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PROFESSIONAL DISCOURSE AND TERMINOLOGY SYSTEM IN COOPERATION

Monograph

Kyiv
Fenix
2025

UDC 811.161.2'276.6:61](02)=111

Approved for publication at the meeting of the Cyclical Methodological Commission on socio-linguistic disciplines of Bogomolets National Medical University (Protocol No. 7 dated 25.02.2025)

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L99 **Lytvynenko N., Misnyk N., Nikolaiev V. Professional discourse and terminology system in cooperation: monograph. Kyiv: Fenix, 2025. 100 p.**

The monograph addresses the issue of the interaction between modern professional discourse and the sectoral terminological system, with a focus on the main characteristics of medical communication and the specifics of medical terminology.

The research results presented in the monograph can be applied in the fields of linguistics, sociolinguistics, language didactics, and the practice of communication among medical professionals.

ISBN 978-617-8547-14-1

CONTENTS

INTRODUCTION

Studying professional language involves examining the connection between communicative models of language and the various forms and mechanisms of communication. Researching the nature of modern professional discourse, which has its standards and characteristics, greatly contributes to this field.

The terminology system of each field reflects the conceptual categorical base of science and serves professional communication, ensuring its effectiveness. The level of terminological competence of a specialist speaker largely determines the effectiveness of their discursive activity. A special study of the medical terminology system allows for the presentation of this lexical layer as an organized system corresponding to the modern level of linguistic science development and the needs of medical practice.

Understanding the interaction between professional discourse and the terminology system is driven by the needs of the sectoral practice. According to the authors, research into such an interaction is most productive when using the example of medical professional discourse, considering that it reflects a vital and ancient sphere of human activity.

The book is an English version of the corresponding sections of the monograph "Ukrainian Medical Discourse" (author N. Lytvynenko) – Chapter 1, the monograph "Formation of Ukrainian Medical Clinical Terminology" (author N. Misnyk) – Chapter 2; the author of Chapter 3 is V. Nikolaiev.

The study's results, presented in the monograph, can be used in theoretical courses on general linguistics and sociolinguistics, special courses on discourse theory, teaching the Ukrainian language to students of higher medical education institutions, and medical specialist communication practice.

CHAPTER 1

SCIENTIFIC-THEORETICAL PARADIGM OF MEDICAL DISCOURSE

Medical discourse, as the object of the proposed study, belongs to a specialized and established type of communication, determined by the social functions of the interlocutors and regulated both in terms of content and form [1].

Modern medical discourse should be studied in the context of analyzing the concept of "discourse", which emerged in the 1960s–1970s in the linguistic science of Western Europe and remains one of the most relevant topics in contemporary linguistics.

The understanding that any linguistic phenomena cannot be adequately analyzed without considering the context of their use led to the emergence of the term "discourse". While preserving the content-formal characteristics of language, this term facilitated the unification of the concepts of language and speech. In the works of scholars, discourse has been viewed as a particular type of speech structured according to the rules of grammar and stylistics while also taking into account the conditions and norms of communication.

Over time, the interpretation of "discourse" expanded beyond its initial understanding. It was increasingly used

to denote speech activity in specific fields, among which professional discourse began to play a significant role. The American philosopher and linguist John Searle actively advocated the activity-based aspect of language [2]. The scholar's views were shaped under the influence of the English logician and philosopher J. Austin, who, in his work "How to do things with words?", raised the question – can reality be created through words [3]? Let us compare*: Я виписую Вам ці ліки* and *У разі застуди потрібно вживати ці ліки.* While the second sentence corresponds to the standard notion of a statement that "reflects" reality, the first one coincides with the very act of prescribing medication – it is the realization of this action. Let us compare further: *Він дотримується режиму* and *Я обіцяю дотримуватися режиму* (= the act of making a promise).

The term "institutional discourse" is used in the context of the concept of *discourse*, which can be represented as the formula "language + action = communicative interaction". This type of discourse is realized in a specific communicative environment, in a particular social sphere of communication: medical discourse, political discourse, business discourse, industrial discourse, etc.

The differentiation of types of discourse began in the late 1960s in the works of the French philosopher and cultural theorist Michel Foucault (1926–1984), who focused on the interaction between various forms of speech, both linguistic and extralinguistic "structures of everyday life" – such

as social, political, and professional structures. In studying the psychiatric discourse of the 19th century and the discourse of contemporary medicine, Foucault introduced the concepts of "discursive knowledge" and "discursive formation", correlating them with such notions as science, ideology and theory. At the same time, he expressed the need for a description of the "institutionalized field", where a medical professional develops their discourse within spheres such as the hospital, private practice, laboratory, and library. According to the French scholar, all of this was considered part of the discourse of medicine [4].

Thus, there are solid grounds to consider that Michel Foucault was the first to suggest the necessity of studying professional discourse not in general, but about specific professional frameworks, which he referred to as institutional. What is especially important for us is that Foucault was one of the first to emphasize the need to study the doctor's discourse.

Institutional discourse involves communication within the frameworks of institutions created in society, determined by formal and informal rules, principles, norms, and attitudes that regulate various spheres of human activity and organize them into a system of roles and statuses, which constitute the social system [4]. Depending on the number of communicants, this type of communicative interaction can take place at the interpersonal, group, and personal-group levels. However, one of the determining factors in the reali-

zation of institutional discourse is the spheres of communication, which implies the presence of a basic pair of communication participants, taking into account their status-role characteristics, the purpose, and the circumstances of the communication.

Status-oriented discourse manifests in official communication, determined by interaction within the given framework of status-role relationships. It is realized in the corresponding types of institutional communication, among which medicine plays one of the leading roles.

Institutional discourse is structured according to a certain template and follows its prototypical order. While this order is often violated in practice, its foundation remains a scheme of necessary and sufficient actions that ensure the existence of the institution in which the discourse functions.

When classifying professional discourse, which belongs to the institutional type of discourse, it is essential to consider the following factors: 1. lexical and grammatical features of the language of the given profession, 2. the role status of the speakers, determined by the sphere in which the language operates and the type of social institution.

This underscores the very essence of the concept of institutional discourse as a speech-and-thought text, taking into account the specifics of the functioning of professional language as a system that serves a particular sphere of communication, as well as the speech activity of its participants. Institutional professional discourse is highly structured; ac-

cording to T.A. van Dijk [5], the sphere of activity imposes constraints dictated by thematic repertoires that shape the communication process. While researchers advise caution in applying the category of "structure" to the concept of "discourse" – given that discourse involves living speech – it is worth noting that, despite the absence of the structural determinism characteristic of linguistic units and levels, institutional professional discourse follows specific standards that regulate its functioning. One such standard is the presence of a fundamental pair of communication participants. In medical discourse, this primarily refers to the doctor and the patient. This, in turn, determines the dialogic nature of communication, which presupposes interaction between the speaker and the listener, united by a shared communicative goal.

An important factor in medical discourse is the pragmatic intentions of the speaking doctor, taking into account their role functions and the communication conditions. How a doctor should talk with an elderly patient versus a teenager, and the style of conversation between a supervisor and a subordinate – these questions will always remain relevant. The well-known truth that "words heal" undoubtedly leads to thoughts about how exactly this happens and how to work with words. Communication between a doctor and a patient should not be entirely spontaneous on the doctor's part, otherwise, adverse situations for the treatment process may arise. However, communication between a doctor-su-

pervisor and a subordinate and between doctors during work must also correspond to the main task – treating people who seek help.

Therefore, discourse should primarily be considered speech in a communicative situation. It is a significant factor in sociocultural interaction, within its structure one can identify specific models and limitations, one of which is the sphere of activity. The peculiarity of the nature of discourse is that, despite the unpredictability of the speech process, it is structured (and not chaotic), and it adheres to the laws of the language system within which it functions. In addition, discourse should be considered as a result of speech, which is determined not only by the circumstances of communication, but also by the roles of its participants and has a dynamically changing nature, unlike the text as a static structure. Unlike text, which is a static structure, it has a dynamic, changing nature. Therefore, in the proposed typology of institutional medical discourse [6] we rely on the status and social-role functions of the doctor during their dialogue in professional communication conditions. According to the classification known in social psychology, this concerns the type of so-called role-based personality.

The emergence of "discourse" has stimulated the study of various forms of life through language use. One such form is the sphere of medical communication.

The typology of Institutional Medical Discourse

The peculiarity of a role-based personality is that it embodies specific roles it performs, dictated by the execution of certain "role activities" by socially approved models ("role requirements") and status. For instance, when considering professional affiliation, the role of a "doctor" may qualitatively differ depending on whether it is performed by individuals of different genders, by someone with or without experience, or by a researcher versus a practitioner. In medical communication, a role may also be imposed by the situation in which the individual finds themselves, such as the role of a patient.

The concepts of role and status are interconnected. Status answers "Who is the individual?" while role answers "What does the individual do?".

Status-role communication is based on the expectation that the language personality will adhere to language norms according to their position and the nature of their relationship with the interlocutor. For instance, a doctor is expected to provide advice and assistance, while a patient must follow the treatment regimen. Each role contains a specific set of rights and obligations. The concept of typical role performance forms stereotypes of role behavior. These stereotypes are formed based on experience, frequent repetition of traits that characterize behavior, and manner of speaking. Thus, in the minds of society members, an idea crystallizes about what the performance of a specific role by a speaker should be like.

There are two types of role communication situations: symmetrical and asymmetrical. The first is characterized by the equality of social status of the interlocutors, while the second involves different participants' positions in communication. In medical discourse, these are the situations of "doctor to doctor" and "doctor to patient". Since the defining feature of the doctor's discourse is its professional nature, which manifests itself differently depending on the communication partner, it is appropriate to distinguish between two types of medical discourse: discrete (continuous) and non-discrete (non-continuous).

Discrete discourse (latin: discretus – separate, interrupted) is a type of institutional discourse that involves interruptions in verbal expression due to the specifics of the communication circumstances. In the professional activity of a doctor, such circumstances involve communication with a patient. Therefore, the discourse in "doctor-patient" dialogues can only be discrete, as the doctor's speech interrupts the patient's speech and leaves its imprint on it.

The features of discrete medical discourse, which imply inequality of partners in terms of their status-role functions, include the following: interruption in the verbal expression of the doctor's intentions, the interprofessional component in the doctor's speech, and the asymmetrical nature of communicative interaction when the professional roles of the communicants do not coincide.

The peculiarity of discrete medical discourse is that its potential and intentionally defined recipient is a specialist with the necessary level of specialized knowledge to understand and process the information presented in the discourse. The pragmatic goals of the sender of discrete medical discourse, such as summarizing accumulated experience, recording scientific knowledge, and reporting research results, determine the doctor's use of key communicative strategies.

The main pragmatic goal of the speaking doctor is to elicit a reaction from the patient aimed at combating the disease and following the doctor's recommendations.

Thus, in discrete discourse, there is a combination of informational and emotional influence on the recipient during communicative interaction.

The discrete discourse of a doctor is determined by the interprofessional nature of communication, which involves the doctor's choice of words appropriate to the specific speech situation and the emergence of new meanings in commonly used words. These may also include euphemisms or colloquial, low-style vocabulary, creating an atmosphere of informal communication.

An important feature of discrete medical discourse is communication asymmetry due to the doctor's communicative preferences. These preferences, dictated by status, professional competence, personal traits, practical skills, and abilities, contribute to the doctor's leading role in com-

munication, guided by specific standards of the communicative situation and thematic material.

Asymmetry in communication is a regular phenomenon in discrete medical discourse, as the doctor holds the communicative initiative. This is reflected in the communication's character, modality, and tone.

Status inequality in discrete medical discourse has both index and situational characteristics. Index status inequality refers to the inequality caused by a permanent feature of the communication participants, where one of the communicants possesses specific knowledge that can be useful to those lacking it. The doctor's professional knowledge causes Index inequality.

Situational inequality is determined by the patient's initial speech act. The one who seeks help places themselves in a position that implies subordination.

So, the discrete discourse between a doctor and a patient is a discourse of unequal partners. While the patient usually initiates contact with the doctor, the doctor unquestionably leads the communication. The doctor asks questions, and the patient must answer them; the doctor gives orders and must comply. The doctor advises, forbids, and warns about the possible consequences of violating their prescriptions, and this does not provoke protest, as the system of role expectations of the patient anticipates it.

The doctor and the patient can periodically switch roles of speaker and listener. Although their communication is

generally characterized as a dialogue, there may be substantial monologic speech fragments within the structure of this dialogue. This occurs, for example, when the doctor takes the patient's medical history and listens to the patient's narrative about all their past and current health issues. Discrete discourse also involves the presence of pauses, which the doctor usually regulates, while they listen to heart rhythms, measure blood pressure, etc. Note that in the context of non-discrete discourse in professional communication situations of equal partners, pauses appear entirely spontaneous and unpredictable.

