



Sociopragmatic Competence in Medical Higher Education: Structure, Criteria, and Measurement Methods

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Abstract

Sociopragmatic competence—the ability to use language appropriately in accordance with social, institutional, and cultural context—represents a critical yet comparatively underexplored dimension of medical professional communication. In Uzbek-medium higher education, validated structural models and assessment frameworks for this construct appear to remain limited, particularly within the Central Asian context. This study aimed to develop a theoretically grounded structural model of sociopragmatic competence for medical higher education, articulate component-specific assessment criteria, and identify appropriate measurement methods through a systematic integrative literature review conducted across Scopus, Web of Science, ERIC, PubMed Central, and Google Scholar, yielding 54 sources retained for thematic synthesis following PRISMA-ScR screening procedures and employing abductive reasoning evaluated against criteria of internal coherence, theoretical grounding, and practical applicability. The study proposes the five-component MedSPC Model, organized across two hierarchical planes. The foundational plane encompasses Sociopragmatic Knowledge and Discourse Organizational Competence, while the performative plane comprises Interactional Role Competence, Face Management Competence, and Pragmatic Adaptability. The model is accompanied by a component-specific four-level assessment rubric and a Multi-Method Assessment Battery (MMAB) consisting of four complementary instruments. All components are theoretically grounded and presented as a structured research agenda subject to empirical validation. The MedSPC Model is presented not as a set of validated claims but as an empirically generative framework that produces testable hypotheses about the structure, development, and assessment of medical sociopragmatic competence, with empirical validation constituting the essential and immediate next step in this research agenda.

Keywords: MedSPC Model, professional discourse, pragmatic assessment, Central Asian higher education, integrative literature review

ARTICLE INFO

Research Article

Received: Sunday, May 10, 2026

Accepted: Saturday, May 30, 2026

Published: Thursday, October 1, 2026

Available Online: Friday, June 19, 2026

DOI: <https://doi.org/10.22049/jalda.2026.31530.1982>

Online ISSN: 2821-0204; Print ISSN: 28208986



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Introduction

The growing complexity of multilingual clinical environments has renewed attention to the communicative preparation of medical professionals. In Uzbekistan, language instruction has traditionally prioritized grammatical accuracy and lexical acquisition while neglecting the sociopragmatic dimensions of professional medical discourse. This gap is not unique to the Uzbek context: competency-based approaches integrating communication, critical thinking, and professional skills within ESP frameworks yield measurable benefits, while revealing persistent deficits in soft skills that content-focused instruction fails to address (Dashtestani & Forutanian, 2025). The gap is consequential: a physician commanding grammatical correctness but lacking sociopragmatic competence—the ability to deploy linguistic resources appropriately in accordance with social context, interactional roles, institutional power relations, and culturally embedded norms (Leech, 1983; Brown & Levinson, 1987)—may still fail to communicate effectively with patients, colleagues, and caregivers (Thomas, 1983; Kasper & Rose, 2002). This competence underpins sensitive history-taking, delivery of difficult diagnoses, informed consent negotiation, and interprofessional coordination (Heritage & Maynard, 2006). Yet no validated assessment framework currently exists for Uzbek-medium medical education, limiting both curriculum design and learner evaluation.

Three terminological distinctions are operative throughout. *Communicative competence* denotes the overarching construct encompassing all dimensions of effective and appropriate language use (Hymes, 1972; Canale & Swain, 1980). *Pragmatic competence* refers to the broader capacity to interpret and produce language for communicative intent, comprising pragmalinguistic and sociopragmatic competence (Thomas, 1983). *Sociopragmatic competence*—the central construct—denotes contextually and socially appropriate linguistic deployment; where cited authors use 'pragmatic competence,' their original terminology is preserved.

This study aims to develop a theoretically grounded structural model of sociopragmatic competence applicable to Uzbek-medium medical higher education and to identify criteria and methods for its assessment, pursuing four objectives: (1) analyzing theoretical foundations within communicative competence research; (2) identifying structural components as they manifest in medical professional discourse; (3) establishing assessment criteria for medical students; and (4) critically reviewing measurement methods suited to the Uzbek-medium context. These correspond to three central questions: what constitutes the structural architecture of sociopragmatic competence in medical communication, what criteria best serve its assessment, and which measurement methods suit the Uzbek-medium educational context.

Literature Review

Thomas (1983) laid the conceptual foundations of sociopragmatics by distinguishing pragmalinguistic failure—inability to encode communicative intentions through appropriate linguistic forms—from sociopragmatic failure—inability to select contextually appropriate speech acts regardless of linguistic accuracy, demonstrating that grammatical competence alone does not guarantee

communicative success. Leech's (1983) Politeness Principle established that effective communication requires orientation toward social harmony—a culturally variable dimension requiring explicit instruction. Brown and Levinson's (1987) face theory systematized the relationship between social variables—power, distance, and ranking of imposition—and politeness strategy selection; in medical interaction, face-threatening acts are pervasive, from delivering terminal diagnoses to refusing treatment preferences (Rees et al., 2007).

Communicative competence, introduced by Hymes (1972) and operationalized by Canale and Swain (1980), provided the disciplinary infrastructure within which sociopragmatic competence found its place. Bachman and Palmer (1996) advanced the field by positioning pragmatic knowledge as a testable, teachable dimension of language ability—particularly relevant to medical education, where consultations, ward rounds, and multidisciplinary meetings require sustained pragmatic attunement.

Mishler (1984) characterized the physician-patient encounter as a site of tension between the voice of medicine—objective, biomedical—and the voice of the lifeworld—experiential, patient-centered. Heritage and Maynard (2006) demonstrated that tacit sociopragmatic conventions carry significant consequences for patient outcomes, with conversation-analytic research consistently confirming this across multiple health systems and languages (Barnes & Woods, 2024). In the Central Asian context, however, research remains critically sparse: no empirically grounded, Scopus-indexed studies examining physician-patient interactional discourse in Uzbek-medium clinical settings could be identified, and discourse-analytic methods have yet to be systematically applied to Uzbek medical education contexts (Imafuku et al., 2022)—gaps constituting the primary scholarly justification for the present study.

Sociopragmatic Norms in Uzbek Medical Communication: Cultural and Institutional Specificities

Applying Western sociopragmatic frameworks to Uzbek-medium medical education requires structural reconceptualization, not merely contextual sensitivity. Brown and Levinson's (1987) politeness theory provides a robust account of face management, but its cross-cultural universality has been contested (Kasper & Rose, 2002), and the Uzbek clinical context presents four constitutive departures from Western interactional models.

First, in hierarchical and collectivist healthcare cultures such as Uzbekistan, illness is understood as a family matter, with treatment decisions routinely negotiated with family representatives rather than the patient alone (Claramita & Susilo, 2024), extending the dyadic Brown-Levinson model to multi-party face negotiation as a normal institutional feature. Second, bad news delivery follows graduated indirect disclosure grounded in *andisha*—considerate restraint in service of relational harmony—with religious formulations such as *Xudo xohlasa* ("God willing") functioning as institutionally sanctioned mitigation devices rather than mere politeness markers (Mishler, 1984). Third, the *ustoz-shogird* (master-apprentice) hierarchy governs trainee communication: disagreement with senior physicians is

expressed through indirect, face-preserving reformulations—typically questions rather than counter-assertions—diverging substantially from assertiveness-oriented models in English-language clinical literature (Rees et al., 2007). Fourth, language choice carries sociopragmatic meaning absent in monolingual Western contexts: encounters may unfold in Uzbek, Russian, or code-mixed *shargish*, while rural patients frequently present dialectal features requiring real-time register adaptation.

