even made some comparisons between cancer and diabetes und used the same parameters in their research:

> A 39-item, norm-referenced measure of psychologic adjustment in diabetic patients, with established reliability and validity, was modified for use with cancer patients. While there are clear differences between the two illnesses, diabetes and cancer share several features in common. Both are principally chronic illnesses with considerable etiologic, epidemiologic, and clinical heterogeneity; patients experience symptoms ranging from mild to life-threatening; treatment regimens are often intrusive and are associated with unpleasant side effects; diagnosis involves additional burdens of ignorance, fear, and social stigma; the physician-patient relationship is pervaded by difficult issues involving information disclosure and decision-making; and the associated costs in personal, family, social, and economic terms are high. The six subscores from the diabetes questionnaire, measuring perceptions of disease-specific stress (Fl1), feelings of control and competence (F2), shame and isolation (F3), disaffection with medical practitioners (F4), disease

> severity (F5), and denial (F6), were felt to be applicable to the psychologic -adjustment of cancer patients (Dunn et al. 1993: 990).

The results have shown a great range of individual reactions and effects of cancer diagnosis on the patients:

> Common responses to the diagnosis of cancer were shock (Fl), concern about the inconvenience and side effects of treatment (Fl and F2), a sense of being unclean (F3), anger (F4), fear (F5), and disbelief (F6). Patients felt that having cancer produced changes in their self-perception and relationships. Some patients preferred to hide their illness from friends and family; others preferred to talk about it. Some patients expressed negative feelings toward hospital staff, poor hospital conditions, and the lack of information available (Dunn et al., 1993: 991).

As opposed to these outcomes it has been discovered that honesty and open use of the word 'cancer', (although it may cause a short-term increase of anxiety among the patients-) is beneficial due to the following reasons:

> Euphemisms for cancer abound, but their use by professionals in an environment that clearly conveys a connotation of cancer to the patient - such as a cancer ward or clinic, or a department of cancer medicine - may be detrimental to honest communication between patient and professional. It is possible that the uncertainty, fear, and worry felt by patients when their diagnosis is in doubt activate feelings of embarrassment, secrecy, and isolation, which may delay effective adjustment. Certainly, open use of the word cancer does produce a moderate increase in short-term anxiety, but it also reduces the ambivalence of the patients' situation and enables people to think more clearly about their illness and commit themselves more effectively to its treatment. More talk about cancer might help to reduce the fear and shame and perhaps encourage more people to seek medical advice earlier, when it can be most effective (Dunn et al., 1993: 995-996).

According to some research the change of the attitude towards informing cancer patients about their diagnosis is probably a result of treatment improvements and especially of the doctrine of informed consent:

> Patient-physician communication with respect to disclosure of information about cancer has undergone significant changes over the past three decades in the United States. Studies up to the mid- 1960s show that most doctors did not inform cancer patients of their diagnosis [l, 21. A study done in 1977, however, reported 97% of physicians said they routinely disclosed the diagnosis of cancer [3]. Now, most patients in the United States are informed of their diagnosis and the view that patients should be given information about their illness is widely accepted. Several factors have been cited as reasons why the practice in the United States on disclosure of cancer diagnosis has changed. These include the development of therapeutic technology, improved rates of survival of cancer patients, involvement of several professionals in care, altered societal attitudes about cancer, awareness of death, physicians' fear of malpractice suits and increased attention to patients' rights [3-S]. Among these, probably the most influential factor has been the doctrine of informed consent developed in medical ethics and law, and which is now recognized as one of the most important ethical principles of medicine

> [6]. According to this principle, patients have a right to make autonomous choices regarding their own care, and physicians have a duty to give all material information to enable them to make such decisions. Physicians must not withhold information even if the information may have a negative effect on patients. It is supposed that by acquiring control over information, patients can secure more control over their own body and life, rather than depend on physicians to act in their best interest. This doctrine has been the major discursive ground on which the struggle for a more equal power relationship between patient and doctor takes place [7] (Naoko, 1993: 249).

Medical communication and terminal illness

In spite of the doctrine some research have shown that the doctors still control the information while communicating with terminally ill patients:

> In fact. there are a number of critiques which suggest that physicians continue to control information and which indicate patients' dissatisfaction about getting information [11, 121. Examining truth telling to cancer patients, Taylor observed that although physicians disclose the diagnosis of breast cancer to patients, doctors experience this task as stressful and routinize it by often 'dissimulating' or 'evading' the true nature of the illness [13]. In another study by Good rt (I/. [14], American oncologists they interviewed thought that the disclosure of diagnosis is necessary for treatment and for building a partnership between the physician and the patient but that total frankness about prognosis and treatment is not an operative norm (Naoko, 1993:250).