Non-discrete (solid) medical discourse involves dialogues between doctors on professional topics directly related to the daily issues of the treatment process. Therefore, a defining feature of this type of discourse is that it operates among representatives of the same speech category, united by their professional affiliation.

The language used by representatives of non-discrete professional discourse is the so-called "ideal" professional language, not in terms of its compliance with literary norms but in terms of the professional orientation of its representatives.

Professional speech is primarily communication on professional topics between specialists. In contrast, communication on such professional topics between specialists and non-specialists represents a "lowered" version of professional speech, which pertains to discrete professional discourse.

The dominant feature of non-discrete discourse in specialists' dialogues determines its main characteristics: homogeneity (continuity, solid) of interpersonal communication in the professional sphere, which involves only specialists; collegiality as a decisive factor in the process of communicative interaction; symmetrical nature of communication in cases of equal partners (colleague doctors) and asymmetrical nature of communication in cases of unequal status characteristics (doctor-supervisor – doctor-subordinate); and the presence of an interaprofessional component in the doctor's speech.

A prerequisite for the functioning of non-discrete discourse is the presence of a team of specialists who jointly implement a program targeted at their activities within a particular system of rules and procedures. All participants in non-discrete discourse must possess the appropriate conceptual-categorical apparatus and a specific system of terms dictated by the professional nature of the thematic material.

This determines the stereotypes of communicative behavior, verbal tools that ensure the coherence of participants' actions, and feedback mechanisms. The intra-professional component of a doctor's speech is realized within a specific socio-professional community. In the professional sphere of communication, a medical specialist uses professional language, which includes the sublanguage of medicine and professional colloquial language. The sublanguage of medicine

is characterized by precision, clarity, logic, and compression. Its terminology can be both scientific and commonly used.

Professional colloquial language consists mainly of vaguely defined professional words and jargon and primarily serves for everyday communication among people in a specific field. The appearance of professionalism is caused by intraфlingual factors (the desire to name an object, process, or phenomenon more concisely than in terminological language: *фармакологія – фарма*, *медико-профілактичний – медпроф*, *гістологія – гіста*) and extralingual factors (the communication situation, psychological climate, strength of tradition in the professional collective, social characteristics of speakers, etc.).

The presence of inter-professional and intra-professional components in a doctor's discourse, one of the criteria for dividing it into discrete and non-discrete types, determines the specificity of a doctor's speech activity based on professional and communicative competence.

Each participant in non-discrete professional discourse always represents a specific hierarchical level in the structure of communicative interaction, which involves performing established professional duties. Hierarchical communication is the interaction of subjects at hierarchical positions and activity roles, with certain conventional and communicative types of language behavior assigned to them.

Hierarchical interaction is built on the basic postulates of successful communication formulated in general com-

munication theory, such as tact, politeness, completeness of information, coherence of actions, accuracy, clarity, correctness, and literacy.

The effectiveness of hierarchical communication depends on the communicants' ability to maintain the necessary communicative distance, adequately respond to changes in the tone of communication, develop the topic of conversation using generally accepted communicative formulas and moves, construct texts in various situations of organizational interaction, and correctly use various types of verbal and non-verbal means.

In non-discrete medical discourse, we distinguish two main types of relationships: 1. doctor – doctor; 2. doctor-supervisor – doctor-subordinate.

Communicative models of non-discrete medical discourse are distinguished by the fact that their functioning is dominated by status-based determinism. Thus, in non-discrete professional medical discourse operating within the doctor–doctor interaction, the defining criteria include etiquette forms of corporate medical communication; official instructions for professional communication; constructive criticism of a colleague's actions; the professional competence of one of the doctors as a determining factor in communicative initiative; adherence to conventional norms of collegiality and professional mutual assistance.

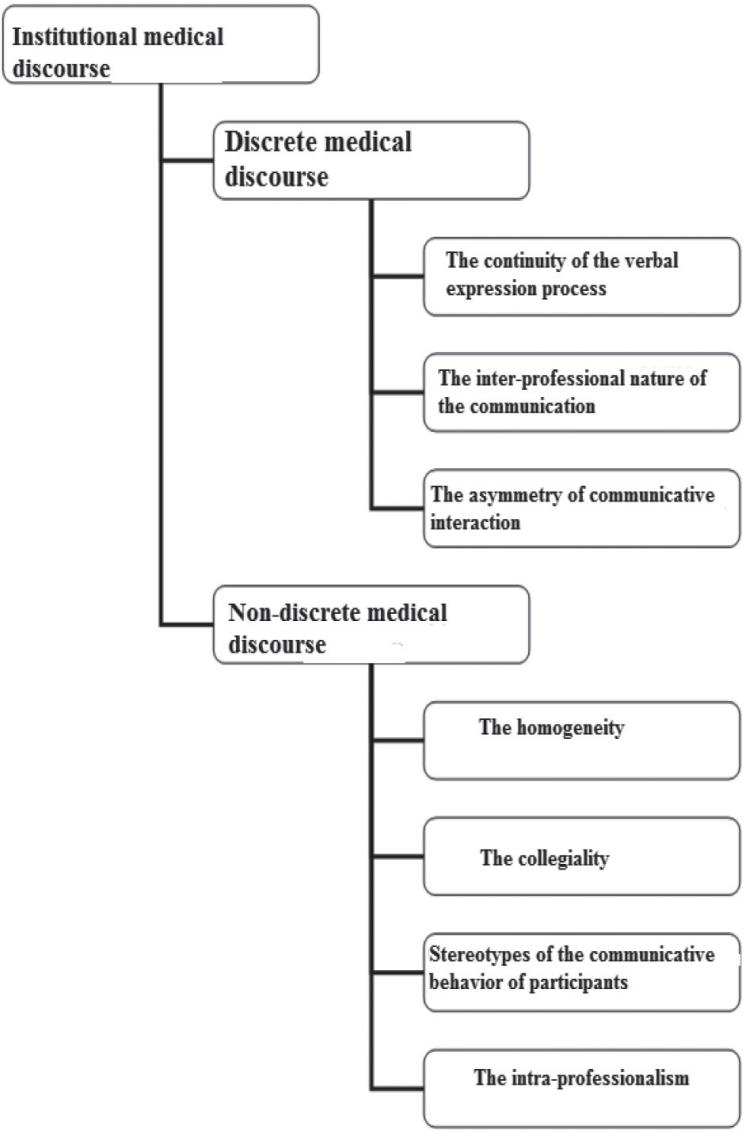
Stereotypes of communicative behavior in non-discrete medical discourse within the doctor–supervisor–doctor–

subordinate relationship include the following features: categorical and non-categorical directives as a characteristic of the supervisor's speech; self-positioning and occupational distancing; rejection of received information as professionally inadequate; communicative initiative as a status-related trait.

A defining feature of non-discrete institutional medical discourse is its dynamism, which necessitates the constant adaptation of doctors' strategies and tactics depending on the situation (*операція*, *спільний огляд*, *«п'ятихвилинка»*, *звіт*, *чергування*, *обхід*, *аналіз операції*, etc.) and the nature of the communicative intent.

In both types of discourse, professional status is reflected in semantics, syntax, and pragmatics, as well as in the characteristics of all communicative and grammatical categories. These features manifest according to the socio-role expectations of the communication partner, which are determined by the circumstances essential for the functioning of each discourse type. Discrete discourse involves communicative interaction between the doctor and the patient, while non-discrete discourse arises in professional communication situations among doctors.

Each type of institutional medical discourse is determined by a set of differential features that reflect its communic.



Pic.1.1. Types of institutional medical discourse and their differential features

Situational factor in the formation of institutional medical discourse

It is entirely logical that different types of discourse are realized in different contexts. Although these contexts often overlap and may even form a certain unity, they remain distinct concepts requiring separate interpretations as research elements. As we have already noted, in discrete medical discourse, the defining factor of communicative interaction between speakers is the stages of doctor-patient communication. In contrast, in non-discrete discourse, it is only the communicative situation.

The structuring of medical discourse and the identification of its stages are determined by models of subject-referential situations that arise during doctor-patient interaction. The characteristic features of such situations include their typicality, recurrence, and necessity.

Based on this, we distinguish four stages, each with its own strategic goal and the corresponding tactics chosen by the doctor. These are the stages of acquaintance, systematic inquiry, objective examination, and recommendations. This classification is based on the fact that it accumulates the key moments of doctor-patient communicative interaction, during which the doctor's discourse is predominant.

At the acquaintance stage, the doctor aims to accomplish the following tasks: establish contact with the patient and obtain necessary information about their physical condition and various life circumstances.

Establishing an informal connection with the patient and creating an atmosphere of trust and mutual understanding is a crucial process that determines the subsequent course of doctor-patient communication. This process is facilitated by the use of etiquette and phatic speech forms, with non-verbal communication playing a significant role.

The etiquette forms used by the doctor during the introduction are functionally determined by their professional communicative orientation: to create an emotionally positive atmosphere of trust and understanding. This is supported by dialogic speech, which adheres to stereotypical patterns of the doctor's communicative behavior and typically reflects the social roles of the dialogue participants. Additionally, the phatic function of communication in medical discourse aims to distract the patient from anxious thoughts, worries, and fears, alleviating nervous tension.

Linguistic behavior stereotypes manifest themselves at the very beginning of the doctor's conversation with the patient, who is typically asked traditional general questions such as: *Що сталося? На що скаржитеся? Що змусило Вас прийти до лікарні?* Spontaneous questions may also arise that are not directly related to the symptoms of the disease but instead focus on the patient's psychological state.

According to F. Batsevych, phatic speech is "the speaker's verbal behavior aimed at expressing themselves and achieving understanding, that is, maintaining speech contact as such" [7]. Phatic communication involves the ability to joke

and encourage others, thus diversifying the standardized forms of medical communication.

By analyzing phatic information, the doctor indirectly extracts professionally significant data. The patient's reaction to the doctor's non-medical remarks serves as an important source of information. Moreover, the doctor pays special attention to the patient's non-verbal behavior during the first meeting, as it contributes to a better perception of the information being communicated.

The second stage of communicative interaction between the doctor and the patient is the stage of systematic questioning. The specificity of the content space of medical discourse at this stage reflects the peculiarities of the conceptualization of reality in the form of an information request. The questioning aims to identify the primary complaint as the leading symptom on which all diagnostics are based. From a formal-structural point of view, this is expressed in different types of questions with grammatical, semantic, and pragmatic differences.

At the stage of systematic questioning, the doctor clarifies the reasons that prompted the patient to seek medical attention, the nature of the complaints, etc. After receiving the first answer, the doctor usually clarifies the information with questions like: *А ще які скарги? А що ще турбує?* Subsequently, the doctor directs the conversation by asking the patient to clarify details, focusing on the main issue. Well-formulated questions by the doctor narrow the range of diagnostic searches.

Careful attention to non-verbal information helps to check whether any important signs of the disease have been missed and, simultaneously, to conclude the objectivity of the obtained data.

Medical discourse at the questioning stage is characterized by the multifaceted nature of the topics that determine the structure of the doctor's dialogues with the patient.

The unfolding of the dialogue during the questioning depends on the personal traits of the doctor and the patient. The doctor must remember that any disease imprints on the emotional sphere. Therefore, the nature of various questioning techniques is primarily determined by psychological factors, and the way of implementing them in the doctor's communicative behavior can only be identified through linguistic analysis.

In the third stage, the objective examination, the doctor directs the patient's actions, using specific manipulations for the examination. Visual and tactile methods are also used in parallel with the verbal source of information. The means of obtaining verbal information is identifying the localization and nature/intensity of pain (*Тут болить? А тут? Так боляче?*). Such verbal assistance from the doctor is not mandatory, but it is primarily an integral element of his communicative interaction with the patient at the stage of objective examination.

A characteristic feature of the doctor's remarks at this stage may be imperative modality. This is expressed in the forms

of verbs in the imperative mood (*Лягайте! Роздягайтеся! Підніміть сорочку*!), forms of the first-person plural in the present tense, used with the meaning of the second-person imperative mood (*Одягаємося! Встаємо! Заплющуємо ліве око!*), sentences with modal verbs (*Можна встати! Треба підійти сюди!),* infinitive constructions (*Не дихати! Відрити рот!*). The doctor's imperative remarks at the stage of objective examination can be supplemented with various etiquette formulas to reduce categoricity (***Будь ласка***, *підніміть сорочку!* ***Прошу*** *не дихати декілька секунд).*

Directive speech behavior is not characteristic of the doctor at this stage. However, he can use speech forms of imperative semantics during the examination of the patient, as he controls the situation that requires appropriate actions.

