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Professional multiculturalism in the medical field

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Abstract. *The present article aims to illustrate the professional multiculturalism in the medical field, starting from an analysis of the definitions of multiculturalism in the literature, with three main approaches in the public discourse (ideological-normative, programmatic-political, demographic-descriptive) and the preponderance of socio-human fields; we have proposed a new definition of multiculturalism as a method (the incorporation of elements from other cultures into elements specific to one's own culture in order to create versions of products, services, solutions, etc. adapted to other cultural contexts) and as a phenomenon from two perspectives i)a reality characterized by a diversity of people and / or values, goods, practices (and so on) of different cultural backgrounds; ii) the multicultural man who lived in several countries and assimilated and integrated in a syncretic way values from those cultures. Furthermore, we have illustrated the ways in which the concept of multiculturalism is approached in academic and professional discourse in the medical field: a) ethnic-cultural human diversity by: proposing the concept of "cultural competence" as a strategy and skill developed by the medical units, and improve medical services for patients of diverse cultural backgrounds; the cultural diversity of international medical students and the medical staff and its implications; b) international cooperation between medical units and organizations, governmental or nongovernmental institutions in the medical field. Finally, we have exposed forms and aspects underlying multiculturalism in the Romanian clinical environment in relation to the innovative process of adopting advanced medical technologies, as well as research guideline.*

Keywords: multiculturalism, cultural competence, private clinical environment, medical technology, international cooperation, clinical engineering, innovation

JEL Codes: I15, M16, 039

1. Introduction. Defining multiculturalism in the global context

Multiculturalism is a force, a great planetary necessity. Organizations with international / transnational or at least intercultural activity, starting from business, need multiculturalism to adapt and develop in the context of a market that has already been touched by globalization for decades and in which important mutations take place:

1) The need for organizations to become as original as possible, to find solutions, innovative development strategies
2) The need for organizations to be able to adapt their "recipe" (strategies, products, services, policies, etc.) to the needs of the clients / beneficiaries

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Practically, organizations need multiculturalism as an innovative method for folding to local cultures in the markets in which they operate. In this sense, multiculturalism helps them to select their members, to personalize their values, products, services, policies and management, marketing, sales, PR, CSR strategies, to manage their accounting, and so on.

The concept of multiculturalism is very complex, being approached from three perspectives in the public discourse: demographic-descriptive, ideological-normative and programmatic-political (The International Federation of Library Associations and Institutions -IFLA).

- from the demographic-descriptive point of view, the word "multicultural" is used with reference to the existence of various ethnic or racial segments within the population of a society or state;
- from programmatic-political perspective, "multiculturalism" refers to certain types of programs and policy initiatives designed to respond to and manage ethnic diversity;
- the ideological-normative sense of multiculturalism is a slogan and a model for a political action based on sociological theorization and an ethical-philosophical approach to the place of those with distinct cultural identities in contemporary society.

Multiculturalism as a professional method consists of incorporating elements from other cultures into the classical elements of its own culture of origin from which the original products / services / policies / strategies (etc.) were created, resulting in versions adapted to the respective local cultural contexts; The method is customizable for every person, organization, or community, and can only be done through live actors - individuals or institutions, organizations. Thus, we need to create multicultural contexts and appropriate people who are open to change.

Multiculturalism as a phenomenon is addressed in this paper, part of a larger project, from two perspectives:

a) Defining the multicultural man as a person who lived, worked, developed, created in several cultures, in several countries, and assimilated and integrated values from those cultures in a syncretic way. People and professional multicultural organizations have real, practical life and professional experience. They are forced not only to live and work in other cultures but also to understand their characteristics in order to adapt their businesses / services to those cultures and prosper in their markets.

Thus, the work aims to capture the multicultural aspect from the perspective of the leadership of foreign organizations that have established or expanded their activity in the territory of other countries. The purpose of such an approach to multiculturalism is to learn how some business organizations - in the case of the present project - private medical units in Romania with foreign leadership or shareholders - have made changes to strategies through a multicultural approach not necessarily of respect for that culture but simply from very concrete and very calculated economic interests found in their components, especially in the quality of products and services and in the satisfaction of clients / beneficiaries (patients and medical staff) - essential for the operation of any system.

