„BABEȘ-BOLYAI” UNIVERSITY
CLUJ-NAPOCA
FACULTY OF HISTORY AND PHILOSOPHY
DOCTORAL SCHOOL OF PHILOSOPHY

Refusal of medical recommendations: bioethical and philosophical incursions

DOCTORAL THESIS SUMMARY

Doctoral supervisor:
Prof. dr. habil. Ion Copoeru

Doctoral student
Someşan Andreea-Iulia

2023

I. Content

II. Keywords

refusal of medical recommendations, clinical bioethics, risk, therapeutic empathy, doctor-patient relationship, the person, ethical value, principle, quality of life, sanctity of life, informed consent, interpretative phenomenological analysis, irresponsible self-medication, patient objectification, anguish, medical decision, second medical opinion, trust in the doctor, subjectivity of perception, ethical dilemma of the Good Samaritan

III. Synthesis of main ideas

Introduction

The doctoral research debates, through a theoretical and an empirical approach, the implications of the Good Samaritan dilemma – it is about the distinction between obligatory and ideal beneficence – in the problem of refusing medical recommendations. In this context, we begin with the hypothesis according to which the attitude of the doctor and the way in which he will manage the moment of verbal expression of a medical refusal will have a decisive impact on the patient's subsequent behaviour towards the public health system, but also on the extent to which he will be compliant or not. Not taking into account the patient as a person, the reasons behind his refusal or his preferences will lead, in many cases, to non-compliance. If the doctor has poor management of the patient's medical refusal, this will shake the patient's trust. It may also lead to the radical breaking of the doctor-patient clinical collaboration, irresponsible self-medication, and distancing of the patient from the medical system.[1]

A *bottom-up* approach is used in solving most cases of clinical bioethics: from case to theory. In poor ethical management – like in our case of the management of the medical refusal –a set of fundamental moral values specific to the context is overlooked. Therefore, the following two questions are fundamental to the research: *How can the patient gain the certainty that the doctor is acting in his best interest? What moral value is fundamental in the conduct in response to the refusal of the medical recommendation?*

The interdisciplinary and transdisciplinary approach of the present research aims both the theoretical and the methodological level. The theoretical part of the work is based on methods of interrogation and reflexive analysis specific to a philosophical approach[2]. The second part of the thesis concerns an empirical study with a paradigm specific to narrative ethics – the interpretative phenomenological analysis, being a psychological type of approach in phenomenology.

The topic of refusal of medical recommendations is socially relevant in that Romania is among the first countries at European level in terms of irresponsible self-medication. On the other hand, the refusal of medical recommendations becomes even

---

[1] See Jr. M. Lipkin et al "The Medical Interview: A Core Curriculum for Residencies in Internal Medicine.", 1984.

[2] Jaqueline Russ, *Methods in Philosophy,* (Translated by Vasile Tonoiu), 1999.

more relevant in the postpandemic context, when low vaccination rates against Covid-19 can be found in the Romanian geographical area. However, these issues are not only relevant in the Romanian context which is in our focus, but at the global level.

Summary of chapters

In the first chapter the aim was the theoretical explanation of the fundamental concepts and theories in order to make correlation with the present topic. The chapter is open by presenting the institutionalization of medicine, as the basis for the formation of a standardized approach[3] on the patient in the clinical space. Michel Foucault presents, in his work *The Birth of the Clinic*, how the doctor-patient collaboration is deeply formalized due to the establishment of a medical jargon, often difficult to be explained to the patient. Language plays an important role in doctor-patient collaboration[4] and therefore communication may be improved if the doctor speaks in the language used by the patient.

The clinical bioethics, to which the topic of the present research is subscribed, refers to the deontological aspects of the medical profession in collaboration with the patient. [5] The protocols and guidelines of good practice of the clinical field are based on the four ethical principles formulated by Beauchamp and Childress (1994). Autonomy, beneficence and nonmaleficence aim the direct doctor-patient relationship; that is why, within the chapter, we focus on them. Some other elements of bioethics defined are: the concept of *person*, of *ethical value*, of *quality of life* and that of *sanctity of life*, the construct of *informed consent*. The concept of *person*, in the Kantian sense – of an individual capable of giving himself laws, is the intellectual foundation for the justification of a medical refusal. The moral value is part of the patient's motivation to express a certain decision in relation to the proposed treatment. *Quality of life*[6] is a standard set by the WHO, World Health Organization, regarding the holistic level of health of an individual. *The sanctity of life*[7]refers to the relationship of the patient to his own body in conjunction with the divinity. This concept is relevant to our subject because certain religious denominations impose some medical restrictions on their members.

---

[3] Michel Foucault, *The birth of the clinic,* 2003, p. 110

[4] Peter A. Peter A. Ubel, *Critical decisions : how you and your doctor can make the right medical choices together.* 2012 p. 61

[5] Albert R. Jonsen, Mark Siegler, and William J. Winslade, *Clinical Ethics: A practical approach to ethical decisions in clinical medicine,* Seventh Edition, 2010, p. 1.

[6] Stephen J. Walters, *Quality of Life Outcomes in Clinical Trials and Health-Care Evaluation. A Practical Guide to Analysis and Interpretation.* 2009, p. 2.

[7] Maria Aluaș, *Medical Bioethics,* 2016, p. 33.

Informed consent[8] is a construct established by law, which aims to provide the patient with the necessary context in order to be able to express his/her adherence to treatment or his/her refusal. The legislative demand to provide informed consent implies the responsibility for the doctor to offer clear information to the patient on his/her decision in an accessible language.

The issue of medical refusal is approached traditionally from two opposing theoretical perspectives of the morality origin in the decision-making process: the consequentialist perspective[9] or that of the theories of respect[10]. On the other hand, in the context of a *top-down* ethical approach[11], there is no real collaboration between the doctor and the patient through a mutual exchange of values and information. In addition, ethical disputes can also arise because of *the prima facie duties* that David Ross talks about[12]. Subjectivism inevitably appears in applying ethical theories that have a general character to a case. These issues may be solved through a *bottom-up* ethical approach[13], when the ethical principles and moral values involved are inferred from a case.

In its early days, phenomenology was defined as a logical science (method) concerned with what things are themselves and which tries to present the subjectivism of consciousness in an objective, scientific, way.[14] Two of its important stages are *the epoché* type reduction[15], which involves putting in parentheses the researcher's bias and *the transcendental intersubjectivity,*[16] which involves observing the traits that common to a certain type of experience. In order to be able to practice phenomenology, it is necessary to rid ourselves, as Martin Heidegger points out, of the natural attitude because the object itself is not observable to the fleeting gaze.[17] Maurice Merleau-Ponty, however, brings to our attention the fact that the viewer will always be immersed in the world and we cannot have real scientific data that does not come from a human viewer.[18] Thus, phenomenology

---

[8] Bruno Halioua, "Du procès au code de Nuremberg :principes de l'éthique biomédicale" In : Emmanuel Hirsch (ed.) *Ethique, médicine et société. Comprendre, réfléchir, décider.* 2007, p 159

[9] Philip Petit, "Consecinţionalism," In: Peter Singer, *Op. Cit.*, 2006, p. 259

[10] See M. Gochnauer, "Refusal of Medical Treatment: Taking Respect for the Person Seriously.", 1987.

