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Original Research

Face, hierarchy, and autonomy in Uzbek clinical communication: A Situational Judgement Test study

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Effective clinical communication requires not only bioethical knowledge but sociopragmatic competence, the capacity to navigate competing professional, cultural, and relational expectations in medical encounters. This exploratory, cross-sectional study asked which domains elicited the greatest sociopragmatic tension among Uzbek medical students and how their appropriateness judgements varied across year groups. A scenario-based survey was administered in Uzbek to 100 undergraduate students at seven institutions. Participants completed a six-scenario Situational Judgement Test (SJT): five scenarios used a five-point Likert-type appropriateness scale (Cronbach's alpha = .785, reported only as a descriptive indicator of interrelatedness for a deliberately multidimensional instrument), and one used a three-option forced-choice format. Non-parametric analyses (Spearman correlations, Kruskal-Wallis tests, Fisher's Exact Test) were applied, and results are interpreted as sample-level patterns rather than population estimates. Mean ratings ranged from 1.86 to 2.20, below the neutral midpoint, indicating that target actions were more often rated inappropriate than appropriate. The patient-consent scenario showed the widest dispersion (M = 2.15, SD = 1.24). Gift-giving responses were divided among professional refusal (30%), acceptance explicitly framed in the instrument as cultural reciprocity (37%), and collective departmental acceptance (33%). Year group was associated with response choice, although the result was borderline and exploratory (simulated p = .038, Cramér's V = .304). After Holm adjustment across the five scenario-level tests, year-group differences remained significant for S3, S4, and S5. The exploratory total score, which was not included in the adjustment family, also differed across year groups ($H(5) = 35.01$, unadjusted $p < .001$); given the cross-sectional design and small, uneven groups, these differences cannot be interpreted developmentally. These findings provide initial evidence from an underrepresented setting and a basis for validated, longitudinal research on culturally responsive communication training.

Keywords: face management, intercultural pragmatics, medical education, patient autonomy, situational judgement test, sociopragmatic competence, Uzbekistan

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1. INTRODUCTION

Effective medical communication involves far more than the accurate transfer of information. Physicians must elicit patients' concerns, respond to emotional cues, sustain therapeutic relationships, and support informed decision-making, all within encounters marked by deep asymmetries of knowledge, authority, and expectation. Patient-centred communication of this kind improves adherence,

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self-management, satisfaction, and clinical outcomes, and its constituent skills are teachable within medical training (Levinson et al., 2010; Street et al., 2009). Such communication is never culturally neutral, however. Patients and practitioners bring divergent assumptions about authority, disclosure, family involvement, and decision-making, and these assumptions carry direct consequences for both the process and the outcome of care (Betancourt et al., 2003; Schouten & Meeuwesen, 2006). Cultural background conditions communicative expectations in ways that challenge any universalising model of patient-centred practice (Blackhall et al., 1995).

The competence required to manage these expectations is sociopragmatic rather than narrowly linguistic or ethical. Sociopragmatic competence is the capacity to recognise how contextual variables, including social role, institutional status, interpersonal distance, and cultural norms, determine what counts as appropriate communicative conduct (Spencer-Oatey, 2002; Thomas, 1983). In the present study, appropriateness therefore refers not to grammatical correctness or to abstract ethical rule following, but to a respondent's evaluative judgement of whether a given communicative action is fitting once competing professional and cultural expectations are taken into account. Thomas (1983) distinguishes such pragmatic judgement from linguistic knowledge by showing that communicative breakdown can occur when interlocutors assign divergent social meaning to an utterance in the absence of any structural error. A student may know what to communicate yet remain uncertain about how to do so without transgressing locally salient norms of respect, hierarchy, or relational harmony.

Difficulty in clinical communication may therefore arise not only from gaps in linguistic or ethical knowledge but also from uncertainty where internationally promoted professional principles meet locally salient expectations (Betancourt et al., 2003; Schouten & Meeuwesen, 2006). Six such points are central to this study. The disclosure of a serious prognosis can set a patient's right to information against family expectations of protective non-disclosure (Kagawa-Singer & Blackhall, 2001; Surbone, 2006). Patient safety can place the responsibility to raise a clinical error in tension with deference to senior authority (Carrillo et al., 2024; Rechel et al., 2011). Valid individual consent can be complicated by expectations of spousal or family participation in decision-making (Blackhall et al., 1995; Kagawa-Singer & Blackhall, 2001). Verification of patient understanding can fail when verbal assurances are accepted without active checking (Schillinger et al., 2003). Empathic acknowledgement may be displaced by task pressures, although responding to emotional cues is central to patient-centred communication (Epstein & Street, 2011; Levinson et al., 2010). Professional boundaries may likewise be tested by expectations of reciprocity surrounding gift exchange (Stepurko et al., 2013). These points foreground the constructs at the centre of the inquiry, namely patient autonomy, hierarchical deference, family involvement, face management, and professional responsibility. They are especially relevant to medical students, whose judgements develop within institutional hierarchies and professional role expectations (Carrillo et al., 2024; Rechel et al., 2011) and may not be fully ascertained by conventional knowledge-based assessment (Lievens & Sackett, 2012; Patterson et al., 2016)

Assessing this kind of judgement is central to competency-based medical education (CBME), which has reoriented evaluation from time-based completion towards demonstrated professional reasoning in authentic contexts (Frank et al., 2010; Frenk et al., 2010). Situational Judgement Tests (SJTs) are well suited to this purpose. An SJT presents realistic, role-relevant scenarios and asks respondents to rate the appropriateness of a specified communicative action, thereby eliciting the evaluative reasoning that individuals apply to complex workplace dilemmas (Lievens & Sackett, 2012; Patterson et al., 2016). Because they assess how a situation is judged rather than what is recalled, SJTs may make such sociopragmatic tensions analytically visible through contextualised dilemmas.

This study applies a scenario-based SJT to medical students in Uzbekistan's post-Soviet educational and clinical environment. Soviet-era hierarchy and bureaucratic paternalism continue to influence health systems in the region and may privilege senior physician authority and institutional conformity over collaborative critique or student-led intervention (Rechel et al., 2011). The scenarios examine how medical students judge situations involving authority, direct disagreement, face-sensitive communication, patient autonomy, and professional accountability. The study therefore tests responses to situations in which internationally promoted professional principles may conflict with hierarchical and relational considerations.

Against this background, the present study identifies which communication domains generated the greatest sociopragmatic tension in a sample of Uzbek medical students and examines how their appropriateness judgements varied by year group. Three research questions guide the inquiry:

1. Which scenarios showed the strongest indications of sociopragmatic tension, reflected in stronger rejection of the target action (lower mean appropriateness ratings) or greater disagreement among respondents (greater response dispersion) in the five Likert-rated scenarios, and in a more even division of responses between the alternatives in the forced-choice scenario?

2. What do students' appropriateness ratings suggest about orientations towards patient autonomy, hierarchical deference, family involvement, face management, and professional responsibility?

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3. Which communication domains identified in the exploratory analysis may warrant further investigation as potential areas for culturally responsive communication training in Uzbek medical education?

The study makes three deliberately limited contributions. Its primary contribution is empirical and contextual. It provides initial evidence on scenario-based communicative judgements from an underrepresented post-Soviet Central Asian medical education setting. Second, it explores the potential usefulness of SJT-based methods for identifying sociopragmatic tension in contextualised clinical communication dilemmas. Third, it proposes the Medical Sociopragmatic Competence (MedSPC) framework as a provisional heuristic that links each scenario to a sociopragmatic competence component and identifies the professional principle and competing contextual expectation represented in the dilemma. The framework is intended to support subsequent instrument development and cross-contextual validation. It is not presented as a validated model or an established basis for curricular prescription.

2. METHODOLOGY

2.1. Study design

This study employed a cross-sectional, scenario-based survey design using a purpose-built SJT to elicit Uzbek medical students' evaluative judgements about realistic clinical communication dilemmas. SJTs are well established for assessing professional judgement, interpersonal reasoning, and decision-making in contextually rich situations (Lievens & Sackett, 2012; Patterson et al., 2016). Their scenario-driven format also permits examination of sociopragmatic judgements that fall outside the scope of knowledge-based assessment. The study was descriptive and analytical in scope and examined evaluative judgements concerning potential conflicts among professional, ethical, cultural, and relational expectations. It did not observe or assess clinical behaviour. Reporting followed transparent web-survey principles covering survey mode, target population, participation conditions, and data-handling procedures (Eysenbach, 2004).

2.2. Instrument development and validation

The instrument was a six-scenario SJT administered in Uzbek via Google Forms. Its development proceeded in three stages: generation of candidate scenarios, selection of the final set, and expert content validation.

Scenario generation. An initial pool of ten candidate scenarios was drafted from the intercultural pragmatics and rapport-management literature (Spencer-Oatey, 2002; Thomas, 1983), research on family-centred clinical communication (Blackhall et al., 1995; Kagawa-Singer & Blackhall, 2001), and competency-based frameworks for professional communication (Frank et al., 2010). No local or experiential sources were used; all candidates were derived from the published literature. Each candidate was designed to instantiate a tension between an internationally promoted professional communication principle and a competing contextual consideration. The scenarios were developed from published literature and selected to represent domains of the proposed MedSPC framework. They should be understood as exploratory hypothetical scenarios, not as a validated inventory of Uzbek clinical practice.

Selection of the final set. From the ten candidates, six were retained by the author against three criteria: (a) the strength and clarity of the tension the scenario posed between a professional principle and a competing contextual consideration; (b) distinct mapping onto one of the five MedSPC components (Table 1), so that the set as a whole represented the framework without redundancy; and (c) the need to keep the instrument short enough to sustain completion in a voluntary, unincentivised online survey. The four scenarios not retained were set aside because they were weaker on these criteria: each either duplicated a tension already represented more sharply by a retained scenario or mapped less distinctly onto the MedSPC components, and their inclusion would have lengthened the instrument without adding a distinct sociopragmatic dimension. One retained scenario, the gift-giving scenario (S6), was revised before administration to sharpen the contrast among its response options. The six retained scenarios span prognosis disclosure (S1), hierarchical correction (S2), individual consent under family objection (S3), comprehension verification (S4), emotional acknowledgement under time pressure (S5), and professional boundaries in gift exchange (S6).

Scope of the instrument. The instrument was deliberately confined to six scenarios for an exploratory, first-stage study. Other clinically significant communication dilemmas, including confidentiality, informed refusal of treatment, breaking bad news, apology after error, language choice in multilingual consultations, gender-sensitive interaction, mental-health stigma, end-of-life decision-making, informal payments, and communication with parents or elderly relatives, were considered relevant but were not included in this version. Several overlap conceptually with retained scenarios (for example, breaking bad news with S1, and informal payments with S6), while the remainder are identified as priorities for expanded, separately validated future iterations.

Expert content validation. Before administration, the instrument was evaluated by a panel of twelve subject-matter experts with backgrounds in medical education, clinical practice, and medical ethics and communication, and with professional experience ranging from five to more than twenty years. For every scenario, each expert rated how suitable the scenario was for measuring sociopragmatic competence, using a five-point relevance scale, and judged

the overall adequacy with which the six scenarios collectively cover clinical communicative competence in Uzbek medical education. Item-level content validity was quantified using the Content Validity Index (Lynn, 1986; Polit & Beck, 2006), with the two highest scale categories treated as relevant. Item-level CVI values ranged from 0.92 to 1.00, with five of the six scenarios reaching full agreement and the comprehension-verification scenario (S4) receiving one rating below the prespecified relevance threshold; the scale-level index (S-CVI/Ave) was 0.99, exceeding the conventional threshold of 0.90. All twelve experts considered the six-scenario set sufficient (six completely and six mostly), and none proposed additional scenarios. These findings provide evidence of expert-judged content validity for the relevance and coverage of the six scenarios; they do not validate the MedSPC framework, the score structure, or interpretations of participants' underlying motives (Section 5.7). The complete anonymised expert ratings — comprising each expert's five-point relevance rating for scenarios S1—S6 and the overall coverage judgement, from which the I-CVI and S-CVI/Ave values are computed — are available through the repository identified in the Data Availability Statement, together with the corresponding analysis script.