The pragmatics of the doctor's actions at this stage can be marked by elements of empathy (*Неприємно трішки, так? Я зробила Вам боляче? Потерпіть трішечки, Ви молодчинка!*).

The intrusion into the patient's personal (intimate) space is compensated by lowering the voice volume. An additional discursive function of this prosodic technique is the manifestation of therapeutic suggestive influence.

At the stage of objective examination, the doctor must determine the diagnostic version. The essence of this task is primarily to study the textbook manifestations of the disease. At the same time, knowledge of the classical course of diseases is a platform from which the diagnostic search

begins for diseases with incomplete or atypical clinical pictures.

The last stage is the stage of recommendations, where the doctor prescribes treatment or further examination and gives appropriate advice to the patient.

It should be noted that the main factor for identifying a specific type of speech action is the speaker's intention. By its intentionality, the recommendation is the speaker's influence on the addressee. In medical discourse, implicit speech actions caused by the doctor's reluctance to reveal his intentions are widespread, as he needs to either persuade the patient to perform an action that they are afraid of or, for ethical reasons, not to voice the test results, or to postpone the announcement of the diagnosis.

The doctor's recommendation is often an instructive explanation of the sequence of actions that the patient must follow. Communicative initiative always belongs to the doctor as the agent of institutional discourse. The patient usually needs to carefully listen to the doctor and be ready to follow his recommendation, which is often formulated in a modality of mandatory execution (*Ви повинні.., Вам потрібно.., Вам варто…)*. A softened form of directive meaning of the recommendation is possible. This occurs when it takes on the characteristics of advice (*Я би радив Вам ...)*.

Thus, the doctor's recommendation is organically connected with such forms of his will expression as advice, request, instruction, prohibition, and permission.

A feature of this stage is that the doctor's recommendation takes the form of an expanded expression of will in response to a question that contains a hidden or expressed statement of an unfavorable situation and a request for help. The doctor's recommendation primarily involves an instructive list of actions to correct the unfavorable situation caused by the illness and (optionally) explain these actions. The final element of the doctor's communication with the patient at this stage is the speech act of the patient's gratitude.

The stage of recommendations is a typical institutional action of medical discourse, which is realized in an official atmosphere and is determined by the status-role function of the doctor-speaker.

Thus, the identified stages of communicative interaction in the structure of discrete medical discourse are different in their purpose, affecting the doctor's dialogue with the patient.

In non-discrete discourse, identifying stages is impractical, as doctors' communication does not fit into a strictly defined sequence. A sure standardization of their actions can only be discussed regarding hierarchical subordination, namely, doctor-supervisor – doctor-subordinate.

In studying non-discrete medical discourse, it is logical to highlight the communicative situation because this concept corresponds to the criteria characteristic of professional communication.

We understand the communicative situation as the circumstances of communication caused by objective and subjective factors of actual reality, taking into account the personal characteristics of the communicants.

In non-discrete medical discourse, such situations involve communication between doctors within a medical institution (hospital).

These situations can be both dialogic and polylogic, depending on the composition of the participants in the communication.

A dialogic communicative situation, in which mainly two communicants participate, is characterized by alternating remarks structurally and substantively related to each other. This form of communication is equally typical for non-discrete and discrete medical discourse. At the same time, this is the main form of communication for discrete discourse. In contrast, polylogue is quite common in non-discrete discourse, as a collective form of communication characterizes this type of discourse due to collegiality.

A polylogic communicative situation is represented by several participants whose remarks alternate but have a general situational unity and are characterized by spontaneity and non-linearity. Participants in a polylogic communicative situation have equal linguistic activity. Such polylogic unities can occur during collective actions of doctors, such as surgery, childbirth, diagnostic hardware examination, discussion of professional issues in the staff room, etc.

Thus, the communicative situation is the basis for the functioning of both types of medical discourse. The concept of "stages" is used only for discrete discourse. Discrete and non-discrete types of institutional medical discourse are realized in dialogue - a form of communication involving interaction between the speaker and the listener, united by a common goal.

Dialogue as a constant of professional medical discourse

The culture of dialogue touches upon a rather important issue of implementing oral discourse in the structure of human activity.

During dialogue in professional discourse, the stereotype of linguistic behavior that characterizes representatives of a particular professional community is formed.

An example of such behavior in medical discourse is the professional dialogic speech of the doctor, who purposefully creates speech situations aimed at constructive, communicative interaction with the patient, the purpose of which is to solve a problem or make a decision. The form of communication in the system of discrete medical discourse is usually dialogue, in which the speech of the doctor and the patient is approximately proportional in terms of the volume of information expressed, which primarily determines the discontinuity of the doctor's discourse. In the dialogue with the patient, the doctor acts as a communicative leader,

building the communication methodology. The doctor's level of speech competence determines his ability to engage the patient in conversation during the dialogue and thus obtain as much information as possible from him, which is necessary for determining the causes of the disease, prescribing, and providing treatment [8].

Communication within the structure of non-discrete discourse involves dialogues determined by the communication situation, which includes factors such as subordination ("doctor-supervisor – doctor-subordinate") and the equality of partners when the speakers are colleagues. This also leaves its mark on the structure of dialogues and the peculiarities of their linguistic implementation.

The peculiarities of the doctor's dialogic speech in the structure of both types of oral medical discourse – discrete and non-discrete – manifest themselves in remarks-utterances that differ in nature, structure, and intonation. Remarks-utterances that form a dialogic unity are the basis of the structure of different types of sentences.

During the doctor's consultation, specific behavioral scenarios are realized, involving the use of appropriate strategies and tactics by the doctor-speaker.

The course of the dialogue largely depends on the doctor's correct choice of communicative strategies and tactics implemented in the context of different dialogues.

Dialogicity promotes self-expression and self-realization of the doctor in real-life situations determined by profes-

sional activities, where, in making a choice (to remain silent or speak, agree or protest, etc.), the specialist is primarily guided by corporate interests, often determined by medical ethics.

The ability to be heard largely depends on the ability to listen. This ability depends on the circumstances of communication and the ultimate goal of the communicants: the doctor and the patient [9].

The peculiarity of the doctor's dialogic speech is that in discrete discourse, it must take into account the level of knowledge, emotional state, and needs of the person seeking medical care to ensure effective and understandable communication, promote better treatment outcomes, and strengthen trust. In non-discrete discourse, the emphasis is on the precision of terminology intended for professional communication. However, in both types of discourse, the dialogue must be adapted to the interlocutor, whether a patient or a colleague.

Coordinated dialogic discourse is built through the implementation of a set of communicative strategies that are, firstly, directly related to the speech behavior of each participant in the dialogic interaction and are not considered by the interlocutors outside of it, and secondly, are marked in a certain way by the use of appropriate linguistic indicators that can reflect the hierarchical organization of dialogic discourse, presented as speech tactics.

Communicative strategies and tactics in the discursive activity of a doctor

Given that in the grammatical structure of discourse, its linguistic expression implicitly concentrates the speaker's intentions, such categories of pragmatics as strategies and tactics, which correct the individual's linguistic actions in the communication process, acquire particular significance for the study of discourse.

A distinctive approach to interpreting strategies and tactics as integral elements of discursive activity can be observed in the works of T.A. van Dijk [5]. The scholar considers these concepts in analyzing situational models of discourse, highlighting such parameters as individual experience, attitudes and intentions, feelings and emotions of communicants, and the parallel process of information processing.

This provides the strategic approach with flexibility, efficiency, and dynamism and contributes to identifying a two-level structure of discourse: the superficial level, oriented towards societal norms, and the deep level, determined by the disposition of the individual's psychological structure.

A specialist, particularly a doctor, must possess specific communicative skills, effectively formulate a communicative strategy, use various tactical communication techniques, and effectively present themselves as a participant in the communicative process.

Effectiveness is qualified as the individual's correlation of verbal and non-verbal techniques with the goals and objectives of communication, communicative intention and perspective, and the practical feasibility of certain tactical moves. Ultimately, all this determines the consequences of communication, during which the individual uses their communicative competence, determines the strategy and tactics of communicative behavior, and accumulates specific experiences.

A communicative strategy is a set of tactical moves planned in advance by the speaker and implemented in the process of a communicative act aimed at achieving a communicative goal, while communicative tactics are a set of practical moves in the real process of speech interaction, serving as a practical means of achieving the communicative goal. For example, a senior doctor, to encourage a subordinate, particularly a junior doctor, may say: "*Мабуть, Вам іще важко буде вести дві палати. Очевидно, доведеться призначати Петра Івановича. Хоч у Вас чудовий контакт із цими хворими*". The intentions and goals here are different, but ultimately, within the strategy, the intentions contribute to achieving the ultimate goal.

The course of conversation in any manifestation of discourse (conversation, dialogue, private conversation, etc.) is not a chaotic process but a fully organized phenomenon. Determining the nature and degree of this organiza-

tion is usually very problematic. At the same time, it is the strategic direction and tactical techniques chosen by the speaker, who is the initiator of communicative interaction, that determine its course. The strategy of linguistic communication covers the entire sphere of building the communication process, where the goal is to achieve certain long-term results.

Strategy is the ability to manage, determined by correct predictions regarding the purpose of communication, while tactics (more precisely, tactics) are techniques that facilitate the achievement of this purpose. The communication strategy focuses on the development of communicative tactics, maintaining the tone of communication. Therefore, it is reasonable to consider the strategy in professional communication as a kind of communicative plan that involves appropriate professional competence. It is also important to consider the method of correcting linguistic interaction during information transfer, as well as the structure and mechanisms of influencing the partner to solve professional and practical tasks.

Communicative tactics encompass a set of techniques for conducting a conversation and determine the line of behavior at a certain stage within a specific conversation, aimed at achieving a desired result or preventing an undesirable one.

The communicative situations of discrete medical discourse, determined by the social roles of doctor-patient,

define the general pragmatic goal of the doctor-addressee, such as assisting the patient at all stages of communicative interaction. This pragmatic goal determines the direction of the doctor's main communicative strategies and tactics." The intentions and goals here are different, but ultimately, within the strategy, the intentions contribute to achieving the ultimate goal.

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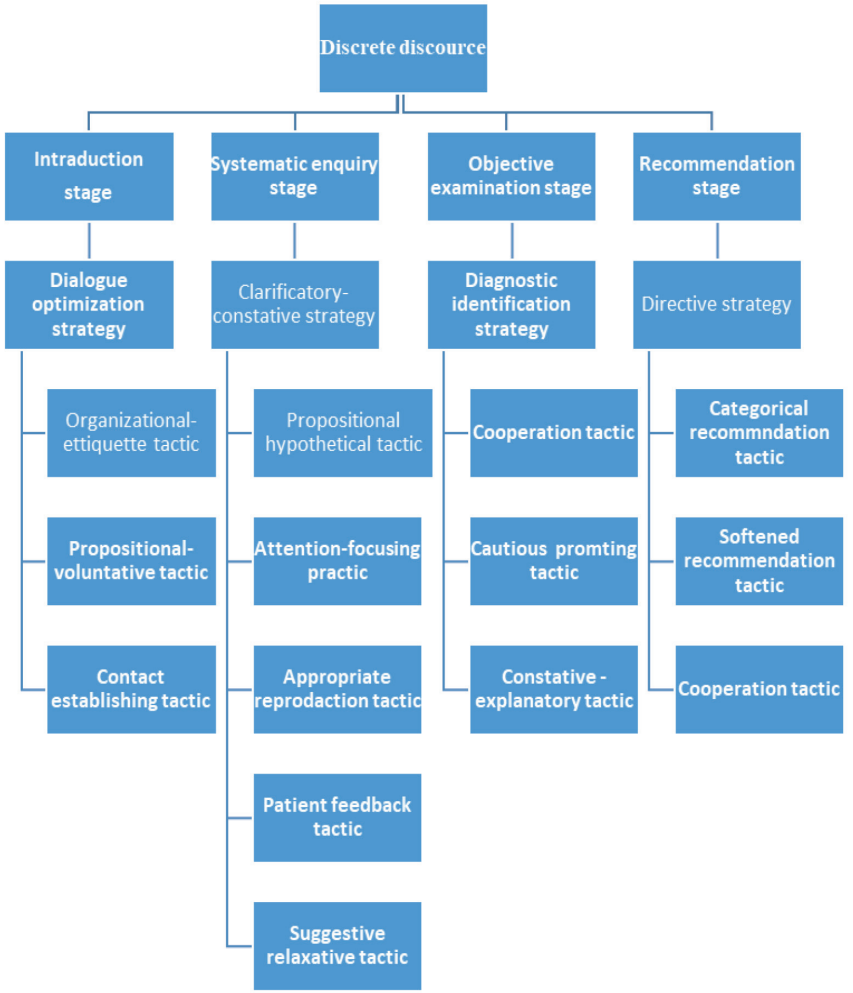

Pic. 2. Communicative strategies and tactics of medical discrete discourse

Communicative situations of non-discrete medical discourse with predefined social roles, such as doctor – doctor, encompass general pragmatic goals, including the generalization of accumulated experience, the application of scientific knowledge, and the interpretation and justification of obtained results. These goals determine strategies of a different orientation, which, in turn, entail using distinct tactics. This can be demonstrated through the example of non-discrete discourse between asymmetrical partners: doctor-supervisor and doctor-subordinate (pic. 3).

