Hungary

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General Introduction

1. At the time of writing the first overview on the Hungarian medical law for an international audience, this field of law is not only a rapidly extending legal domain but is also provoking a great deal of debate among the professionals and the public. One of the fundamental issues in contemporary medical and biomedical law is how to delineate the frontiers of this discipline. A century ago medical law was a part of administrative law. It was only about 20 years ago that medical law in Hungary, as in the rest of Europe, received stimulus from the concept of human rights. Civil law exerted an important influence even later. And currently we can observe new inter-disciplinary influences. There is a good chance, for instance, that insurance law and intellectual property rights will have significant effect on the further development of medical law. Problems resulting from the separate development of the medical and non-medical domains could have been noticed in the pre-genetic area, as well. With the appearance of biotechnology and genetics, however, these problems started to matter. Maybe it is because since its birth, genetics has always received more attention due to its eugenic past and its broad impact on our social perception on humankind. 'Harmonisation' of these norms now seems to be inevitable since (e.g.) the principle of non-discrimination cannot be respected if it applies only to the domain of biomedical research, but not in the field of access to insurance and employment. Similarly, the issue of the non-commercialization of the human body and body parts cannot be separated from the questions whether certain genetic inventions can be patented or not. Duality of legal norms, in the field of health care law and in the field of commercial law, is problematic since it may create a devaluation of the human rights-based principles in general. Consequently it seems to be desirable to make at least some cross-references between medical law and other areas of law.

2. In this monograph I cannot cover all the contemporary problems of the Hungarian medical law. I can provide only an insight to the basic legal norms that have been adopted, especially during the last five years. Although it is only twelve years since the political and economic transition, many of the newly created institutions have already proved their efficiency. Most changes occurred in the domain of patients' rights, but only a few successes have so far been reached in health care reform.

3. Post-transitional political regimes in Central and Eastern Europe had to solve the problems connected with the re-interpretation of the welfare right (such as, right to health, right to social security, right to employment) which was incorporated in
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their Constitutions during the previous political regime but had lost its legitimacy in the new market economy. The collapse and disappearance of the strong paternalistic state was a rapid and often shocking process. The privatization of industry and agriculture was rapid in Hungary. However, health care in general (except primary care) remained almost unchanged despite the economic reforms.

Chapter 1. General Background of the Country

§1. Geography and Climate

4. Hungary, officially Republic of Hungary or Magyar Köztársaság, is a medium-size country in Central Europe, with a surface area of 93,030 square kilometres (35,909 square miles), and had a total population of 10.05 million inhabitants at the beginning of 2000. 52 per cent of the population are women.¹ Hungary shares its' border on the north with Slovakia, on the north-east with the Ukraine, on the east with Romania, on the south with Yugoslavia (the Vojvodina region of Serbia) and Croatia, on the south-west with Slovenia and on the west with Austria. Budapest, the capital city, which is the dominant centre of economic, political, and cultural life in the country, is situated on both banks of the Danube (Duna) River. Hungary has a four-season continental climate, influenced by the location of the country in the middle of the Carpathian Basin and by the mountains surrounding its territory.


§2. Cultural Composition

5. Historically Hungary was a multi-ethnic state, from the crowning of St. Stephen (in 1000), the first King of Hungary, to the Trianon Treaty after World War I, which resulted in major territorial changes at the expense of the Hungarian people and state. In 1920, 40 per cent of the pre-war ethnic Hungarian population found itself separated from the new mother country, which was only one-third its previous size. The problems of national identity and national minorities were avoided during the forty years of state-socialism and 'socialist brotherhood' in Central and Eastern Europe, only to resurface during and after the political transition in 1989–1990. The accession of Hungary and its neighbours to European economic and political institutions will solve this sensitive issue for the benefit of all countries and peoples involved.

6. In modern Hungary, more than 90 per cent of the population is ethnically Hungarian, and less than 5 per cent has another language other than Hungarian (Magyar) as its mother tongue. The Hungarian language is generally classified as a member of the Ugric branch of the Uralic languages. It is most closely related to the Ob-Ugric languages, Khanty and Mansi, which are spoken in Western Siberia. It is also related to the Turkish languages. Ethnic Hungarians are a mix of the Magyars, who occupied the Carpathian Basin after 896 AD, and various assimilated Slavic, Turkish, and Germanic peoples. About 4.5 per cent of the population is Gypsy (Hungarian, Romany or Beash speaking), and an additional 4 per cent is made up of Germans, Slovaks, Romanians, Chinese, Croats, Ruthenians, Greek,
and others. In the 2001 Population census 129,259 people declared themselves Gypsy/Roma, 62,233 German, 17,692 Slovakian, 15,620 Croatian, 7,995 Romanian, 5,070 Ukrainian, 3,816 Serbian, 2,509 Polish, 2,509 Greek, 1,098 Ruthenian, 1,358 Bulgarian and 620 Armenian.¹


7. In that same census a question on affiliation to a church/denomination or religious community was also included. In compliance with the 1992 Data Protection Act, that classified religion and nationality as special data, it was the first time in the history of the Hungarian censuses that the questionnaire did not contain the names of the persons. According to the official statistics on the religious composition of the population, among those who answered this question 74 per cent of the people are Catholic. (5.3 million Roman Catholics, 269,000 Greek Catholics). Most Roman Catholics live in the Western and Northern parts of the country, the majority of the Greek Catholics live in the North-East part of the country. 1,623,000 people declared affiliation to the Calvinist church and 304,000 are Lutherans. Nearly 13,000 persons declared affiliation to the Jewish religion.¹ The Jewish community, which constituted five per cent of the population before World War II, represents less than one per cent of the population since the Holocaust. This picture, however, alters if we take into consideration the spread of atheism and non-religious beliefs during the state-socialist period, as well as the rapid spread of new religious movements in the country during the transition, most of which can claim a much more active membership than the 'historical churches'.


§3. Political System

8. The modern parliamentary system in Hungary fluctuated between its more liberal and more authoritarian forms during much of the 19th and 20th centuries. Soon after World War II, a Soviet-style political system was introduced in the country, in which the Communist party (under different names) played a leading role, effectively dominating the legislative and executive branches of the government, as well as the legal system. Though other political parties were not declared illegal, their activities were made practically impossible until 1988, when most of the 'historical' political parties re-entered the political scene, and the intellectual opposition to the Communist Kádár-regime also formed new political organizations.

9. At the beginning of 1989, dramatic political reforms started to complement the gradual economic transformation of the country from a centrally planned economy to a mixed, market-regulated and state-controlled one. Bowing to the pressure coming from domestic opposition movements and international economic organizations, as well as seeing an opportunity for transferring their political might into economic power, the pragmatic and technocratic faction gradually took over the leadership of the ruling party (Hungarian Socialist Workers Party, MSzMP), and agreed to engage in roundtable negotiations with the opposition on the political future of the country.

10. The roundtable negotiations resulted in a series of agreements on the establishment of a true multi-party parliamentary system of representative democracy, on the election of a Constitutional Court by the parliament and on the establishment of ombudsman offices. Another important outcome of the negotiations was the weakening of the ruling party which was streamlined and renamed the Socialist Party in October 1989, which eventually lost the parliamentary elections in the Spring of 1990. The declaration of the Republic of Hungary on 23 October 1989 was a powerful symbolic enactment that made the political changes in the country irreversible.

11. During the Autumn of that year (1989), the outgoing parliament, dominated by the members of the Socialist party, passed all the bills proposed by the roundtable negotiations. One of these is the election law, which established a mixed system of direct and proportional representation, in which candidates may be elected in individual constituencies or as top-ranked members on national and regional party lists. Any Hungarian citizen aged 18 years or over has a right to vote and to be voted for.¹ Voters may cast one vote on an individual candidate and one vote on a political party that has previously collected a sufficient number of votes to appear on the ballot. In the former case, if a candidate gains an absolute majority in the first round of the elections, he or she becomes a member of parliament directly. If none of the candidates earn an absolute majority, a second round of elections must be held. Candidates on national and regional lists cannot be elected if their party fails to receive at least 4 per cent of the national aggregate of votes. Parliamentary elections were held in April 2002 and resulted in a victory for the Socialist party (MSZP).

1. Act No. XXXI of 1989 on the election of the members of the parliament.

12. The political and economic transition in Hungary in 1989 was also accompanied by a peaceful 'civil rights-revolution'. Constitutional rights, including both negative civil liberties and positive welfare rights already existed in the Hungarian Constitution, nevertheless hardly anyone took them seriously until 1990. The civil rights revolution started in 1989 when a Parliamentary Act significantly extended the catalogue of rights in the Hungarian Constitution. Previously, the 1949 Constitution guaranteed the right to work as the basis of all constitutional rights, whereas the new catalogue after 1989 began with the recognition of right to life and dignity as intrinsic and inalienable rights of everyone in the territory of the Hungarian Republic.


13. It is important to note that in the Communist constitution only the workers¹ right to health was guaranteed and the concept of constitutional protection of health
equated occupational health with health in general. The widest formulation of the right to health was incorporated not during the communist period but during the democratization process. Since 1989, Section 70/D of the Hungarian Constitution guarantees the right to everyone who lives in the territory of the Hungarian Republic the highest possible level of physical and mental health. Despite the honest intent to place general health condition among the highest priorities of the new democratic state, both in practice and in constitutional theory there is uncertainty about whether this provision can be taken seriously.

1. Section 47(1) of the 1949 Constitution: ‘A Magyar Népköztársaság védő a dolgozók egészségét...’.

14. An essential part of the political and economic transition was to take constitutional rights seriously. The mere reference to rights in the political discourse resulted in the situation that the state socialist political regime was challenged by democratic demands that apply the language of citizens’ ‘rights’. This attitude was in sharp contrast with the previous political language in which the ‘state ensured certain goods and welfare services to the workers.’

15. Evidently, during the first phase of the political-economic transition priority was given to political participatory right, such as freedom of association and freedom of expression and freedom of religion. Later, as the rights revolution expanded, it slowly reached undeveloped areas, such as health care. Throughout the world health care systems persistently face the problems of how to finance new and increasingly expensive health care services. Nevertheless; the area of health care in Hungary is especially problematic not only in the economic sense but also from ethical and legal aspects.


16. Parallel to the incorporation of new rights in the Hungarian legal system various mechanisms for rights monitoring and rights enforcement have been introduced.

17. The Hungarian Constitutional Court was established in 1989. It provided a possibility for citizens to challenge any legal norms and judicial decisions on the ground unconstitutionality. In comparison with other legal systems, the Hungarian judicial review includes both pre-norm and retrospective ‘abstract norm control’. It is also accompanied by some special petition, such as ‘constitutional complaint’ (alkotmányi jogi panasz) and the recognition of an unconstitutional situation by the failure to adopt a law (miaszításban megnyilvánuló alkotmányellenesség). Looking at this wide scope of jurisdiction there is little wonder that citizens, rights activists, lawyers and politicians frequently file petitions to the Constitutional Court. The active role of the Constitutional Court contributed to a large extent to the shaping of the new legal regime that emerged after 1989.

18. The conflict between legal and political transition on the one hand and the economic transition on the other could be analyzed if one looks at the decisions of the Constitutional Court on the austerity laws in 1995.

1. 36/2000, (X. 27). Constitutional Court’s decision on competence and psychiatric patient.

19. The other very effective and popular institutions among citizens are the Office of the Parliamentary Commissioner on Citizens’ Rights. The status and competence of the Parliamentary Commissioner was established in 1993 with a Parliamentary Act. There are four Parliamentary Commissioners in Hungary. A Parliamentary Commissioner for Citizens’ Rights, the General Deputy, the Parliamentary Commissioner for the Rights of National and Ethnic Minorities and a Parliamentary Commissioner for Data Protection. Although in law the term Parliamentary Commissioner for Citizens rights is mentioned, the term ‘Ombudsman’ is more frequently used both in the media and in the public discussions on this institution. The Ombudsmen are elected by Parliament. As such it follows that they are responsible only to Parliament. Apart from responding and investigating particular complaints by the citizens, each Ombudsman can conduct systematic surveys and investigations ex officio.

20. In addition to the Parliamentary Commissioners, there is one special Ombudsman in the Ministry for Education dealing with rights of education.


21. Although there is no specialized Ombudsman in the field of health, the Parliamentary Commissioner and the Deputy have conducted numerous investigations in relation to health care complaints depending on the contested right, in theory any of the Ombudsmen can face the problems of patients’ right. If the complaint is related to the Roma ethnic group’s access to health care then both the Ombudsman for Minority Rights and the General Ombudsman (or Deputy) can have a competence in handling the issue. If the confidentiality of medical data is the question, then most probably the Commissioner for Data Protection is the most competent to handle it. In some cases more than one Ombudsman can be involved in the process of dealing with one complaint.

22. One of the main reasons for the wide public recognition of the Ombudsmen are that, as opposed to lengthy and costly court procedures the investigations conducted by the Ombudsmen are relatively shorter and free of charge. Since the Ombudsmen cannot sanction or penalize the parties, this mechanism is capable of responding not only to clear violation of rights but also to some controversial practices.
§4. POPULATION AND VITAL STATISTICS

23. While in 1870 37 per cent of the Hungarian population were children and only 55 per cent were older than 60, by 2000 only 17 per cent of the population are children and 20 per cent are older than 60. Mortality and morbidity statistics are frequent subjects of political and public policy debates in Hungary. In comparison with countries within the European Union, the average life expectancy both for women and men are lower and this tendency has not improved in recent years. The most frequent causes of death in Hungary are cardiovascular diseases. One of the most important characteristics of the Hungarian mortality statistics at present is the sharp rise in tumour induced mortality.

24. While it decreased in most Western European countries between 1970 and 1999, deaths related to tumours increased by 31.6 per cent in Hungary. In 1999, 119 per 10,000 persons died from tumour related diseases, 29 died from cancerous diseases and four died of lung cancer. Cases involving tumours in the mouth, the oral cavity, and the pharynx increased most rapidly. Today more than three times more people die of these diseases than three decades earlier. The increase of colorectal cancer, breast cancer, and prostate cancer is also notable. Suicide mortality, however, has declined by 13 per cent compared to 1970. Despite this significant decrease, the 0.031 per cent suicide mortality is the fifth highest after Russia and the three Baltic States. Since 1990 the number of suicides have decreased from 4,133 to 3,269. Still the number of suicide per 100,000 persons is 32.2 (In some parts of Hungary, such as in the Southern Great plain the suicide, committed by men, is 78.9 per 100,000 persons).1


25. The overall state of public health in Hungary has been almost in continuous decline for more than thirty years. In 1999, average life expectancy at birth for the male population was 66.37 years, and for the females it was 75.24 years, well below the European Union average (where in 1997 the rate for males was 74.84 years and for females it was 81.24 years), and also lower than corresponding data from neighbouring Central and Eastern European nations. The mortality rate for middle-aged males is particularly high, even when compared worldwide.

26. The leading cause of mortality in people under the age of 65 (which qualifies as premature) are disorders of the circulatory system (the same as for overall mortality). Within this category, high blood pressure plays a decisive role in the onset of coronary heart disease (primarily myocardial infarction) and cerebro-vascular diseases (stroke and other cerebrovascular accidents). Among Hungarians, premature death due to coronary heart disease is three times the average rate for the European Union, and it is four times the average for cerebro-vascular diseases. Mortality due to malignant neoplasms is also far in excess of the EU average (1.8 times higher).

27. Among males, lung cancer is the type of tumor with the highest death rate, while among females the prime killers are breast and cervical cancer. Hungary's premature male mortality rate from lung cancer and premature female mortality rate from cervical cancer are particularly high when compared to the EU average. The male premature lung cancer mortality rate is 2.5 times over the EU average, and the female premature cervical cancer mortality rate is 3.5 times higher. At the same time, premature death due to malignant colon and colorectal tumors has been rising among both genders.

28. Another acute problem is the 7-8 fold increase in premature death due to chronic liver diseases and cirrhosis of the liver – mostly alcohol induced – over the past 30 years. By the mid-1990s this mortality rate was sevenfold the EU average. Death due to violence is twice the EU average. Within the category of violent death, premature death due to suicide continues to be more than double the average level among EU-residents, even though it has continuously declined over the past decade.

29. In 2001 a National Programme on Basic Principles of the Public Health was introduced1 with the intention of solving some of the most pressing problems of public health. One of the targets of the Programme on Public Health, adopted in 2001, is to make health one of the central values for the vast majority of Hungarian citizens. According to this programme, every necessary step has to be made to increase the average life expectancy among Hungarian men to 70 years, and among Hungarian women to 78 years. At the same time, the differences in life expectancy figures among various social groups have to be diminished by redressing social inequalities.


§5. SOCIAL AND CULTURAL VALUES

30. Compulsory education in Hungary was introduced in 1611 by the Catholic Convent. One of the prominent laws on compulsory education and the freedom of education was adopted by József Eötvös in the 1868 Parliamentary Bill. In 1958 the system of compulsory primary school with eight classes was introduced. Despite the lack of funding in science during the 20th century, many Hungarian scientists received Nobel prizes, including some in the fields of medical and biological science. Inventions of materials and methodologies such as Vitamin C by Albert Szent-Györgyi, the physiology and pathology of the vestibule by Robert Bárány, the physics of the cochlea by György Békésy, are worth mentioning here. But other important inventions such as matches, the dynamo, the carburetor, the diesel engine, the helicopter, the telephone centre, the use of nuclear fission, the computer, the BASIC programme language, the ball-point pen, the holo gram, and the development of game theory were also the product of the Hungarian inventive mind. Thus perhaps it is not an exaggeration to say that Hungarians can be proud of the scientific achievements of their country. Part of the Hungarian national identity is that there is a nationwide support for and high expectations towards scientific research, including biomedical science. The current research in
31. There are 1,887 research institutes and departments in Hungary which employ 23,000 researchers.