Response format. Five scenarios used a five-point Likert-type appropriateness scale with descriptive, context-specific anchors that expressed distinct relational considerations, including the primacy of family consent and deference to senior authority. The sixth scenario used a three-option forced-choice format. The anchors were designed to focus appropriateness judgements on the professional, relational, and institutional considerations presented in each scenario. The instrument was administered in Uzbek. The Uzbek and English versions were reviewed for semantic equivalence by two bilingual reviewers holding a DSc in Applied Linguistics. Their review resulted in a clarification to the wording of Option B in Scenario 6, which was revised to state explicitly that acceptance of the gift would not constitute bribery. The full instrument, including all six scenarios, every Likert anchor, and the forced-choice options, with original Uzbek wording and English translation, is provided in Appendix A.

2.3. Scenario—construct mapping

The instrument was developed with reference to the Medical Sociopragmatic Competence (MedSPC) framework, a provisional analytical taxonomy proposed by the author for this study. Each scenario was assigned to one or more MedSPC components and presented a potential conflict between a professional communication principle and a competing contextual expectation. Table 1 shows the correspondence among the scenarios, MedSPC components, professional principles, and competing expectations. Appendix A provides the complete scenario texts. Section 3.4 describes the five MedSPC components. The framework is a heuristic pending psychometric validation.

Table 1
Proposed MedSPC component mapping and competing considerations

SCENARIO	MedSPC COMPONENT(S)	PROFESSIONAL PRINCIPLE	COMPETING CONTEXTUAL CONSIDERATION
S1. Prognosis disclosure against family veto	Face and Rapport Management; Sociopragmatic Knowledge	Patient's right to information and transparent disclosure	Family-mediated protection and indirect disclosure
S2. Publicly challenging a senior physician's error	Interactional Role Competence	Patient safety and professional accountability	Hierarchical deference and protection of seniority-based face
S3. Proceeding with surgery based on patient's consent despite spousal objection	Sociopragmatic Knowledge; Pragmatic Adaptability	Individual patient autonomy and valid consent	Family or spousal participation in decision-making
S4. Accepting surface-level confirmation from an elderly rural patient	Discourse Organisational Competence	Active verification of patient comprehension	Reliance on verbal confirmation and avoidance of over-questioning
S5. Prioritising information delivery during emotional crisis	Pragmatic Adaptability; Face and Rapport Management	Empathy-first communication and emotional	Task completion under time and clinical pressure
S6. Gift acceptance from a patient's family	Face and Rapport Management	Professional boundary maintenance	Reciprocity, gratitude, and avoidance of relational offence

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2.4. Participants and recruitment

One hundred medical students from seven institutions across Uzbekistan participated voluntarily and anonymously, representing all six undergraduate year groups: Year 1 (n = 43), Year 2 (n = 8), Year 3 (n = 10), Year 4 (n = 16), Year 5 (n = 10), and Year 6 (n = 13). The overrepresentation of Year 1 students reflects the convenience sampling approach and should be borne in mind when interpreting year-group comparisons. Participating institutions included Bukhara State Medical Institute, Tashkent State Medical University, Tashkent Medical Academy, Samarkand State Medical University, Andijan State Medical Institute, Fergana Public Health Medical Institute, and the Tashkent branch of I.M. Sechenov First Moscow State Medical University. Recruitment proceeded through institutional contacts and peer referral networks. No personally identifying data were collected. The original survey dataset comprised year of study, institutional affiliation, five Likert-type scenario ratings, and the forced-choice gift-giving response. Institutional affiliation and submission timestamps were removed from the de-identified dataset supplied for reproducibility.

2.5. Data collection procedure

The SJT was administered online via Google Forms in Uzbek. Participants received a written statement covering the study's purpose, voluntary participation, anonymous data handling, and the right to withdraw; form submission constituted implied consent consistent with standard anonymous online survey practice (Eysenbach, 2004). The online format enabled multi-institutional participation, though the self-administered environment precluded standardisation of completion conditions.

Data were collected between January and March 2026. Eligible participants were currently enrolled undergraduate medical students at medical higher education institutions in Uzbekistan, spanning all six year groups. Eligibility was based on current undergraduate enrolment, and participant age was not among the variables collected. The survey link was initially distributed through institutional contacts, who posted it to student social media groups, and it could subsequently be shared onward by students through peer referral. Because the link could be forwarded in this way, the total number of people who received it could not be determined, and a conventional response rate is therefore not calculable. The final sample of 100 comprised all eligible complete responses received during the collection period rather than a predetermined target.

All questionnaire items were configured as required, so every submitted response was complete. To limit duplicate submissions, the form was configured to accept one response per Google account. This restriction operated at the account level only. No email addresses or other account identifiers were collected, stored, or made visible to the researcher at any stage, so the survey remained anonymous and no participant is identifiable from the dataset.

2.6. Ethical considerations

The study was conducted in accordance with the Declaration of Helsinki (World Medical Association, 2013) and complied with all applicable ethical guidelines, regulatory standards, and institutional requirements governing research involving human participants, including applicable institutional review board requirements. Before participation, all participants received written information explaining the study's purpose, procedures, voluntary nature, anonymous data handling, right to discontinue before submitting the form, and foreseeable risks. Informed consent was obtained electronically through an implied-consent procedure: after reading this information, participants indicated consent by choosing to proceed with and submit the questionnaire.

The survey involved no intervention or deception and asked participants to evaluate hypothetical clinical communication situations. The foreseeable risk was limited to possible mild discomfort when considering ethically sensitive scenarios. This risk was minimised by allowing participants to discontinue before submission without penalty and by collecting no names, identification numbers, contact details, email or account identifiers, or other directly identifying information. The data were stored securely and were accessible only to the author before preparation of the anonymised research dataset.

2.7. Data preparation

Responses were exported from Google Forms and checked for completeness, format consistency, and coding accuracy. All respondents provided complete data; no cases were excluded. Likert-type responses were coded numerically from 1 to 5, with higher values indicating greater perceived appropriateness. Forced-choice responses for Scenario 6 were coded nominally: Option A (professional ethics-based refusal), Option B (culturally oriented acceptance), and Option C (pragmatic compromise: collective departmental acceptance). Appendix A lists the Likert scale anchor descriptors used for each scenario.

2.8. Statistical analysis

All analyses were performed in *R* v. 4.3.1 (R Core Team, 2023). Descriptive statistics (means, standard deviations, and percentage distributions) summarised response patterns. Likert-type responses were retained in their ordinal 1—5 structure, preserving full variance; standard deviation served as the principal dispersion indicator. Internal consistency across S1—S5 was estimated using Cronbach's α (Tavakol & Dennick, 2011); Scenario 6 was excluded due to its categorical format.

Non-parametric procedures were used for association and year-group analyses because the Likert-type responses were ordinal and the year-group sizes were small and unequal. Associations among S1—S5 were examined using Spearman's rank correlation (ρ). Year-group differences for S1—S5 and the exploratory Total SJT Score were evaluated using the Kruskal—Wallis H test (Corder & Foreman, 2011). The five scenario-level omnibus p values were adjusted using the Holm procedure to control the familywise error rate. The Total SJT Score was excluded from this five-test adjustment family. Scenarios with an unadjusted omnibus $p < .05$ were examined using Dunn's pairwise tests with Bonferroni correction across the 15 year-group comparisons within each scenario (Dunn, 1964). Because 72% of the expected frequencies in the six-year-group-by-three-option contingency table were below five, the Pearson chi-square approximation was considered unreliable. The association between year group and the Scenario 6 response was therefore tested using Fisher's exact test with a Monte Carlo simulated *p* value in *R* (stats::fisher.test, simulate.p.value = TRUE, B = 10,000). The random seed was set to 2024 to reproduce the simulated result. Cramér's V was computed in base R as a descriptive effect size. The Total SJT Score was calculated as the sum of S1—S5, with a possible range of 5—25 and was interpreted as an exploratory sum score pending confirmatory analysis in larger samples. The analysis script and de-identified participant-level dataset are available through the repository identified in the Data Availability Statement. Statistical significance was set at $p < .05$.

3. THEORETICAL BACKGROUND

3.1. Sociopragmatic competence, face, and rapport in clinical communication

Medical communication is a socially situated activity in which participants negotiate authority, relational expectations, and professional accountability alongside the exchange of clinical information. The perceived appropriateness of a communicative action depends on its propositional content and on its interpretation within a social and cultural context (Carmo, 2026). Sociopragmatic competence is the capacity to recognise how contextual variables influence perceived appropriateness and to adjust communicative choices accordingly, without relying solely on abstract rules (Ilyina, 2026; Thomas, 1983). Thomas (1983) separates pragmatic from linguistic failure by showing that communicative breakdown can occur when interlocutors assign divergent social force to an utterance in the absence of any structural error, so that a speaker may know what to say yet misjudge how the saying of it will be received.

The central theoretical resource for analysing this social interpretation is the study of face and rapport. Face, understood as a person's publicly claimed self-image and the interactional work that sustains it, was elaborated by Goffman (1967) and formalised by Brown and Levinson (1987), whose politeness theory proposes that face-threatening acts constitute a universal concern and are managed through positive- and negative-politeness strategies. What is well established across this tradition is that speakers orient to face and work to mitigate threats to it (Shevchenko et al., 2026)). What remains disputed is the claim to universality. Empirical work in non-Western settings has shown that the social meaning of respect, deference, and interpersonal obligation varies substantially, and that group-oriented and relationship-oriented value systems generate face sensitivities that individualist models do not capture (Gu, 1990; Matsumoto, 1988). Spencer-Oatey's (2002) rapport management framework responds to this dispute by shifting the unit of analysis from discrete politeness moves to the management of social relations as a whole, encompassing face sensitivities, sociality rights, and interactional goals, which makes it well suited to hierarchical institutional settings such as clinical medicine. Face and rapport are particularly consequential in clinical communication because disclosing a prognosis may conflict with family-protective expectations, publicly correcting a senior colleague may threaten hierarchical relations, and declining a gift may be interpreted as a relational offence. Communicative competence in medicine must therefore include the management of face-sensitive interaction alongside professional accountability, a requirement that ethical rules and communication scripts alone do not meet.

3.2. Culture, authority, and ethical communication in clinical encounters

Clinical encounters can differ according to cultural setting in patient and family participation, information exchange, emotional expression, and doctor—patient relationships (Betancourt et al., 2003; Schouten & Meeuwesen, 2006). Literature on disclosure illustrates this variation. Blackhall et al. (1995) found that Korean American and Mexican American respondents were more likely to favour family-centred decision-making, whereas African American and European American respondents were more likely to favour a patient-autonomy model. Kagawa-Singer and Blackhall (2001) examined two cases of end-of-life care involving differing cultural beliefs, values, and practices in truth-telling and family participation. Surbone (2006, 2008) similarly described cultural variation in interpretations of autonomy, truth-telling practices, and family roles in cancer care. Recent empirical research confirms the continuing relevance of these questions. Mei and Tu (2021) used ethnographic and interview data from a Chinese cancer hospital and found that disclosure decisions reflected actors' values together with their medical and interpersonal skills. Wu et al. (2021) reported that 77% of surveyed patients wanted full disclosure at initial diagnosis, while medical staff tended to inform family

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members first. He et al. (2024) found that family decisions shifted between disclosure and concealment during the course of illness and were influenced partly by the hope associated with available treatment. What this body of work establishes is that direct, individually addressed disclosure is neither universally expected nor universally preferred. What it leaves open in Uzbek medical education is how trainees weigh these competing expectations when making a decision.

To keep this question tractable without stereotyping, culture is not treated here as a fixed predictor of individual behaviour. Following Oyserman et al. (2002), culture is conceptualised as a repertoire of interactional expectations, including respect for seniority, family participation, communicative indirectness, and relational harmony. The relevance of these expectations may vary according to the situation and influence judgement without determining it. On this view, a low appropriateness rating for direct disclosure or public correction need not signal ethical deficiency; it may reflect a respondent's reasoned reading of locally significant interactional risk. The analytical aim is accordingly not to classify students as ethical or unethical but to map how they position themselves within contested normative space, an aim consistent with competency-based accounts that define professional competence as the mobilisation of knowledge, skills, values, and judgement in demanding situations (Frank et al., 2010; Frenk et al., 2010). This focus is especially pertinent in the post-Soviet setting of the present study, where senior authority and institutional conformity have historically carried substantial weight in professional socialisation (Rechel et al., 2011). Comparative evidence indicates that trainees in very different systems tend to withhold voice when they perceive a patient safety concern, and that this reluctance is conditioned by cultural and interpersonal barriers as much as by individual knowledge (Carrillo et al., 2024).

