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PATIENTS' DIGNITY. UNEQUAL ACCESS TO MEDICAL TREATMENT

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Abstract: *This article examines how unequal access to medical treatment generates systemic discrimination and undermines patients' dignity. Although Article 3 of Law 46/2003 on patient rights guarantees respect for all persons without discrimination, patients belonging to vulnerable groups, such as ethnic minorities, disabled persons, or older persons, continue to face structural barriers that restrict their access to adequate medical care. The analysis assesses both the national and European legal frameworks, highlighting the mechanisms through which financial, linguistic, and infrastructural barriers perpetuate implicit discrimination.*

Key words: *patient rights, discrimination, dignity, inequality*

1. Introduction

Equal access to healthcare transcends matters of institutional and administrative management, serving as an embodiment of the respect owed to human dignity. In a state governed by the rule of law, every individual seeking medical assistance should be entitled to an equivalent standard of professional attention, empathy and care, irrespective of the socio-economic background, ethnicity, language, age, or beliefs.

Despite the universal endorsement of equality in healthcare, its implementation and functionality vary significantly across countries. Pronounced disparities are particularly visible when comparing healthcare systems in developed states with those in developing ones. In India, for instance, entrenched social hierarchies and gender-based prejudice continue to generate discriminatory practices, which can be observed in a considerably higher percentage of infant mortality rates in females. It is important to acknowledge that these outcomes cannot be solely attributed to healthcare systems, as they are also heavily influenced by societal attitudes inconsistent with the ethical standards of the 21st century.

Although the principle of non-discrimination is incorporated in the laws and regulations of most countries, imposing sanctions of varying severity for discriminatory conducts, the phenomenon remains widespread in practice. One underlying cause of the persisting discriminatory treatment is the difficulty of punishment due to the evidentiary

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requirements. Furthermore, the inherently subjective nature of discrimination, which originates in individual attitudes and social practices, makes it challenging to be prevented. The Romanian system, although advanced in terms of existing services, continues to generate profound inequalities, often manifested through subtle or invisible barriers: inadequate communication, limited cultural responsiveness, discriminatory attitudes, or lack of institutional protection mechanisms.

At the European level, empirical evidence indicates that discrimination in access to healthcare is multifactorial and should not be ascribed to a single determinant. According to the European Agency for Fundamental Rights (FRA), more and more people are facing "multiple discrimination" resulting from the interaction of several factors: ethnicity, age, gender, disability, etc. (Bobbia, 2024, p.190). These intersecting factors create complex patterns of marginalisation, which are resistant to legal and institutional actions, posing significant obstacles to an equitable healthcare system.

In Romania, patients belonging to national minorities often encounter specific forms of discrimination. The lack of healthcare professionals fluent in the languages spoken by these people, or the absence of translators to ensure effective communication, constitutes more than a logistical limitation, being a violation of the patient's right to information and, by extension, their dignity. The patients' incapacity to comprehend or convey information regarding their diagnosis causes them to become passive participants in their own care, undermining the effectiveness of medical treatment. Such circumstances unavoidably result in the violation of patients' dignity at a moment of utmost vulnerability—during illness.

2. Conceptual and Legal Framework

2.1. Dignity – (Non-)discrimination

Within the medical field, human dignity is not an abstract ideal, but a fundamental right, which requires healthcare professionals – including doctors and nurses – to provide care that embodies certain characteristics, such as respect, empathy and equality.

The World Health Organization (WHO) defines health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity". In contrast, discrimination represents a fundamental violation of dignity. Morar (2015) conceptualises discrimination as different treatment or unjustified deprivation of certain rights based on unfounded criteria. Horta (2010) emphasizes that the occurrence of discrimination does not require concrete harm, as it is sufficient that an individual is treated less favourably than others on the basis of an arbitrary criterion. Consequently, when a patient experiences discrimination—regardless of the specific criterion—they are entitled to compensation for the violation of their dignity.