The multiculturalism thus approached is based on the principle of the Master-Disciple relationship, according to which an entity - person or organization – clings to the needs of the other identity to help it evolve itself without giving up its own identity.

Companies have taken this vision at the level of organizational structures. In order to satisfy customers in another culture, the firm must learn to integrate values of that culture into its identity if

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it is not found in its culture of origin (Bibu, 2006: 74). For example, a car company will create cars with design and / or functions appropriate to environmental, road, tax, and customer preferences in a particular country, retaining the quality and design features specific to its home culture (VolkswagenAg.com, *Different Countries, Different Models*, 2017; ToyotaGlobal.com.*Smart Mobility Society*, ITS World Congress, 2014) or adapt its marketing strategies by promoting, for example, the same car model in different cultures / countries under different names or brands for reasons that are specific to local languages or the popularity of a brand (Autoguide.com.,*10 cars with different names in different countries*, 2016).

The employees of business organizations have a key role to play in meeting the needs of customers in a new market. When they incorporate new values, they must "feel" the customers - feel, think, live as they do to create products, services to satisfy them. With respect to medical units, clients are patients. According to the research in the field, patient satisfaction is directly related to their perception of interpersonal, technical, intelligence and medical staff skills. Of all, a priority for patients are the interpersonal communication skills of medical staff. In other words, emphasis needs to be placed on identifying patients' needs so that healthcare professionals can meet them, using appropriate medical techniques and procedures (Development Strategy - Monza Hospital Strategy, 2017-2020: 5)

All employees adhere to and find themselves in internal politics, in the organization's values, as well as in the common cause that motivates them daily to work in the company. No business organization can exist without a real mission that responds to a community need and at the same time to be original and satisfactory for its employees. They are no longer motivated solely by the financial resources received (otherwise they would remain simple mercenaries), but by the finality and result of that work in which they identify as creative beings, giving them a meaning in life and valorisation derived from the satisfaction the results of their work offer to the community. Employees can be compared to soldiers devoted to the cause they are fighting for, and companies / organizations with the performing armies in the former empires (Burcu, 2007: 84). In order to work with such soldiers, the firms will make changes to the recruitment criteria. Currently the main criteria are professional experience and skills. But it is not enough. It is necessary to prioritize criteria related to the human, moral quality of people, to their psychological profile: passion, vocation for the field; the interest or at least the opening to the knowledge of the culture of origin of the employing organization and of the local culture in which it operates, intrinsic motivation, the desire to know other cultures from which to learn. For example, Romanian employees of a foreign firm active in Romania if they develop the passion for the culture of the country of origin of the firm, become ambassadors of that culture as well as of the organization among the Romanian society. In other words, Romanian employees, irrespective of their position, represent the bridge between the organization and the Romanian market. As the bearers of the values of Romanian culture, they are the ones who can "feel" their conational / fellow clients and, if they have the necessary motivation, can give maximum yield in the creation of innovative products / services corresponding to the needs and to the preferences of Romanian clients and at the same time remain representative of the identity of the company and its culture of origin.

b) A reality characterized by a diversity of people, technologies, practices, values of different cultural origins. This approach applies to organizations with multidisciplinary teams, employees and other categories of staff coming from multiple cultures; they need a favourable context to harmonize with

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each other, to learn from each other in order to collaborate in a project. If each person involved in the project contribute with his/her value and feels good by exchanging values with others different from him/her, then each one progresses more by putting passion, and the final result - product or service - will be a unique one, of success, that will incorporate an increased degree of originality, and at the same time will rely on the requirements of the market in which it operates.

This version of multiculturalism corresponds in part to what management researchers call "intercultural management" or "cross cultural management" (Nicolescu & Ionescu, 2011) defined as "a type of management that takes place in organizations where employees come from different national cultures, through which cultural differences between them are taken into account." This type of management has developed "with the acceleration of the internationalization process. When a group of people from different cultures work in a company, management has to operate with different cultural and religious values systems, which implies new approaches in the company's motivational and decision-making system. Intercultural management is important in preventing interethnic conflicts, and if they occur, in reducing possible consequences. Intercultural management has an important role to play in creating a new organizational culture that integrates values from each representative cultural system for company employees in order to avoid any form of discrimination" (Nicolescu & Ionescu, 2011: 46).