The structuring of medical discourse is determined by models of subject-referential situations that arise during communicative interactions between a doctor and patients or colleagues. These situations are characterized by their typicality, recurrence, and necessity, which shape the set of communicative strategies and tactics in a doctor's discursive activity. For instance, the discourse of "senior doctor – subordinate doctor" is marked by adherence to subordination and communicative diversity, requiring consideration of both situational factors and the professional-status roles of the participants. Accordingly, strategies and tactics are employed based on these factors. The leading role of the senior doctor in the dialogue necessitates using a coordination-directive strategy, realized through clarification-control, impact-reducing, and directive tactics.

Pic. 3. Strategies and tactics of medical discourse in "doctor-supervisor – doctor-subordinate"

Meanwhile, the subordinate doctor assumes a secondary role in the dialogue, primarily employing a reporting-informative strategy, realized through reporting and clarifying-questioning tactics. The discourse of the subordinate doctor correlates with their socio-professional function.

As for the discourse of "doctor-patient", it unfolds according to its own distinctive characteristics. During a medical consultation, specific behavioral scenarios take shape, requiring the doctor to select strategies and tactics influenced by various factors: the patient's age, social status, physical condition, and psychological readiness for treatment.

Thus, the strategies of medical discourse are determined by fundamental intentions that form the basis of a particular type of doctor-patient communication. The so-called autonomous model prevails in contemporary medicine, granting the patient the final say in choosing the treatment method. Unlike the paternalistic model, which dominated medical practice for a long time, the autonomous model prioritizes the personal characteristics of the individual seeking medical help. Therefore, it is referred to as a subject-oriented approach. This approach is realized through the doctor's strategies in communicative interaction with the patient, involving appropriate linguistic forms [6].

A doctor's strategy aims to obtain the necessary information as efficiently as possible. When establishing the dialogue's intent, the doctor structures the conversation to prompt the patient toward necessary actions.

Mastery of dialogue strategies and tactics with a patient is part of the doctor's communicative competence, which cannot always be expected of the patient. Constructive cooperation between patient and doctor is essential for accurate diagnosis and treatment. However, the patient does not always know how to facilitate communication with the doctor through verbal interaction. In certain conditions, they may be unable to control their speech and actions. Therefore, the doctor is responsible for effective communication and social interaction. This means that medical discourse must be strategically oriented despite the unpredictability and spontaneity of communication [6].

In professional discourse, a communicative strategy is a type of communicative behavior or interaction in which the speaker employs various verbal and non-verbal means to solve professionally relevant communicative tasks. A strategy serves as the framework of the speaker's behavior, defining the communicative act, while communicative tactics are practical speech actions that express the communicative semantics of discourse. This is primarily related to realizing communicative intentions aimed at achieving treatment outcomes.

Conclusions

Modern trends in the development of linguistic science have highlighted the importance of approaches to studying language phenomena that focus on speech and communicative activity. In this context, the study of different types of dis-

course, depending on the nature of the communication subjects, has gained particular significance. These types include personal (subject-oriented) and institutional (status-oriented) discourses, with medical discourse belonging to the latter.

The unique semantic space of medical discourse has emerged due to the structural organization of the medical institution. It is formed in the consciousness of communication participants as behavioral stereotypes at various levels.

Medical, institutional discourse, which stands out in the system of institutional discourse due to its social-role characteristics, communicative, and structural-semantic features, can be categorized into discrete and non-discrete, considering all factors that shape its structure.

Discrete Medical Discourse: This type of discourse involves unequal partners and is realized in the "doctor-patient" communication sphere. Key features include discontinuity of the verbal expression process, the interprofessional nature of communication, and asymmetry in communicative interaction. These characteristics are influenced by the doctor's communicative preferences, status, professional competence, personal traits, and practical skills.

Non-Discrete Medical Discourse: This discourse involves equal partners ("doctor-doctor") who are representatives of the same communicative category, united by professional affiliation. It is characterized by homogeneity, collegiality, stereotypes of the communicative behavior of participants, and intraprofessionalism.

A significant factor in both types of discourse is the direction of the communicative strategies and tactics employed by the doctor. The goal of communication determines the strategy and specific objectives in each act of speech interaction set the doctor's communicative tactics.

The primary form of discrete medical discourse is dialogue, in which the speech of the doctor and the patient is approximately proportional in the amount of information expressed. In a dialogue with the patient, the doctor acts as a communicative leader, structuring the method of communication.

Dialogues within the structure of non-discrete discourse are determined by the situation of communication and the status-role functions of its participants.

The features of the doctor's dialogical speech in the structure of both types of oral medical discourse – discrete and non-discrete – are influenced by factors such as the stages of interaction between the doctor and the patient and the communicative situations of interaction between doctor colleagues. This manifests in utterances of different nature, structure, and intonation, which convey the intentions of the speaking doctor.

An important factor in medical discourse is terminology, which ensures accuracy and clarity in transmitting information, which is critically important for professional communication. Competent use of terms demonstrates the doctor's professionalism at all stages of communication with the patient, helping to ensure clear and coordinated actions among medical professionals during their duties.

CHAPTER 2

UKRAINIAN MEDICAL TERMINOLOGY: CURRENT STATE AND PROSPECTS

The term as the main element of medical professional language

The language of a specialty is a natural environment for the emergence and functioning of terms that name the conceptual base of a particular field. Professional knowledge requires mastering the corresponding sublanguage, the basis of which consists of specialized vocabulary.

In linguistics, a sublanguage is considered a thematically limited set of specialized and general language means used in a specific sphere of human activity [10]. Proficiency in the language of a specialty primarily involves mastering the terminology of one's field and the ability to use its thematic dominants in professional speech, as terminology constitutes the specificity of the sublanguage of various sciences.

It should be noted that different approaches have been developed in terminology studies for interpreting the concept of "professional language" or "languages for special purposes" (LSP). National sublanguages of science are viewed as functional varieties of national literary languages.

All definitions of the concept of "professional language" inevitably point to the term as the primary, central element of the professional language of a particular field of knowledge.

In this work, the term "professional language of medicine" is defined as the set of all language means used in a professionally limited communication sphere to achieve mutual understanding among specialists working in the medical field.

The connection between professional and general language remains constant, with lexical units potentially transitioning from one to another. However, in terms of specific fields of knowledge and activity, professional language is characterized by particular specificity in vocabulary, syntax, and word formation compared to literary and colloquial languages. Language signs exhibit their properties in professional languages somewhat differently than in the general national language: nominality is realized peculiarly, pragmatic aspects of meaning are narrowed, and there is an asymmetry of functions and change in combinability.

Professional languages are organized horizontally, forming term systems and vertically, according to communicative requirements (theoretical-scientific, professional-practical, and non-professional layers). Forming a professional language as an open, dynamic system can never be complete. Upon reaching a certain level in forming the corresponding base of terms, rules, and regularities of their creation and

use, the progress of medicine stimulates the emergence of new terms, the obsolescence of outdated ones, and the imbuement of the latter with new meanings.

The most important feature of professional language is that alongside general language means, the sublanguage of medicine operates with specialized vocabulary, with terms as indicators of professional affiliation.

Viewing the professional language of medicine as the natural environment for the existence of medical terminology, we understand the term as the genesis of knowledge and the generalization of professional material.

In modern linguistics, various approaches have emerged to address the problem of identifying terms within a given sublanguage. Researchers employ different definitions of the term, proposing methods and criteria that allow for unambiguously identifying terminological units that denote concepts and relationships within a specific field of knowledge. This, in turn, helps delineate the scope and boundaries of terminology.

Traditionally, a set of standard features has been established to define the essence of any term as a lexical unit with specialized, restricted functionality: 1) Nominative (the ability to name a concept); 2) The presence of a definition (definitiveness); 3) A tendency toward monosemy (having a single meaning) within a given terminological system; 4) The absence of expressive or emotional connotations; 5) Stylistic neutrality [11; 12; 13].

Emphasizing the term's nominative and definitive functions, we define it as a word or phrase belonging to a specialized domain, which serves as the designation of a specific concept and requires a clear definition.

The fundamental characteristic of terminology is systematicity. In terminological studies, a system is an organized set of objects – a coherent unity of interrelated entities, phenomena, or actions. The objects of this system are terms, the units of terminology. According to L. Symonenko, terminology is "a collection of specialized designations across various branches of science and technology, used in professional communication. Terminology exists in two dimensions: as a result of the codification of scientific knowledge (terminological dictionaries) and as a functioning entity (scientific and educational literature)" [10].

For this study, the following working definition of a medical term is applied: a word, phrase, or abbreviation that denotes a scientific medical concept is part of the conceptual system of this field, is restricted to a specialized domain of usage, has been established in clinical medicine, and is regulated by a formal definition.

To identify a medical term, it is crucial to recognize that the studied terminology functions as a complex subsystem serving a vital field – clinical medicine – within the broader literary language. "Clinical medicine" is a general designation for various medical knowledge domains. At the same time, its terminology constitutes a

system of terms representing the conceptual framework of all relevant fields.

In this study, fundamental medical terminological subsystems, such as anatomical and pharmaceutical terminology, are not the primary focus. Instead, the emphasis is on clinical terminology, a general medical terminological system component. Along with other subsystems, it reflects the intricate conceptual structure of medicine – a scientific and practical discipline whose primary objective is to study physiological processes in both healthy and diseased individuals, preserve and enhance health, diagnose and treat diseases, and prevent their occurrence [14].

The examined terminological system serves as the core of the general medical terminological domain. Given the specificity of terminological units from related sciences, which are closely linked to clinical terminology, they are excluded from this analysis. Therefore, the term "medical terminology" is deemed appropriate to designate the object of this study.

A comprehensive understanding of medical science is achieved by systematically integrating all its conceptual categories. This research aims to construct a system of logical connections among medical terms, modeling a terminological system that, having evolved from the development of both general medical and specialized terminologies, reflects the conceptual structure of clinical medicine through linguistic means.

Classification of medical terms based on logical and conceptual principles will, in our view, enable the multifaceted and multidisciplinary body of medical terminology to be presented in the form of systematically organized, hierarchically structured macro- and micro fields. Since most terminological units can be grouped based on shared semantic components, studying these terms within a defined semantic system will allow a deeper exploration of their development and evolution.

The selection process of lexical units for the studied terminological system delineated its boundaries within the general medical terminology array by identifying semantic groups ("semantic fields").

We proceed from the fact that "medical terminology" refers to the terminological continuum of medical knowledge related to a diseased organism. In some medical terminology fields, the core concept is "disruption of the organism's vital activity." The center of the identified terminological field consists of terms that denote diseases.

It is known that a practicing physician's lexical field consists of words and phrases used in dialogue with the patient, terms, and term combinations used to describe the disease in the medical history and methods of its treatment. Additionally, the vocabulary of a practicing physician includes the names of medical instruments, operations and treatment methods, hospital equipment, and property.

The presence of certain lexical-thematic groups largely determines the systematic nature of terminology, the study of which is significant for researching the hierarchical structure of the terminological system. In this regard, it is necessary to determine the thematic structure of the studied terminology based on the general tasks and logical scheme of the main sections of clinical medicine and rely on various concepts that make up their conceptual systems.

According to the semantics of the analyzed terms and their functional purpose, the following thematic groups of words can be distinguished: processes and morphological structures inherent to the human body; disorders of physiological functions of organs and body states; diseases and their classifications; forms of course and signs (symptoms, syndromes) of diseases; causes of diseases; research methods; names of sciences, specialists; names of disease carriers; treatment methods (names of surgical operations); means of treating diseases (medical-technical terms).

