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CLIL for Medical Universities: Pluricultural Outcomes for the Glocal Classroom

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This article offers insights into the knowledge, skills and attitudes medical educators need to teach effectively to culturally diverse cohorts of medical students. "CLIL in Medical Education: Reaching for Tools to Teach Effectively in English in a Multicultural and Multilingual Learning Space" (CLILMED), an Erasmus+ Strategic Partnership, designed a profile to assist medical educators in the process of intentional goal-setting and self-reflection around their pedagogy, language and culture. It is the pluricultural outcomes of education that will be addressed here, since favouring the development of knowledge, attitudes and skills related to otherness, plurality and diversity have a direct impact on the quality of healthcare provision (Bradshaw, 2019; Corbett 2011; Tiwary et al., 2019). Understanding what competences medical educators need in an intercultural classroom greatly influences their ability to intentionally design, implement and develop their teaching. The CLILMED Glocal Competence Profile for Medical Educators, centred around the intended pluricultural outcomes of Content and Language Integrated Learning (CLIL), is intended to clarify and support lifelong learning for helping medical professionals interact effectively and appropriately with students from other linguistic and cultural backgrounds.

KEYWORDS:

Content and Language Integrated Learning (CLIL), medical education, pluricultural outcomes, Continuous Professional Development (CPD), competence profile

Ez a cikk betekintést nyújt abba, hogy milyen ismeretekre, készségekre és attitűdökre lehet szüksége az orvosképzésben résztvevő oktatóknak ahhoz, hogy orvostanhallgatók kulturálisan sokszínű csoportjait is magas színvonalon, hatékonyan képezzék. A vizsgálatot a 'CLIL módszer az orvosképzésben' (CLILMED: Reaching for Tools to Teaching Effectively in English in a Multicultural and Multilingual Learning Space) nevű konzorciumban végeztük, ami egy Erasmus+ KA2 stratégiai partnerség. Egy olyan oktatásmódszertani segédletet állítottunk össze, ami segítheti az orvosképzésben résztvevő oktatókat pedagógiai, nyelvi, és interkulturális kérdések integrálására oktatási céljaik átgondolása során. Az oktatás plurikulturális kölcsönhatásaival foglalkoztunk, mivel a mássággal és a sokszínűséggel kapcsolatos ismeretek, attitűdök, és készségek fejlesztése közvetlen hatással lehet az egészségügyi ellátás minőségére is (Bradshaw, 2019; Corbett 2011; Tiwary, A., Rimal, A., Paudyal, B., Sigdel, K. R., & Basnyat, 2019). Az orvosképzésben résztvevő egyetemi oktató szükségesnek tarthatja plusz kompetenciák elsajátítását ahhoz, hogy interkulturális hallgatói csoportok oktatását is eredményesen tudja végezni. A fejlesztett oktatásmódszertani eszközünk, a 'CLILMED Glocal Competence Profile for Medical Educators' középpontjában a tartalom- és nyelvi integrált tanulás (CLIL) áll. Célunk, hogy szakmai továbbképzést nyújtsunk egészségügyi szakembereknek, hogy hatékonyan és megfelelően tudjanak együttműködni a más nyelvi és kulturális háttérrel rendelkező hallgatóikkal.

KULCSSZAVAK:

szakmai tanulás idegen nyelven, orvosképzés, kultúrálisan beágyazott oktatási eredmények, folyamatos szakmai továbbképzés, kompetencia profil

Background and Context

In the last two decades internationalisation has moved from ad hoc activities and initiatives toward looking at curriculum integration in higher education institutions (HEIs). Internationalisation of higher education can also be understood more broadly to address the quality of education and to improve programme delivery (Leask, 2015), since it has clear potential to enhance "the quality of education and research for all students and staff, and to make a meaningful contribution to society" (de Wit et al, 2015, p. 281). More recently, the internationalisation of higher education has shifted from student mobility and teaching in English to also equip graduates with competences to face societal challenges (Jones, Leask, Brandenburg & de Wit, 2021). Concurrently, this echoes the call for quality education of Sustainable Development Goal 4 (SDG4) (United Nations, 2015). Here, SDG4 defines quality education as being inclusive and equitable through a lifelong learning perspective that considers all stakeholders involved as learners, including teaching staff. Target 7 of SDG4 specifically calls for education for global citizenship, human rights, gender equality, appreciation of cultural diversity and culture's contribution to sustainable development as a way to achieve quality education (UNESCO, 2017).

It is with this perspective in mind that the CLILMED project attempts to address what this particular view of quality education means for medical educators. The synergy between SDG4.7 and the internationalisation of higher education is clear: both aim at ensuring quality in education, which itself aligns with several concepts such as global citizenship (Cantòn & Garcia, 2018), internationalisation at home (Nilsson, 2003; Beelens & Jones, 2015) and internationalisation of the curriculum (Leask, 2015). These frameworks call for implementing pedagogical approaches for sustainable education through student-centred approaches, action-oriented learning, and transformative learning (Leicht, Heiss & Byun, 2018; Båge, Jellinek, Pagèze, Valcke & Welikala, 2020). Additionally, the OECD (2019a) calls for HEIs, among which medical universities, to equip future graduates with the knowledge, skills and attitudes adapted to meet the changing needs of a globalised world. The critical question for CLILMED is, then, whether HEIs are prepared to provide such quality education. Are the academic teachers appropriately trained and equipped with competences suitable to empower students with the required knowledge, skills and attitudes of a globalised world?