[11] Tom L. Beauchamp and James F. Childress, *Op. Cit.*, pp. 391-397

[12] Peter Singer, *Treatise on Ethics,*2006, p. 249

[13] *Ibid.*, pp. 397-401

[14] Edmund Husserl, *Cartesian Meditations: An Introduction to Phenomenology,1994*, p. 104

[15] Massimiliano Tarozzi and Luigina Mortar, *Phenomenology and human science research today,* 2010, pp. 27-28

[16] Edmund Husserl, *Op. Cit.,*1994, p. 126

[17] Martin Heidegger, *Fiinţă şi timp,* (Translated by Gabriel Liiceanu and Cătălin Cioabă), 2003, p. 47

[18] Maurice Merleau-Ponty, *Phenomenology of Perception,* 1999, p. 14

becomes the logical infrastructure on which the humanities can be based[19] within which the phenomenological paradigm is used in research. The researcher adopts the phenomenological attitude as a continuous dance between phenomenological reduction and reflexivity. In this context, he approaches the study with the eyes of a novice, trying to look at the participants' experience from their perspective. In the empirical approach of the current research we are concerned with clarifying how the world around the research participants is constituted and how they give meaning to the experience lived by themselves.[20]

In the second chapter, we present a few approaches from which the patient can be viewed in the clinical space in relation to the issue of refusal of medical recommendations. Thus, the first types of collaboration between doctor and patient were paternalism[21] and consumerism[22]. The negative side of the first relational model was that, regardless of whether or not the patient was informed about the medical decision, the doctor was considered able to discern the best patient's interest and, therefore, his decision was always followed. Consumerism – also called the informational model – emerged as a reaction to the lack of autonomy of the previous one. In this context, the patient considered the doctor just a technician and a source of information, going so far that the doctor could not give advice to the patient in order to restrict his/her autonomy. In Romania, there was a rapid evolution of doctor-patient relationship from paternalism to consumerism and then to deliberative models, with the change of the political regime in 1989. The signing of the Copenhagen Convention, with its three amendments, represented an important step in the evolution of the medical system, the reform of which was continued by the introduction of Law nr. 95, published in 2006.

In order to establish the hypotheses of the present research, a short introductory study on the perception of resident physicians on the collaboration with patients who express their refusal of medical recommendations was carried out. [23] The study of the second chapter revealed the hypothesis according to which patients may go from medical refusal to irresponsible self-medication if they go through contexts in which the attending doctor does not take into account their personal values and fails to propose medical prescriptions

---

[19] Jean-François Lyotard, *Phenomenology, 1997,pp*. 45-49

[20] Stuart J. Murray and Dave Holmes, "Interpretive Phenomenological Analysis (IPA) and the Ethics of Body and Place: Critical Methodological Reflections." 2014, p. 17

[21] Liviu Oprea et al., *Doctor-Patient Relationship,* 2013, p. 58.

[22] *Ibid.,* p. 58.

[23] See Andreea-Iulia Someşan:"Non-compliant patient - ethical views", 2018.

that meet their expectations. As the study revealed, there are many cases in which the doctor is preoccupied just with the fulfilment of the norms and laws, by simply giving the form to the patient for assuming his/her medical refusal. However, these attitudes reinforce the decision of the patient, who does not accept to follow the proposal of the attending doctor, but informs himself from alternative sources. The underlying aspects of non-compliance can vary greatly in terms of their nature; we are talking here about social, economic and, cognitive factors (knowledge or ignorance in front of risks), psycho-emotional, religious aspects, etc. The sets of value that underlie the medical decisions are deeply rooted in the psycho-emotional life of the individual. This is a justification for bringing into discussion the relevant ethical values and principles from the perspective of the proposed topic.

The concept of *non-compliance*[24] designates an attitude of deviation of the patient from the recommendations of the attending doctor. The term *adherence to treatment* is more used[25] in literature to suggest the active role of the patient in the clinical doctor-patient collaboration. Refusal of medical recommendations is the expression of the intention (verbally or written) not to follow the doctor's recommendation.

The current Romanian medical context highlights the persistence of a conflictual and unfavourable perspective towards the medical system: Romania is on the top position in Europe in regards of irresponsible self-medication.[26] Irresponsible self-medication is a subject of interest because it can have undesirable consequences: the degradation of the patient's health and the negative impact on the marketing of medical services. Our presumption is that in the transition from medical refusal to irresponsible self-medication, the following steps may appear: (1.) Formulating a medical recommendation that is not in accordance with the patient's preferences; (2.) Verbal expression of refusal; (3.) The lack of a dialogue aiming the patient's values; (4.) Information from unauthorised sources; (5.) Accentuation of distrust in the doctor and in the public health system; (6) Recourse to irresponsible self-medication.

Then, we refer to three types of refusal, being about contexts with a strong psycho-emotional impact on the patient. The first one is the refusal of prophylactic treatments:

---

[24] .AI. Secăreanu şi T. Neamţu, *Complianţă terapeutică: Coordonate medicale şi psihologice*, 1996, pp. 8-9

[25] David B. Resnik, "The Patient's Duty to Adhere to Prescribed Treatment: An Ethical Analysis.", 2005, p. 168

[26] Alexandrina Constantinescu, "Automedicaţia la români.", 2012, p. 54

here the anguish appears in relation to the possible impairment of the quality of life. The second one is the refusal in the context of an undesirable existence: it leads to an anguish induced by the certainty of the impossibility to change the quality of life for better. And, finally, it is about refusal based on personal duties and beliefs: the transgression of the rules imposed by the Superego generates anguish. These three typologies of refusal reveal the fact that behind a medical refusal there may be reasons that come from other spheres of the patient's existence, which, most of the times, remain foreign to the doctor merely preoccupied with fulfilling his obligations by the protocol.

F. Svenaeus[27] talks about the descriptions in first-person that come to complete the causal explanations deciphered by the doctor, giving a personal meaning to the state of illness. Based on these, the doctor could come up with a medical alternative that will be acceptable to the patient from the perspective of his values. Then, it is important for the doctor to be aware of the relevance of the phenomenological perspective that T. Fhuchs[28] brings to the emotions because they have an always intentional aspect, being oriented towards values; they are inseparable from the patient's decision. In this context, the affect is pre-given because there is no need for a specific cause of its existence; although it influences the decisions taken.

The third chapter concerns the empirical research, which had the purpose of highlighting the patients' feelings regarding the poor ethical management of their verbally expressed medical refusal. The study was conducted with the agreement *of the Center for Lifestyle and Preventive Medicine Herghelia*. The three participants in the study are the following: the respondent of the 2B questionnaire is Beatrix (infected with *Staphylococcus aureus*, she refuses medical prescriptions many times), the respondent of the 7G questionnaire became Georgiana (she refuses the recommendations on thyroid cancer and a gall surgery) and the respondent of the 11K questionnaire is named Karoly (patient with food deficiencies, he refuses psychiatric consultation).

The conduct of the study involved the following steps: providing questionnaires for sorting the possible participants in the study; signing of the individual participation agreement after studying the research information; conducting the practical exercise – an activity named *Scribble drawing therapy*[29]; and, finally, the participation in the interview

---

[27] Fredrik Svenaeus, "A Defense of the Phenomenological Account of Health and Illness", 2019, pp. 459–478.

[28] See Thomas Fuchs, "The Phenomenology of Affectivity.", 2013.