All of the mentioned terminological categories are represented within the terminology of highly specialized clinical disciplines, which we consider subsystems of the Ukrainian medical terminological sphere. These include the terminologies of obstetrics and gynecology, anesthesiology, genetics, dermatology, epidemiology, oncology, pediatrics, dentistry, therapy, traumatology, urology, surgery, and other fields. These elements allow us to determine the conceptual structure of medical terminology.

Medical terminology exhibits a complex interweaving of multiple subsystems, which actively interact with one another and are based on narrower, more specialized subfields. Thus, clinical medicine terminology is composed of a set of terminological micro fields, which collectively encompass the entire conceptual system of this field of human activity and reflect its structure.

Specific systems of terminological units corresponding to the semantic classifications outlined above can be analyzed regarding their semantic structure and linguistic representation.

A detailed examination of the composition of the medical terminological system requires consideration of its linguistic structure, types of meanings, hierarchical relationships, and origins.

At the present stage, with the revitalization of national identity across various domains, the scope of Ukrainian medical terminology is expanding, encompassing scientific, practical, and educational activities.

Summarizing the above, it is evident that the development and formation of modern Ukrainian medical terminology, as a subsystem of scientific language, has been influenced by both general linguistic trends and extralinguistic factors. Terminological systems in the natural sciences have undergone a long and complex evolutionary process, emphasizing the importance of studying medical terms.

A brief historical overview of the development of Ukrainian medical terminology allows for an examination of the studied terminological system from a genetic perspective and an analysis of the sources of its formation.

Genetic characteristics of clinical medicine terminology

Medical terminology has been formed over a long period on a national lexical basis, supplemented by borrowings from genetically related and unrelated languages. The history of the development of this science, changes in scientific views, integration and differentiation of scientific disciplines, cultural connections, and the development of the lexical-semantic system of the language all influence the formation of the terminological system.

Medical terminology is heterogeneous in its origin. There is a close genetic connection between the vocabulary of the general literary language and medical terminology, with a constant exchange of lexical units.

Researchers note that the foundations of any national terminology were formed based on concepts that emerged from the material and spiritual culture of the people who speak the language [15]. Folk terminology, which has developed over centuries, includes older terms: common Slavic (*біль, кашель, кила, пропасниця, свербіж*) and specifically Ukrainian terminological names (*пухлина, жовтяниця, пронос*), as well as nominations formed

by the technologization of commonly used words (*рак, камінь, пісок*).

Foreign terms that have entered the domestic scientific medical dictionary are associated with numerous source languages from which they were borrowed directly or through the mediation of other European languages (German, Polish, French). Among them are borrowings from Latin: *ботулізм, вакцина, вірус, галюцинація*; Greek terms: *анемія, артерія, бактерія, гормон, діабет, мікроб, травма*; English terms: *гайморит, дальтонізм, блокада, стрес*; French terms: *бюлетень, грип, бандаж, зонд, буж, шок*; German terms: *бор, шприц, клапан, шпатель, бюгель*; Italian terms: *інфлюенца, скарлатина, пелагра.*

Hybrid (mixed) nominations are term combinations that combine native and borrowed components (*амніотична рідина, токсикоз вагітних, артеріальний тиск, прискорений пульс*, etc.).

Thus, from a genetic perspective, the studied terminological system is heterogeneous. The majority of medical terms are international terms borrowed from classical languages, occasionally from Western European languages, and others. The language of modern medicine includes a significant layer of specifically Ukrainian terminology; to a lesser extent, hybrid nominations of specialized medical concepts are used, whose usage is functionally determined.

The analysis of medical terminology showed that, despite the specifics of formation and development, the studied ter-

minological system is an integral and inseparable part of the Ukrainian literary language. The diversity of formation sources and the heterogeneity of the lexical composition is due to the interaction of the terminological system with the vocabulary of the literary language, the scientific terminological system, the terminological systems of related fields of knowledge, general medical terminology, and the terminological systems of specialized medical sciences. Thus, modern Ukrainian medical terminology is a relatively stable and traditionally established lexical-thematic group in continuous movement, interaction, and gradual improvement.

Medical terminology occupies a special place in the peripheral zone between general and specialized vocabulary, leading to its increasingly active assimilation by speakers. A significant group of medical terms belongs to polyfunctional vocabulary. Their terminological nature is determined by context and field of use. When used in medical language, such words are terms, but when used in general literary language, they function as ordinary words. This group includes words like recovery, fever, fainting, inflammation, etc. Their presence once again confirms the close connection between terminology and literary language. Common features of terminology and general vocabulary are also found in their structure: terms are characterized by the use of simple, derived, and compound words.

It is known that any sectoral system of concepts includes the following main groups: general scientific, concepts of re-

lated fields, and specialized. General scientific terms that are part of the clinical medicine terminological system occupy an intermediate place between general literary and specialized vocabulary. Some features of general scientific words allow them to be distinguished as a special group of specialized vocabulary. A significant part of them is abstract in nature, for example: secretion, reduction, deformation, enhancement, disorder, sign, localization, etc. These lexemes acquire medical meaning when they function as components of terminological phrases.

The deepening of knowledge about the vital activity of the human body, the application of methods from cybernetics, physics, and chemistry to the study of living systems has led to the emergence of new sciences related to medicine and the transition of units belonging to the terminological systems of the aforementioned fields into medical terminology. Terms from non-medical sciences are especially widely used in the subsystem "Methods and ways of examining the body."

Analysis has shown that from a structural perspective, ukrainian medical terminology is a systematic formation with a compact but heterogeneous core. This core consists of clinical medicine terms that reflect the specifics of its main sections. Thus, the main array of the medical terminology vocabulary consists of medical vocabulary, which can be divided into three groups: 1) general medical terms that are part of most subsystems of medical terminology;

2) interdisciplinary terms that function simultaneously in two or more terminological systems of related fields of medicine; 3) narrowly specialized terms of individual subsystems. Among the general medical terms, we distinguish groups of words that denote the main directions of medical activity: *профілактика, дослідження, діагностика, лікування*; a group of terms that indicate the stages of disease development: *напад, криза, реабілітація, одужання*; a group of terms that characterize the course of the disease: *симптоми, синдром, клінічна картина*. Despite the differences in specific studies of individual medical sciences, they are united because they are all somehow related to humans and their diseases. This explains the presence of several concepts common to all fields of medicine. The terms that denote these concepts belong to the general medical vocabulary.

Each branch of medicine, being an independent scientific discipline, uses the terms of related disciplines. Such terms are on the periphery of the medical terminology system. Several subsystems of the studied terminological system are distinguished by their so-called "non-medical" specificity (for example, medical-technical terminology). They are not organic components of the medical terminological system.

Problems of medical terminology standardization

The current stage of terminology science development focuses on practical aspects: systematization and codification of terminological systems. Recently, terminology scientists have emphasized that the organization of terminology is necessary for the effective development of scientific research, international cooperation, the publication of scientific and reference literature, and the improvement of specialist training in higher education institutions.

Urgent issues of organizing sectoral terminological systems were the focus of participants at scientific conferences such as "Ukrainian Terminology and Modernity" (Kyiv, 2013, 2019), "Problems of Ukrainian Terminology SlovoSvit" (Lviv, 2018, 2022, 2024), and others. The results of these conferences highlighted the insufficient organization of terminology, which complicates the preparation and professional communication of scientific and technical workers and causes errors in the preparation of technical documentation.

The problems of functioning and improving ukrainian medical terminology are no less important today, the main corpus of which has already been formed but requires significant organization and standardization. The trend towards the organization and systematization of terminological concepts is manifested in the desire to avoid such undesirable phenomena as polysemy, synony-

my, multi-component terms, overload with foreign units, eponyms, etc.

It is undeniable that today, the linguistic foundations for improving terminology are sufficiently developed, an important prerequisite for this process. As is known, the main features of a term as a designation of a unique scientific concept are determined by the linguistic, content, and logical aspects of its normativity.

The term system's organization begins with the concept of system's organization. This process primarily involves a thorough acquaintance with the structure of the field of knowledge whose terminological system needs improvement. It should be noted that the problems of improving terminology at the conceptual-logical level have been the focus of attention in several works by both linguists and sectoral specialists (K. Horodenska, S. Yermolenko, Ye. Karpilovska, etc.).

The methodological principles of work on organizing medical terminology do not differ significantly from the corresponding principles of work with terminology in any other field of science. In our study, we will consider the problem of improving medical terminology and its practical implementation, which we interpret as a whole complex of works on systematization, unification, standardization, and codification of terminology.

As is known, the viability of any terminological system is primarily determined by its organization. The organiza-

tion of terms involves bringing sectoral terminology into a realistically possible system at all necessary levels using specialized methods and models sufficient to create a term as a means of unambiguous, adequate expression of a special concept [16]. The problem of organizing medical terminology involves a set of tasks, primarily the development of basic criteria for term selection; filling terminological gaps at the significative-nominative level; improving the mechanism of harmonious interaction between international and national components.

Unification, according to researchers, is a multi-aspect activity aimed at bringing sectoral terminology into a possible system at the conceptual, logical, and linguistic levels [16]. The unification of terminological systems can be carried out in various aspects; it can be both intralingual (conducted within one language) and interlingual (unified based on several languages, as well as within international terminology). As a result of the latter, the emergence of common term funds and the strengthening of the process of term internationalization can be qualified.

The unification of medical terms occurs at several levels: a) lexical, which involves selecting the most appropriate terminological inventory to denote the corresponding concept (*тиснучий – стискальний* біль); and also the creation of neologisms to name new concepts; b) word-formation: unification of morphological variants (*легень – легенів, болів – болей*). The basis for the unification of the studied

terminological system should be the main criteria for the term: frequency of use, activity of the term's word-formation model, and inclusion in the microfield with the corresponding reference component.

In the specialized literature devoted to the problems of unifying terminological systems, scientists increasingly operate with the concept of "terminological planning" (A. Dyakov, T. Kiyak, Z. Kudelko), which is understood as "a set of measures for terminological modernization and standardization" [13]. It should be noted that terminological modernization involves the construction of new terms and is aimed at realizing the potential of the language in a particular field, considering that term creation at the present stage is a consciously managed linguistic process that involves aligning any terms with the fundamental laws of the language. "Terminological planning is organized and coordinated work on terminological modernization and standardization, aimed at forming appropriate professional languages and developing individual terminological systems. Responsible institutions or individuals can carry out terminological planning, but regardless, this process always has a centralized character" [13].

Thus, interpreting the concept of "terminological planning" as a set of measures for creating new terminological units, normalization, and standardization of sectoral terminological systems is, in our opinion, a further development of the stated problem.

One of the current tasks of modern linguistics is to record, study, and analyze lexical-semantic innovative processes and subsequently codify the terminological system itself. Codification is considered a conscious and fixed norm [17]. The codification of certain forms is based on general trends in language development, the use of international term creation experience, and the consideration of the genetic and synchronous connection of the linguistic phenomenon with the terminological system. The principles of systematization, denotative-significative correlation, relevance, and historicism serve as specific guidelines for codification.

The main aspects of the development and codification of terminology include the study of the processes of terminological system formation, the recording of the time of its appearance, and the determination of formation paths; the development of basic models for creating new terms; the creation of sectoral dictionaries; the development of state standards for terms and definitions that would cover all areas of scientific and technical activity; the analysis and normalization of existing terms in the language [17].

One of the priority areas of terminological work in medicine at the present stage is the normalization of terminological vocabulary.

Normalization is revising the terminological system per the modern Ukrainian literary language norms. Researchers note that the language norm is the most appropriate variant

of pronunciation, word formation, form creation, or constructive phrase formation from the perspective of the communication function [17 et al.]. Language normalization aims to bring it in line with those speech or lexical variants and models that best facilitate the communicative function. The normalization of specialized vocabulary is carried out considering that terminology has some specific features that distinguish it from general vocabulary. In this regard, some specific norms operate within the specialized vocabulary, which differs from general literary norms and narrows their scope. Emphasizing the specificity of the concept of the norm in terminology, it highlights the "professional variant of the norm," which should correspond to the general trends in word formation and word usage in the language as a whole [17].

The practical needs of daily professional communication, specialized education, documentation, and the publication of specialized literature condition the linguistic analysis of terms concerning compliance with relevant language norms.

The normalization of the Ukrainian medical terminological system directly depends on solving several problems: violations of the general literary lexical norm, inaccurate lexical designation of scientific concepts, the use of words and forms not inherent to the Ukrainian language, the presence of excessive terminological polysemy, homonymy, synonymy, etc. The most important aspect is devel-

oping a unified concept of term creation using the experience and positive achievements of scientists from different generations.