This article will describe how the Erasmus+ Strategic Partnership called "CLIL in Medical Education: Reaching for Tools to Teach Effectively in English in a Multicultural and Multilingual Learning Space" (CLILMED, https://clilmed.eu/) addresses the above questions. In this way, the CLILMED partners (from HEIs in Hungary, Ireland, Poland and Sweden) hope to strengthen the capacity of medical HEIs in preparing students to become qualified doctors through developing the competences of medical educators to teach through additional languages. CLILMED wishes to provide educators with tools to concurrently teach their discipline while increasing students' language competences through a Content and Language Integrated Learning (CLIL) approach focusing on its pluricultural outcomes[1]. Before we consider what these outcomes may be, let us first take a look at what a medical classroom looks like today.

The Glocal University Classroom

For the benefit of today's society, students in their classrooms should develop knowledge, skills and attitudes of active global citizens who are eager to foster sustainable development through a wider understanding of cultural diversity (Block, Poeck, & Östman, 2019). They should think globally and act locally, in a "glocal" way. Glocal competence therefore is "the ability of instructors to interact with students in a way that supports the learning of students who are linguistically, culturally, socially or in other ways different from the instructor or from each other" (Dimitrov, Dawson, Olsen, & Meadows, 2014, p. 89). In turn, an educator's own glocal competence will develop as the result of a reflective approach to teaching, learning, language and culture and will involve attitudinal changes toward one's own and others' cultures.

Adopting the glocal approach to education at tertiary level depends on the education systems of individual countries and, to some extent, on teachers implementing these educational programmes. As a result of these differences, students who are "products" of their systems enter education at the tertiary level unevenly prepared. Indeed, the first-ever PISA 2018 Global Competence report (OECD, 2020) shows that HEIs would do well to offer a curriculum that values openness to the world, provide a positive and inclusive learning environment, offer opportunities to relate to people from other cultures and have educators who are prepared for teaching global competence (Schleicher, 2020).

Recent statistics (2017-2019) show that "one in ten persons living today in the OECD is foreign-born; among youth, more than one in five has immigrated or is native born with immigrant parents" (Gurrìa, 2018) and demonstrates the linguistic and cultural diversity present in HEIs today. Nonetheless, it is important to note that there are huge disparities between the countries of the CLILMED partners, where Poland has 2.0% foreign-born citizens, and Hungary, Ireland and Sweden have 5.8%, 17.8%, and 19.5% respectively. In these countries, the number of international students at tertiary education has been steadily growing until the onset of the pandemic. The 2019 data shows that there were 35,000 international students in Hungary (13% of total tertiary student enrolment), 25,000 in Ireland (11%), 31,000 in Sweden (7%) and 55,000 in Poland, which constitutes only 4% of the global international student population (OECD, 2019a). Student diversity in medical universities tends to be higher in these countries compared to the national average

because in all of these countries medical education opened to international audiences several decades earlier (e.g., the first English-language medical programme in Hungary started in 1984, in Poland - in 1993) than in other disciplines. This means the CLILMED project partners, together, have a considerable amount of experience about teaching medicine to diverse international student cohorts. If these experiences can be aligned with recent global developments and agendas about quality teaching in the medical field, then a common goal is to formulate appropriate, standardised professional development to local medical educators who consider inclusive learning environments enriching students' learning (Leask & Caroll, 2013).

Yet, the complex nature of a multilingual and multicultural classroom makes it difficult for both students and teachers and often affects the teaching and learning conditions (Lauridsen & Gregersen-Hermans, 2019). Variations in English Language proficiency represent a major challenge (Devereaux & Palmer, 2021), variations in prior knowledge, skills and attitudes, as well as the differences in cultural backgrounds further complicate the teaching and learning environment for both students and teachers (Biggs & Tang, 2011). International and local medical students bring a multitude of cultural backgrounds to the classroom, including values associated not only with life, death, sickness, disabilities, vulnerabilities, health or mental health, but also with teaching and learning, as well as corresponding varying degrees of language proficiency. However, the extent to which educators are equipped to create an inclusive learning space has not been measured rigorously before (Valcke, Nashaat-Sobhy, Sánchez-García & Walaszczyk, 2022). HEI educators seldom have access to appropriate pedagogical training to prepare them for such multicultural and multilingual learning spaces (Gregersen-Hermans & Lauridsen, 2021), and when such opportunities do exist, they seldom focus on pedagogical skills (Sandström & Hudson, 2018). Additionally, most teachers in international tertiary education are not native speakers of English and teaching through English poses additional challenges for them. As a result, teachers may not be equipped to harness the diverse cultural backgrounds of their students and even less so to manage their heterogeneous linguistic abilities (Gregersen-Hermans & Lauridsen, 2021). Since the role of the academic teacher has shifted to be even more transformative than ever before (Båge et al., 2020; Stains et al., 2018), there is now a clear need to provide teachers with innovative tools and guidelines to enable them to design and deliver the expected quality teaching and learning that is aligned with the goals of SDG4 target 7 and of internationalisation of higher education (Schleicher, 2020). Evidence-based scholarship of teaching and learning practices for the international classroom shows that innovative approaches, centred on student learning, are essential if we are to enact the promise of quality education SDG 4 (Block et al., 2019; Marinoni, 2019; Stains et al., 2018; Hanson, 2010). The pluricultural dimension of the CLIL approach provides such an angle and it has not been formally explored in medical education before.

