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ЯРОСЛАВСКОГО ГОСУДАРСТВЕННОГО МЕДИЦИНСКОГО УНИВЕРСИТЕТА
И РОССИЙСКОГО НАЦИОНАЛЬНОГО ИССЛЕДОВАТЕЛЬСКОГО МЕДИЦИНСКОГО
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АДРЕС РЕДАКЦИИ ул. Островитянова, д. 1, г. Москва, 117997

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адрес: ул. Островитянова, д.1, г. Москва, 117997, Россия, 8(495)434-03-29

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LANGUAGE TRAINING AS A MEANS OF DEVELOPING COMMUNICATIVE COMPETENCY IN MEDICAL STUDENTS

Krotova MA ✉

Yaroslavl State Medical University, Yaroslavl, Russia

As the demands for professional doctor-patient communication are growing, communicative competency of a physician has acquired particular importance. This article explores this competency as a key objective in foreign language training for medical school students. Learning Latin in medical schools is traditionally associated with mastering anatomical, clinical, and pharmaceutical terminology. At the same time, the discipline is not used to the fullest extent though it allows to develop the communicative culture of future doctors and helps them interact effectively and ethically with patients. Teachers must explicitly convey to students that studying Latin (as well as any other foreign language) ultimately aims to build communicative competency. It is a universal professional trait that fosters professional growth and personal development due to the successful mastery of specialized disciplines.

Keywords: the Latin language, medical terminology, communicative competency, medical ethics, professional communication, language learning

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✉ **Correspondence should be addressed:** Marina A Krotova
Revolutionary Street, bld. 5, Yaroslavl, 150000, Russia; krotova-marina@mail.ru

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ЯЗЫКОВОЕ ОБУЧЕНИЕ КАК СРЕДСТВО ФОРМИРОВАНИЯ КОММУНИКАТИВНОЙ КОМПЕТЕНТНОСТИ СТУДЕНТОВ-МЕДИКОВ

М. А. Кротова ✉

Ярославский государственный медицинский университет, Ярославль, Россия

В условиях повышения требований к профессиональной коммуникации врача и пациента особую значимость приобретает его (врача) коммуникативная компетентность, которая в настоящей статье рассматривается как актуальная цель языкового обучения студентов медицинского вуза. Изучение латинского языка в медицинском вузе традиционно соотносится с освоением анатомической, клинической и фармацевтической терминологии, в то же время его потенциал для формирования коммуникативной культуры будущих врачей, позволяющей эффективно, в соответствии с этическими принципами, взаимодействовать с пациентом, остается недостаточно реализованным. Необходимо эксплицировать для студентов, что изучение дисциплины «Латинский язык» (а также иностранных языков и языковое обучение в целом) в итоге направлено на формирование коммуникативной компетентности как универсального качества специалиста, обеспечивающего становление профессиональной идентичности (благодаря успешному освоению профессиональных дисциплин) и личностное развитие.

Ключевые слова: латинский язык, медицинская терминология, коммуникативная компетентность, медицинская этика, профессиональная коммуникация, языковое обучение

Вклад автора: М. А. Кротова — анализ и синтез литературы по теме, обобщение педагогического опыта, подготовка текста статьи.

✉ **Для корреспонденции:** Марина Александровна Кротова
ул. Революционная, д. 5, г. Ярославль, 150000, Россия; krotova-marina@mail.ru

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Today, future physicians need to acquire both clinical competence and essential communication skills during medical training. *Communicative competency* shows how effectively a doctor communicates with a patient, establishing the trust and sense of security that can ultimately impact treatment outcomes.

Terminological literacy, which is based on knowledge of Latin medical terminology, is undeniably a vital and ethically significant part of professional training. In turn, language learning, and specifically the mastery of Latin, is essential for developing communicative competency. Thus, a Latin teacher in a medical school does not only transmit linguistic knowledge, but also acts as an *ethical mediator*. With the help of the mediator, students can be aware of their potential and use it for their communicative, cultural and professional development.

APPROACHES TO DEFINING COMMUNICATIVE COMPETENCY

Communicative competency, which is one of the key elements of the outcome-based approach, can be treated as the ability to communicate effectively through the skill of understanding the interlocutor, expressing own thoughts clearly, selecting proper language means and changing own behavior while taking into account the situation and social standards.

Researchers suggest that communicative competence is a set of communicative, digital, cross-cultural, linguistic, discursive, pragmatic, strategic, socio-cultural and other competencies. In their article, Yatsenko VV and Naidis IO review various approaches to how communicative competency

(competence) should be defined and explore the components [1]. It should be noted that communicative *competence* is frequently taken as a *system* of knowledge and abilities, whereas communicative *competency* is true *ability to use* the knowledge and skills, as well as their practical use in a certain activity. In medical discourse, communicative competency relies on the principles of ethics and requires to be tactful, delicate and empathic while discussing tabooed and disturbing topics with a patient (serious diagnosis, certain procedures related to the intimate sphere, etc.) [2, 3]. Medical terms (*hyperhidrosis*, *transvaginal*, *helminthiasis*, *decapitation*, etc.) can relieve emotional tension and make the conversation neutral. Use of *euphemisms* (avoidance of those words and expressions that, according to the speaker's opinion, are undesirable, fail to correspond to the purpose of communication, and can result in a communicative failure) can eliminate communicative discomfort. Thus, discussions involving the semantic categories of racial, ethnic, or age-based discrimination, particularly when related to low social status, as well as terms concerning physical or mental disabilities, severe or sensitive illnesses, and their clinical management, must be expressed in a manner that is mutually acceptable to the participants [2]. Successful use of euphemisms requires a speaker who understands the topic and the situation and shows communicative competency because the speaker "should be capable and willing to make own speech softer" [4].

The basis of any competence is formed by knowledge and skills of their practical use combined with certain personal qualities, moral and ethical settings, and the ability to interact and collaborate while taking certain decisions. Communicative competence can be taken as the leading one because it promotes development of many other competences (for instance, helps a physician to solve professional tasks through effective cooperation with patients and colleagues) [1].

The knowledge of foreign languages is essential for professional success under the conditions of globalization and intense international collaboration. Thus, *foreign communicative competency* can be taken as a complex personality feature. The feature is manifested through its ability to execute effective interpersonal and professional communication with foreigners due to the active use of a foreign language. Foreign communicative competency has a complex structure. It covers a wide range of competencies, which are necessary for effective communication in a foreign language. It should be underlined that it is necessary to communicate orally and in writing in professional and daily life, translate specific texts and, crucially, develop the skills of oral and writing speaking skills independently [5].

DEVELOPMENT OF COMMUNICATIVE COMPETENCY AS THE PRINCIPAL GOAL OF THE MODERN LANGUAGE EDUCATION

Enhancing educational standards remains a critical global concern today. Her decision stems from the modernization of educational content, the optimization of educational methods and technologies, and reinterpretation of its goals and outcomes [6].

It is essential to recognize that in this context, communication and social interactions serve as both the means for and the outcome of constructing social reality. The more educated people are, the better they understand the idea of communication and how to communicate. This involves a shift toward instrumental values (including quality, beliefs, or means that a person uses as tools to achieve main life goals, i.e., values and means) within the communicative competency [7].

There is no doubt that the primary goal of university education is the professional training of a qualified specialist. According to Chernyavsky MN, "the formation of a professional language is an essential factor in a doctor's training". In turn, the foundation of this language is medical Latin terminology, the mastery of which determines the development of their "professional linguistic culture" [8]. During the first lesson students are introduced to the foundational principle of medical ethics: *Noli nocere!* (Do no harm!). It also explores lesser-known Latin aphorisms, such as *In via est in medicina via sine lingua Latina* (The path in medicine is impassable without Latin) and *Non tam praeclare est scire Latine, quam turpe nescire* (It is not so much glorious to know Latin as it is shameful not to know it). After uncovering the meaning of these phrases, the lesson highlights why studying Latin is still crucial for well-educated individuals. It is stated that Latin served as the global language of science, philosophy, and medicine until the late 18th century, meaning that a lack of Latin proficiency has been for a long time viewed as a sign of ignorance and unprofessionalism both for doctors and lawyers. The Latin language is viewed as the universal language of medicine, which forms the basis of medical terminology. Latin aphorisms and catchphrases are an important part of cultural heritage.

Thus, when answering the question regarding the purpose of studying Latin during the first lessons, students note the connection between the language and "anatomy", "writing prescriptions", etc. Meanwhile, various factors such as academic workload and the difficulties of mastering a *new* discipline (unlike, for example, English or German), reduce academic motivation by the 3rd-4th lesson, causing first-year students to doubt the relevance of studying Latin.

Indeed, one of the main problems in education today is that the amount of knowledge is growing, but there isn't enough time to learn it all. Though teachers have to follow the regulatory document, they can be flexible while teaching. Then they will not only help future doctors understand the material, but will also develop their analytical and systemic thinking while enhancing motivation and ease of study. Undoubtedly, the most attractive forms of work used to motivate students and maintain their interest in the subject when *learning a foreign language* are role-playing and communicative games (simulating doctor-patient communication), and watching and subsequently analyzing film and TV series clips on relevant topics in the foreign language.

At the same time, as has been repeatedly noted, Latin language lessons at a medical university also have significant potential for developing communicative competency [9], which students need to be reminded of, emphasizing the importance not only of the result but also of the *process* of language learning. To maintain interest in learning and make students motivated while studying Latin, the following types of activities should be used:

Working with a textbook, specifically by *taking notes*, is a vital component of the learning process. Many students, however, may face difficulties when doing the task. That's why during the first lessons it's better to *work with the diagrams* offered by a teacher. The diagrams can guide you through the learning process. For example, the grammatical information about nouns takes up 13 pages in the textbook. Simultaneously, the students explore 1-page diagram that explains the new topic. At home the students are asked to read the relevant paragraphs, paying attention to the main points presented in the diagram. Moreover, utilizing diagrams enables teachers to minimize blackboard use while presenting high-quality visual data.

Participating in olympiads allows you to demonstrate/test your knowledge, *speaking at conferences* allows you to explore

topics not discussed in classes, showcase public speaking skills and your ability to interact with the audience, answer questions, create and submit presentations, etc.

Working with texts (“Gaudeamus,” “Hippocratic Oath”) can be carried out as part of preparing reports or abstracts for Student Scientific Society meetings.

The update of interdisciplinary and intradisciplinary connections (comprising anatomy, Russian, and English) plays a particularly vital role. For instance, the ability to see Latin stems in Russian words such as *manual* — *hand/manus*, *ruby*, *rubric* — *red/ruber*, or a more complex “procedure” which also requires the ability to find the stem in the genitive case: *captain*, *capitulation* — *head/caput*, *capitis*; *sanguine* — *blood/sanguis*, *sanguinis*, *generalissimo* — *kind/genus*, *generis*; seeing correlations with English: *simplex* — *simple*, *longus* — *long*, etc.

Integrating *gamification through information and communication technologies* complies with contemporary pedagogical trends. For instance, at the beginning of a lesson, you can use *mini-tests*, so-called *quizzes*, which include no more than 10 multiple-choice questions, for a frontal survey. The procedure is as follows: students use the QR code provided by the teacher and start the test. They have to answer 10 multiple-choice questions (during a limited amount of time). While answering each question, they see their current ranking,

and upon completing the test, they receive their final result. The test will allow not just to check the knowledge but also start a competition, thus, increasing motivation.

Utilizing “*individual achievement self-assessment forms*” [10] is highly valuable. Incorporating self-reflection and self-evaluation guides students into a “*state of conscious incompetency*,” which ultimately helps them take greater ownership of their academic progress.

CONCLUSION

The study of foreign languages, particularly the Latin language, is an important component of medical education. Medical Latin forms the basis of the professional language of physicians; mastering it ensures the conscious and competent application of medical terminology of Latin and Greek origin. Overall, language learning should be understood as one of the means of professional development for future physicians. It is crucial to recognize how much Latin contributes to building communication skills among medical students. This communicative competency is essential for interacting effectively with both patients and peers, ultimately allowing future doctors to successfully carry out their professional duties in clinical practice.

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ETHICAL AND LINGUODIDACTIC PRINCIPLES OF SELECTING LINGUISTIC CONTENT FOR FOREIGN LANGUAGE CLASSES AT A MEDICAL UNIVERSITY

Berngardt AV ✉

Yaroslavl State Medical University, Yaroslavl, Russia

The article reviews the ethical aspects of selecting educational resources to be used during foreign language lessons at a medical university under the conditions of digital transformation. Theory and practice are utilized to conclude that a teacher of a foreign language doesn't only translate linguistic knowledge, but also acts as an ethical mediator who determines the professional and communicative competence of future doctors. The principles of bioethics (autonomy, beneficence, non-maleficence and justice) are reviewed as the criteria for assessing the learning content, the significance of the intercultural approach and critical selection of authentic digital resources. A thematic plan and reflective practices that allow to include ethical issues into foreign language lessons with medical students and particular linguistic tasks are offered. It is concluded that the approach allows to develop linguistic skills, shape the professional identity and moral consciousness of medical students.

Keywords: technological mediation, bioethical principles, intercultural approach, reflection, professional and communication competence, media literacy

Author contribution: Berngardt AV — analysis and synthesis of related literature, analysis of the method that uses technological mediation at universities, preparation of the article.

✉ **Correspondence should be addressed:** Anetta V Berngardt
Revolutsionnaya St., 5, Yaroslavl, 150000, Russia; oxberngardt@mail.ru

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ЭТИЧЕСКИЕ И ЛИНГВОДИДАКТИЧЕСКИЕ ПРИНЦИПЫ ОТБОРА ЯЗЫКОВОГО МАТЕРИАЛА ДЛЯ ЗАНЯТИЙ ПО ИНОСТРАННОМУ ЯЗЫКУ В МЕДИЦИНСКОМ ВУЗЕ

А. В. Бернгардт ✉

Ярославский государственный медицинский университет, Ярославль, Россия

В статье рассматриваются этические аспекты отбора учебных материалов для занятий по иностранному языку в медицинском вузе в условиях цифровой трансформации образования. На основе теоретических положений и практического опыта делается вывод о том, что преподаватель иностранного языка выступает не просто транслятором лингвистических знаний, а этическим медиатором, формирующим профессионально-коммуникативную компетентность будущих врачей. Рассматриваются принципы биоэтики (автономия, благодеяние, не навреди, справедливость) как критерии оценки учебного материала, а также значимость межкультурного подхода и критического отбора аутентичных цифровых ресурсов. Предлагаются тематический план и рефлексивные практики, позволяющие интегрировать этическую проблематику в занятия по иностранному языку со студентами-медиками и конкретные языковые задания. Делается вывод, что такой подход способствует развитию языковых навыков, формированию профессиональной идентичности и морального сознания студентов-медиков.