These four features are constitutive of the MedSPC Model's architecture: Cultural Norm Sensitivity (Criterion 1.3) encodes culturally variable FTA ranking; Interactional Role Competence incorporates the *ustoz-shogird* hierarchy; and Pragmatic Adaptability includes register and language-variety flexibility as a specifically Uzbek competence dimension. The model is thus a culturally situated reconceptualization, not a contextual adaptation of Western frameworks.

Measurement of Sociopragmatic Competence: Methods and Challenges

The operationalization of sociopragmatic competence for assessment presents considerable methodological challenges. The Discourse Completion Test (DCT), widely adopted for its administrative feasibility, elicits responses that frequently diverge from naturally occurring interaction, reflecting explicit rather than real-time pragmatic processing (Blum-Kulka et al., 1989; Bardovi-Harlig, 2010). Role-play methodologies elicit interactive spoken data approximating natural discourse (Kasper, 2008), while the Standardized Patient (SP) methodology offers the highest ecological validity through trained actor-patients evaluated against structured criteria (Yudkowsky, 2002). As Roever (2011) argues, robust frameworks combine multiple methods to capture both the knowledge and performance dimensions of sociopragmatic competence. The successful operationalization of such multi-method frameworks, however, extends beyond instrument design to encompass practitioners' assessment literacy; research has demonstrated that targeted educator preparation can substantially shape implementation attitudes, with practical constraints such as time and institutional readiness emerging as significant barriers (Zohrabi & Khalili, 2025). This study is guided by the following research questions:

1. What theoretical and empirical foundations inform the conceptualization of sociopragmatic competence in Uzbek-medium medical higher education contexts?
2. What components constitute a coherent structural model of sociopragmatic competence for medical professionals in Central Asian higher education, and how are these components hierarchically organized?
3. What assessment framework and instruments are most appropriate for operationalizing and measuring the proposed components of the MedSPC Model?

Method

Research Design

This study adopts a systematic integrative literature review combined with conceptual framework development—appropriate when the aim is to synthesize existing theoretical and empirical knowledge to construct a novel conceptual model

rather than generate new primary data (Torraco, 2005; Whittemore & Knafl, 2005). The integrative review was preferred over a conventional narrative review for its explicit, replicable procedures for source identification, inclusion, and synthesis, enhancing transparency and rigor. Methodological rigour was further ensured through systematic attention to validity and reliability considerations across all stages of the review and conceptual development process (Zohrabi, 2013). PRISMA-ScR (Tricco et al., 2018) was referenced for procedural guidance and adapted to align with the integrative review design (see PRISMA-ScR Adaptation section below). The methodological logic follows three stages: (1) systematic identification and screening of relevant literature; (2) thematic synthesis and critical analysis; and (3) conceptual modeling, translating synthesized insights into a coherent structural framework with defined components, criteria, and assessment implications.

Literature Search Procedure

A systematic search was conducted across Scopus, Web of Science, ERIC, PubMed Central, and Google Scholar—selected to ensure comprehensive coverage across applied linguistics, language education, medical education, and health communication—using Boolean combinations of the keyword clusters summarized in Table 1.

Table 1

Systematic Review Search Terms and Construct Categorization

Cluster	Search Terms
Core construct	<i>sociopragmatic competence, pragmatic competence, communicative competence</i>
Domain	<i>medical education, health communication, clinical communication, medical discourse</i>
Language context	<i>Uzbek, Central Asian, post-Soviet, second language, professional language teaching</i>
Assessment	<i>pragmatic assessment, language testing, discourse completion test, standardized patient</i>

The search was limited to English and Russian publications covering 1983–2024, with 1983 selected as the lower boundary to coincide with Thomas's foundational articulation of the sociopragmatic/pragmalinguistic distinction. This language restriction was considered methodologically appropriate for two reasons. First, English constitutes the primary medium of international scholarly communication in applied linguistics, pragmatics, and medical education research. Second, Russian remains a significant language of academic publication across Central Asian higher education contexts, including Uzbekistan, owing to the enduring influence of the Soviet-era scholarly tradition; Russian-medium literature therefore provides regionally relevant theoretical and empirical grounding directly pertinent to the Uzbek-medium institutional context under investigation. Uzbek-language academic literature on sociopragmatic competence was not included due to

the near-absence of peer-reviewed empirical work on this construct in that language at the time of the search.

Inclusion and Exclusion Criteria

Inclusion criteria encompassed peer-reviewed journal articles, book chapters, or scholarly monographs addressing sociopragmatic, pragmatic, or communicative competence in educational or professional contexts; studies focusing on medical or health communication or professional language use; theoretical and empirical works proposing or validating competence models or assessment frameworks; and publications indexed in Scopus or Web of Science, or cited in foundational works in the field. *Exclusion* criteria covered non-peer-reviewed sources, conference abstracts, or grey literature; studies confined to non-professional language learning contexts with no transferable theoretical implications; works addressing medical communication in culturally or linguistically irrelevant contexts; and duplicate publications or studies superseded by subsequent work by the same authors.

Of 142 identified records —defined as individual search results returned across all queried databases and sources prior to deduplication— 24 duplicates were removed, leaving 118 for title and abstract screening; 31 were excluded as outside thematic scope. Of the remaining 87 retrieved for full-text assessment, 33 were excluded (12 non-peer-reviewed; 21 outside relevant linguistic or cultural scope), yielding a final corpus of 54 sources—40 cited in the main text and 14 appearing in Appendices A–D as supporting references for rubric and instrument development. Selection followed PRISMA-ScR adapted procedures (Tricco et al., 2018).

PRISMA-ScR Adaptation and Procedural Transparency

Although PRISMA-ScR (Tricco et al., 2018) served as the procedural reference, three adaptations were made to align the framework with the integrative review design (Whittemore & Knafl, 2005) rather than a strict scoping review, as detailed item-by-item in Table 2.

Table 2

PRISMA-ScR Adaptation Record for the Present Integrative Review

PRISMA-ScR Item	Standard Requirement	Present Study	Adaptation Rationale
Title	Identify as scoping review	Identified as integrative review	Design is integrative (Torraco, 2005), not scoping; PRISMA-ScR adapted for procedural transparency only
Structured summary	Report PCC framework (Population, Concept, Context)	Research questions used in place of PCC	PCC framework is scoping-review-specific; research questions provide equivalent conceptual scope
Protocol registration	Pre-registration on OSF or PROSPERO	Not pre-registered	Conceptual framework development studies are not

PRISMA-ScR Item	Standard Requirement	Present Study	Adaptation Rationale
			conventionally pre-registered; acknowledged as limitation
Sources	Report all databases searched	Five databases reported (Scopus, WoS, ERIC, PMC, Google Scholar)	Fully compliant
Search strategy	Report full Boolean strings	Keyword clusters reported in Table 1	Full Boolean strings available on request from corresponding author
Selection process	Duplicate screening by ≥ 2 reviewers	Single primary reviewer; independent verification of 30% random sample	Resource constraints; verification subsample reported below
Data extraction	Structured extraction form	Thematic coding protocol (Thomas & Harden, 2008)	Integrative review uses synthesis coding rather than discrete data extraction
Synthesis	Report evidence mapping	Thematic synthesis across three stages	Evidence mapping not applicable to conceptual framework development
Critical appraisal	Appraise sources for risk of bias	Theoretical adequacy and empirical grounding assessed	Formal risk-of-bias tools (e.g., CASP) designed for primary empirical studies; theoretical adequacy criteria applied instead

Note. Items not listed above were followed as specified in PRISMA-ScR (Tricco et al., 2018). PCC = Population, Concept, Context; OSF = Open Science Framework; WoS = Web of Science; CASP = Critical Appraisal Skills Programme.