CLILMED, Language and Pluriculturalism

English has long been recognised as a basic requirement for medical training internationally (Maher, 1986) and healthcare higher education institutions across the world offer programmes in medical education that are fully or partially taught in English (Altbach, Reisberg & Rumbley, 2009). Effective communication skills in healthcare practices help professionals better understand a patient as a whole person, the impact disease may have on their life, and how best to manage the patient's ill health (Lu & Corbett, 2012). Evidence suggests that healthcare provider-patient communication is directly linked to patient satisfaction, adherence to treatment and subsequent health outcomes (Betancourt, 2003). Integrating language and culture in teaching medicine and healthcare thus moves language beyond a narrow focus on linguistic competence, and even beyond a concern for communicative skills and strategies, towards a wider conception of language ability that draws upon a knowledge and appreciation of different value systems (Corbett, 2011, pp. 314–15). In this way, attitudes, values and beliefs are moved from the margins of pedagogy to occupy a more central position (Frenk et al., 2010). The focus of the CLILMED project is thus precisely to identify which communication skills and professional behavioural attitudes are fit for medical students and how their educators should intentionally plan and integrate them into teaching and learning.

Medical classrooms provide "opportunities to use language/s in a variety of settings and contexts in order to enable [students] to operate successfully in a plurilingual and pluricultural Europe" (Marsh, 2002, p. 52). In today's diverse classrooms, it is important to afford flexibility in the language of education. According to Doiz, Lasagabaster and Sierra (2014), teachers should move away from an obsession with "correctness" (Canagarajah 2008, p. 223) and opt for what is an appropriate usage in a particular context instead. In medical education, language and culture should thus be positioned within a larger discourse of developing quality

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for inclusive and equitable education. The "ideal" medical educator should understand the role of language as crucial to quality medical education. Since content delivery in a medical context still today mostly consists of traditional lecturing (Stains et al., 2018), there remains very little time and space for debate, reflection, or critical analysis of data by students - let alone space for students to develop, practice and reflect on their communication skills and intercultural competence. Without a systematic approach to evidence-based instructional practices, the dilemma of the course leader will remain how to balance between the amount of content and the amount of student-centred activities within given time limitations. Should a teacher break tradition and reduce the amount of content to allow more time for developing communication skills within their course? It seems that research points us in this direction, indeed (Meyer, Coyle, Imhof & Connolly, 2018; White, McGowan & MacDonald, 2019). Nonetheless, any change in teaching traditions needs careful planning and support by HEI stakeholders. The process must be monitored if an individual course leader is to shift pedagogical mindset in order to align with global and institutional goals for quality education. This monitoring must not only be driven by university stakeholders, but it also must employ monitoring tools which can reliably inform both teachers and leadership about their professional development over time. In this way the tools developed by the CLILMED project could support such a move - you will find a roadmap for how to use CLILMED tools in Appendix A.

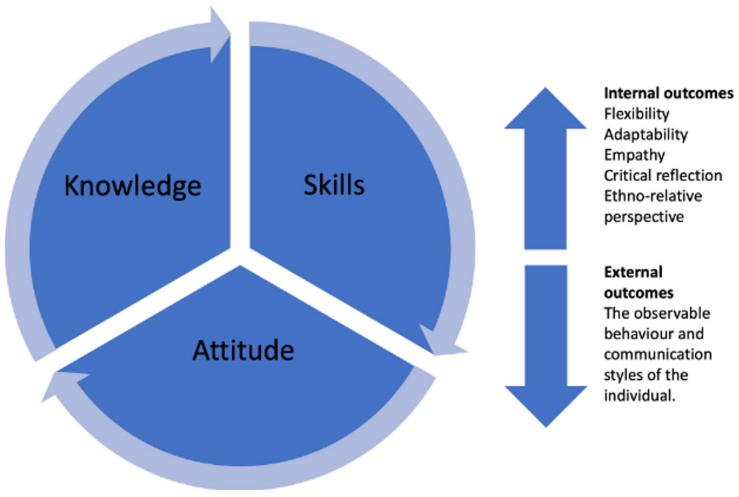
Defining the Competences of Educators Teaching in a Glocal Classroom

To systematically develop a comprehensive definition of the competences medical educators ought to have in order to successfully teach in a glocal classroom, the CLILMED team turned to existing scholarship of teaching and learning. The team focused on defining the knowledge, skills/understanding, attitudes/values compatible with glocal competences useful for medical educators to situate their own professional development needs – in this respect intercultural competence is viewed as an integral part of the competences needed by medical educators.