32. In October 2002 singling him out for ‘writing that upholds the fragile experience of the individual against the barbaric arbitrariness of history,’ the Royal Swedish Academy of Sciences awarded the 2002 Nobel Prize for Literature to Hungarian author and Auschwitz survivor, Imre Kertész.

§6. THE HUNGARIAN LEGAL SYSTEM AND THE ROLE OF THE COURTS

33. The Hungarian legal system is a civil law based system. Although it is a statutory law regime, in recent years the Courts also played a significant role in shaping the legal system. In the field of medical law it is worth mentioning that even before the political and economic transition patients could sue state-owned hospitals if due to a medical malpractice they suffered injury during their medical treatment. Later in the 1990s the Courts contributed to the rights revolution by enforcing civil liberties. Judicial proceedings and the interpretation of personality rights¹ helped patients, even before the explicit formulation of their rights in the 1997 Health Care Act,² to challenge the paternalistic attitudes at hospitals. Hungarian judicial proceedings also had an enormous impact on the development of patients’ rights. However even under the state health care system patients could sue hospitals for negligence based on the provisions of delictual liability in the Civil Code.

1. In Hungarian: ‘személyes jogok’ it includes for instance the right to respect dignity, right to self-determination, right not to be treated in a discriminatory way etc.
2. The chapter on Patient’s rights will analyze this Act in detail.

34. The number of medical negligence cases, however, significantly grew by the recognition of the right to choose doctors. The claims for higher compensation and non-pecuniary losses have also grown significantly.

35. It follows from the jurisprudence that if a patient who has consented to a medical treatment but has not been fully advised of the inherent risks, complications and possible side effects, the procedure is regarded as it has been performed without a legally valid consent. Informed consent plays a very important role in the Hungarian medical litigation.

36. Hungarian law applies a shift in the onus of proof in cases of delictual (extra-contractual) liability. In practice it means that the hospital or the private physician has to prove that their act was not negligent and that they did everything which could be expected of them in the given situation. This shift promotes hospital to take measures to avoid further claims for damages. Information and consent are evaluated.

Chapter 2. General Description of the Health Care System

37. The Hungarian health care system is based on a comprehensive, compulsory, national health insurance scheme that provides near universal coverage both in terms of treatments and in terms of population. Nearly all citizens receive care regardless of whether or not they contribute. Prior to 1990 the health care system operated as an integral part of the government with no separate budget or accounting system. Within the new scheme, the purchasing and service-provision functions are separated with the National Health Insurance Fund Administration (HIFA) entering into performance-based contracts with hospitals, outpatient clinics and independent caregivers. Most of the HIFA’s revenue derives from earmarked payroll and poll taxes levied on employees and employers. These are supplemented by direct subsidies from the central budget, which can cover the deficit. Public Health Care Activities and the National Ambulance Service are financed from the state budget, while investments are funded by state and local governments who own most of the health facilities.

§1. FINANCING THE HEALTH CARE SYSTEM

38. A growing proportion of total spending is financed privately through co-payments (on pharmaceuticals, some dental procedures and prosthetics), by under-the-table payments made directly to caregivers (so-called ‘gratitude money’ halapénz, or paraszolovencia)¹ and via direct out-of-pocket payments. The law also provides for voluntary mutual and private insurance funds to ensure supplementary coverage to the basic health care system.

1. The Committee on Paraszolovencia (Halapénz Bizottság) was established in December of 1996 by the Ministry of Health, Árpád Gégi. It was initiated by Péter Baláz. The findings of the Committee have been published in a Report in 2000.

39. In 1992 Parliament Act No. LXXXIV ordered the introduction of a prospective payment plan, called HBCS (Homologue Disease Groups) which is very similar to the American DRG 5 (Diagnosis Related Groups) system. This is a financing system based on the calculated length of stay and amount of costs in a defined package of hospital services. One critic of the Diagnostically Related Groups is that they place unjustifiable cost-conscious pressures upon physicians which jeopardize the traditional fiduciary relationship between physician and patient.

40. The austerity package of 1995 also had reverberations in the field of health care. The Minister of Welfare submitted a proposal to the Parliament in May 1996, with the title ‘On the Liability of Providing Health Care Services and the Regional Norms of Provision’. This proposal targeted a 15–20 billion Forint (then US$ 80–100 million) decrease in health care expenditure. Adding to the financial difficulties, while the sources of revenue diminished, the operational costs of the health care industry increased.
I. Health Insurance Fund

41. The Act XXXIX of 1998 on the Financial Funds of Social Insurance and the State Supervision of the Social Insurance Organizations stated that the supervision of the Health Insurance and Pension Insurance Funds (together Funds) and the management of the social insurance administration remain within the competency of the state. The Funds are supervised by the Government, and the social insurance administration is managed by the Government through persons defined by the designated Government Order. The Health Insurance Fund is administered by the National Health Insurance Bursary and the Pension Insurance Fund by the National Pension Insurance Authority.

42. The capital of the Funds and the assets of the insurance self-governments are state owned. The management organizations of the National Health Insurance Bursary are the following: the Health Insurance Bursaries at county level and in the capital city of Budapest, as well as the branch offices of these the Social Insurance Administration of the National Railways, the Social Insurance Unit of Journalists and the National Institute of Medical Experts.

§2. Regulations of the Health Care System

I. Historical Background

43. Regulations affecting health law have a long past in Hungary. At the beginning they existed as part of administrative law, although these early regulations and their related literature were only the first shoots of health law, in as much as they were thematically separated from other aspects of administrative law. The administrative legal nature of health law is based on unique historical development, namely the steps taken to eliminate epidemics.

44. Hungarian health law has existed for 230 years. The Generale Normativum in Re Santitatis health law written in Latin, is considered the first standard known in this area. It made very significant distinctions within medical activities: the medicus were doctors carrying out private practice, while physicus were doctors appointed by, or representing the authorities. According to early health law a doctor would request the right to practice from the leader of the community in which he wished to work. Those representing the authorities, for instance a town council, would review the documents proving the doctor’s qualifications, and then sign a contract specifying the conditions under which the doctor might open his practice. The last such document awarded to a surgeon without a medical degree was in 1872. In 1876 Act No. XIV was passed, widening the ambit of health care by, for example, assigning one doctor for every 6,000 citizens. Act No. XIX of 1907 established a unified accident and health insurance system. After the World War II, the property structure of the health care system followed the Soviet model. This meant that the insurance companies, the social insurance funds as well as the system of health care provisions were nationalized.

45. The Health Care Act of 1972 stated that the right to health care is part of the citizenship rights, and it promised free health care for everyone. State provided health care system was successful in some areas such as epidemiology and in the fights against infectious diseases. Thus, by the 1960s, the spread of tuberculosis was ultimately halted.

46. Following the fall of the socialist regime in 1989, the new health care politics was based on the respect of human dignity and the freedom of choice, and on the principles of equity and subsidiarity, efficiency, transparency and quality.

§3. Institutional Framework of the Hungarian Health Care System

47. The national health policy is determined by the government through the Ministry of Health (until 1998, the Ministry of Welfare) in conjunction with the HIFA which proposes and implements reforms. The financial parameters of the system, including the health insurance premiums paid by employers and employees and the budget of the Health Insurance Fund (HIF), are decided and promulgated each year by parliament in its ‘Act on the Budget for Social Insurance Funds’. The Ministry of Finance formulates the initial draft of the budget in consultation with the HIFA, which until mid-1998 was a subordinate body of the now abolished Health Insurance Self-Government (HISG).\(^1\)

48. The Ministry of Health operates the National Public Health and the Medical Officer Service (NPHMOS), a centralized public-health service created in 1991. It is primarily a traditional epidemiology and hygiene service that is also responsible for the licensing and professional supervision of health care institutions (such as hospitals and general practitioners’ practices); it also operates a number of local-level health promotion and prevention programmes; and the facilitation of contracting between the HIFA and local governments. Day-to-day administration of the health care system is split between the local governments, who are responsible for service provision, and the government’s purchasing agent (the HIFA) and its network of 19 County Health Insurance Fund Offices.
I. Primary Care

49. Primary care is paid for on a flat per-patient fee (capitation) basis which is adjusted according to the level of qualification of the physician and the demographic characteristics of the patient. In 2000, 5,159 general practitioners operated in the territory of Hungary, 993 of them in Budapest. The average number of consultations per year per GP (in Hungarian: hősörvos) was 9,225. Outpatient treatment is paid through a German-style point system and hospital care is reimbursed according to the Homogenous Diseases Groups (HDGs) inspired by the American Diagnosis Related Groups System. The capitation and points system are capped, and until 1998 so was the HDG system. The relative weight of each sub-budget in total health care expenditure was determined by the share of spending in 1992 and has changed little since. Although caregivers within the sub-systems can compete with one another for their share of the sub-budget, funds cannot be redistributed between them without a parliamentary amendment to the Health Insurance Budget Act and the total payments under the HDG and points systems cannot exceed the budgeted amount.

50. The final major health care payment provided by the HIF is out-of-hospital pharmaceutical subsidies, which are paid at varying rates, depending on the drug prescribed. Several services (mother and child health care nurses) are given a global budget by the HIF, while the Public Health Service, additional drug subsidies for the poor, and (beginning in 1998) the National Ambulance Services and the National Blood Transfusion service are financed directly from the central budget.

51. The right to choose a general practitioner doctor was one of the first patients’ rights which existed before the adoption of the new Health Care Act. It was approved by Government Decree 55/1992 (III. 21.). The right to choose a primary care doctor is instrumental to the exercise of many other rights, so it seems – at least legally speaking – that this right has been compromised by the Parliamentary Act No. II of 2000 on independent medical practice (Praxis Act). In this Act, Parliament significantly changed this choice element in the primary care system by introducing a ‘right to practice’ that is given to doctors by the Hungarian Medical Chamber (HMC). Under §2 (1) of the Praxis Act independent medical practice can be conducted only personally. The medical services are personal in the sense that they are based on the agreement between the patient and the particular doctor. The patient chooses one doctor and, as a general rule, the doctor cannot transfer his/her duty to another physician. However, in paragraph (3) of §2 of the Act the right to practice can be inherited and even purchased by another doctor. Even the order of inheritance is specified in the Praxis Act: first the spouse and then the children of the doctor can inherit the right to practice. The reasons for this legal change are purely economic; the right of inheritance is supposed to encourage doctors to invest in their office. It also intends to furnish some decent income to elderly physicians who would be motivated to leave the practice if they were guaranteed some financial stability after retirement.

II. Specialized Health Care Services

52. The Public Health Care Act classifies health services to type and place. Preventive care services include, but are not limited to, immunizations against contagious diseases, diagnostic screenings to protect the family, women and youth, preventive dental services, paediatric and adolescent services, general and locally justified screening examinations, and prenatal and maternal health care.

53. Health care treatments may be carried out at the place of residence of the patient (for primary health care), outpatient care based on referral (or in some cases on the request of the patient, hospital or emergency wards). The Act also authorizes an ambulance service and emergency medical services rehabilitation, pharmacology psychotherapy and clinical psychology, and non-conventional (traditional) practices.

54. The Health Care Act does not restrict the providers of these services, although as recently as 10 years ago, the state had a monopoly or service provision. Today, the state, public welfare authorities and local municipalities provide health care as do religious and civil organizations, foundations, private enterprises and individuals. Nevertheless all providers are subjected to the same code of professional regulation. Health care providers, whose services are covered by health insurance include GPs (family doctors), family paediatricians, outpatient service providers (polyclinics operated by the local municipalities or by hospitals), dentists, hospitals, pharmacies and the national ambulance services. In theory, every citizen is registered with a family doctor/family paediatrician.

55. The Health Care Act generally outlines the rights and obligations of individuals and health care providers. The law extends to all individuals living, or organizations operating, in Hungary. However, the entitlements to health care on the one hand, and rules for operation of the system on the other, are set forth in other instruments. Act No. LXXX of 1997 on Eligibility for Services Provided by the Social Security and on Private Pensions defines those who are entitled to social security services – and therefore, to health care services beyond life saving interventions. Article 2(1) of this law stipulates that participation in the social security system is obligatory for all Hungarian citizens, and (in accordance with other regulations) foreign citizens residing in Hungary. Social security contribution is proportionate to each citizen’s earned income. Payment of the social security is a prerequisite for health insurance eligibility. Registration at the social security authority is automatic upon birth: children get their social security number on the basis of their birth certificates and their personal identification number issued by the Central
56. Care of the healthy development of the foetus, preparation for breast feeding, child delivery and child care falls under a system of family and woman protection care. A special feature of the Hungarian health care system is the mother and child health nurses 'MCH nurses.' All MCH nurses provide free, general health care services with or without GP referral.

2. The list of free services available without referral is regulated in Art. 2 of the Order of Implementation (Government Decree 217/1997) of Act LXXXIII of 1997 on the Services Provided by the Mandatory Health Insurance (Health Insurance Act).

III. Health Care Providers

57. The regulation of health care providers occurs at all levels of the health care system. The Health Care Act authorizes the training of health care workers at primary, middle and higher educational facilities as well as continuing education to maintain and develop acquired knowledge. It establishes a body to supervise the quality of health education, called the Health Education and Training Council. It consists of the representatives of a variety of educational institutions, the professional chambers or other representative bodies, and professional boards.

1. Ibid. Art. 117.

58. The Welfare Ministry Order No. 21/1998 (VI. 3.) sets out in 17 appendices the minimal conditions that health care providers and facilities have to fulfill in order to qualify. Separate ministerial orders cover home health care workers and MCH nurses.


59. Nurses must have college degrees, but some graduate from specialized high schools and some are ‘untrained’ nurses. College graduates are required to study at least eight semesters or a minimum of 4,600 hours, pass the final exam, after which, a diploma will be awarded. The total number of health ancillary health workers is 95,809.


60. Hungary has a long tradition of mother-and-child care nurses. In 2000, more than 4,000 MCH nurses were practising throughout the country. MCH nurses also complete their training in colleges, in eight semesters (minimum 4,600 hours). The content of their training is specific to their role as a health care provider and social worker. They study basic anatomy, dietology and family care as well as psychology, philosophy, sociology. The tasks of MCH nurses are, to protect women, to care for pregnant women, to care for women after delivery and to care for newborn children. Their work includes providing advice on family planning, but also in preparing for motherhood, in helping the formation of a harmonious parent-child relationships, and providing all regular health services which do not need the intervention of a doctor (such as immunizations, measuring and weighing infants). MCH nurses also educate women on the importance of breast feeding, investigate circumstances which might endanger the healthy development of the child, inform students about health issues, family planning and addictions. In other words, the MCH nurse safeguards the healthy mental and physical development of children (and mothers insofar as they are attached to them) both in and out of the home. The MCH nurse also receives applications for abortions, and determines whether the applicant woman has to pay a fee for the service. Given the range of tasks, MCH nurses often face difficulties in fulfilling all these demands.

2. The regulations are set forth in Welfare Ministry Decree No. 5/1995 (II. 8. ), and No. 38/1995 (X. 7.).

61. Since 1997, the law stipulates the individuals’ right to information that is necessary for the protection and development of their health and which is necessary to make informed decisions in questions relating to their health. According to the Health Care Act, everyone has the right to information concerning the characteristics and accessibility of the services offered by health care providers, the rules for access, the rights of patients and the enforceability of those rights.

62. Individuals will be ejected from HMC if they were sentenced to prison for more than one year, or if they have been permanently banned from medical practice.

§4. RULES ON ACCOUNTABILITY

63. In case of suspicion of violation of ethical norms the HMC will carry out an ethical inquiry. In the application of this rule an ethical violation is seen as the intentional or neglectful violation of professional medical standards or medical ethical standards as established by the regulations and compulsory requirements in the HMC constitution, or other statute.
64. In the case of a violation of ethical standards by physicians in public employment, or working under public contract, the local chamber or the chamber's organization carrying out the inquiry will, in writing, initiate punishment proceedings with the employer.

65. In the case of a violation of ethical standards in which criminal or regulatory proceedings have begun, ethical proceedings must be initiated within three months of the legal ending of such proceedings even if the deadline, established in paragraph (3) of Art. 27 in the Parliamentary Act No. XXVIII of 1994 on the Hungarian Medical Chamber, has passed. The three-month deadline commences from the time the local chamber has been informed of the legal decision.

66. The lower ethical board will summarize the logic of its findings in writing, and will send this summary to the physician under inquiry, and to those who called for an ethical inquiry.

67. The physician under inquiry, or those who called for an ethical inquiry, may appeal against the ruling of the lower board within 15 days of receiving notice of the board's findings.

68. The secondary ethical board will summarize the logic of its findings in writing, and will send this summary to the physician under inquiry, to those who called for an initiation of the ethical inquiry, and to the lower ethical board. This decision should be reached, if possible, within 30 days of the request for appeal.