The incorporation of multicultural values, the flexibility of an organization, its wisdom and the ability to cling to the values of another culture are a set of essential virtues in the new global context. They are the opposite of globalization made erroneously, by force, by imposing a cultural model at the expense of the **others.**

1.2. Phenomena that do not associate with multiculturalism

Multiculturalism should not be confused or associated with the following phenomena:

a) Importing the values of another culture and dissolving the values of own culture

Globalization, a natural process accelerated with the development of colonial empires, and especially after the Second World War, with the technological revolution, has had less desirable effects and now has negative connotations in the context of the socio-economic crisis because of the wrong way it has been managed over the past decades. The more developed economies and business organizations within them have tried to hold their monopoly, to impose their own cultural model, including the types of services, products, from positions of superiority and domination, and benefiting from the resources of dominated markets. Thus, it has been applied the principle of social darwinism, the survival of the strongest ("surival of the fittest"), which has resulted in a corrupt corporate spirit of aggressive competition, eliminating competition for fear of being dominated and deprived of resources by it (Bibu, 2006:73). Current social, economic, political, moral crises at global level are also a consequence of this way of thinking and managing relationships with third parties - individuals, organizations, communities, states. An imbalance has been created through the impoverishment of dominated markets, which also has consequences for the well-being of countries with more developed economies.

Properly managed globalization will use a multicultural approach based on value principles of fair sharing, transfer of expertise and values according to the needs and specifics of each individual / entity / organization / society. Organizations have begun to realize the need to live in a world with more power poles, each with its own identity and cultural model, organized into networks to survive.

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(Flanja, 2012; Badrus & Rădăceanu, 1999: 99-101; Lisovschi, 2007: 42). Professors Gheorghe Badrus and Eduard Rădăceanu (2009: 102) state on the national economies that "they are and remain a fertile environment for growth and economic development, including in the conditions of globalization. To realize this potential it is necessary that national economies should neither be converted into bastions, the less in autarchic islands (which would not be possible) nor in deposits of goods sold to foreigners wholesale or villages without dogs allowed at the discretion of transnational hunters."

The new principles of society's evolution - cooperation and creativity - redefine old human behaviours: the desire for power and primacy, the sense of competition. They remain just as current in this phase of the evolution of society and the economy, but now they are manifested not by reference to the outside, by opposition to other systems, markets or competitors, but by their own capacity to create values and externalize them, to the degree of originality embedded. Markets are valued not by their territorial or financial dimensions but by the ability of their products, services or rewards to loyalty customers, partners, suppliers, the community. Thus, a new paradigm is entering the economic world: the value of an organization or its products and services is even greater as they become more well-accepted by all social actors equally: from the ecological environment, to the community one, to family and the private life of the individual (Burcu, 2007: 81-82).

This new optics in the universe of the economic process is all the more necessary for socially active actors in a new market with a distinct local culture where its members may have different criteria for assessing the value of an organization or the results of its work.

b) Adaptation to another culture. If, for example, a person in a particular country is settling in a different country where he/she adapts himself or herself out of need, but does not acquire any values of the new host country, and when returning has the same behaviour, lifestyle, mentality, that person can not be considered a multicultural man/woman.

c) Cultural assimilation. If the person established in another country adapts and completely forgets his/her national-cultural identity, it means that he/she has been culturally assimilated and, again, he/she is not a multicultural person.

d) The opening, for example, by a company of five subsidiaries in five countries without having assimilated values from those cultures, but only imposing their values from the culture of origin

Not all corporations capitalize on multiculturalism but come with their own vision that they use in all countries in which they operate. The franchise, for instance, is a prototype of a business reproduced all over the world, without the need to take local cultures into account. Personalized products tailored to local culture (e.g. McDonald's McMici in Romania, McPinto Deluxe in Costa Rica, Maple & Bacon Poutine in Canada, Deluxe Shrimp Burger in Korea or the McPaneer Royal in India - businessinsider.com.2015) are innovations that have been allowed to local franchises to make them in a particular country, in addition to franchise-specific products and / or services. However, in the case of franchises such as those in the food industry (McDonald's, KFC), the need to enter the markets where more products / services are tailored to customer preferences can be noticed. The need for such franchises to innovate is even greater the stronger local cultural identity is the greater the cultural differences between the original market of the franchise and the local market are.