Ключевые слова: технологическая медиация, биоэтические принципы, межкультурный подход, рефлексия, профессионально-коммуникативная компетенция, медиаграмотность

Вклад автора: А. В. Бернгардт — анализ и синтез литературы по теме, анализ методики применения технологической медиации в высшей школе, подготовка текста статьи.

✉ **Для корреспонденции:** Бернгардт Анетта Валерьевна
ул. Революционная, д. 5, г. Ярославль, 150000, Россия; oxberngardt@mail.ru

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Modern medical education is going through profound digital transformation, where technologies are turning from mere tools to active intermediaries (mediators) between teachers, students and professional knowledge [1]. Foreign language teachers at medical universities play a critical role in this process. They are responsible for developing not only linguistic skills, but also the professional and communicative competencies required to analyze foreign literature, participate in international clinical trials, and communicate ethically with patients and colleagues. The digital transformation of a higher school teacher is a complex and contradictory process that

raises numerous ethical concerns and requires careful analysis and consideration [2].

The key role of a teacher of a foreign language at a medical university of today goes far beyond the traditional language education. Such a teacher acts as a mediator [3]. On the one hand, they decode a complex linguistic code of medical discourse consisting of terminology, grammar constructions and clinical cliches. On the other hand, they acquaint medical students with those values that constitute the essence of this profession. Learning medical discourse in a foreign language is not just about mastering vocabulary. It also forms the

foundation of a professional culture that determines the attitude of healthcare providers to the life and health of patients.

An ethical problem of selecting linguistic material arises right at the junction of these two tasks. Any text, dialogue or any other content used during a foreign language lesson has a hidden ethical meaning. A teacher who works with future doctors can't take a neutral position. An ethical component, if ignored, distorts the idea of a profession when a language exists separately from ethics. Thus, only a conscious approach to the selection of content allows you to use professional reflection during every lesson. Development of media communications requires use of ethical standards for all participants of an educational process at a medical university. The international medical educational space where foreign languages are taught under conditions of digitalization has certain requirements for the form and contents of education. Technological mediation, thus, becomes particularly pressing [2].

COMPLIANCE OF THE EDUCATIONAL CONTENT WITH THE BASIC PROFESSIONAL VALUES OF THE MEDICAL FIELD

Most foreign language textbooks for medical students deal with texts, when symptoms and diagnoses are translated with the help of medical vocabulary. The texts fail to reflect the main four principles of bioethics such as autonomy, beneficence, non-maleficence and justice formulated by Thomas Beecham and James F. Childress neither in implicit, nor in explicit ways [4].

The ethical principle of a patient's autonomy can be easily incorporated within the linguistic content, when a doctor doesn't just order a patient using the imperative but also lets the patient choose whether the assigned treatment plan should be followed or not ("You may consider...", "Another option would be..."). The doctor can use the phrases instead of such a strict imperative structure as "I prescribe you the treatment...". This approach not only introduces diverse foreign vocabulary and grammar but also transforms the core meaning of the communication.

Dealing with the informed consent forms is an alternate side of the autonomy principle during the foreign language lessons. The forms are available on sites of international clinics. The linguistic content allows to see the close interrelation between the medical and legal issues. Medical students can find and analyze the modal structures used to describe risks or rights of a patient to refuse from treatment.

Any foreign text describing a clinical case and treatment strategies can illustrate the principle of beneficence if the medical facts are not only described but also urge medical students to speculate if a doctor who offers similar treatment methods acts with the greatest benefit for the patient. Supporting the position, the student inevitably makes a conscious decision related to the choice of words, modal verbs, and subjunctive mood to reflect the ethical assessment.

The non-maleficence principle, which can be implemented in the language practice through analysis of texts about iatrogenic complications, medical mistakes and their reporting to the patient, is of no less importance. The content must not only name the mistake, but also use the language that makes the case less traumatic for a patient and recognizes the patient's right to know the truth.

For instance, when direct structures ("We damaged the nerve.") are compared with more sensitive structures ("The procedure resulted in an unexpected neural response."), the students comprehend that every word in the language is of an ethical value. The documents of practical medicine, including informed consent forms, confidentiality forms, and protocols of

ethical committees are written in the language, which reminds of the language used in legal documents. The content is ideal for examining medical translation tricks and understanding how the legal doctor-patient relations are executed using the language means.

The principle of justice in distribution of resources is of particular interest now, when the issues of donating organs, fair distribution of expensive medicines and access to costly treatment are actively discussed. Texts on this topic (for instance, how medicines are distributed during the pandemics) allow students to learn words, and provide for arguments against discrimination based on social grounds.

EMPHASIZING THE INTERCULTURAL APPROACH

Medicine has become globally available long time ago. Doctors have practice in different countries where they go for working purposes, patients look for treatment abroad, and clinical research is carried out at international centers.

Globalization, however, does not mean unification of ethical and communication standards. The intercultural approach here is not determined methodically, but becomes an ethical necessity.

In different countries, a doctor's speech can be different even within the same language [5]. This is what a foreign language teacher needs to explain to medical students. An analysis of the communicative strategies used by physicians from the USA highlights their directness when informing patients about their medical status. This approach stems from a healthcare tradition in the United States that upholds a patient's right to receive a complete, unfiltered diagnosis without the use of euphemisms. This can be compared to eastern cultures, where family members are informed of the real situation, while the patient doesn't know the truth, which helps to ensure psychological comfort.

If the cultural differences are ignored, the student may have an opinion regarding the universality of ethical standards in doctor-patient communication. The knowledge is essential both globally and in Russia, when the number of migrants from Asia keeps growing. When patients are informed of their condition directly, they can be shocked. The ability to communicate with various patients shows their respect for cultures and traditions. Thus, educational content should include authentic texts and dialogues displaying cultural differences. Knowledge of the data allows to be ethically sensitive, providing for a better understanding of patients from diverse cultural backgrounds.

ETHICAL PRINCIPLES OF TECHNOLOGICAL MEDIATION WHILE CHOOSING AND USING AUTHENTIC CONTENT

The expansion of the Internet and total digitalization have provided medical university language teachers with virtually boundless access to authentic content for classroom integration. The variety, however, can have hidden ethical risks. When teachers act as technological mediators to guide interaction among students, content, and themselves through digital tools [2], they need more than basic tech skills. They must also possess the ethical discernment necessary to assess the content of vocabulary.

Acting as an ethical mediator, a medical university teacher is responsible not only for selecting language content for foreign language courses but also for verifying its reliability and representativeness. Consequently, teachers must be familiar with the World Medical Association's Code of Medical Ethics and the Declaration of Geneva, as these documents provide verified ethical vocabulary and outline moral duties of

Table. The course “Foreign Language” in a medical university. Approximate subject plan

The module	Ethical focus	Language tasks
Informed consent	Autonomy, voluntarism	Form filling, making dialogues with alternatives, examination of modalities (must, may, should)
Palliative care	Beneficence, non-maleficence, respect for dignity	Analyzing the articles related to hospice, writing an essay entitled ‘What is death with dignity?’, a role-play with relatives
Medical confidentiality	Confidentiality	Discussion about the scope of medical confidentiality, analysis of legal texts devoted to medical issues
Intercultural communication	Justice, respect for diversity	Comparison of communication protocols, practicing communication phrasing for interacting with culturally diverse populations
Distribution of resources	Justice	Debates concerning triage, social responsibility phrasing, dealing with letters to ethical committees

a physician [6]. These primary sources can also be used as reference materials in a foreign language lesson.

Furthermore, it is essential to direct students toward current clinical texts sourced from prestigious medical journals, including *The New England Journal of Medicine*, *The Lancet*, and *BMJ* [7]. Within the “Clinical Cases” and “Ethical Dilemmas” sections, the authors go beyond merely describing the treatment to reflect on the moral implications of the decisions made. Medical literature is characterized by a high frequency of passive constructions, which are typical of scientific discourse. By analyzing these constructions with students, teachers can conduct linguistic work while simultaneously demonstrating how such structures help authors depersonalize and distance themselves from expressing direct opinions on a particular issue.

Medical television series resonate strongly with medical students. The most famous television series favored by medical students of today are *House, MD*, *The Good Doctor*, and *Grey’s Anatomy*. Naturally, the behavior of characters in these television series should not be viewed as exemplary; it rather serves exclusively as a catalyst for subsequent ethical analysis [8]. Episodes that demonstrate a violation of ethical principles in medical practice should be analyzed and commented on, accompanied by a language task aimed at correcting the dialogues. Only under these conditions will authentic content serve as an effective foundation for ethical reflection.

Consequently, ethical engagement with foreign medical sources relies on the foundational principles of reliability, legality, and cultural tolerance [2].

Teachers must not only possess the ability to verify sources but also cultivate students’ critical evaluation skills; this involves teaching proper citation practices, securing necessary permissions (e.g., for reproducing clinical imagery), and preventing plagiarism.

PRACTICAL IMPLEMENTATION

It’s important to understand the ethical aspects of working with foreign-language sources in medical university language courses. This theoretical understanding should be complemented with appropriate methodological resources. One highly effective strategy is to develop a thematic plan that links each section of the course to a particular ethical issue. The plan can be developed based on the established stages of technological mediation. These progress from reproductive (simply following rules) and productive (intentionally applying ethical standards) to creative (developing ethically focused scenarios and providing mentorship) [1, 3].

Having analyzed the basic ethical problems and aligned them with the topics covered in the foreign language curriculum

for a medical student, an approximate thematic plan can be composed (Tab.).

Every module contains an ethical problem. It is better to start with an authentic text. During post-reading activities, students go through vocabulary and grammar to complete education with a final role-play or classroom debate.

Every lesson should incorporate reflective components, utilizing either group oral discussions or individual written assignments. The reflective questions can range from ‘What ethical challenges seemed the most challenging to you?’ to ‘Do you have any stereotypes that influence the attitude to an ethical problem?’. Reflection helps not only to repeat the vocabulary or use the grammar constructions being studied but also enables students to formulate their own positions, accept or not accept ethical standards and values, and broaden their cultural and medical horizons.

The teacher can increase task complexity in accordance with the established levels of technological mediation [1]. At the reproductive stage, teachers merely select predefined classroom activities. At the production stage, teachers analyze the ethical load of the content and independently create assignments. The creative level requires the teacher to develop a lesson plan with an emphasis on ethical issues. This approach is essential for implementing both the linguistic and ethical competencies of a medical student learning a foreign language.

CONCLUSION

Choosing linguistic content that incorporate medical ethics matches the current state of society, when empathy, compassion for patients, and respect for their rights are considered essential qualities for any doctor.

Through the careful selection of linguistic content, medical university professors enable students to look beyond grammar and vocabulary, using the foreign language as a tool to comprehend core moral and ethical values. Using a unified textbook is good for the teacher, but not for the student. Ethically focused medical texts, role-playing activities, and authentic intercultural content successfully shape not only the language proficiency of medical students but also their professional identity. The ethical dimension of technological mediation is inherently linked to the educational process and is grounded in both competence-based and contextual approaches [3]. All of these factors necessitate adjustments to training programs for foreign language teachers, the development of modern, authentic, and ethically verified linguistic content for medical universities, and the establishment of interdisciplinary connections with the departments of bioethics and medical psychology.

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TEACHING A FOREIGN LANGUAGE AND SOFT SKILLS AT A MEDICAL UNIVERSITY: MOVING FROM VOCABULARY TO LIVE CONVERSATION

Kuznetsova EB ✉

Yaroslavl State Medical University, Yaroslavl, Russia

This article explores how learning a foreign language helps medical students develop soft skills. The author proves it is necessary to move beyond rote vocabulary learning and shows that a foreign language creates a distant environment for developing empathy, tact and the ability to conduct a delicate professional dialogue. The article examines three useful activity types: ethical dilemma case studies, role-play activities, and debates. A system for their integration into the educational process is proposed, and the teacher's role as a guide for ethical communication is discussed. The text emphasizes how the professional identity of a doctor grows through technical mediation skills and careful self-reflection on their daily clinical practice.

Keywords: soft skills, medical education, foreign language, empathy, ethical dilemmas, case method, role-playing, debates, technological mediation, professional communication

✉ **Correspondence should be addressed:** Ekaterina B Kuznetsova
Revolutsionnaya St., 5, Yaroslavl, 150000, Russia; kuropatka@mail.ru

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ЯЗЫКОВАЯ ПОДГОТОВКА И SOFT SKILLS В МЕДИЦИНСКОМ ВУЗЕ: ОТ ТЕРМИНОВ К ЖИВОМУ ДИАЛОГУ

Е. Б. Кузнецова ✉

Ярославский государственный медицинский университет, Ярославль, Россия

Статья посвящена проблеме формирования мягких навыков (*soft skills*) у студентов-медиков в процессе обучения иностранному языку. Автор обосновывает необходимость выхода за рамки традиционной терминологической подготовки и показывает, что иностранный язык как дистанцирующая среда создает уникальные возможности для развития эмпатии, тактичности и умения вести деликатный профессиональный диалог. В работе детально анализируются три эффективных формата работы: разбор кейсов с этическими дилеммами, ролевые игры и дебаты. Предлагается система их интеграции в учебный процесс, а также обсуждается роль преподавателя как фасилитатора этически ответственной коммуникации. Особое внимание уделяется связи с компетентностью технологической медиации и необходимостью рефлексивной практики для становления профессиональной идентичности врача.

Ключевые слова: мягкие навыки, медицинское образование, иностранный язык, эмпатия, этические дилеммы, кейс-метод, ролевые игры, дебаты, технологическая медиация, профессиональная коммуникация

✉ **Для корреспонденции:** Екатерина Борисовна Кузнецова
ул. Революционная, д. 5, г. Ярославль, 150000, Россия; kuropatka@mail.ru

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For decades, teaching a foreign language in medical universities has been based on three pillars such as terminology, reading annotations, and written translation of protocols. The student focused on memorizing diseases, treatments, and procedures, as well as distinguishing *hypertension* from *hypotension*, and believed that it was sufficient. Historically, doctors mostly communicated through written texts; they rarely attended conferences, and treating patients from other countries was quite unusual. Today, the situation is totally different. Medical university graduates can work in international clinics, join worldwide research teams, and treat patients from all over the world. In this context, even the most expansive vocabulary proves entirely insufficient.