69. Action may be taken against the secondary ethical board's findings within thirty days of their transmission through civil courts as established under the Civil Procedure Act, Chapter XX.

70. Investigative procedures should be carried out in case of lower or secondary level ethical procedures, during which an interview with the physician charged with ethical violations should be made possible.

§5. The Hospital Act

71. As the health care sector has recently developed various institutional forms, the political aims and legal norms put into words by the Act No. CLIV of 1997 on Health Care (Health Care Act) should be complemented by legislation that regulates this institutional diversity of medical activity. It was common that within the hospital various forms of private and public health care providers, subcontractors operated. This complicated the questions of liability and transparency within the hospital. The aim of the Hospital Act was to clarify these complex connections and to regulate the various forms of health care services provided at health care institution.


72. Under the Hospital Act the health care institution may be a public health care institution, a health care institution that belongs to a religious organization or a private health care institution.

1. Art. 12(1) of the Hospital Act.

73. If the state or a local municipality has a majority ownership in a health care institution and it provides public service, then it is a public health care institution under the Hospital Act. There are three organizational forms of this type:

(a) an institution administered through the central government budget,
(b) an institution administered through the budget of a local municipality, or,
(c) a society of public benefit.

1. Art. 12(3) of the Hospital Act.

74. If a health care institution operates under the auspices of a church then under the Hospital Act it is regarded as a denominational health care institution. If a health care institution does not fit the description of either one of the above, then it is deemed a private health care institution.

1. Art. 12(4) of the Hospital Act.

75. The University Clinic is an organizational unit of a university of medical (health) sciences. This provides theoretical and practical training for university students at graduate and post-graduate levels within the broader framework of general health care provisions.


76. If a health care institution is not an organizational part of a university, but has a contract with a university to provide educational training or continuing education in medical sciences, then this institution may be deemed an 'educational hospital'. If only one or more of the hospital's departments take part in medical education and not the hospital as a whole then these units are called 'educational hospital department'.

1. Art. 16 of the Hospital Act.

77. Health care services may be provided in the form of health care enterprises. These enterprises are administered and operated either as individual entrepreneurial activities or as corporate entrepreneurial activities.

1. Art. 17(1) of the hospital Act.

78. Only persons whose names are listed in the operative directory of health care workers and have the necessary level of medical training as defined by separate law may provide health care services in individual enterprise form.

1. Art. 17(1) of the Hospital Act.
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79. The individual health care entrepreneur must have a valid professional license and liability insurance in order to be able to provide, only in his/her name and for his/her own responsibility, the health care services defined in his/her license.¹

1. Art. 17(3) of the Hospital Act.

80. The individual health care entrepreneur has unlimited liability for the duties ensuing from the entrepreneurial activity. The individual health care entrepreneur cannot be a member of any other enterprise with unlimited liability.¹

1. Art. 17(5) of the Hospital Act.

81. Corporate health care entrepreneurial activity may be provided in organizational forms defined by separate law, under valid professional license and liability insurance. The corporate health care enterprise is entitled to use the title ‘medical practice community’ in their name, if and only if there are only medical doctors and dentists among its members.¹

1. Art. 17(7) of the Hospital Act.

82. Medical and dental practice can be conducted by an employed medical doctor or dentist, a freelance medical doctor or dentist, and medical doctor or dentist entrepreneur.¹

1. Art. 18 of the Hospital Act.

83. An employed medical doctor or dentist may only conduct his/her medical activity under an employment or service contract, as a public worker or public administrator. An employed medical doctor or dentist may not provide freelance medical or dental practice, and cannot fulfil the tasks delineated in the employment contract as an entrepreneur.¹


84. In order to become a freelance medical doctor or dentist, one has to be listed in the official directory of medical doctors and dentists, must have proper training in the medical profession and the necessary certificates, and has to sign contract.¹

1. Art. 20(1) of the Hospital Act.

§6. ALTERNATIVE (TRADITIONAL) HEALTH CARE

85. Though various forms of alternative health care treatments have been practised since the beginning of the 20th century, health laws promulgated only the established forms of medical practice. The first legal recognition of alternative therapies can be found in the Health Care Act of 1997. The Parliamentary Act No. LXII of 1999 amended this part of the Health Care Act and provided a new title, ‘Non-conventional treatments.’ A government decree and a subsequent Welfare

Ministry decree limited their provision of services.¹ University or college graduate health care professionals with further training may practice traditional healing.² A ministerial order³ defines the content of the additional training required to become a qualified practitioner.

1. 40/1997, (III. 5.) Korm. rendelet a természetgyógyászati tevékenységről (governmental decree on alternative therapies).

86. Traditional Chinese, or homeopathic health care may only be practised by physicians, while other forms of alternative health care may be practised by anyone who has successfully completed the necessary training.¹ In each case, the professional quality of the education and the exams are supervised by the Institute for Health Care Studies,² while the activities of practitioners are regularly inspected by the Medical Officer’s service.³ The same regulatory scheme pertains to the production and sale of traditional medicines. At present there is no official statistical data about the use of traditional medicine.

1. Appendix 1 of Welfare Ministry Order No. 11/1997, (V. 28) provides full list.
2. Ibid. Art. 5.

§7. HEALTH CARE SERVICES TO BE PROVIDED ON THE BASIS OF WAITING LISTS

87. Although the shortage in the health care system is a well-known phenomenon, the 1997 health law reform,¹ aimed to establish transparency within the system.


1. Adopted by the Committee of Ministers on 7 March 2001.

I. Definition of the Waiting List

89. Waiting list: a list for the provision of certain health care services for patients, which they have been unable to receive for a prolonged period, (longer than two months), due to a shortage of capacity or to the nature of the treatment.

90. The health care provider has to provide the health care services to patients who fall under the waiting list provisions unless the provision of the treatment is exempted due to a medical emergency. The rules for administering waiting lists are
applicable to any health care treatment where the patients applying for treatment cannot receive the treatment — because of long-term shortage of services or because of the nature of the treatment dictates — within the appropriate time, and the patient is not accepting the treatment offered at another health institution.

91. Waiting lists are drawn up per treatments by waiting list committees functioning at the health care providers providing the treatments, and the National Transplant Committees organized according to the type of tissues or organs to be transplanted.

92. The waiting lists should contain the patient's data i.e. the patient's identification and her treatment, the reasons for being on the waiting list, the circumstances connected to the nature and progress of the illness and the circumstances connected to the patients' health.¹

1. 22/1998 (XII. 27) EAM rendelet a várlista alapján nyújtott egészségügyi ellátásokról (Services based on the waiting list) Art. 3(1).

93. The waiting list is part of the medical documentation, in the sense that the patient only has the right to access to medical documentation with regard to her own data.

94. The waiting time of patients for the respective treatment should be made available for the doctors who assign patients for the treatment and for the health care providers providing the respective treatment. Part of the doctor's duty to provide information for the patient is the duty to inform the patient of the waiting list with respect to that particular treatment.

II. Rules for Administering Waiting Lists

95. Inclusion to a waiting list shall be recommended — after the informed consent of the patient — by the doctor in charge of the treatment. If the doctor does not recommend inclusion, the patient can ask for a second opinion.

96. The patient cannot be included on an institutional waiting list if another health care provider authorized to provide the same treatment could provide the treatment for the patient after a short waiting time or without inclusion to a waiting list in a similar manner, and the patient accepts this treatment.

97. The health condition of the patients being on the waiting list shall be checked as systematically as requested by the specificity of the illness and the condition of the patient. In case of medical emergency the patient shall be treated immediately. If immediate treatment is not possible, the patient shall be replaced on the waiting list so that as soon as the treatment becomes available, he/she can receive the treatment within the time appropriate for his/her health condition.

98. Patients being on the waiting list shall receive treatment in accordance with professional medical practice and the expected results. If a distinction between the patients cannot be made on the above grounds, treatment shall be given according to their order of inclusion on the waiting list.¹

1. ¹ Ibid. Art. 5(3).

99. According to the basic rule everybody should be included to the waiting list, if, according to medical opinion they are, fit to undergo the treatment, and the treatment can cause improvement to the condition of the patient or can stabilize their condition. In case of changes in the condition of the patient, or if the patient did not receive the proper medical treatment within the time limit set by the professional rules for that treatment, the patient's inclusion on the waiting list should be re-examined.

100. Any decisions concerning a patient's inclusion to the waiting list, or defining the ordering, prioritization or their deletion from the list, shall be made by the Waiting List Committee at the relevant health care provider. In case of waiting lists for transplantation the decisions are made by the relevant — according to the type of transplant — Transplantation Committee.

101. In case of medical emergency the medical director of the institution or of the department providing the treatment can authorize carrying out the treatment, even if this is inconsistent with the order of the waiting list. Such a decision has to be justified by the Waiting List Committee at the following meeting.

102. If, due to the necessity of the treatment, the summoning together of the transplantation Committee is not possible, the choice has to be made based on professional criteria by the medical director of the health care provider which provides the treatment, with the concomitant notification to the relevant Transplantation Committee. If a decision is inconsistent with the placement of the transplantation on the waiting list the director of the institution making the choice has to justify the decision when notifying the Transplantation Committee.

103. The chair of the Transplantation Committee is (for organ transplantation) the director of the Transplantation Clinic and for tissue transplantation it is the director of the National Haematological and Immunology Institute or the persons delegated by them. Committee decisions are made with an open vote, on a majority basis. The chair's vote will be decisive when there is no majority. More than half of the members of the Committee have to be present in order for the Committee to make a valid decision, but a decision can only be made if that member of the Committee who has the medical specialization relevant for the respective treatment is present.

¹ Ibid. Art. 9(3) amended by the 20/1999 (VI. 30). EAM decree.

104. The boards specialized according to the different treatments with help of the relevant Waiting List Committees and the Transplantation Committee and in
agreement with the relevant national institutions define, and make it public and accessible to the concerned health care providers and the patients, the indications and contraindications for being included on the waiting list.

105. The following health care treatment is provided based on transplantation waiting lists: Organ – heart, lung, kidney and pancreas transplantation, tissues transplantation – bone-marrow transplantation, biological cornea transplantation and biological cardiac valve transplantation.

106. The Committee in charge of accepting patients on the waiting list has the ex officio duty to inform the patient and his/her doctor about opportunities for treatment at different health care providers before inclusion to the waiting list.

Chapter 3. Sources of Medical Law

§1. HISTORY OF MEDICAL LAW IN HUNGARY

107. Dr. József Imre (a professor of medicine) collected and published lectures on medical ethics in 1925. The professor studied Hungarian and German literature, and it is surprising even today to see the degree to which the necessity of informing the patient, and receiving his/her consent before carrying out medical procedures, was recognized and considered ethical at the start of the 20th century. Several authors were also concerned with the issue of medical responsibility at that time in Hungary. In ‘The Doctor’s Responsibility,’ published in 1938, Béla Kassai and Sándor Szőke exhaustively analyzed elements of civil and criminal liability, as well as the problems of proof. In his ‘Medical Responsibility and the Proof of Probability’, published in Kolozsvár (Cluj) in 1943, Sándor Túry analyzed special problems related to the doctor-patient relationship, and the proof of maltreatment.

108. Following the Second World War Hungarian legal literature was long overburdened with issues related to pregnancy termination. Very little attention was paid by contrast to the discussion of legal issues related to new treatments. In his ‘Laws on Organ and Tissue Transplantation’ (1970) Endre Nizsalkovszky analyzed legal regulations including the most essential issues of responsibilities and, he analyzed the legal issues related to organ transplantation with such thoroughness that his work is to be found in English in the greatest medical university libraries world-wide. György Ádám devoted 549 pages of his thesis to ‘The Establishment of Responsibility’, László Dezső wrote a lengthy study on medical criminal responsibility, while in his thesis Gábor Jobbágyi introduces unique aspects of medical legal relations. Gábor Jobbágyi has focused more than anyone else in Hungary on the legal status of the foetus. One of this author’s most significant works in this field was published in 1994 as ‘The Foetus’ Right to Life’.

109. Béla Blasszauer has played a very important role in the dissemination of ethical theories of the respect for individual autonomy of informing the patient.1


110. Gábor Jobbágyi’s works from the 1980s played a significant role in the analysis of medical law as an independent category of law.1 In 1986 Károly Törő wrote a basic work on medical legal relations, and permanently set the standard for directing medical law toward civil legal regulations. Károly Törő also made unquestionable advances in the analysis of personality rights in the doctor-patient relationship.2 In her 1996 book, ‘Medicine and Judgement’ the author of this monograph (Judit Sándor) monitored the medical litigation practice in Hungary, and through critical analysis attempted to work out certain elements of medical liability.3

1. Jobbágyi Gábor (1984), A gyógyító munka polgári jogi vonatkozásai, különös tekintettel
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In addition to the legal system own developments, the primary sources of medical law are the statutes and decrees. The major legislative step was the adoption of the 1997 Parliamentary Act on health care, the Parliamentary Act No. CIV of 1997.

The 1997 Parliamentary Act encompasses practically all aspects of health care. The Act includes principles of health care, patients' rights, patients' duties,

Public health, health promotion, family-, child-, youth- and women care, sports medicine, nuclear safety, occupational health, basic rules on epidemics and infectious diseases, vaccinations, the system of health care services, preventive care, primary care, out-patient services, in-patient services, ambulance, hospice, rehabilitation, medical devices, psychotherapy, medication, non-conventional treatments, professional rules for medical practice, quality assurance, the rights and duties of health care staff, the state responsibility for health care, research on human subjects, medically assisted human reproduction, psychiatric care and services, organ and tissue transplantation, cadavers, post-mortem examinations, blood supply, urology, medical treatment in cases of national disasters, health experts, natural curative sources, (e.g. the use of thermal water) and international provisions (health services for non-citizens, international agreements). Some of the topics are largely unchanged and have simply been copied from the 1972 Health Care Act. However, new provisions have been introduced, such as patients' rights, assisted reproduction, patients rights representatives, etc. Since 1997 numerous decrees have been added to further specify some chapters of the Health Care Act. The Parliamentary Act has also been amended several times.


1.15. Specific health services that are provided based on the mandatory and general health insurance are included in a separate Act which was also adopted in 1997.


1.16. A separate Parliamentary Act covers the protection of the health care data,1 and the Hospital Act specifies various forms of medical activity.

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Selected Bibliography


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Part I. The Medical Profession

Chapter 1. Access to the Medical Profession

117. Physicians, dentists, and pharmacists are required to complete a university degree, while dieticians, nurses and MCH nurses (among other 'allied' medical professionals), must obtain a college degree.1 Physicians study 12 semesters (a minimum 6,000 hours). In the 2000/2001 academic year the total number of medical students at the eleven medical faculties in Hungary was 6,635.2 Studies terminate by passing a final state exam in general medical knowledge, which covers several specific subjects. In order to become a specialist, a physician must continue his or her training while working at a hospital between one to six years, depending on the field and on their course load. The specialized training also terminates by a final state exam, consisting of written, oral and practical parts.3 All medical professionals must pursue their education, by enrolling in professional training courses at least once every five years.4 In Hungary the total number of working physicians was 30,533 in 2000. 1,243 of them worked as obstetrician and gynaecologist. The National Register of Physicians included 46,560 names in 1999. (That is 46,4 doctors per 10,000 persons).

Chapter 2. The Practice of Medicine

118. In the Parliamentary Act No. CVII of 2001 the medical profession is defined very broadly. Article 2 of the Act states that medical practice is any form of independent health care activity that is performed by persons who have a medical/dental diploma.


119. Medical and dental practice can be conducted by an employed medical doctor or dentist, a freelance medical doctor or dentist or a medical doctor or dentist entrepreneur.

120. The National Registry¹ includes medical doctors, doctors of dentistry, pharmacists, clinical psychologists and dentists with health qualifications. The Ministry of Health is responsible for the register. Subsequent to registration the Ministry notifies the National Health Insurance to issue the medical stamp² that qualifies the registered person to prescribe medication. The Operational registries are administered by the Hungarian Medical Chamber and the Hungarian Chamber for Pharmacists.

1. 30/1999. (VII. 16). ELTM rendelet az orvosek, a fogorvosok, a gyógyszerészek, valamint a klinikai szakpszichológusok alapnyilvántartásáról és működési nyilvántartásáról, valamint a működési nyilvántartásban nem szereplő személyek tevékenységének engedélyezéséről (Ministry Decree on the registration of medical doctors, dentists, pharmacists, clinical psychologists).
2. 20/1999. (XI. 5.). NM rendelet az orvosi bélyegzéséről (Ministry Decree on medical stamps).

121. Inclusion on the National Register for Health Care Staff is valid for 5 years and can be renewed by the individual’s request. Registration is cancelled if the concerned individual fails to renew registration, or because of deterioration of their health the registered person is unable to continue the health care activity, or if the doctor has lost competence as a result of a court ruling or if they declared false data. The private practice of medical doctors was regulated at the time of the political and economic transition, and since then frequent changes have occurred in this domain.¹


122. In 2000 a new Act was adopted on independent medical practice.¹ This law created a new legal framework by making the so called 'practice license' purchasable and inheritable. The law is valid only for family doctors and serves the purpose that elderly doctors will be encouraged to terminate their practice when

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they are unable to continue and at the same time provide financial stability in their retirement. This Act also intended to support private investment in the medical practices. This new concept, however, is not entirely in harmony with the concept of personal medical service that is based on the patient’s choice of doctor and the agreement between the medical doctor and patient. The personal data of patients are not purchasable but without transferring the 'clients' list' it is very unlikely that anyone would 'buy' the medical practice.