Culture is considered one possible source of interactional expectations, together with professional norms, institutional hierarchy, family relations, and immediate situational pressures. Cultural categories do not determine individual judgement, and variation within a cultural setting must be expected (Oyserman et al., 2002). The study did not measure cultural identity or collect participants' explanations for their responses. Cultural explanations are therefore presented as hypotheses supported by previous research. The empirical findings remain descriptions of appropriateness judgements and differences between year groups.

3.3. Scenario-based assessment

SJTs present realistic professional situations and ask respondents to evaluate possible courses of action, requiring context-sensitive judgement in addition to declarative knowledge. No scenario-based studies of sociopragmatic judgements among Uzbek medical students were identified in the literature reviewed for this study, while the limited empirical research from neighbouring post-Soviet medical education systems has focused on learning environments and curriculum reform, with little attention to communicative judgement (Schubiger et al., 2019). Two qualifications to this evidence base bear on the present design. First, much of it derives from high-stakes selection in Western training systems, so the transportability of SJT-based inferences to other educational cultures cannot be assumed. Second, an SJT elicits judgements about hypothetical situations, not observed clinical behaviour, a distinction that constrains interpretation and to which this study returns in its limitations. Within these limits, the value of the format here lies in its capacity to confront respondents with communicative dilemmas that resist assessment by decontextualised knowledge tests or standardised checklists, and to render the resulting evaluative responses comparable between scenarios and year groups.

The literature reviewed above establishes three points and leaves one open. It establishes that clinical communication is face-sensitive, culturally variable, and socially situated; that protective, family-mediated, and hierarchy-sensitive practices are widespread and are not reducible to ethical deficiency; and that scenario-based judgement is a tractable object of measurement. What it does not establish is how medical students in a post-Soviet, Central Asian setting evaluate the specific dilemmas in which a globally promoted professional communication principle collides with a locally salient competing expectation. Their criterion-related validity for predicting academic performance and professional behaviour is well documented, including in a systematic review and meta-analysis of validity evidence for selection (Lievens & Sackett, 2012; Patterson et al., 2016; Webster et al., 2020).

This gap concerns theory and method as well as geographical coverage. Universalist politeness theories do not fully account for culturally specific face sensitivities documented in non-Western settings (Gu, 1990; Matsumoto, 1988). Cultural-competence frameworks describe relevant knowledge, attitudes, skills, and institutional practices but provide no scenario-level procedure for analysing conflicts between professional and cultural expectations (Betancourt et al., 2003). The SJT literature reviewed for this article addresses selection, professional judgement, interpersonal reasoning, and performance but does not examine communicative conflict involving cultural expectations among Uzbek medical students (Lievens & Sackett, 2012; Patterson et al., 2016; Webster et al., 2020). The literature reviewed for this study contained no established framework that classifies clinical communication scenarios according to their professional principle, competing cultural expectation, and corresponding area of communicative competence.

3.4. The MedSPC framework

The Medical Sociopragmatic Competence (MedSPC) framework is proposed as a provisional response to the established gap. It is an author-developed heuristic taxonomy that has not undergone independent psychometric validation. In this study, the framework is used to classify the scenarios and support their analysis. The validation programme is described in Section 5.7. The framework comprises five proposed components. *Sociopragmatic Knowledge* refers to awareness of the social and cultural expectations that influence communicative appropriateness. *Discourse Organisational Competence* concerns the structuring of communication to support comprehension and participation. *Interactional Role Competence* concerns the management of role relations among students, physicians, patients, and families. *Face and Rapport Management Competence* concerns the handling of face-threatening communication while sustaining professional accountability. *Pragmatic Adaptability* concerns the adjustment of communicative choices when professional, institutional, and cultural expectations conflict simultaneously.

These five components provide categories for relating the professional principles to the competing contextual expectations represented in the scenarios. Two examples illustrate this classification. One concerns professional accountability and expectations of deference to authority, avoidance of direct confrontation, and face-sensitive restraint. The other concerns professional boundary maintenance and the expectation that refusing a sincerely offered gift may be read as withholding acceptance and causing offence. The framework further distinguishes two responses to normative conflict that an appropriateness rating cannot separate on its own. Pragmatic compromise denotes reluctant accommodation to cultural pressure at the cost of a professional principle, whereas pragmatic integration denotes a hybrid course of action that satisfies relational and professional demands simultaneously. Whether a given response reflects integration or compromise is examined empirically in the Results and is not assumed in advance. The collective departmental acceptance option in the gift-giving scenario provides one example. The findings constitute an initial application of the framework in a single national setting and provide a baseline for structural validation with larger and more diverse cohorts.

4. RESULTS

4.1. Reliability and content validity

The five Likert-type scenarios yielded a Cronbach's alpha of .785. Because the instrument was designed to be multidimensional, this value is not interpreted as an index of the reliability of a single latent construct or as validating the composite score; it is reported only as a descriptive indicator of the degree of interrelatedness among the S1—S5 ratings (McNeish, 2018). The forced-choice scenario (S6) was excluded from this calculation because its categorical three-option format precludes ordinal reliability analysis; it was examined separately (Sections 4.6 and 4.7).

A twelve-member expert panel reviewed the six scenarios for relevance, suitability, and overall coverage prior to administration, as described in Section 2.2. Item-level Content Validity Index values ranged from 0.92 to 1.00, and the scale-level index (S-CVI/Ave) was 0.99. These findings provide evidence of expert-judged content validity for the relevance and coverage of the six scenarios; they do not validate the MedSPC framework, the score structure, or interpretations of participants' underlying motives. Reliability and content validity are distinct properties, and the composite Total SJT Score (Section 4.5) is accordingly interpreted as an exploratory index rather than a validated measure of a single latent construct.

4.2. Scenario-level descriptive statistics

Mean appropriateness ratings in all five scenarios ranged from 1.86 to 2.20 — consistently below the neutral midpoint (3.0) — indicating systematic disapproval of the target communicative actions, with meaningful variation across scenarios reflecting different degrees of sociopragmatic tension (Table 2). S3 showed the greatest dispersion (SD = 1.24), while S5 generated the strongest consensus (SD = 1.02; 80% disapproval) (Figure 1).

4.3. Scenario-specific response patterns

S1 Prognosis disclosure against family veto. Direct disclosure was rated inappropriate by 75%, neutral by 16%, and appropriate by 9% (Table 2).

S2 Publicly challenging a senior physician's error. Public correction was rated inappropriate by 72% and appropriate by 16%, the highest proportion of appropriate ratings among the five Likert scenarios.

S3 Proceeding with surgery based on patient consent despite spousal objection. Proceeding was rated inappropriate by 67% and appropriate by 17%. This scenario had the widest dispersion (SD = 1.24) and the most even division of ratings among the five Likert scenarios.

S4 Accepting surface-level comprehension confirmation. This response was rated inappropriate by 73% and appropriate by 14%.

S5 Continuing information delivery during emotional crisis. This response was rated inappropriate by 80%, the highest agreement among the five Likert scenarios.

4.4. Associations among scenario ratings

The strongest association was S2—S3 (ρ = .539, p < .001): ratings of public correction of a senior physician were positively associated with ratings of proceeding with surgery on the patient's individual consent. Moderate associations were observed for S4—S5 (ρ = .394) and S3—S5 (ρ = .388).

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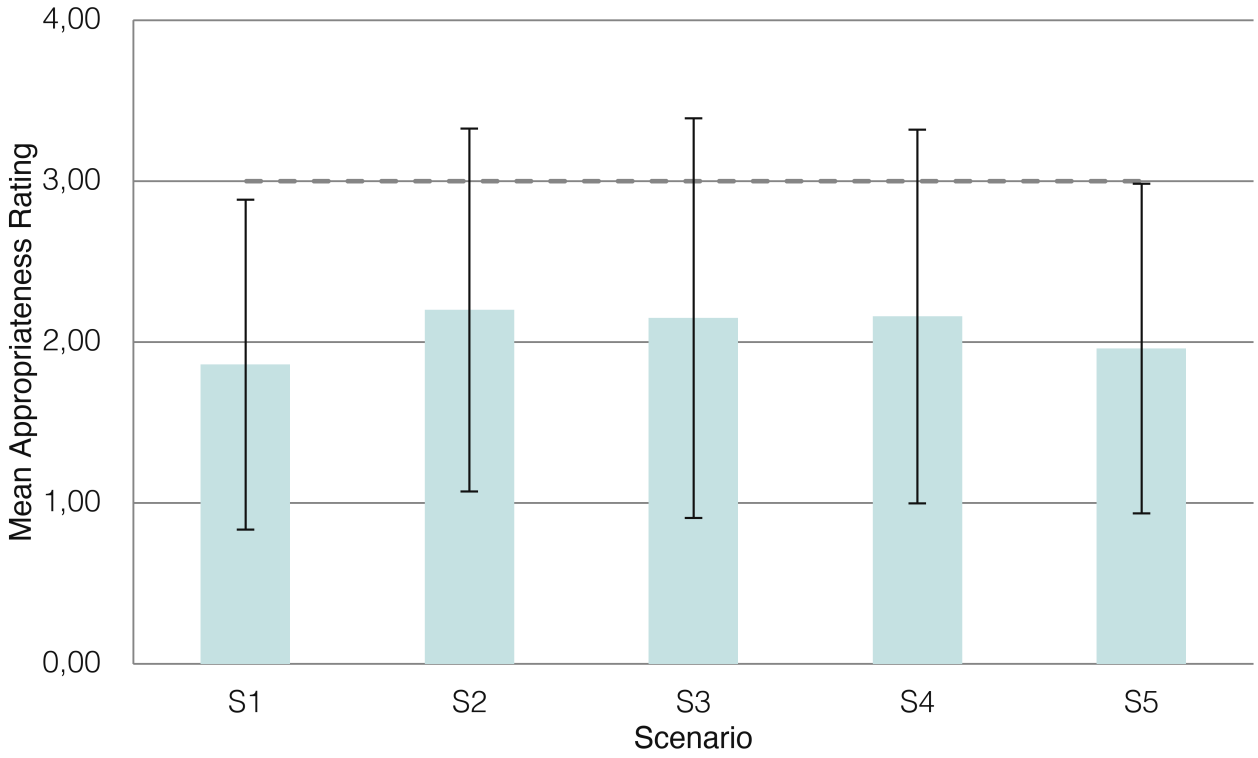
Table 2
Scenario-level descriptive statistics for the five Likert-type SJT scenarios (N = 100)

SCENARIO	M	SD	RATING 1–2, N (%)	RATING 3, N (%)	RATING 4–5, N
S1. Prognosis disclosure against family veto	1.86	1.03	75 (75%)	16 (16%)	9 (9%)
S2. Publicly challenging a senior physician's error	2.20	1.13	72 (72%)	12 (12%)	16 (16%)
S3. Proceeding with surgery based on patient's consent despite spousal objection	2.15	1.24	67 (67%)	16 (16%)	17 (17%)
S4. Accepting surface-level confirmation from an elderly rural patient	2.16	1.16	73 (73%)	13 (13%)	14 (14%)
S5. Prioritising information delivery during emotional crisis	1.96	1.02	80 (80%)	11 (11%)	9 (9%)

Note. Ratings were recorded on a five-point Likert-type scale (1 = completely inappropriate; 5 = completely appropriate). Ratings 1–2 = inappropriate or mostly inappropriate; 3 = neutral or context-dependent; 4–5 = mostly or completely appropriate.



Note. Error bars represent ±1 standard deviation, and the dashed line indicates the neutral midpoint (3.0). Ratings were recorded on a five-point Likert-type scale (1 = completely inappropriate; 5 = completely appropriate). S1 = prognosis disclosure against family veto; S2 = publicly challenging a senior physician's error; S3 = proceeding with surgery despite spousal objection; S4 = accepting surface-level comprehension confirmation; S5 = prioritising information delivery during emotional crisis.