Recent studies have clearly proven this. Even if a doctor is fluent in medical terms, they often struggle with simple things, like expressing sympathy, communicating unfavorable diagnoses, or easing anxiety during interactions with aggressive

individuals. Without these *soft skills* [1], even perfect medical English remains practically useless. The doctor speaks fluently, but nobody listens, because no real empathy is seen.

Here comes the paradox. It turns out that mastering a foreign language like English is actually an excellent precondition for developing *soft skills*. When speaking a non-native language, students have to weigh every word, control their intonation, and closely monitor their interlocutor's reaction. This state of heightened awareness serves as an ideal training ground for developing empathic communication skills [2]. Moreover, foreign language classes offer a safe space to simulate stressful professional scenarios without actual consequences, allowing students to practice emotion management. According to some data, the practice helps reduce the risk of professional burnout even before the student crosses the threshold of the clinic [2].

The ethical constituent of technological mediation represented by the meaningful use of digital tools should

permeate the entire system of teaching a foreign language at a medical university [3]. However, let's focus on the practical aspects: how three specific methods such as case studies, role-play activities, and debates can turn a regular language lesson into a masterclass in professional communication, teaching students to act not merely as translators, but as real doctors who speak a foreign language with genuine empathy.

CASES WITH ETHICAL DILEMMAS: WHEN WORDS FUNCTION AS DIRECT ACTIONS

In medical education, the case method is not a new idea. It is used across clinical departments to practice diagnostic skills and treatment strategies. The tool, however, functions differently in a language learning class. At this point, the case is no longer just a test of protocols. It turns into a moral dilemma where every word in English matters deeply.

Here is a real-life example. Students review the medical history of a dying cancer patient in English. The patient decides to discontinue treatment and enter a hospice. Relatives insist on continuing the fight for survival and seek a medical consultation. The doctor must choose a position and decide how to talk to the patient. The problem has to be solved without using their native tongue.

At first glance, it may seem like a total cliché: *"I hear you," "I understand your decision,"* and *"Let's discuss what matters most to you"*. But experience proves that a single phrase is not enough. Students quickly realize that they need to find words that take into account the patient's wishes and avoid hurting the feelings of family members. How to object politely? How to offer an alternative without pressure?

In this case, we come across an important observation, which is confirmed by colleagues from other Universities [4]: students often perceive empathy in communication as a "ritual", as if all what they need is uttering a standard phrase. Real empathy, however, is not just about words. That is why our case studies are aimed at not just memorizing remarks, but at analyzing the situation from different angles, testing various approaches, and discussing how words can either hurt or heal.

An "Ethical audit" is one of the favorite methods of students [3]. When the method is used, several online articles are selected in advance. They contain deliberate ethical violations such as missing references, clinical photos used without patient consent, or links to ads instead of serious sources. The group tries to find all inaccuracies and suggest a corrected option. The task does not only improve cognitive skills but also develops professional integrity, the ability to critically verify information and distinguish true data from untrue ones. In the context of digitalization, this is of particular relevance.

The peer-review method is widely used in the educational process. Students are provided with a brief text in English and a list of ethical criteria to decide whether it should be published [3]. This task is challenging, as students must consider conflicts of interest, statistical accuracy, and respect for subjects' rights. Analyzing such cases goes beyond merely learning vocabulary. It involves the issues of professional responsibilities and how written words can shape medical practice.

Moreover, it has been established that case studies are more effective beyond in-class learning. Thus, students should keep a log of their ethical dilemmas, recording situations with ambiguous data or moments of discomfort encountered while reading [3]. This practice enables transformation of external knowledge into internal belief, which is more valuable than pure memorization of terms.

ROLE-PLAYING: NOT JUST A GAME BUT A CHANCE TO TRY A NEW PROFESSION

Unlike the case method aimed primarily at the cognitive educational component, role-playing games activate the emotional and sensory sphere of the student. The student happens to be involved in the dynamics of a real professional interaction while turning from an external observer to a direct participant whether it is a doctor, a patient, a relative or a nurse. In such scenarios, students experience tangible physical and mental reactions — tachycardia when delivering a diagnosis, difficulty speaking when answering tough questions, or unease when facing criticism from colleagues. Crucially, all these reactions occur while communicating in a foreign language, which significantly heightens both cognitive and emotional stress.

How does it work? In a role play, a language is not abstract any longer. It becomes a tool, a shield, a bridge, and a medicine. It all depends on the situation. The students forget about cases and tenses. They only think about how to sound softer, not to offend a patient, help him understand the most important issues without suppressing him. During these intense times, when feelings are strong and words are hard to find, a true shift happens. The language becomes tangible, visceral, and alive.

We have tried many different approaches in our work. They included an informed consent, talking to relatives next to the resuscitation ward, and interdisciplinary consultation (or a multidisciplinary team meeting) where a therapist, a surgeon and an oncologist argue about the treatment strategy. According to the research of colleagues [4], attempts to solve difficult tasks are highly effective for the development of their skills. Meanwhile, it is essential not just to perform a task but also to provide qualitative feedback. Apart from the traditional analysis of language-related mistakes, it is critically important to review such ethical aspects as being polite and kind during a conflict, and listening attentively to what the other person says. Providing such feedback requires sensitivity and honesty.

According to the research results, Russian researchers often note that patients can lose their personal identity, which makes it important to study what helps doctors and patients interact well [5]. The researchers point out three types of empathy. They include cognitive (when you know how another person feels), emotional (when you share their feelings) and behavioral (when you help) [5]. Role playing allows to train all the three levels at the same time, as the student should understand the situation and respond adequately in a foreign language.

Role-playing games help people develop empathy very well. This is true when you repeat the stories many times with new partners and get advice from multiple teachers [6]. When the lessons can not be included into the educational process on a regular basis, even a limited number of qualitatively conducted role-play games can ensure significant results.

Regarding technology, people remain skeptical about AI chatbots replacing real human interaction [7], even though some research explores using them to practice dialogue. Empathy is a unique human quality that is developed while interacting with a real person only. Thus, traditional role games are preferable.

DEBATES: LEARN TO ARGUE IN ORDER TO NEGOTIATE

The debate is our third educational format. Students use English in a structured argument. They defend opposing positions, supporting their own views while refuting their opponent's arguments. It is a focused exercise in developing

critical thinking and persuasion skills. Though it may seem that debates are inconsistent with the image of a diplomatic physician, they are essential. Medical practice contains numerous examples without the only true solution. They include the issues of life prolongation at any cost or its quality, ethics of distributing deficient resources, truth and compassion while reporting the diagnosis. In this case, at least two reasonable points of view always exist.

Debates help future doctors build their own views. They teach students to back up those views with logic, listen to others attentively, and respect opposing points without making personal remarks. Speaking a non-native language makes this much harder. You must pronounce medical words right, build complex sentences, and use soft phrases like “*one might argue*”, “*while it is true that...*”, and “*nevertheless*” to sound less harsh. You also need to refer to ethics and study results.

We carefully select our topics for debate, such as whether euthanasia respects freedom or breaks the rule to do no good, if a doctor may hide bad news from a psychologically unstable patient, and how to share donor organs fairly. In these debates, cultural, religious, and professional views inevitably lead to strong arguments. Debating in a foreign language helps students remain composed. They must choose words with care. This reduces strong emotions and keeps the conversation organized. In the process, a teacher acts not as a judge, but as a supporter who guides the discussion, helps formulate the thoughts and asks clarifying questions.

At the end of the discussions, we often ask students to write an essay, but with an unusual condition: they need not to defend their own point of view, but to argue for the opponent's position instead. This approach works best to grow empathy. Seeking strong points for a new view helps us understand why people act differently. This builds true professional tolerance.

HOW CAN THE FORMATS BE UNITED WITHIN A SINGLE MEANINGFUL SYSTEM?

Each of the three educational formats helps achieve specific goals. To reach the highest level of efficiency, they must be linked together in a step-by-step logical chain. We use a spiral approach. First, we study real cases to learn the topic, master key terms, and grasp the core ideas of ethical problems. This is followed by *role-playing games*. These games let people use their new knowledge in real, highly charged situations. The final stage is represented by *debates*. They help students

develop abstract thinking, prove their points of view and fight off critics.

The complexity of tasks scales with the students' year of study. First- and second-year students study simple cases with clear ethical standards to master standard expressions. Graduate students deal with complex challenges with unclear answers that take into consideration legal rules and cultural traditions.

As it was mentioned in the previous article [8], building skills in technological mediation helps people grow deeper critical thinking abilities. The described formats allow to achieve this exact outcome.

CONCLUSION

The traditional model of memorizing and translating words no longer works. It produced text experts who feel unprepared for live social contact. Medicine is, however, mostly about talking, sharing ideas, and meeting people.

Soft skills like empathy, tact, and active listening are no longer just nice extras for your resume. They are now a core part of being a true professional. It may sound strange that a foreign language is an excellent practice tool for that. It forces you to be conscious, reflective, and attentive to the word.

We have presented three practical models. The cases sharpen the mind, role-playing engages the emotions, and debates build the skill of conversation. Individually, these tools are helpful. Combined, they build a space where students learn to talk like real doctors. Now they do it with a professional skill, the right mindset, and deep responsibility.

To make it work, the teacher has to play another role. They are no longer transmitters of knowledge, but facilitators, creators of a safe space where you can make mistakes, reflect, and try. The ethical component of previously mentioned technological mediation [3] should go through all stages of work, from setting the task to the final reflection. When a teacher embraces this approach, students gain more than a language certificate. They gain a genuine ability to build trusting relationships with patients and coworkers across the globe.

There is still a lot of work ahead, including empirical testing, clear standards for judgment, and research into how advanced tools like neural networks impact mediation ethics [9]. But one can start right now by asking: What more can I teach my class today besides English? We believe the answer determines if the graduate can use the language as a working tool only or turn it into a core part of their professional motto.

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PRINCIPLES OF ETHICAL REGULATION OF KNOWLEDGE CONTROL WHILE TEACHING THE LATIN LANGUAGE TO MEDICAL STUDENTS

Illarionova IN ✉

Yaroslavl State Medical University, Yaroslavl, Russia

This article reviews the core ethical rules for assessing knowledge of students during Latin language classes in medical universities. The text analyzes the survey results of first-year medical students. Even though most survey participants think Latin is important for medical studies, not all students are ready for their homework to be assessed during every class. The author presents the opinions of students about in-class testing and their attitude to homework. The article also describes the ethical issues that arise during tests, such as academic cheating, and the difficulties associated with their elimination. Essential forms and functions of control are found out. The basic requirements for control organization are presented. It is emphasized that tests must be unbiased and done on a regular schedule.

Keywords: ethical principles of control organization, control of knowledge and skills, requirements for conducting control, ethical issues of conducting control works

✉ **Correspondence should be addressed:** Iina N Illarionova
Revolutsionnaya St., 5, Yaroslavl, 150000, Russia; irina.illarionova@list.ru

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ПРИНЦИПЫ ЭТИЧЕСКОЙ РЕГЛАМЕНТАЦИИ КОНТРОЛЯ ПРИ ОБУЧЕНИИ ЛАТИНСКОМУ ЯЗЫКУ СТУДЕНТОВ-МЕДИКОВ

И. Н. Илларионова ✉

Ярославский государственный медицинский университет, Ярославль, Россия

В статье раскрываются основные этические принципы организации контрольных мероприятий на занятиях по латинскому языку в системе высшего медицинского образования. Приводится анализ данных, полученных в ходе анкетирования студентов-первокурсников медицинского университета. Несмотря на то что большинство участников опроса считают курс латинского языка важным для изучения медицины, далеко не все обучающиеся готовы к контролю подготовленных заданий на каждом занятии. Автор приводит мнения студентов о предлагаемых на занятиях формах контроля, об отношении к домашним заданиям. В статье также описываются этические проблемы, возникающие при проведении контрольных работ, например, академическое мошенничество, и трудности, связанные с их устранением. Выделены важные формы и функции контроля. Приведены основные требования, предъявляемые к организации контроля. Подчеркивается важность объективности и регулярности проведения контрольных работ.

Ключевые слова: этические принципы организации контроля, контроль знаний и навыков, требования к проведению контроля, этические проблемы проведения контрольных работ

✉ **Для корреспонденции:** Ирина Николаевна Илларионова
ул. Революционная, д. 5, г. Ярославль, 150000, Россия; irina.illarionova@list.ru

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One of the main missions of Yaroslavl State Medical University (the University's Mission) is to "provide modern high-quality medical, pharmaceutical, psychological and social education ..." [1].

The Great Medical Encyclopedia states that "medical education is a training system for healthcare workers that covers general and specialized subjects and essential practical skills" [2].

Training (or educating) medical staff is the process of sharing and active learning new knowledge, skills, abilities, and cognitive methods [3]. Control of obtained knowledge, skills and abilities is a key part of education.

Internal regulations govern how Yaroslavl State Medical University organizes and carries out control activities. First, we follow the Regulation on the current control of progress and interim assessment of students. The document regulates the

requirements for planning, organizing, and managing ongoing control and all forms of interim assessment [4]. Second, we use the student performance rating system to measure academic success in university programs. The document is the basis for developing the performance rating method at the department [5], which, in turn, aims to provide for a differentiated gradual assessment of the Latin language learning progress objectively and on a regular basis.

The requirements for the organization of the educational process, defined by the Law of the Russian Federation "On Education" and local regulations, represent the formal principles of ethical regulation of the educational process. Their correct implementation by a teacher with strong ethical standards reflects its deep content, which is based on "... morality, ethics, moral culture of the teacher, moral activity, and the situation of making a moral decision" [6].

In modern teaching, control of knowledge, skills, and abilities shapes the organization of the educational process, on the one hand, and connects the obtained results with the set goals of education, on the other hand [3]. It is necessary to point out the specifics of the Latin language course, the purpose of which is to master medical terminology. Zimnyaya IA stresses that a language is said to be mastered successfully in "the union of three factors such as knowledge of language units and the rules of their combination, skills of using these units and ... the ability to use existing knowledge ... in a new situation" [7]. Latin language teachers focus on helping students acquire the phonetic, lexical, and grammatical knowledge, skills and abilities necessary to effectively master anatomical, clinical, and pharmaceutical terminology [8].

BASIC PRINCIPLES OF ETHICAL REGULATION OF CONTROL

During the study, the following tasks were solved:

- 1) analyzing the ethical basis of how to organize and conduct the current control of knowing medical terms during the Latin class;
- 2) finding out what students think about the research topic;
- 3) searching for ethical issues and deciding how to solve them. The researchers used a questionnaire for the study. One hundred first-year students from the medical, pediatric, and dental programs completed the survey. We asked the students about the importance of systematic control of skills and abilities, the use of various forms of control in practical classes, integration of a rating system for evaluating their academic achievements in learning Latin, their view on homework, etc.

