REPRESENTING HEALTH: MENTALITY, ETHICS, AND PERSUASION IN CONTEMPORARY ENGLISH AND RUSSIAN MEDICAL DISCOURSE

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Abstract. This article examines how ethical orientations, persuasive strategies, and culturally grounded mental representations of health are constructed in English and Russian medical discourse. Combining associative evidence, corpus analysis, and pragmatic-rhetorical examination, the research identifies the interplay between professional ethics (deontological vs. patient-centered), linguatherapeutic strategies, and cultural scripts that shape patient care narratives. The English subcorpus (Leipzig Corpora Collection) and Russian associative resources (Ufimtseva & Cherkasova; Selezneva et al.) were analyzed using sememe interpretation (Total Brightness Index), rhetorical move analysis, and pragmatic coding of modality and mitigation. Results show convergences (health as a universal axiologeme; medicine linked to science) and divergences: English medical discourse foregrounds specialist credentials, evidence-based persuasion, and lifestyle/preventive framing; Russian medical discourse foregrounds institutional conditions, procedural descriptions, and ambivalent evaluative reactions (e.g., бессильна). Ethical language in English tends to emphasize autonomy and informed consent; in Russian it more often encodes duty, paternalism, and state responsibility (including the notion of free medicine). The paper proposes practical recommendations for translation, intercultural clinician training, and the design of bilingual patient information that respects differing mentality features.

Keywords: medical mentality; ethics; persuasion; linguatherapy; English; Russian; institutional discourse; Total Brightness Index.

1. Introduction. Medical discourse is a site where language, ethics, and social expectations intersect. Institutional communication in healthcare not only transmits technical knowledge but also enacts ethical stances, constructs persuasive narratives, and reproduces cultural models of authority and responsibility. The present study builds on prior work that conceptualizes mentality as a system of stable axiologemes and cultural scripts reflected in language. It asks: How are ethical orientations and persuasive strategies linguistically realized in English and Russian medical discourse, and how do these realizations reflect underlying mentality models?

The question is timely. Recent socio-technological changes (digitalization, telemedicine, pandemic-era public health campaigns) have altered communicative practices in medicine, intensifying the need to understand how language mediates trust, compliance, and ethical expectations across cultures. This study focuses on two linguacultures - English and Russian - whose differing linguistic profiles (characterized as "language of time" vs. "language of space") and divergent health systems provide a productive contrast for examining how ethics and persuasion are encoded in medical language.

2. Literature Review

2.1 Mentality, Linguistic Mentality, and Medical Discourse

Mentality is understood as a relatively stable system of images, values, and behavioral templates shared by a community and reflected in language. Linguistic mentality is the manifestation of these collective mental structures in lexical priorities, metaphors, and discourse patterns. Medical discourse, as an institutional discourse, is particularly revealing because it combines scientific knowledge, professional judgment, and communicative strategies aimed at persuasion, reassurance, and instruction. Prior research highlights medical discourse's

constitutive features (roles, motives, genre), institutional signs (chronotypes, ritualized behavior), and unique orientations such as deontological ethics and linguatherapeutic practices.

2.2 Ethics and Persuasion in Health Communication

Ethical orientations in medical communication are enacted through lexical choices, syntactic patterns, and pragmatic strategies. Deontological frames emphasize duty and professional obligations; patient-centered frames foreground autonomy and shared decision-making. Persuasion in health communication operates through ethos (authority), logos (evidence), and pathos (narrative). Linguatherapeutic strategies—deliberate use of language to comfort, motivate, or reframe—are recognized as clinical tools that influence patient outcomes.

2.3 Comparative Linguacultural Perspectives: English vs Russian

Comparative studies suggest that English-language medical discourse often privileges patient autonomy and explicit informed consent, reflecting legal and cultural norms. Russian medical discourse, shaped by different institutional histories and state structures, often exhibits stronger paternalistic tendencies and a focus on institutional provision (e.g., free medicine). Associative and corpus studies (Ufimtseva & Cherkasova; Leipzig Corpora) indicate divergent associative fields around medicine, suggesting different evaluative orientations and priorities.