Analytical Procedure: Thematic Synthesis

The corpus was analyzed using thematic synthesis (Thomas & Harden, 2008) across three stages: inductive line-by-line coding against the research questions (Stage 1); grouping of related codes into descriptive themes with convergences and divergences mapped explicitly (Stage 2); and abstraction of descriptive themes into higher-order categories constituting the model's structural components, guided by Bachman and Palmer (1996), with competing positions documented rather than artificially resolved where definitional ambiguity was encountered (Stage 3; Booth et al., 2016). A randomly selected 30% subsample ($n = 16$ sources) was independently reviewed by a second coder; no formal κ statistic was computed—a methodological limitation acknowledged here—with discrepancies, concentrated primarily at the Interactional Role/Face Management boundary, resolved through structured discussion until consensus.

The structural model was derived through abductive reasoning (Timmermans & Tavory, 2012) and evaluated against criteria of internal coherence, theoretical grounding, and practical applicability, with each component's primary and secondary theoretical sources and medical communication justification presented in Table 3.

Table 3*Derivation of MedSPC Model Components: Theoretical Sources and Medical Justification*

Component	Primary Theoretical Source	Secondary Sources	Medical Justification
Sociopragmatic Knowledge	Thomas (1983)	Leech (1983); Brown & Levinson (1987)	Declarative norm knowledge is prerequisite to performative deployment; explicitly teachable in preclinical years
Discourse Organizational Competence	Heritage & Maynard (2006)	Swales (1990); Sacks et al. (1974)	Medical consultations follow institutionally recognized phase structures; violations are immediately consequential for patient care
Interactional Role Competence	Goffman (1967); Mishler (1984)	Hyland (1998); Brown & Levinson (1987)	Physicians enact multiple shifting roles within single encounters; role miscalibration is among the most-cited communication failures in medical education
Face Management Competence	Brown & Levinson (1987)	Claramita & Susilo (2024); Heritage & Maynard (2006)	Medical interaction is exceptionally rich in face-threatening acts; face management quality is the strongest predictor of patient satisfaction outcomes
Pragmatic Adaptability	Kasper (2008); Anderson (1983)	Sacks et al. (1974)	Distinguishes expert from novice performance; coordinates all other components under real-time pressure

Note. A three-component model (Knowledge, Discourse, Interaction) was rejected for insufficient granularity in face management and adaptability—both empirically distinct constructs in the medical communication literature (Roever, 2011)—while a six-component model incorporating a separate Empathic Communication component was rejected on grounds of construct overlap with Face Management Competence and in the interest of parsimony and assessment feasibility.

Rationale for Five-Component Architecture

The five-component structure was retained over simpler and more elaborate alternatives on three grounds. First, empirical parsimony: Roever (2011) identifies face management and metacognitive adaptability as empirically distinguishable constructs in second language pragmatic assessment, supporting their separation from a general interactional category. Second, pedagogical operationalizability: each component maps onto a discrete instructional phase within the five-year medical curriculum (Table 3), making five components the minimum granularity required for curriculum alignment without excessive complexity. Third, assessment feasibility: each component is assessable through at least two instruments in the MMAB, ensuring no component relies on a single measurement method—a requirement a six-component model would compromise given available assessment resources. A three-component model fails the first criterion; a six-component model fails the third.

Ethical Considerations

As this study is based entirely on published scholarly literature and involves no human participants, data collection, or experimental intervention, no institutional ethical approval was required. All sources are properly attributed in accordance with academic integrity standards. No conflicts of interest are declared.

Results

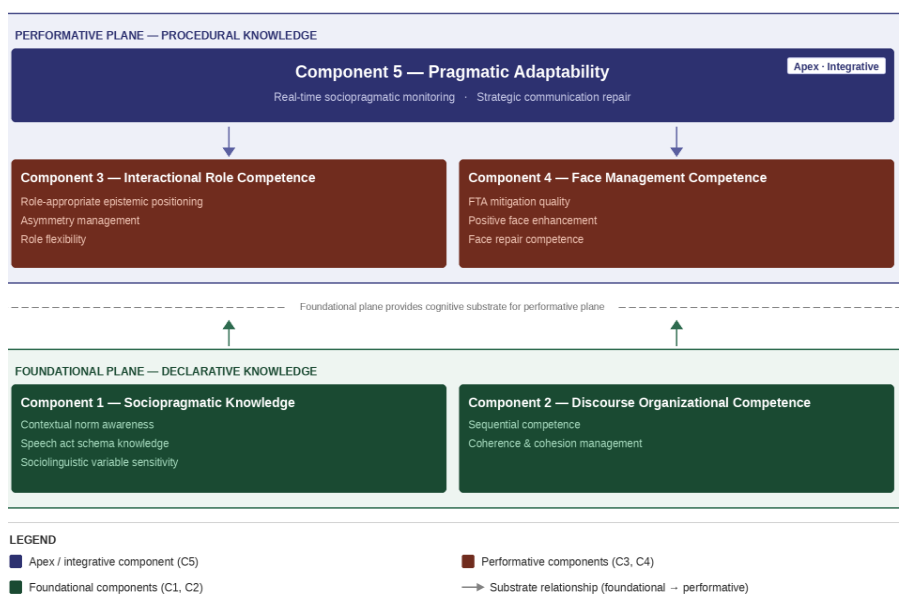
Research Question 1: What theoretical and empirical foundations inform the conceptualization of sociopragmatic competence in Uzbek-medium medical higher education contexts?

Overview of the Proposed Model

The thematic synthesis yielded the MedSPC Model (Medical Sociopragmatic Competence Model)—a five-component structural model organized across two hierarchical planes: a foundational plane comprising knowledge-based components, and a performative plane comprising skill-based and strategic components—reflecting the theoretical consensus that sociopragmatic competence is not a unitary construct but a complex, multi-layered ability that develops unevenly across its constituent dimensions (Bachman & Palmer, 1996; Roevers, 2011).

Figure 1

The MedSPC Model: Structural Architecture of Medical Sociopragmatic Competence



Note. Arrows indicate the substrate relationship between hierarchical planes, not temporal developmental sequence. The foundational plane (C1, C2) provides the declarative cognitive basis upon which performative competence (C3, C4, C5) is built. Pragmatic Adaptability (C5) functions as the integrative executive mechanism coordinating all components under real-time interactional pressure. Hierarchical architecture derived from Anderson (1983) and Bachman & Palmer (1996).

Research Question 2: What components constitute a coherent structural model of sociopragmatic competence for medical professionals in Central Asian higher education, and how are these components hierarchically organized?

Component 1: Sociopragmatic Knowledge

Sociopragmatic Knowledge constitutes the foundational cognitive layer of the MedSPC Model—defined as declarative understanding of social norms, contextual variables, and cultural conventions governing communicative conduct in a given institutional setting (Thomas, 1983): knowledge of when it is appropriate to perform a given speech act and what social consequences follow from particular communicative choices. Three sub-components are distinguished: (a) contextual norm awareness—knowledge of institutionally and culturally sanctioned norms regulating physician-patient, physician-colleague, and physician-administrator interaction, including power asymmetries, consultation sequencing, and culturally specific expectations regarding directness and emotional expression (Mishler, 1984; Heritage & Maynard, 2006); (b) speech act schema knowledge—declarative knowledge of conventional forms through which recurrent medical speech acts are realized in Uzbek-medium professional discourse, organized around prototypical schemas internalized through exposure to professional discourse communities (Kasper & Rose, 2002); and (c) sociolinguistic variable sensitivity—awareness of how Brown and Levinson's (1987) social variables—power (P), distance (D), and ranking of imposition (R)—systematically shape speech act selection and formulation. As the component most amenable to explicit instruction and declarative assessment, it constitutes the necessary cognitive substrate upon which performative competence is built (Bachman & Palmer, 1996), hence its foundational positioning.