Figure 1. Mean appropriateness ratings across five Likert-type SJT scenarios (N = 100)

As shown in Table 3, the scenario ratings were positively associated with one another, with the strongest association between S2 and S3 ($\rho = .539$, $p < .001$) and moderate associations between S4—S5 ($\rho = .394$) and S3—S5 ($\rho = .388$). These correlations indicate that the ratings varied together; they do not by themselves establish a shared way of reasoning across scenarios. Possible interpretations are considered in the Discussion (Section 5.4).

Table 3
Spearman's rank-order correlations among Likert-type scenario ratings (N = 100)

SCENARIO	S1	S2	S3	S4	S5
S1. Prognosis disclosure against family veto	—	.303**	.333***	.294**	.275**
S2. Publicly challenging a senior physician's error	.303**	—	.539***	.305**	.330***
S3. Proceeding with surgery based on patient's consent despite spousal objection	.333***	.539***	—	.366***	.388***
S4. Accepting surface-level confirmation from an elderly rural patient	.294**	.305**	.366***	—	.394***
S5. Prioritising information delivery during emotional crisis	.275**	.330***	.388***	.394***	—

Note. Spearman's ρ reported. **p < .01. ***p < .001.

4.5. Year-group differences

Kruskal—Wallis tests were conducted for each of the five Likert-type scenarios and the total SJT score. To account for multiplicity across the five scenario-level omnibus tests, Holm-adjusted p values were computed. After adjustment, differences across year groups remained significant for S3, S4, and S5.

The exploratory total SJT score, which was not included in this adjustment family, also differed across year groups (Table 4).

S1 showed no statistically significant evidence of a year-group difference (H(5) = 7.50, p = .186). S3 produced the largest Kruskal—Wallis statistic among the five scenarios (H(5) = 28.89, p < .001), indicating the strongest evidence of a year-group difference in the patient-consent scenario. The total SJT score also differed significantly across year groups (H = 35.01, p < .001). Because the design is cross-sectional, this association cannot be interpreted as a relationship between training stage and evaluative orientation within individual students (Table 5).

Table 4
Kruskal–Wallis Tests for Year-Group Differences (N = 100)

OUTCOME	H (df = 5)	*p*	*p* (Holm-adjusted)
S1. Prognosis disclosure against family veto	7.50	.186	.186
S2. Publicly challenging a senior physician's error	11.78	.038	.076
S3. Proceeding with surgery based on patient's consent despite spousal objection	28.89	< .001	< .001
S4. Accepting surface-level confirmation from an elderly rural patient	14.52	.013	.038
S5. Prioritising information delivery during emotional crisis	18.72	.002	.009
Total SJT score (S1–S5)	35.01	< .001	—

Note. df = 5 for all tests (six year groups). Holm-adjusted p values control the familywise error rate across the five scenario-level omnibus tests; the total SJT score is not part of that family and is reported without adjustment. Statistical significance set at p < .05.

As illustrated in Figure 2, the mean Total SJT Score was highest in Year 1 (M = 12.72) and lower in the mid-to-advanced cohorts, reaching its lowest value in Year 4 (M = 7.44); Years 5 and 6 did not continue this pattern. Because the design is cross-sectional, these year-group differences are not interpreted as change over training (see Section 5.4). Pairwise post-hoc Dunn's tests with Bonferroni correction were conducted for the scenarios with a significant unadjusted omnibus effect (S2, S3, S4, S5); of these, S3, S4, and S5 also remained significant after Holm adjustment of the omnibus tests. For S3, S4, and S5, the significant contrasts were between Year 1 and the mid-to-advanced cohorts, and no significant differences emerged between contiguous year groups; no contrast survived correction for S2. The full matrix of pairwise comparisons is provided in Appendix B. Table 6 summarises the significant contrasts.

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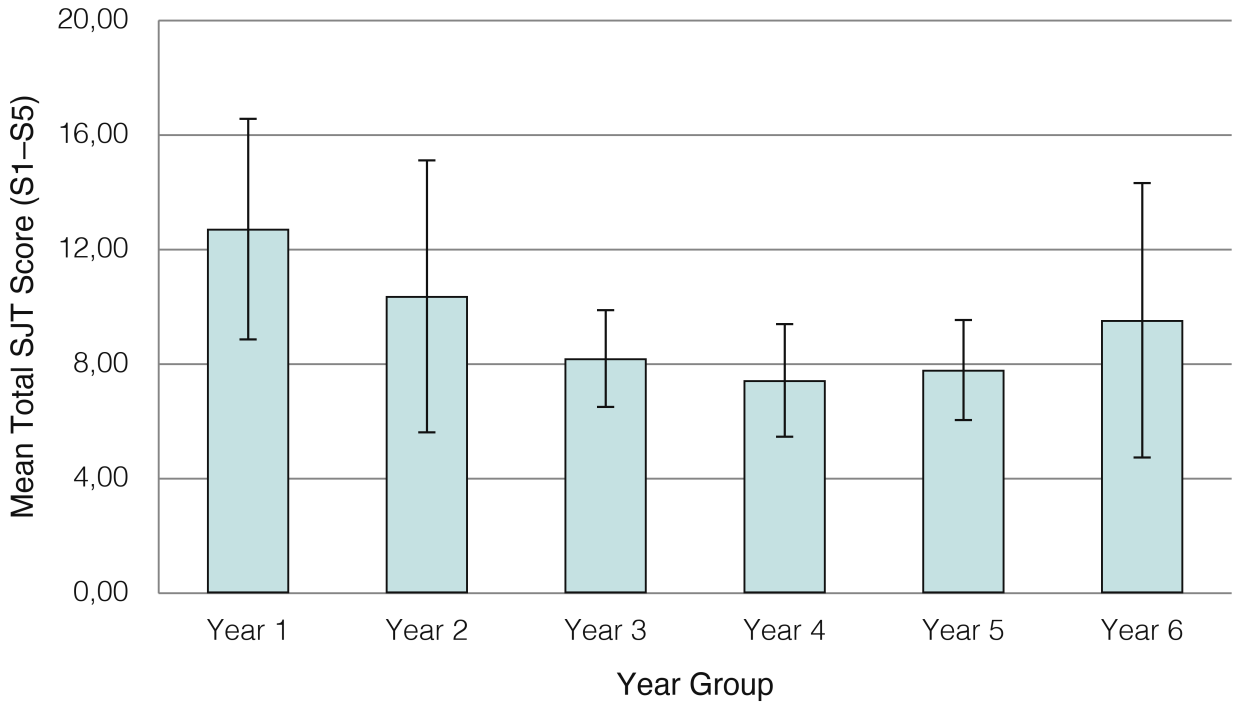
Table 5
Total SJT score by year group

YEAR GROUP	N	M	SD	MEDIAN	IQR
Year 1	43	12.72	3.86	14.00	10.00–16.00
Year 2	8	10.38	4.75	10.00	7.50–11.00
Year 3	10	8.20	1.69	9.00	7.00–9.00
Year 4	16	7.44	1.97	7.50	6.00–8.25
Year 5	10	7.80	1.75	8.00	7.25–8.75
Year 6	13	9.54	4.79	8.00	8.00–9.00

Note. Total SJT Score = sum of S1–S5 Likert-type ratings (range: 5–25). Higher scores indicate greater endorsement of target communicative actions. IQR = interquartile range. The cross-sectional design precludes developmental inference; observed score differences across year groups may reflect cohort composition, differential clinical exposure, institutional variation, or sampling artefact rather than individual longitudinal change.



Note. Bars show the mean of the summed S1–S5 Likert ratings (possible range 5 to 25) for each year group; error bars represent ±1 standard deviation. Because the design is cross-sectional and the year groups are small and unequal in size, the differences between groups cannot be interpreted as developmental change over training; they may reflect cohort composition, differential clinical exposure, institutional variation, or sampling variability.

Figure 2. Mean Total SJT Score by year group (N = 100)

4.6. Forced-choice gift-giving scenario

The gift-giving scenario used three response options: Option A (professional ethics-based refusal), Option B (culturally oriented acceptance), and Option C (pragmatic compromise: collective departmental acceptance). Responses to Scenario 6 were distributed across the three alternatives, with no single option selected by a clear majority (A: 30%, B: 37%, C: 33%; Table 7). Because the alternatives contained explanatory and evaluative wording, these results describe choices among the options as presented and do not directly measure stable cultural or ethical views.

Table 6
Significant pairwise post-hoc comparisons: Dunn's test with Bonferroni correction (S3, S4, S5)

SCENARIO	COMPARISON (COURSE VS. COURSE)	TEST STATISTIC (Z)	UNADJUSTED *p*	ADJUSTED *p* (BONFERRONI
S3 (Patient consent vs. Spouse)	Year 1 vs. Year 3	3.914	<.0001	.0014**
	Year 1 vs. Year 4	3.547	.0004	.0058**
	Year 1 vs. Year 5	3.569	.0004	.0054**
S4 (Comprehension verification)	Year 1 vs. Year 4	3.349	.0008	.0122*
S5 (Communication in crisis)	Year 1 vs. Year 4	3.324	.0009	.0133*

Note. For readability, only the statistically significant Bonferroni-adjusted contrasts are shown here; the complete matrix of all 15 pairwise comparisons per scenario, including every non-significant contrast with Z statistics and both unadjusted and adjusted p-values, is provided in Table B1 (Appendix B) Bonferroni correction was applied across the 15 comparisons within each scenario. S1 (H = 7.50, p = .186) showed no significant omnibus effect, and S2 (H = 11.78, p = .038) yielded no pairwise contrast surviving correction. *p < .05. **p < .01.

Table 7
Overall response distribution: gift-giving scenario (N = 100)

RESPONSE OPTION	N	%
Option A. Professional ethics: refuse	30	30%
Option B. Cultural reciprocity: accept	37	37%
Option C. Pragmatic compromise: collective use	33	33%
Total	100	100%

4.7. Gift-giving responses by year group

Response distributions by year group are presented in Table 8 and illustrated in Figure 3. The observed and expected frequencies across all six cohorts are provided in Table 9. Year 1 students selected Option A at nearly twice the expected frequency (observed = 21, expected = 12.9), the largest absolute deviation in the table. Year 3 and Year 5 students selected Option A least often (observed = 0 and 1 against expected values of 3.0) and were concentrated in Option B (60% in both years). Year 6 students showed the highest proportion of Option C relative to expectation (observed = 6, expected = 4.3). The interpretation of these year-group differences, and the reason they cannot be read developmentally, is addressed in Section 5.4.