The following qualitative and quantitative data were obtained while analyzing the responses.

Most students (82%) believe that the Latin course is important for future medical studies. 13% of students think Latin is not very important. Only 5% are not sure what to say.

Half of the students (50%) say that there is no need for tests every lesson. Meanwhile, 46% believe that it is necessary to systematically control skills and abilities during every lesson. 4% of students state they prefer to be tested during the exam only.

Written tests belong to the most popular routine control methods, favored by 61% of students. Written surveys are preferred by 42%, while 16% choose oral terminology reports. Additionally, 12% prefer presentations and abstracts, and 2% hold no preference.

Almost half of those surveyed (51%) believe that it is useful to integrate the rating system into the process of learning Latin. According to them, rating is essential for academic performance: "the rating disciplines and requires systematic training, which is necessary to obtain high-quality knowledge." 40% of students are "ready to study well in any environment," so the rating system does not really matter to them. 5% consider the rating "useless". 4% found it difficult to answer this question.

Students feel mixed about the requirement of a teacher to do homework for every class. 62% of students believe that "homework is essential as it allows to understand the subject better". 31% of students are ready for extra studies, but "are against strict rules". 5% treat home tasks as "extra work", while 2% of the students failed to answer the question.

For some students, Latin classes cause stress, particularly during their first semester. They feel anxious about tests, written quizzes, and exams because they have never studied the language before. Perhaps for this reason, or because they acted like that when they were at school, first-year students might ask direct questions about word forms or term translations during exams. They have to be convinced that a test is a possibility to check their knowledge. Thus, a teacher must not support them at this very moment. Teachers are ready to help them, answer their questions, and advise them on learning materials. However, it can never be done during the test.

Academic cheating is probably the essential ethical problem faced while exercising control during practical classes. We can't ask the students to hand in a smart phone or smart watch, look under the student's chair, approach the student or make a tactile contact. Facing the ethical dilemmas of today [6], it is necessary to act in a calm, tactful and professional way. We need to refer to the rules of performing tests which are accepted in the University, remind the students that independent work is required and offer them to write a new test or exam.

Thus, it can be concluded as follows:

1. Proper organization of Latin tests requires proper compliance with basic ethical principles, which include, first of all, strict adherence to federal and local regulations, as well as the methodology for rating academic achievements developed at the department. The basic provisions of the document are shown to students during the first lesson.
2. Keeping the focus on the practical use of Latin, a teacher uses various types of daily checks of skills and abilities such as written tests, written and oral surveys, and exams to develop terminological accuracy of students. Preparing reports and abstracts helps expand their knowledge and raises the cultural and learning level.
3. A teacher is ready to help students in overcoming the difficulties that arise while studying Latin and encourage their independence in completing tests. PF Kapterev, a famous Russian teacher and psychologist, stressed: "It is impossible to teach everyone without changing the method of teaching" [9]. Thus, we can use individual consultations to ensure an individual educational approach.
4. We try to solve the ethical problems arising during the tests patiently and tactfully without violating the comfortable academic atmosphere and without limiting the student's freedom.

CONCLUSION

Control is an important and responsible stage of the educational process. It requires multi-faceted educational and methodological support from the teacher. Organizing control activities in education demands objectivity, regular checks, and clear, precise tasks [10]. Another important requirement for the organization of control is its consistency. Only regular testing of student's progress across every section of the course will ensure strong Latin proficiency and terminological literacy of students.

Appropriately organized control exercises important checking, correcting, developing, educational, and methodological functions in education. Meanwhile, checking is the most important function that both determines the results of activities exercised by teachers and students and assesses the educational work of the entire educational institution, as well as the measures used to improve it [3].

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TEACHING THE RUSSIAN LANGUAGE TO INDIAN MEDICAL STUDENTS: ETHICAL CHALLENGES FACED BY A TEACHER OF RUSSIAN AS A FOREIGN LANGUAGE

Suryaninova JA ✉, Bergardt OV

Yaroslavl State Medical University, Yaroslavl, Russia

The article explores the ethical issues arising when teaching Russian as a Foreign Language (RFL) to medical students from India at Russian medical universities. The issues of intercultural communication, ethical training, medical ethics concepts for foreign medical students, and ethical challenges faced by a RFL teacher in a diverse classroom are reviewed. The role of language standards, language mediation, and associated moral and ethical challenges is shown. The ways to solve these ethical issues based on scientific literature and teaching practice at Yaroslavl State Medical University are suggested.

Keywords: Russian as a foreign language (RFL), medical education, students from India, professional ethics, deontology, intercultural communication, language mediation

Author contribution: Suryaninova JA, Bernhardt OV — analysis and synthesis of literature related to the topic, generalization of pedagogical experience, preparation of the text of the article.

✉ **Correspondence should be addressed:** Julia A Suryaninova
Revolutsionnaya Str., 5, Yaroslavl, 150000, Russia; julia.grisch@inbox.ru

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ОБУЧЕНИЕ РУССКОМУ ЯЗЫКУ СТУДЕНТОВ-МЕДИКОВ ИЗ ИНДИИ: ЭТИЧЕСКИЕ ДИЛЕММЫ ПРЕПОДАВАТЕЛЯ РКИ

Ю. А. Сурьянинова ✉, О. В. Бернгардт

Ярославский государственный медицинский университет, Ярославль, Россия

Статья посвящена анализу этических аспектов преподавания русского языка как иностранного (РКИ) студентам-медикам из Индии в российских медицинских вузах. Рассматриваются проблемы межкультурной коммуникации, деонтологического воспитания, формирования представлений о профессиональной этике будущих врачей у иностранных студентов, а также этические дилеммы, возникающие в деятельности преподавателя РКИ в поликультурной образовательной среде. Анализируется роль языкового стандарта, языкового посредничества и сопряженные с этим этические трудности. На основе анализа научной литературы и педагогической практики в рамках ЯГМУ предлагаются пути решения выявленных этических проблем.

Ключевые слова: русский язык как иностранный (РКИ), медицинское образование, студенты из Индии, профессиональная этика, деонтология, межкультурная коммуникация, языковое посредничество

Вклад авторов: Ю. А. Сурьянинова, О. В. Бернгардт — анализ и синтез литературы по теме, обобщение педагогического опыта, подготовка текста статьи.

✉ **Для корреспонденции:** Юлия Анатольевна Сурьянинова
ул. Революционная, д. 5, г. Ярославль, 150000, Россия; julia.grisch@inbox.ru

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Teaching foreign medical students at Russian universities plays a key role in international educational cooperation. According to media sources, India remains a major provider of medical students for Russian universities. This trend exists because being a doctor means holding high social status in India. Students from India study in several Russian universities such as Sechenov University, Orenburg State Medical University, Omsk State Medical University, Krasnoyarsk State Medical University named after Professor Voyno-Yasenetsky, Samara State Medical University and similar institutions that frequently provide training in English.

Students from India face many challenges in their education. These problems involve the language barrier and deep cultural differences, including the ones seen in the academic environment. Studies show that Indian students stay very close

to their home culture while they study. They struggle language interference and difficulties associated with the daily ways of life in Russia.

In these circumstances, the ethical aspects of teaching Russian as a foreign language are of particular importance. Teaching Russian plays a primary role among all subjects in shaping the character of a future doctor, building good moral values, and growing their creative skills. However, this study is important because science literature does not fully discuss the ethics of teaching RFL to medical students in India.

Teaching foreign medical students in Russia is part of the global market for education services. Export of medical education services also means the need to think carefully about important moral and ethical questions. In this context, the RFL teacher does not only teach a language, but also

acts as a representative of the Russian education system for foreign students. Unethical actions like discrimination or cultural insensitivity can harm both the reputation of a specific University and the Russian medical education overall.

The article aims to identify and classify the ethical issues that arise when teaching Russian as a foreign language to medical students from India, and to develop helpful solutions.

THE INTERCULTURAL ASPECT OF THE ETHICS OF TEACHING RFL

Teaching Russian to Indian medical students involves bridging a wide cultural and mental gap between Russia and India. According to the theory of pedagogics, top-quality education requires moral growth. This growth builds a person who can accept spiritual, moral, social, and family values. However, the very process of translating these values faces ethical obstacles.

A Russian as a Foreign Language (RFL) teacher at a medical university does not only speak the native language, but also acts as a bridge for the culture and values of the Russian society. According to Abramova MV, Russian as a foreign language teachers talk to people from other cultures all the time. They know from real experience that teaching works best when you respect the unique culture and language habits of your students [1]. Understanding backgrounds and native languages of foreign students helps teachers prevent mistakes in both organization of the teaching process and cross-cultural communication.

Indian and Russian value systems also differ. It means that teachers need strong intercultural competence. Teaching methods must rely on competence-based and profession-oriented higher education. They should also use a linguistic and cultural approach that unites language, regional, cultural and semiotic, as well as axiological skills [2].

Indian students adapt to the new language and culture while building an attitude of being tolerant to others. Using materials in RFL classes that let students compare Russian and Indian cultures is very important here. The Student Scientific Society (SSS) at Yaroslavl State Medical University (YSMU) engages with international students, including those from India.

Students write reports to study Russian, English, and Hindi medical idioms containing words like “doctor”, “treat”, and “medicine”. They compare doctor-patient conversations in different languages and study where cultural and linguistic differences cause gaps in understanding. All this helps Indian students join the educational process and Russian academic environment in general.

A study of scientific literature on RFL in medicine reveals a lack of information about communication ethics. This creates problems when students who have not acquired the appropriate skills in language classes may not be ready for professional communication with Russian-speaking patients, which inevitably leads to communication failures and even conflict situations in clinical practice.

In this regard, one of the key tasks of teaching Russian to medical students is the development of their professional ethics and deontological competence. As Lashova SN points out, medical students have their own unique deontological competence. The competence is a key part of their future medical activity, which cannot be fully successful without this core value [3].

RFL classes provide unique opportunities for fostering medical ethics. Integrating audio and video recordings into doctor-patient communication training resolves ethical issues. It helps Indian medical students understand Russian healthcare realities and compare them with modern practices in India.

Good patient care requires doctors to respect each person's unique background, culture, and personal values. International medical students must learn Russian grammar and words. They also need to choose the right language style for different medical talks and social situations.

ETHICAL DILEMMAS FACED BY RFL TEACHERS

An RFL teacher at a medical university faces unique ethical challenges. To solve the issues, both strong professional skills and deep personal character are required. The language standard is one of the most significant issues. In RFL teaching, the “language standard” is considered as a baseline model, which is used by teachers and in educational materials as a guide.

The dilemma exists as English, which is formally a bridge language for Indian students, does not represent a single standard in reality. “Indian English” [4] is a unique dialect, which differs significantly from the British or American styles that Russian English teachers are usually familiar with. “Indian English” is a fixed form of the English language with its own steady sound and grammar rules. When Indian medical students are taught the Russian language, English is used as a bridge. A RFL teacher should decide how to deal with the specific features of “Indian English” while teaching Russian without making learners feel that their native communication style is “inadequate” or “deficient”. The issue of language mediation is closely connected with the dilemma. Students often do not possess sufficient knowledge both of English and Russian. Teachers then have to make a difficult choice. They can keep teaching in Russian to follow the official plan or they can change the materials to make them easier. This second choice often goes against the rules of the curriculum.

Another problem is that even the “good” English of an Indian student is strongly influenced by the phonetic systems of the native languages [4]. Indian students commonly do not distinguish between the sounds [s] and [sh], and they can't pronounce the sounds [kh], [shch], and [ts] properly [5]. Students from India face additional pronunciation challenges because Latin and Cyrillic letters look alike. For instance, they often pronounce the Russian letter “a” like the English sounds [æ] or [ə]. Similar difficulties arise while pronouncing Russian letters “e” and “y”. As Hindi lacks phonemes [y], [zh], and [ts], speakers often make numerous pronunciation mistakes [6].

Recognizing this issue means that Russian language teachers must take a balanced view of the bridge language. They can no longer rely solely on British or American English as the global standard. Otherwise, such practice creates a risk that students whose language competence does not meet this standard may be perceived as poorly prepared, which creates a feeling of linguistic inferiority. Thus, the teacher may have to adapt to the specific features of Indian English as an independent language style and teach based on their true language skills. Mind, however, that this kind of action can lower the need for language study. If we ignore this issue, many Indian students will not understand key explanations, comparisons, and analogies.

Here, comparing the native language and the target language can become one of the best solutions for teaching RFL. It allows to implement to principle of awareness [1]. Even though Indian students might find this answer very clear, it still requires looking at three different things at the same time. First, Russian and Indian English are compared. Next, the student's first language, such as Hindi, Tamil, or Bengali, is brought into the study. This methodological task is complex

as the teacher needs to know the Russian language alongside with phonetics and grammar of several language systems. Research shows that teachers should use an intermediary language and a nationally focused method (ethnomethodology) when teaching Russian as a cultural or target language to Indian students. This approach helps address their specific ethnopsychological traits [7].

Other key challenges for an RFL teacher involve student testing and how lessons affect learning. Teachers face the ethical challenge of grading fairly and objectively when managing classrooms with mixed language abilities and different student motivation. The challenge of pedagogical effects comes from the core idea that a RFL teacher must both teach students and shape their character. The ethics of how much teachers should guide adult students from other cultures is still being debated. Researchers note that Indian students are seriously motivated to choose a medical profession, but this does not automatically mean that they accept the medical values and ethical rules used in Russia [8].

LANGUAGE MEDIATION: EXTENT AND LIMITS

Using English as a third language to explain Russian material creates a problem of language mediation, which is very similar to the issue of choosing a language standard. The dilemma lies in determining the extent and boundaries of using the intermediary language and raises the question of when and to what extent its use is justified, and when it begins to be an obstacle for studying the Russian language.

A bridge language is definitely indispensable at the initial stage of language learning. It performs numerous important functions, allows to compare language phenomena and overcome interference [9]. Russian grammar should be taught in comparison with the respective English grammar structures. This is how the students can see similarities (singular or plural nouns) and differences (no gender in English, no articles in Russian) [1].

As students gain stronger language skills, teachers should use the intermediary language less often during RFL classroom activities [9]. Excessive use of English makes students get stuck on translating in their heads. They fail to learn how to think directly in Russian. An artificial language setting is also emerging. It does not match the true conditions of future jobs, specifically talking with Russian-speaking patients. As a result, motivation to learn Russian independently is lost, which affects the quality of language training for foreign medical students.