Component 2: Discourse Organizational Competence

Discourse Organizational Competence refers to the ability to structure extended medical communicative events—consultations, case presentations, patient education sessions, multidisciplinary discussions—in accordance with their institutionally recognized sequential organization, drawing on conversation-analytic (Heritage & Maynard, 2006; Sacks et al., 1974) and genre-theoretic (Swales, 1990) traditions. Two sub-components are distinguished: (a) sequential competence—the ability to manage the phase structure of medical encounters across opening, middle, and closing sequences, deploying phase-appropriate communicative resources at each transition; and (b) coherence and cohesion management—the ability to maintain thematic continuity, manage topic transitions, and organize complex biomedical information into sequentially accessible discourse, particularly consequential during patient education (Roter & Hall, 2006). Deficiencies in this component—disorganized consultations, omitted case presentation phases, incoherent patient instructions—are sociopragmatic rather than purely linguistic failures, reflecting inability to map linguistic resources onto institutional discourse structure rather than insufficient vocabulary or grammar.

Component 3: Interactional Role Competence

Interactional role competence is defined as the ability to enact, negotiate, and maintain the communicative rights and obligations associated with specific institutional roles within medical encounters, grounded in [Goffman's \(1967\)](#) concept of interactional footing and [Mishler's \(1984\)](#) analysis of competing voices in medical interaction. Three sub-components are identified: (a) *role-appropriate epistemic positioning*—calibrating claims to knowledge and authority through hedges, boosters, and evidential markers in accordance with one's institutional role ([Hyland, 1998](#)); (b) *asymmetry management*—navigating power asymmetries both downward (toward institutionally vulnerable patients) and upward (toward senior physicians and administrators) through differential politeness strategies ([Brown & Levinson, 1987](#)); and (c) *role flexibility*—shifting communicative register and relational positioning as encounter demands evolve, from authoritative diagnostician to empathic counselor to collaborative partner in shared decision-making ([Roter & Hall, 2006](#)). Failures in this component—overly authoritative communication with patients, inappropriate informality with senior colleagues, inability to shift from biomedical to patient-centered discourse—are among the most frequently cited communication deficiencies in medical education literature ([Rees et al., 2007](#)) and are directly associated with adverse patient outcomes.

Component 4: Face Management Competence

Face management competence refers to the ability to protect, repair, and where appropriate strategically threaten the face wants of all interactional participants, grounded in [Brown and Levinson's \(1987\)](#) politeness theory and its systematic account of face-threatening acts (FTAs) and available mitigation strategies—positive politeness, negative politeness, off-record strategies, and bald-on-record performance. Three sub-components are distinguished: (a) *mitigation competence*—softening, hedging, or reframing face-threatening acts, particularly critical in Uzbek clinical culture where direct contradiction of a patient's expressed beliefs may be severely face-threatening ([Claramita & Susilo, 2024](#)); (b) *positive face enhancement*—affirming patients' and colleagues' positive face wants through recognition, validation, and solidarity-building, strongly associated with patient adherence and treatment engagement ([Heritage & Maynard, 2006](#)); and (c) *face repair competence*—recognizing and remediating face threats through apology, explanation, humor, or topic redirection, requiring real-time interactional monitoring and rapid sociopragmatic adjustment ([Goffman, 1967](#)). Research consistently demonstrates that patients' evaluations of physician communication quality are more strongly predicted by perceived face-sensitivity than by informational content ([Roter & Hall, 2006](#)), making this component the most directly implicated in patient satisfaction, therapeutic alliance, and informed consent outcomes.

Component 5: Pragmatic Adaptability

Pragmatic adaptability occupies the apex of the MedSPC Model's performative plane. It is the metacognitive and strategic capacity to monitor ongoing

interactions, identify sociopragmatic challenges, and flexibly reconfigure communicative behavior in response to interlocutor feedback and situational shifts. This component draws on Kasper's (2008) concept of pragmatic interactional competence and Anderson's (1983) declarative-procedural distinction, which establishes that genuine communicative expertise requires not merely sociopragmatic knowledge but its fluent proceduralization under interactional pressure. Two sub-components are identified: (a) *real-time sociopragmatic monitoring*—tracking interlocutor responses, detecting signs of misunderstanding, discomfort, or face threat, and adjusting strategy without disrupting interactional coherence (Sacks et al., 1974); and (b) *strategic communication repair*—initiating and executing repair sequences when breakdowns occur, a critical competence in high-stakes encounters involving emotionally distressed patients or complex ethical decisions (Yudkowsky, 2002). Pragmatic adaptability most clearly distinguishes advanced communicative competence from rule-following. A student who performs well in scripted role-play but fails with an uncooperative or distressed patient has not yet achieved it. For this reason, it is both the most challenging component to develop pedagogically and the most demanding to assess reliably.

Structural Architecture of the MedSPC Model

The five components form an integrated, hierarchically organized system. Foundational components—Sociopragmatic Knowledge and Discourse Organizational Competence—provide the cognitive substrate for performative ones. Pragmatic Adaptability functions as the dynamic coordinating mechanism governing competence deployment under real-time interactional pressure.

Research Question 3: What assessment framework and instruments are most appropriate for operationalizing and measuring the proposed components of the MedSPC Model?

Assessment Criteria and Measurement Methods for Sociopragmatic Competence in Medical Higher Education

Integrating the MedSPC Model into medical education practice requires explicit, operationalizable assessment criteria aligned with each component and measurement methods that are both theoretically valid and practically feasible within Uzbekistan's medical higher education system. The framework is guided by three principles: *construct validity*—criteria must capture sociopragmatic competence as defined in the model, not surrogate constructs such as grammatical accuracy (Bachman & Palmer, 1996); *consequential validity*—the framework must generate productive washback effects that incentivize genuine competence development rather than surface-level performance (Messick, 1989); and *contextual authenticity*—assessment tasks must approximate the sociopragmatic demands of actual medical communication closely enough to support ecologically valid inferences about real-world communicative ability (Yudkowsky, 2002).

Part I: Assessment Criteria

Criterion System Design

Each of the five MedSPC Model components is evaluated against component-specific behavioral descriptors rated on a four-level proficiency scale: Inadequate (1), Developing (2), Proficient (3), and Advanced (4), with domain-specific behavioral anchors grounded in the medical discourse literature, following the precedent of the CEFR ([Council of Europe, 2001](#)). A four-level scale was preferred over binary pass/fail because medical communicative competence develops progressively and unevenly across components, and a scalar system captures this developmental heterogeneity while providing actionable diagnostic information for instructional planning ([Roever, 2011](#)); the effective deployment of such rubrics is contingent on assessors' assessment literacy, and targeted instrument development grounded in systematic validation procedures substantially enhances rubric reliability and practical utility ([Rastegar et al., 2022](#)). Full component-specific criteria and behavioral descriptors are presented in Appendix A. (*submitted as supplementary material*)

Part II: Measurement Methods

Methodological Framework

The selection of measurement methods was guided by [Kane's \(2013\)](#) argument-based approach to validity, requiring that each interpretive claim based on an assessment score be supported by an explicit validity argument connecting task, observed performance, and construct. A fundamental implication follows: no single instrument can generate valid inferences across all five MedSPC Model components, as they differ in whether they are best captured through declarative, performance-based, or observational evidence—making a multi-method assessment battery theoretically required, not merely preferable.