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2. Methodology

The present paper, part of a broader research program, has a predominantly theoretical component, based on specialty literature review. Within this, we first sought out a review of the definitions of multiculturalism in the literature; Thus we have noticed the existence of three main approaches of multiculturalism in the public discourse (demographic-descriptive, programmatic-political, ideological-normative) and the fact that in the literature, both abroad and especially in Romania, multiculturalism was treated mostly by fields of the socio-humanities sphere: ethnic-national, philosophical-ideological, diplomacy and international relations, communication, economics (marketing, human resources, management), sociology (population migration), education / pedagogy. Later, we proposed a new definition of multiculturalism as a method (incorporating elements from other cultures into elements specific to one's own culture in order to create versions of products, services, solutions etc. adapted to other cultural contexts) and as a phenomenon from two perspectives with which we operate in the present study: i) a reality characterized by a diversity of people, values, goods, practices (and so on) of different cultural backgrounds; cultural-ethnic human diversity ii) the perspective of the multicultural man who lived in several cultures / countries and assimilated and integrated in a syncretic way values from those cultures. We have further illustrated the ways in which the concept of multiculturalism is approached in academic and professional discourse in the medical field: a) human-cultural diversity by: proposing the concept of "cultural competence" as a strategy and skill that medical units develop for improving their medical services for patients of diverse cultural backgrounds; the cultural diversity of international medical students and the medical staff and its implications; b) international cooperation between medical units and organizations, governmental or nongovernmental institutions in the medical field. Finally, we have exposed forms and aspects under which multiculturalism is found in the private clinical environment in Romania, which are also guidelines for further research.

3. The state of knowledge of the medical field from the perspective of multiculturalism

Medical and scientific professionals have noticed the impact of global changes on the role, functions, shape and mode of operation of health care systems. Changes with the greatest influence include: the rising importance of knowledge as a factor of economic growth in the context of the global economy, the information and communication revolution, the emergence of the worldwide labour market and global socio-political transformations (Graham, 2005:80).

Globalization and multiculturalism represent a fundamental challenge of how the West has understood, conceptualized and implemented medical practice. The medical system in Western societies is a repository of tradition and culture, language, knowledge and abilities that is often in contradiction with changing local and national contexts, which in turn are the product of globalization and multiculturalism (Editorial, The Lancet, 2002 quoted by Graham, 2005:79).

The impact on health care and the education of practitioners in the global knowledge economy requires more than just the establishment of curricula on international issues in languages, history and culture. Healthcare systems are now in a position to compete with other systems in other countries, for both patients and staff. These patients and staff move to other countries in an ascending rhythm in search of lifestyle changes, opportunities and options, and thus affect quality indicators globally. On the other hand, the specialists also recognize the less pleasant effects: increasing the gap between the economically developed and the poor countries. The global labor market encourages a brain and skill drain that hit the most in developing or transitional economies, creating a series of moral dilemmas that health professionals have not yet faced (Graham, 2005:80).

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In academic and professional discourse in the medical field, the term "multiculturalism" is mainly used in the sense of ethnic-cultural diversity. Since the 1980s, the concept of cultural competence has been proposed and developed in the Western scientific world in relation to medical service providers. Thus, the concept of cultural competence is used to describe a variety of strategies, abilities, interventions that aim to improve the accessibility and efficiency of health care services for people belonging to racial or ethnic minorities. It has emerged as a response to a new reality: cultural and linguistic barriers, cultural differences in communication styles, the difference in knowledge of practices and health care standards between healthcare providers and patients could affect the quality of healthcare providers. (Weech-Maldonado et al., 2012, Health Research & Educational Trust, 2013; Jongen et al, 2017, Truong et al., 2014). This requires healthcare practitioners to understand the range of cultures and social structures they are likely to interact with in their area of activity. This understanding is not limited to the model of medical practice but also includes patients' perceptions of illness and health care, their interpretation of the causes of illness and misfortune, the effect of medical technology on their self-concept and the socio-cultural aspects of physical disability and impairment (Graham, 2005:79).