[29] See Carolyn Mehlomakulu, "Scribble drawings for relaxation." 2013.

itself. Each of the mentioned stages of the study took into account the fulfilment of specific objectives in order to achieve the goal set for empirical research: to analyze the patients' experience/embodiments lived in the context of verbal expression of medical refusal. Thus, the following objectives were targeted by offering questionnaires: obtaining demographic and quantitative data about the participants, as well as receiving the agreement for participation in the next stages of the study, after reading the documentation. The practical exercise, *Scribble drawing therapy,* aimed to remember the lived experience and building a relationship of trust between the participant and the researcher. And the interview, the essential part of the empirical study, supposed that the participants expressed in their own words the experience lived in the context of verbalizing the medical refusal in front of a doctor.

The interview was conducted according to the method of interpretative phenomenological analysis (IPA)[30], being a semi-structured type of interview, with in-depth questions. Within it, a limited number of cases are used (3-6) and attempts are made to find recurrent patterns/themes during the interview. The researcher who works with this paradigm, although he will still remain influenced by his subjectivism, is preoccupied with finding the meaning of the participants' experience from their own perspective. Therefore, the fundamental question of the phenomenological approach proposed by this research would be the following: *How do the patients experience the doctor's attitude in response to their medical refusal?* In order to conduct the semi-structured interview, 12 questions were formulated in which the main issues targeted during this research were structured.

Beatrix and Karoly have largely the habit of self-information and self-medication. Moreover, Beatrix sees autonomy as being an important principle. For Georgiana, the principle of the sanctity of life plays a significant role, as well as the duty to the family. With a behavioural tendency similar to that of Beatrix, Karoly suggests that the doctor's attitude towards the patient must take into account the respect for the person’s dignity. Then, even though respect is important, the effectiveness of the treatment is the most important to Karoly and it can outpace the aforementioned aspects. After the presentation of each interview, we summarized the participants' experiences and attitudes in certain similar trends and behavioural differences, trying to provide a global perspective on the results. Thus, there is, predominantly, about some experiences of: sadness, fear and

---

[30] See Linda Finlay, *Phenomenology for Therapists. Researching the Lived World,* 2011.

disgust. However, Georgiana and Beatrix talk about the joy and hope of meeting doctors with different approaches, specific to alternative medicine. Then, Karoly mentions sensitivity as a feeling of vulnerability in relation with the doctor who sometimes does not treat him as a human being.

According to the data provided by the three interviews, the doctor has, in general, a paternalistic, consequentialist oriented approach, insisting on the treatment scheme or procedure with the most chances of success from a medical point of view. In this context, the doctor's unavailability to listen to the patients' personal values and preferences appears which is why the patient feels more like the object of medicine than the patient receiving an adequate medical care. In order to emphasize the experiences lived in the context of verbalization of medical refusal, patients use several metaphors and analogies regarding the type of doctor-patient relationship: *as a child*, *as a number* (Beatrix), *as animals* (Karoly).

The patients' concerns during the medical decision refer to the following aspects: the effectiveness of the treatment itself, the observance of the personal vision and values, the observance of the deliberative capacity of the patient, the doctor's empathy towards the particularities of the personal case. Patients value the following aspects as ethical principles: affirmation of autonomy, trust in the doctor and empathy of the doctor. However, the interviewed patients mention some unethical behaviour of their doctors in relation to the expressed refusal: annoyance (Beatrix), indifference (Georgiana), irony and disregard (Karoly). The doctors that the patients are talking about were working in the public health system, from where the distrust towards this form of organization of medicine appears. Therefore, patients express a greater preference and confidence towards doctors working in private or towards medical centers that practice alternative medicine.

The purpose of the fourth chapter, the final one, is to analyze the ethical-philosophical recurring topics in the patients' experiences of refusing medical recommendations and identifying an essential ethical value in the amelioration of its ethical management. A first topic suggested by the metaphors and analogies of the interview participants is the objectification of the patient, which is a philosophical construct that appears based on of over-technological surrounding. Günter Anders talks about the alienation of the individual who fails to remain "up to date" in rapport with the objects produced by himself.[31] In the medical context, objectification is in the first instance the result of standardized medicine. The "third person" approach on the patient according to a non-personal perspective supposes limiting it to a series of parameters and data provided by biotechnological devices. The body becomes an asset in the commodity market, and health is also a tradable good.

Thus, the anguish that appears in the medical space has as its source precisely the excessive development of biotechnologies whose intrusion into human life can no longer be controlled. Sigmund Freud[32] talks about the Ego’s trials to bring the outer world into harmony with the Superego and the Self. In the event of a failure to harmonize them, a type of anguish appears: anguish in the face of real danger, moral anguish or neurotic anguish. Analyzing the medical refusal by the three typologies mentioned in the second chapter, there will become observable the appearance of anguish which is translated into the patients' experience as an abhorrence to live a similar experience in the future. The patient's anguish concerns the extent to which he/she perceives whether or not he would have control on the outside world and the quality of his/her future life. On one hand, previous personal experiences with certain medical professionals, the stories circulating in his entourage, those in the media or social media can contribute to the development of mistrusts in front of the public health system. On the other hand, the language gap leads to an increase of the patient's anguish because he does not even have the words necessary to explain his refusal.[33]

The over-technologization brings us to the reality of the risk society, an aspect of which the patient is not always aware. Thus, no matter what medical decision the patient will take, his/her option is exposed to a certain degree of danger: that of the disease itself or that assumed by following the treatment scheme. Most of the time, the individual looks at the individual risk and ignores the reality of the venture society in which we talk about the need to take a collective risk in order to reduce the real dangers at the level of society. Besides the fact that the patient wants as little as possible to take risks in his/her decisions, he/she tries to extend his autonomy as much as possible.

The paradox of autonomy arises by recognising the limits of independent autonomy by rapport to the autonomy gained through the deliberative process. This subchapter will

---

[31] Anders Günter, *L'obsolescence de l'homme*, 2002, p. 30

[32] Sigmund Freud, *Operas vol. 10, Introduction to Psychoanalysis, 2004,p*. 525

[33] Ivan Illich, *Medical Nemesis. The Expropriation of Health*, 1982, p. 62

prove that information from unauthorised sources is uncertain and full of risks, this not the path that will lead to knowledge. But, as in *The Myth of the Cave,* the patient needs a mentor or a counsellor to direct knowledge, exposing information that runs counter to evidence-based medicine.[34]

The doctor still has the legal and deontological obligation [35] to respect the patient's right to a second medical opinion. But some confusion may arise precisely because there is possible to be discrepancies between the first and second medical opinion. The approaches of different medical specialties or different practitioners may differ, without there being, *de facto,* a correct medical approach and a wrong one. Moreover, this context reveals the importance of developing trust in the attending doctor because the patient's decision is based on it for the choose one of the two doctors in following a therapeutic scheme.[36]

Instead, the doctor is faced with an abyss that targets the patient's feelings in relation to his medical decision. The patient is influenced, in the medical decision made, by the entire sphere of his/her existence – family, religion, etc. This surrounding world does not represent objective reality, but is *his/her surrounding world only to the extent that he/she knows it, coming into direct contact with it, as he/she understands it by its apperception.* In this context, the question for the doctor is: How is to be the patient who has to make a medical decision? That happens because often some aspects of the patient's personal sphere remain foreign to the attending doctor.