Method 1: Sociopragmatic Judgment Task (SJT). Students evaluate the sociopragmatic appropriateness of scripted medical exchanges in vignette format, rating each on a Likert scale, identifying features rendering behavior appropriate or inappropriate, and proposing alternative formulations where applicable ([Roever, 2005](#); [Rees et al., 2007](#)). The SJT targets Component 1 primarily and Component 2 secondarily, offering administrative feasibility for large cohorts and systematic manipulation of contextual variables (P, D, R). Its principal limitation is assessment of declarative rather than procedural knowledge ([Bardovi-Harlig, 2010](#)); SJT scores must never serve as sole indicators of overall sociopragmatic competence. *Recommended administration: semesterly, as pre- and post-instruction diagnostic.*

Method 2: Written Discourse Completion Task (DCT). Students provide the missing physician turn in partially scripted sequences designed to elicit face-threatening or sequentially complex speech acts—delivering a difficult diagnosis,

refusing a patient's request, negotiating consent, correcting a colleague's error (Blum-Kulka et al., 1989; Yudkowsky, 2002; Roevers, 2011). Targeting Components 1, 3, and 4, responses are scored against a Speech Act Appropriateness Rubric with inter-rater reliability established through Cohen's κ prior to large-scale administration. Its principal limitation is that written responses elicit reflective rather than spontaneous behavior, precluding valid assessment of Component 5 (Bardovi-Harlig, 2010; Kasper, 2008). *Recommended administration: formatively at the conclusion of each instructional unit.*

Method 3: Oral Role-Play Assessment (ORP). Students engage in structured interactive scenarios with trained interlocutors enacting standardized patient, colleague, or supervisor roles, generating the full range of sociopragmatic challenges: phase management, face-threatening act performance, role transitions, and real-time repair demands (Kasper, 2008; Rees et al., 2007). Targeting all five components—with particular strength for Components 3, 4, and 5—performances are video-recorded and scored by two trained assessors using the MedSPC Analytical Rating Scale, with discrepancies exceeding one scale point resolved through third-rater adjudication. Limitations include resource intensity and scheduling constraints for large cohorts. *Recommended administration: as a summative assessment at the end of each academic year, supplemented by formative role-play throughout the instructional cycle.*

Method 4: Standardized Patient Assessment (SPA). Trained actor-patients present standardized clinical scenarios approximating genuine clinical encounters (Barrows, 1993), generating validity evidence superior to written or role-play instruments for constructs involving real-time interpersonal communication (Yudkowsky, 2002). Targeting Components 3, 4, and 5 with highest ecological validity, scoring employs a dual system: trained assessors complete the MedSPC Analytical Rating Scale, while standardized patients complete a structured Patient Communication Experience Questionnaire (PCEQ) evaluating perceived respect, clarity, emotional sensitivity, and overall interaction satisfaction—capturing face management dimensions not fully visible to external assessors. SPA carries the highest resource demands of all proposed methods. *Recommended administration: as high-stakes summative assessment at clinical transition points—entry to clinical rotations and pre-graduation competency certification.*

Proposed Multi-Method Assessment Battery (MMAB)

The four methods are most appropriately deployed as an integrated Multi-Method Assessment Battery (MMAB) in which each contributes targeted validity evidence for specific components while compensating for the limitations of others, as represented in Table 4.

Table 4*Multi-Method Assessment Battery: Component Coverage by Method*

MedSPC Component	SJT	DCT	ORP	SPA
1. Sociopragmatic Knowledge	●●	●●	●	●
2. Discourse Organizational Competence	●	●●	●●	●●
3. Interactional Role Competence	○	●●	●●	●●
4. Face Management Competence	●	●●	●●	●●
5. Pragmatic Adaptability	○	○	●●	●●

Note. ●● = Primary assessment method; ● = Secondary assessment method; ○ = Not applicable.

The MMAB is designed for progressive implementation: SJT and DCT are introduced in early years as formative tools; ORP in middle years as clinical training begins; and SPA is reserved for high-stakes summative assessment at clinical transition points—ensuring assessment demands are calibrated to students' evolving competence and generating longitudinally coherent evidence of development.

Inter-Rater Reliability and Assessor Training

ORP and SPA validity depends critically on rater reliability. Evidence from institutional assessment contexts confirms that rubric design quality directly influences inter-rater reliability outcomes, and that assessor-informed rubric refinement—where practitioner feedback is systematically incorporated into descriptor revision—yields significant improvements in scoring consistency and pedagogical relevance (Zargaran & Ghorbanpoor, 2026). All assessors must complete a standardized training program comprising: orientation to the MedSPC Model; anchor performance calibration; live rating practice; and periodic recalibration to prevent assessor drift. Inter-rater reliability is calculated using intraclass correlation coefficients (ICC) for continuous ratings and Cohen's κ for categorical judgments, with acceptable thresholds set at $ICC \geq 0.75$ and $\kappa \geq 0.70$ (Streiner et al., 2015). Assessor pairs failing to meet these thresholds undergo additional calibration before rating student performances.

Pilot Administration

A preliminary SJT pilot was conducted with $N = 35$ medical students across eight Uzbek medical higher education institutions. Given the limited sample, data are hypothesis-generating only. Three findings warrant attention. First, S1 and S3—involving collective versus individual clinical decision-making frameworks—produced near-identical negative judgment distributions (combined negative: 85.7%), suggesting that collective orientation in Uzbek clinical culture extends face management obligations to family interlocutors, consistent with Criterion 1.3. Second, S6 (gift acceptance) revealed that 88.6% of respondents endorsed culturally

framed responses deviating from formal ethics standards, illustrating the inadequacy of ethics instruction alone as a substitute for explicit sociopragmatic competence development. Third, S5 was the only scenario yielding a noteworthy year-of-study association ($r_s = -.420$, $p = .012$, uncorrected; adjusted $\alpha = .010$ across five comparisons), suggesting face management sensitivity develops through clinical exposure rather than declarative instruction alone. Full statistics are reported in Appendix B.

Discussion

This study addresses a critical gap at the intersection of applied linguistics, medical education, and language assessment by proposing the MedSPC Model—a theoretically grounded, contextually situated framework for conceptualizing, teaching, and evaluating sociopragmatic competence in Uzbek-medium medical higher education. The need for such a framework is underscored by emerging evidence that medical professionals frequently demonstrate strong domain-specific expertise while remaining insufficiently equipped in the communicative and linguistic dimensions of professional practice; this tension between professional knowledge and linguistic competence represents a defining challenge in medical education contexts where English or other non-native languages serve as media of instruction or professional communication (Khalili et al., 2025).

Theoretical Contributions

The MedSPC Model disaggregates sociopragmatic competence into five hierarchically organized components, each with a distinct theoretical lineage and observable behavioral manifestations—advancing prior frameworks, including Bachman and Palmer (1996), whose treatment of pragmatic competence at a level of generality limits applicability to domain-specific professional education. The foundational–performative distinction operationalizes Anderson's (1983) declarative–procedural knowledge divide, providing a principled account of why students with strong declarative knowledge frequently fail in real-time clinical interaction (Kasper & Rose, 2002). Positioning Pragmatic Adaptability at the apex establishes metacognitive self-monitoring as a teachable, assessable competence dimension rather than an innate trait.