So, what intercultural competence is required to move between cultures? The CLILMED project used Bennett's (1998) definition of culture: it is "a learned set of shared interpretations about values, beliefs, norms and social behaviours that affect behaviour" (p. 2). This definition underlines that culture is not inherited; rather, it is taught through explanations, learned mostly through the observation of others, and changed by individual interpretation and exposure to others - and most importantly, can also be unlearned. However, shared interpretations about values are heavily influenced by the context of the medical profession. Interpretations of human values (autonomy/self-determination, non-maleficence/non-violence, beneficence/charity, justice/equity) are believed by most medical professionals to be absolute and universal (Oji, 2020), therefore shared by doctors from diverse cultures. This shared belief in the core values of the medical profession makes it possible to define and guide the development of intercultural competence of medical professionals, which "is the ability to develop targeted knowledge, skills and attitudes that lead to visible behaviour and communication that are both effective and appropriate in intercultural interactions" (Deardorff, 2006, p. 258).

Figure 1 shows the constituent elements of intercultural competence (Deardorff, 2006), namely: (1) *Knowledge* which comprises cultural self-awareness (meaning the way your culture has influenced your identity and worldview, as well as your biases about the core values of the medical profession), *knowledge* of own and other cultures, sociolinguistic awareness, and, most importantly, understanding other worldviews, as well as having a grasp of the glocal issues and trends related to healthcare; (2) *Skills* such as observation, listening, evaluating, analysing, and interpreting are key skills in developing effective intercultural communication as

Figure 1. *The elements of intercultural competence (Deardorff, 2006).*



well as in laboratory or clinical settings, as well as critical reflection, flexibility and adaptability; (3) *Attitudes* including respect, openness, curiosity, empathy and resilience. All of these attitudes imply a willingness to risk and to move beyond one's comfort zone. In communicating respect to others, it is important to demonstrate that others are valued even under ambiguous situations. These attitudes are the foundation upon which all skills and knowledge can be developed for better intercultural competence. Such foundations lead to both *internal and external outcomes.* (4) *Internal outcomes* comprise the (1) knowledge, (2) skills and (3) attitudes that lead to flexibility, adaptability, empathy, critical reflection and an ethno-relative perspective; while (5) *External outcomes* refer to the observable behaviour and communication styles of the individual as a result of the above knowledge (1), skills (2) and attitudes (3). They are the visible evidence that the individual is, or is learning to be, interculturally competent.

Importantly, evidence shows that mere exposure to diverse languages and cultures does not automatically lead to the development of intercultural competence (for mobility, see Vande Berg, Paige & Lou, 2012; for internationalisation at home, see Gregersen-Hermans, 2016). Thus, intercultural competence needs to be addressed explicitly and intentionally in learning and teaching, as well as in staff development. Importantly, intentionally scheduled sessions with critical reflections about absolute and relative values of the medical profession may become a powerful tool on the journey towards achieving better intercultural competence of teaching staff and students.

Each individual element of intercultural competence was defined and linked to the overarching competences for educational developers established by the Erasmus+ EQUiiP project (2019) as shown in table 1. The CLILMED partners aimed to adapt the EQUiiP profile to fit the needs of medical educators.

Table 1. *Competences for educators in medical universities (adapted from EQUiiP, 2019)*

	Competences for Educators in Medical Education:
1. Promote inclusive behaviours	Promote inclusive behaviours leading to transformative intercultural and glocal learning, enhanced by and appropriate for the diversity of the academic community, clinical settings and society at large. This includes ensuring reciprocity by mutually generating and exchanging knowledge, ideas and resources within and across cultures and intellectual traditions.
2. Develop and facilitate learner-centred pedagogies	Develop and facilitate learner-centred programmes that recognize and value students' diverse educational, linguistic and cultural resources and that accommodate the distinct learning needs of students, as well as enhance the friendship potential (Roberts, 2009) in the glocal classroom.
3. Promote intercultural engagement and effective intercultural relations	Promote intercultural engagement and effective intercultural relations in learning environments that support the transformation of intercultural experiences toward intercultural learning and development through collaborative dialogue. This effort should be underpinned by empathy, equity and sensitivity to diversity, as well as by an understanding of cultural, linguistic, professional and personal ways of interacting, communicating and working with others.
4. Enable and embed a glocal learning experience	Enable a glocal learning experience, informed by international interactions and/or knowledge perspectives, outward, inward and virtual mobility, cultural immersion and language acquisition. Embed these aspects in intended and reflective pedagogical approaches.
5. Integrate social responsibility in teaching and learning	Integrate social responsibility in the curriculum through addressing glocal issues and inequalities related to the medical and healthcare disciplines or professions considering their impact on cultures and the wider society.
6. Integrate learning from different international and disciplinary contexts	Apply learning from different international and disciplinary contexts to your institution, professional responsibilities and disciplinary areas, based on an in-depth and/or comparative understanding of the relevance and the impact of these contexts.
7. Integrate the various means of creating, critiquing and exchanging knowledge	Evaluate and integrate, where relevant, the various means of creating, critiquing and exchanging knowledge within and across local and global communities, including availability, accessibility, acceptability, and quality (WHO, 2019).
8. Engage in critical reflection and continuous professional development	Engage in critical reflection through evaluation of teaching practices and self-reflection, and in continuous professional development through collegial sparring and scholarship relating to teaching and learning in the international classroom.