1. 2000. évi II. Törvény az önálló orvosi tevékenységről.

§1. ILLEGAL PRACTICE OF MEDICINE

123. The Hungarian Criminal Code contains nine sections relating to health services.¹ The first, Section 171 (Endangering within the Sphere of Occupation) is a general protective measure against any kind of health-endangering activity. It states that any person who negligently – that is by violating the rules of her/his profession – exposes the life, bodily integrity or health of another person or persons to harm, or causes bodily harm, commits a misdemeanour, may be punished by imprisonment of up to one year or a mandatory public service or a fine.² If the crime causes a long-term handicap, serious health injury, or national disaster, the punishment is increased to imprisonment of up to three years. If such negligent behaviour causes death, it is punishable by one to five years in prison, or if multiple deaths or a fatal national disaster occurs, the punishment is two to eight years.³ If such behaviour is intentional, the crime is a felony, and the punishment increases from 3 to 10 years depending on the degree of harm caused.

1. Sections 171 (Endangering within the sphere of occupation; in fact, medical malpractice), and Sections 173/a-173/1 (These provisions are regulated under a separate title: Crimes against the order of medical interventions and medical research, and against health self-determination).
2. Subsection (1).
3. Subsection (2).

124. A new sub section of the Criminal Code, effective 1 July 1998,¹ 'Crimes Against the Order of Medical Interventions and Medical Research, and Against Self-determination Related to Health Issues,' concerns biomedical ethics. Criminal activity classified here includes human genome interference,² human gamete usage,³ sex selection and techniques,⁴ human experiment research protocols,⁵ embry and gamete research protocols,⁶ health self-determination and transplantation sale of human body parts and cadavers.⁷ Violations of the legal rules and norms are punished with prison terms of up to five years, with exceptions for violating health self-determination, and the use of the human body/corpse, where punishment is up to three years imprisonment. In some cases, the attempt to commit these prohibited acts is also punishable.⁸

1. Title II, Chapter XII, on Crimes Against Persons.
2. Section 173A.
3. Section 173/B.
4. Section 173/C.
5. Section 173/D.

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6. Section 173/E-G: These Sections basically prohibit all forms of cloning for any reason except if done by, and strictly according to a permission issued in line with the law on health care.
7. Section 173/F: The Section prohibits the unlawful obtaining any kind of sale of all parts of the human body from genes to the whole body.
8. Sections 175/B, E, F, G, I: Preparation is either a misdemeanour punishable by up to 2 years of imprisonment, or a crime in itself, punishable by up to 3 years imprisonment.

125. Any alteration of the human genome, including alteration of the human embryo is punishable up to 5 years of imprisonment. If the human genome is successfully changed the punishment is up to 2–8 years imprisonment.¹

126. Reproductive use of cadaver gametes, including the gametes of the dead embryo is punishable up to 5 years of imprisonment.

127. Sex selection is punishable up to 5 years of imprisonment.¹ The only exception for punishment is, if sex selection of the human embryo is conducted in order to avoid an inheritable disease (Health Care Act 1997 No. CLIV Art. 182).

128. Violation of the rules on human research is punishable up to 5 years of imprisonment.¹

129. Anyone who conducts a research on embryo or on gametes without permission issued under the Public Health Act is punishable up to 5 years of imprisonment.¹

Chapter 3. Control over the Practice of Medicine

§1. Professional Liability

130. In contrast to moral responsibility, legal liability means more than the taking of a moral stance on a disapproved activity or omission. It also encompasses legal sanctions. The goal of compensation is primarily the restitution of conditions existing before injury occurred, and if this is not possible, the provision of adequate financial compensation for the injured party. Beyond the function of compensating for damages, the establishment of legal responsibility also acts as a prevention and deterrence.

131. Civil liability in the field of health care is often replaced by the term ‘medical malpractice’.¹ However, in the legal literature the term ‘medical malpractice’ is inaccurate because it suggests that the outcome of a judicial procedure is exclusively based on a medical assessment. In fact forensic medicine can characterize a practice, as medical malpractice but this qualification is based only upon statistical probability. Contrary to this, the law will always look at the given course of action independently and examine whether the effects of the errors could have been avoided by due care.

1. In Hungarian: 'orvos mi½hiba'.

132. Within civil law one can differentiate between damages done outside a contract (delictual liability), and damage arising from contractual responsibilities. In Hungary the vast majority of civil law litigation that is initiated against health institutions is determined in accordance with the rules of delictual liability.

133. 'Whoever causes unlawful damage to others is required to compensate that damage. If, however, he/she proves that he/she behaved as was to be expected in the given situation he/she is free from liability' (Hungarian Civil Code 339 § (1)).

134. The legal practice of compensation is applied to restitute a victim for losses suffered. The scope of compensation is therefore set according to the extent of damage suffered, and is not to exceed it. The obligation to provide restitution for damage cannot be the source of revenue. At the same time the limitation of restitution by the damage suffered indicates that it is meant to fully compensate the victim for all damages suffered.

135. When one speaks of the legal responsibility of health institutions, it refers to civil liability, the cases in which a patient sues a health institution for damages (of a material or non-material nature) arising from malpractice.¹ The establishment of responsibility is subjective in nature, that is to say that damage (for
instance, damage to the nervous system), *causality* (between, for instance, medical treatment and damage to the nervous system) and ability to attribute guilt (medical intervention "contra legem aris") must all be established to determine responsibility. The fourth step is to establish the unlawful nature of the damage done.


136. Where these four preconditions co-exist, the injured party may demand compensation from those who caused his/her injuries.

137. In case of the combined existence of these four preconditions, the injured party may demand compensation from those who caused his/her injuries.

I. Unlawfulness

138. In the case of unlawfulness the emphasis is, in fact, on the violation of the law, and not on the violation of the injured individual’s rights. This aspect of civic legal responsibility, which is related to the concept of responsibility in criminal law, only becomes operative when the rights of specific individuals have been violated.

139. A similar concept can be found in German law, *Rechtswidrigkeit*, which covers a violation of legal norms without including exceptions that had been determined by law.

140. Put simply, the concept of unlawfulness means that all forms of behaviour, or results from behaviour that violate legal standards – without regard to the subjective understanding of the damage doer – are unlawful. The law recognizes four exceptions to this rule:

1. Damage caused under duress, that is in a situation in which an individual’s life, physical well-being or property are under direct threat, and there is no other way to avoid this threat than through the behaviour engaged in;
2. The prior agreement of the injured party to the damage, unless this agreement violates or threatens social interests;
3. Lawful self-defence; and
4. Legal permission, that is to say behaviour for which the law has given its approval.

141. The general determination of unlawfulness occurs when the violator’s active and/or passive behaviour can be considered unlawful. With regard to the protection of life or physical well being, however, numerous precedents exist showing that although a specific regulation on the standard of care in some situations may not exist, however, the failure to protect life or physical well being can also be considered unlawful.

142. What does unlawfulness mean in terms of damages arising from medical activities? According to earlier legal conceptions medical intervention is not to be considered an unlawful activity, not only because of the existing or supposed agreement of the patient, as a disqualification for unlawfulness, but also because of the objective goals of the intervention. In this traditional legal concept the goal of medical activity is assistance, and not damage, and therefore it cannot be unlawful. Géza Marton disputes this position when he argues that – quite apart from the problematic nature of determining objective intentions – this is only true in the case of intentional acts. A badly, unnecessarily, or carelessly carried out operation can be unlawful regardless of its objective goal. In health law the exceptions to the suppression of unlawfulness are unique: the equivalent to the legal concept of damage caused out of necessity are necessary emergency operations carried out without the patient’s prior agreement, and in medical law prior agreement is understood to mean the requirement to gain written approval for intervention from the patient as stipulated by health law.

143. The establishment of unlawfulness, or a lack of unlawfulness, is very difficult in practice. I believe that the fewest mistakes are made in the establishment of unlawfulness if during the legal judgment of health care we ask ourselves the following question two times: was the medical intervention unlawful?

144. We should answer this question first when we examine the information given to the patient before the procedure was undertaken, and the permission given by the patient after receiving this information. The lack of unlawfulness is established in this case if we can establish that the law was not violated and the injured party (the patient) agreed to the cause of the injury (in this case, the medical procedure), that is to say we have a case of *volenti non fit iniuria*. Some explanation of this concept of unlawfulness is needed here. In common with norms and judgments of civil law in several countries, Hungarian law places emphasis on the medical procedure and considers that procedure to be unlawful if it occurs without the patient’s prior approval, no matter what the procedure, whether it be a tonsillectomy, surgery to repair a hernia or a biopsy. Punishment can range from the consequences of injury to personal rights, to criminal legal sanctions.

145. In continuing our examination to establish unlawfulness, we should again ask that question when we examine the procedure itself (the quality of the operation).

146. It is not widely known that Hungarian law provides a broad range of opportunity to initiate lawsuits in cases of malpractice. In Hungary, because of the reversal of burden of proof – in contrast to regulations in other countries – the defendant must prove that he or she acted in accordance with the law in the given situation, while the plaintiff is not required to prove that the doctor mistreated him/her in the course of treatment.
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147. Although this is the case, sometimes the court will make an error in the requirements it lays down for the establishment of proof. In one such trial the court refused to hear the case submitted because of the paralysis of a new-born baby’s arm. The court declared that ‘the plaintiff was unable to prove that the doctor assisting at birth or the paediatrician had acted incorrectly’.


II. Damage

148. In legal terms damage means a loss or disadvantage occurring to someone. Damage can be material or personal. Material damage can be differentiated as follows:

- Damage arising (damnum emergens), that is the value to which the injured party’s property has fallen in value;
- Justified expenditures, expenditures related to the reduction or elimination of damage incurred; or
- Lost income (lucrum cessans), that is the value to which the injured party’s property might have increased if the injury had not occurred.

149. Other personal rights can be violated in damage incurred by the individual, and these we call non-material damage. By non-material damage (in other legal systems: Niechtervermögenschaden, dommage moral, non-pecuniary loss) we mean damage to an individual’s immaterial goods. Here the quality of what has been damaged is decisive, independently of the fact that financial compensation may have already been provided. Damage to objects can also, in some cases, be considered non-material damage if, for instance, they are of a personal nature or are associated with memories, etc. The most prevalent form of non-material damage is pain, or mental suffering, and the injury associated with the loss of a loved one or the violation of an individual’s dignity or honour.

150. For a very long time such damage has been considered to be practically physical. A good illustration of this fact is to be found in the Roman regulation against singing insulting songs under a victim’s window, which was judged to be damage done to ‘the ears’. However, compensation for such damage has always been restricted to a certain extent. One of the most common methods of restricting such compensation is to be found in the legal practice of only considering damage in relation to the injured party’s social status. László Sólyom has pointed out that the law in fact only protects the part of the personality that is in accordance with social expectations of the individual.


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III. Causality

151. The third element of medical liability is the causal link between the wrongful medical act (or omission) and the occurred damage. The causality has to be proven by the plaintiff (the patient or other victim of the medical intervention). If there is a lack of sufficient information and there are no medical protocols it is often very difficult to prove the link between the symptoms and the medical intervention. The Hungarian courts do not apply the principle of ‘res ipsa loquitur’ (things speak for themselves).

IV. Fault (Negligence)

152. The medical liability is based on the fault-based model. A wrongful act or omission is considered as medical malpractice if it is negligent, in other words if it is subjectively avoidable. A mere causality is not sufficient to claim damages for a medical malpractice. However, it is not the plaintiff but the defendant who has to prove that the act was not negligent by demonstrating that the hospital or the doctor did everything that was prescribed by professional rules (excubatory libality).

V. The Violation of Personal Private Rights

153. The modern concept of inuria is not based upon the classic approach to the individual, but rather on the position of an individual in relation to others. A clear example of this is the protection of private rights in American constitutional law.

1. In their work on the right to privacy Warren and Brandeis (1890) introduce the notion of an abstract, individual private right which was violated when authorities had installed listening devices in public telephone booths.

154. The Griswold case was a milestone in this development, for the court broke with its earlier literal interpretation of the Fourth Amendment and put the concept of protection of privacy into the intimate sphere of marital relations, including issues related to birth control.


155. In American constitutional tradition issues of privacy are part of individual autonomy, although they do not comprise a clearly separate sphere of autonomy. The area separated by the law within individual autonomy is called in professional jargon ‘inviolable personality’.

156. Beyond violations of privacy, of course, serious physical and mental shocks, aesthetic damage, damage to health, and many other non-material forms of damage can arise as a result of medical intervention.

157. Mention should be made of the relatively recently recognized temporary form of emotional damage which English legal literature calls ‘traumatically
induced psychiatric injury. For example, if an individual is a witness to a car accident in which a close relative is killed, in addition to the shock (which can also serve as a basis for compensation for non-material damage), many suffer from post-traumatic stress syndrome, a syndrome that appears in the form of anxiety nightmares, or even the inability to carry out certain tasks (for instance, being unable to cross the street, or get into a car). Such damage can, of course, also arise from medical treatment. Thus, for instance, a woman who, because of insufficient anaesthetic, awakes during the performance of a caesarean section and who, because of the shock of the experience, is unwilling and unable to bear another pregnancy, in my opinion would be justified in demanding compensation.

2. The qualification of sudden shock as damage appeared in earlier judgments such as the British case, Sowrik v. Young (1943) A.C. 92.

158. Correction of non-material damages, and the damage done to the inviolability of privacy, has always been a disputed area of Hungarian liability law. As Géza Marton has shown, in cases of non-material damage it is not the immediately damaged object that will be the deciding factor, but rather the nature of the repercussions following the injury. Damages of a non-material nature have no true financial value here.


159. In the period when I examined medical negligence in my book (1983–1993), the definition, or rather the evaluation of non-material damage, differed from current regulations.

160. Although in Hungary the concept of non-material damage existed before the second world war, it was abolished in 1953 under Soviet law. The concept was re-introduced to the Hungarian system of civil law norms in 1977 with the amendment of the Civil Code.

161. Before the decision 34/1992 (V.I.) by the Constitutional Court, the Hungarian Civil Code interpreted non-material damage only in cases when such injuries caused were lasting or when there was serious damage to the victims ability to take part in social life.


162. The text that was enforced until 1992 defined non-pecuniary losses in the following way:

'The individual who caused injury is required to compensate the individual for non-material damage if the injured party's ability to take part in social life, or in life otherwise, is permanently or seriously impaired, or if there is serious detriment to the party's participation in economic life.'

1. The previous text of the Hungarian Civil Code §354.

163. Before the political transition social utility served as a basis for non-pecuniary losses several forced, even absurd, decisions were reached in this period.

The plaintiff's husband had disappeared from the mental institution, never to reappear. Strangely, the issue at stake in the case was not the degree to which the defendant's employees were bound to protect the patient, but whether or not the plaintiff had truly suffered any form of damage from the loss of her husband. The decision reached by the lower court was that in fact the plaintiff had suffered no real damage due to the loss of her husband. In another case the plaintiff, who was a minor, lost his mother due to a medical error. The court rejected the demand for non-material compensation for the following reason:

In accordance with the directions of the Highest Court material compensation for the death of a relative can only be established if, in addition to the feeling of mourning and the unfortunate fact of orphanhood, the plaintiff's ability to participate in social life, or otherwise in life is permanently or seriously impaired.


164. In 1992 the Constitutional Court determined in its decision (cited above) that the material value of non-material damage could not be measured, and thus the method of protecting civil rights - compensation - was in fact inadequate in comparison to the damage incurred. Since non-material damages had no true financial value, there could be no question of providing any compensation for them in real terms.

165. The Constitutional Court also pointed to the historical roots of the institution, according to which injuries to the personality (injuriata) were to be compensated in a manner determined as adequate by the judge examining the case, in accordance to the best of his judgment. The Parliamentary Act No. XCI. of 1993 cancelled Article 354 of the Civil Code. Although there is no definition for non-pecuniary damage in the Civil Code, the principle of full compensation is still applied.

§2. Quality Assurance

166. The Health Care Act provides only general rules for external and internal quality assurance and for the certificate on compliance. Decree No. 21/1998 (VI. 3) NM sets out the so-called minimal professional requirements of the health care institutions.

1. Arts. 119–124 of the HCA.

167. The decree and especially the annexes of the decree specifies the personal requirements of various medical units, departments, and attaches a list of the necessary medical equipment and facilities of distinct medical departments.

168. Applications for operational licenses are examined by the Public Health Authority to ensure that the criteria specified in the decree are fulfilled.
§3. Disciplinary Organizations

169. Since medical doctors and health care workers can have a different legal status, the applicable disciplinary procedure depends on the type of the contact under which they perform medical treatment. For instance, a doctor who works in a public hospital and has an employment contract is liable for wrongs based on the Parliamentary Act No. XXXIII of 1992 (on the legal status of public employees).  

1. 1992, évi XXXIII. törvény a közalkalmazottak jogállásáról.

170. The Ethics Committee of the Hungarian Medical Chamber deals with violations of ethical principles in the medical profession. Violation of ethics include the violation of the rules of the medical profession and the violation of the rules of conduct included in the Statute of the Hungarian Medical Chamber.