Most existing sociopragmatic research has been conducted in English-language contexts using Western clinical communication models—emphasizing patient autonomy, shared decision-making, and explicit verbal consent—frameworks that cannot be uncritically imported into Uzbek medical education, where distinct configurations of physician authority, family involvement, and norms of indirection obtain (Claramita & Susilo, 2024). The MedSPC Model accommodates this cultural specificity through Criterion 1.3 and the face management component's emphasis on culturally variable FTA mitigation, embedding cultural contextualization into the model's structural architecture rather than treating it as supplementary (Kasper, 2008; Roevers, 2011).

This cultural contextualization raises three theoretical tensions requiring direct engagement. First, the risk of essentialism: characterizing Uzbek medical communication through shared norms risks treating a diverse society as homogeneous. Following Kádár and Haugh (2013), politeness norms are dynamic, generationally variable, and institutionally contested; the model responds by encoding awareness of normative variability as itself a competence dimension within Criterion 1.3. Second, the postcolonial critique: the model's theoretical foundations—Hymes (1972), Canale and Swain (1980), Bachman and Palmer (1996)—carry epistemological assumptions subject to postcolonial scrutiny (Pennycook, 1994); the model responds structurally by embedding Uzbek communicative norms as the constitutive standard rather than a deviation from Western baselines. Third, individual variation: following Terkourafi (2005), politeness norms operate as probabilistic expectations rather than categorical rules; the proficiency scale accordingly captures developmental proximity to communicatively effective performance, while Pragmatic Adaptability at the apex is defined precisely as the capacity to deviate from normative expectations when contextual demands require it, embedding communicative agency at the highest level.

Collectively, these engagements are constitutive of the model's theoretical architecture—converting essentialism risk into a competence criterion, repositioning Western theory as one input rather than the authoritative baseline, and building individual agency into its apex component.

Pedagogical Implications

Curriculum Design

The MedSPC Model argues for reconceptualizing language instruction objectives—from the dominant focus on grammatical accuracy and lexical acquisition toward the explicit development of sociopragmatic competence across all five components—embedding linguistic instruction within communicatively authentic, sociopragmatically rich contexts rather than treating it as an end in itself. The model's hierarchical architecture suggests a developmental curriculum sequence: early years prioritize foundational components (sociopragmatic norms, discourse genre conventions, and the P/D/R social variable framework), while later years shift toward performative components through role-play, case simulation, and standardized patient encounters—mirroring the preclinical–clinical structure of medical education. Estimated additional instructional time is approximately 20–30 contact hours per academic year in Years 1–3, declining as clinical placement hours increase in Years 4–5. This reorientation does not displace existing linguistic content but recontextualizes it within sociopragmatically complex tasks that generate pragmatic development alongside linguistic consolidation (Willis & Willis, 2007), as detailed in Table 5.

Table 5*Illustrative Scope-and-Sequence Framework for a Five-Year Uzbek Medical Program*

Academic Year	Primary MedSPC Focus	Instructional Modality	Assessment Method
Year 1	Sociopragmatic Knowledge (C1)	Explicit instruction; case vignette analysis; SJT practice	Sociopragmatic Judgment Task (SJT)
Year 2	Discourse Organizational Competence (C2)	Genre analysis; transcript study; structured role-play	Written DCT; discourse analysis tasks
Year 3	Interactional Role Competence (C3)	Simulated consultations; peer role-play; video-based reflection	ORP — formative
Year 4	Face Management Competence (C4)	Standardized patient encounters; emotionally complex scenarios	ORP — summative; SP feedback instrument
Year 5	Pragmatic Adaptability (C5)	Clinical rotation communication; unscripted SP assessment; reflective portfolio	SPA — high-stakes

Instructional Methodology

The pedagogical approach most consistent with the MedSPC Model is task-based language teaching (TBLT) with a sociopragmatic orientation—Willis and Willis (2007) demonstrate that TBLT generates more durable pragmatic development than form-focused instruction—requiring tasks that engage students in the full sociopragmatic complexity of clinical encounters rather than scripted phrases. For Pragmatic Adaptability specifically, the principle of deliberate interactional challenge is particularly important: systematically introducing unexpected, face-threatening, or interactionally complex events into practice scenarios requires students to deploy real-time monitoring and strategic repair under genuinely challenging conditions, consistent with the desirable difficulties literature demonstrating that manageable challenges produce more robust skill acquisition than error-free performance environments.

The MMAB's consequential validity (Messick, 1989) creates washback effects aligning students' priorities with genuine professional communication demands, while formative deployment of SJT and DCT instruments provides specific, actionable developmental feedback that generic communicative competence

assessments cannot deliver. However, the fully specified MMAB represents an aspirational system whose complete deployment presupposes institutional resources—trained standardized patients, video infrastructure, assessor training programs, and dedicated contact hours—not uniformly available across Uzbekistan's medical higher education institutions. Three implementation tiers are therefore specified: Tier 1 (Full MMAB: SJT + DCT + ORP + SPA) for high-resource institutions; Tier 2 (Core MMAB: SJT + DCT + ORP) for medium-resource institutions; and Tier 3 (Essential MMAB: SJT + DCT) for constrained settings—with component coverage, validity claims, and recommended cautions for each tier detailed in Appendix D and summarized in Table 6.

Table 6

Tiered Implementation Framework for the MedSPC Multi-Method Assessment Battery

	Tier 1 Full MMAB	Tier 2 Core MMAB	Tier 3 Essential MMAB
Instruments	SJT + DCT + ORP + SPA	SJT + DCT + ORP	SJT + DCT
Components with primary evidence	C1–C5	C1–C4	C1–C2
Components with secondary evidence	—	C5	C3–C4
Components unassessed	—	—	C5
Minimum assessors	2 trained + SP pool	2 trained faculty	1 trained rater
Additional contact hours/year	20–30 (Yrs 1–3)	15–20 (Yrs 1–3)	10–15 (Yrs 1–3)
High-stakes decisions	✓ Supported	⚠ With caution	✗ Not recommended
Formative use	✓ Full	✓ Full	✓ Limited

Institutions are encouraged to adopt the highest feasible tier and plan iterative capacity development toward full MMAB deployment, with a practical decision support guide—including minimum equipment specifications, assessor training outlines, and guidance for adapting tasks to local constraints—provided in Appendix C.

The MedSPC Model's contributions emerge most clearly in direct comparison with established frameworks: relative to [Bachman and Palmer \(1996\)](#), it offers greater domain specificity and developmental explicitness through its hierarchical rather than flat taxonomic architecture; relative to the Calgary-Cambridge Guide ([Silverman et al., 2005](#)), it provides stronger sociopragmatic theoretical grounding, complementing clinical communication frameworks by supplying the linguistic infrastructure they presuppose but do not explicitly develop; and relative to [Roever's \(2011\)](#) pragmatic assessment framework, it offers a more comprehensive structural account addressing the institutional, sequential, and role-

based dimensions that general second language pragmatic assessment frameworks do not capture.

Limitations

Five limitations are consequential for interpretation. First, the MedSPC Model has not yet been empirically validated; the proposed components, criteria, and methods represent theoretically grounded hypotheses requiring instrument development, pilot assessment, factor analytic validation, and longitudinal tracking before underpinning high-stakes decisions. Second, the literature base is heavily weighted toward English-language research, and transferability to the Uzbek clinical context cannot be assumed without empirical verification. Third, ORP and SPA carry substantial resource implications that may limit feasibility in under-resourced settings—tiered implementation guidance is provided in Section 2.3. Fourth, the study does not address how sociopragmatic competence interacts with clinical reasoning, biomedical knowledge, and procedural skills in determining overall physician performance. Fifth, pilot SJT analyses are exploratory and hypothesis-generating only; all reported correlations, including the significant result for S5, await replication with larger samples and appropriate correction procedures (see Appendix B).