3. Materials and Methods

3.1 Research Design

A mixed-methods comparative design was adopted, integrating associative data (Russian), corpus frequency data (English), and pragmatic-rhetorical analysis of ethically salient genres (informed consent forms, clinical consultations, public health advisories, patient education materials). The study triangulates quantitative and qualitative evidence to infer mentality features and communicative strategies.

3.2 Data Sources and Sampling

- **Russian associative data:** Top associative reactions to медицина were taken from Ufimtseva & Cherkasova (2018) and Selezneva et al. (2018). These resources provide counts used to compute the Total Brightness Index (TBI).

- **English corpus data:** Leipzig Corpora Collection (eng_news_2023 subset) provided frequency counts and collocational patterns for medicine and ethically relevant lexical items.

- **Textual samples for pragmatic analysis:** A purposive sample of 120 documents (60 English, 60 Russian) across genres: informed consent templates, clinical consultation transcripts (published or anonymized excerpts), public health advisories, and patient leaflets. English texts were drawn from public health agencies and medical education resources; Russian texts were drawn from institutional publications and regional medical communication samples.

3.3 Analytical Procedures

1. **Quantitative associative/corpus analysis:** For each linguaculture, the top ten reactions to medicine were ranked by frequency and TBI. Comparative tables were produced.

2. **Rhetorical move analysis:** Informed consent forms and public advisories were coded for rhetorical moves (purpose, disclosure of risks, benefits, alternatives, call to action).

3. **Pragmatic coding:** Clinical consultations and patient leaflets were coded for modality (must/should/should not), mitigation devices (hedges, downtoners), politeness strategies, and linguatherapeutic devices (reassurance, reframing).

4. **Ethical language coding:** Instances of explicit ethical language (consent, duty, confidentiality, autonomy) and implicit ethical stances (authority markers, paternalistic directives) were annotated.

5. **Triangulation and synthesis:** Quantitative patterns were triangulated with qualitative findings to infer mentality features.

3.4 Reliability and Validity

- Two independent coders annotated a 20% subsample; inter-coder agreement (Cohen's kappa) exceeded 0.78 across major categories.

- Dictionary definitions (Oxford Advanced Learner's Dictionary; Explanatory Dictionary of the Russian Language) were used to ground semantic interpretations.

- Limitations of cross-method comparability (associative vs corpus data) were acknowledged and addressed through careful normalization and cautious inference.

4. Results

4.1 Associative and Corpus Findings (Top Reactions to medicine)

Russian associative top reactions (selected): врач (doctor) - highest TBI; бессильна (powerless); больница (hospital); наука (science); помощь (help); лечение (treatment); здоровье (health); укол (injection); бесплатная (free); лекарства (medicines). These reactions indicate a semanteme centered on the specialist (врач) with strong institutional and affective components (hospital, powerlessness, injections), and a socio-political marker (free medicine).

English corpus top reactions (selected): food; medical; Dr.; professor; health; physician; patients; University; traditional; doctor. The prominence of food reflects the cultural salience of nutrition and preventive health; multiple specialist nominations and institutional markers (University, professor) indicate emphasis on professional differentiation and education.

4.2 Ethical Language and Modality Patterns

- **English texts:** Higher frequency of autonomy-oriented lexemes (consent, informed, choice). Modal verbs and hedges favored collaborative forms (may wish to, could consider). Consent templates emphasized disclosure and invited questions. Public health advisories used evidence appeals and lifestyle framing.

- **Russian texts:** More frequent duty-oriented lexemes (обязанность, назначено), institutional markers (больница, врач), and directive modality (imperatives, deontic necessity). Consent forms were more formal and legalistic, with less emphasis on shared decision-making.

4.3 Persuasive Strategies and Linguatherapeutic Devices

- **Ethos:** English materials invoked institutional authority (NHS, CDC) and expert consensus; Russian materials invoked state responsibility and institutional provision.

- **Logos:** English materials used statistical evidence and references; Russian materials relied more on professional experience and protocol.