A RFL teacher may face a number of ethically significant problems as far as language mediation goes. Firstly, the right of students to access education is being violated. If the teacher refuses to use the intermediary language, and students do not understand the explanations in Russian, the training becomes formal and ineffective. Secondly, using an intermediary language in groups where students have different levels of English proficiency creates unequal conditions. Students fluent in English benefit from their knowledge of the bridge language rather than their knowledge of Russian. This brings up doubts about how justified the grading is. Thirdly, an intermediary language is not just a tool but also carries specific cultural meanings. When teachers use English, they unwittingly copy Western educational and cultural models, which may conflict with Indian and Russian cultural values and create a problem of cultural sensitivity. Fourthly, for an RFL teacher, a good knowledge of English becomes a necessary professional skill. However, not all teachers possess strong English skills needed for appropriate language mediation. This makes us question if the teacher is good at their job.

To solve the problems, teachers must closely control how and when students use their native language during each step of learning. It can and must be used at the initial stages of learning. However, at advanced stages, its share should gradually decrease [9]. It is necessary to create national textbooks that take into account the linguistic and cultural characteristics of Indian students. As part of advanced professional training, teachers should also learn the basics of Indian English, the unique sound patterns of major Indian languages, and use of non-translational methods of semantics where possible, so that students do not get used to constantly refer to the intermediary language [9]. Combination of these approaches can increase the effectiveness of studying the Russian language and motivation to study the language.

PEDAGOGICAL STRATEGIES FOR SOLVING ETHICAL PROBLEMS IN TEACHING RFL

Strategies for solving ethical problems in teaching RFL to medical students from India can be considered in a theoretical pedagogical context based on axiological and linguocultural approaches. In a multicultural classroom, using an axiological approach to teach Russian means purposefully shaping certain values required for the professional future of students. Within RFL courses, this goal is accomplished by analyzing medical ethics scenarios, reviewing professional codes for physicians, and engaging in dialogue regarding the moral aspects of healthcare. Utilizing a linguacultural approach to cultivate professional medical ethics in RFL classrooms involves exploring the paremiological foundations of two cultures. This is achieved by comparing Russian and Indian proverbs and idioms that express cultural attitudes toward health, illness, professional duty, and patient care.

A promising initiative involves designing and implementing a two-semester preparatory course for international medical students entitled "Introduction to Deontology (Linguistic Aspect)." This curriculum covers speech culture, rhetoric, medical business etiquette, and the strategic use of speech in professional communication.

Interactive methods of education are widely used today. Integrating interactive technologies into the deontological training of medical students allows to simulate actual professional scenarios, enabling to develop ethical communication skills within a secure learning environment [10]. Engaging students in role-play exercises, analysis of clinical cases, and discussions on moral dilemmas fosters the development of their ethical competence and their linguistic proficiency.

RFL teachers who work with Indian medical students should develop their intercultural competence. They need to possess a developed intercultural competence that includes the awareness of Indian cultural traits, understanding the Indian mindset and core values, and the capacity to foster intercultural dialogue within the classroom environment [11].

CONCLUSIONS

The findings indicate that teaching Russian as a foreign language to Indian medical students is associated with interconnected ethical dilemmas that demand deliberate and well-considered solutions.

The central challenge lies in the lack of a clearly defined linguistic standard. Since English, used as an intermediary language, is represented not by a single norm, but by a specific "Indian English" with stable phonetic and grammatical features, the teacher has to choose whether to focus on an international

standard (risking to create a feeling of inferiority among students) or to adapt to the real language skills of students (risking to reduce academic requirements). This creates an ethical tension between demanding the quality of education and respecting the linguistic individuality of students.

Language mediation exposes a tension between the necessity of using English to explain complex issues at initial stages and the risk of encouraging mental translation habits, distorting the linguistic environment, and weakening self-directed habits of studying Russian. The availability of education (refusal to use an intermediary language turns education into a formal process), fair assessment (uneven English mastery leads to unequal conditions), cultural sensitivity (adoption of western models) and professional competence of the teacher who is not always proficient in English acquire ethical importance.

Dilemmas of assessment and pedagogical influence make these ethical issues complete. The absence of uniform evaluation criteria in groups of students with varying proficiency levels challenges the objectivity of academic assessment. Simultaneously, while fulfilling a pedagogical role, the teacher encounters the boundaries of acceptable influence over adult

learners from a distinct cultural background, whose values may differ from Russian medical and pedagogical traditions.

The ethical challenges discussed in this article cannot be resolved through a single, standardized algorithm. A flexible, situational approach is required that takes into account the stage of education, the level of training of a particular group, the individual characteristics of students and the real communicative tasks of future professional activity. Carefully regulation of using the intermediary language per stage, creating national educational materials, boosting intercultural skills and language proficiency of teachers, and maximizing direct semantic techniques without translation belong to the key strategies.

The ethical responsibility of a RFL teacher means the ability to find a balance between the academic requirements of the curriculum and the real needs of students, between the formation of professional language skills and respect for cultural and linguistic diversity, between the need for language mediation and the gradual transition to teaching in Russian. Only this balanced methodology can help us achieve effective proficiency in Russian while safeguarding the intrinsic dignity of every student, which remains the paramount ethical principle in a multicultural academic setting.

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TEACHING THE ETHICS OF HEALTHCARE COMMERCIALIZATION THROUGH ENGLISH-LANGUAGE CASE STUDIES: MEDICAL AND ECONOMICS STUDENTS' PERSPECTIVES

Melnikova EYu ✉

Yaroslavl State Medical University, Yaroslavl, Russia

This article explores the ethics of profit-focused healthcare by looking at English case studies intended for medical and business students. This study aims to find the main contradictions between a patient-centered approach to rendering medical aid and commercialized healthcare model in English texts, and to show why real-world case studies should be included into the process of teaching a foreign language to students majoring in Medicine and Economics. Typical case studies are analyzed in English. A physician or a healthcare manager has to choose between the patient's interests and requirements of cost effectiveness. It is shown that when included into the teaching of a foreign language to medical and economics students, the case studies don't only teach the professional English language, but also develop ethical thinking. It is concluded that the case study method is a perspective tool of teaching medical ethics to future professionals, who can recognize and resolve conflicts between patient care and market demands.

Keywords: medical ethics, medicine commercialization, case study method, patient-oriented medicine, ethical education, conflict of interests

✉ **Correspondence should be addressed:** Elena Y Melnikova
Revolutsionnaya Str., 5, Yaroslavl, 150000, Russia; vinel81@mail.ru

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ЭТИЧЕСКИЕ АСПЕКТЫ КОММЕРЦИАЛИЗАЦИИ МЕДИЦИНЫ КАК ПРЕДМЕТ ИЗУЧЕНИЯ В АНГЛОЯЗЫЧНЫХ УЧЕБНЫХ КЕЙСАХ ДЛЯ СТУДЕНТОВ МЕДИЦИНСКИХ И ЭКОНОМИЧЕСКИХ СПЕЦИАЛЬНОСТЕЙ

Е. Ю. Мельникова ✉

Ярославский государственный медицинский университет, Ярославль, Россия

В статье рассматриваются этические аспекты коммерциализации медицины в аспекте изучения учебных кейсов на английском языке в процессе иноязычной подготовки студентов медицинских и экономических специальностей. Цель исследования — выявить ключевые противоречия между пациентоориентированным подходом к оказанию медицинской помощи и коммерциализированной моделью здравоохранения, отраженные в англоязычных материалах; методически обосновать целесообразность их включения посредством метода кейс-стади в иноязычную подготовку будущих специалистов в области медицины и экономики. Анализируются типичные сюжеты учебных кейсов на английском языке, в которых врач или менеджер здравоохранения вынужден выбирать между интересами пациента и требованиями экономической эффективности. Показано, что включение подобных кейсов в иноязычную подготовку обучающихся по специальностям медицинского и экономического профиля выполняет двойную функцию — обучения профессиональному английскому языку и формирования этического мышления. Делается вывод о том, что метод кейс-стади является перспективным инструментом интеграции медицинской этики в подготовку будущих специалистов, способных осознавать и разрешать конфликты между заботой о пациенте и рыночными императивами.

Ключевые слова: медицинская этика, коммерциализация медицины, метод кейс-стади, пациентоориентированная медицина, этическое образование, конфликт интересов

✉ **Для корреспонденции:** Елена Юрьевна Мельникова
ул. Революционная, д. 5, г. Ярославль, 150000, Россия; vinel81@mail.ru

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The debate over commercialization of medicine has gone past science long time ago. It has turned into the major topic of public talks, litigation, legislative initiatives and public protests. Nevertheless, the issue is insufficiently explored in relation to higher medical and economic education through the prism of the formation of professional and ethical attitudes of future specialists by means of a foreign language.

It should be emphasized that core values and stable models of professional behavior, which subsequently determine the actions of a doctor or manager facing a hard ethical choice, are formed within the educational environment. When medical or

economics students who study a foreign language never come across case studies about financial interests of an organization versus patient care, they are not ready for real-world ethical conflicts.

This paper analyzes the conflict between patient-centered care and profit-focused medicine, widely represented in the works of domestic and foreign researchers [1–4], as well as the methodological potential of including the case studies into the process of teaching English to students majoring in Medicine and Economics.

The proposed case studies were formulated by the author utilizing open-access materials sourced from

reputable, specialized medical platforms and popular science repositories, including Academia.edu, EngagingPatients.org, and ResearchGate. A pedagogical approach dictates that special consideration should be given to both the nature of the conflict and its instrumental role in developing professional ethics among the students majoring in Medicine and Economics. This methodological analysis focuses both on the mere composition of the conflict, and its capacity to serve as a tool for shaping the professional ethics and value systems of future specialists.

ETHICAL ASPECTS OF HEALTHCARE COMMERCIALIZATION

Healthcare commercialization represents a shift in which market mechanisms come to determine not just financial structures, but the very substance, volume, and accessibility of medical services. Under a market-driven healthcare model, a patient's health is viewed as a financial asset, whereas provision of medical care becomes a primary source of profit for insurance providers, pharmaceutical firms, and private medical centers. In the late 20th century, a number of pioneering bioethicists and medical philosophers raised critical ethical concerns regarding commercialized healthcare models. Their primary objections included the commodification of healthcare at the expense of its status as a foundational social good, heightened conflicts of interest that compromise the physician-patient relationship, and the systemic motivation to artificially inflate diagnostic and therapeutic procedures for economic gain [5].

These aspects remain relevant in the 21st century. Furthermore, recent decades have witnessed the advent of novel commercialization pathways driven by digital technological advancements, proliferation of telemedicine, and the active market presence of major biotechnology corporations, thereby broadening the spectrum of emerging ethical dilemmas [6, 7].

In the early 21st century, healthcare commercialization evolved into a worldwide phenomenon. Many global healthcare systems have changed through reforms focused on budget savings, fewer rules, and private ownership. A survey of 1,781 students by researchers from three Turkish medical schools revealed that 87.2% supported at least one commercialized medicine viewpoint, and 20% agreed with over half of these statements [8]. The authors called the result alarming. They stated that this high level of acceptance of commercial medicine conflicts with the rules of medical ethics.

The idea of patient-centered care became official in a report by the US Institute of Medicine entitled "Crossing the Quality Chasm: A New Health System for the 21st Century." This report named it as one of the six main goals for modern healthcare. According to the document, the patient-oriented model of medical care postulates respect and consideration of individual preferences, needs and values of the patient [9].

M. L. Millenson and other authors present modern views on the patient-centered model. The study outlines a structured approach to involve patients and their families in care planning and rendering. This method aims to strengthen medical ethics and boost overall health results [10].

THE CASE STUDY METHOD AS A TOOL OF ETHICAL EDUCATION

In modern pedagogical literature, the case study method has been explored from many different points of view as an effective and technological teaching method [11–14]. Medical

education borrowed this approach from business schools, where it was used to teach managers how to make decisions. Subsequently, this method has become a standard part of courses devoted to medical ethics, bioethics, and health care management. The main idea of the method under study is to find a solution after analysis. The case study method consists of several elements such as building models and describing situations, analyzing and evaluating situations, identifying a problem, finding a solution, applying solutions to similar cases, and developing professional skills. An ethical case study outlines a real-world situation where a student must make a decision in the face of competing interests and ethical uncertainty.

The methodological value of an ethical case is determined by the ability to set up an unclear situation with hard questions that have no single clear answer.

According to the researchers who explored medical ethics, case ambiguity forces students to go beyond the learned algorithms and think about the core values of their future professional activity. Dealing with such case studies helps develop a specific mindset, which is subsequently activated automatically in real-world professional situations [15].

An analysis of medical and economics case studies devoted to healthcare commercialization reveals typical ethical dilemmas such as a conflict of interest arising when a doctor or administrator receives financial remuneration for prescribing specific drugs or procedures to a patient; denial of medical care on financial grounds; overtreatment when medical care is given based on profit and budgets; distribution of medical care based on economic criteria instead of actual patient health needs. Let's examine in detail how these situations can be presented in English case studies.

An ethical conflict often happens when a young doctor starts their career at a private multidisciplinary clinic. A 58-year-old male patient complains of back pain. The objective clinical results show that surgical intervention is not required and that conservative treatment and physiotherapy are highly effective. At the same time, the internal policy of the medical organization rewards doctors if they send their patients to an affiliated center for surgery. What should a doctor do? The described situation exceeds the individual moral responsibility and represents a systemic conflict inherent in a commercialized healthcare system.

In this aspect, the clinical case shared by T. Lemmens and P. A. Singer is a great learning tool for students. This practice involves a physician referring a patient to a privately owned clinic. Such self-referral for profit creates a financial incentive to perform unnecessary medical treatments [16]. Such situations are described in the research literature as a conflict of interest in which financial rewards may unknowingly influence clinical decisions. These case studies ask one core question: how does the conflict of interests between making a profit and caring for the patient affect the treatment process? This phrasing builds an axiological framework in which the interests of the patient serve as an unconditional foundation for evaluating any managerial or clinical decision.

Another common case is related to denial of medical care on financial grounds. Thus, an uninsured 45-year-old patient, who reports shortness of breath under mild exertion, swelling of the legs and occasional chest pain, seeks medical help. The primary survey results (physical examination, ECG, basic laboratory tests, and chest X-ray) were used to establish a preliminary diagnosis of chronic cardiovascular pathology requiring further examination and routine treatment.

To confirm the diagnosis and plan your next treatment steps, an extended diagnostics is required. The patient is unable to pay for additional examinations and long-term treatment, while the existing regulations of the medical institution allow to provide emergency medical care free of charge only in the presence of life-threatening conditions. The clinic administration reports that the patient can obtain the minimum amount of emergency care due to the existing financial constraints, while routine diagnostic procedures and follow-up therapy remain beyond the amount of insurance coverage. The attending physician faces a dilemma whether to follow the administrative and financial regulations of the institution, effectively leaving the patient without timely treatment that could prevent serious complications, or to look for other opportunities (search for charity programs, installment payments, involvement of public resources), going beyond the usual organizational procedures.