Directions for Future Research

Four hypotheses follow directly from the model's structural architecture: H1: MedSPC Component scores will display a hierarchical acquisition sequence, with C1 and C2 attaining proficiency earlier than C3, C4, and C5. H2: SJT scores will not predict ORP or SPA performance at a magnitude sufficient to substitute for performance-based assessment, consistent with [Anderson's \(1983\)](#) declarative–procedural distinction. H3: Students scoring at the Advanced level on C5 will demonstrate significantly greater communicative recovery from interactionally disruptive SP events than Proficient-level students, controlling for C1–C4 scores. H4: Cultural Norm Sensitivity (Criterion 1.3) scores will moderate the relationship between Face Management Competence and patient satisfaction ratings, with higher sensitivity associated with stronger face management outcomes in Uzbek-specific scenarios than in culturally neutral ones.

Four priorities constitute the immediate research agenda: (1) psychometric validation of the SJT, DCT, and MedSPC Analytical Rating Scale, including factor analytic examination of the five-component structure; (2) corpus collection of authentic Uzbek-medium medical interactions to establish empirically grounded behavioral descriptors; (3) prospective longitudinal tracking of MedSPC component development from preclinical years through clinical rotations; and (4) cross-institutional comparative research across Uzbek medical universities to identify best practices and inform national-level education policy.

Conclusion

This study has proposed and theoretically grounded the MedSPC Model—a five-component structural model of sociopragmatic competence for Uzbek-medium

medical higher education—through a systematic integrative review of the applied linguistics, medical communication, and language assessment literature. The central argument is that sociopragmatic competence is not an incidental byproduct of general communicative ability but a complex, domain-specific construct that must be explicitly modeled, deliberately taught, and systematically assessed.

The model makes three principal contributions. Theoretically, it distinguishes foundational and performative competence planes and positions Pragmatic Adaptability as the integrative mechanism coordinating competence under real-time interactional pressure. Methodologically, it proposes a validity-argument-based Multi-Method Assessment Battery addressing the full construct range while remaining sensitive to institutional resource constraints. Practically, it provides a principled basis for curriculum design and assessment policy in a context that has lacked the theoretical grounding needed to move beyond ad hoc communicative instruction. Empirical validation remains the essential next step: the MedSPC Model is offered not as a set of confirmed claims but as a theoretically rigorous, empirically open contribution to an emerging research agenda.

Acknowledgments

The author declares no funding was received for this research. The author thanks the eight Uzbek medical higher education institutions that facilitated pilot data collection and the medical students who participated in the preliminary SJT administration.

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Appendix A

MedSPC Model Assessment Criteria: Component-Specific Behavioral Descriptors

Component	Criterion	Behavioral Descriptors (Advanced → Inadequate)
C1— Sociopragmatic Knowledge	1.1 Norm recognition accuracy	<i>Advanced</i> : accurately discriminates appropriate/inappropriate behavior across culturally ambiguous contexts. <i>Inadequate</i> : misses basic institutional norm violations.
	1.2 Contextual variable analysis	<i>Advanced</i> : nuanced multi-variable weighting of power (P), distance (D), imposition (R). <i>Inadequate</i> : attends to ≤ 1 variable.
	1.3 Cultural norm sensitivity	<i>Advanced</i> : demonstrates awareness of Uzbek-specific norms (indirection, respect marking, family involvement) as distinct from generic/Western-derived models (Claramita & Susilo, 2024). <i>Inadequate</i> : applies Western-default norms uncritically.
C2— Discourse Organizational Competence	2.1 Phase structure management	<i>Advanced</i> : smooth, appropriately signaled transitions across all consultation phases (opening, history, diagnosis, treatment, closing). <i>Inadequate</i> : omitted or disordered phases.
	2.2 Sequential coherence	<i>Advanced</i> : cohesively organized discourse with explicit connectives across case presentations, patient education, handovers. <i>Inadequate</i> : fragmented or thematically inconsistent.
	2.3 Genre appropriateness	<i>Advanced</i> : conforms to institutional generic conventions (consultation, case presentation, discharge instruction, referral) with context-sensitive recognition. <i>Inadequate</i> : genre conventions unrecognized or ignored (Swales, 1990).
C3— Interactional Role Competence	3.1 Epistemic calibration	<i>Advanced</i> : sophisticated deployment of hedges, evidentials, boosters accurately representing certainty while maintaining credibility. <i>Inadequate</i> : overclaims certainty or excessively hedges.
	3.2 Asymmetry sensitivity	<i>Advanced</i> : fluent register and mitigation modulation across patients, peers, senior physicians, allied health professionals. <i>Inadequate</i> : uniform communicative style regardless of relational context.
	3.3 Role transition fluency	<i>Advanced</i> : manages interactional footing shifts (diagnostician ↔ counselor ↔ listener) without sociopragmatic discontinuity. <i>Inadequate</i> : rigid role maintenance disrupts interactional coherence.
C4—Face Management Competence	4.1 FTA mitigation quality	<i>Advanced</i> : contextually appropriate mitigation seamlessly integrated (strategy × FTA severity × relational context) without informational loss. <i>Inadequate</i> : strategy mismatch or awkward deployment.

Component	Criterion	Behavioral Descriptors (Advanced → Inadequate)
C5— Pragmatic Adaptability	4.2 Positive face engagement	<i>Advanced</i> : actively sustains rapport through solidarity-affirming, validation, and acknowledgment behaviors, especially in distress and chronic-disease contexts (Heritage & Maynard, 2006). <i>Inadequate</i> : absent or formulaic engagement.
	4.3 Face repair responsiveness	<i>Advanced</i> : detects and repairs inadvertent FTAs (misunderstanding, abrupt shift, insensitive formulation) restoring relational equilibrium (Goffman, 1967). Assessed by performance-based methods only. <i>Inadequate</i> : face threats unnoticed or unaddressed.
	5.1 Real-time monitoring accuracy	<i>Advanced</i> : proactive detection of patient confusion, emotional escalation, communicative breakdown; preemptive adjustment before breakdown occurs. <i>Inadequate</i> : reactive or absent monitoring.
	5.2 Repair strategy effectiveness	<i>Advanced</i> : repair resolves identified difficulties without secondary interactional problems, confirmed by interlocutor response. <i>Inadequate</i> : repair attempts ineffective or counterproductive.
	5.3 Strategic flexibility range	<i>Advanced</i> : broad repertoire of sociopragmatic strategies selected by contextual demand. <i>Inadequate</i> : single rigid strategy applied regardless of interactional effectiveness.

Note. Four-level proficiency scale: 1 = Inadequate, 2 = Developing, 3 = Proficient, 4 = Advanced.

Appendix B

Preliminary Empirical Illustration: Pilot Sociopragmatic Judgment Task Data

Overview and Rationale

A pilot SJT was administered to $N = 35$ medical students across eight Uzbek medical higher education institutions (Tashkent Medical Academy, $n = 11$; Bukhara State Medical Institute, $n = 10$; Samarkand State Medical University, $n = 6$; Fergana Public Health Medical Institute, $n = 3$; Sechenov–Tashkent branch, $n = 2$; three further institutions, $n = 1$ each), spanning all six curriculum years (Year 1: $n = 2$; Year 2: $n = 3$; Year 3: $n = 6$; Year 4: $n = 11$; Year 5: $n = 6$; Year 6: $n = 7$). The instrument comprised five contextualized vignettes rated on a three-point scale (1 = Completely inappropriate; 2 = Mostly inappropriate; 3 = Neutral/context-dependent) plus one forced-choice gift-acceptance item (S6). Scenarios were mapped to MedSPC components as follows: S1—terminal prognosis disclosure against family objection (C4, C1); S2—open correction of a senior physician's error before a patient (C3); S3—proceeding with surgery on patient's consent against spousal objection (C1, C4); S4—failure to verify comprehension with a dialectal-register rural patient (C2, C5); S5—continued information delivery to an emotionally distressed patient (C4, C5).