The concept of cultural competence has developed into the academic and professional world of Western cultures (North America, Western Europe, Australia, New Zealand) with wide ethnic diversity and is generally applied in urbanized, Western or non-Western developed societies that are more likely to manifest cultural pluralism from an ethnic point of view, but also regarding medical therapies that often coexist and influence one another. An example is western medicine practiced in China and acupuncture, a Chinese method adopted by Western countries as well (Graham, 2005:79).

The concept of cultural competence is constantly developing, so that there is currently no definition of it agreed by the entire scientific community, a definitive conceptual model or framework. For example, the US National Quality Forum (2008:2; Weech-Maldonado et al., 2012: 2) defines cultural competence as "the ongoing capacity of healthcare systems, organizations and professionals to provide for diverse patient populations high-quality care that is safe, patient and family-centered, evidence-based and equitable." The most cited definition belongs to Cross et al. (1989: 13), according to which cultural competence is "a set of congruent behaviors, attitudes and policies that come together in a system, agency or among professionals and enable that system, agency or those professionals to work effectively in cross-cultural situations."

These definitions reflect the current requirement on cultural competence, also referred to in literature in other terms such as "culturally appropriate care" and "multicultural education", to be integrated at all levels of health services and systems; thus, from the level of personal interaction between practitioners and client-patients, to the organizational level and even to the medical system, it is necessary to incorporate them into culturally competent normative frameworks (Jongen et al, 2017, Truong et al, 2014 Weech-Maldonado et al., 2012: 2).

Cultural competence recommends the development of "policies, learning processes and structures by which organizations and individuals develop the attitudes, behaviours and systems that are needed for effective cross-cultural interactions" (National Quality Forum, 2008, p. 2). Emphasis is placed on the professional education of practitioners in the medical system directed towards (Abdullah, 1995; Graham, 2005):

- Developing knowledge of cultural differences
- Integration of the multicultural context into practice

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- Providing experience opportunities to enable trainee practitioners to develop their patient care approach

At the level of professional-patient interaction, several models of cultural competence have been developed in the literature, focusing on the dimension of knowledge (e.g. understanding the meaning of culture and its importance in providing health care), attitudes (such as: respect for variations in cultural norms) and aptitudes (elucidation of patients' models of disease explanation) (Truong et al, 2014:1).

Multiculturalism from the perspective of ethnic human diversity in the direction of intercultural education and communication is also applied in researches on the influence of the foreign language and culture of foreign students at the Faculty of Medicine in Western countries on clinical education processes.

The issues faced by academic and clinical instructors in relation to foreign students are related to different cultural backgrounds, authority and respect issues, and linguistic competence. (Ladyshewski, 1996; Abu-Arab & Parry, 2015, Wang & Greenwood 2015; Wook et al. 2016).

The different cultural background

The provision of medical services in a society is largely influenced by cultural factors at national, local and organizational level. Patients-clients visiting the healthcare unit also come with their own cultural background. All these cultural factors are often unrelated and foreign to the world view of students from other cultures. They may feel unprepared for the practical experience of dealing with patients in the hospital as this implies a high level of awareness of local culture and increased conversational linguistic abilities.

Practical education within the clinic is shaped by country-specific cultural values. The Western model requires students to develop behaviours such as self-orientation, assertiveness by contributing with their own ideas and perspectives, independent problem-solving skills. These values may conflict with those of other cultures such as the Asian ones where it is worthwhile to maintain harmony and ensure regulatory approval.

These issues of different cultural affiliation also have an impact on the quality of medical care provided to patients by students, so supervisors must often be with students to ensure that patients' needs are properly and correctly taken up.