Through discussing and analysing the EQUiiP framework, the CLILMED partners identified four core principles that all medical educators should consider, engage with, and implement in their teaching: (a) learner engagement is the ability to connect with and engage an individual learner or group of learners; (b) learner-centredness means putting the learner first, assessing their needs, understanding their barriers to learning or practice, and tailoring study programmes to meet the learner where the learner is; (c) adaptability refers to the need to adapt programmes, teaching modalities, priorities, and content over time to respond to new learner needs; (d) self-reflection is an educator's ability to think critically about their educational encounters, to gather relevant feedback, and to monitor quality.

Given the myriad of different roles that medical educators might adopt, CLILMED partners felt that the EQUiiP profile included relevant competences for any individual who teaches regularly (Srinivasan et al., 2011) that simply needed to be adapted to the medical context to include: foster inclusion; focus on learning; engage interculturally; adopt a global health perspective; address health inequalities; introduce international disciplinary learning; consider availability, accessibility, acceptability, and quality; and develop a reflective approach to teaching and learning. Through structured questionnaires sent out to HEIs in Poland, Hungary, Ireland and Sweden to analyse the use of learner-centred pedagogies in HE in Project Countries sent out to medical educators, CLILMED was able to identify the competences a medical educator needs in a glocal university classroom. These competences greatly influence medical educators' ability to intentionally design, implement and develop their teaching (Caniglia, et al., 2018), and is a clear step towards enhancing the quality of teaching and learning.

A Glocal Competence Profile for Medical Educators

The Glocal Competence Profile for Medical Educators provides a set of examples and scenarios that show how educators use their knowledge of culture, language, international perspectives and global engagement to demonstrate their glocal competence. It is intended to clarify and support lifelong learning and lead educators towards glocal competence development, so that in turn, they can support their own students' glocal competence. It is a self-assessment tool for teaching competences developed by the CLILMED partners. Its objective is to identify the teaching competences of medical educators for the improvement of educational quality, understood in terms of the integration of content, language and culture in education.

Using Rubrics

In order to create a tool for medical educators to gauge their professional development needs, the CLILMED team looked at existing literature, discussed and designed a competence profile using rubrics. A rubric is a coherent set of criteria for teacher development that includes descriptions of levels of performance quality on the criteria (Brookhart & Chen, 2015). Rubrics can be used by educators to self-assess where they are in terms of their professional development needs for teaching and where they need to go next. Rubrics were chosen due to claims that they facilitate self-assessment, facilitate feedback, and help envision what to do to improve competence (Andrade, 2000; Jonsson & Svingby, 2007). They describe competences for teaching, but are aligned with an adapted version of the OECD Learning Compass (OECD, 2019b) which offers a broad vision of student competence. The rubrics are best used by educators and educational developers as part of an overall reflective learning process that includes setting goals, selecting strategies, self-assessing, providing evidence, and reflecting before setting new goals. The rubric comprises a four-level rating scale that uses performance levels as markers of attainment (Brookhart, 2013) designed: *initiation* which describes emerging competence, *independent* which entails development, *impact* which describes accomplishment, and *innovation* which describes mastery.

Using Can-Do Statements

Rubrics consist of Can-Do statements (American Council on the Teaching of Foreign Languages, 2013), which are self-assessment checklists used by learners to assess what they "can do". Ultimately, the goal for all learners is to develop a functional competence for one's personal contexts and purposes. The Can-Do Statements serve two purposes to advance this goal: for educational developers, the statements provide learning targets for course design, serving as progress indicators; for medical educators, the statements provide a way to chart their progress through incremental steps. Table 2 spells out how to use or not use Can-Do Statements.

Using the Profile

The Profile will provide teachers with a common thread for how to strive for quality education. It is also a way by which HEIs communicate which knowledge, skills, attitudes and outcomes are required, valued, recognized and rewarded with respect to education. The profile can support medical educators in adopting a reflective approach to teaching in the glocal classroom - specific examples for users of the profile can be found in Appendix B. They may realise

"The profile can support medical educators in adopting a reflective approach to teaching in the glocal classroom ."

Table 2. *Can-Do Statements as self-assessment tools*

How to use CAN-DO statements	How NOT to use CAN-DO statements
Can-Do Statements describe what learners c an do consistently over time.	***Can-Do Statements are NOT a checklist of tasks to be demonstrated once and checked off.***
Learners demonstrate what they "can do" consistently in numerous situations throughout the learning process. Learners may be at different levels (initiation, independent, impact, innovation) for different dimensions (knowledge, skills, attitudes and outcomes).	It is not sufficient for learners to show evidence of performance in just one specific situation; the rubrics illustrate how learners might demonstrate knowledge, skills, attitudes and outcomes through a wide variety of evidence.
Can-Do Statements help learners set goals as they progress along the proficiency continuum.	***Can-Do Statements are NOT a limitation of what to learn or teach.***
Can-Do Statements describe what learners can independently do and help pave the way to higher levels. Higher level skills and functions need to be introduced at lower levels and built upon in order to have independent control of those skills and functions at higher levels.	Can-Do Statements do not show what to learn or teach at each level; the descriptors show the skills that are acquired with full control at that level. Learners should work with real-life scenarios at all levels and set goals for how to progress to the next higher level.
The sets of examples can be adapted to align with the curriculum; as well as independent learning goals	***The sets of examples are NOT a prescribed curriculum.***
Learners are encouraged to customise the "I can . . ." examples in order to fit the content and context of the learning and the targeted proficiency level.	The Can-Do Statements include examples of communicative performance to adapt or modify for local curricula; they are not intended to provide ready-made lessons.
Can-Do statements are a starting point for self-assessment, goal-setting, and the creation of rubrics for performance-based grading.	***The Can-Do statements are NOT used as an instrument for determining a letter or number grade***
Learners use the statements for self-evaluation to become more aware of what they know and can do. By using rubrics, learners can more easily chart their own progress.	Growth in acquiring glocal competence is measured over time when tasks are integrated into performance development talks and evaluated using rubrics.