1. Art. 25 of the Parliamentary Act No. XXXVIII of 1994 on the Hungarian Medical Chamber.

171. The sanctions that can be imposed on doctors include notification, reprimand and financial penalty (according to the law: the maximum penalty should not exceed the level that is the minimum monthly salary multiplied by 10. The most grievous sanction is the suspension of membership to the Hungarian Medical Chamber of up to 6 months.

172. Pharmacists may be held liable for ethical or disciplinary misdemeanors based on the Parliamentary Act on Chamber of Pharmacists.

1. 1994, évi LI. Törvény.

Chapter 1. General Description

§1. Rights and Duties of Physicians and Patients

I. Patients’ Rights

173. Since the political transition Hungary has been going through a ‘rights revolution’. The Constitutional Court was established and has now begun to play a very active role in the promotion of human rights. Basic elements of rule of law have been laid down. However, rule of law also means the existence of a structure in which all significant actors including the government must respect and uphold the accepted normative order. The process to create a friendly attitude and environment where the new rights are implemented and protected requires enormous efforts in education, knowledge and also the necessary financial resources. If the gap between the right in books and rights enforced are too wide, it leads to a devaluation of rights which can be an obstacle to the protection of basic human rights. Also it would be undesired if the general legal norms and provision of the Civil Code did not correspond with the new patients’ rights norms.

174. Patients’ rights legislation is a very important tool in creating a better doctor-patient relationship and higher quality of medical care. However, it also requires significant financial resources, considerate and benevolent day-to-day interpretation, fast court procedures when it becomes necessary, and access to non-judicial dispute settlement methods (ombudsman, administrative patient’s complaint procedures etc.). Patients’ rights have to be consistent with other legal norms such as duties of the doctors and health care workers, personal rights in Civil Code and naturally with the basic rights enlisted in the Constitution.

175. One of the most important reforms accomplished by the Health Care Act1 and its implementing orders is the protection of the patients’ rights. Classified in various legal codes, patients theoretically have a chance to be equal participants in their health care treatment.

1. The Hungarian term ‘Egészségügyi törvény’ can be translated in many ways. The literary translation of this Parliamentary Act is ‘Act on health matters’. Some commentators translate it as Public Health Care Act, though in my opinion that could be ‘Közegészségügyi törvény’. Since the Hungarian 1997 Act is a compilation of various topics, such as patients’ rights or the institutional framework of the health care system, I provided a general term for the translation.
176. Patients' rights were incorporated into the Hungarian legal system unexpectedly. The legislative process started without an articulated legislative policy. In 1996 the legal reform was initiated when the paternalistic model in the health care system was still dominant. The Hungarian Ministry for Welfare initiated comprehensive health law reform and by the end of 1997 the Hungarian Parliament adopted the Health Care Act. This legal reform was based implicitly on two principles. One was to stress the new, autonomy based doctor-patient relationship. The second aim was to cover new technologies and the development of the national health care system. A result of these efforts a new, comprehensive Act was drawn up with the participation of about 150 experts. This new Act, for the first time in the history of the Hungarian medical law gave priority to patients' rights. In December 1997 the Hungarian Parliament adopted a new comprehensive Health Care Act that influenced the entire sphere of medical law. The new Health Care Act promoted the principle of patients' autonomy and provided a catalogue of enforceable rights for patients. This concept was in sharp contrast with the previous legislative model that imposed vague and often unenforceable duties on health care professionals.

177. From the abovementioned two fundamentally different principles a relatively extensive catalogue of patients' rights has emerged. The chapters on patients' rights apply a specific language and to this respect they are in sharp contrast with the system of rights attached to persons in the Civil Code and which is based on a rather abstract conception of general personal rights. Patients' right in the Health Care Act were inspired by the pragmatic Anglo-Saxon school of legal theory which was engaged not only with the expression of rights but also in providing effective means for enforcement through legislative drafting.

178. The Health Care Act provides detailed provisions concerning some patients' rights while many aspects of the doctor-patient relationship still remain unclear.

179. As a result of a comprehensive legal reform in 1997, a chapter in the new Health Care Act was dedicated to the patients' rights. The most important effort of this Parliamentary Act was to demonstrate the change in the paradigm of the doctor-patient relationship that had so far been overwhelmingly paternalistic since it was based on the 'doctors knows best' model. In this previous model health care consumers were almost totally neglected. The Health Care Act, in contrast promotes the principle of autonomy and provides enforceable rights. This purpose had been achieved by creating a comprehensive Health Care Act, including a concrete formulation of rights.

180. This form of legislation was necessitated by the constant difficulties which arose in legal disputes between the health care providers and consumers. Until 1997 when patients' rights were at stake courts and legal advocates had to apply an indirect method to derive patient's rights. This method was based partly on the interpretation of the Health Care Act and the Civil Code in which a protection of personal rights was formulated in general clausula and not in enumeration of rights. The outcome of this interpretation was often vague and opened the door for judicial discretion. This uncertainty did not satisfy the principles of constitutionalism and the rule of law.

181. The other element of interpretation relied on the Health Care Act of 1972 in which doctors and health care workers' duties are listed in a form of independent duties serving the best interest of the patients. This traditional vision of health care often masked the real purpose of professional rules: to uphold trust in medical services. These duty-based norms, however, did not provide enforceable rights for the patients. It has also been argued in the legal debate that patients' presumed interests perceived by health care professionals cannot prevail against the concrete rights of the patients.

182. The need for the explicit right-based law emerged from two very different areas. On the one hand the change introduced was essential to the recognition of patients' rights by the 'raising right consciousness movement' of university professors, philosophers, lawyers, teachers of medical ethics and law. By expressing in their lectures and writings the importance of recognizing the human element in the medical profession, as well as by demonstrating the drawbacks of the patron-client model in the doctor-patient relationship, they created a favourable atmosphere for legislative change. At the same time patient groups have grown in strength. This line of thinking challenged the existing legislation on the basis that it was not clear, that it was often ignored and that it did not expressively contain all the rights which would enable a citizen to participate in the process of his/her treatment as an equal individual.

183. The second group of those who supported the explicit formulation of patients' rights included doctors and health care managers who started to be convinced by the consequences of growing medical litigation and of the possible effects of uncertainty which the previous situation has maintained. Their motivation was not to promote the extension of the catalogue of patients' rights, but instead to narrow it by making clear what they ought to do in their everyday practice. They wanted to make sure that there would be no room for broad and unfavourable judicial interpretation of the health care laws.

184. This pragmatist scholarship is hallmark of prominent scholars such as Dworkin and George Annaus and contributed to the creation of a Patient's Rights Bill that has an activist approach and contains a relatively extensive catalogue of rights.

185. As stated previously, the Health Care Act provides detailed regulation concerning some patients' rights while many aspects of the doctor-patient relationship still remained unclear. The following describe only those rights that are listed expressively in the Act.

- right to health care;
- right to respect of human dignity in health care;
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- right to have regular and flexible access to relatives during the course of treatment;
- right to leave the health care institutions;
- right to be informed;
- right to self-determination;
- right to refuse medical treatment;
- right to access medical documentation;
- right to medical secrecy and right to privacy protection;
- right to enforce patients' rights;
- right to complain; and
- the establishment of a patients' rights representative.

A. Right to Health Care

186. This is one of the most controversial rights in the catalogue of health care rights in every country. Although many attempts have been made to define the content of good health care, European countries are culturally so different, socially and economically that meaningful international standards have not yet been established.

187. Under the Health Care Act the general rule is that every patient has a right to receive necessary, appropriate, continuous non-discriminative and accessible health care within the framework of the health care system.¹

1. Health Care Act Art. 7(1).

188. Appropriate health care is defined in the Health Care Act as a treatment which is performed in order to preserve the health of patients and the possible restoration of health by those licensed treatments which meet the requirements of professional and ethical standards.

189. The principle of non-discrimination is fulfilled if no distinction has been made during the course of treatment based on the patients' social status, political ideas, origins, nationality, religion, sex, sexual orientation, age, marital status, physical or mental impairment, education or any other condition which is unrelated to their state of health.

190. In case of medical emergency every patient has the right to life-saving treatment and treatment preventing serious and permanent damage to health, the alleviation of pain and the reduction of suffering.¹

1. Ibid. Art. 6.

191. Moreover, the patient has the right to choose, as professionally justified by her condition, the health care provider and – unless the law provides otherwise – in the case of consent the medical doctor performing the treatment, provided that the professional content of the treatment justified by the patient's health condition,

the urgency of the treatment or the contractual relation standing at the basis of access to the treatment do not exclude that.¹

1. Ibid. Art. 8(1).

192. The patient may consult a different doctor in connection to any diagnosis established by a previous doctor, to any suggested treatment, to the planned release from in-patient institution or transfer to another health care provider.¹

1. Ibid. Art. 8(3).

B. Right to Respect of Human Dignity

193. This right is a core right from which various other rights follow. It can also be interpreted as a subsidiary right when no specific right provides protection, but the manner in which the medical treatment is performed is regarded as a violation of basic human rights. Some of the rights within this core right are enunciated in the Bill, such as the right to respect bodily integrity, intimacy, the right not to be exposed to unnecessary waiting, the prohibition of physical, chemical, biological or psychological constraint.

194. The patient's right to human dignity shall be respected throughout the health care treatment. Only medical intervention necessary for the treatment can be carried out on the patient – unless the law provides otherwise.

195. Throughout the treatment, the rights of the patient can only be restricted in a manner, to the extent and for a period that is justified – as defined by law and by the patient's health condition.

196. The personal freedom of the patient can be restricted – during treatment – with physical, chemical, biological or other methods only in cases of medical emergency, or for the protection of the life, bodily integrity, or health of the patient or others. The restriction cannot have a punitive character, and can only last until the cause for it still exists.

197. The application of restrictive methods or procedures – unless the law provides otherwise – can be prescribed by the doctor in charge. The doctor, preceding the application – if this is not practicable within the least possible time from application – puts down in the health care documentation the restrictive methods and procedures, the reason for their application and the duration of their application. In the absence of permanent medical control – in exceptionally justified cases – restrictions can also be prescribed temporarily by a qualified nurse. The doctor has to be notified without delay about the restriction and she has to approve that restriction within 16 hours. In the absence of such approval the restriction has to be suspended.

198. In case of the application of restrictive methods and procedures, the condition and bodily necessities of the patient have to be inspected regularly – in accor-
dance with professional rules. The fact and the results of the inspection have to be included in the medical documentation of the patient.

199. In regard to the right to intimacy of the patient throughout the treatment, the clothing of the patient can be removed only when professionally justified and for the necessary length of time.

200. The patient has the right to have the examination and treatment in a place where, unless otherwise consented to by the patient, they cannot be seen nor heard by others, except in the case of medical emergency or an endangering situation where this is unavoidable.

201. The patient has the right to name the person who shall be notified about his/her placement in an in-patient institution, or about changes in his/her health condition. Conversely, a patient has the right to exclude persons from this information. The in-patient institution has the obligation to notify the person named by the patient about the placement and changes in this placement, and about significant changes in the health condition of the patient.

C. Concept of Discrimination within the Health Care System

202. Principle on non-discrimination appears not only in the Constitution but also in the Health Care Act. The concept and the interpretation of the principle of non-discrimination went through significant changes after the political transition. The Hungarian Constitutional Court interpreted the prohibition of discrimination in connection to various rights. In one of its early decisions the Court argued [9/1990 (IV.25) AB hat.]:

'The prohibition of discrimination does not mean that all differential treatment, even differential treatment aiming at greater social equality is prohibited. Prohibition of discrimination means that the law shall treat all persons equally, as persons with equal human dignity, that is the basic right to human dignity shall not be violated. The determining factors of the distribution of entitlements and advantages shall be defined with equal concern and respect, and equal consideration for all individual perspectives.'

1. The decision of the Court has been translated by Andrea Krizsan, Ph.D. candidate.

203. Later the Court decided to create a genuine right to equality, and not just an accessory obligation related to the other rights protected by the Constitution. The Court stated: 'Nobody has the right to receive any forms of ex gratia benefits. However the principles stated in article 70/A of the Constitution refer to ex gratia benefits, as well.' [16/1991 (IV.20) AB hat.] It later generalized the principle by saying:

'The requirement of equality before the law is present in all regulations . . .

204. Thus the state might not have the constitutional duty to provide specific services, but once it decides to give some benefit or entitlement it has to provide it without discriminating on any of the grounds stated under Article 70/A (1).

205. The constitutional principle of non-discrimination is based on a general definition, which derives discrimination from the violation of the right to human dignity. However, it falls short of providing guidance in understanding what concept of discrimination it refers to.1

1. There is a Draft Bill on anti-discrimination that may provide a broader interpretation of the concept and may include concrete measures in fighting against discrimination.

206. Among the Principles of the Health Care Act equal opportunity is mentioned as a guiding principle in allocating health care services.1 Article 7 (4) interprets further the principle of non discrimination by stating that in the access to services no distinction should be made based on the social position, political views, origin, nationality, religion, gender, sexual orientation, age, family status, physical or mental disability education and all other circumstances that have no relation to the health condition of the patient. Though the Health Care Act reinforces the principle of non-discrimination, so far this provision has provided only a little help to patients when claiming good quality health care services.

1. Art. 2 (2) of the Health Care Act.

207. Parliamentary Act No. XXVI of 1998 on the equal opportunity of people with disability includes specific measures for the disabled. This Act goes beyond the mere declaration of the non-discrimination and provides concrete actions for this vulnerable group of people and patients. The National Disability Council participates in policy and lawmaking in this field.

D. Right to Maintain External Contacts1

208. This is a right of in-patients where flexible contacts with family members, friends and colleagues often serve the interest of treatment as well. If a patient suffers from a grievous disease she has a right to have some close relatives with her during the health care.

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209. The patient who is in an in-patient institution has the right to maintain contact with other persons in writing or orally, and to see visitors. The patient can prohibit the disclosure to other persons of the medical treatment or any other information connected to the treatment. This can only be disregarded in the interest of the treatment upon the request of a close relative or the person who has the duty to take care of the patient.¹

1. Health Care Act, Art. 11(2).

210. The patient who is in a critical condition has the right to have a chosen person by his/her bedside. In case of an incompetent patient the person defined in the Health Care Act can provide substituted decision. According to this paragraph the patient is in critical condition if due to her condition she is physically incapable of taking care of himself/herself, or their pain cannot be relieved with medication, or he/she is in psychical crisis situation.¹

1. Ibid. Art. 11(3).

211. Patients who are minors have the right to have a parent, legal representative or a person chosen by them or their legal representative around them.¹

1. Ibid. Art. 11(4).

212. A woman in labour has the right to have her chosen adult person around her during the entire period of labour and delivery and after the delivery – unless excluded by her or the infant’s health condition – to be placed in the same room with the infant.

213. Patients have the right to maintain contact with a representative of the religious denomination they belong to, and the right to exercise their religion freely.

E. Right to Leave the Health Care Institution¹

214. Health care institutions should not be closed institutions. Human rights considerations, as well as the patients rehabilitation process support the idea of transparency in medical treatment. Therefore the 1997 Parliamentary Act provided the patient with a right to leave the health care institution whenever he/she chose to do so, unless it constitutes danger to others. The patient’s intention to leave has to be reported to the doctor, who includes this fact in the medical documentation of the patient, as well as the unusual termination of medical treatment before the individual health care plan has been completed. This right is limited in case of non-voluntary psychiatric treatment.

1. Ibid. Art. 12.

F. Right to be Informed¹

215. The 1972 Health Care Act had already recognized the duty to inform patients in two substantially different cases. One is general information provided during the entire treatment on the diagnosis and the future prospects of the patients. The other right focused on the decision-making process before medical treatment. This distinction demonstrates that though information and consent are closely linked, they do not always coincide. The 1997 Health Care Act went much further in elaborating the concept of informed consent. The first Draft before the Parliamentary debate contained a very detailed list of the necessary information.²

1. Ibid. Art. 13.
2. According to this version the patient had to be informed before the medical treatment about the following:
   - the presumed diagnosis and the prognosis of the disease;
   - the necessary medical interventions and their time scheme;
   - treatment proposed by the responsible physician and the possible consequences of this treatment;
   - the nature, the degree of the potential risks, the probability of their appearance, also about the frequency and degree of the side effects of the treatment;
   - the alternative treatments and methods;
   - the purpose and the presumed advantage of the planned medical intervention and the consequences of the refusal of the treatment;
   - information about the patients’ right to make decision on the proposed medical treatment;
   - indirect and direct possible harms and consequences of the consent and the refusal of medically indicated care;
   - the nature, the manner of treatment, the duration and presumed pains and other effects of the projected medical treatment and possibility of further medical treatment that might become necessary during the administration of the treatment;
   - the availability of treatments offered by other health care providers under the same indication;
   - the possible changes in the patients’ condition subsequent to the medical treatment the treatment and rehabilitation and the necessary proposed changes in the life-style of the patients after the treatment;
   - the therapeutic effects of the medication, side effects, and interference with other medicaments.