Table B1

Pilot SJT Results: Response Distributions, Descriptive Statistics, and Year-of-Study Correlations (N = 35)

Scenario	Completely inappropriate % (n)	Mostly inappropriate % (n)	Neutral % (n)	Combined negative %	M (SD)	rs (year)	p
S1—Prognosis disclosure	54.3 (19)	31.4 (11)	14.3 (5)	85.7	1.60 (0.74)	.158	.366
S2— Hierarchical error correction	25.7 (9)	65.7 (23)	8.6 (3)	91.4	1.83 (0.57)	-.160	.358
S3—Spousal consent override	51.4 (18)	34.3 (12)	14.3 (5)	85.7	1.63 (0.73)	-.147	.398
S4—Dialectal comprehension	31.4 (11)	60.0 (21)	8.6 (3)	91.4	1.77 (0.60)	-.247	.153
S5—Emotional state management	57.1 (20)	37.1 (13)	5.7 (2)	94.3	1.49 (0.61)	-.420	.012
Overall				85.7–94.3	1.66 (0.66)		

Note. Three-point scale: 1 = Completely inappropriate, 2 = Mostly inappropriate, 3 = Neutral/context-dependent. * $p < .05$ (uncorrected; Bonferroni-adjusted $\alpha = .010$). r_s = Spearman rank-order correlation with year of study.

Key Findings. Combined negative judgment rates ranged from 85.7% to 94.3% across all scenarios (overall $M = 1.66$, $SD = 0.66$). S1 and S3—both involving collective versus individual clinical decision-making—produced near-identical distributions (combined negative: 85.7%), supporting the model's claim that collective orientation extends face management obligations to family interlocutors (C4, Criterion 1.3). S2 and S4 produced distributions concentrated at *mostly inappropriate*, reflecting ustoz-shogird norms of indirect hierarchical disagreement (C3) and physician communicative accountability (C5). S5 produced the strongest negative pattern (94.3%; $M = 1.49$) and the only significant year-of-study correlation ($r_s = -.420$, $p = .012$), suggesting face management sensitivity develops through clinical exposure. S6 (gift acceptance): 88.6% endorsed culturally framed responses deviating from formal ethics standards (Option B: 48.6%; Option C: 40.0%), directly

illustrating Criterion 1.3 and the inadequacy of ethics instruction as a substitute for explicit sociopragmatic competence development.

Limitations. $N = 35$ precludes inferential generalization; the three-point response scale constrains score sensitivity; the cross-sectional design prevents causal inference about developmental trajectories; five correlations were computed without alpha correction. All results are hypothesis-generating only and require replication with larger samples and appropriate correction procedures.

Appendix C

Institutional Decision Guide for MedSPC Assessment Implementation

Step 1—Resource Audit. Before selecting an implementation tier, institutions should conduct a brief resource audit addressing: (a) number of trained language assessors available; (b) availability of video or audio recording equipment; (c) feasibility of standardized patient recruitment and training; (d) additional contact hours available for sociopragmatic competence instruction per academic year.

Step 2—Tier Selection. Based on the resource audit, institutions select the highest feasible tier using Table 5 as a guide. Institutions uncertain about tier placement are encouraged to begin at Tier 3 and build capacity incrementally.

Step 3—Assessor Training Minimum Standards. Regardless of tier, all assessors must complete: (a) orientation to MedSPC Model component definitions; (b) calibration on at least three anchor performances per proficiency level; (c) live rating practice with feedback prior to student assessment. For ORP and SPA, acceptable reliability thresholds are $ICC \geq 0.75$ and Cohen's $\kappa \geq 0.70$ (Streiner et al., 2015); assessor pairs failing these thresholds must undergo additional calibration before rating student performances.

Step 4—Formative-Summative Balance. At all tiers, assessment instruments should be deployed formatively before summative use. SJT and DCT should be administered at least once formatively before contributing to summative records. ORP should be used formatively in at least two practice sessions before summative deployment.

Step 5—Capacity Development Planning. Institutions should establish a three-to-five-year capacity development plan specifying: target tier for Year 3 and Year 5 of implementation; resource investments required for tier advancement; and external support needs (assessor training, standardized patient recruitment, equipment acquisition). Institutions are encouraged to adopt the highest feasible tier and plan iterative progression toward full MMAB deployment.

Appendix D

Tiered Implementation Specifications for the MedSPC Multi-Method Assessment Battery

Note. SJT = Sociopragmatic Judgment Task; DCT = Written Discourse Completion Task; ORP = Oral Role-Play Assessment; SPA = Standardized Patient Assessment. C1 = Sociopragmatic Knowledge; C2 = Discourse Organizational Competence; C3 = Interactional Role Competence; C4 = Face Management Competence; C5 = Pragmatic Adaptability.

	Tier 1—Full MMAB	Tier 2—Core MMAB	Tier 3—Essential MMAB
Instruments	SJT + DCT + ORP + SPA	SJT + DCT + ORP	SJT + DCT
Primary evidence	C1–C5 (all components)	C1–C4	C1–C2
Secondary evidence	—	C5 (via ORP unscripted segments)	C3–C4 (written level only)
Unassessed	—	—	C5 (Pragmatic Adaptability)
Minimum assessors	2 trained + SP pool (≥ 4 SPs/cohort)	2 trained faculty; audio/video recording required	1 trained rater; written format only
Contact hrs/year (Yrs 1–3)	20–30	15–20	10–15
High-stakes decisions	✓ Supported	⚠ With caution; supplement with faculty observation	✗ Not recommended; formative/diagnostic use only
Key caution	Highest resource demand; SP recruitment and training required	Face management dimensions visible only to the interlocutor (patient-perceived rapport) not captured without SPA	No valid performative claims for any component; insufficient for clinical readiness certification
Recommended deployment	High-stakes summative at clinical transition points (rotation entry; pre-graduation certification)	Summative ORP from Year 3; formative SJT/DCT in Years 1–2	Formative diagnostic only; introduce SJT/DCT from Year 1; plan tier advancement

Note. Institutions should select the highest feasible tier and plan capacity development iteratively. Tier 1 provides the fullest construct coverage and ecological validity; Tier 2 preserves coverage for C1–C4 with strong primary evidence; Tier 3 is restricted to formative diagnostic use only and is insufficient for high-stakes clinical readiness decisions.

Author Biography



Gulnoza Salimova is an independent researcher and Methodist at the Department of Youth Affairs, Spirituality, and Enlightenment, Abu Ali ibn Sino Bukhara State Medical Institute, Bukhara, Uzbekistan. Her research focuses on sociopragmatic competence development in Uzbek-medium medical education, with emphasis on integrative instructional frameworks combining Language for Specific Purposes, Content and Language Integrated Learning, Intercultural Communicative Competence, and Genre Pedagogy. Her broader interests lie at the intersection of instructed pragmatics, medical communication, and professional language education in post-Soviet Central Asian contexts. She aims to develop empirically validated sociopragmatic training programmes for Uzbek-medium medical education upon completing her PhD.