Table 8
Gift-giving responses by year group

YEAR	N	A: ETHICS	B: CULTURE	C: COMPROMISE
Year 1	43	21 (49%)	10 (23%)	12 (28%)
Year 2	8	3 (38%)	2 (25%)	3 (38%)
Year 3	10	0 (0%)	6 (60%)	4 (40%)
Year 4	16	3 (19%)	8 (50%)	5 (31%)
Year 5	10	1 (10%)	6 (60%)	3 (30%)
Year 6	13	2 (15%)	5 (38%)	6 (46%)
Total	100	30 (30%)	37 (37%)	33 (33%)

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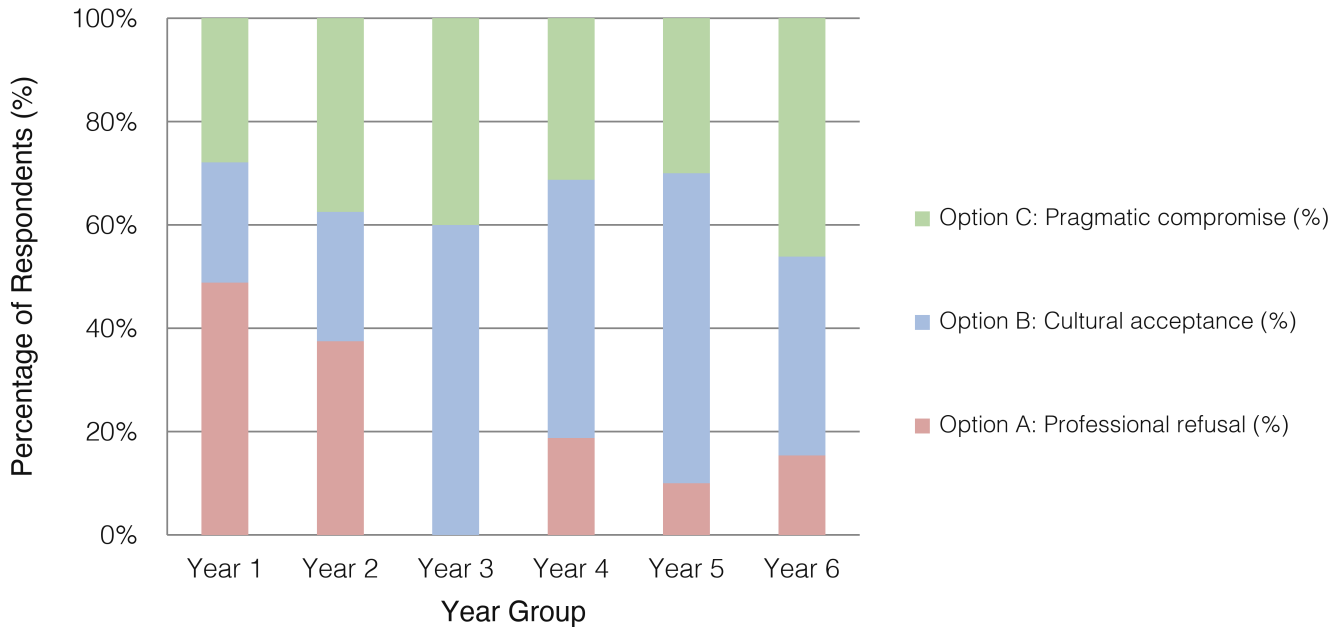

Note. Values represent within-year percentages within each year group. Option A = professional ethics-based refusal; Option B = culturally oriented acceptance; Option C = pragmatic compromise (collective departmental acceptance). Overall: A = 30%, B = 37%, C = 33%. The association between year group and response orientation was statistically significant (Fisher's Exact Test, simulated p = .038, 10,000 replicates; Cramér's V = .304).

Figure 3. Gift-giving response distribution by year group (N = 100)

Table 9
Cross-tabulation of observed and expected frequencies for Scenario 6 responses across academic years

ACADEMIC YEAR	OPTION A (REFUSAL) [OBS / EXP]	OPTION B (ACCEPTANCE) [OBS / EXP]	OPTION C (COMPROMISE) [OBS / EXP]	TOTAL (N)
Year 1	21 / 12.9	10 / 15.9	12 / 14.2	43
Year 2	3 / 2.4	2 / 3.0	3 / 2.6	8
Year 3	0 / 3.0	6 / 3.7	4 / 3.3	10
Year 4	3 / 4.8	8 / 5.9	5 / 5.3	16
Year 5	1 / 3.0	6 / 3.7	3 / 3.3	10
Year 6	2 / 3.9	5 / 4.8	6 / 4.3	13
Total	30	37	33	100

5. DISCUSSION

5.1. Principal findings

Across the five Likert scenarios, mean appropriateness ratings were uniformly low (1.86 to 2.20), so the target communicative actions were more often rated inappropriate than appropriate throughout. Because the means varied little, the mean alone does not discriminate well between scenarios. This study thus views sociopragmatic tension as a composite indexed by three complementary facets: the strength of disapproval (lower mean appropriateness), the degree of disagreement among respondents (dispersion and the evenness of the response split), and the sensitivity of judgement to year-group membership. These facets establish different things, and a scenario can be high on one and low on another. Read against the first research question, the dispersion facet is the most discriminating.

Scenario 3, in which a patient's individual consent conflicts with spousal objection, produced the widest dispersion (SD = 1.24), the most even split among the Likert items, and the strongest evidence of a year-group difference ($H(5) = 28.89$, $p < .001$). Scenario 6, the forced-choice gift-giving item, produced the most evenly divided distribution (A: 30%, B: 37%, C: 33%). By contrast, Scenario 5 combined a low mean with the highest agreement, with 80% rating the target action inappropriate, indicating strong consensus that the action was inappropriate and little disagreement among respondents.

5.2. Prognosis disclosure and emotional communication

In Scenario 1, the low mean (M = 1.86) indicates that most respondents judged direct disclosure of the prognosis against the family's wishes to be inappropriate. The result is compatible with a preference for family involvement and relationally sensitive communication, although the study cannot establish respondents' reasons or stable preferences. Rapport management (Spencer-Oatey, 2002) and politeness theory (Brown & Levinson, 1987) emphasise that communicative acts have relational consequences in addition to their informational and ethical content. Direct disclosure in this scenario therefore presents a potential conflict between the patient's right to information and family-mediated protection. The legal context adds an important qualification. Article 25 of the Law of the Republic of Uzbekistan 'On the Protection of Citizens' Health' (No. 265-I, 1996) gives citizens the right to receive information about their health. In cases of an unfavourable prognosis, it provides that the information should be communicated in accordance with medical ethics to the citizen and to family members, unless the citizen has prohibited disclosure to the family or designated another person to receive the information. The data do not show whether respondents knew or applied this provision, so no conclusion can be drawn about its influence on their ratings. Research in other settings has documented family involvement and disagreement among patients, relatives, and clinicians concerning diagnosis and prognosis disclosure (Blackhall et al., 1995; He et al., 2024; Kagawa-Singer & Blackhall, 2001; Mei & Tu, 2021; Wu et al., 2021). The present hypothetical judgements describe the responses of the participating students and do not establish the preferences of Uzbek patients, families, or clinicians. Scenario 5 concerns a different communicative demand. Respondents strongly rejected continued information delivery that disregarded acute distress. This judgement is consistent with patient-centred standards favouring empathic acknowledgement (Epstein & Street, 2011). Professional standards and relational considerations therefore support the same response in Scenario 5, while Scenario 1 concerns a potential conflict between direct disclosure and family-mediated protection.

5.3. Hierarchy and accountability

Scenario 2 produced the highest mean among the Likert items (M = 2.20), yet 72% rated public correction of a senior physician as inappropriate and only 16% rated it appropriate. This result is compatible with reluctance to challenge senior authority publicly when patient safety is at issue. Evidence from several training systems similarly indicates that cultural and interpersonal barriers may contribute to trainees' reluctance to raise patient-safety concerns (Carrillo et al., 2024). The 16% who rated correction as appropriate cannot be assumed to act similarly in clinical practice. No clinical outcomes, observed behaviour, or patient-safety events were measured, so these responses cannot support an inference about adverse-event risk. Further research should examine patient-safety communication and the conditions under which trainees are willing to speak up.

5.4. Consent, gift-giving, and shared authority

Scenario 3 was the most polarised Likert item (M = 2.15; SD = 1.24; 67% rating the target action inappropriate). A low appropriateness rating here should not be read as a rejection of patient autonomy in principle. Under Article 26 of the Law of the Republic of Uzbekistan 'On the Protection of Citizens' Health' (No. 265-I, 1996), the informed voluntary consent of the citizen is a necessary precondition for medical intervention, so the competent adult patient's own consent is the legally operative requirement in the scenario. A low rating is therefore more plausibly compatible with a perception that enacting an individual patient's consent against explicit spousal objection is socially hazardous in ways that abstract principle does not resolve, particularly given the gendered framing of the scenario, in which a wife's autonomous decision is contested by her husband. This finding complicates universalist accounts of autonomy (Blackhall et al., 1995) because the difficulty may concern its enactment under explicit family opposition, even when the autonomy principle itself is recognised. The strongest inter-scenario association occurred between Scenario 2 and Scenario 3 ($\rho = .539$). This association is compatible with the hypothesis that perceptions of authority may have influenced judgements in both scenarios. Because the study did not collect respondents' explanations, the correlation cannot establish that the same consideration influenced both sets of judgements.

In the gift-giving scenario, the near-equal three-way split indicates that no single normative frame commanded a majority. The split is compatible with tension between professional boundary maintenance and an expectation of reciprocity. Under this expectation, declining a sincerely offered gift may be perceived as an insult despite its ethical justification. Option B explicitly described the gift as an acceptable expression of gratitude and stated that its acceptance would not constitute bribery. Similar distinctions

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'Given the exploratory data, the findings support hypotheses for curriculum development and evaluation but do not justify curricular prescriptions. Scenarios associated with disagreement or low appropriateness ratings concern the application of ethical principles under relational pressure. Repetition of ethical principles alone may therefore be insufficient. Scenario-based instruction, including simulated consultations, standardised-patient encounters, and structured reflection, may permit students to practise context-sensitive clinical communication. These methods are established in clinical education (Kneebone et al., 2002) and are consistent with competency-based medical education (Frank et al., 2010; Frenk et al., 2010).'

between gratitude and corruption have been reported in post-communist and post-Soviet health systems, where members of the public may regard in-kind gifts as expressions of gratitude while viewing cash payments negatively (Stepurko et al., 2013). The divided responses may therefore be considered in relation to this regional evidence, although the data cannot establish respondents' motives. Option C preserves a professional boundary against personal gain while honouring the relational obligation and may represent pragmatic integration. Appropriateness data cannot distinguish integration from simple accommodation. The year-group differences in this scenario (Section 4.7), in which the first-year group selected professional refusal more than expected and later year groups were concentrated in acceptance or compromise, describe variation between year groups in this sample. Because the design is cross-sectional, these differences do not demonstrate change within individual students. Cohort composition, differential clinical exposure, institutional variation, and sampling artefact remain equally plausible explanations. Only longitudinal data can distinguish among them.

5.5. Implications

The third research question concerns possible priorities for communication training. Given the exploratory data, the findings support hypotheses for curriculum development and evaluation but do not justify curricular prescriptions. Scenarios associated with disagreement or low appropriateness ratings concern the application of ethical principles under relational pressure. Repetition of ethical principles alone may therefore be insufficient. Scenario-based instruction, including simulated consultations, standardised-patient encounters, and structured reflection, may permit students to practise context-sensitive clinical communication. These methods are established in clinical education (Kneebone et al., 2002) and are consistent with competency-based medical education (Frank et al., 2010; Frenk et al., 2010). Potential instructional topics include explicit comprehension verification associated with the teach-back method, as suggested by Scenario 4 (Schillinger et al., 2003). Scenario 5 supports further investigation of empathy-first sequencing under time pressure. Scenario 2 supports further investigation of graded, face-sensitive, and professionally unambiguous methods for raising concerns within a hierarchy. These topics remain hypotheses because the data are limited to appropriateness judgements from a single national sample. Any culturally responsive curriculum would require consultation with Uzbek students, clinicians, patients, and families, followed by independent evaluation.

5.6. Contribution

The study's primary contribution is empirical. It provides initial scenario-based evidence on the sociopragmatic judgements of medical students in an underrepresented post-Soviet Central Asian medical education setting. Comparable research in neighbouring systems has focused on learning environments and curriculum reform, with little attention to communicative judgement (Schubiger et al., 2019). Methodologically, the study applies an SJT format to examine interpersonal judgement in hypothetical clinical communication dilemmas that knowledge-based assessments do not directly address, consistent with wider evidence on SJT validity (Webster et al., 2020). Finally, it introduces the MedSPC framework as a provisional, author-proposed heuristic that links clinical communication scenarios to sociopragmatic competence components and identifies the professional principles and competing contextual expectations represented in those scenarios. The framework is intended to support later instrument development and validation in other settings. It has not undergone independent validation and does not provide an established basis for curricular prescription.

5.7. Limitations and future directions

Several methodological limitations affect the interpretation of these findings.

First, SJT responses measure evaluative judgement about hypothetical scenarios and do not demonstrate actual clinical behaviour. Students' awareness that the instrument concerned ethically sensitive dilemmas, the absence of interpersonal consequences, and the omission of non-verbal communication may produce differences between hypothetical decisions and clinical practice (Lievens & Sackett, 2012; Patterson et al., 2016). Future studies should combine SJT data with standardised-patient encounters, OSCEs, and video-stimulated recall. Validated measures such as the Marlowe—Crowne Social Desirability Scale or

'In response to the first research question, the degree of sociopragmatic tension varied by scenario. The strongest indications occurred in the scenario in which a patient's individual consent conflicted with spousal objection, which produced the widest dispersion among the Likert items, and in the forced-choice gift-giving scenario, which produced the most evenly divided responses. Agreement was stronger in the scenarios concerning emotional acknowledgement during a crisis and disclosure of a serious prognosis against the family's wishes. Regarding the second research question, the responses were compatible with greater acceptance of family involvement and hierarchical deference in some situations than of direct individual assertion.'

the Balanced Inventory of Desirable Responding (Paulhus, 1991) could also be administered to assess whether socially desirable responding is associated with SJT ratings.