that progression may not be the same for each element: knowledge, skills, attitudes, and outcomes. This is to be completely expected. For example, they may progress more quickly from initiation to impact levels in Knowledge, if they shift their attention away from the teaching of the discipline to the learning of the discipline. For this reason, it is best to determine progress on the proficiency levels by assessing each rubric separately. Educators may choose to include evidence electronically or in a hard copy to support specific Can-Do Statements as part of their teaching portfolio, for instance.

Limitations and Future Research

The CLILMED project aimed to create a roadmap for the professional development needs of medical educators for interacting effectively and appropriately with people from other linguistic and cultural backgrounds. The CLILMED Glocal Competence Profile for Medical Educators, centred around the intended pluricultural outcomes of Content and Language Integrated Learning (CLIL), aims to clarify and support lifelong learning in the glocal univeristy classroom. We consider this paper a starting point for a larger conversation on the continuous professional development of university educators when teaching glocal classrooms, regardless of discipline.

Future research efforts should be directed at validating and evaluating this tool to ensure that it is useful, robust, and generalizable. We encourage medical educators to pilot its usability and explore it with regards to their own local context. Medical educators and educational developers might find it useful for career development in teaching, assessment and quality assurance fit for the glocal classroom. ■

"We consider this paper a starting point for a larger conversation on the continuous professional development of university educators when teaching glocal classrooms, regardless of discipline."

Table 3. *Glocal Competence Profile for medical educators*

Glocal Competence Profile for Medical Educators	
Knowledge	
Levels of attainment	**Descriptors**
Initiation	I can identify issues related to diversity and identity, social justice and equity, globalisation and interdependence, sustainable development, peace and conflict, human rights, power and governance in relation to my discipline and context.
	I can engage with glocal issues and relate them to their impact on my local context.
	I can integrate various means of creating, critiquing, and exchanging knowledge.
Independent	I can ensure reciprocity by mutually generating and exchanging knowledge, ideas and resources within and across cultures and intellectual traditions.
	I can engage critically with sense-making when colleagues/students exploit their own experiences as sources of knowledge.
	I can promote a collaborative approach, based on equity and inclusion.
Impact	I can reflect in depth about critical similarities, differences, and intersections between my own and others' cultures so as to demonstrate a deepening or transformation of my original perspectives.
	I can use skills to negotiate cross-cultural situations or conflicts in interactions inside or outside the classroom effectively.
	I can demonstrate understanding of fundamental concepts and methods that produce knowledge about plural societies and systems of classification.
Innovation	I can adopt and model a perspective that is anti-racist, anti-sexist, anti-imperialist and pro-social justice.
	I can embed knowledge perspectives, cultural immersion, language acquisition, as well as outward, inward and virtual mobility in my pedagogical approaches.
	I can use comparative, intersectional, or relational frameworks to examine the experiences, cultures, or histories of two or more cultural groups within a single society or across societies, or within a single historical timeframe or across historical time.
Skills	
Levels of attainment	**Descriptors**
Initiation	I can reflect upon and update my worldview.
	I can understand the role culture plays in teaching and learning in higher education.
	I can adapt to an intercultural mindset and work flexibly with people from different cultures.
	I can communicate and adjust social and academic registers of language to the demands of my specific learner groups.
Independent	I can analyse how people's norms, beliefs and values shape their worldviews and the knowledge they accept as truth.
	I can accommodate the diverse learning needs of my students.
	I can foster positive intergroup contact, reflect on how to address prejudice, and manage critical incidents.
	I can adapt course design so that it includes intended language, culture and content learning outcomes.
Impact	I can integrate collaborative dialogue into my pedagogical frameworks.
	I can develop approaches or strategies based on learner-centred pedagogies that recognize and value students' diverse educational, linguistic, and cultural backgrounds.
	I can design and facilitate teaching and learning in an interactive, learner-centred way that enables exploratory, action oriented and transformative learning.
	I can merge language, culture and content learning skills into an integrated approach at course level.
Innovation	I can understand my place in the world relative to historical, geopolitical, and intellectual trends, including the geographic, socio-cultural, economic, and ecological influences on these trends.
	I can demonstrate understanding of the basis of human diversity and socially-driven constructions of difference: biological, cultural, historical, social, economic, or ideological.
	I can promote inclusive behaviour and can challenge exoticism, stereotypes, and misinformation directly.
	I can merge language, culture and content learning skills into an integrated approach at programme level.