This abyss can be overcome only by cultivating an empathetic attitude towards the patient, as the patient himself expects. Michel Slote is among the promoters of empathetic altruism: empathy, although distinct from sympathy, presupposes a sense of warmth, of interest in the other.[37] Therefore, empathy is a moral value in the ethics of care – our argument is that it can be cultivated / learned. Nevertheless, we have to mention that it cannot constitute a system of ethical decision-making, although it is an essential value in the ethical management of the verbal refusal of medical recommendations.

The end of the chapter deciphers how empathy can play a significant role in doctor-patient collaboration in the context of medical refusal. Thus, we bring to attention the

---

[34] Oprea et al., *Doctor-Patient Relationship,* 2013, p. 60

[35] See *Code of Medical Deontology*, 2017.

[36] Edmund D. Pellegrino and David C. Thomasma,: *Virtues in Medical Practice,* 1993, p.66

[37] *Ibid.,* pp. XXVI-XVIII

potential of therapeutic empathy as a moral value of the doctor-patient relationship.[38]An unexpressed expectation of the patient is that the doctor will show empathy for his case. Therapeutic empathy is an intentional act oriented towards the other and it has a pre-reflective character, assuming an immediate recognition of the other as another person. The doctor would go through the following stages in the manifestation of therapeutic empathy: (1.) contemplation and comprehension of other’s emotion; (2.) transforming these apperceptions into an empathetic attitude oriented towards the patient.

Conclusions

The philosophical discourse of the ethical dilemma of the Good Samaritan in the context of clinical bioethics reveals the fact that, in medical practice, beneficence is not limited to the literal observance of the legislation, of the *Code of Medical Deontology* and of the protocols, but it involves the cultivation of a therapeutic empathy in relation to the patient. This is in line with the observance of the amendment *of the Code of Medical Deontology* on the continuous improvement of the moral conduct of the doctor. This implies the integration into clinical practice of an attitude that favors listening to the way the patient experiences, in the first person, the disease and the medical decision.

Our empirical research has revealed that, to the extent that the patient feels the doctor's empathy for his personal worries, he will be more inclined to maintain clinical collaboration and perhaps even adhere to treatment. Based on the empathy he perceives from the doctor, the effectiveness of the treatment and the comprehension of the language used, the patient will choose to collaborate with a particular doctor.

---

[38] See Valeria Bizzari et al.: "Defining therapeutic empathy: the philosopher's view." 2019.

IV. Bibliografie

1. ALUAŞ, Maria, *Bioetică Medicală,* Medicală Universitară „Iuliu Hațeganu”, Cluj-Napoca, 2016.

2. ALUAŞ, Maria, "Aspecte etice privind evoluția relației medic-pacient", *STUDIA UBB BIOETHICA*, LIX, 1-2, 2014, pp. 11 - 22.

3. ANDREI, Petre, *Filosofia valorii,* Polirom, Iaşi, 1997.

4. ASCROFT, Richard et al. *Case analysis in Clinical Ethics.* Cambridge University Press, Cambridge, 2005.

5. AXON, A. et al. „Ethical and Legal Implications in Seeking and Providing a Second Medical Opinion.” *Digestive Diseases* Vol. 26 Num. 1, 2007, pp. 11–17.

6. „Automedicația rațională-Antibiotice”,

https://studentocratia.com/2017/03/10/studentii-farmacisti-promoveaza-automedicatia-rationala/ (accesat la 05.05.20018)

7. BABBIE, Earl, *Practica cercetării sociale,* (Traducere de Gherghina Sergiuet al.). Polirom, Iaşi, 2010.
8. BĄK-SOSNOWSKA, Monika et al. „The Influence of Selected Psychological Factors on Medication Adherence in Patients with Chronic Diseases”, *Healthcare (Basel)*, Vol. 10 Num. 3, 2022 Feb 24,.
9. BARA, Ana-Claudia et al., "Reforms of Health Care System in Romania", *Croatian Medical Journal*, Nr. 43 Vol. 4, 2002, pp. 446-452.

10. BAZIN, Hervé, *Histoire des refus vaccinaux,* Bull. Acad. Natle. Med., 2010. 194, n°s 4 et 5, 705-718, séance du 11 mai 2010.

11. BEAUCHAMP, Tom L., și CHILDRESS. James F. *Principles of Biomedical Ethics,* seventh edition, Oxford University Press, Oxford, 2013.

12. BECK, Ulrich. *Risk Society, Towards a New Modernity,* SAGE Publications Ltd, Londra, 1992.

13. BENNADI, Darshana, „Self-medication: A current challenge”, *J Basic Clin Pharm.* Vol. 5 Num. 1, December 2013-February 2014, pp. 19–23.

14. BERGLUND, M, et al. „Suffering caused by care--patients' experiences from hospital settings”, *International journal of qualitative studies on health and well-being* Vol.7, 2012, pp. 1–9.
15. BIASIO, Luigi Roberto et al. „Assessing COVID-19 vaccine literacy: a preliminary online survey”, *Hum Vaccin Immunother,* Vol. 17 Num. 5, 2021 May 4, pp. 1304-1312.
16. BIBLER, Trevor M. et al. „Caring for Unvaccinated Patients in the ICU: Beyond Frustration, Toward Beneficial Relationships”, *Crit Care Explor.* Vol. 3 Num. 12, 2021 Dec 2, p. e0581.
17. BIZZARI, Valeria, et al. „Defining therapeutic empathy: the philosopher's view”, *Journal of the Royal Society of Medicine* Vol. 112 Num. 3, 2019, pp. 91-95.
18. BLAGA, Lucian, *Cunoaşterea luciferică, Trilogia cunoaşterii,* Editura Humanitas, Bucureşti, 1993.
19. BLOCK, Stan L. "The Pediatrician's Dilemma: Refusing the Refusers of Infant Vaccines", *Journal of Law, Medicine & Ethics,* Genomic research results to a participant's family, Vol. 43 Num. 3, 2015.
20. BODDINGTON, P. „Rethinking the problems of adherence to medications”, *Clinical Ethics* Vol. 10 Num. 4, 2015, pp. 91–96.
21. BOSWORTH, Hayden (ed.), *Improving Patient Treatment Adherence: A Clinician's Guide,* Springer Science+Business Media, LLC, Durham, 2010.
22. BRAGA, Corin, *Morfologia lumilor posibile. Utopie, antiutopie, science-fiction, fantasy*, Editura Tracus arte, Bucureşti, 2015.
23. BUCHANAN, D. R. „Autonomy, paternalism, and justice: ethical priorities in public health”, *American journal of public health*, Vol. 98 Num. 1, 2008, pp. 15–21.
24. BURKI, Talha, „The online anti-vaccine movement in the age of COVID-19”, *Lancet Digit Health*. Vol. 2 Num. 10, 2020 Oct, pp. e504-e505

25. CARSON, Savanna L. et al. „COVID-19 Vaccine Decision-making Factors in Racial and Ethnic Minority Communities in Los Angeles, California”, *JAMA Netw Open*. Vol. 4 Num. 9, 2021 Sep 1, pp. e2127582.

26. CĂTINEANU, Tudor, *Elemente de etică, Volumul 1*, Editura Dacia, Cluj-Napoca, 1982.

27. CHAMAYOU, Grégoire, *Les corps vils. Expérimenter sur les êtres humains aux XVIII et XIX siècles,* La Découverte, Paris, 2014.