Like any terminological system, a detailed consideration of how to normalize Ukrainian medical terminology is impossible without a comprehensive (empirical, theoretical, and technological) understanding of the term's concept.

Determining the methods of terminology normalization, we proceed from the fact that the study of scientific terminology is characterized by a close intertwining of theoretical and methodological (applied) aspects, which are determined by the need to justify the foundations of organization and unification of terms, primarily during their lexicographic processing [18].

The lexicographic principle is the generally recognized principle of normativity. Terminology normalization is primarily carried out through thorough lexicographic processing, creating a clearly verified register of terminological units and, subsequently, a terminological dictionary.

In recent decades, the status of the terminological dictionary as the primary source of systematization and normalization of sectoral terminology has been actively discussed in domestic linguistics [17]. Therefore, we consider the terminological dictionary as a normative document where codified terms are recorded. Thus, thermographic work should be primarily aimed at normativity, where the terminological unit should be considered in the context of

its recommendation/non-recommendation for widespread use in scientific language.

Based on the works we have mentioned, which highlight the main methodological principles of the lexicographic aspect of sectoral terminology normalization and define the normative requirements for the term, we aim to outline the main directions of work in ensuring the linguistic normativity of terms documented in the modern lexicographic and scientific literature on medicine.

The effectiveness of terminology normalization work largely depends on the choice of specific ways to improve terminology and the appropriateness of certain means. Ensuring the linguistic normativity of terms should occur at all conceptual and linguistic levels – phonetic, orthoepic, orthographic, lexical, word-formation, and syntactic.

We see our task comprehensively considering all the above aspects to determine the main ways to normalize modern medical terminology.

The analysis of terminological vocabulary was conducted based on lexicographic works and scientific texts from periodicals. This made it possible to compare the use of terms in texts and dictionaries to define the concept of "norm" concerning the analyzed terminological vocabulary.

Medical terminology develops and normalizes considering its national and international functions and, as already noted, is characterized by a specific feature – the presence of a predominant number of terms of foreign origin.

Borrowing is one of the sources of enriching the terminology of any language, and specialized terminology is projected not only on internal and national contacts but also on external and international ones, with its international communicative function increasingly growing [17].

In medicine, a significant part of terms of foreign origin function in parallel with ukrainian ones. Depending on stylistic differentiation, foreign terms function in the purely scientific professional sphere, while native terms are used in educational and popular science literature.

In modern ukrainian medical terminology, the parallel functioning of native and foreign terms is observed, which are practically equal, for example, hemorrhage – *крововилив – геморагія, короткозорість – міопія, переливання крові – гемотрансфузія*, etc. Sometimes, medical professionals prefer native ukrainian terms over foreign ones: *защемлення* instead *інкарцерація*, *чутливість* instead *сенсибельність, сенситивність*. At the same time, in medical practice, specialists traditionally use international terms, for example, *abscess* (compare *гнояк*), *injection* (compare *впорскування*), *puncture* (compare *прокол*), *palpation* (compare *обмацування*), *fixator* (compare *закріплювач*). Such phenomena in the professional language of medical professionals are insufficiently studied and are an interesting direction for further research.

Medical terminology cannot be done without borrowing. This is due to the increasingly international nature of

scientific research and the internationalization of terminology. However, borrowings are not always justified, especially when an equivalent is formed on a national basis. Hence, the conclusion is that borrowing must be justified.

In our opinion, the problem of the correlation between national and international components in the medical terminological system is related to the following main aspects: 1) considering the traditions of term usage that have developed in medicine over centuries; 2) the appropriateness of using existing equivalent terms in the native language to foreign ones; 3) the creation of new terms that would correspond to the word-formation models of the Ukrainian language.

Recently, there has been a trend to avoid foreign influences (while undoubtedly preserving the constructive international basis inherent in many European languages, which have long been adopted in the Ukrainian language).

The practical aspect is important – the process of selecting an equivalent to a foreign term. It is necessary to remember that the most informative word should be selected when normalizing the terminological system.

When proposing a native word as an equivalent to a foreign word, it is important to constantly consider the complex semantics, word formation, and other associations that surround it and may affect its understanding.

Since sectoral dictionaries play a significant role in the systematization, normalization, and standardization of ex-

isting terminological systems, they should reflect the actual state of modern medical terminology.

Most medical dictionaries we use today confirm the creation and use of terms adequate to the essence of concepts and correspond to the word-formation structure of the language that generates or assimilates them. The terms presented in dictionaries are informative, conceptually clear, and consistent with the general criteria of literary language culture.

The problem of the correlation between international and national elements in the medical terminological system remains open. It needs to be addressed by establishing reliable criteria for determining the necessary and appropriate use of borrowed terms, neologisms, and archaic or dialectal names, aiming to strengthen medical terminology and any terminological system of the Ukrainian language. The degree of organicity of the proposed unit for the language structure and its communicative suitability should be considered. Professional terminology should be unified and presented to the user in a form requiring minimal use and interpretation effort.

Undeniably, the presence of an international element significantly facilitates communication between speakers of different languages. We join those linguists who see the advantages of the internationality of sectoral terminology in the development of a common lexical fund that promotes everyday communication, has wide application in the study

and teaching of foreign languages, and conveys information about cultural and historical contacts between different peoples [19].

In modern medical lexicographic practice, the complexity of the interrelationships between language norms and synonymy in terminology is reflected. As already mentioned, synonymy is associated with searching for the most appropriate word to denote a particular medical concept.

The compilers of most medical dictionaries present existing synonyms of medical terms based on the fact that synonymy at the stage of creating and accumulating scientific terms allows for the selection of the most suitable terms for scientific work.

The abundance of synonymic rows in medical terminology was primarily created due to the introduction of words of different origins into scientific circulation. Thus, in the medical dictionary, we find different names for the same concepts; for example, the concept "такий, що стосується черева" is denoted as *абдомінальний, вентральний, целіакальний, черевний*; for the concept "the process of acquiring the properties of a malignant tumor by normal or pathologically altered tissue, as well as benign tissue, based on the disruption of cell proliferation and differentiation," the terms *злоякісність, малігнізація, малігнітет, перніціозність* are used. Compare also: *аурантіаз* (шкіри) (of the skin) – *ксантоз, ксантодермія, ксантохромія, каротиноз, каротинодермія; базаліома – базальноклітинний рак,*

базальноклітинна епітеліома, коріумкарцинома, шкірний карциноїд, улькус роденс.

The functioning of such large synonymic rows is unjustified, especially since a significant part of the mentioned names are dialectal or artificially created and do not meet the requirements we set for a term or the state of development of medical science at the present stage.

The organization of naturally formed terminological systems and the compilation of terminological dictionaries and standards should be based on a preliminary linguistic analysis of sectoral terminological vocabulary, particularly on studying the causes and features of variant relations in this terminology.

Linguistic variability, as one of the central problems of language culture and a characteristic feature of the literary norm, has been the subject of research by many linguists. In particular, terminological variability has been studied by M. Zhovtobryukh, L. Symonenko, L. Malevych, and O. Radchenko.

Regardless of the differences in defining variability as a linguistic universal by individual linguists, all definitions of this concept invariably indicate that it is a form of existence of linguistic units. Given this, variability is directly reflected in terminology. A variant of a term within one terminological system is considered to be one whose content remains unchanged despite some changes in the formal means of expression.

In terminology, the problem of variation has specific aspects. Analyzing the variability of medical terminology, we proceed from understanding the medical term as a functional unit. Therefore, we consider it appropriate to apply a functional approach to linguistic phenomena, where the identity of functions (denoting the same concept) of several nominative units allows us to state variant relations between them [20].

Paradigmatic (context-independent, universal) and syntagmatic (context-dependent) variability are distinguished [21]. Syntagmatic variability of terminological units is mainly observed in texts. This refers to specific speech manifestations of variability: elliptical forms (when one or more term components are omitted), abbreviations, descriptive phrases, pronouns, etc.

Paradigmatic variability primarily includes formal variants of terms: phonetic, accentual, orthographic, word-formation, and grammatical. One type of formal variation of words, while maintaining word identity, can be considered accentual variation, which is quite common in medical terminology: *я ́ду́ха*, *речови́на́*, голосова *щі́ли́на*, *ліжко́ви́й* режим, *про́сти́й* герпес. These accents are neutral and do not perform word- and form-distinguishing (distinctive) functions. Factors that cause the emergence of parallel accents in a terminological name include the peculiarities of the word's internal structure, the action of analogy, insufficient assimilation of terms of foreign origin, and the specifics of accent functioning in spoken language.

The existence of many accentual variants in the studied terminology is explained by the fact that norm variability is highly developed in the Ukrainian literary language, especially in accentology.

The process of normalizing medical terminology reduces the number of variant terms by eliminating words that do not conform to the language system.

In the studied terminology, the phenomenon of phonetic (phonemic) variation can be observed in examples such as *брахіцефалія* and *брахікефалія*, *макроцефалія* and *макрокефалія*, *ретикульома* and *ретикулома*, *туберкульома* and *туберкулома*, where sounds lose their distinctive function. Among the reasons for the emergence of phonetic variants of terms, we have already mentioned the tendency to ease articulation, the action of analogy, and the peculiarities of adapting borrowed vocabulary. The main reason for such term variability is that their borrowing from ancient Greek and Latin occurred in different ways and at different historical periods. Phonetic variability clearly led to the corresponding terms' graphic variation.

Orthographic variability of medical terms is mainly associated with the functioning of foreign terms, whose written form results from phonetic and graphic adaptation of borrowings. In particular, variant transcription of term elements has caused the parallel functioning of terms such as like *невропатія, нейроцитома, невринома* (from Greek *neuron – жила, сухожилок, волокно; нерв*); compare also

хейро-, хір-, -хейрія, -хірія (Greek *cheir – рука*), *ятро-, -іатрія* (Greek *iater – лікар*), for example: *хейромегалія, хіроскопія, ахейрія, ятрогенія, педіатрія.*

Thus, examples of variant terms that arose due to different transcription of the same term element (Greek ev-) include words such as *євгеніка, євхаристія, евтрофний, евтаназія, ейтаназія, ейтрофія, ейфорія, еубіоз, еутиреоз.* Such variability complicates medical terminology because a false discrepancy regarding the content gradually arises due to differences in the form of the term, which can lead to different interpretations of variant terms. Modern medical science predominantly uses the term *евтаназія* compared to *ейтаназія*, so the normative term should remain *евтаназія*.

To illustrate word-formation variation, let us consider native terms such as *кровоспинний/кровозупинний, одужання/видужання, природжений/уроджений* гіпотиреоз and borrowed *еритробластний/еритробластичний, іррадіація/іррадіювання* болю, *апоплектичний/апоплексичний, хромгідроз/хромідроз, etc*. These and similar variant terms have arisen as different word-formation models, which may differ in productivity.

In medical terminology, there are several terms with the suffixes ***-к(а), -нн(я)*** to denote the same concept, formed from the same verb base: *зупинка/зупинення* кровотечі, *пересадка/пересадження* органа, *затримка/затримання* сечовипускання. In modern terminology,

preference is given to terms with **-нн(я):** *встановлення* діагнозу, *очищення* повітря, *оброблення* інструментів, etc.

Grammatical variability in medical terminology includes the parallel functioning of the term lexeme rhinitis as a masculine noun in some lexicographic sources and as a feminine noun in others. As a result of this variability, we encounter different forms of the genitive case *нежитю* and *нежиті* in medical and other (particularly advertising) literature. The academic dictionary defines the lexeme *нежить, -тю* as masculine [14].

Normalization is needed for the use of the noun біль in medical practice. Different lexicographic sources give it the plural forms болей and болів. The normative form is болів, which is recorded in the medical terminological dictionary.

Thus, as the study has shown, the existing diverse formal variation in medical terminology indicates the need to organize this terminological sphere.

Significant paradigmatic variability in terminology is caused by lexical doublets – native and borrowed names, the appropriateness of which we have already considered. Coexisting with native names, international terms form doublet pairs that vary freely.

A differentiated approach to various types of variability in medical terminology, based on the study of its causes and manifestations, will contribute to the normalization of this terminological system.

The actual functioning of terms in modern Ukrainian medical publications indicates the incompleteness of normalizing the terminological system, particularly with numerous violations of lexical and morphological norms still present. This primarily concerns the use of unjustified calques and russisms such as *виздоровлювати* (normative *одужувати*), *заживлення* (normative *загоювання*), *малокрів'я* (normative *недокрів'я*), *область серця* (normative *ділянка серця*), etc.