Furthermore, while communicating with terminally ill patients doctors follow some basic principles:

> *Telling* what *patients need to know.* Patients' need to know, although subordinate to patients' desire to know, is another major criterion physicians said they use to assess what information to give to patients. If the physician regards it as necessary for the patient to have certain information, s/he will give the information actively regardless of the patient's desire (Naoko, 1993:252).

The actual truth-telling depends not only on the patients´ right to know, but on many factors which are mainly evaluated by the doctor:

> Factors influencing physicians' evaluation are patients' age, gender, personality and emotional state. If the patient is anxious and appears insecure, more than threequarters of the physicians say they tailor the information they give to patients or give it more gradually and carefully (Naoko, 1993: 253).

Yet, as the author of the research suggests, the main five principles which doctors personally pointed out regarding communication with terminally ill patients are mostly patient-centered: ″ In this section I summarize 5 principles the physicians commonly mentioned as a basis for their behavior: (1) respect the truth; (2) patients' rights; (3) doctors' duty to inform; (4) preserve hope;

(5) individual contract between patient and doctor″ (Naoko, 1993: 253) .

Furthermore he points out that some physicians are very critical towards family members and their role in disclosing information to the patient:

> Three-quarters of the doctors, therefore, disagree with the family's restricting information to patients. More than half of physicians say they usually disclose bad news to the patient for the first time when the patient is alone. Some physicians mention the family's need to know, but this is minimized by the priority given to patients' control over their life and death (Naoko, 1993: 253).

Moreover, physicians advocate the idea of giving open and exhaustive information to the patients instead of euphemizing for the sake of persuasion and ethics:

> When asked about treatment, most doctors say they try to give patients a lot of information, mentioning principles of respect for the truth, patients' rights and the physician's duty to inform patients. More than 90% of the physicians answer that they do not withhold or sweeten some information even when they think that the information will make the patient unwilling to undergo a treatment (Table 1, item 4). Some answer that they provide more information to persuade the patient. Many of them argue that withholding information is unethical and unfair to patients. (Naoko, 1993: 257).

The actual reason why they sometimes prefer to speak about treatment rather than the diagnosis is the so called counterbalancing: ″*Counterbalancing.* One other ostensible reason why most physicians prefer to speak about treatment rather than prognosis is their wish to counterbalance the bad news with hopeful information″ (Naoko, 1993: 259).

Finally, the results of this particular study have once again shown the complexity of medical communication and how it is not only affected by exclusively linguistic factors, but also by some extra-linguistic factors:

> This study shows the importance of patients' characteristics, such as age, gender, educational level, and occupation, for physicians' assessment of patients' needs and wants, and for the way in which they actually give specific information. Doctors seem to give more detailed, specific explanations to patients with higher education and an influential role in society and in the family. Corresponding to the findings here, empirical studies have shown that more information is given to patients who are upper middle class, more educated and middle-aged (Naoko, 1993: 262).

The paragraphs above mostly were connected to the pragmatical and extra-linguistic aspect of medical communication, which must not be ignored while researching medical euphemisms since they are only one small part of a very complex thing called medical communication.

Euphemisms in linguistic research - Warren´s model of euphemism

Euphemisms, furthermore, being the integral part of the present-day communication, have been the object of many linguistic research which mostly dealt with trying to explain the concept of the euphemism and its categorization into subgroups according to some basic linguistic principles and concepts. The linguist who made the greatest contribution to the field of research on euphemisms is Beatrice Warren. She imposed the following explanations and categories within her model concerning euphemisms, as found in Šebková (2012):

> Warren's model is based on the idea that "novel contextual meanings", i.e. new meanings for words in a particular context, are constantly created in language. This creation is rule governed and the acceptability of new meanings depends on, for example, the strength of ties between the novel term and its referent, whether the novel term is considered to be of lasting value, i.e. the referent has no other name, or if the novel term is a "desirable alternative" (Warren, 1992:130). It is this latter situation that results in the creation of euphemistic terms. In her theory, Warren gives four devices for euphemism formation. To organize the wide variety of euphemisms that exist, these categories are divided into sub-categories of formation devices.