Issues of authority and respect

In Asian cultures, teachers often have the same status as students' parents. Therefore, expressing their own opinions and justifying them is considered to be a lack of respect for the teacher or supervisor who has had more professional and life experience. At the same time, in oriental cultures, traditionally, public expression by students of the weaknesses of their performance is not encouraged, nor the positive ones in order to keep themselves modest. As a result, many Western professors-supervisors tend to label these students as lacking self-assessment and problem-solving skills.

Linguistic competence

The linguistic competence of foreign medical students in a country with a different culture and language is another challenge for them. Inability to select or understand the correct word can affect their ability to develop a relationship with the patient. In relation to native speakers of a local language, foreign students may encounter difficulties in replacing one word with another in the patient's mind, in formulating complex sentences in a timely manner when interacting with patients. Thus, it becomes difficult for them to pack communication in a cultural context. Communication therefore seems cold and clinical, lacking empathy towards the patient, although the student may be really concerned about his client.

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Within the medical units cultural diversity can be also found at the level of the staff. The international movement of health care professionals has resulted in the creation of more or less multicultural and multilingual staff, providing benefits such as the influx of specialized skills. At the same time, new and unique challenges arise when trying to inform and maintain best practices. Robert Nieves, Vice President of Health Informatics, Elsevier, provides some examples:

- Variation in linguistic competence and documentation standards, resulting in the loss of critical clinical information;
- Variation in educational backgrounds, clinical experience, areas and periods of practice and knowledge retention results in a wide variation in the way doctors practice their profession, directly influencing the quality of health care and determining poor adherence to institutional good practice standards.

Even positive results can also pose challenges such as:

- New skills entering the institution from specializations that did not have enough resources. This in turn entails the need for training and development time for generalized or non-specialized trained staff to learn new practices;
- In addition, new staff may not be in place at work long enough to be properly prepared for a period of weeks or months.

Consequently, the author argues that institutions are exposed to the potential of expensive unexpected events, omissions in care, errors in command or delegation of tasks, operational and knowledge variability and missed opportunities to obtain high quality care and results.

Another multicultural aspect in the medical field addressed in the literature refers to the international cooperation activity. This cooperation is achieved either through bilateral or multilateral agreements between governments, with or without the coordination of regional or global international organizations, or through alternative, private partnerships between different organizations from different countries: private or public medical institutions (or their professionals) along with other social actors: non-governmental organizations, professional medical associations, vocational training centers, governments.

As a rule, cooperation takes place between economically developed countries as providers of expertise, human and / or technological resources and those under development, as beneficiaries; this is the dominant model, known as the North-South, after the geographic positioning of the majority of the developed countries (Alves et al., 2017: 2224) Often, private co-operations aim to develop training or professional development programs for medical staff in developing countries, the use of new diagnostic or treatment methods, or the familiarization with new medical technologies (Frigiola et al, 2016; Strategy Monza Hospital, 2017; Deutsche Gesellshaft fur Internationale Zusammenarbeit (GIZ) Gmbh;

International cooperation plays an important role particularly in solving a problem faced by many countries with universal health systems: lack of medical staff, especially in rural areas; half of the world's rural population has access to less than 25% of the world's doctors. Thus, international cooperation focuses on technology transfer and human resources delivery and especially on building leadership and promoting autonomy, in order to strengthen the structures of the medical system of a country (Alves et al., 2017: 2224).

The international community led by the developed countries within the Development Assistance Committee from the Organization for Economic Co-operation and Development (OECD) provides several Official Development Assistance initiatives aimed at eradicating poverty in developing countries, with health sector being found in many of these initiatives. The United Nations has set eight Millennium Development

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Goals to reduce extreme poverty around 2000 and three of them are associated with the health sector: reducing the infant mortality rate (objective no. 4), reducing the maternal mortality rate (objective no.5), combating HIV / AIDS, malaria, tuberculosis and other communicable diseases (objective no. 6). (France's strategy for international health cooperation: 2012, 2: Kim: 2015, 133-134).