The central question of the case is a clash of professional duty to prevent a predictable deterioration of the patient's condition with the economic constraints of the system. Can a doctor justify an actual refusal to provide full medical care if the patient's inability to pay for treatment is the only obstacle? The described training case illustrates an ethical dilemma where a doctor's duty to stop a patient's health deterioration clashes with financial constraints and hospital rules.

According to A. Edelman and K. E. Adams, such conflicts occur in healthcare systems that do not guarantee an adequate amount of medical care for vulnerable populations, which raises the question of the obligations of both individual clinicians and medical organizations. The case under consideration illustrates the structural contradiction between economic barriers limiting access to planned care and the need for a doctor to find a balance between compliance with regulations and the implementation of principles of professional ethics [17].

The role of case studies in the training of students specializing in economics, healthcare management and health insurance, deserves separate consideration in the framework of this discussion. For them, the conflict between the principles of "patient-oriented care" and "commercialized healthcare" often appears not as a personal moral dilemma, but as a managerial task requiring to optimize processes and allocate resources. Nevertheless, we are talking about the same contradictions in terms of content. For example, the case when an insurance company refuses to cover an expensive drug, appeals to the previously outlined value system. Is it possible to justify the refusal of treatment for economic efficiency? What is "a medical necessity" when this concept is defined not by a doctor, but by an actuary?

The inclusion of case studies modeling the conflict between patient-centered medical care and a profit-oriented model of healthcare organization in the process of teaching professional English carries out several interrelated educational functions:

- a cognitive function: the case study shows students how real conflicts work. It explains which official rules and systems create a conflict between clinical and financial imperatives;
- a language function: the English-language case develops a professional vocabulary that allows you to talk about complex ethical issues in the language used by the international academic and professional community;
- axiological: while analyzing the case, the student identifies and defends his position, which contributes to the development of stable professional values.

It is advisable to mention the fundamental limitations of the case study method. By its nature, the case is a didactic tool that simplifies real multidimensional situations of a moral choice to a manageable classroom activity.

Genuine medical ethical dilemmas unfold in a more complex chronotope, including uncertainty, tight time frames, vertical management relationships and the influence of corporate norms. Consequently, the methodological value of the case study method lies in the formation of an algorithm for reasoning and ethical analysis of the situation, though the impossibility of simulating the full range of psycho-emotional experiences of the decision-maker belongs to its inherent limitation. Experts in ethical education recognize that active teaching methods, including the case study method, affect knowledge and attitudes of students, but their impact on real professional behavior requires further study. However, it would be wrong to underestimate the potential of this method. A study comparing the results of traditional and case-oriented learning showed that students who used active methods of study had significantly improved knowledge quality indicators, since the case method makes a student think and not just memorize [18].

Special attention should be paid to how conflicts of interest are treated in case studies, as it is one of the most common manifestations of commercialization of medicine. A conflict of interest arises when secondary interests, such as financial rewards, career considerations, or personal relationships may distort a doctor's professional judgment.

It is in this aspect that English-language cases on business ethics in healthcare seem to be a particularly valuable resource. Many of them directly reproduce situations when a doctor receives gifts, lecture fees, or sponsored trips from pharmaceutical companies, and then has to make a decision about prescribing a drug. The methodological value of such cases is determined primarily by their ability to transpose an abstract ethical principle into a specific professionally recognizable situation with which the student can relate his own future experience.

The cases addressed to economics students commonly look at the same problem from a fundamentally different point of view: not as a moral choice that must be confronted on a personal level, but as a managerial task that requires an institutional solution. The development of codes of ethics, disclosure systems on conflicts of interest and independent control mechanisms is taken as a response of a medical organization to systemic risks, and not as a moral choice of a doctor. This approach is no less valuable from the pedagogical point of view, as it teaches future healthcare managers to think structurally rather than individually, thereby including ethics into the logic of organizational management.

Two users of educational cases described above, including students who study Medicine and Economics, allows to start a challenging pedagogical experiment such as a joint review of the cases by various specialists. In such a model, a doctor and a future healthcare manager look at the same event from various perspectives. The doctor is interested in the best treatment for the patient. The manager wonders how the treatment fits into the organization's budget, and whether it is covered by insurance. When these opposing views meet, they help students think deeply about how they make professional choices.

However, merging these elements needs caution. The main risk is that in conditions of coeducation, the economic framework might take over, simply because it is

more operational, measurable, and familiar to the learning process. When the ethics of care is replaced by the ethics of cost and efficiency, experts see a major shift caused by turning medicine into a business that changes how doctors think.

Reproducing this transformation in the educational process, designed to counteract it, would ruin the main pedagogical goals of using real-life examples in class. Thus, it is essential that the cases used to jointly teach future doctors and economists maintain the axiological priority of the patient-oriented approach as a starting principle.

This provision does not imply ignoring economic realities. On the contrary, the case studies have the methodological value that they force the student to comprehend and integrate the existing constraints into the decision-making process, while these constraints should act as set conditions, and not influence the final decision. The answer to the question how a patient should be treated if the budget is limited is totally different from the one whether we should treat a patient if it is not profitable.

Teachers who work with cases in a foreign language often pay attention to the linguistic aspect, which is worth mentioning. English is the *lingua franca* used by the global medical and economic society. Studying English-language case studies develops not only the ethical, but also the linguistic competence of the student. The student can discuss complex professional situations in global English, which is especially important for planning an academic career, working with global partners, or joining international medical teams.

CONCLUSION

The following conclusions can be made based on the analysis. The conflict between patient-centered care and commercialized healthcare is not a theory, but a real-world challenge for doctors, nurses, and healthcare managers. The nature of this conflict is institutional, as it is determined by systemic incentives built in organizational structures and financing models.

Using ethical dilemmas in English learning cases has a great teaching value. It helps students learn how to make smart choices, explain their views, and build a strong professional and moral position. The case study method helps train professionals in three main ways. First, it builds cognitive skills by teaching the structure of conflict. Second, it builds language skills by teaching global professional vocabulary. Third, it builds values by shaping strong professional attitudes. The greatest pedagogical effect is achieved when the case study method is integrated into a broader educational strategy that includes discussion of health policy, funding models, and institutional mechanisms for managing conflicts of interest.

Ethical education in the field of medicine and health economics is indispensable if it allows to preserve the axiological priority of the patient's interests. Economic constraints define the conditions of the task, whereas ethical principles determine the criteria for its solution. A strong teaching case ensures productive interaction of both registers. Following the training, a specialist is able both to apply the learned algorithms, and also to critically assess the conditions under which they stop working.

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ETHICAL ASPECTS OF MEDICAL, SOCIAL, AND PEDAGOGICAL SUPPORT FOR CHILDREN AT RISK OF SOCIAL ORPHANAGE

Gabidullina LF¹ ✉, Kotlovsky MY^{1,2}

¹ Yaroslavl State Medical University, Yaroslavl, Russia

² Semashko NA National Research Institute of Public Health, Moscow, Russia

This study is relevant due to the need to balance child protection and respect for the family, while mitigating the risks of stigmatization and confidentiality breaches during cooperation between agencies. This study aims to identify the ethical dilemmas that arise while supporting children at risk of social orphanhood and to provide recommendations for improving these support tendencies. The research methods include analyzing regional practices, algorithms of interaction between agencies, the work of specialized commissions and councils, and the legal and regulatory framework, which includes the Convention on the Rights of the Child and Russian social service standards. According to the results, the most ethical and effective methods rely on minimal intervention, family partnership, and transparent communication. Collaborative visits by specialists and parents, interdisciplinary consultations, and adapted methodologies for considering the child's views are effective. Researchers used data from the Yaroslavl region to find the major ethical issues such as treating informed consent as a mere formality, risk of data leakage in central databases, ignoring the life experience of families, and treating a child's opinion without deep care.

Key words: ethical effectiveness, stigmatization, medical, social and pedagogical support

Author contribution: Gabidullina LF — data collection, data analysis, literature analysis, research planning, text writing, editing; Kotlovsky MY — data analysis, data interpretation. The authors contributed equally to this work.

✉ **Correspondence should be addressed:** Landysh F Gabidullina
Revolutsionnaya St., 5, Yaroslavl, 150000, Russia; landush10@yandex.ru

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ЭТИЧЕСКИЕ АСПЕКТЫ МЕДИКО-СОЦИАЛЬНО-ПЕДАГОГИЧЕСКОГО СОПРОВОЖДЕНИЯ ДЕТЕЙ ГРУППЫ РИСКА ПО СОЦИАЛЬНОМУ СИРОТСТВУ

Л. Ф. Габидуллина¹ ✉, М. Ю. Котловский^{1,2}

¹ Ярославский государственный медицинский университет, Ярославль, Россия

² Национальный научно-исследовательский институт общественного здоровья имени Н. А. Семашко, Москва, Россия

Актуальность исследования обусловлена необходимостью баланса между защитой ребенка и уважением к семье, а также рисками стигматизации и нарушения конфиденциальности при межведомственном взаимодействии. Цель работы — выявить этические дилеммы практики сопровождения детей группы риска по социальному сиротству и предложить ориентиры ее совершенствования. В качестве методов использован анализ региональных практик, алгоритмов межведомственного взаимодействия, работы профильных комиссий и консилиумов, а также нормативно-правовой базы (включая Конвенцию о правах ребенка и российские стандарты социального обслуживания). Результаты показывают, что наиболее этичными и результативными являются подходы, основанные на принципе наименьшего вмешательства, партнерстве с семьей и прозрачной коммуникации. Эффективны совместные выезды специалистов и родителей, междисциплинарные консилиумы, адаптированные методики учета мнения ребенка. На материалах Ярославской области выявлены ключевые этические узлы: формализация информированного согласия, риски утечки данных в единых базах, обесценивание жизненного опыта семьи, поверхностный учет мнения ребенка.

Ключевые слова: этическая эффективность, стигматизация, медико-социально-педагогическое сопровождение

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✉ **Для корреспонденции:** Ландыш Фаритовна Габидуллина
ул. Революционная, д. 5, г. Ярославль, 150000, Россия; landush10@yandex.ru

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Medical, social, and pedagogical support for children at risk of social orphanhood is more than a set of services; it is a system where every choice involves significant ethical responsibility. The balance between protection of a child and respect for the family, cooperation between agencies and confidentiality, as well as expert views and parental

experience determines if support becomes helpful or stressful [1].

In the Yaroslavl region, authorities deal with this issue through various institutions and cooperation between agencies. Ethical problems, however, become very serious when real help is provided.

Context and problem statement

As of June 1, 2026, the Yaroslavl Region Ministry of Education reports that 2,853 local children are orphans or without parental care. Of these, 2,422 children are being raised in foster homes, while 420 children stay in state guardianship institutions. These numbers show how big the problem is. They also indicate at the shift toward family care, which is a main goal of national policy.

Meanwhile, social orphanhood is often associated not with the lack of parents, but with the inability of a family to care for a child because of poverty, addictions, mental illness, or social isolation. These families are noticed by the prevention system, where the competencies of doctors, teachers, social workers and guardianship authorities intersect.

In practice, support is based on three key stages:

1. At the stage of **comprehensive evaluation**, the child is seen by doctors, psychologists and teachers. The examination relies on the final decision of the local Psychological, Medical and Pedagogical Commission (PMPC). The Commission follows the rules set by the Ministry of Education and the Ministry of Health [2]. Its task is not to find a problem, but to identify what the child needs and the resources of the family [2].
2. The conclusion made by the PMPC is used to generate an individual support program, when goals, terms, rights and obligations of the parties are recorded. This is the agreement that makes the process transparent when **assistance is planned** to be provided.
3. **Implementation of support strategies** includes medical aid, educational and corrective activities, and social support of the family (employment, registration of benefits, and psychological assistance).

Different specialists such as teachers, psychologists, doctors, social workers, employees of child protection agency participate in the activity. Effectiveness relies on the coherence of their actions and on how ethically their interactions with each other, with the child and the family are structured.

MATERIALS AND METHODS

What is effective already?

The experience of the region shows that the most ethical and effective approaches include those focused on preserving the family and maintaining the bond between the child and the parents.

Joint visits of specialists and parents to institutions allows to solve several tasks at once:

- maintain the emotional connection between the child and the family;
- help the child feel less isolated;
- make parents feel included in the process instead of being blamed.

Thus, during these visits, both formal meetings and joint activities like art workshops, games, and parties are organized. Children get a signal that they are not abandoned, while parents have a chance to see their child in a safe environment and be supported by experts.

Discussing the case during the **interdisciplinary council meeting** together with all experts and parents prevents from taking uncoordinated decisions [3]. At these meetings, the team looks at problems and family strengths, sets rules for when to step in more, and names a person in charge.

Restoring parental rights for a mother or father facing family struggles is not a consequence. It is a way to understand the root causes of the problem and explain what steps are required to become a good parent. If things are improving and the child is safe, they should stay with their family.

Key ethical dilemmas

Despite the effective mechanisms, ethical conflicts happen at work on a regular basis.

A child's well-being stems from living within a family, no matter what kind of a family it is. **Taking a child away from their family** is painful for all parties involved, but the child is hurt the most. The decision should be taken only after trying all other options.

Labelling a child with negative terms and revealing the issue too late causes families to self-isolate.

An ethical solution is represented by "careful communication." First, you offer help and support. You only use teamwork between different agencies when you truly need it.

Being confidential and sharing data between agencies are important, but they bring risks of leaks and privacy loss. Families often do not know who can see their personal information or why they are using it.

Taking into account the opinion of a child when planning support is a fundamental right under the Convention on the Rights of the Child, not just a formality. In real life, however, people often treat this as just a simple box to check off on a list.

The child must understand that what they say will be used not against their parents, but rather to provide the appropriate support. Even with good intentions, being tactless, dismissing the hard work of parents, or sounding like you blame them will destroy trust. Specialists must view empathy, respect for family life, pedagogical tact, and professional interaction styles as core job skills, not just soft skills.

Normative and value bases

International and Russian laws require that services for children and families follow the principles of the Convention on the Rights of the Child, the Declaration on Child Protection, and national social service standards. Key ethical principles include as follows:

- respect for the dignity and autonomy of the individual;
- informed consent for assistance and data exchange;
- involving the child and family in decision-making.
- harm minimization and the principle of least interference;
- justice and lack of discrimination.