i) Word formation devices. As seen in figure 1, Warren gives five ways to form euphemisms using this mechanism. An example of each of these is:
1) Compounding: 'hand job' [masturbation], the combining of two individually innocuous words forms a euphemism for an otherwise unacceptable term.
2) Derivation: 'fellatio' [oral sex], the modification of a Latin term ('fellare', to suck) to form a printable modern English word (Rawson, 1981).
3) Blends: Warren gives no examples of what she means by this term, or of how a blend is formed.
4) Acronyms: SNAFU ['Situation Normal All Fucked Up'], a military euphemism for a possibly catastrophic event.
5) Onomatopoeia: 'bonk' [sexual intercourse], here the sound of 'things' hitting together during the sexual act is employed to refer to the act itself.
ii) Phonemic modification. "The form of an offensive word is modified or altered," (Warren, 1992:133), for example:
1) Back slang: 'enob' [bone/erect penis], Rawson (1981:88) and 'epar' [rape] (Warren,1992:133). The words are reversed to avoid explicit mention.
2) Rhyming slang: 'Bristols' [breasts], a shortened, and further euphemised, version of 'Bristol cities' [titties] which becomes a "semi-concealing device," (Burchfield,1985:19).
3) Phonemic replacement: 'shoot' [shit], which Rawson terms "a euphemistic mispronunciation," (1981:254), i.e. one sound of the offensive term is replaced.
4) Abbreviation: 'eff' (as in "eff off!") [fuck (off)].
iii) Loan words. "…it has always struck me as curious that most, if not all, the banned words seem to be of Saxon provenance, while the euphemisms constructed to convey the same meaning are of Latin-French," (Durrell, 1968:ix). Some examples of this include:
1) French: '*mot*' [cunt] (Allen and Burridge, 1991:95), '*affair(e)*' [extramarital engagement] and '*lingerie*' [underwear], (Stern, 1931).
2) Latin: '*faeces*' [excrement] and '*anus*' [ass-hole]. Aside from typical motivations for euphemism, Latin is often favoured as the uneducated and the young cannot interpret the

meanings (Allen and Burridge, ibid.:19). However, "often such substitutions are just as vulgar if one understood the meaning of the latinate," (Liszka, 1990:421).
3) Other languages: '*cojones*' [testicles], is Spanish (Nash, 1995), and '*schmuck*' [penis] in Yiddish literally means 'pendant' (M. Adams, 1999).
iv) Semantic innovation. In this case, a "novel sense for some established word or word combination is created," (Warren, 1992:133). Examples of Warren's seven categories of semantic innovation are:
1) Particularisation: a general term is used, which is required to be 'particularised' within the context to make sense, e.g. 'satisfaction' [orgasm] and 'innocent' [virginal], both of which require contextually based inference by the reader/listener to be comprehensible.
2) Implication: In this case, several steps are required to reach the intended meaning, e.g. 'loose', which implies 'unattached', which leads to the interpretation [sexually easy/available]. Warren warns against possible misinterpretation of this type of euphemism, though it seems this could occur with many examples of 'semantic innovation'.
3) Metaphor: A multitude of colourful metaphorical euphemisms surround menstruation, centring around 'red', e.g. 'the cavalry has come'- a reference to the red coats of the British cavalry, 'it's a red letter day' and 'flying the red flag,' (Allen and Burridge, 1991:82). Other metaphorical euphemisms include 'globes', 'brown eyes' and 'melons' [breasts] (Rawson, 1981:38), and 'riding' [sex], which is common to many languages, including English, Greek and Middle Dutch (cf. Allen and Burridge, ibid.).
4) Metonym: Otherwise called 'general-for-specific', this category includes the maximally general 'it' [sex] and the contextually dependent 'thing' [male/female sexual organs, etc.].
5) Reversal: or 'irony'. Including 'blessed' [damned] (Stern, 1931) and 'enviable disease' [syphilis], both of which enable reference to something 'bad' by using opposites.
6) Understatement: or 'litotes'. Examples like 'sleep' [die], 'deed' [act of murder/rape] and 'not very bright' [thick/stupid] fall into this category.
7) Overstatement: or 'hyperbole'. Instances include 'fight to glory' [death] and those falling under Rawson's (1981:11) "basic rule of bureaucracies: the longer the title, the lower the rank." For example, 'visual engineer' [window cleaner] and 'Personal Assistant to the Secretary (Special Activities)' [cook] (Rawson, ibid.) (Warren, 2012: 230-232).

The analysis of the corpus included in this research paper will be based on the above represented model of Beatrice Warren and provides some of the more frequent or more representative euphemisms in the English medical jargon.

Corpus analysis

A typical use of metaphor is the adjectivr active, which means ″not physically impaired by age or illness″ and it is an example of a metaphor. Some further examples of metaphors refer to death, for example, negative patient care outcome, to face your maker (to be mortally ill). One more example of a metaphor is unmentionable disease (venereal disease). Disability is an example of a metaphor for limiting mental condition. Misadventure is an example of metaphor for the consequence of an error. Absentmindedness is a metaphor for amnesia.

The common thing when it comes to metaphors is that they are difficult to understand without the context.

In contrast to metaphors, metonymies are based on logical connection between the source and the target. Metonymic euphemisms are usually based on the general -for-specific principle: Intervention is a metonymy for surgery. Esthetic procedures refer to plastic surgery. Institutionalization is a metonymy for hospitalization in a mental institution. To be special means to be mentally retarded. Protheses refer to artificial limbs. Female operation refers to hysterectomy. Radical procedure is a different name for mastectomy. Mitotic disease is a euphemism for cancer.