216. The final version of the Parliamentary Act included a simpler list of the content of the information. There is one general formulation of the right to information: The patient has the right to receive comprehensive and individualized information.¹


217. The patient has the right to ask questions during and after the process.¹

1. Ibid. Art. 13(3).

218. The patient has the right to be informed during her treatment about the result, and eventually the failure, or the results which differ from those anticipated and the reasons for that, of each examination and medical intervention.
219. The patient has the right to be informed about the names, professional qualifications and status of all persons directly involved with their treatment.\(^1\)

1. Ibid. Art. 13(6).

220. The patient has also the right to information in cases where her consent is not a precondition for starting the treatment.

221. Under the Hungarian Health Care Act the patient has the right to receive detailed information concerning:

- his/her health condition, including the doctor's judgment of the condition; the proposed examinations and medical interventions, the risks and advantages of carrying out or not carrying out the proposed examinations and medical interventions; the expected timing of the examinations and medical interventions; his/her right to decide about the proposed examinations and medical interventions; the possible alternative procedures and methods;
- the process of the treatment and the expected outcome; further treatments; and the proposed lifestyle following intervention.\(^1\)

1. Ibid. Art. 14(2).

222. In addition to this detailed information doctors have to routinely offer the patients the possibility of asking further questions. It is a novelty of the new Health Care Act that the duty to provide information does not expire at the moment of obtaining consent to medical treatment. The 1997 Health care Act prescribes the duty of the physician, which is to disclose information on the outcome, including failure of the medical treatment and also on the unintended result of the medical care.

223. Information provided to the patient has to be disclosed in a manner which is comprehensible for the patient and which corresponds with their age, education, and emotional condition. If the patients' needs require an interpreter then one has to be made available.\(^1\)


G. Right to Self-determination\(^1\)

224. The patient has the right to self-determination. The right to self-determination can only be restricted in the cases defined by the law and in the manner defined by the law. In accordance with the right to self-determination the patient can decide freely whether she wants to make use of health care services, and which medical interventions he/she is going to consent to and which ones he/she is going to refuse.

1. Ibid. Arts. 15-19.

225. The patient has the right to participate in the decisions connected with his/her treatment and examination. Except in the situations defined by this law the precondition of all medical interventions is that the patient gives his/her informed consent, as decided without deception, threat, or coercion.

226. The written consent of the patient or — if they are not capable of that — their consenting statement or other declaration made before two witnesses simultaneously is needed for invasive interventions.

227. If during an invasive intervention an unforeseeable extension of the intervention becomes necessary, in the absence of consent, the intervention can only be carried out if it is justified by medical emergency, or its cancellation will be potentially harmful to the patient.

228. It is not clear from the jurisdiction of the Hungarian Constitutional Court whether human dignity encompasses the right to self-determination. Still it follows from the Civil Code that the individual has the final word in deciding what should be done with his/her body, health, etc. Self-determination in health care has two different aspects: one is in the field of organizing and planning the health care system, the other one is in the level of the individual decision making.

229. The Health Care Act focuses on the individual aspect of these rights and regulates the condition of valid consent before the medical treatment. Patients can withdraw their consent verbally at any time before the treatment.

230. What is also new to the 1997 law is that the patient may authorize someone to make decisions on his/her behalf in case they become unable to make a decision.

H. Right to Refuse Medical Treatment\(^1\)

231. In the jurisdiction of the Constitutional Court human dignity has an outstanding role in interpreting various applied rights in the field of health care. Under Article 54 (1) of the Hungarian Constitution everyone has an inherent right to life and dignity of which no one shall be arbitrarily deprived.


232. This formulation of rights to life and human dignity is regarded by the court as a birthright which provides core rights of various other rights such as the right to be treated with respect, right to self-determination, right to consent and the right to be informed prior medical treatments.

233. It is not clear whether constitutional protection of human dignity involves the right to self-determination in the interpretation of the Constitutional Court.

234. Although there is a petition pending in the Constitutional Court regarding euthanasia, the Court has yet to decide on this question. There has been no time for a public debate on this very important issue and no research has been conducted on the practice of doctors when making decisions to end the life of a patient.
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235. One of the most passionate debates therefore concerns the right to refuse medical treatment. The Health Care Act acknowledges the right of patients to refuse medical treatment, even treatments which are life saving or life supporting. For such a refusal to be valid it is necessary for the statement to be made in front of a notary. Since both the Hungarian Medical Chamber as well as the National Board on Research and Ethics is against the recognition of any form of euthanasia, this innovation of the law is under constant criticism. On the other hand, if the position of the act is the promotion of the patients' autonomy, it was inconsistent to provide a limited right to patients to give consent to medical treatment.

236. Competent patients have the right to refuse treatment unless the omission of the treatment constitutes danger to the life and bodily integrity of others.\(^1\)

1. Ibid. Art. 20(1).

237. If the omission of the treatment causes severe and permanent damage only to the patient, the patient may only refuse the treatment if he/she makes expressive statement to this effect in a notarial document or a private document signed by two witnesses, or, in the case of inability to write, in a declaration made before two witnesses.\(^1\)

1. Ibid. Art. 20(2).

238. The refusal of life sustaining and life saving treatment in order to allow for the natural development of the illness is only permissible if the patient suffers from an illness which, considering the actual state of medicine – regardless of the appropriate medical treatment – would lead to death within a short period of time. Refusal of subsistence treatment or life-saving intervention has to fulfil the formal conditions defined in the Health Care Act.\(^1\)

1. Ibid. Art. 20(3).

I. Condition for the Validity of the Refusal

239. A three member medical commission (the patient's doctor during treatment, a qualified doctor – who has not taken part in the treatment of the patient – and a psychiatrist) examines the patient and unanimously declare in a written form whether the patient has made their decision in the light of its consequences, and whether the legal requirements were satisfied.\(^1\)

1. Ibid. Art. 20(4).

240. The patient on the third day starting from the declaration of the medical commission has to declare again before two witnesses his/her intention to refuse treatment. If the patient does not consent to the examination of the medical commission, the declaration to refuse treatment cannot be taken into consideration.

241. The patient has to be informed repeatedly about the consequences of not intervening.

J. Right to Access to Medical Documentation\(^1\)

242. According to the Health Care Act pregnant women cannot refuse medical treatment. 'The patient cannot refuse subsistence treatment or life saving intervention if she is pregnant and presumably capable to bear the child to the full term.'

243. Even if the patient has already refused health care they can withdraw their declaration to refuse treatment at any time without any formal requirements.

244. A competent person can – for the case of future incompetence – name in a notarial document a substituted decision-making person who can exercise his/her right.

245. One of the most contested fields of medical law is how to provide access to health care information. Even before medical litigation an independent legal procedure is sometimes required for obtaining the necessary medical records. According to the Health Care Act the patient has the right to gain knowledge of the data contained in the medical documentation themselves. The medical documentation is at the disposal of the health care provider, the data contained in the documentation is at the disposal of the patient.

1. Ibid. Art. 24 of the Health Care Act.

246. The patient has the right to receive information concerning the processing of the data connected to their medical treatment, to have access to their medical data, to have access to the medical documentation, and to receive copies of it at their expense, to receive a final report upon their release from the health care institution, and to receive – if justified – at their own expenses a written summary or outline of the medical data.\(^1\)

1. Ibid. Art. 24(3).

247. The patient has the right to initiate the correction or completion of her medical documentation if he/she deems it inexact or deficient. This request has to be put on the documentation by the doctor in charge or other data processor together with their professional opinion. Incorrect medical data cannot be deleted after the complaint, it has to be corrected so that the original data remains visible.

248. If the medical documentation contains data which could compromise the privacy of other persons, the right of access to the data can only be exercised with regard to the data referring to the patient.

249. In case of the death of the patient his/her legal representative, close relative and legatee – based on a written request – has the right to get access and receive copies – at his/her own expense – of the medical documentation and the medical data connected or presumably connected to the cause of death and the medical treatment carried out before death.\(^1\)

1. Ibid. Art. 24(11).
K. Right to Medical Confidentiality

250. The patient has the right to medical confidentiality. As such, the persons who participated in the medical treatment has to treat all personal and medical information about the patient as confidential.¹

1. Ibid. Art. 25(1).

251. The patient has the right to make a declaration regarding who can receive information on his/her illness and its expected outcome and who is to be excluded from getting partial or full access to his/her medical data.¹

1. Ibid. Art. 25(2).

252. The medical data of the concerned patient can be made accessible without the patients’ consent if the protection of the life, bodily integrity and health of others makes this necessary.

253. Medical data, which if ignored could lead to the damage of the patient’s health can be disclosed without the consent of the patient to the person responsible for the care and treatment of the patient.¹

1. Ibid. Art. 25(4).

254. The patient has the right to have present at her examination and treatment only those persons whose presence is necessary for the treatment, i.e., those persons the presence of whom the patient has consented to, unless the law provides otherwise.¹

1. Ibid. Art. 25(5).

II. Restriction of Patients’ Rights

A. Restriction of Patients’ Rights in the Treatment of Infectious Diseases and Epidemics

255. According to the Health Care Act, the epidemiological practice aims to prevent and fight infectious diseases and epidemics and intends to improve the ability of citizens to resist infectious diseases. In case of epidemiological emergency, the authorities do not have to wait for the patient’s consent but he or she still has the right to obtain information about the epidemic and the actions which will be taken.¹

1. Health Care Act, §56 (3).

256. If a person is listed as a mandatory recipient of a preventive vaccine, and he/she does not comply with this duty, then the epidemiological authorities may issue an order that enforces the reception of this vaccine. In this case, the recipient cannot claim any legal protection. If the recipient of the vaccine suffers any kind of damage from the act of receiving the vaccine, or dies, he/she or the person who is dependent on the patient will be compensated by the state.¹

1. Health Care Act, §56 (7).

B. Regulation Concerning the Treatment of AIDS Patients

257. The law on HIV testing and screening was introduced in 1988, and although it has been amended a number of times since then, it is still in force today. The law is a decree by the Ministry for Social Welfare and Health which regulates the conditions for mandatory testing and screening.¹

1. 5/1988 (V. 31), SZEM rendelet a szerzett immunológiaos titkosító testjedésnek megállása érdekében szükséges intézkedésekkel és a szervezőség megvalósítása elrendelésével.

258. The law on health care data passed in 1997 by Parliament eliminated anonymous testing for HIV. Section 15 (6) of Act XLVII of 1997, ‘On the Administration and Protection of Medical and Related Personal Data,’ requires that if the result of an HIV screening is positive, the person involved must provide his personal identification data at the request of the provider of medical care. The person involved shall be informed of this prior to the screening.

259. The following persons are required by law to submit themselves to HIV screening:

- people suffering from venereal diseases or who are suspected to have contracted venereal diseases;
- the sexual partners of people who are infected by the HIV virus;
- anyone among the family members, friends, and acquaintances of the HIV infected person who might also be suspected of having contracted the virus;
- people who are under criminal investigation for businesslike debauchery;
- young people who have been sentenced to correctional institutions; and
- people who take drugs intravenously.

260. The medical doctors are required to submit their patients to HIV testing in cases where it might be suspected that he/she has been infected by the HIV.

261. Before tissue or organ transplantation, the voluntary tissue or organ donors are required to submit themselves for HIV screening. Their tissue or organ can be donated for medical use only if the test result is negative. The donor shall be informed about the test result. In cases of tissue or organ donation from cadavers, the deceased person’s blood has to be tested for the HIV virus.

262. In cases of assisted procreation, the sperm of the donor can be used for the purpose of artificial insemination only if it tested negative on the occasion of the donation and six months after the first screening.
263. During the regular monitoring of blood samples selected for blood transfusion or the production of blood products, these samples are subjected to HIV screening. The blood donors have to be informed about the HIV screening before the actual blood donation.

III. The Duties of the Patient

264. During the debates on patients’ rights many health care professionals demanded the inclusion of patients’ duties. Conceptually there are numerous counter-arguments against this idea as patients may well cause self-harm by irresponsible behaviour. Moreover, a patient who causes harm to others can be punished based on the general legal norms. In addition to this, no law on patients’ right is intended to exempt patients from their general duties of not causing harm to others and there are no laws which exempt them from the fulfilment of other legal norms. Nevertheless the need for patients’ duties was so strong that some provisions had to be included in the chapter on patients rights and duties even though the duties were very vaguely formulated.


265. One of the basic duties of patient using a health care services is the duty to respect the laws and institutional regulations applicable to that service.\(^1\)

1. Ibid. Art. 26(1).

266. The patient has a duty to inform the health care personnel about everything that is necessary to establish the diagnosis, to prepare the appropriate treatment plan and carry out the interventions, especially previous illnesses, medical treatments, use of medicines or medicinal substances and health damaging risk factors.\(^1\)

1. Ibid. Art. 26(2)(a).

267. The patient also has to inform health care personnel of all facts connected to his/her own disease that could endanger the life or bodily integrity of others, especially contagious diseases and diseases and conditions that might effect the health care service delivery.

268. To sum up the patient must inform of the following:

- of all facts necessary to establish the diagnosis, to prepare the appropriate treatment plan and carry out the interventions, especially previous illnesses, medical treatments, use of medicines or medicinal substances and health risk factors,
- of all facts connected to their own disease – that could endanger the life or bodily integrity of others, especially contagious diseases and diseases and conditions that might effect the health care service delivery,
- in case of contagious diseases included in the order of the Health Care Minister name the persons, who might have infected them or who may have been infected by them, inform them of all legal declarations made earlier that are relevant to their medical treatment.

IV. Rights and Duties of the Health Care Personnel

269. While the 1997 Health Care Act gave a priority to patients’ rights and the correlative duties to patients’ right, the duties and rights of the health care staff were placed only in Chapter Six of the Health Care Act.

270. One of the most important duties is the ‘duty of care’. This duty is not necessarily based on some form of contractual relationship. For instance, in case of medical emergency health care personnel, regardless of time and place, must offer first aid or other necessary measures. The doctors’ duty of care can also be based on the ‘territorial principle’. The doctor’s duty of care is limited by his professional competence. If a patient’s treatment goes beyond a doctors’ competence, they must refer the patient to the doctor or to the health care institutions where conditions for their adequate treatment are available.\(^1\)

1. Health Care Act, §126 (2).

271. Physicians may choose freely between alternative remedies and diagnostic methods within the professional rules and standards, unless the risks of medical intervention extend beyond the advantages of the recommended treatment, (therapeutic privilege).\(^1\)

1. Ibid. Art. 129(1).

272. Physicians may refuse to treat a patient if the treatment prevents the doctor from treating another patient or if the personal relationship between the doctor and the patient leaves the doctor no option but to consider the refusal necessary.\(^1\)

1. Ibid. Art. 131(1).

§2. The Patients’ Rights Representative

273. One of the most important innovations of the new chapter on patients’ rights is the institution of the patients’ rights representative. In the field of constitutional rights such an office was already active. Five years before the Health Care Act came into force, the Office for the Parliamentary Commissioners for Citizens’ Rights had been created by the Constitution. The functions and the procedures of the Commissioners have been regulated by Parliamentary Act No. LIX of 1993.

1. The general rules are included in Arts. 30–33 of the Health Care Act.

274. Since 1995 a Parliamentary Commissioner’s Office has been in operation in various fields of human rights. The General Commissioner has already played a very important role in the promotion of human rights by writing a report and rec-
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275. The need towards special rights monitoring within the health care systems, however, was independent from this office. Hospitals can be regarded as very special semi-closed institutions in which rights monitoring is often difficult. Medical documentation is not necessarily a reliable source for a retrospective evaluation of medical activity.

276. Therefore a new model became inevitable in which hospital based monitoring has become an important contribution to the work of the Parliamentary Commissioner's work. In the first phase of implementing patients' rights it is important to provide tangible and independent help for patients and hospitals, and also to enforce legal rights.

I. Role of the Patients' Rights Representatives in the Health Care Act

277. The goal of the citizens' participation and the empowerment of patients can be achieved only if basic patients' rights are implemented. A patients' rights advocacy system was introduced with the hope that basic rights would be observed in daily practice. It is in harmony with current European tendencies. The Council of Europe's Committee of Ministers developed a set of guidelines for Member States on developing structures for citizens and patient participation in decision-making processes on health care.2

1. 77/1998, (XII. 29), EüM rendelet a betegi jogi képviselő jogállásáról és az eljárásra vonatkozó szabályokról, amended by the 27/2001 (VIII. 22), EüM r.

278. The patients' rights representative protects the patients' rights based on Article 30 of the Health Care Act. His/her main duty is to provide information on patients' rights and to enforce them.

279. The tasks of the patients' rights representative include the following:

- to provides assistance in access to medical documentation and in questions related to such documentation, helps patients to articulate their complaints and initiate investigation based on these complaints.
- helps formulate patients' complaint, initiate the investigation of the complaint and on a written authorization makes notification of the complaint to the director of the health care provider institution, to the supplier of the institution, or - in cases relating to the treatment of the patient - initiates the procedure with the competent authority and represents the patient throughout the procedure,
- informs health care workers regularly about the regulations referring to the rights of patients, changes in these, respectively the enforcement of the rights of patients in the health care provider institution.

280. The patients' rights representative can only proceed in individual cases within the framework of the authorization received from the patient.

281. The patients' rights representative has to inform the health care provider's director or the supplier of the health care provider about the unlawful practices and other omissions connected to the functioning of the health care provider institution as noticed throughout their activity, and make suggestions for their termination. If the problem persists, the patients' rights representative has the right to take the complaint to the competent organ or person.