In practice, these rules often do not turn into real actions. True informed consent turns into just signing papers, while family participation means showing up at meetings only. This causes an ethical gap between the rules from the normative values and the real daily tasks of experts.

RESEARCH RESULTS

Ethical guidelines for improvement

Discussing the cases studies in the Yaroslavl region helps us suggest certain ethical rules to make them better [4].

Firstly, there are **transparent and uniform risk criteria** with clear boundaries of professional intervention that are easy to understand both by a family and specialists.

Secondly, **routing of assistance** focuses on keeping the child at home safely by providing urgent services, crisis

housing, allowing the parents to rest, and legal or psychological support.

Thirdly, **the mechanisms of family and child participation:** clear feedback, the right to appeal, and participation in the preparation and revision of an assistance plan.

Fourthly, **supervision and interdisciplinary council meetings** with ethical competence allow professionals to discuss tough situations without blame. These discussions aim at offering assistance instead of exercising control.

Finally, it is necessary to look at more than just quality and quantity [5]. We should also see if the child feels happy living with family and relatives.

When gathering data on registered families, members must be informed of the data collected, where the data are stored, and how the data can be given back.

Thus, communicating with these families during these events, it is necessary to inspire them with confidence in professionals and hope for the future.

If the child remains separated from the family, maintaining contact with relatives is essential, and regular meetings and joint activities should be organized [6].

DISCUSSION OF RESULTS

Case studies from the Yaroslavl Region: ethical challenges and potential solutions

Studying local examples shows how these dilemmas appear in practice and which approaches are useful to solve the problems.

In a number of municipalities in the Yaroslavl region, there is an algorithm for cooperation between agencies: if a teacher believes that a child is at risk (systematic absences, signs of beatings, neglected appearance, complaints of hunger), he fills out an "alarm card" and transmits it to the Commission for juvenile affairs and/or social protection service. Actually, it often happens that the teacher follows the rules, but fails to build trust with the family. As a result, the family only finds out about the issue after social services show up, and they feel attacked and invaded [7]. Consequently, the family stays isolated, stops asking for support, and the child becomes even more vulnerable than before [7].

Following the rules without open and honest communication turns into the risk factor. The solution is to add a mandatory talk with the family before sending any alert. This talk includes a social worker and a psychologist. The goal is not just to find fault or gather proof, but to offer help and support. This is how informed consent works in practice: the family knows why we collect data, who will see it, and what support options are available.

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The patronage of pregnant women at risk in the Nerekhtsky district illustrates the transition from control to partnership. First, they checked a home of the lonely pregnant woman and tried to stop her from giving up her baby. Consultation with psychologists and other specialists was followed by giving her money, setting clear rules for help, and moving on to teamwork. Thus, the woman could decide how to use the temporary flat given to her after her baby was born, and she waited for the guards to come and check on it. Such intervention both reduced child abandonment and enhanced confidence in professionals.

Council meetings of agencies rely on ethical principles to make decisions. The case when two children in the Yaroslavl region were separated from their alcohol-dependent mother can serve as an example. After stopping the separation of the children and their transition to a social institution, the council watched this woman closely. The curator visited the mother every day, examined her care plan, and spoke with her neighbors. The main point was to follow the rule of least involvement. Separation was taken as a final choice.

Sharing data between different agencies creates new ethical risks. Unified databases aim to improve cooperation. In practice, they, however, often break privacy rules. Data gets copied and shared with workers who do not need it. Also, families often do not know what data is saved or how to delete it.

Including a child in assistance planning requires extra ethical care. In several centers across the Yaroslavl region, adjusted methods of "a child's opinion" are being implemented. They include short questionnaires, safety scale discussions, and accessible reviews of assistance plans. Instead of treating the process as a checkbox exercise, it is necessary to establish a safe environment where children understand the limits of confidentiality and know that their honesty will not result in parental punishment.

CONCLUSION

Enhancing medical, social, and educational assistance for children at risk of social orphanhood is primarily an ethical duty, rather than just an administrative or methodical challenge. How well the system balances keeping kids safe and respecting families, while staying effective and protecting human dignity, affects more than just individual parents and children. It also shapes how much the public trusts our social institutions.

As practice shows, even strong and trusted systems like full evaluations, good planning, and cooperation between agencies can still be ethically vulnerable unless they have transparent procedures, trained workers, and real mechanisms of participation for families and children. We must focus on these key parts while attempting to improve the support system.

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THE BIOPSYCHOSOCIAL PATIENT-CENTERED APPROACH IN THE ERA OF EVIDENCE-BASED MEDICINE

Yaltseva NV ✉, Gauert VR, Leontyeva EA, Politova DA, Yaltsev AV, Politov SY, Belova BG

Yaroslavl State Medical University, Yaroslavl, Russia

The article examines the contradiction between the biopsychosocial approach and evidence-based medicine. The traditional biomedical model, that has been dominating since the 17th century, focuses on pathophysiology and ignores the psychological and social factors. The alternative biopsychosocial model, offered by Engel G (1970–1990), treats a disease as a result of interacting biological, psychological and social factors. It corresponds to the definition of health provided by the WHO. The approach is, however, limited due to highly personalized nature, complex objective assessment of factors and risk of subjectivism. As evidence-based medicine became widespread, clinical focus transitioned toward statistically average patient populations. Consequently, this standardization minimized the individual differences, particularly psychosocial factors. The doctor-patient relationship becomes mechanistic. The authors stress that the biopsychosocial and evidence-based approaches cannot be opposed. Their synthesis is perspective. They rely on evidence-based data taking into account psychosocial characteristics of a patient. They include various integration options from the way the multidisciplinary team functions to the formation of the basis of patient's profiles indicating psychosocial features. The central idea that unites three groups of factors as viewed by the patients includes the internal picture of illness. The complex approach is taken as an essential element of modern clinical thinking and medical culture.

Key words: biopsychosocial approach, evidence-based medicine, biomedical model, internal picture of illness, personalized medicine, psychosomatics, doctor-patient interaction, holistic approach, health factors, clinical reasoning

✉ **Correspondence should be addressed:** Natalia V Yaltseva
Revolutionnaya Str., 5, Yaroslavl, 150000, Russia; yaltsewa@yandex.ru

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БИОПСИХОСОЦИАЛЬНЫЙ ПОДХОД К БОЛЬНОМУ В ЭПОХУ ДОКАЗАТЕЛЬНОЙ МЕДИЦИНЫ

Н. В. Яльцева ✉, В. Р. Гауэрт, Е. А. Леонтьева, Д. А. Политова, А. В. Яльцев, С. Я. Политов, Б. Г. Белова

Ярославский государственный медицинский университет, Ярославль, Россия

В статье рассматривается противоречие между биопсихосоциальным подходом и доказательной медициной. Традиционная биомедицинская модель, доминирующая с XVII в., фокусируется на патофизиологии, игнорируя психологические и социальные факторы. Альтернативная биопсихосоциальная модель G. Engel (1970–1990 гг.) рассматривает болезнь как результат взаимодействия биологических, психологических и социальных факторов, что соответствует определению здоровья ВОЗ. Однако внедрение этого подхода ограничено высокой персонализированностью, сложностью объективной оценки факторов и риском субъективизма. С распространением доказательной медицины (evidence-based medicine) акцент сместился на статистически усредненные группы пациентов, что привело к стандартизации и нивелированию индивидуальных, особенно психосоциальных, особенностей больного. Отношения врач–пациент приобретают механистический характер. Авторы подчеркивают, что нельзя противопоставлять биопсихосоциальный и доказательный подходы. Перспективным является их синтез: опора на доказательные данные с одновременным учетом психосоциальных характеристик пациента. Предлагаются различные варианты интеграции — от работы мультидисциплинарной команды до формирования баз профилей пациентов с указанием психосоциальных особенностей. Центральным понятием, объединяющим три группы факторов с позиции самого больного, предлагается считать внутреннюю картину болезни. Такой комплексный подход рассматривается как неотъемлемый элемент современного клинического мышления и медицинской культуры.

Ключевые слова: биопсихосоциальный подход, доказательная медицина, биомедицинская модель, внутренняя картина болезни, персонализированная медицина, психосоматика, взаимодействие врач–пациент, холистический подход, факторы здоровья, клиническое мышление

✉ **Для корреспонденции:** Наталья Викторовна Яльцева
ул. Революционная, д. 5, г. Ярославль, 150000, Россия; yaltsewa@yandex.ru

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In Russian and global medicine, the pathophysiological framework remains the cornerstone of the etiology and pathogenesis of somatic diseases [1]. The biomedical model [2], which traces its roots back to the mechanistic model of illness formulated by René Descartes, has established

itself as the dominant framework in medical science since the 17th century. Classical Russian textbooks written by Lang GF, Tareev EM, Myasnikov AL, monographs of Zakharyin GA, Konchalovsky MP, and Ado AD, which are currently used to prepare academic programs, contain a brief and poorly

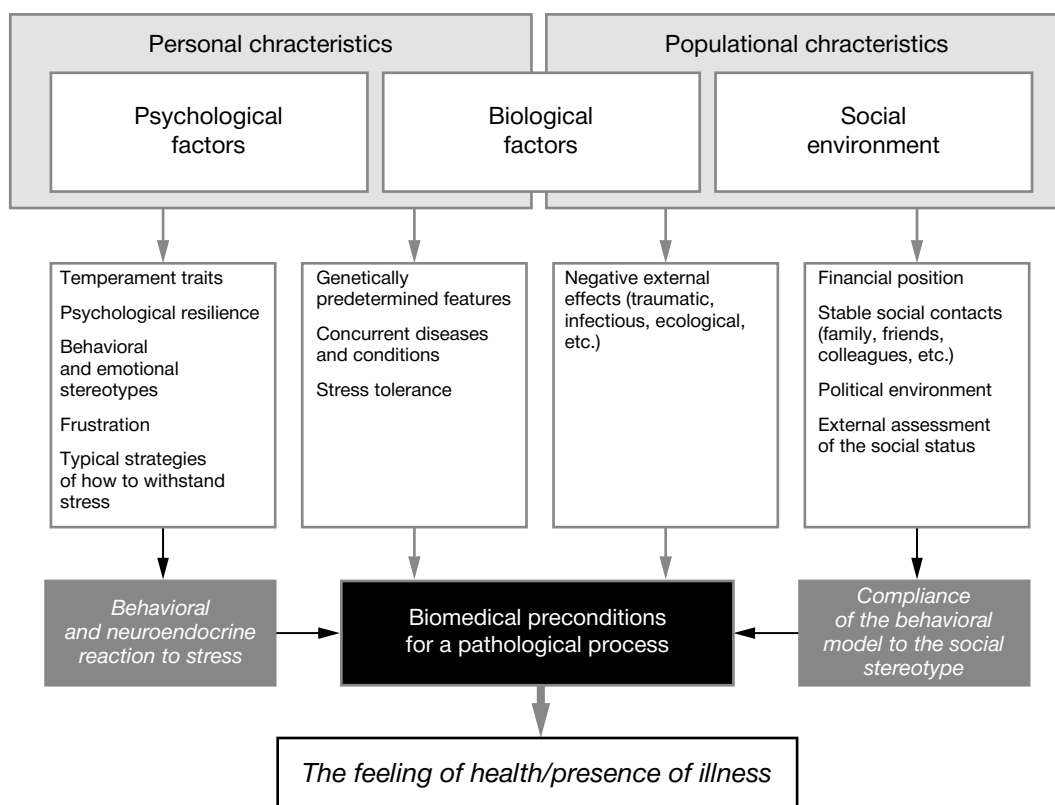


Fig. Modern interpretation of the biopsychosocial model of human health and diseases [6]

systematized psychological characteristic of patients, whereas the social constituent of the disease is largely overlooked [1,3]. Similar tendencies have been observed in foreign publications until several theories have been formed by the middle of the 20th century that included the component of a personal emotional and behavioral reaction of the patient to the structure of the disease. This involves behavioral medicine with the main branch of behavioral psychotherapy developed in the 1950–1960s (Thorndike E, Bekhterev VM, Skinner B, etc.), Selye H theory of general adaptation syndrome (1940s), and biopsychosocial model by Engel G (1970–1990).

These concepts and some other ones implied direct inclusion of personal characteristics of a patient, their ability to react and influence of the sociocultural environment on the onset of the disease and recovery. The biopsychosocial model that declares a compulsory presence of three groups of factors — biological, psychological and social ones — within the mechanism of the disease seems the most representative [3–5]. The evolution of this model resulted in a broader understanding of the interrelations among the mentioned factors (fig.). Thus, it was clear that the modern paradigm includes not static, but dynamic model components and interacting formations, that make a person feel healthy or sick [6].

According to the scheme, it is important for an individual to understand the condition which complies with the definition of health accepted by the WHO that states as follows: “health is a condition of total physical, mental and social well-being, and not just the lack of diseases and physical defects.

The biopsychosocial approach to the development of diseases, that was formed more than 50 years ago, generated certain interest in medical science and practice. A special status was acquired in psychiatry where the correlation between a personality and a disease was the strongest [3]. However, in

somatic medicine, the concept was used while treating acute and chronic pain, as well as psychosomatic diseases.

In spite of obvious advantages of the biopsychosocial paradigm over the biological one, its universal application was hampered due to the extremely personalized approach to a patient. On the one hand, it was necessary to consider an excessive number of factors, many of which might have a negligible impact on how the disease develops in a specific patient. On the other hand, the inability to objectively evaluate every component of the model allowed room for subjective interpretations based solely on the clinician’s personal judgment. Meanwhile, simplifying and formalizing the model meant replacing thorough psychological diagnostics with standard quality-of-life questionnaires, which ultimately made the interaction less effective.

A major hurdle in widely using the biopsychosocial approach is its poor fit for various medical fields, such as emergency care, trauma treatment, and acute infections [5]. Consequently, this approach has mostly been confined to managing chronic conditions and geriatric care. Even within these fields, its actual implementation remains limited.

However, a more significant reason is currently driving the shift in medical methodology back toward biomedical approaches. Medicine in the 20th century relied heavily on a clinician’s personal experience and unique perception of a patient. In contrast, the 21st century is defined by the rise of evidence-based medicine. This term was offered by Sackett DL and then introduced into practice by a group of scientists from McMaster University (Toronto) in 1996. Evidence-based medicine is a medical practice founded on verified proof of safety and effectiveness, established through testing on large groups of patients. This concept was the cornerstone of medical research, clinical guidelines, and textbooks during the first two decades of the 21st century.

The widespread adoption of evidence-based medicine has shifted clinical practice from individual patient care to population-based medicine. It means that each case is now evaluated based on aggregated data from similar observations. Additionally, a clear advantage is the ability to apply proven clinical data from a studied group to an individual patient, where the safety of treatment and likelihood of success are already established.