There is a vice versa concept as well, which means a specific -for -general principle. In the field of medical euphemisms it usually a situation in which a single symptom is euphemized and refers to the whole disease. For example, a growth or a neoplasm is a euphemism for carcinoma. The symptom of falling served as a means of denoting epilepsy as falling sickness. A pink puffer is an emphysema victim. This particular euphemism is directly related to the symptom of having difficulties with breathing. Blue bloater is a euphemistic name for a patient with chronic bronchitis. It is also based on the symptom of breathing difficulties.
A positive O sign refers to a patient in coma, specifically to the shape of his mouth.
A positive suitcase sign is a euphemistic term for a hypochondriac. An action of coming to the hospital with a beautifully packed suitcase and an intention to stay there for a longer period of time ends up being diagnosed with hypochondria as a result.

An example of understatement is long illness instead of cancer. It is used in the context of a death after a long illness. For this reason it can be regarded as an understatement since it makes the fact of dying less traumatic for the family of the patient. Not very well instead of very ill is a further example of an understatement. Differently abled is also an understatement since it alleviates the fact of being crippled.

An example of derivation by means of negative prefix is miscarriage for abortion. Blighty is a loan word from the military jargon used to denote a serious but not fatal wound. Sight - deprived for blind and cut-and-paste job are two examples of compounds. Cut-and-paste job stands for a surgical procedure in which a patient is opened up and sewn up without any surgical intervention due to the patient's hopeless condition.
AIDS, CABG (coronary bypass graft) and GORK or God-only-really knows (physically and mentally unresponsive patient) are the examples of acronyms.
TOP or termination of pregnancy is an example of abbreviation.
Hansen-´s disease (lepropsy) and Down´s syndrome are only some of the examples of eponyms

which served as medical euphemisms with the aim of raising the public awareness of the severity of the diagnosis.

Conclusion

To sum up, in my paper I wanted to point out that medical euphemisms should not be researched as a single linguistic unit. By introducing the basic principles and extra -linguistic features of medical communication and providing the opinions of medical workers and patients on specific types of euphemisms, I think that I have successfully supported and justified my statement. By representing Warren´s model and my corpus analysis I have represented the linguistic nature of euphemisms, but while doing the research for my paper I have come to the conclusion that medical euphemisms in the 21st century are omnipresent linguistic units strongly influenced by many different extra-linguistic factors.

Appendix 1

The list of euphemisms according to R. W. Holder (2002), J. S. Neamann and C. G. Silver (1991)

1 ableism - insensitivity towards lame or injured people

2 active - not physically impaired by age or illness

3 afflicted - subject to physical or mental abnormality

4 big C - cancer

5 big D - death

6 blighty- a serious but not fatal wound

7 cardiac incident - a malfunction of the heart

8 combat ineffective - dead, seriously ill or badly wounded

9 decline - an irreversible physical or mental condition

10 differently abled- crippled

11 disability- limiting mental or physical condition

12 an eating disorder - anorexia nervosa or bulimia

13 face your maker - to be mortally ill

14 falling sickness - epilepsy

15 growth - a carcinoma

16 hard of hearing - deaf

17 heart condition - a malfunction of the heart

18 impaired hearing - deafness

19 intervention - surgery

20 Irish fever - typhus

21 long illness - cancer

22marytr to - suffering from

23 medical correctness - the avoidance in speech of direct reference to a taboo condition or illness

24 misadventure - the consequence of an error or negligence

25 mitotic disease - cancer

26 neoplasm - cancer

27 no active treatment - allow to die

28 no i/v access -allow to die

29 not very well - very ill

30 poorly - very seriously ill

31 prey to - suffering from

32 sight - deprived - blind

33 smear - a test for cervical cancer

34 spot - a tubercular infection

35 tumour - cancer

36 turn - a sudden illness

37 unmentionable disease - a venereal disease

38 unsighted - blind

39 visually impaired - with very poor eyesight

40 white plague - pulmonary tuberculosis

41 absentmindedness - amnesia

42 acutely visually handicapped - blind

43 CABG - coronary bypass graft

44 cut - and - paste job - a surgical procedure in which a patient is opened up and sewn up due to hopeless condition

45 esthetic procedures - plastic surgery

46 GORK - physically and mentally unresponsive patient

47 Hansen´s disease - lepropsy

48 institutionalization - hospitalization in a mental institution

49 miscarriage - abortion

50 pink puffer - an emphysema victim

51 a positive suitcase sign - a hypochondriac

52 a positive O sign - a patient in coma

53 prostheses - artificial limbs

54 special - mentally retarded

55 a summer squash - an unresponsive or comatose patient who has little or no brain function

56 blue bloater - patient with chronic bronchitis

57 female operation - hysterectomy or lumpectomy

58 negative patient care outcome - death

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