28. CHILDRESS, James F., „Paternalism in Healthcare and Health Policy”, *Oxford Medicine Online,* 05.2020.

https://oxfordmedicine.com/view/10.1093/med/9780199798483.001.0001/med-9780199798483-chapter-3 (accesat la 24.02.2022).

29. CIOCA, Vasile, *Jocul de-a arta,* Editura Limes, Cluj-Napoca, 2007.

30. CODOBAN, Aurel, *Imperiul comunicării, Corp, Imagine și Relaționare,* Ed. Idea Design & Print, Cluj-Napoca, 2011.

31. Colegiul Medicilor din România, „Codul de Deontologie Medicală”, 06.01.2017.

https://www.cmr.ro/new/wp-content/uploads/2017/01/COD-DEONTOLOGIC.pdf (accesat la 20.09.2020).

32. CONSTANTINESCU, Alexandrina, „Automedicaţia la români”, *Farmacist+ro* (http://www.prolekare.cz/pdf?id=38619) Anul IX. Nr. 146 (3), 2012, (accesat la 20.09.2020).

33. COSTANTINO, Andrea et al. „COVID-19 Vaccination Willingness and Hesitancy in Patients With Inflammatory Bowel Diseases: Analysis of Determinants in a National Survey of the Italian IBD Patients' Association” *Inflamm Bowel Dis.* 2;28 Vol. 3, 2022 Mar, pp. 474-478.

34. COPLAN, Amy, și GOLDIE, Peter, *Empathy. Philosophical and Psychological Perspectives,* Oxford University Press, Oxford, 2011.

35. CORDOBA-SANCHEZ, Veronica et al. „HPV-Vaccine Hesitancy in Colombia: A Mixed-Methods Study”, *Vaccines (Basel).* Vol. 10 Num. 8, 2022 Jul 27, pp. 1187.

36. DERME, Assétou Ismaëla, și SIRIMA, Sodiomon Bienvenu. „Le consentement individuel, libre et éclairé dans le cadre des essais de vaccin en milieu rural africain.” *Journal international de Bioéthique* Vol. 20 Num. 1, 2009, pp. 105-118.

37. DESCARTES, Rène, *Meditaţii metafizice,* (Traducere de I. Papuc), Crater, Bucureşti, 1997.

38. DIAZ, Karen L., "Refusal of Medical Treatment Based on Religious Beliefs: Jehovah’s Witness Parents", *The Journal Of Contemporary Legal Issues*, Vol. 16 Num. 1, 2007.

39. DIEKEMA, Douglas S., "Physician Dismissal of Families Who Refuse Vaccination: An Ethical Assessment" *Journal of law, medicine & ethics,* Genomic research results to a participant’s family, Vol. 43 Num. 3, 2015, pp. 654-660.

40. DONG (ROMAN), Xu et al. „Lay health supporters aided by mobile text messaging to improve adherence, symptoms, and functioning among people with schizophrenia in a resource-poor community in rural China (LEAN): A randomized controlled trial”. *PLoS Med*. Vol. 16 Num. 4, 2019 Apr 23.

41. ĐORDEVIC,J Milošević et al. „Links between conspiracy beliefs, vaccine knowledge, and trust: Anti-vaccine behavior of Serbian adults”, *Soc Sci Med.*, Vol. 277, 2021 May.

42. DRUMMOND, John J. *Historical Dictionary of Husserl's Philosophy (Historical Dictionaries of Religions, Philosophies and Movements),* The Scarecrow Press, Inc., 2007.

43. EMBREEH, Lester, *Analiza reflexivă. O primă introducere în investigația fenomenologică,* Editor Ion Ed. îngrijită de Ion Copoeru, (Traducere de Nicoleta Szabo și Ioan Blaj), Casa Cărții de Ştiință, Cluj-Napoca 2007.

44. ENGELHARDT, Jr., H. Tristram, *The Foundations of Bioethics,* Oxford University Press, New York, Oxford, 1996.

45. FARCAS, Adriana et al. „Possible predictors of Covid-19 vaccine hesitancy in the psychiatric population - A scoping review”. *Psychiatry Res Commun*. Vol. 2 Num. 4, 2022 Dec,.

46. FINLAY, Linda, *Phenomenology for Therapists. Researching the Lived World,* John Wiley & Sons Ltd, Oxford, 2011.
47. FINLAY, Linda, și BALLINGER, Claire. *Qualitative Research for Allied Health Professionals: Challenging Choices,* Whurr Publishers Limited, Chichester, 2006.
48. FOUCAULT, Michel, *Istoria sexualităţii. I. Voinţa de a şti,* (Traducere de Cătălina Vasile), Univers, Bucureşti, 2004.
49. FOUCAULT, Michel, *Naşterea biopoliticii,* (Traducere de Bogdan Ghiu), Ideea&Design Print, Cluj, 2007.
50. FOUCAULT, Michel, *Securitate, teritoriu, populaţie,* (Traducere de Nicolae Ionel), Idea Design & Print, Cluj, 2009.
51. FOUCAULT, Michel, *Society must be defended,* (Traducere de David Macey), Picador, New York , 2003.
52. FOUCAULT, Michel, *The Birth of the Clinic,* (Traducere de A.M.Sheridan) Routledge, London, 2003.
53. FRESSOZ, Jean-Baptiste, *L'apocalypse joyeuse. Une histoire du risque technologique,* Le Seuil, Paris, 2012.
54. FREUD, Sigmund, *Opere vol. 10, Introducere în psihanaliză,* (Traducere de Ondine Dăscălița et al.), Editura Trei, Bucureşti, 2004.
55. FUCHS, Thomas, „The Phenomenology of Affectivity”, In: K.W.M. Fulford et al.*:The Oxford Handbook of Philosophy and Psychiatry,* Oxford Unviversity Press, Oxford, 2013.
56. GHELASE, Mugurel Ştefan (ed.), *Bioetică,* Editura Medicală Universitară, Craiova, 2011.
57. GHURA, Mansukhani Sonal et al. „Development of a New Patient-Reported Medication Adherence Instrument: Concerns Influencing Medication Adherence”. *Patient Prefer Adherence*. Vol. 15, 2021 Sep 9, pp. 1991-2007.
58. GOCHNAUER, M., „Refusal of Medical Treatment: Taking Respect for the Person Seriously”, *Canadian Journal of Law and Society* Vol. 2, 1987, pp. 121–140.