South Korea, for example, sends Korean professionals to developing countries as part of a project of Official Development Assistance through the Korean International Cooperation Agency (KOICA)with the Korean government. In the medical field, KOICA delivers International Cooperation Doctors (ICDs) from 19 specialties: nurses, physical therapists, radiology technologists, nutritionists, laboratory medical technologists, occupational therapists and dental hygienists in countries like Asia, Africa, Latin America, Oceania, the community of former Soviet independent states. (Kim, 2015: 133-134)

The North-South cooperation model also has its disadvantages for developing countries as it has been ascertained since the 1970s, due to the vertical imposition by some donor countries of the priorities and objectives of cooperation, of resources without a multicultural approach that takes into account the needs, the cultural specificity and the projects already carried out by the beneficiary countries; Insufficient planning, for example, resulted in overlapping activities and waste of resources. (Alvez et al., 2017: 2224; Bader, 1977: 443-444).

Dr. Halfdan Mahler, Director-General of the World Health Organization in 1977, said that the process of transferring medical technology to developing countries "was based on a model of health development which has proved to be too uniform for our pluralistic world, and even in some cases counterproductive ... Indeed, the very underdevelopment of health, as health conceived in the WHO Constitution, is intimately connected with this technological distortion of social relevance."(Bader, 1977: 443)

Researchers considered that if Mahler's urge to "adapt rather than adopt" technology was widely applied, it could diminish to a great extent the inequities of technological colonialism in international health care cooperation, which served the financial interests of large corporations producing ultramodern and expensive technology. This would require costly medical technologies to be tailored by a regional approach to the needs and financial possibilities of the countries in the developing regions, and each country to be supported by WHO in applying for low-cost technology (Bader, 1977: 453); this translates into what Bader and Schumacher (1977: 453) called "intermediate medical technology": simple diagnostic tools and procedures, limited pharmaceutical options, rural medical centers rather than modern cardiac surgical hospitals. With regard to staff, it was found that primary health services predominantly needed in developing countries can be successfully met by auxiliary staff for which training costs are much lower than doctors training; in the 1970s, China and Tanzania have successfully streamlined their medical systems, relying heavily on auxiliary medical staff in rural areas (Bader, 1977: 453).

As a result of the inconveniences brought by the dominant model of international cooperation in the field of health (North-South) and the new global geopolitical context, a new cooperation model has been developed: South-South, based on the principles of mutuality, horizontality and autonomy. According to the new paradigm, Southern Hemisphere countries with similar difficulties share strategies to address their problems and receive support without involving subordination (Alves et al., 2017: 2224).

An example of South-South cooperation is the one between Brazil, Angola and Cuba, presented by Alves et al (2017). The cooperation between Angola and Brazil is mediated by the Brazilian Cooperation Agency, affiliated to the Ministry of Foreign Affairs, whereas the one between Cuba and Brazil - by the Pan American Health Organization (PAHO) and by the Central Medical Cooperation Unit (Unidad Central de Cooperación Médica - UCCM) (Alves et al, 2017: 2228)

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The Angola-Brazil cooperation initiative from between 2006-2016 aimed at strengthening technical and training capacity, promoting health and combating endemic diseases and led to the following actions and results: establishment of the National Public Health School (for building training capacities in the field); strengthening Technical Schools of Health and the Angolan National Public Health Institute; short-term trainings and internships for staff in the Angolan government; developing local technical capacities in the area of public health education by creating the Master's program in Public Health within the National School of Public Health. All these actions were supported by the Oswaldo Cruz Foundation, which is linked to the Brazilian Ministry of Health and with extensive expertise in public health (Alvez et al, 2016: 2228-2229).

Brazil and Cuba have been cooperating since the 1990s by sending Cuban doctors to Brazilian states with a shortage of staff to meet primary health care needs. The most recent initiative, the Mais Médicos Program (More Doctors No), considered by the Brazilian government as the largest initiative to address urgently the need for medical staff, brought 11,400 Cuban doctors with at least 10 years of professional experience and who had previously also worked in other countries (Alves et al, 2017: 2229).