Attitudes

Levels of attainment	Descriptors
Initiation	I can use appropriate language and communication methods that consider others' points of view and respect differences. I can understand myself as a cultural being whose beliefs, values, and assumptions shape and are shaped by one's society and environment; awareness of others reflects the ability to recognize others as similarly complex cultural beings.
Independent	I can understand the connection between my own personal behaviours and their impact on global systems. I can analyse and explain the impact of culture and experience on my own world view and behaviour, including the assumptions, biases, prejudices, and stereotypes that I make.
Impact	I can support the transformation of intercultural experiences toward intercultural learning for my students. I can develop behavioural capacities to act collaboratively and responsibly to find glocal solutions for glocal challenges and to strive for the collective good.
Innovation	I can promote intercultural engagement and effective intercultural relations in my learning environments. I can demonstrate respect and support for the common good of the world community, including its diversity, attention to human rights, concern for the welfare of others, and sustainability of natural systems and species

Internal outcomes

Levels of attainment	Descriptors
Initiation	I can view and interpret the world from other cultural points of view and identify my own.
Independent	I can tolerate ambiguity when responding to new, uncertain, and unpredictable intercultural encounters and adapt my behaviour.
Impact	I can develop awareness and sensitivity to others' feelings and emotions and how these are expressed across cultures.
Innovation	I can accept the relativity of my own ways of seeing, thinking, and doing.

External outcomes

Levels of attainment	Descriptors
Initiation	I can reflect on my own cultural influences and environments in order to understand my own beliefs and values.
Independent	I can compare values and beliefs, reconsider my own prejudices, express an interest to continue learning about and with others.
Impact	I can gain knowledge, insight, and understanding of cultural differences and accept that my worldview is not universally shared.
Innovation	I can foster intercultural pedagogical contact and develop skills to negotiate cultural conflicts.

Notes

1 CLIL is an acronym used mostly in primary and secondary education, while ICLHE (Integrating Content and Language in Higher Education) is used in tertiary education. While both highlight the dual focus on language and content, it must be noted that the specificity of the higher education context and the medical field are taken into consideration by the CLILMED project.

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Appendix 1

Roadmap for how to use the CLILMED tools

CLILMED tools will allow medical educators to identify their strengths and weaknesses in terms of their professional development for teaching in multilingual and multicultural learning environments through 4 steps (as illustrated by Figure 2). All the tools are available through the project website: https://clilmed.eu/

STEP 1: What competences do educators need?

Defining the requirements of medical educators will allow them to reflect on what their needs are.

STEP 2: How can educators assess their competences?

Next, educators can assess their self-perception of linguistic and cultural competences needed for teaching glocal classrooms through taking a self-assessment survey.

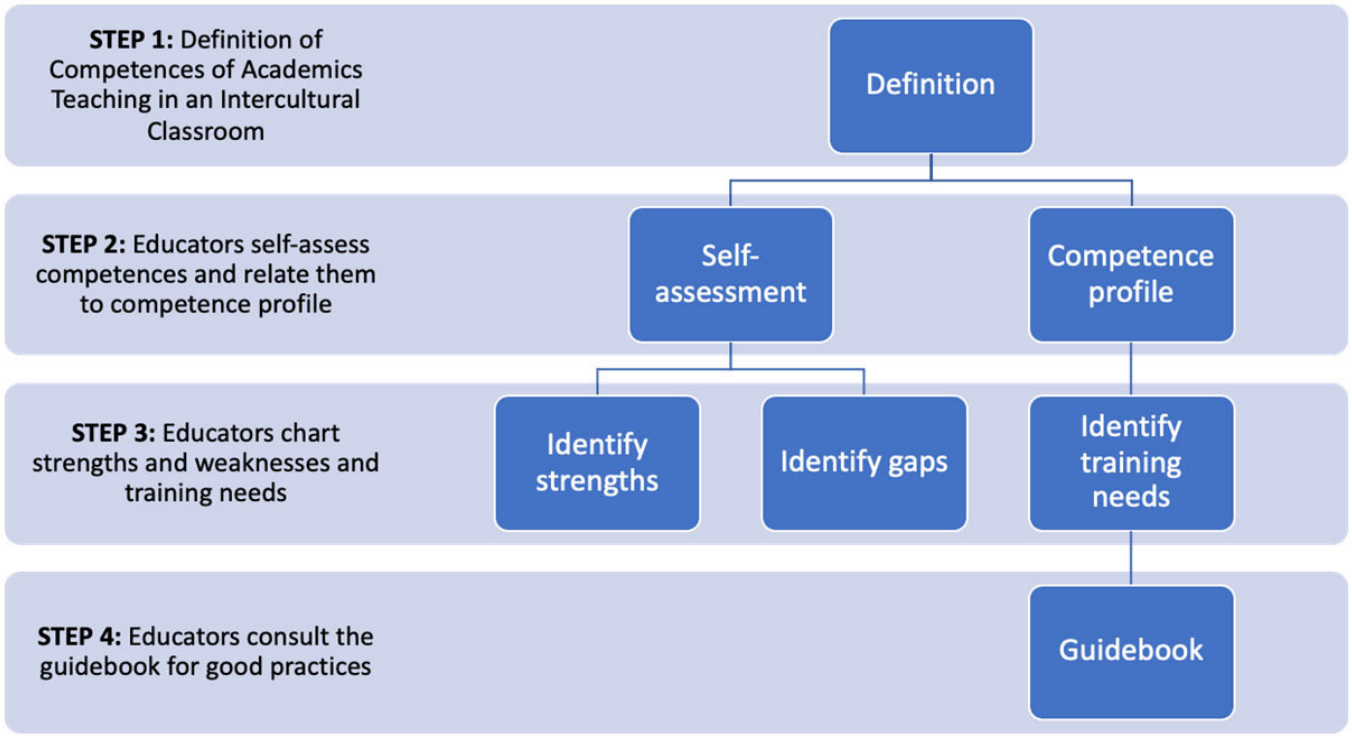
STEP 3: How can educators identify where they stand?