Other poorly formed terms include: *протікання хвороби* (normative *перебіг хвороби*), *попередити захворювання* (normative *запобігти захворюванню*), *викликані вірусом* (normative *спричинені вірусом*), etc.

The elimination of unproductive word-formation models facilitates the normalization of medical terminology, particularly the limitation of active participles with the suffixes ***-уч-***, ***-юч-*** (*домінуючий* симптом, *сильнодіючий* препарат); preference is given to formations with the suffixes ***-н-***, ***-л-***, ***-альн-***, for example: *стискальний біль (*instead *стискаючий біль), супровідне захворювання (*instead *супроводжуюче захворювання, супутнє захворювання),* compare: *заспокійливий засіб, зміцнювальна гімнастика, снодійний препарат,* etc.

Violations of morphological norms are most often observed in determining the genitive singular form of nouns in words such as *засіб, біль, кашель, струмінь, шлунок, бюлетень* тощо (the correct forms are: *засобу, болю, кашлю, струменя, шлунка, бюлетеня*).

Under the influence of lexical and grammatical compatibility restrictions, stable models of word combinations are formed in the language. They are also common in the professional language of medical practitioners: *дотримуватися гігієни, перебувати на обліку, перебіг хвороби*, etc. The peculiarities of word compatibility determine the specificity and uniqueness of the national language. The word combinations cause difficulties when translating a specialized text, for example: *завдати болю*, *потребувати медичної допомоги*, *хворий на грип,* etc.

We proceed from the fact that knowledge of the normative variants of the analyzed linguistic units, mastering the basic medical terminology in the context of its functioning at the lexical and grammatical levels of the modern Ukrainian language, and consolidating the understanding of the compatibility and contextual use of terminological vocabulary in working with professional texts are the factors that will contribute to the process of normalizing medical terminology at the present stage.

Thus, the normalization of Ukrainian medical terminology, as one of the most important directions for its improvement, should occur through the alignment of national and international components, elimination of synonymy, variability, and removal of violations of the Ukrainian language's lexical, morphological, and syntactic norms.

Further work on the enrichment, normalization, and codification of medical terminology should be built with

mandatory consideration of the specifics of the field. It should meet both the internal national needs of science and the level of international standards.

Conclusions

Professional language is the natural environment for the emergence and functioning of terms that nominate the conceptual base of a specialized field of knowledge. An adequately organized sublanguage of medicine uses established medical terms to denote complex medical concepts.

Ukrainian medical terminology is a complex dynamic system with clear boundaries within the lexical system of the Ukrainian language. The high communicative significance of the studied terminological system is evidenced by its interconnections with the literary language, general scientific, and other terminological systems, as well as its active use in non-professional spheres. Continuously enriched with new terms due to the development of relevant fields of science and technology and constantly improving, medical terminology is an open, non-closed system capable of various innovations.

Medical terminology is represented by terms with different semantics covering the extensive medical field. Depending on the degree and nature of specialization, they can be classified into general scientific, interdisciplinary, and purely medical names, forming a transparent system together. The presence of thematic groups of terms of differ-

ent volumes and structures ensures its integrity. The main thematic categories of clinical medicine terminology are "names of processes and morphological structures inherent to the human body,"; "names of disorders of physiological functions of organs and body states," "names of diseases and their symptoms," "names of methods and ways of examination and treatment."

The microsystem "medical terminology" is a semantically close set of linguistic units united by logical-conceptual connections that reflect the relationships objectively formed in the relevant field.

Modern Ukrainian scientific medical terminology results from the long historical development of the Ukrainian language, particularly its medical vocabulary. The development of Ukrainian medical terminology is characterized by specific features. It is determined by several extralinguistic (the level of medical development in Ukraine) and intralinguistic factors (the state of the Ukrainian language and the degree of development of relevant styles).

The heterogeneity of the composition of medical terminology in terms of its origin reflects the long historical process of the development of the terminological system. The basis of Ukrainian medical terminology is general vocabulary, filled with new, specialized content that has changed its functional purpose. The differences between a term and a general word are primarily observed in their semantics. The consequence of the term's correlation with a scientific

or technical concept is its precise extralinguistic definition in its unique expression. A distinctive feature of Ukrainian medical terminology is the presence of a significant number of words of foreign origin, the primary sources of which are Greek and Latin, and, to a lesser extent, Western European languages, whose words entered Ukrainian both directly and through foreign mediation. Some words of international origin functioned in the language of Kyivan Rus, and later they became part of the Ukrainian language (gangrene, plague, cholera).

As a result of conscious term creation, it is quite possible to regulate the process of normalizing the terminological system. Linguistic normalization of terminological vocabulary, as one of the most important types of improvement, involves revising the terminological system by the norms of the Ukrainian language. The need for this is dictated by speech practice in connection with expanding the functions of the Ukrainian language as a state language. Criteria such as the conformity of the term to typical forms of general word formation or special term formation models, the alignment of national and international components, the elimination of excessive and unjustified borrowings that do not correspond to the word formation models of the Ukrainian language or have undeservedly neglected native equivalents, the targeted elimination of excessive synonymy, variability, as well as violations of lexical, morphological, and syntactic norms are taken into account.

The study confirmed that the normalization of the terminological system should be carried out at all levels – conceptual and linguistic – phonetic-orthoepic, lexical-semantic, orthographic, etc. From the perspective of the studied problem, the attitude towards the sources of terminology formation, primarily foreign, dialectal, and colloquial, is important. In solving this issue, it is necessary to consider the expansion of the functions of the Ukrainian language and the development of its terminological system.

Lexicographic terminology processing on solid scientific grounds is the final stage of its normalization and codification.

Chapter 3

FUNCTIONING OF THE TERM IN MEDICAL DISCOURSE

As previously mentioned, the key aspects of term functioning in professional discourse include systematization, normativity, and standardization. Medical terms are part of a nomenclature that ensures their unambiguous understanding among specialists and is based on international classifications, such as the International Classification of Diseases (ICD). At the same time, systematization and standardization are defined as fundamental characteristics of discursive activity. Combining these characteristics clearly manifests the interaction between discourse and terminological systems.

The functioning of a term in medical discourse is associated with its specific features, communicative role, and impact on the perception of professional information. This is due to the presence of the following functions inherent to the term:

Nominative function: ensures clarity in naming concepts and pathological conditions (e.g., anemia, myocardial infarction, gastritis, meningitis).

Cognitive function: contributes to the systematization of knowledge by reflecting the relationships between phenom-

ena and processes (e.g., in cardiology, ischemic heart disease (IHD) includes several pathologies related to insufficient blood supply to the heart muscle).

Communicative function: enables the efficient and rapid transmission of professional information (e.g., Doctor: The patient is in a state of decompensated diabetes mellitus with ketoacidosis).

Diagnostic function: helps formulate not only the general diagnosis of the patient but also the stage of disease progression (e.g., hypertensive crisis, type 2 diabetes, chronic obstructive pulmonary disease (COPD) stage II).

Prognostic function: facilitates the specification of disease prognosis (e.g., benign tumor, malignant neoplasm).

To analyze the peculiarities of term functioning in the discursive environment and their role in organizing discursive activity according to the above-mentioned functions, it is essential to rely on the texts of "doctor-patient" dialogues.

Dialogue 1
Manifestations of the nominative function (naming a specific concept):

Doctor: Доброго дня! Що вас турбує?

Patient: Доброго дня, лікарю! Останні кілька тижнів відчуваю постійну втому, головний біль і періодичне запаморочення.

Doctor: Чи є у вас інші симптоми, наприклад, нудота, порушення зору чи біль у грудях?

Patient: Ні, але іноді з'являється задишка, особливо після фізичних навантажень.

Doctor: Коли Ви піднімаєтеся сходами, у Вас буває задуха?

Patient: Мені важко підніматися. Я просто задихаюся.

Doctor: Тобто Ви змушені зробити перепочинок, потім можете знову підніматися, так?

Doctor: Зрозуміло. Давайте виміряємо ваш артеріальний тиск... (вимірює) Ваш тиск 150/95 мм рт. ст., що свідчить про артеріальну гіпертензію.

Patient: Це серйозно?

Doctor: Це означає, що у вас підвищений кров'яний тиск, і якщо його не контролювати, може розвинутися гіпертонічна хвороба, що підвищує ризик інсульту або інфаркту міокарда.

Patient: Що мені робити?

Doctor: Спочатку зробимо біохімічний аналіз крові, щоб перевірити рівень холестерину та глюкози, а також електрокардіограму для оцінки серцевої діяльності.

Patient: Добре. А чи потрібен якийсь режим чи зміни в харчуванні?

Doctor: Так, важливо зменшити вживання солі, насичених жирів і алкоголю, а також збільшити фізичну активність. За необхідності призначимо антигіпертен-

зивні препарати, наприклад, інгібітори АПФ або бета-блокатори.

Patient: Я зрозумів. Дякую, лікарю!

Terms such as *артеріальна гіпертензія, гіпертонічна хвороба, інсульт, інфаркт міокарда, біохімічний аналіз крові, електрокардіограма, холестерин, глюкоза, антигіпертензивні препарати, інгібітори АПФ, бета-блокатори* perform a nominative function, meaning they name specific medical phenomena, conditions, or procedures. This is important for professional communication in medical discourse.

Nominating characteristics, processes, and states, conducted by a doctor using terms, helps clarify and specify the symptoms of a disease. For this purpose, the doctor employs a constative-explanatory strategy and the tactics it determines (see Pic. 1) to obtain the information necessary for forming a clinical picture of the patient's condition (Classification by N. Lytvynenko).

Dialogue 2
Manifestations of cognitive function
(conveys knowledge):

Patient: Доброго дня, лікарю! Мене звати Віктор, і я отримав травму після автомобільної аварії. Відчуваю сильний біль у правій нозі, особливо в ділянці стегна.

Doctor: Доброго дня, пане Вікторе. Давайте детально розглянемо Вашу ситуацію. Розкажіть, будь ласка, як саме сталася аварія та які симптоми у вас спостерігаються, крім болю?

Patient: Я зіткнувся з іншою машиною під час аварії. Спочатку відчув удар і раптову втрату рівноваги, а зараз біль локалізується в ділянці правого стегна, а також з'явився набряк та боляче рухатися.

Doctor: Зрозуміло. Схоже на травму з елементами прямого удару, що може призвести до різних пошкоджень. Нам необхідно провести детальний клінічний огляд. Чи відчуваєте ви оніміння або поколювання в нозі?

Patient: Так, іноді буває поколювання, особливо коли намагаюся рухати ногою.

Doctor: Це може свідчити про нервову компресію або подразнення. Спершу я пропоную провести рентгенографію, щоб виключити можливість перелому або тріщини кістки. Також, зважаючи на симптоми, можливо, знадобиться комп'ютерна томографія (КТ) для детальнішої візуалізації уражених структур.

Patient: Розумію, лікарю. А що може бути причиною такого стану? Чи є ризик, що кістка зламалася?

Doctor: На основі вашого опису існує підозра на можливий перелом шийки стегнової кістки або навіть дислокацію суглоба. Перелом означає розрив цілісності кісткової тканини, а дислокація – зміщення суглобових поверхонь відносно одна одної.

Patient: Це звучить дуже серйозно. Чи буде потрібно хірургічне втручання?

Doctor: Залежно від результатів обстежень, якщо ми виявимо нестабільний перелом або складну дислокацію, може знадобитися оперативне втручання для стабілізації кісткової структури. Після цього – «іммобілізація» – процес фіксації кінцівки для забезпечення правильного загоєння.

Patient: А які методи лікування застосовуються при таких травмах?

Doctor: Стандартно лікування включає консервативну терапію або хірургічну корекцію залежно від типу пошкодження. При консервативному лікуванні використовують методи репозиції кістки, накладення гіпсової або спеціальної ортопедичної шини, що допомагає стабілізувати перелом, тобто для утримання кісткових уламків у правильному положенні.

Patient: Добре, лікарю. Які ще обстеження ви плануєте провести, щоб уточнити діагноз?

Doctor: Крім рентгенографії та КТ, я також пропоную зробити магнітно-резонансну томографію (МРТ). МРТ допоможе оцінити стан м'яких тканин – зв'язок, сухожиль, м'язів та нервів, що особливо важливо, якщо існує підозра на супутню травму, як-от розтягнення або розрив зв'язок. Також можемо провести ультразвукове дослідження для оцінки кровопостачання і виявлення можливих гематом.

Patient: Чи вплине таке комплексне обстеження на швидкість початку лікування?

Doctor: Ні, навпаки, завдяки детальній діагностиці ми зможемо оперативно визначити оптимальний план лікування.