The European Economic and Social Committee (Muscalu, et al. 2024, p. 38) asserts that the right to dignity, as a fundamental patient right, inherently includes the principle of non-discrimination. This principle obliges healthcare professionals to treat patients with respect and not subjected to derogatory remarks or prejudicial attitudes.

2.2. European legal framework

The European legal framework protects human dignity and enshrines the principle of non-discrimination. Relevant provisions include:

- Article 14 of the European Convention on Human Rights requires signatory states to ensure that everyone can exercise the rights and freedoms recognized by the convention without any distinction based, in particular, on grounds of sex, race, colour, language, religion, political or other opinion, national or social origin, association with a national minority, property, birth, or other status.
- The Treaty of Lisbon prohibits discrimination on grounds of race, ethnic origin, religion, age, disability, or sexual orientation.
- The Charter of Fundamental Rights of the EU states in Article 1 that "human dignity is inviolable" and in Article 35 enshrines the right to preventive healthcare.
- Directive 2000/43/EC ("Racial Equality Directive") provides for the applicability of these principles including in healthcare services. This was transposed into Romanian law by Government Ordinance No. 137/2000.

2.3. The legal framework in Romania

In Romania, the principle of non-discrimination is enshrined in the Constitution. Article 16 of the Constitution guarantees equality before the law, prohibiting privileges or discriminatory treatment, and its inclusion in the fundamental law was intended to emphasize its significance in safeguarding the dignity of every individual.

The principle is also reflected in medical legislation, with Article 3 of Law No. 46/2003 on patient rights stipulating that: "The patient has the right to be respected as a human being, without any discrimination", and Article 650 of Law No. 95/2006 requires medical staff to respect the dignity, privacy, and cultural values of patients. These provisions show that without dignity, the right to life and physical integrity remains purely formal.

The Romanian law imposes sanctions for any violation of healthcare professionals' obligations, which may include disciplinary, administrative, civil, or criminal penalties. The concept of malpractice encompasses both violations of medical duties, such as the administration of inappropriate treatment, and breaches of ethical obligations, including inadequate provision of information, failure to obtain informed consent for medical procedures, and discriminatory conduct.

3. Discrimination Criteria and Vulnerable Groups

Vulnerability reflects an individual's exposure to risk and a lack of adequate support. Popescu (2009) highlights that factors contributing to vulnerability may include membership in a stigmatised group, disability, advanced age, or poverty. Romanian Law No. 292/2011 on social assistance defines vulnerable groups and includes in this category individuals or families at risk of losing their capacity to meet daily living needs due to illness, disability, poverty, drug or alcohol addiction, or other situations that lead to economic and social vulnerability. Within this framework, our analysis illustrates and

discusses several specific situations that can be identified in which patients' dignity is compromised.

One primary factor contributing to discrimination is poverty. Individuals from low-income backgrounds, including the homeless and children in state care are economically vulnerable and among the groups most affected by discriminatory practices. In these cases, discrimination may manifest directly—for instance, when individuals are denied access to emergency services or other hospital wards due to their bad physical condition or hygiene, which may elicit negative reactions from medical staff or other patients —or indirect, for example, being referred to other hospitals on the grounds of unavailable beds, appointments, or specialists.

People living in poverty are often perceived as "inferior" and consequently experience limited access to healthcare services. As Tomescu (2010) notes, people from disadvantaged backgrounds use medical services less frequently across European countries.

Ethnic minorities constitute another category that is particularly affected by discrimination, being relatively prevalent in Romania. According to the European Union Agency for Fundamental Rights (FRA, 2011) individuals belonging to ethnic minority groups are five times more likely to experience discrimination. In healthcare, Ziegler (1976) illustrates that although professionals have an ethical obligation to protect patients while preserving their dignity, the subjectivity and personal biases of the medical staff often cause discriminatory behaviours, which, in turn, can significantly alter the mental well-being of patients being already vulnerable due to illness.

The Roma represent one of the most stigmatized ethnic minorities and stereotypical attitudes among healthcare professionals are often observed in clinical practice. These biases frequently lead to dismissive or superficial medical services, particularly in obstetrics-gynaecology and paediatrics, reflecting stereotypes that Roma families have more children than those of majority population. A notable example involves a case in which a doctor refused treatment to a pregnant Roma woman, reportedly stating: "What's wrong with you? That's how g*psies are -," illustrating the persistence of prejudice and its impact.