59. GORDON, John-Stuart şi BURCKHART, *Holger Global Ethics and Moral Responsability. Hans Jonas and his Critics*, Ashgate, Surrey, 2014.
60. GÜNTER, Anders, *L'obsolescence de l'homme,* Nuisances, Paris, 2002.
61. HALLER, Karl et al. „Associations Between Personality Functioning, Childhood Trauma and Non-adherence in Cardiovascular Disease: A Psychodynamically-Informed Cross-Sectional Study”. *Front Psychol*. Vol. 13, 2022 Jun 23,.
62. HANSON, Stephen S., *Moral Acquaintances and Moral Decisions. Resolving Moral Conflicts in Medical Ethics,* Springer Netherlands, Dordrecht, 2009.
63. HANSSON, S. O., „The Ethics of Making Patients Responsible”, *Cambridge Quarterly of Healthcare Ethics* Vol. 27, Num. 01.2017, pp. 87–92.
64. HIRSCH, Emmanuel (ed.), *Ethique, médicine et société. Comprendre, réfléchir, décider,* Vuibert, Paris, 2007.
65. HEGEL, G. W. F. *Fenomenologia spiritului,* (Traducere de Virgil Bogdan), Editura Iri, Bucureşti, 2000.
66. HEIDEGGER, Martin, *Fiinţă şi timp,* (Traducere de Gabriel Liiceanu și Cătălin Cioabă), Humanitas, Bucureşti, 2003.
67. HESZEN-KLEMENS, Irena, „Patients' noncompliance and how doctors manage this”, *Social Science & Medicine* 24, nr. 5, 1987, pp. 409-416.
68. HUSSERL, Edmund, *Ideas pertaining to a pure phenomenology and to a phenomenological philosophy. Second book. Volume III,* (Traducere de Richard Rojcewicz și Andre Schuwer), Kluwer Academic Publisher, Dordrecht, 1989.
69. HUSSERL, Edmund, *Idei privitoare la o fenomenologie pură şi la o filozofie fenomenologică. Cartea întâi: Introducere generală în fenomenologia pură,* (Traducere de Christian Ferencz-Flatz), Humanitas, Bucureşti, 2011.
70. HUSSERL, Edmund, *Meditaţii carteziene: O introducere în fenomenologie,* (Traducere de Aurelian Crăiuţu), Humanitas, Bucureşti, 1994.
71. IACOB, Ionela Florina, *Sănătate, boală, vindecare: O perspectivă socio-culturală,* Pressa Universitară Clujeană, Cluj, 2013.

72. ILLICH, Ivan, *Medical Nemesis. The Expropriation of Health,* Pantheon Books, New York, 1982.

73. JONSEN, Albert R., SIEGLER, Mark și Winslade, William J., *Clinical Ethics: A practical approach to ethical decisions in clinical medicine,* Seventh Edition, McGraw-Hill Medical, New York, 2010.

74. JONSEN, Albert R. „Casuistry as methodology in clinical ethics", *Theorethical Medicine*, Vol. 12 Num. 4, 1991, pp. 295-307.

75. JUNG, C. G. *Opere complete. 6. Tipuri psihologice: Ediţie revizuită şi întregită,* (Traducere de Dana Verescu și Vasile Dem), Zamfirescu. Editura Trei, Bucureşti, 2003.

76. KANT, Immanuel. *Critica raţiunii practice,* (Traducere şi prefaţă: I. Brãileanu, Traian) Editura Paideia, Bucureşti, 2003.

77. KARIMOVA, Hokuma, „The Emotion Wheel: What It Is and How to Use It", *PositivePsychology.com,* 24.12.2017. https://positivepsychology.com/emotion-wheel/ (accesat la 01.10.2018).

78. KELLY, Janet C., "Operational conditions: Legal capacity of a patient soldier refusing medical treatment", *Nursing Ethics*, Vol. 18 Num. 6, 2011.

79. KING, Nancy M. P., *Making Sense of Advance Directives,* Georgetown University Press, Georgetown, 1996.

80. KIRÁLY, István V., *A betegség – az élő létlehetősége. Prolegoména az emberi betegség filozófiájához / Illnes – A possibility of Living Being. Prolegomena to the Philosophy of the Living Being,* Kaligram, Pozsony, 2011.

81. KIRKSEY, Lee et al. „COVID- 19 Vaccination: Potential Challenges and Reforms", *J Natl Med Assoc.* Vol. 113 Num. 4, 2021 Aug, pp. 368-370.

82. KLITZMAN, Robert, *When Doctors Become Patients,* Oxford University Press, Oxford, 2008.

83. KNOBEL, Phil et al. „Do conspiracy theory and mistrust undermine people's intention to receive the COVID-19 vaccine in Austria?” *J Community Psychol,* Vol. 50 Num. 3, 2022 Apr, pp. 1269-1281.

84. KUHSE, Helga și SINGER, Peter, *A Companion to Bioethics,2nd ed.* Blackwell Publishing Ltd, Chichester, 2009.

85. Les vaccinations - dossier, *in* « adsp (actualité et dossier en santé publique) », Num. 71, iunie 2010.

86. LEVINAS, Emanuel, *Între noi. Încercare de a-l gândi pe celălalt,* (Traducere de Ioan Petru Deac). Bic All, Bucureşti, 2000.

87. LIPKIN, M., Jr. et al., „The Medical Interview: A Core Curriculum for Residencies in Internal Medicine”, *Annals of Internal Medicine* Vol. 100 Num. 2, 1984, pp. 277-284.

88. LYOTARD, Jean-Francois, *Fenomenologia,* (Traducere de Horia Gănescu), Humanitas, Bucureşti, 1997.

89. LOCKE, John, *An Essay Concerning Humane Understanding, Volume I.,* https://ro.scribd.com/book/317251507/An-Essay-Concerning-Humane-Understanding-Volume-I, 2013. (accesat la 03.05.2019)

90. MARCUS, Stroe, *Empatie şi personalitate,* Editura Atos, Bucureşti, 1997.

91. MARSH, Henry, *Să nu faci rău,* (Traducere de Irina Barteş), Litera, Bucureşti, 2020.

92. MAZILU, Laura et al., *Probleme de etică în comunicarea cu pacientul oncologic,* Revista Română de Bioetică, Vol. 8, Nr. 3, Iulie – Septembrie 2010, p. 83

93. MEHLOMAKULU, Carolyn, „Scribble drawings for relaxation.” *Creativity in therapy.* 18.02.2013, https://creativityintherapy.com/2013/02/scribble-drawings-for-relaxation/ (accesat la 18.05.2022).

94. MERLEAU-PONTY, Maurice, *Fenomenologia percepţiei,* (Traducere de Ilieş Câmpeanu și Georgiana Vătăjelu), Edicutra Aion, Oradea, 1999.

95. MAZILU, Laura et al., „Probleme de etică în comunicarea cu pacientul oncologic”, *Revista Română de Bioetică,* Vol. 8, Num. 3, iulie - septembrie 2010.

96. MORRIS, Martin, *Rethinking the Communicative Turn Adorno, Habermas, and the Problem of Communicative Freedom,* State University of New York Press SUNY Series in Social and Political Thought, New York, 2001.

97. MUREŞAN, Valentin, *Managementul eticii în organizaţii,* Editura Universităţii din Bucureşti, Bucureşti, 2009.

98. MURRAY, Stuart J. și HOLMES, Dave, „Interpretive Phenomenological Analysis (IPA) and the Ethics of Body and Place: Critical Methodological Reflections”, *Human Studies. A Journal for Philosophy and the Social Sciences,* Vol. 37, Num. 1, 2014: 15-30.

99. MYTHEN, Gabe, *Ulrich Beck. A Critical Introduction to the Risk Society,* Pluto Press, London, 2004.

100. NAGEL, Thomas, *Perspectiva de nicăieri,* (Traducere de Bogdan Lepădatu) Editura Vellant, Bucureşti, 2009.

101. NAGEL, Thomas, *Veşnice întrebări.* (Traducere de Germina Chiroiu), Editura All, Bucureşti, 1996.

102. NEUBERGER, Julia, „Do we need a new word for patients? Let's do away with “patients” ”, *BMJ.,* Vol. 318 Num. 7200, 1999, pp. 1756-1758.

103. NORDENFELT, Lennart (ed.), *Concepts and Measurement of Quality of Life in Health Care,* Springer Netherlands, Dordrecht Boston London, 1994.