Second, the voluntary convenience sample (n = 100) included a disproportionate number of first-year students (n = 43) and is not statistically representative of the Uzbek medical student population. The findings are therefore limited to the participating sample and should not be interpreted as population estimates. The single-country design also limits their applicability to other post-Soviet, Central Asian, or culturally comparable healthcare settings (Schouten & Meeuwesen, 2006). Comparative studies in several settings are needed to determine which findings are specific to this sample and which may recur elsewhere.

Third, the cross-sectional design precludes conclusions about change during medical training. Students were recruited from seven institutions, but institution was not retained in the de-identified analytical dataset. Differences between year groups could therefore not be separated from possible institutional or recruitment-network effects. These differences may reflect cohort composition, educational exposure, institutional variation, recruitment procedures, or self-selection instead of individual change over time (Cook & Beckman, 2006). Longitudinal studies and studies that retain anonymised institution codes are needed to distinguish these explanations.

Fourth, the instrument has two related design limitations. Although expert content validation produced a strong Content Validity Index, no pilot testing or cognitive interviewing with students was conducted before administration. Respondents may therefore have understood some scenario descriptions or response anchors differently. Scenario 6 also restricted respondents to three predetermined choices. Future versions should include open-ended explanations, cognitive interviews, or think-aloud procedures to examine the considerations informing students' choices.

Fifth, the composite Total SJT Score should be interpreted cautiously. The scenarios represent distinct sociopragmatic dilemmas and may assess different constructs, so their sum cannot yet be assumed to represent a single underlying attribute. The reported Cronbach's α of .785 is therefore a descriptive measure of association among the S1—S5 ratings and does not establish the reliability of a unidimensional scale (McNeish, 2018). Further instrument development should create several items for each proposed MedSPC component. A substantially larger sample could then be used to examine the instrument's factor structure and calculate reliability estimates appropriate to the structure supported by the data.

The MedSPC framework also requires evaluation independent of its use in the present study. This process could include a Modified Delphi study with applied linguists, medical ethicists, clinicians, students, and patient representatives to assess the relevance and clarity of its proposed components. Cognitive interviews and retrospective think-aloud procedures could establish whether students' stated reasoning corresponds to the proposed categories. After sufficient items have been developed for each component, studies with larger multi-institutional samples could examine structural, convergent, and discriminant validity. Qualitative research, including discourse-completion tasks and ethnographic observation, could provide additional evidence about clinical communication. Subsequent controlled studies could test whether specific sociopragmatic training improves performance in simulated or observed clinical encounters (Kneebone et al., 2002).

6. CONCLUSION

This study examined how Uzbek medical students evaluated hypothetical clinical communication scenarios involving professional, ethical, cultural, institutional, and relational considerations. The findings are exploratory.

In response to the first research question, the degree of sociopragmatic tension varied by scenario. The strongest indications occurred in the scenario in which a patient's individual consent conflicted with spousal objection, which produced the widest dispersion among the Likert items, and in the forced-choice gift-giving scenario, which produced the most evenly divided responses. Agreement was stronger in the scenarios concerning emotional acknowledgement during a crisis and disclosure of a serious prognosis against the family's wishes.

Regarding the second research question, the responses were compatible with greater acceptance of family involvement and hierarchical deference in some situations than of direct individual assertion. The instrument did not

collect open-ended explanations, interview data, or observations of clinical behaviour. These interpretations are therefore provisional and do not establish students' dispositions or communicative competence.

In response to the third research question, the findings indicate possible topics for further investigation in culturally responsive clinical communication and pragmatics training in Uzbekistan. They do not independently justify specific curricular prescriptions.

The contribution of the study is deliberately limited. It provides initial empirical evidence from an underrepresented post-Soviet Central Asian medical education setting and indicates that an SJT may be useful for examining sociopragmatic tension in hypothetical clinical communication. The MedSPC framework is presented as a provisional classification scheme that requires independent validation. The findings concern judgements about hypothetical situations and do not demonstrate clinical competence. The cross-sectional design and uneven convenience sample preclude developmental and population-level conclusions, and the composite sum score remains exploratory. Future research should independently validate the instrument, collect qualitative explanations of students' reasoning, recruit larger and more balanced multi-institutional samples, and use longitudinal designs or observed assessments of clinical performance.

References

Betancourt, J. R., Green, A. R., Carrillo, J. E., & Ananeh-Firempong, O., II. (2003). Defining cultural competence: A practical framework for addressing racial/ethnic disparities in health and health care. *Public Health Reports, 118*(4), 293–302. https://pmc.ncbi.nlm.nih.gov/articles/PMC1497553

Blackhall, L. J., Murphy, S. T., Frank, G., Michel, V., & Azen, S. (1995). Ethnicity and attitudes toward patient autonomy. *JAMA: The Journal of the American Medical Association, 274*(10), 820–825. https://dx.doi.org/10.1001/jama.1995.03530100060035

Brown, P., & Levinson, S. C. (1987). *Politeness: Some universals in language usage*. Cambridge University Press.

Carmo, C. M. (2026). Systemic functional linguistics and social cognition: A theoretical approach to the relationship between language, society and culture. *Russian Journal of Linguistics, 30*(1), 33–54. https://dx.doi.org/10.22363/2687-0088-48784

Carrillo, I., Serpa, P., Landa-Ramírez, E., Guilabert, M., Gómez-Ayala, Y., López-Pineda, A., & Mira, J. J. (2024). Speaking up about patient safety, withholding voice and safety climate in clinical settings: A cross-sectional study among Ibero-American healthcare students. *International Journal of Public Health, 69,* Article 1607406. https://doi.org/10.3389/ijph.2024.1607406

Cook, D. A., & Beckman, T. J. (2006). Current concepts in validity and reliability for psychometric instruments: Theory and application. *The American Journal of Medicine, 119*(2), 166.e7–166.e16. https://dx.doi.org/10.1016/j.amjmed.2005.10.036

Corder, G. W., & Foreman, D. I. (2011). *Nonparametric statistics for non-statisticians: A step-by-step approach*. Wiley.

Dunn, O. J. (1964). Multiple comparisons using rank sums. *Technometrics, 6*(3), 241–252. https://dx.doi.org/10.1080/00401706.1964.10490181

Epstein, R. M., & Street, R. L., Jr. (2011). The values and value of patient-centered care. *The Annals of Family Medicine, 9*(2), 100–103. https://doi.org/10.1370/afm.1239

Eysenbach, G. (2004). Improving the quality of web surveys: The Checklist for Reporting Results of Internet E-Surveys (CHERRIES). *Journal of Medical Internet Research, 6*(3), Article e34. https://doi.org/10.2196/jmir.6.3.e34

Frank, J. R., Snell, L. S., ten Cate, O., Holmboe, E. S., Carraccio, C., Swing, S. R., Harris, P., Glasgow, N. J., Campbell, C., Dath, D., Harden, R. M., Iobst, W., Long, D. M., Mungroo, R., Richardson, D. L., Sherbino, J., Silver, I., Taber, S., Talbot, M., & Harris, K. A. (2010). Competency-based medical education: Theory to practice. *Medical Teacher, 32*(8), 638–645. https://dx.doi.org/10.3109/0142159X.2010.501190

Frenk, J., Chen, L., Bhutta, Z. A., Cohen, J., Crisp, N., Evans, T., Fineberg, H., Garcia, P., Ke, Y., Kelley, P., Kistnasamy, B., Meleis, A., Naylor, D., Pablos-Mendez, A., Reddy, S., Scrimshaw, S., Sepulveda, J., Serwadda, D., & Zurayk, H. (2010). Health professionals for a new century: Transforming education to strengthen health systems in an interdependent world. *The Lancet, 376*(9756), 1923–1958. https://dx.doi.org/10.1016/S0140-6736(10)61854-5

Goffman, E. (1967). *Interaction ritual: Essays on face-to-face behavior*. Anchor Books.

Gu, Y. (1990). Politeness phenomena in modern Chinese. *Journal of Pragmatics, 14*(2), 237–257. https://dx.doi.org/10.1016/0378-2166(90)90082-O

He, X., Liang, J., Liang, H., Yue, P., Zeng, D., & Gong, N. (2024). Informing or concealing — Dynamics of telling disease-related bad news among family members of older cancer patients: A qualitative study. *International Journal of Nursing Studies, 159,* Article 104871. https://doi.org/10.1016/j.ijnurstu.2024.104871

Ilyina, E. N. (2026). Language as an indicator of worldview interference among residents of a contemporary village. *Vestnik Tomskogo Gosudarstvennogo Universiteta, Filologiya, 101,* 29–40. https://dx.doi.org/10.17223/19986645/101/2

Kagawa-Singer, M., & Blackhall, L. J. (2001). Negotiating cross-cultural issues at the end of life: 'You got to go where he lives'. *JAMA, 286*(23), 2993–3001. https://doi.org/10.1001/jama.286.23.2993

Kneebone, R., Kidd, J., Nestel, D., Asvall, S., Paraskeva, P., & Darzi, A. (2002). An innovative model for teaching and learning clinical procedures. *Medical Education, 36*(7), 628–634. https://dx.doi.org/10.1046/j.1365-2923.2002.01261.x

Levinson, W., Lesser, C. S., & Epstein, R. M. (2010). Developing physician communication skills for patient-centered care. *Health Affairs, 29*(7), 1310–1318. https://doi.org/10.1377/hlthaff.2009.0450

Lievens, F., & Sackett, P. R. (2012). The validity of interpersonal skills assessment via situational judgment tests for predicting academic success and job performance. *Journal of Applied Psychology, 97*(2), 460–468. https://doi.org/10.1037/a0025741

Lynn, M. R. (1986). Determination and quantification of content validity. *Nursing Research, 35*(6), 382–386. https://doi.org/10.1097/00006199-198611000-00017

Matsumoto, Y. (1988). Reexamination of the universality of face: Politeness phenomena in Japanese. *Journal of Pragmatics, 12*(4), 403–426. https://dx.doi.org/10.1016/0378-2166(88)90003-3

McNeish, D. (2018). Thanks coefficient alpha, we'll take it from here. *Psychological Methods, 23*(3), 412–433. https://doi.org/10.1037/met0000144

Mei, X., & Tu, J. (2021). Values, skills, and decision-making: A cultural sociological approach to explaining diagnostic disclosure. *Social Science & Medicine, 279*, Article 114034. https://dx.doi.org/10.1016/j.socscimed.2021.114034

Oyserman, D., Coon, H. M., & Kemmelmeier, M. (2002). Rethinking individualism and collectivism: Evaluation of theoretical assumptions and meta-analyses. *Psychological Bulletin, 128*(1), 3–72. https://dx.doi.org/10.1037/0033-2909.128.1.3

Patterson, F., Zibarras, L., & Ashworth, V. (2016). Situational judgement tests in medical education and training: Research, theory and practice: AMEE Guide No. 100. *Medical Teacher, 38*(1), 3–17. https://dx.doi.org/10.3109/0142159X.2015.1072619

Paulhus, D. L. (1991). Measurement and control of response bias. In J. P. Robinson, P. R. Shaver, & L. S. Wrightsman (Eds.), *Measures of personality and social psychological attitudes* (pp. 17–59). Academic Press. https://doi.org/10.1016/B978-0-12-590241-0.50006-X

Polit, D. F., & Beck, C. T. (2006). The content validity index: Are you sure you know what's being reported? Critique and recommendations. *Research in Nursing & Health, 29*(5), 489–497. https://dx.doi.org/10.1002/nur.20147

R Core Team. (2023). *R: A language and environment for statistical computing* (Version 4.3.1) [Computer software]. R Foundation for Statistical Computing. https://r-project.org

Rechel, B., Kennedy, C., McKee, M., & Rechel, B. (2011). The Soviet legacy in diagnosis and treatment: Implications for population health. *Journal of Public Health Policy, 32*(3), 293–304. https://dx.doi.org/10.1057/jphp.2011.18