As Birau (2018, p.44) observes, the condition of the Roma population in Romania involves social stigmatisation, despite the fact that being one of the country's largest minority groups, they benefit from social welfare programs aimed at preventing discrimination.

The situation in Romania is not an isolated one. At the European level, stereotypes that generate discrimination against ethnic and national minority groups have become increasingly prevalent, particularly in the current context of large-scale refugee inflows from Africa and Asia. In France, for instance, an article published earlier this year in the prominent daily *Le Monde* describes the so-called "Mediterranean syndrome" (France, 2025), a phenomenon in which medical professionals presume that patients of North African or Black origin exaggerate their pain. This assumption often leads to superficial clinical assessments and the dismissal of reported symptoms, a behaviour that can, in some cases, have fatal consequences.

With regard to the activity of the state authorities responsible with preventing and combating discrimination, the 2024 activity report of the National Council for Combating Discrimination (NCCD, 2024) indicates that 5.5% of the complaints received concerned ethnic discrimination, while 8.3% were based on nationality. The most common cited grounds for discriminatory conducts in the complaints addressed to the national authority were social status (19.8%) and disability (8.8%). However, these figures suggest an improvement in public services, taking into account that in 2010 complaints based on ethnic discrimination represented 20% of all submissions to the NCCD.

People belonging to minority groups are subject to be discriminated against not only on the grounds of entrenched prejudices, but also as a consequence of linguistic barriers. In this regard, Article 13(2)(c) of the European Charter for Regional or Minority Languages requires signatory states to establish the necessary legislative framework to enable citizens from the national minorities to use their mother tongue in their interactions with certain public institutions.

In 2018, Romania amended Law No. 95/2006 on health reform to ensure compliance with the Charter, namely that, "to the extent that public authorities are competent in the area where regional or minority languages are used and if this is possible [...] ensure that social institutions, such as hospitals, nursing homes, and shelters, offer the possibility of receiving and caring for speakers of a regional or minority language who require care for reasons of health, age, etc., in their own language." Article 7(m) of Law No. 95/2006 requires medical institutions in areas with national minorities representing 20% of the population or at least 5,000 residents to provide specialized medical staff speaking the language of that particular minority.

The legal provision was challenged before the Constitutional Court on grounds of both extrinsic and intrinsic unconstitutionality. The claim of extrinsic unconstitutionality rested on the argument that an ordinary law cannot amend an organic law, while the claim of intrinsic unconstitutionality alleged a violation of constitutional guarantees of non-discrimination, as the employment of specialists proficient in a minority language would shift hiring criteria away from professional competence and toward considerations of nationality, ethnicity, or language. In Decision No. 328/2017, the Constitutional Court rejected the challenge, stating that the contested provision does not require the employment of individuals from the respective national minority, but, in essence, stipulates that the medical staff hired must possess knowledge of the relevant minority language. Accordingly, the Court concluded that no breach of the constitutional principle of non-discrimination had occurred.

To emphasise the need of effective communication with patients belonging to national minorities or other vulnerable groups, such as refugees, the National Council for Combating Discrimination sanctioned a medical institution in Timișoara after three children of Hungarian ethnicity being examined and treated there received incomplete prescriptions and medical care, due to the fact that the responsible professionals did not speak Hungarian. A similar situation, which is more and more frequent, is that of the Ukrainian refugees, who have settled in large numbers in Romania since the start of the war.

People with severe mental disorders, such as schizophrenia, alienation, or mental retardation, face stigmatisation from society in general and medical staff in particular. Very often, the inhumane or degrading treatments seriously affect their rights and even their quality of life (Burtea and Mosoiu, 2018, p.108). The phenomena documented by the cited authors in the specialised hospital in Brașov are similarly observed in other European contexts. According to Cersosimo (2015, p.90), the institutional discrimination identified in specialised hospitals in southern Italy can be prevented through collaborative agreements between public and private social and medical services. However, the education of patients and their families is a more effective solution than solely enhancing the technical capabilities of medical institutions. Among the most serious forms of discrimination which is committed against them, is the prescription and administration of treatments without informed consent, exploiting the impairment or complete absence of their decision-making capacity.