104. NOVEANU, Alina, *Arta interpretării. Dialogurile hermeneutice ale lui Hans Georg Gadamer,* Editura Grinta, Cluj-Napoca, 2010.

105. ÖHLÉN, J., „Violation of Dignity in Care-Related Situations”, *Research and Theory for Nursing Practice,* Vol. 18 Num. 4, 2004, pp. 371–385.

106. OPREA, Liviu et al., *Relația medic-pacient,* Editura Polirom, Iaşi, 2013.

107. OPREA, Liviu, și GAVRILOVICI, Cristina, *Bazele comportamentului individual în sănătate,* Editura, Prouniversitaria, Bucureşti, 2015.

108. ORTEGA-JIMENEZ, Patricia et al. „A Nationwide Cross-Sectional Study of Self-Reported Adherence and Factors Associated with Analgesic Treatment in People with Chronic Pain”. *J Clin Med,* Vol. 9 Num. 11, 2020 Nov 14.

109. OSTASESKI, Frank, *Cele cinci invitaţii. Ce ne poate învăţa moartea despre viaţă,* (Traducere de Diana Ciornenschi), Pagina de psihologie, Bucureşti, 2022.

110. PAGARIA, Sourabh, „Consumerism in Healthcare – Current Status, Benefits and Challenges”, *HealthManagement.org The Journal,* Vol. 20 Num. 9, 2020, pp. 662-664.

111. PANTEA, Ana Gabriela, *Între eu şi celălalt: introducere în intersubiectivitatea cotidiană,* Editura Eikon, Bucureşti, 2010.

112. PARLAMENTUL ROMÂNIEI, „Legea nr. 95/2006 privind reforma în domeniul sănătății (**republicată**),” *Monitorul Oficial al României nr. 652,* 2015-08-28.

113. PARLAMENTUL ROMÂNIEI, „Lege nr. 46/2003 drepturilor pacientului.” *Monitorul Oficial al României nr. 51,* 01 2003-01-29.

114. PASAY-AN, Eddieson Astodello et al. „Incidence of patients leaving against medical advice in government-subsidized hospitals: a descriptive retrospective study”. *Pan Afr Med J,* Vol. 42, 2022 Jun 30.

115. PÂNIŞOARĂ, Ion-Ovidiu, *Comunicarea eficientă,* Ediţia a IV-a, revăzută şi adăugită, Editura Polirom, Iaşi, 2015.

116. PELLEGRINO, Edmund D. și THOMASMA, David C., *Virtues in Medical Practice,* Oxford University Press, Oxford, 1993.

117. PESTRE, Dominique, *A contre-science: Politiques et savoirs des societes contemporaines,* Editura Seuil, Paris, 2013.

118. PLATON, *Opere, Vol. V. Republica,* (Traducere de Andrei Cornea) Editura Ştiinţifică şi Enciclopedică, Bucureşti, 1986.

119. PLATONOVA, E. A. et al., „Understanding Patient Satisfaction, Trust, and Loyalty to Primary Care Physicians”, *Medical Care Research and Review,* Vol. 65 Num. 6, 2008, pp. 696–712.

120. RANCIÈRE, Jacques, *Le maître ignorant: Cinq leçons sur l'émancipation intellectuelle,* Editura Fayard, Paris 1987.

121. RANCIÈRE, Jacques, *The Aestethics unconscious,* Editura Polity, Cambridge, 2009.

122. RAJKA, Mária, și ALUAȘ, Maria, „Legal regulations on patient’s right to refuse medical treatment”, *STUDIA UBB BIOETHICA,* Vol. LXI Num. 1-2, 2016: pp.111-118.

123. RĂDULESCU, Vasi, *O să te tragă curentu (şi alte mituri despre sănătate),* Editura Readers Do Good, Bucureşti, 2019.

124. RESNIK, David B., „The Patient's Duty to Adhere to Prescribed Treatment: An Ethical Analysis”, *Journal of Medicine and Philosophy* Vol. 30 Num. 2, 2005, pp. 167-188.

125. ROSS, David W., *The right and the good,* Oxford University Press, Oxford, 2007.

126. RUGHINIŞ, Cosima şi FLAHERTY, Michael G.,”The Social Bifurcation of Reality: Symmetrical Construction of Knowledge in Science-Trusting and Science-Distrusting Discourses”, *Front Sociol.* Vol.7, 2022 Feb 9, pp. 782851.

127. RUSS, Jaqueline, *Metodele în filosofie,* (Traducere de Vasile Tonoiu), Univers Enciclopedic, Bucureşti, 1999, pp. 123 - 189.

128. RUGHINIŞ, Cosima şi FLAHERTY, Michael G., ”The Social Bifurcation of Reality: Symmetrical Construction of Knowledge in Science-Trusting and Science-Distrusting Discourses”, *Front Sociol.* Vol.7, 2022 Feb 9, pp. 782851.

129. Sabin Vaccine Institute, *Revizuirea Cadrului Legislativ: Abordări legislative privind imunizarea din întreaga regiune europeană,* ianuarie 2018.

130. SANDMAN, L. și Munthe, C., „Shared decision-making and patient autonomy”, *Theoretical Medicine and Bioethics,* Vol. 30 Num. 4, 2009, pp. 289–310.

131. SANDU, Antonio*, Appreciative Ethics*, Lumen, Iaşi, 2012.

132. SANDU, Antonio, *Etică şi deontologie profesională*, Editura Lumen, Iaşi, 2012.

133. SAVULESCU, Julian, „Rational Non-interventional Paternalism : Why Doctors Ought to Make Jugements of What Is Best for their patients”, In: Boylan, Michael: *Medical Ethics*, , pp. 83-90. Wiley-Blackwell, Singapore, 2014.

134. SCHLEGEL, V. și Leray, E., „From Medical Prescription to Patient Compliance: A Qualitative Insight into the Neurologist-Patient Relationship in Multiple Sclerosis”, *International journal of MS care*, Vol. 20 Num. 6, 2018, pp. 279–286.

135. SCHNEEWIND, J. B.*, Inventarea Autonomiei. O istorie a filosofiei morale moderne*, (Traducere de Nicoleta Mihăilescu et al.), Polirom, Iaşi, 2003.

136. SCHUMANN, John Henning, „If Slow Is Good For Food, Why Not Medicine?”, *NPR.* 07.12.2014.

https://www.npr.org/sections/health-shots/2014/12/05/368736643/if-slow-is-good-for-food-why-not-medicine?sc=tw&t=1645353916606 (accesat la 22.02.2022).

137. SECĂREANU, AI. și NEAMŢU, T., *Complianţă terapeutică: Coordonate medicale şi psihologice.* Editura Gloria, Cluj-Napoca, 1996.

138. SINACI, Maria, *Normativitate şi bioetică. Aspecte filosofice contemporane,* Presa Universitară Clujeană, Cluj-Napoca, 2014.

139. SINGER, Peter, *Altruismul eficient. Ghid pentru o viaţă trăită în mod etic,* Traducere de Carmen Ardelean. Editura Litera, Bucureşti, 2017.

140. SINGER, Peter (ed.), *Tratat de etică,* Blackwell, (Traducere de Vasile Prof. Univ. Dr. Boari și Raluca Mărincean), Editura Polirom, Iaşi, 2006.

141. SLATMAN, Jenny, *Our Strange Body Philosophical Reflections on Identity and Medical Interventions,* Amsterdam University Press, Amsterdam, 2014.