4. The utility of multiculturalism for business organizations in the medical field in the Romanian society. Research Perspectives

Multiculturalism can be found in the private clinical environment in Romania in various forms and aspects. For further research, we propose the following guidelines:

- Medical and technical staff of foreign origin: doctors, nurses, health technicians, medical analysts and others. In Romania, both in the private and state medical units, there are also active foreign citizens, many of whom are graduates of medical schools in Romania;
- Foreign Founders / shareholders / employers / managers - for hospitals and private clinics that are part of an international group, have been set up as an entrepreneurial initiative by a foreign national or represent the initiative of foreign investors;
- Foreign students of Romanian medicine faculties who are in practice in private medical units and / or learn about the use of new advanced technologies;
- Foreign clients-patients who use the services of private medical units. These categories of patients can offer a personal perspective compared to the experience of their own country of origin;
- The strategies, the solutions adopted by the management of the foreign medical units in order to adapt the values, the policy and the organizational culture to the Romanian realities and cultural specifics;
- International cooperation between private medical units and its professionals and foreign private or public institutions in order to improve the medical practice in various forms: training and courses for professional development, performing of surgical interventions by Romanian-foreign mixed teams, participation of foreign and Romanian professionals at scientific congresses in Romania and in the partner country on new therapies, medical practices or new technologies; training courses on the use of new medical technologies;
- Adoption by private medical units of practices, policies, management methods specific to other cultures. Examples of Oriental culture practices are feng shui style ambiental décor and a chromatic that induce a positive state of physical and mental health. The Italian private medical group Policlinico di Monza, also present in Romania, in Bucharest, uses paintings, engravings and statuettes in such a way that the hospitality arrangement recreates the atmosphere of family life (Development strategy - Strategy Monza Hospital, 2017-2020: 5). Western practice is

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considered to be the provision of miniature prescriptions to patients, but also information on the use of direct medical equipment and technologies;

- Strategies for improving the cultural competence and promotion of medical services among potential foreign clients-patients residing in Romania or abroad (for example, medical consultations in foreign languages such as English or French, or Hungarian - for the Hungarian ethnic minority in Romania);

- Strategies for attracting the different socio-professional categories of Romanian client-patients (natural and legal persons) in order to increase the market share;

- Advanced medical technologies - most of them are manufactured and patented abroad.

    - choice of technologies that meet the safety and quality standards adopted in Romania.

    - collaborating with advanced medical technology suppliers and manufacturers

    - challenges posed by the Romanian society regarding the implementation and use of advanced technologies

    - marketing strategies on ways of presenting new technologies tailored to the Romanian staff and patients

- Strategies of approaching the foreign medical staff and integrating them among the Romanian medical staff so that the activity of the hospital is carried out in optimal conditions that do not affect the quality of medical services;

- Strategies to motivate medical staff to adhere to the values and policies of the medical unit and to use innovative technologies;

- The relationship of management of private medical units with the Romanian governmental institutions

5. Conclusions

Internationally, multiculturalism has been treated primarily in the following aspects: philosophical-ideological, ethnic / national (historical or contemporary) diversity, human rights (integration of migrants), international relations. In the medical field, this phenomenon is approached largely from the point of view of the ethnic-cultural diversity of the patient population, medical staff or foreign students of the medical schools. Another reality that may be associated with the phenomenon of multiculturalism refers to the international cooperation between private or state medical units in different countries and other organizational entities with a medical profile: government institutions, NGOs etc. in which it was demonstrated the importance of adapting solutions to different cultural contexts. In Romania, multiculturalism is analysed by the social disciplines. Areas less approached in relation to multiculturalism as a phenomenon and as an innovative method are clinical engineering and the adoption of advanced technologies; the multicultural aspects of this process of innovation in the private clinical environment are mainly related to the process of adopting advanced medical technologies, most of them manufactured and patented abroad, methods of presenting them appropriately to Romanian society; by the human factor: foreign founders, patrons, shareholders, foreign managers, medical staff, students, clients-patients, as well as certain practices, norms, policies taken from other cultures, methods of clinging the culture and practices of foreign medical unitstot the Romanian socio-economic reality, the relationship between the management of the private medical units and the governmental institutions in the field, the international and intercultural cooperation between the private medical units in Romania and the organizational entities from abroad.

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