Patient: Які ризики та ускладнення можуть виникнути, якщо травма буде не лікуватися належним чином?

Doctor: Якщо не надати адекватну медичну допомогу, може виникнути ряд ускладнень: ненормальне загоєння кістки («переломний псевдоартроз»), хронічний біль, обмеження рухливості суглоба, а в разі ушкодження судин чи нервів – порушення кровопостачання або неврологічні дефіцити.

Patient: Це дуже важливо знати. Чи можна запобігти цим ускладненням?

Doctor: Так, своєчасна діагностика та правильне лікування є ключовими факторами профілактики ускладнень.

Patient: Ясно, дякую. А коли можна очікувати результати обстежень, і як скоро розпочнеться лікування?

Doctor: Результати рентгенографії та КТ ми отримаємо вже протягом наступних кількох годин. Після їх аналізу ми зможемо визначити точну природу пошкодження і прийняти рішення щодо консервативного чи оперативного лікування. Якщо все буде стабільно, консервативна терапія може бути розпочата одразу після

обстеження, а в разі необхідності оперативне втручання планується якнайшвидше.

In the dialogue, the cognitive function of terms is expressed by creating a structured, comprehensible, and systematic picture of the pathological process, which is essential for quality decision-making and effective treatment.

Classification of Pathologies:

- Terms like *перелом*, *дислокація*, *репозиція* allow doctors to differentiate types of injuries. This helps them understand the trauma mechanism and subsequent actions.

Structuring the treatment process:

- Concepts such as *іммобілізація*, *консервативна терапія*, *оперативне втручання*, *реабілітація* help organize the treatment plan into a logical sequence that is understandable for both the doctor and the patient.

Improving Information Perception:

- When the doctor explains the meanings of terms like *антикоагулянти*, *тромбоз*, *емболія*, the patient can better understand possible complications, which promotes active participation in the treatment process. The doctor employs an explanatory-assertive strategy, particularly the feedback tactic, which helps establish contact with the patient and clarify the course of the disease.

Forming a common understanding:

- Terms like *рентгенографія*, *КТ*, *МРТ* not only denote examination methods but also create a unified cognitive base that facilitates communication between doctors and patients and among different specialists.

Dialogue 3
Manifestations of the communicative function (effective information transfer)

Doctor: Добрий день, шановний! Що Вас турбує?

Patient: Добрий день, лікарю. Останні кілька днів мене турбує сильний біль у животі, особливо після їжі. Крім того, відчуваю нудоту та загальну слабкість. Останнім часом відчуваю печію після їжі та відчуття важкості в животі. Інколи біль буває різким.

Doctor: Зрозуміло. Чи могли б ви уточнити, де саме локалізується біль? Чи відчуваєте ви його більше у правій чи лівій частині?

Patient: Біль, здається, більше зосереджений у правій нижній частині живота.

Doctor: Добре. А чи виникали у вас раніше подібні симптоми? Можливо, були якісь зміни в апетиті?

Patient: Ні, подібного не було, але за останній тиждень помітив, що апетит знизився.

Doctor: Дякую за інформацію. За вашими скаргами можна запідозрити *гастроезофагеальну рефлюксну хво-*

робу (ГЕРХ) або *функціональну диспепсію*. Для уточнення діагнозу я рекомендую провести *ендоскопічне* обстеження – *гастроскопію*, а також обов'язкове лабораторне дослідження крові на наявність Helicobacter pylori, призначу Вам також деякі лабораторні аналізи крові та сечі для уточнення діагнозу. Вжитимете поки що протизапальний засіб для тимчасового полегшення болю.

Patient: Добре, лікарю. А на що мені слід звернути увагу перед обстеженнями?

Doctor: Важливо, щоб Ви заздалегідь не вживали їжу перед *гастроскопією*. Також якщо виникнуть додаткові симптоми, як-от висока температура чи різке посилення болю, негайно зверніться до лікарні.

Patient: Добре. Зрозумів.

Doctor: Прошу. Ми зробимо все можливе, щоб швидко встановити точний діагноз та розпочати лікування. Якщо у вас будуть ще запитання або з'являться нові симптоми, телефонуйте в клініку.

Patient: Дякую, лікарю. До побачення!

Doctor: До побачення, бережіть себе!

Medical terms and specialized vocabulary play an important communicative function in the given dialogue. The use of terminology allows the doctor to clearly and unambiguously convey information about the necessary examinations and prescribed treatment. Such terminology ensures clarity and precision in communication between the specialist and the patient.

When the doctor uses professional terms, it helps build patient trust, reinforcing the impression of competence and professionalism. For the patient, it is crucial to see that the doctor possesses specialized knowledge, which in turn helps reduce anxiety.

Combining medical terms with explanations enhances the interactivity of the dialogue and fosters a partnership-based relationship where both sides participate in decision-making regarding further treatment. Such dialogues are also characteristic of the questioning stage, where the doctor applies the previously mentioned clarifying-constative strategy, which facilitates gathering information about the patient's condition.

By using this strategy, the doctor can identify key facts and, based on them, confirm symptoms typical of a particular disease. When asking general questions, the doctor employs attention-focusing, guiding the patient toward key symptoms essential for diagnosing.

At this stage of communication, specialized terminology conveys information and plays a social-psychological role, ensuring accuracy, trust, and effective interaction between the doctor and the patient.

Dialogue 4
Manifestations of the diagnostic function (reflecting the patient's condition):

Patient: Добрий день, лікарю. Як мої аналізи?

Doctor: Добридень, Володимере! Заходьте. Сідайте. Так, ми отримали результати ваших обстежень, і зараз ми їх обговоримо. Подивимось, що ми тут маємо. Так. Ну що, дуже поганого такого ми тут нічого не бачимо, але *ішемічні зміни, гіпоксичні зміни в міокарді* є. І *ліве передсердя* працює із затримкою. І *аритмія* ось тут, бачимо, *мерехтлива аритмія.*

Patient: Ішемічні зміни? Чи це означає, що ситуація серйозна?

Doctor: Це сигнал, що вашому серцю потрібна додаткова увага. Стабільна стенокардія, як правило, контролюється *медикаментозною терапією* та змінами способу життя. Наразі немає ознак гострої небезпеки, але якщо її не лікувати, ризик може зрости з часом.

Patient: Ой, Іване Семеновичу, звідки ж воно в мене взялося, як сніг на голову…

Doctor: Ми будемо тепер контролювати цей процес, він лише в початковій стадії, тому особливої загрози для нас поки що немає...Тільки треба тримати себе в руках і допомагати мені в усьому.

Patient: Які кроки ми повинні зробити далі?

Doctor: Перше – це оптимізація лікування. Ми збільшимо дозу деяких препаратів, які допомагають розширити *коронарні артерії* і знизити частоту нападів. Також я рекомендую внести корективи у спосіб життя та харчування.

Patient: Чи потрібно мені робити ще якісь додаткові обстеження?

Doctor: На даний момент нам достатньо регулярно контролювати ваш стан за допомогою періодичних оглядів та *ЕКГ.* Якщо з'являться нові симптоми або якщо нападів стане більше, ми розглянемо можливість проведення *коронарної ангіографії* для детальнішої оцінки судинної системи серця.

Patient: Добре, лікарю. Я готовий дотримуватися ваших рекомендацій. На що мені варто звернути особливу увагу вдома?

Doctor: Так, уважно стежте за появою болю в грудях, особливо якщо він з'являється навіть у стані спокою, або якщо відчуваєте задишку, пришвидшене серцебиття чи інші незвичні симптоми. У такому разі, будь ласка, негайно зверніться за медичною допомогою. Також рекомендую вести щоденник симптомів – це допоможе нам відслідковувати динаміку стану.

Patient: Зрозуміло, я буду уважний. Дякую за детальні пояснення і рекомендації.

Doctor: Прошу. Нашою метою є зберегти ваше здоров'я і запобігти розвитку ускладнень. Якщо у вас ви-

никнуть будь-які питання чи сумніви, не вагайтеся звертатися. Ми разом подбаємо про ваше серце.

Patient: Дякую, лікарю. Почуваю себе спокійніше після розмови.

Doctor: Радий це чути. Побачимося на наступному прийомі, і пам'ятайте – регулярний контроль та правильний спосіб життя дуже важливі. Бережіть себе!

Such a comment, incorporating specialized terminology, contributes to expanding the socio-psychological role of the patient, who is not merely a bearer of specific complaints and symptoms but is also actively engaged by the physician in analyzing the present signs of the disease. This type of dialogue typically occurs during the stage of objective examination when the physician identifies symptoms and signs of the disease for further analysis and, based on their expertise, determines the disease – i.e., establishes a diagnosis (from Greek diagnōsis – "recognition, determination").

At this stage of communicative interaction with the patient, the physician employs a strategy of diagnostic identification, which is generally implemented through the tactics of cooperation, cautious prompting, and constative-explanatory approaches.

Dialogue 5
Prognostic function (indicating the possible development of the disease):

Doctor №1: Ми отримали результати останніх обстежень пацієнта з гострим коронарним синдромом. Як ви оцінюєте клінічну динаміку та прогностичні показники у цього випадку?

Doctor №2: З огляду на результати *ехокардіографії, ЕФ* становить близько 35 %, що свідчить про знижений систолічний функціональний резерв. Проте, завдяки своєчасному *перкутанному коронарному втручанню (ПКВ)* та початковій медикаментозній терапії, прогноз є позитивним. Ми можемо розраховувати на поступове покращення кардіодинаміки протягом наступних 4–6 тижнів.

Doctor №1: Чудово. Враховуючи це, які ключові критерії Ви б визначили для оцінки ефективності лікування протягом цього прогнозованого періоду?

Doctor №2: Основними критеріями є підвищення фракції викиду (ЕФ) на 5–10 %, зниження рівня *мозкового натрійуретичного пептиду (BNP)* та стабілізація серцевого ритму. Також важливо враховувати клінічні ознаки, зокрема зменшення *задишки* та нормалізацію *артеріального тиску.*

Doctor №1: Зрозуміло. Якщо протягом запланованого терміну (4–6 тижнів) ми не побачимо очікуваної позитивної динаміки, які кроки варто буде вжити?

Doctor №2: У такому випадку необхідно буде провести детальну ревізію терапевтичного протоколу. Це може включати корекцію дозування *інгібіторів АПФ,* додавання *бета-блокаторів* або навіть розгляд можливості повторного *інтервенційного втручання*. Також доцільно повторно оцінити рівень біомаркерів для уточнення патофізіологічного процесу.

Doctor №1: Добре. Будь ласка, забезпечте щотижневий моніторинг клінічних та лабораторних показників, і своєчасно повідомляйте про будь-які відхилення від норми. Наш прогноз лікування тісно пов'язаний із дотриманням встановленого терміну для оцінки динаміки.

Doctor №2: Зрозуміло. Наразі ведеться регулярний аналіз даних, і я надам оновлення щодо змін клінічного стану пацієнта. Також враховуватимемо індивідуальні особливості реакції на лікування.

Doctor №1: Дякую. Такий підхід дозволяє нам оперативно коригувати терапію та забезпечувати високий рівень медичної допомоги. Продовжуємо роботу в цьому напрямку.

"In the continuous discourse of doctors, the leading strategy is the diagnostic-recommendation strategy, which includes questioning-clarifying and prognostic tactics".

Doctors discuss the patient's treatment prognosis using specific medical terms (echocardiography, EF, BNP, PCI, ACE inhibitors, etc.). They outline the timeframes for the

expected improvement in clinical indicators, establish criteria for assessing treatment effectiveness, and consider an action plan in case of insufficient progress.

This approach ensures systematic monitoring of the patient's condition and timely therapy adjustments, crucial for optimizing the treatment process. Physicians often accompany their prognoses with detailed explanations of the proposed measures' necessity, feasibility, and long-term benefits.

Conclusions

The study of oral medical discourse demonstrates that it represents a field of communication where the interaction between thought and its linguistic realization is particularly close, especially at the communicative-lexical level. This level is manifested in dialogic speech and serves as the natural environment for the functioning of medical terminology.

Key characteristics of medical discourse, such as standardization and systematicity, are crucial in ensuring clarity and effectiveness in doctor-patient communication. The defining element in this process is the medical term, whose nature inherently implies structure and organization.

In dialogue, the physician actively employs medical terminology, adapting it for the patient. Some terms retain scientific precision, while others require explanation in language accessible to the patient. This approach ensures effective communication, which is the primary goal of medical

discourse. Ultimately, the value of medical discourse lies in the interaction between discourse and terminology, highlighting the importance of their interconnection in medical communication.

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