142. SMITH, David Woodruff, *The Circle of Acquaintance. Perception, Consciousness, and Empathy,* Springer Netherlands, Dordrecht Boston London, 1989.

143. SOMEŞAN, Andereea Iulia, „Non-compliant patient - ethical views”, *STUDIA UBB BIOETHICA* LXIII, Vol. 1-2, 2018, pp. 79 - 88.

144. SOVERI, Anna et al. „Trait reactance and trust in doctors as predictors of vaccination behavior, vaccine attitudes, and use of complementary and alternative medicine in parents of young children” *PLoS One*, Vol. 15 Num. 7, 2020 Jul 27.

145. STEIN, Edith, *On the Problem of Empathy,* ICS Pubns, Washington, 1989.

146. STENTZEL, Ulrike et al. „Predictors of medication adherence among patients with severe psychiatric disorders: findings from the baseline assessment of a randomized controlled trial (Tecla)”, *BMC Psychiatry*. Vol.18 Num. 1, 2018 May 29.

147. SUTHERLAND, L. R. și VERHOEF, M. J., „Why Do Patients Seek a Second Opinion or Alternative Medicine?”, *Journal of Clinical Gastroenterology* Vol. 19 Num. 3, 1994, pp. 194–197.

148. SVENAEUS, Fredrik, „A Defense of the Phenomenological Account of Health and Illness”, *Journal of Medicine and Philosophy,* Vol. 44, 2019, pp. 459–478.

149. SVENAEUS, Fredrik, *Phenomenological Bioethics. Medical Technologies, Human Suffering, and the Meaning of Being Alive,* Routledge, New York, 2017.

150. SVENAEUS, Fredrik, *The Hermeneutics of Medicine and the Phenomenology of Health. Steps Towards a Philosophy of Medical Practice,* Springer Science+Business Media, Dordrecht, 2000.

151. SVENAEUS, Fredrik, „The Phenomenology of Objectification in and Through Medical Practice and Technology Development”, *academia.edu.* 2020.

https://www.academia.edu/44490935/The_Phenomenology_of_Objectification_in_and_Through_Medical_Practice_and_Technology_Development (accesat 19.06.2022).

152. TAHERI, Narjes Khaton et al. „Experiences of the Patients with Behcet's Syndrom from Adherence to Treatment: A Qualitative Content Analysis” *Int J Community Based Nurs Midwifery*. Vol. 9 Num. 4, 2021 Oct.

153. TAROZZI, Massimiliano, și MORTAR, Luigina, *Phenomenology and human science research today,* Editura Books, Bucureşti, 2010.

154. TEODORESCU, Mihai C., *Valorile vitale şi morale în practica medicală,* Editura "Progresul Românesc", Bucureşti, 1996.

155. TIMMERMANS, S., și ALMELING, R., „Objectification, standardization, and commodification in health care: A conceptual readjustment”, *Social Science & Medicine,* Vol. 69 Num. 1, 2009, pp. 21–27.

156. UBEL, Peter A., *Critical decisions : how you and your doctor can make the right medical choices together —1st ed,* https://ro.scribd.com/read/163625533/Critical-Decisions-How-You-and-Your-Doctor-Can-: EPub Edition ©, 2012. (accesat 12.03.2020).

157. UBEL, P. A., et al., „Autonomy: What's Shared Decision Making Have to Do With It?” *The American journal of bioethics : AJOB* Vol. 18 Num. 2, 2018, pp. W11–W12.

158. VALLECILLO, Gabriel et al. „COVID-19 vaccination coverage and vaccine hesitancy among people with opioid use disorder in Barcelona, Spain”. *Drug Alcohol Rev*. Vol. 41 Num. 6, 2022 Sep, pp. 1311-1318.

159. VAN DALEN, I., J. et al., „Motives for seeking a second opinion in orthopaedic surgery”, *Journal of Health Services Research & Policy* Vol. 6 Num. 4, 2001, pp. 195–201.

160. VIAFORA, Corrado (ed.), *Clinical bioethics: A search for the foundations,* Vol. INTERNATIONAL LIBRARY OF ETHICS, LAW, AND THE NEW MEDICINE. Vol. 26. Springer, Dordrecht, 2005.

161. WANG, Tao, et al., „Definition and Characteristics of Medical Communication." In: *Medical Communication. From Theoretical Model to Practical Exploration*, https://www.worldscientific.com/, 2020, (accesat la 15.04.2018).

162. WALTERS, Stephen J., *Quality of Life Outcomes in Clinical Trials and Health-Care Evaluation. A Practical Guide to Analysis and Interpretation,* John Wiley and Sons, Chichester, 2009.

163. ZECKHAUSER, Richard, și SOMMERS, Benjamin, „Consumerism in Health Care: Challenges and Opportunities", *Virtual Mentor*, Vol. 15 Num. 11, 2013, pp. 988-992.

164. ZHANG, Eva et al. „Misconceptions Drive COVID-19 Vaccine Hesistancy in Individuals with Inflammatory Bowel Disease". *Can J Gastroenterol Hepatol*. Vol. 2022, 2022 Sep 10, p. 4527844.

Resurse Online

165. Juridice.ro, Iniţiativă legislativă privind dreptul la medicină personalizată, 21.12.2022, https://www.juridice.ro/805615/initiativa-legislativa-privind-dreptul-la-medicina-personalizata.html (accesat la 18.01.2023).

166. MANIFESTUL UNEI SUPRAVIEȚUITOARE: "90% DIN LUPTA CU CANCERUL E PUTEREA EMOȚIEI" | Fain & Simplu cu Mihai Morar, https://www.youtube.com/watch?v=FnDF5hx8Hp8 (accesat la 05.01.2023).

167. MENDELSOHN, Daniel R. H., "Comment. The right to refuse: should prison inmates be allowed to discontinue treatment or incurable, noncommunicable medical conditions?", *Maryland Law Review*, Vol. 71, 2011, https://digitalcommons.law.umaryland.edu/mlr/vol71/iss1/14 (accesat la 05.03.2019).

168. PACILLO, Vincenzo, "Free to become martyrs? The right to refuse medical treatment on religious grounds in a comparative perspective", *Stato, Chiese e pluralismo confessionale, Rivista telematica* (www.statoechiese.it), Num. 29, 2016,(accesat la 05.03.2019).

169. *Reforma Sistemului de Sanatate / Politici de Sanatate Publica,* Romtens, http://romtens.ro/ro/activitate/reforma-sistemului-de-sanatate-politici-de-sanatate-publica (accesat la 05.12.2022).

170. *ROMANIA TE IUBESC - AUTOMEDICATIA LA ROMANI HD* https://www.youtube.com/watch?v=9a7qztSBYQY,publicat la 30.03.2018 (accesat la 06.07.2020).

171. *sanatate.findtalk.biz,* http://sanatate.findtalk.biz/t1950-vigantol-vitamina-d3-sau-cum-iti-poti-distruge-copiii-cu-avizul-medicului, (accesat la 03.05.2018).

172. „Situația vaccinării în România", *Vaccinare Covid-19*, https://vaccinare-covid.gov.ro/situatia-vaccinarii-in-romania/, (accesat la 10.12.2022).

173. „Tratamente Eficiente" In : *Romedic.ro*, https://www.romedic.ro/forum/s/tratamente-eficiente, (accesat la 06.07.2020).