Schillinger, D., Piette, J., Grumbach, K., Wang, F., Wilson, C., Daher, C., Leong-Grotz, K., Castro, C., & Bindman, A. B. (2003). Closing the loop: Physician communication with diabetic patients who have low health literacy. *Archives of Internal Medicine, 163*(1), 83–90. https://doi.org/10.1001/archinte.163.1.83

Schouten, B. C., & Meeuwesen, L. (2006). Cultural differences in medical communication: A review of the literature. *Patient Education and Counseling, 64*(1–3), 21–34. https://doi.org/10.1016/j.pec.2005.11.014

Schubiger, M., Lechthaler, F., Khamidova, M., Parfitt, B. A., Prytherch, H., van Twillert, E., & Wyss, K. (2019). Informing the medical education reform in Tajikistan: Evidence on the learning environment at two nursing colleges. *BMC Medical Education, 19,* Article 85. https://doi.org/10.1186/s12909-019-1515-0

Shevchenko, V. D., Ashraf, M., & Ahmad, H. A. (2026). Polydiscursiveness and semantic categories. *RUDN Journal of Language Studies, Semiotics and Semantics, 17*(1), 351–360. https://dx.doi.org/10.22363/2313-2299-2026-17-1-351-360

Spencer-Oatey, H. (2002). Managing rapport in talk: Using rapport-sensitive incidents to explore the motivational concerns underlying the management of relations. *Journal of Pragmatics, 34*(5), 529–545. https://doi.org/10.1016/S0378-2166(01)00039-X

Stepurko, T., Pavlova, M., Gryga, I., & Groot, W. (2013). Informal payments for health care services — Corruption or gratitude? A study on public attitudes, perceptions and opinions in six Central and Eastern European countries. *Communist and Post-Communist Studies, 46*(4), 419–431. https://dx.doi.org/10.1016/j.postcomstud.2013.08.004

Street, R. L., Jr., Makoul, G., Arora, N. K., & Epstein, R. M. (2009). How does communication heal? Pathways linking clinician–patient communication to health outcomes. *Patient Education and Counseling, 74*(3), 295–301. https://doi.org/10.1016/j.pec.2008.11.015

Surbone, A. (2006). Telling the truth to patients with cancer: What is the truth? *The Lancet Oncology, 7*(11), 944–950. https://doi.org/10.1016/S1470-2045(06)70941-X

Surbone, A. (2008). Cultural aspects of communication in cancer care. *Supportive Care in Cancer, 16*(3), 235–240. https://doi.org/10.1007/s00520-007-0366-0

Tavakol, M., & Dennick, R. (2011). Making sense of Cronbach's alpha. *International Journal of Medical Education, 2*, 53–55. https://doi.org/10.5116/ijme.4dfb.8dfd

Thomas, J. (1983). Cross-cultural pragmatic failure. *Applied Linguistics, 4*(2), 91–112. https://doi.org/10.1093/applin/4.2.91

Webster, E. S., Paton, L. W., Crampton, P. E. S., & Tiffin, P. A. (2020). Situational judgement test validity for selection: A systematic review and meta-analysis. *Medical Education, 54*(10), 888–902. https://doi.org/10.1111/medu.14201

World Medical Association. (2013). World Medical Association Declaration of Helsinki: Ethical principles for medical research involving human subjects. *JAMA, 310*(20), 2191–2194. https://dx.doi.org/10.1001/jama.2013.281053

Wu, J., Wang, Y., Jiao, X., Wang, J., Ye, X., & Wang, B. (2021). Differences in practice and preferences associated with truth-telling to cancer patients. *Nursing Ethics, 28*(2), 272–281. https://dx.doi.org/10.1177/0969733020945754

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Appendix A. Full text of SJT scenarios

All six scenarios were presented to participants in Uzbek. The English translations provided below are prepared by the author for the purposes of transparency and international peer review.

Response scale anchors and option labels reflect the exact wording used in the administered instrument (Tables A1—A6).

S1: Prognosis Disclosure Against Family Veto

Uzbek original:

Onkologiya bo'limida 5 yildan buyon palliativ davo olayotgan, kognitiv funksiyalari to'liq saqlangan (hushyor va qaror qabul qilishga qodir) 54 yoshli bemor Nazarov Hamid shifokorga yuzlanib: 'Doktor, menga to'g'risini ayting — qancha vaqtim qoldi? Men hamma narsaga tayyorman,' — deb so'raydi. Shu payt bemorning yonida o'tirgan o'g'li shifokorga ko'z qisib, otasiga haqiqatni aytmaslikni imo-ishora orqali qat'iy so'raydi. Tibbiy prognozga ko'ra, bemorning umri 3 oydan 6 oygacha qolgan. ***Savol:*** *Shifokorning oila a'zosi ishorasiga qaramay, bemorga uning prognozi haqida to'g'ridan-to'g'ri ma'lumot berishi qanchalik professional va etik jihatdan o'rinli?*

English translation:

A 54-year-old patient, Hamid Nazarov, who has been receiving palliative care in an oncology unit for five years and whose cognitive functions are fully intact (alert and capable of decision-making), addresses the physician: 'Doctor, please tell me the truth — how long do I have? I am prepared for everything.' At that moment, the patient's son, seated beside him, winks at the physician and emphatically gestures, that the truth should not be disclosed to his father. According to the medical prognosis, the patient has between three and six months to live. **Question:** To what extent is it professionally and ethically appropriate for the physician to provide the patient with direct information about his prognosis, despite the family member's signal?

S2: Publicly Challenging a Senior Physician's Error

Uzbek original:

Siz talabasiz. Klinika rahbari — respublika miqyosidagi hurmatli professor — bemor ishtirokida diagnostik xulosa chiqarmoqda. Siz laboratoriya natijalarini diqqat bilan o'rganib, professorning xulosasida jiddiy patologik xato borligini (masalan, dozalash yoki tashxisda) payqadingiz. Bemor xonada va muloqotni diqqat bilan kuzatib turibdi. Professor sizga qarab: 'Xo'sh, hammasi tushunarlimi? Sizga dorilar ro'yatini beraman. Davolanishni hoziroq boshlaysizmi?' — deb savol beradi. ***Savol:*** *Talaba professorning xatosini bemor huzurida ochiq ko'tarib chiqishi qanchalik to'g'ri?*

English translation:

You are a medical student. The head of the clinic — a respected professor of national standing — is delivering a diagnostic conclusion in the patient's presence. Having carefully reviewed the laboratory results, you identify a serious clinical error in the professor's conclusion (for example, an error in dosage or diagnosis). The patient is present in the room and is attentively following the exchange. The professor turns to you and asks: 'Well, is everything clear? I will give you the medication list. Shall we begin treatment right away?' **Question:** To what extent is it appropriate for the student to openly raise the professor's error in the patient's presence?

S3: Proceeding With Surgery Based on Patient Consent Despite Spousal Objection

Uzbek original:

42 yoshli ayol bemorga shoshilinch jarrohlik amaliyoti zarur. Bemorning o'zi operatsiyaga to'liq rozi va hujjatlarga qo'l qo'yishga tayyor. Biroq uning turmush o'rtog'i: 'Men ruxsat bermayman, hali uyga borib maslahatlashishimiz kerak, farzandlarimiz nima deydi?' — deb qat'iy e'tiroz bildiradi. Tibbiy nuqtai nazardan, vaqt o'tishi asoratlar xavfini keskin oshiradi. Er esa shifoxonadan ketishga taraddud ko'rmoqda. ***Savol:*** *Shifokorning faqat bemor (ayol)ning roziligi asosida operatsiyani boshlashi qanchalik to'g'ri?*

English translation:

A 42-year-old female patient requires an emergency surgical procedure. The patient herself fully consents to the operation and is ready to sign the necessary documents. However, her husband firmly objects: 'I do not give permission. We still need to go home and discuss this — what will our children say?' From a medical standpoint, any delay significantly increases the risk of complications. The husband is preparing to leave the hospital. **Question:** To what extent is it appropriate for the physician to proceed with the surgery based solely on the patient's own consent?

S4: Accepting Surface-Level Confirmation of Understanding from an Elderly Rural Patient

Uzbek original:

Qishloq hududidan kelgan 68 yoshli nuroniy otaxon faqat o'zbek tilida (mahalliy shevada) gapiradi. Siz unga dori qabul qilishning murakkab tartibini tushuntiryapsiz. Otaxon muloqot davomida bir necha bor 'Ha, tushunarli, baraka topgur' deb tasdiqlaydi. Biroq, keyingi qabulda ma'lum bo'lishicha, u dorilarni mutlaqo noto'g'ri ketma-ketlikda ichgan. Bu uning sog'lig'iga salbiy ta'sir ko'rsatgan. ***Savol:*** *Birinchi qabulda shifokorning tushuntirishi yetarli bo'lgan deb baholash qanchalik to'g'ri? (Bemor tushundim deb, xato qilgan holat)*

English translation:

A respected 68-year-old man from a rural area speaks only in Uzbek (in a local dialect). You are explaining a complex medication regimen to him. Throughout the consultation, the patient repeatedly confirms his understanding by saying 'Yes, I understand, bless you.' But at his next appointment, it becomes apparent that he had been taking the medications in entirely the wrong sequence. This has had an adverse effect on his health. **Question:** To what extent is it appropriate to evaluate the physician's explanation during the first consultation as having been sufficient? (This is a case in which the patient said he understood yet made an error.)

S5: Prioritising Information Delivery During a Patient's Emotional Crisis

Uzbek original:

Siz bemorga operatsiyadan keyingi parvarish bo'yicha juda muhim va murakkab ko'rsatmalarni tushuntiryapsiz. Bu ma'lumotlar hayotiy zarur. To'satdan bemor hissiyotlarini jilovlay olmay yig'lab yuboradi va: 'Doktor, men baribir tuzalmayman, hammasi tamom, shundaymi? Barcha harakatlarimiz bekor! Men o'lamanmi?' — deb savol beradi. Sizda vaqt juda kam, eshik tagida navbatdagi bemorlar kutib turibdi va siz hali muhim tibbiy tavsiyalarni aytib ulgurmadingiz.

Savol: *Shifokor ma'lumot berishni davom ettirishi qanchalik to'g'ri — hissiy holatni e'tiborsiz qoldirib?*

English translation:

You are explaining critically important and complex post-operative care instructions to a patient. This information is vital to the patient's health. Suddenly, the patient becomes overwhelmed and begins to cry, asking: 'Doctor, I won't recover anyway, will I? It's all over, isn't it? Everything we've done has been pointless! Am I going to die?' You have very little time; the next patients are waiting outside the door, and you have not yet delivered all of the important medical instructions. **Question:** To what extent is it appropriate for the physician to continue giving the instructions while disregarding the patient's emotional state?

S6: Gift Acceptance from a Patient's Family

Uzbek original:

Murakkab jarrohlik amaliyotidan so'ng bemor sog'lom holatda shifoxonadan chiqmoqda. Bemorning yaqinlari shifokorning xonasiga kirib, ko'rsatilgan yuksak xizmat uchun minnatdorchilik sifatida 'sovg'a' (masalan, pul yoki qimmatbaho buyum) berishmoqchi. Shifokor bu amaliyot uchun oylik maosh oladi va qo'shimcha to'lov olish professional etikaga zid ekanligini biladi. Biroq, bemorning yaqinlari: 'Doktor, biz sizdan juda rozimiz, bu sizning choyingizga, iltimos, bizni xafa qilmang' deb turib olishdi. ***Savol:*** *Shifokorning bemor yaqinlarini xafa qilmaslik (yuzini qaytarmaslik) uchun sovg'ani qabul qilishi qanchalik o'rinli?*

English translation:

Following a complex surgical procedure, a patient is discharged from hospital in good health. The patient's family enters the physician's office to offer a 'gift' (for example, money or a valuable item) in gratitude for the excellent care provided. The physician receives a regular salary for such procedures and knows that accepting an additional payment would violate professional ethics. However, the family insists: 'Doctor, we are very pleased with your care. Please accept this as a token of our appreciation; do not hurt our feelings.' **Question:** To what extent is it appropriate for the physician to accept the gift to avoid offending the patient's family (that is, to avoid turning them down)?