The elderly represents another vulnerable group, facing both direct and indirect discrimination, commonly referred to as “ageism” and which results in the denial of costly medical interventions for older individuals, based on the perception that such treatments may be an unnecessary expenditure of time and resources which could be allocated more efficiently to younger patients. Such refusal of treatment, together with other breaches of medical ethics, establishes the legal liability of healthcare professionals for these violations (Jugastru, 2017, p.47).

An example of discrimination was highlighted in a recent case settled by the Bucharest Fourth District Court (decision 7447/2025 published on rejust.ro). The action was brought by the daughter of an elderly patient, who stated that her mother was denied necessary diagnosis and treatments due to her advanced age, causing her death shortly after hospital admission. The court dismissed the claim of the plaintiff, as no evidence of ethical malpractice could be proven, especially because the patient suffered from multiple comorbidities that were more likely to have caused her death, rather than the inappropriate medical care. As pointed out by Oană (2021, p. 12), Western healthcare systems, in order to optimise resources allocated to medical care, have used the practice of discontinuing interventions for extremely ill or dying patients.

Another category of patients exposed to discrimination is represented by people with different sexual orientations. These individuals are often discriminated against and, more seriously, as Spârchez (2023, p.139) states, discrimination can also affect children from such families, especially since same-sex marriage is prohibited in Romania, and same-sex marriages or partnerships legally concluded abroad are not recognized. Evans (2005) shows that doctors are influenced by their own perceptions and prejudices. LGBTQ+ patients, especially those with HIV/AIDS, have limited or no access to surgical and dental procedures, transportation for bleeding patients, or C-sections for HIV-infected pregnant women. For these individuals, in addition to the disease itself, the consequences of discrimination can be even more severe and hurtful.

4. Final Considerations

Discrimination, regardless of the criteria, is present in many areas of social life, its

effects being more serious when it occurs in the healthcare system because it affects people who are already vulnerable due to illness. Although there are effective legal mechanisms against discrimination, such as disciplinary or even criminal sanctions against medical or auxiliary staff, fines, and civil damages, in many cases discriminatory attitudes and practices go unpunished or are insufficiently punished. There are many reasons for this, including:

- insufficient information provided to the population on procedures for identifying or sanctioning discrimination, largely due to the low level of education among the poor or certain minority groups;
- humiliation and fear of society's reaction;
- economic reasons;
- inability to act – this usually occurs in the case of elderly or mentally ill people who cannot defend their rights on their own;
- solidarity among medical staff - if the people discriminated against limit themselves to filing a complaint with the professional body of the physician, the misconduct is investigated by people within the profession who often adopt a self-defensive mechanism and a subjective attitude that results in discrimination and insufficient sanctions or no sanctions at all;
- if the individuals discriminated against go beyond the scope of these bodies and turn to civil or criminal justice, the procedures are time-consuming, and their duration is a factor that causes many people to give up appealing to state institutions to punish acts of discrimination in the healthcare system.

One solution for preventing and reducing cases of discrimination would be the active involvement of medical staff through specific courses and seminars, but also through media coverage of the psychological consequences of discrimination on vulnerable patients and the penalties imposed on those who have committed such acts. The role of healthcare professionals is essential in guaranteeing access to quality healthcare. They are often responsible for determining who can access medical treatment and what types of treatment can be offered.

I conclude by recalling an idea that is worth mentioning in the context of discrimination, which is a tendency that every individual can encounter. The Museum of Tolerance in Los Angeles has two entrances, the first inscribed with "prejudiced" and the second with "not prejudiced". Those who consider themselves qualified to enter through the second door will find that it is always closed, as a reminder that, in reality, we are all exposed to discriminatory behaviour.

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