282. The patients' rights representative gives special consideration to the protection of the rights of patients who are exposed because of their age, physical or mental disability, health condition or social status. The patients' rights representative has the right to enter the work place of the health care provider, have access to relevant documentation and ask questions of health care employees.

283. The patients' rights representative can initiate a private complaints procedure provided consent has been granted.

284. The patients' rights representative is obligated to keep the medical facts relating to the patient confidential and to process the patient's personal data in accordance with the relevant laws.

285. The patients' rights representative operates within the institutional framework of the Public Health Authority.

286. The patients' rights representative cannot be employed by the health care providers where the patient whom they represent is being (was) treated.

II. Enforcement of Patients' Rights

287. The health care provider has the duty to inform the patient, upon acceptance into the institution, before treatment, about the rights of patients, possibilities for their enforcement and the rules of the institution.

288. One of the legislative guarantees to ensure that patients rights will be observed is the duty imposed on all health care providers to provide information on the rights of the patients before medical treatment.

289. Patients have the right to complain about the health care. They may also refer the petition to the supervisory body of the health care institution. The health care provider and/or the supervisory body has to investigate the complaint and send a written report on it within 10 days.

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III. Achievements and Current Problems with the Patients’ Advocacy Model in Hungary

290. When the law on the patients rights representatives was adopted, experts in the field of human rights and health care law strongly opposed the involvement of the Public Health Authority in the advocacy model.\(^1\) They supported the creation of an Office for the Parliamentary Commissioner on Health Care. This function would have guaranteed an independent control of the health care system. However, due to the fear of the patients’ rights representatives and politicians, the institution was eventually placed within the health care sector.


291. In Hungary protection of patients’ rights and constitutional rights take place on two separate levels. Since 1993 Hungarian citizens have been able to turn to the Parliamentary Commissioner for Citizens’ Rights for violations of constitutional rights, whereas the institution of patients’ rights advocacy established by the 1997 Health Care Act, has been in operation for only a year. After a very controversial first year, ANTSZ\(^1\) started to recognize the importance of this quality-monitoring model. However, because of financial constraints the patients’ rights representatives have to allocate their time between many health care institutions. 13 patients’ rights representatives started work in Budapest in 2000. This number is far below patients’ needs. Some of the representatives serve at 8 different health care providers. Around 45 patients’ rights representatives are employed in the countryside. In addition, there is a Co-ordination Council for Patients’ Rights that consists of 7 members. Their main task is to control and harmonize the practice of the patients’ rights representatives.

1. Állami Népegészségügyi és Tisztsügyi Szolgálat (Public Health Service).

IV. The ‘Szószóló’ Model

292. The other viable model was the use of already existing NGO’s in the field of health care. The first patients’ rights organization that launched a pilot study in this field was the Szószóló (Spokesperson) Foundation for the Rights of the Patients.\(^1\) The Szószóló initiated a pilot study to develop methods of patients’ rights advocacy in Hungary. Initially the Szószóló pilot study focused only in eight hospitals (five in southern Hungary and three in Budapest) with not more than eight patients’ rights representatives. Later the project was extended with eight patients rights representative in the field of psychiatric care at seven psychiatric health care institutions. Although this pilot study at 14 health care institutions cannot be regarded as a national survey, the experience derived from 300 debate settlements and numerous general surveys and reports was invaluable. Despite the high level of the training of the representatives (some of them had two university diplomas), the success of the representatives was very much based on the special characteristics of the representative’s personality.

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293. This activity within the civil sector started in 1996 inspired greatly the 1997 Health Care Act that incorporated the concept of patients’ rights representatives (though this part of the law came into force only in 2000) and established a national system of patients’ rights representation. The Parliamentary Act that assigns the principal functions of the patients’ rights representative was inspired by the experience of the Szószóló Foundation.

294. The Foundation started to train volunteers even before the Health Care Act entered into force. The ombudsmen of the Szószóló Foundation\(^1\) began their work under trying circumstances. The institution was practically unknown at the time in Hungary. The then President of the Hungarian Medical Chamber, who later became Minister for Health, openly opposed their work. He considered lawyers working on medical malpractice to be adequate representation for patients. In the post-evaluation of the trial period one critique often aired was that the ombudsmen could only answer insignificant questions, and that the establishment of a positive doctor-patient relationship did not solely rely on the work of a patient’s representative. Lacking support, patients’ representatives were literally left alone in hospitals.

1. The Szószóló Foundation has been operating since 1994.

295. Considering the fact that the new Health Law and its accompanying decrees introduce a number of new institutions and practices, certain problems of interpretation may arise in the application of law.

296. Therefore patients’ rights representatives can play a significant role in the development of a unified practice of interpretation in the future. They can also provide hospitals with real assistance in understanding the new legal institutions.

297. It is especially important that, in the unique conditions of health provision, a procedure be available within the institution in which an unbiased individual also takes part to assist in clearing up a dispute or conflict between parties. Conflicts often arise from ethical or employment rights related issues, or from the vagueness of instructions in health provision. One characteristic of health provision is that it is accompanied by a great deal of risk. Failure can lead to death, permanent injury, or long-term and painful rehabilitation. The harm done by medical error also explains why those working in the field take criticism as an affront to their prestige and react with a great deal of passion and fear.

298. The great difference in the power and prestige of individual actors in the health care hierarchy leads to a characteristically unequal competition within the field. Although relatively effective democratization occurred at a great pace in most spheres in Hungary, health care has been largely unaffected by this process. In the
majority of health care institutions, access to patients determines access to professional advancement as well as to cash tips, and who gets access to patients is generally determined by the physician directing the ward.

299. This is why the spirit of the Hungarian health law represents a so-called rights based form of advocacy. At the beginning it was difficult to separate advocacy and social work, for patients' representatives are often also faced with explicitly social problems.

300. Patients' rights representatives should primarily help patients understand their rights, assist in the smooth practical implementation of the new legal health care regulations, and help resolve conflicts in interpretation that may arise between patients and health care workers.

301. Since the majority of patients' rights representatives react to specific complaints, the potential lack of channels of direct communication with the institution's management, or with those developing health care policy, is of serious concern.

302. The experimental model provided by the Százszöd Foundation showed that it is especially important to resolve as many problems as possible between patients and caregivers within the health care institution.

303. Patient's rights representatives especially need to be able to develop, maintain and manage interaction and communication, and to develop and maintain rules of interaction (e.g., no-one should dominate a meeting, and those in conflict should be able to freely present their views). Representatives frequently need to be able to search for inventive solutions as well. Health care representatives are often faced with problems that are entirely new, and for which no solution has been developed. To be able to work effectively, health care workers must know the case background and must be acquainted with and understand each suggested solution, must be able to analyze what is common among these problems, and see how individual suggestions may fit together. To do so they need creativity and imagination.

304. Patients' rights representatives must assist in finding a solution, and in the interest of reaching a solution they must try to help the disputing parties to give up or change their attitudes that prevent the achievement of the solution. They must, as much as they can, assure that the solution reached is a personal one, and so must take into consideration the involved parties' position and personalities.

305. In many controversial cases it is the duty of the ombudsman to effect new communication between the doctor and the patient. No matter how difficult, the representative must tell the doctor that the patient must hear what is said about him/her, even if it is not addressed to him/her. At such times calming words from the representative are not enough, for the patient will be more convinced if he/she hears the doctor say that his/her disease can be treated, that the doctor only needed to know more about the family to understand the case fully, and that the patient will not meet the same end as his/her grandparent.

V. Advocacy and Representation

306. It appears that children are more likely than adults to be treated as objects of examination, and not as sick individuals. During one visit a sleeping child was suddenly made to stand up. The child was terrified, and broke into tears, at which point the doctors doing the rounds simply left the child. Such practice could be the result of years of indifference to which doctors have become accustomed. It is the job of an impartial outsider with feeling for rights and the law, such as patients' rights representative, to debate and bring change to such ethically problematic practices.

307. Although the patients' rights representative primarily acts within the hospital's walls, nevertheless he/she can also initiate some external proceedings in case the hospital management does not respond positively to the problem.

308. The Patients' rights representative is not a representative in the sense of representatives who work at various Patients' Organizations to protect the interest of certain patients' groups (e.g. Society of Kidney Patients, or Association of Patients Suffering from Rheumatoid Diseases).

309. The patients' rights representative has to make a special report on the patients' request.

310. Although there are a lot of misunderstandings concerning the function of the patients' rights representative, many patients' rights representatives feel strong support from patients.

311. In paediatric units children use this possibility very effectively. If they need support or if they wanted to ask questions or just to establish contact with their parents, they turn to the patients' rights representative.

312. One of the representatives mentioned that while the health care staff did not understand the difference between the role of the social worker and the role of the patients' rights representatives, patients, including psychiatric patients, could make a perfect differentiation between the two functions.

VI. Difficulties and Expectations

313. The patients' rights representative has to work in an environment that is sceptical of rights. The sudden and radical change in the paradigm of doctor-patient relationship created some uncertainties. Health care providers found themselves in a new legal environment.

314. The lack of public debates on the ethical and legal aspect of health care means that it is often difficult to 'translate' the new rights and new legal institutions.
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315. Political transition towards democracy including the respect for human rights and constitutional rights, received recognition at the same time economic transition required a market economy and transformation of the immature welfare state.

316. These two trends often dictate different legislative responses. One recent example is the form of privatizing primary care. Just some years after the patients' right to choose a general practitioner was recognized, based on economic incentives, a new law provided a right for GPs to sell and even transfer their established practice to another doctor through inheritance. The object of this property transfer includes the established links with the health care consumers. Obviously this transfer seriously impinges on the free choice of the patients. Interestingly, the political debate that developed around this question focused almost entirely on the economic aspects of the new possibility and on the concerns whether other groups of doctors on the basis of this possibility might suffer from discriminatory treatment.

317. There is a fear of patients' rights representative since some people see them as medical litigators. In reality their function is the opposite; they are filters and they help to prevent medical litigation by solving conflicts and miscommunication between doctors and patients.

318. The most frequent pragmatic counter-arguments pointed out that the patients' rights advocacy system is expensive. However, if one looks at the composition of the staff of huge health care institutions, it is difficult to uphold the statement that one single person on the side of the consumer would be a luxury.

319. Concerns for the cost of rights, including patients' rights, often play an important role in designing health care legislation and more importantly the level of the implementation of patients' rights. Nevertheless, it is often overlooked that in the long run patients who learnt to participate in their health care system will go to a doctor in time and may understand better the consequences of their medical condition. Understanding rights and duties promote a sound environment at the hospitals and also may prevent unnecessary and time consuming debates after hospitalization.

VII. Investigation of Patients' Complaints

320. The patient has the right to make complaints concerning the provision of health care services at the health care provider and at the supplier of the health care provider.

321. The health care provider, and the supplier of the health care provider has the obligation to investigate the complaint and inform the patient in written content within 10 days of the results of the investigation. Exercising their right to complain has nothing to do with the right of patients to take their complaints to investigation – as provided for in other laws – to other organs. The provider has the obligation to inform the patient of this possibility. Complaints have to be registered and the documents relating to the complaint and to its investigation have to be kept for five years.

§3. MEDIATION IN THE HEALTH CARE SECTOR

322. The time and costs associated with disputes on medical negligence can be greatly reduced if the disputants are able to settle out of court. One precondition for such extra-judicial settlements, however, is that the supervisory council be unbiased and professional. Mediation was made available by law in Hungary in 1997, but the detailed rules governing mediation were only fully worked out in Parliamentary Act No. CXVI of 2000.

323. According to the Act, the health care provider and the patient may make use of the mediation service in a legal dispute to help reach a swift and effective extra-judicial settlement.


324. The patient or, in case of the patient's death, his or her next-of-kin or the beneficiary of his or her will, and the provider can request the mediation procedure. The request for mediation is to be submitted in the expert legal chambers located closest to the patient's home, or to the health provider's office.

325. The request is to contain the patient’s name, his or her home address, the provider’s name and office address, a description of the nature of the injury, and when it was sustained, a description of consequences suffered and of demands made.

326. The health care provider should ensure that the method of initiating the procedure of demanding mediation is correctly carried out, and is to be fully acquainted with the process of mediation. The patients' rights representative must also inform the patient about the possibility of entering extra-judicial mediation.

327. Within 15 days of receiving the request for mediation from one party the chamber is to send the request to the other party. The other party must inform the chamber within 15 days of receiving the request of whether that party agrees to mediation.

328. If both parties decide to enter mediation the chamber will call upon each of the parties to reimburse the chamber for half the standard costs of mediation. Once the parties have paid the costs of mediation, the chamber will ask the parties to determine the composition of the mediating council which will carry out the mediation.

329. The parties are to choose council members from the list of qualified media-
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330. One member of the council should be a lawyer, while the other selected from the list of mediators may hold a different university-college degree. If the parties are unable to agree upon the mediator, each party may name a single member of the council. The parties may also agree that an intermediary is to represent them to the council.\(^1\)

1. *ibid. Art. 4(2).*

331. Mediators who request inclusion to HLEC’s lists can be, those who have a lawyer’s, a physician’s, or other university-college medical degrees, or those with at least 8 years of sociological or clinical psychology experience.\(^1\)

1. *ibid. Art. 5(1).*

332. Those on the list must be competent and must not have been convicted of any crime. Judges, prosecutors, or those with legal relationships with public officials may not be included on the list as long as their disqualifying legal status is maintained.\(^1\)

1. *ibid. Art. 5(2).*

333. When a process of mediation is initiated the provider must inform the insurer maintaining the liability policy and the chamber of the insurer’s name and office address. The insurer must be invited to the council session, and must be provided the opportunity to make remarks during the procedure. The provider may also request that the insurer not be included in the mediation procedure.\(^1\)

1. *ibid. Art. 6(1).*

334. The council meeting is scheduled with the agreement of the mediators and the chamber, within 30 days of agreement on the identity of the mediators. The parties are then invited to personally attend.\(^1\)

1. *ibid. Art. 6(2).*

335. Non-governmental organizations may represent the patient in as much as their founding documents state that their mission is to protect patients’ rights, human rights, or to advocate patients’ interests. The provider may be represented by a non-governmental organization advocating provider’s rights, or by his/her professional organization.\(^1\)

1. *ibid. Art. 6(5).*

336. In the course of the mediation the mediating council must insure that the parties are treated equally. The content of what is said during the mediation session is to be recorded in writing. At the request of the parties, and in the interest of clarifying the facts, the council may call upon the testimony of other parties with knowledge of the case.

337. If the parties agree, the council may request an expert opinion. Anyone may serve as an expert who has expert knowledge of the issue at hand, and who has the agreement of both parties. The parties may also select an expert from the list of legal experts. The expert must restrict his or her opinion to the issue raised by the mediators.

338. Within eight days of receiving the chamber’s request, the expert should inform the chamber whether he/she agrees to or rejects participation in the case. If the expert agrees to testify he/she must state that he/she holds no personal interest in the case, or is biased in any way.\(^1\)

1. *ibid. Art. 9(2).*

339. When possible, the expert is to base his/her expert opinion on the existing medical documentation, but may also personally examine the patient if such is required.\(^1\)

1. *ibid. Art. 9(3).*

340. The expert must transmit his/her opinion in writing within 30 days of receiving the request. This time period may be extended once if so agreed upon by both parties.\(^1\)

1. *ibid. Art. 9(2).*

§4. THERAPEUTIC FREEDOM

341. A physician has a right to choose between various diagnostic and therapeutic methods except if they are forbidden by law. The physician can perform the treatment only if he/she has the necessary facilities and training to perform the chosen medical intervention. Further legal requirements include: the patient has to consent to the recommended treatment, and the predicted benefits of the treatments should prevail over the potential risks of the treatment.\(^1\)

1. *Art. 129 (1) of the Health Care Act.*

342. The physician has a right to instruct the other health care staff during the course of the medical treatment. The instruction should include an accurate description of the task and the place and the time of the medical intervention.

1. *Refusal of Medical Care*

343. A physician may refuse to perform a medical treatment if the urgent duty of care towards another patient prevents him/her from treating the patient.

344. In the case of a personal relationship where the physician cannot perform the treatment on that particular patient he/she then has to refer the patient to another doctor.
345. A physician must refuse to carry out treatment if his/her medical condition makes it impossible to perform the treatment.¹

1. Art. 131 (2) of the Health Care Act.

§5. Medical Secrecy — Confidentiality

346. All members of the health care staff and anyone who has a contractual relationship with the health care institution have the duty to preserve all information related to the medical condition of the patient, as well as any information that was revealed in connection with the medical care.¹ Only the patient or the law may authorize the disclosure of this information to third parties.


Chapter 2. The Physician-Patient Relationship in Specific Terms

§1. The Minor Patient

347. The recognition of patients’ rights initiated a process in which special groups of patients’ rights received separate legislation. In every country those drafting health law are challenged to apply standards of independent decision-making ability to patients who have not yet reached 14 years of age, but who are competent to make decisions for themselves. The disregard of inflexible rules on age is especially justified in case of less serious medical intervention. It is more difficult to resolve issues when there is a difference of opinion between parents and children. For instance, in the case of pregnancy of a girl of less than 14 years of age, Hungarian regulations clearly give the parents the right to determine whether or not an abortion should be carried out, and the child has no right to decide about her own operation (she can only be informed as to what will happen). This leads to difficulties in practice if the child’s and parents’ opinions differ. Even so, the New York Convention on Child Rights (12, Art. 1) determined that in states that are signatories to the Convention, children are to be allowed to freely express their opinions in issues affecting them, and their opinions are to be given due consideration with regard to their age and maturity.