- **Pathos:** Both cultures used narrative and reassurance, but English materials framed prevention as empowerment; Russian materials emphasized compliance and procedural clarity.

- **Linguatherapeutic devices:** English clinicians combined reassurance with shared decision language; Russian clinicians used authoritative reassurance and clear procedural directives.

4.4 Genre-Specific Observations

- **Informed consent forms:** English forms prioritized comprehension checks and plain language; Russian forms were more formal and legalistic.

- **Public health advisories:** English advisories foregrounded lifestyle and preventive measures; Russian advisories emphasized institutional measures and access to services.

5. Discussion

5.1 Mentality Models and Ethical Orientations

The observed linguistic patterns reflect distinct mentality models. English-language medical discourse encodes a mentality that privileges **individual agency, professional differentiation, and evidence-based persuasion**. This is visible in the multiplicity of specialist titles, the prominence of University and professor in associative fields, and the frequent use of hedging and shared decision language. The English model aligns with a cultural script that values informed choice and preventive self-management.

Russian-language medical discourse encodes a mentality that foregrounds **institutional provision, procedural clarity, and professional duty**. The associative prominence of врач, больница, and бесплатная reflects a cultural script in which the state and medical institutions are central actors. The presence of бессильна as a salient reaction indicates ambivalence and critical evaluation of institutional effectiveness, suggesting that the mental model includes both reliance on institutions and skepticism about outcomes.

5.2 Persuasion, Trust, and Communication Outcomes

Persuasive strategies differ in their reliance on ethos vs logos. English discourse leans on logos (evidence) and ethos (institutional credibility) to build trust, while Russian discourse relies more on institutional ethos and procedural assurances. These differences imply that messages emphasizing evidence and choice may be more persuasive in English contexts, whereas messages clarifying procedures and institutional support may be more effective in Russian contexts.

5.3 Clinical and Educational Implications

Linguatherapeutic strategies must be culturally calibrated. In English contexts, clinicians can leverage collaborative language and motivational framing to enhance adherence. In Russian contexts, clinicians may need to combine clear procedural explanations with authoritative reassurance to address concerns about effectiveness and institutional conditions. Medical education should include modules on linguistic mentality and cross-cultural pragmatics to improve clinician communication skills.

6. Practical Recommendations

1. **Translation and Localization:** Preserve distinctions among specialist titles and institutional references; explicate specialization where necessary when translating into Russian.

2. **Consent and Patient Materials:** English-to-Russian translations of consent forms should include plain-language explanations and comprehension checks; Russian-to-English translations should preserve autonomy-oriented phrasing where appropriate.

3. **Public Health Messaging:** Tailor messages to cultural emphases: lifestyle and preventive framing for English audiences; clear procedural guidance and institutional access information for Russian audiences.

4. **Clinician Training:** Integrate linguistic mentality and cross-cultural communication modules into medical curricula.

5. **Telemedicine Templates:** Design bilingual telemedicine scripts that reflect differing expectations: emphasize specialist credentials and shared decision language in English; emphasize procedural clarity and institutional support in Russian.

7. Limitations and Directions for Future Research

- **Data comparability:** Associative and corpus data differ methodologically; future work should collect parallel psycholinguistic data across both linguacultures.

- **Sociodemographic variation:** Age, region, and socio-economic status likely modulate associative profiles; future studies should stratify samples.

- **Reception and outcome measures:** Experimental reception studies measuring comprehension, trust, and behavioral outcomes would validate communicative implications.

- **Longitudinal effects:** Investigate how pandemic experiences and digitalization reshape mentality features over time.

Conclusion

Ethical orientations and persuasive strategies in medical discourse are shaped by underlying mentality features that differ across English and Russian linguacultures. English discourse foregrounds specialist differentiation, evidence-based persuasion, and patient autonomy; Russian discourse foregrounds institutional provision, procedural clarity, and a mixture of trust and skepticism toward effectiveness. Recognizing these differences is essential for effective translation, intercultural clinician training, and the design of patient-centered communication in multilingual healthcare settings. Future research should expand comparative datasets, incorporate reception experiments, and monitor ongoing shifts driven by digitalization and global health crises.

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