At the same time, this raises the question of whether a real patient truly matches a statistical average. A standardized approach overlooks some individual traits, with psychological and social factors being the most neglected. Experts often point out that by strictly following evidence-based medicine and viewing the patient merely as a representative of a research group, clinicians risk adopting a mechanical approach that damages the doctor-patient relationship. Eypasch E believes that the problem is rooted in the inappropriate integration of the principles of evidence-based medicine into daily practice. On the other hand, Ioannidis J, Fava G or Horwitz R contend that the reason for destructing the interrelations lies within the principle of data extrapolation, when the minimal attention is focused on the patient's personal characteristics. Conversely, Borrel-Carrió F, et al. argue that while the emotional doctor-patient bond created through holistic care is beneficial, it must not become the primary focus. They emphasize that psychological and social factors should not be given more attention than the core biomedical aspects of an illness. It should be noted that it is impossible to equate the concepts of "biopsychosocial medicine" and "individualized medicine", just as it is impossible to contrast them with evidence-based medicine, although such a contradiction is explicitly stated in the works of Kent D, Miles A or Beckmann J.

Contemporary healthcare should be personalized taking into account the biopsychosocial traits of the patient while remaining firmly grounded in evidence-based medicine. To achieve this, current research advocates for an integrated framework that successfully combines the strengths of both methods [4]. Additionally, Ahmadvand et al. suggest updating and broadening the biopsychosocial model into a biopsychosocial-digital model, driven by the integration of telehealth services and remote patient monitoring. While we cannot stop using statistical probabilities for individual patients, we can still fully integrate their unique personal characteristics. Sotomayor C, et al. introduce a hybrid care model where a multidisciplinary medical team manages the patient. Within this team, a clinical psychologist utilizes evidence-based data to tailor the treatment plan according to the patient's unique psychological profile. Horwitz R, et al. suggest an alternative approach: creating a database of patient profiles that details individual psychosocial traits to complement the existing evidence base for specific diseases. Additionally, medical professionals can base their treatment decisions on solid clinical evidence while comparing individual cases to similar patient profiles to anticipate unexpected reactions caused by unique personal traits.

A biopsychosocial approach to the patient, as a holistic perception of his personality and disease, should be an integral part of medical culture and clinical thinking [1]. Given the many variables involved, we must isolate the most critical psychosocial factors of the illness. The concept of the internal picture of the disease (illness perception) offers a comprehensive framework that aligns perfectly with modern paradigms. It blends the biological, psychological, and social dimensions of an illness, displaying them from the patient's own perspective.

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ETHICAL BARRIERS TO PROMOTING OWN LABELS IN PHARMACEUTICAL RETAIL

Zheltkevich OV ✉

Yaroslavl State Medical University, Yaroslavl, Russia

The article comprehensively analyzes the attitudes of pharmaceutical workers to own labels (OLs) of pharmacy chains, identifies motivation and demotivation factors in promotion of OLs, and assesses the relevance of OLs by product categories and ethics of established sales practices. As a result of an anonymous survey of pharmaceutical workers, a rating was formed on the relevance of presenting OLs in various product categories of the pharmacy range. Barriers, motivators for promotion for pharmaceutical workers when working with OLs, and tools for building customer trust when choosing OLs have been identified. The phenomenon of systemic cognitive dissonance has been established. According to it, professional doubts are suppressed by financial incentives, which looks like a conflict of interests. A model of transition from bonus promotion to an expert-oriented system is proposed.

Keywords: own labels, pharmacy chains, pharmaceutical ethics, conflict of interest, cognitive dissonance, pharmaceutical retail

Author contribution: the author made a significant contribution to the preparation of the work: he developed the concept and design of the study, collected and processed the material, wrote and edited the text in order to ensure the integrity of all parts of the article.

✉ **Correspondence should be addressed:** Olga V Zheltkevich
Revolutsionnaya str., 5, Yaroslavl, 150000, Russia; neshina.yma@list.ru

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ЭТИЧЕСКИЕ БАРЬЕРЫ ПРОДВИЖЕНИЯ СОБСТВЕННЫХ ТОРГОВЫХ МАРОК В ФАРМАЦЕВТИЧЕСКОЙ РОЗНИЦЕ

О. В. Желткевич ✉

Ярославский государственный медицинский университет, Ярославль, Россия

Статья посвящена комплексному анализу отношения фармацевтических работников к товарам собственных торговых марок (СТМ) аптечных сетей, выявлению факторов мотивации и демотивации при их продвижении, оценке уместности СТМ по ассортиментным категориям и этической оценке сложившейся практики. В результате анонимного анкетирования фармацевтических работников был сформирован рейтинг уместности представления СТМ в различных товарных категориях аптечного ассортимента. Выявлены барьеры, мотиваторы к продвижению для фармацевтических работников при работе с СТМ, инструменты по формированию доверия у покупателей при выборе СТМ. Установлен феномен системного когнитивного диссонанса: профессиональные сомнения подавляются материальной заинтересованностью, что создает признаки конфликта интересов. Предложена модель перехода от бонусного продвижения к экспертно-ориентированной системе.

Ключевые слова: собственные торговые марки, аптечные сети, фармацевтическая этика, конфликт интересов, когнитивный диссонанс, фармацевтическая розница

Вклад автора: автор внес существенный вклад в подготовку работы: разработал концепцию и дизайн исследования, провел сбор и обработку материала, написал и отредактировал текст с целью придания целостности всем частям статьи.

✉ **Для корреспонденции:** Ольга Валерьевна Желткевич
ул. Революционная, д. 5, г. Ярославль, 150000, Россия; neshina.yma@list.ru

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The Russian pharmaceutical retail market is going through intensive consolidation. Thus, by the end of 2025, the top 20 pharmacy chains had consolidated roughly 75% of the retail market, whereas the top companies earned a total of 1.58 trillion rubles. In the first nine months of 2025, the total market volume reached 1,663 billion rubles [1, 2]. Facing tough competition, large pharmacy chains are actively developing their own labels (OLs), i.e. products which are manufactured by the outside factory and sold under the brand name of the retail chain. OLs offer higher profit margins than selling outside brands, let chains create unique product selections, and help lower prices for customers [3–5].

The literature contains almost no analysis on how pharmacy staff, who offer own label solutions, view this

practice. Meanwhile, OLs are promoted in pharmacy primarily by a pharmacist. Good advice is the most effective tool to make customers trust these OLs. This requires knowing the ethical rules for the current practice, especially the regulations concerning conflicts of interest in Article 74 of Federal Law No. 323-FZ “On the fundamentals of protection of the public health in Russia” [6, 7].

This study aims to examine the views of pharmacy staff on pharmacy chain OLs, find what motivates or discourages staff from promoting the OLs, check how relevant the OLs are by category, and evaluate current practices using pharmaceutical ethics and legislation in effect.

Table 1. OL presentation relevance within a wide pharmacy product range ($n = 352$)

Reference number	Product category	Mean score $\pm$ standard dev.	Range
1	Hygiene and medical products	4.10 ± 0.82	1
2	Dietary supplements and vitamins	3.98 ± 0.91	2
3	Cosmetic products	3.88 ± 0.96	3
4	Non-prescription drugs	3.49 ± 1.12	4
5	Baby and diet food	3.24 ± 1.18	5

Table 2. Demotivation factors of pharmacy workers engaged in OLs promotion ($n = 352$, multiple choice is possible)

Reference number	Demotivation factor when promoting OLs	Abs.	%
1	Concerns about product quality	228	64,7
2	Lack of financial motivation	193	54,9
3	Lack of product awareness and trouble handling objections	172	49,0
4	Pressure from management to implement the sales plan	158	45,0
5	Unwillingness to sell a cheaper or unknown product	152	43,1

Table 3. Motivation factors of pharmacy workers while promoting OLs ($n = 352$, multiple choice is possible)

Reference number	Motivation factors while promoting OLs	Abs.	%
1	Sales bonus	311	88.3
2	Certainty regarding customer advantages	207	58.8
3	Interesting promotional offers and marketing materials	207	58.8
4	Sales plan and management requirements	138	39.2
5	Simple product line	76	21.6

MATERIALS AND METHODS

The study was conducted at the Institute of Pharmacy of Yaroslavl State Medical University of the Ministry of Health of the Russian Federation (Yaroslavl) between 2024 and 2025. The researchers used an anonymous questionnaire survey composed by the author and completed by pharmacy staff. The questionnaire included 15 questions covering product category rankings by relevance of OL presentation (1 is the least relevant, 5 is the most relevant), selecting motivation and demotivation factors (multiple choice, no more than three options), evaluation of trust-building tools; attitude to the sale of OLs through marketplaces; questions regarding the role of the manager and the pharmacist in the promotion of OLs.

Inclusion criteria were as follows: active pharmaceutical workers occupying any position and being employed by any type of pharmacy who have given voluntary informed consent to participate in the survey. Exclusion criteria were not applied.

The study involved 352 pharmacy workers, including pharmacy technicians and pharmacists (71.2%), and heads of pharmaceutical organizations (28.8%). Statistical processing used descriptive statistics methods. Thus, arithmetic means and standard deviations were computed for quantitative data, while absolute and relative frequencies were used for categorical variables. The calculations were done using Microsoft Excel 2019.

The survey was completely voluntary and anonymous. All study participants gave their consent before the survey was initiated.

RESULTS AND DISCUSSION

According to the ranking results, hygiene products and medical products scored highest (4.10 ± 0.82 points) for OL presentation relevance in pharmacies. As shown in Table 1, they are followed by dietary supplements and vitamins (3.98 ± 0.91 points), cosmetic products (3.88 ± 0.96 points), non-prescription drugs (3.49 ± 1.12 points), and baby and diet food (3.24 ± 1.18 points).

Uncertainty about product quality was identified by respondents as the biggest (64.7%) barrier when dealing with OLs. It was followed by the lack of financial motivation (54.9%), lack of product awareness and trouble handling objections (49.0%), pressure from management to implement the sales plan (45.0%), and unwillingness to sell a cheaper or unknown product (43.1%) (Table 2).

The main factor that makes pharmacy workers promote OLs is represented by sales bonus (88.3%). Being certain regarding customer advantages (58.8%), interesting promotional offers and marketing materials (58.8%), sales plan and management requirements (39.2%), and a simple product line (21.6%) are viewed as significant factors as well (Table 3).

According to those surveyed, the most effective tool for building customer trust includes an active consultation by a pharmacist (82.4%), followed by sample offers (74.5%), social media reviews (60.8%), visual material (49.0%), and positioning beside the top brand (23.5%).

The data show that the current way of promoting OLs is structurally dysfunctional from the point of view of professional ethics. The basic collision is that pharmacists both promote OLs (82.4%) considering their private consultation as the key element of trust, and still have doubts about their quality (64.7%). This contradiction leads to three types of cognitive dissonance.

The first type relates to Concerns about product quality (64.7%) vs Sales bonus (88.3%). Getting paid prevents pharmacists from worrying about professional risks. This mechanism works best in areas with very low health risks, such as hygiene, medical items, and beauty products. This matches their high relevance scores of 4.10 and 3.88 points respectively.

The second type deals with Lack of product awareness (49.0%) vs Certainty regarding customer advantages (58.8%). Lack of product-related information is compensated by mentioning a profitable price. Thus, saying that it's better to buy the OL as it is cheaper, but has the same qualities, the pharmacist transforms uncertainty into pseudo-certainty.

The third type concerns Unwillingness to impose a product (43.1%) vs Interesting promotional offers (58.8%). Owing to the promotion, the focus is changed from quality to benefit. This is how a pharmaceutical worker doesn't feel responsible for a doubtful recommendation.

International research reports similar conflicts between professional values and commercial interests in relation to the promotion of generic and over-the-counter drugs [8, 9]. OL economic incentives are built directly into the organization of pharmacy chain instead of coming from outside drug manufacturers, making government rules much harder to apply.

Federal Law No. 323-FZ defines a conflict of interest as a situation in which a pharmaceutical employee's personal desire for money affects or may affect the proper performance of professional duties. With regard to the bonus promotion of OL, all three conflict rules occur simultaneously. They include a personal financial interest (bonus), the impact on the consultation quality (recommendation of a product that raises professional doubts) and a contradiction to the interests of the buyer (replacement of the preferred brand).

Meanwhile, a legal conflict exists. Thus, Article 74 of that law prohibits payment for promoting outside items, whereas bonuses for OLs of own chain are not officially included in this restriction [9, 10].

The ethical recommendations of the World Health Organization on the promotion of medicines (1988) explicitly state that promotion must be open, accurate, and complete. Failure to disclose that a pharmacist has a financial interest

in selling a particular product meets the criteria of hidden promotion [11].

Comparing the relevance rating and the nature of the consumer's decision allows us to distinguish between three zones of an ethical conflict. Hygiene goods, medicines, and cosmetics belong to the lowest risk group because a choice of the wrong item causes no major harm to health, and the buyer can directly evaluate the functional properties of the product. Dietary supplements belong to the medium-risk area as high variability of bioavailability and composition makes independent quality verification difficult. Over-the-counter medicines and baby food carry high risks because shoppers view the recommendation regarding over-the-counter medicines as professional health guidance, while babies belong to sensitive groups. It is significant that these categories received the lowest relevance scores (3.49 and 3.24 points), which shows that the professional community has instinctive moral awareness of the problem [9–11].

CONCLUSIONS

1. Hygiene products, medical products and dietary supplements have the greatest potential for the development of OLs in the pharmacy range; baby and dietary nutrition is the least promising from the point of view of the professional community.
2. Financial bonuses drive staff motivation most at 88.3%, while doubt about product quality is the main barrier at 64.7%. These factors happen at the same time and create steady cognitive dissonance. This dissonance shows up in three conflicting pairs such as quality against bonus, lack of knowledge against buyer profit, and not wanting to push others against promotional offers.
3. The established practice of bonus promotion of OLs contains signs of a conflict of interest, despite the existing legal conflict, formally removing in-network bonuses from the scope of this provision.
4. The ethical risk in promoting OLs is differentiated by categories. Thus, it is minimal for hygiene products and cosmetics, moderate for dietary supplements, and high for over-the-counter medicines and baby food, which correlates with the relevance rating according to pharmaceutical workers.
5. For the sustainable and ethically responsible development of OLs, a transition from the "bonus for sale" model to the "expert confidence" model is necessary. To do that, provision of staff with verified product information, internal product testing, and a balanced system of performance indicators, including customer satisfaction indicators, are required.

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