Through their responses to the self-assessment survey from step 2, medical educators will be able to map their professional development needs by situating themselves along the lifelong learning continuum mapped by the Glocal Competences Profile through 4 phases of proficiency: initiation, independent, impact and innovation.

STEP 4: What good practices exist?

Finally, medical educators can consult the CLILMED guidebook to identify good practices in teaching glocal classrooms.

Figure 2. *CLILMED tools provide medical educators with a roadmap to assess and identify their professional development needs*



Appendix 2

Examples for the descriptors of the Glocal Competence Profile for Medical Educators

Glocal Competence Profile for Medical Educators

Knowledge

Levels of attainment	Some examples of teaching and learning activities
Initiation	Identifying cultural/gender stereotypes in healthcare. Reflecting on healthcare in other cultures and the impact of culture on the provision of healthcare.
Independent	Researching the impact of cultural/gender stereotypes on the quality of healthcare provision. Reflecting on the role empathy plays in dealing with patients and colleagues.
Impact	Reflecting on medical cases and their treatment in different cultural settings and in low-, middle-, and high-income countries. Reflecting on how culture affects disease diagnosis and treatment.
Innovation	Analysing the concept of health as a Human Right and its implications for countries at different income levels through the lens of the SDGs. Collaborating across professions on a project to design an action-oriented guide to perform home visits to pregnant women and their infants throughout pregnancy and infancy in indigenous communities.

Skills

Levels of attainment	Some examples of teaching and learning activities
Initiation	Communicating effectively with professionals from other fields. Simulating treatment options to patients from diverse linguistic and cultural backgrounds.
Independent	Analysing norms, beliefs and values shape their worldviews and the knowledge they accept as truth. Discussing past medical practice and how to address any lack of inclusivity.
Impact	Co-designing assignments and rubrics for assessment with your students. Discussing how healthcare should be given to use all genders and races where possible and appropriate.
Innovation	I can understand my place in the world relative to historical, geopolitical, and intellectual trends, including the geographic, socio-cultural, economic, and ecological influences on these trends. I can demonstrate understanding of the basis of human diversity and socially-driven constructions of difference: biological, cultural, historical, social, economic, or ideological. I can promote inclusive behaviour and can challenge exoticism, stereotypes, and misinformation directly. I can merge language, culture and content learning skills into an integrated approach at programme level.

Attitudes

Levels of attainment	Some examples of teaching and learning activities
Initiation	Practising inclusive language and communication methods that consider others' points of view and respect differences. Reflecting on how a student's cultural being (beliefs, values, and assumptions) shape understanding of health or ill health.
Independent	Connecting personal behaviours and their impact on global health systems and medical practices. Analysing and explaining the impact of culture health behaviours, including the assumptions, biases, prejudices, and stereotypes that are made.
Impact	Exploring the impact of representation in medical imagery, models, and life models. Using the Sustainable Development Goals for finding glocal solutions to glocal challenges (for example, tuberculosis control through SDG1 and SDG10, or, antibiotic resistance through SDG3).
Innovation	Discussing how intersecting identities impact on power dynamics and experiences in health care systems, proposing solutions and good practices. Exploring and reflecting on patient lived experiences through literature, cinema, art and drama.

Internal outcomes

Levels of attainment	**Some examples of teaching and learning activities**
Initiation	Researching and interpreting doctor-patient relations from across the world.
Independent	Role-playing scenarios when responding to new, uncertain, and unpredictable medical cases.
Impact	Reflecting on patients' feelings and emotions, and how these are expressed across cultures, when delivering a medical diagnosis.
Innovation	Discussing scenarios/models of how patients' realities, clinicians' mental models, and medical records/ journals can misalign to produce distortions in comprehension and treatment.

External outcomes

Levels of attainment	**Some examples of teaching and learning activities**
Initiation	Reflecting on how culture influences own beliefs and values about health.
Independent	Analysing how communication styles, in the meaning of words and gestures, impact what can be discussed regarding the body, health, and illness, and varies across cultures or socio-economic contexts.
Impact	Debating the Right to Health (1946 Constitution of the World Health Organisation) and its entitlements (for example: the right to a system of health providing equality of opportunity, access to essential medicines, or access to reproductive health).
Innovation	Collaborating on a project that researches whether cultural humility increases patient satisfaction, and care outcomes.