Table A1
S1 response scale

RATING	UZBEK LABEL	ENGLISH TRANSLATION
1 – *Mutlaqo o'rinsiz* Completely inappropriate	*Oila a'zolarining roziligi va bemorning ruhiy xotirjamligi birinchi o'rinda*	The family's consent and the patient's peace of mind must come first
2 – *Ko'proq o'rinsiz* Mostly inappropriate	*Qisman ma'lumot berish yoki mavzuni chetlab o'tish lozim*	Only partial information should be provided, or the topic should be avoided
3 – *Neytral / Vaziyatga bog'liq* Neutral / context-dependent	*Madaniy va huquqiy normalar o'rtasidagi ziddiyat*	There is a conflict between cultural and legal norms
4 – *Ko'proq o'rinli* Mostly appropriate	*Bemorning o'z holati haqida bilish huquqi ustun turishi kerak*	The patient's right to know about their own condition should take precedence
5 – *To'liq o'rinli* Completely appropriate	*Bioetik 'avtonomiya' tamoyili bo'yicha shaffoflik shart*	Transparency is required under the bioethical principle of autonomy

Table A2
S2 response scale

RATING	UZBEK LABEL	ENGLISH TRANSLATION
1 – *Mutlaqo o'rinsiz* Completely inappropriate	*Ierarxiya va ustozning nufuzi har qanday vaziyatda birinchi o'rinda turishi kerak*	Hierarchy and the professor's authority must take precedence in all circumstances
2 – *Ko'proq o'rinsiz* Mostly inappropriate	*Xatoni faqat yakkama-yakka tarzda, xonadan chiqqandan so'ng aytish lozim*	The error should be raised only privately, after leaving the room
3 – *Neytral / Vaziyatga bog'liq* Neutral / context-dependent	*Vaziyatga va xatoning hayotiy xavflilik darajasiga bog'liq*	Depends on the situation and the degree of clinical risk posed by the error
4 – *Ko'proq o'rinli* Mostly appropriate	*Xatoni ehtiyotkorlik bilan, 'savol berish' strategiyasi orqali hozirning o'zida ko'rsatish kerak*	The error should be raised immediately, cautiously, and in the form of a question
5 – *To'liq o'rinli* Completely appropriate	*Bemor xavfsizligi har qanday akademik ierarxiyadan ustun turadi*	Patient safety takes precedence over any academic hierarchy

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Table A3
S3 response scale

RATING	UZBEK LABEL	ENGLISH TRANSLATION
1 – *Mutlaqo o'rinsiz* Completely inappropriate	*Oila boshlig'ining (erining) ruxsatisiz amalga oshirilgan ish kelgusida nizolarga sabab bo'ladi*	Proceeding without the permission of the head of the family (the husband) will lead to future conflict
2 – *Ko'proq o'rinsiz* Mostly inappropriate	*Shifokor avval erini ko'ndirishi yoki boshqa qarindoshlarni jalb qilishi shart*	The physician must first persuade the husband or involve other family members
3 – *Neytral / Vaziyatga bog'liq* Neutral / context-dependent	*Huquqiy jihatdan to'g'ri bo'lsa-da, ijtimoiy va madaniy jihatdan murakkab holat*	Although legally correct, this is a socially and culturally complex situation
4 – *Ko'proq o'rinli* Mostly appropriate	*Bemorning hayoti xavf ostida bo'lganda, shaxsiy rozilik ijtimoiy bosimdan muhimroq*	When the patient's life is at risk, individual consent outweighs social pressure
5 – *To'liq o'rinli* Completely appropriate	*Bemorning avtonomiya huquqi qonunan kafolatlangan va shifokor faqat unga bo'ysunishi kerak*	The patient's right to autonomy is legally guaranteed, and the physician must follow the patient's decision alone

Table A4
S4 response scale

RATING	UZBEK LABEL	ENGLISH TRANSLATION
1 – *Mutlaqo o'rinsiz* Completely inappropriate	*Shifokor bemorning tushunganini qayta so'rash orqali tekshirishi shart edi*	The physician should have asked again to verify the patient's understanding
2 – *Ko'proq o'rinsiz* Mostly inappropriate	*Shifokor bemorning yoshi va lingvistik darajasini hisobga olmagan*	The physician failed to consider the patient's age and language proficiency
3 – *Neytral / Vaziyatga bog'liq* Neutral / context-dependent	*Shifokor o'z vazifasini bajargan, bemorning noto'g'ri ichishi uning o'z mas'uliyatsizligi*	The physician fulfilled their duty, and the patient bears responsibility for taking the medication incorrectly
4 – *Ko'proq o'rinli* Mostly appropriate	*Agar bemor 'tushundim' deb tasdiqlagan bo'lsa, shifokorda shubha qilishga asos bo'lmagan*	If the patient confirmed understanding, the physician had no grounds for doubt
5 – *To'liq o'rinli* Completely appropriate	*Shifokor barcha zarur ma'lumotlarni taqdim etgan, muloqot muvaffaqiyatli yakunlangan*	The physician provided all necessary information, and the communication was successfully completed

Table A5
S5 response scale

RATING	UZBEK LABEL	ENGLISH TRANSLATION
1 – *Mutlaqo o'rinsiz* Completely inappropriate	*Hissiy inqiroz holatidagi bemorga berilayotgan tibbiy ma'lumot o'z qiymatini yo'qotadi*	Medical information delivered to a patient in emotional crisis loses its value
2 – *Ko'proq o'rinsiz* Mostly inappropriate	*Avval empatiya ko'rsatilishi, keyin ma'lumotga qaytilishi shart*	Empathy must be shown first; information delivery should resume afterwards
3 – *Neytral / Vaziyatga bog'liq* Neutral / context-dependent	*Vaqt tanqisligi sharoitida shifokor ikkala vazifa o'rtasida muvozanat topishi qiyin*	Under time pressure, it is difficult for the physician to balance both tasks
4 – *Ko'proq o'rinli* Mostly appropriate	*Tibbiy ko'rsatmalar hayotiy zarur, hissiyotlar esa vaqtinchalik holat*	The medical instructions are vital, whereas the emotional state is temporary
5 – *To'liq o'rinli* Completely appropriate	*Shifokorning vazifasi – davolash va reja bo'yicha ma'lumot berish, psixologik xizmat emas*	The physician's duty is to provide treatment and information about the care plan, not psychological support

Table A6
S6 response options

OPTION	UZBEK LABEL	ENGLISH TRANSLATION
A	*Professional etika va qonun-qoidalar har qanday moddiy minnatdorchilikdan ustun turadi.*	Professional ethics and regulatory standards take precedence over any material expression of gratitude.
B	*O'zbekona 'rizolik' tamoyiliga ko'ra, sovg'ani rad etish bemor yaqinlarini kamsitish hisoblanadi; bu pora emas, balki chin dildan qilingan hadyadir.*	According to the Uzbek notion of *rizolik* (approval or satisfaction), refusing the gift would be regarded as disrespectful to the patient's family. The gift is not a bribe but a sincere expression of gratitude.
C	*Shifokor sovg'ani shaxsan o'zi uchun emas, balki bo'lim ehtiyojlari yoki jamoa uchun 'shirinlik' sifatida qabul qilishi – eng maqbul murosadir.*	The most acceptable compromise is for the physician to accept the gift not for personal use but for the department's needs or as a 'treat' for the team.

Appendix B. Pairwise post-hoc comparisons

Table B1
Full pairwise post-hoc comparisons (Dunn's test with Bonferroni correction) for the four scenarios with a significant Kruskal–Wallis omnibus effect (S2–S5)

SCENARIO	COMPARISON	Z	*p* (unadj.)	*p* (Bonf.)
S2	Year 1 vs Year 2	0.892	0.3724	1.0
S2	Year 1 vs Year 3	2.139	0.0324	0.4862
S2	Year 1 vs Year 4	2.687	0.0072	0.1082
S2	Year 1 vs Year 5	1.854	0.0638	0.957
S2	Year 1 vs Year 6	1.988	0.0468	0.7019
S2	Year 2 vs Year 3	0.859	0.3902	1.0
S2	Year 2 vs Year 4	1.024	0.3058	1.0
S2	Year 2 vs Year 5	0.648	0.5171	1.0
S2	Year 2 vs Year 6	0.636	0.5247	1.0
S2	Year 3 vs Year 4	0.089	0.9293	1.0
S2	Year 3 vs Year 5	-0.224	0.8225	1.0
S2	Year 3 vs Year 6	-0.29	0.7722	1.0
S2	Year 4 vs Year 5	-0.338	0.7356	1.0
S2	Year 4 vs Year 6	-0.422	0.673	1.0
S2	Year 5 vs Year 6	-0.051	0.9593	1.0

SCENARIO	COMPARISON	Z	p (unadj.)	p (Bonf.)
S3	Year 1 vs Year 2	1.086	0.2774	1.0
S3	Year 1 vs Year 3	3.914	0.0001	0.0014*
S3	Year 1 vs Year 4	3.547	0.0004	0.0058*
S3	Year 1 vs Year 5	3.569	0.0004	0.0054*
S3	Year 1 vs Year 6	2.114	0.0345	0.5182
S3	Year 2 vs Year 3	2.015	0.0439	0.6582
S3	Year 2 vs Year 4	1.433	0.1518	1.0
S3	Year 2 vs Year 5	1.76	0.0785	1.0
S3	Year 2 vs Year 6	0.558	0.5768	1.0
S3	Year 3 vs Year 4	-0.832	0.4055	1.0
S3	Year 3 vs Year 5	-0.271	0.7864	1.0
S3	Year 3 vs Year 6	-1.676	0.0937	1.0
S3	Year 4 vs Year 5	0.531	0.5953	1.0
S3	Year 4 vs Year 6	-0.99	0.322	1.0
S3	Year 5 vs Year 6	-1.388	0.1651	1.0
S4	Year 1 vs Year 2	0.9	0.3679	1.0
S4	Year 1 vs Year 3	1.217	0.2236	1.0
S4	Year 1 vs Year 4	3.349	0.0008	0.0122*
S4	Year 1 vs Year 5	2.353	0.0186	0.2792
S4	Year 1 vs Year 6	1.833	0.0668	1.0
S4	Year 2 vs Year 3	0.17	0.8651	1.0
S4	Year 2 vs Year 4	1.464	0.1431	1.0
S4	Year 2 vs Year 5	1.011	0.3121	1.0
S4	Year 2 vs Year 6	0.519	0.6034	1.0
S4	Year 3 vs Year 4	1.373	0.1698	1.0
S4	Year 3 vs Year 5	0.892	0.3725	1.0
S4	Year 3 vs Year 6	0.363	0.7163	1.0

SCENARIO	COMPARISON	Z	p (unadj.)	p (Bonf.)
S4	Year 4 vs Year 5	-0.383	0.7014	1.0
S4	Year 4 vs Year 6	-1.073	0.2834	1.0
S4	Year 5 vs Year 6	-0.585	0.5586	1.0
S5	Year 1 vs Year 2	0.853	0.3938	1.0
S5	Year 1 vs Year 3	1.803	0.0714	1.0
S5	Year 1 vs Year 4	3.324	0.0009	0.0133*
S5	Year 1 vs Year 5	2.93	0.0034	0.0508
S5	Year 1 vs Year 6	2.608	0.0091	0.1367
S5	Year 2 vs Year 3	0.642	0.5206	1.0
S5	Year 2 vs Year 4	1.49	0.1363	1.0
S5	Year 2 vs Year 5	1.477	0.1397	1.0
S5	Year 2 vs Year 6	1.106	0.2687	1.0
S5	Year 3 vs Year 4	0.844	0.3986	1.0
S5	Year 3 vs Year 5	0.885	0.3762	1.0
S5	Year 3 vs Year 6	0.457	0.6475	1.0
S5	Year 4 vs Year 5	0.138	0.8905	1.0
S5	Year 4 vs Year 6	-0.396	0.6919	1.0
S5	Year 5 vs Year 6	-0.484	0.6286	1.0

Note. Bonferroni correction was applied across the 15 pairwise comparisons within each scenario. Contrasts marked * are significant at the Bonferroni-adjusted level ($p < .05$); these are the contrasts reported in Table 6 of the main manuscript. S1 ($H = 7.50$, $p = .186$) showed no significant omnibus effect and is therefore not decomposed here.

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