§2. The Mental Patient

348. There is a world-wide tendency to use a less stigmatizing term such as mental health consumer or patients at the psychiatric units.

349. It has been already expressed in Recommendation 1235 (1994) of the Parliamentary Assembly of the Council of Europe that lobotomies and electroconvulsive therapy may not be performed unless informed written consent has been given by the patient or a person, counsellor or guardian, chosen by the patient as his or her representative and unless the decision has been confirmed by a select committee not composed exclusively of psychiatric experts. Although medical interventions without the previously obtained and valid consent are considered as battery, this concept has not been put into practice or enforced in Hungary.

350. If one recognizes that mental disorder does not necessarily exclude the ability to understand the presence and the meaning of choice, just like ‘normal’ patients cannot always grasp the potential outcome of their decision, it follows that the process of informed consent must be more individualized and tailored specially for the patient’s condition and personality. A patient must receive an accurate and detailed account of the treatment they are receiving.

351. However the question still remains in cases where psychiatric patients are
unable to communicate and make decisions. There are existing legal criteria that patients must have free access to a ‘counsellor’ who is independent of the institution, however, there are no sufficient guidelines as to how the legal proxy should communicate with the hospital staff during the course of treatment or what should happen if the patient strongly opposes the decision of his/her proxy. Even if the patient is considered of having no capacity in deciding on the questions of his medical care, he should receive a certain amount of information before his treatment. It is not acceptable that medical treatments are called by a misleading name in front of patients: e.g. electroshock therapy is still often believed and called by some patients as ‘sleeping therapy’. Electroconvulsive therapy (ECT) causes a nervous system seizure by means of electric current. The workings of this therapy is still unknown, but it is believed to involve major neurotransmitter responses at the cell membrane.

352. Although this therapy is considered very efficient compared to biochemical treatment a laboratory examination as well as an EEG (electroencephalography) is necessary before the commencement of this treatment. Memory loss and confusion, cardiac disorder, aneurism, bronchopulmonary diseases are frequent side effects of ECT. These side-effects should be disclosed before the treatment either to the proxy or to the patient. ECT cannot be exercised in those hospitals where there are no adequate technical means to conduct a safe pre-examination.

353. According to Council of Europe Recommendation R (9) 83 if a person suffering from a mental disorder is not capable of understanding the nature of the treatment, ‘the doctor should submit the matter for decision to an appropriate independent authority prescribed by law which should consult the patient’s legal representative, if any.’

354. Where non-consensual treatment of mental disorder is permitted by law, when the patient is legally not capable of understanding the nature of the medical treatment the proxy’s consent must first be obtained.

355. Psycholeptic and mind altering drugs represent a very serious danger since their application is almost invisible and their serious and often long-term effect might be considered as a ‘natural course of disease’.1

1. No wonder that during the previous regime such hallucinations, like Haloperidol, Azimistin, Titrastin was frequently used to treat politically disobedient or the ‘notorious petitioners’.

356. In Hungary the first dramatic change was the Parliamentary Act No. LXXVII of 1994 which amended the provisions of the Health Care Act which dealt with admissions to psychiatric hospitals, illustrates how domestic law has been influenced by the Rome Convention. It follows from the Convention that compulsory admission must only be used in exceptional cases i.e. if there is a serious danger to the patient or another person. An additional criterion for admission could be that the absence of placement in a psychiatric hospital could lead to a deterioration or prevent appropriate treatment of the patient. In the event of compulsory admission, the decision regarding placement in a psychiatric institution must be taken by a judge and the placement period must be specified.

357. The Parliamentary Act reflects these criteria, but reading the Health Care Act Amendment, however, one might have a feeling that a psychiatric patient only exists at the time of admission and at the time of discharge from the psychiatric institution. This law is carrying out for a comprehensive Mental Health Care Act, since the necessity of the judicial decision in non voluntary hospital detention and judicial control over all forms of mental hospitalization is to be derived from the ratified Rome convention itself, there are no directives ensuring the right to obtain individually planned care or to providing the right to adequate information about the illness, or the right to challenge medical records etc.

358. Although the 1994 amendment of the Health Care Act has been accompanied with a feasibility study, however it was perceived after several months of experimenting that the financial resources planned to cover the costs of the new judicial procedure were inefficient. Judges’ travel expenses within cities and other administrative areas were not covered and fees for proxy and forensic psychiatric experts have been inconsistent.

359. Judges who were appointed to participate in these procedures set aside one or two days a week for these procedures. In case of a large institute, like the National Psychiatric Institute in Budapest two judges hear 200-250 patients a day under the supervisory procedure. Forensic experts deliver their verbal opinion during these procedures. Patients wear a pyjama or dress that is common at the hospital. Voluntary patients must only decide if they want to remain in the institution.

360. One of the other deficiencies of the system is that a patient who is considered as having a permanent, non-curable mental state, is directed to a mental welfare home where there is no judicial control. Also the mental hygienic prevention is completely missing from the health insurance consideration.

361. In 1990 Hungary initiated a legal harmonization process to adapt the European Convention on Human Rights and Fundamental Freedoms. It was clear that in order to be compatible with Article 5 of the Convention, Hungary had to work out a system in which the courts not only supervise the detention in psychiatric wards, but also exercise control right after the condition of the patient requires admission to the psychiatric institution. Legislators have recognized that this small change required significant financial sources: first of all, judges must be employed to decide in these cases, there must be sufficient number of forensic psychiatric experts, their travel expenses must be reimbursed and psychiatric institutions or the courts must be able to provide resources for the large number of non voluntary detentions in the psychiatric institutions. An independent psychiatric expert must also be available during these trials and their cost must also be covered. Since this procedure was new, training was also inevitable.
362. Recommendation R (83) 2 concerning the legal protection of persons suffering from mental disorders stipulates that 'clinical trials of products and therapies not having a psychiatric therapeutic purpose on persons suffering from mental disorder, subject to placement, should be forbidden.'

363. Recommendation R (90) 3 restricts still further the possible scope of experiments since it limits these to therapeutic tests which have a direct benefit on those involved.

364. Like many other legislative attempts to harmonize the legal system to European law the biggest deficiency of the abovementioned Health Care Act amendment was that it only harmonized. In my view, the requirement that an Act should prescribe condition for all forms of deprivation of liberty and that deprivation must be ordered by the Court in a reasonable time are simple outlines of a comprehensive Mental Health Act in which other elements of treatment should also be regulated.

365. Psychiatric care went through profound changes during the past 15 years in Hungary. Though the number of registered patients in psychiatric care was always around 130,000, the length and forms of treatment have changed significantly. Various civil rights activists have petitioned for more transparency, less restrictive forms of treatment and community based care.¹


366. In 1996 the Parliamentary Commissioner on Citizens' Rights, Katalin Gönczöl, published a report on the situation of patients at mental welfare homes. She documented serious abuses that violate the Hungarian Constitution and she called for immediate action to improve the conditions at social care homes.

367. The Health Care Act represents a new paradigm in the doctor–patient relationship, which is based on the principle of autonomy and on the promotion of patients' rights in general. Within this framework a chapter on psychiatric care was adopted. Although many experts demanded an independent and comprehensive Act on psychiatric care, this concept was refused. The question is therefore: how much can a general development of patients' right effect the domain of psychiatric care? How far can it help to break through the existing mental barriers and rigid institutional framework?

368. The feelings and obstacles against a comprehensive regulation in this field were clear even when in 1990 Hungary initiated a legal harmonization process to adapt the European Convention on Human Rights and Fundamental Freedoms. Drafters of the new Amendment recognized that in order to be compatible with Article 5 of the Convention, Hungary had to work out a system in which the courts not only supervise the detention in psychiatric wards but also exercise control when the patient's condition requires admission to the psychiatric institution. However, like in the case of many other legislative attempts to harmonize a legal system to the European laws the biggest deficiency of the abovementioned Hungarian Health Care Act amendment was that it only harmonizes. The chapter in the Health Care Act does not go far enough to providing a minimal regulation of psychiatric care. Still even small changes in legislation require tremendous understanding and benevolent interpretation on the side of psychiatric services otherwise we cannot really effect the position of psychiatric patients.

369. The current law on the rights of the psychiatric patients is incorporated in Chapter X (Arts. 188–201) of the Health Care Act entitled 'Medical Treatment and Care of Psychiatric Patients'.

370. The practice of psychiatry is more vulnerable to criticism than any other area of medicine. The reasons for this are complex. While treatment for physical conditions always depends upon the consent of the patients, the psychiatrist may be called upon to treat the unwilling. It follows that patients' rights do apply for psychiatric patients as well, however, the rights of psychiatric patients are considered as special patients' rights.

371. Under the Act a psychiatric institution is defined as any institution providing health care services, that cover the provision, supervision and care of psychiatric patients 24 hours a day, independently of any other services provided by the institution, by the owner or in the name of the institution. In Articles 189–195 institutes providing out-patient services of psychiatric patients, hospices for psychiatric patients, and rehabilitation institutes are also considered as psychiatric institutes. The distinct regulations for hospices for psychiatric patients and rehabilitation institutes are set out in a different Act. Distinct regulations refer to involuntary medical treatment prescribed by the penal procedure, to the Judicial Observation and Psychiatric Institute which prescribes temporary involuntary medical treatment and pursues psychiatric observation.

372. The definition of endangering conduct plays an important role in the justification of hospital detention. It is defined in the Health Care Act as the patient – due to the disturbance of mental faculties – who might cause serious danger to the life, bodily integrity or health of himself/herself or others, and their illness cannot be helped unless hospitalized.

373. The rights of the psychiatric patients have two main sources: one is the catalogue of general patients' rights and the other is a special right guaranteed under Chapter X of the Health Care Act. This chapter emphasizes that the personal rights of the psychiatric patient during the entire medical treatment deserve special protection.

374. The rights of the psychiatric patients during medical treatment can only be restricted according to this Act, to the extent and for a time which is considered professionally necessary to prevent harm, endangering conduct or directly endangering conduct. Right to human dignity cannot be restricted even in the abovementioned cases.
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375. Every psychiatric patient is entitled to:

- have psychiatric treatment as far as is possible in a family environment or in the community;
- have psychiatric treatment which has the least disadvantageous and least unpleasant methods, and which correspond to the state of the patient and protects the physical safety of the other patients; and
- restrictive or coercive measures, which may only be applied in cases in which it is absolutely necessary when during the psychiatric treatment the patient constitutes a danger to themselves or to others.

376. This provision of the Health Care Act makes an attempt to promote community-based care. This form of treatment provides significant benefits for the patients. The problems of re-socializing will become easier, the environment is similar to a normal home life, social stigmatization will be partially eliminated. Here one observation can be made: if a right to be treated in a community-based system is recognized then it is inevitable that the whole psychiatric system needs to be restructured and reallocated financial resources. In the short term the need for additional financial resources will be acute since new and smaller homes, daily hospitals and community houses will be necessary for this form of treatment. Psychiatrists have to be more flexible in this regime. They have to be ready to travel to visit patients in their home.

377. Under the Health Care Act the institutional detention of the psychiatric patient can be carried out under the following conditions and cases:

- based on the consent of the patient or at the request of the statutory authorized person (voluntary medical treatment);
- in cases of directly endangering conduct necessitating the immediate medical treatment in the institution, on the basis of the measures taken by the doctor observing the display of the conduct (emergency medical treatment); or
- on the basis of the decision of a court ruling (involuntary medical treatment)

378. General rules are applied to cases where consent to psychiatric treatment has been given. In the case of non-voluntary hospitalization, however, the consent of the patient can be disregarded until he/she behaves dangerously. However, even in these circumstances, information has to be disclosed to the patient as much as possible. After the dangerous conduct has been terminated the patient has to be provided full information according to the general rules.

379. The patient hospitalized in a psychiatric institution has to be informed about the medical intervention and treatment.

380. The restriction of personal liberty of the patient can only be exercised if the patient shows endangering conduct or directly endangering conduct. The limitation of personal liberty can be upheld only as long as it is absolutely necessary and to the extent that is absolutely necessary to prevent harm.

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381. Limitations of personal liberty should follow the procedure that is prescribed by law. The doctor has to be notified about the limitation immediately and he has to approve the limitation within two hours. If there is no medical approval, the limitation must be terminated and unless sanctioned by the doctor, the limitation must be suspended immediately.

382. The right to know the medical history of a patient can be restricted if it can be shown on reasonable grounds that knowing the content of medical notes would endanger the recovery of the patient, or it would offend the personal rights of another person. The limitation can only be instituted by a doctor. The patient's representative and the legal proxy or durable power of attorney has to be notified immediately about the ordering of any restrictive measure based on the Health Care Act.1

1. Health Care Act Art. 194(1).

383. The patient has the right to occupational therapy, but cannot be coerced to perform therapeutic or other kinds of work.

384. If an improvement in the health of the patient is expected from such therapy then the patient may work voluntarily in the maintenance of the institution. The patient has to be paid for her work in accordance with the decree of the Minister of Welfare. [At present: Minister of Health, Welfare and Family].

I. Psychiatric Treatment in Institutions

A. Voluntary Treatment1

385. Medical treatment can be regarded voluntary, if the placement in a psychiatric institute of the competent patient has taken place following written consent.2 Patients who are incompetent or have restricted legal capacity can be hospitalized for medical treatment in psychiatric institution at the request of the legally authorized person. The court examines the justifiability of the medical treatment in the institution.

1. Ibid. Arts. 197–198.
2. Health Care Act, §197.

386. The head of the psychiatric institute/department has the duty to immediately forward the requests and immediately notify the court about the hospitalization.

387. The court has 72 hours from the receipt of the notification to rule whether the conditions for voluntary medical treatment are fulfilled. Before ruling the court will hear from the patient, the head of the institution or department or the doctor appointed by the head of the institution, and will procure the opinion of an independent — who has not taken part in the medical treatment of the patient — forensic psychiatrist.
388. If medical treatment is not justified, the court will rule that the patient has to be discharged from the hospital. As a result the patient must be released from the institution within 24 hours of the judgment. In the case of the invalidity of the written consent or request serving as the basis of the voluntary medical treatment, the court will rule the detention as involuntary if the conditions for involuntary treatment no longer exist.

389. The patient has to be released from the institution at the request of the patient in case of competent patients, at the request of the person requesting the hospitalization in case of patients who are incompetent or restricted legal capacity.\(^1\)

1. *Ibid. Art. 197(7).*

390. The patient hospitalized on a voluntary basis cannot be released if during the medical treatment he/she displayed endangering conduct or directly endangering conduct and as such medical treatment in the institution is necessary. In this case a special legal procedure has to be followed.

391. In the case of voluntary detention the court has to review periodically the necessity of the involuntary, medical treatment. The review takes place every 30 days in psychiatric in-patient institutes, every 60 days in rehabilitation institutes, every six months in hospices for psychiatric patients.

B. Emergency Medical Treatment

392. If the patient due to her psychic condition or addiction displays direct endangering conduct and this can only be avoided by the immediate placing of the patient in an institution for psychiatric medical treatment, the observing doctor will take the appropriate measures directly aimed at the hospitalization of the patient in the appropriate psychiatric institution. If necessary the police will help to place the patient in the psychiatric institute.\(^1\)


393. The head of the psychiatric institute/department has 24 hours following the hospitalization of the patient to establish the justifiability of the hospitalization and the ruling of involuntary medical treatment by notifying the court.\(^1\) The court decides in 72 hours from receipt of the notification. The patient can be kept temporarily in the institute until the decision of the court is made. Pending the decision all endeavours have to be made in order to terminate the acute endangering conduct or to prevent the fast deterioration of the state of health of the patient. Interventions, which make the judging of the psychic state of the patient by the court at the personal hearing impossible have to be avoided to the professionally possible extent and manner. If such interventions take place they have to be documented and justified in detail. In cases where patients are hospitalized following an emergency procedure the court will rule involuntary medical treatment if the patient displays endangering conduct and their medical treatment in the institution is necessary. Before reaching a decision the court will hear the patient, the head of the institution/department or the doctor appointed by the head, and obtain the opinion of an independent judicial psychiatric specialist – who has not participated in the medical treatment of the patient.

1. *Ibid. Art. 199(2).*

394. In case of patients hospitalized following an emergency procedure the legal procedure has to be conducted even if the patient consented to the medical treatment in the institution at the time when the decision was made.

C. Compulsory Psychiatric Treatment

395. Compulsory psychiatric treatment is ordered by a court in the case of a patient who due to her psychiatric illness, or addiction displays endangering conduct, but emergency medical treatment is not justified.\(^1\)

1. *Health Care Act, Art. 200 (1).*

396. The procedure of involuntary medical treatment is initiated by the specialist doctor of the psychiatric health care provider, who establishes the necessity for such treatment, by notifying the court and advising the psychiatric institute to carry out the medical treatment.

397. The court must rule on cases of coercive medical treatment within 15 days from receipt of the request.\(^1\)

1. *Ibid. Art. 200(5).*

398. Before ruling the court will hear from the patient, an independent – who has not participated in the medical treatment of the patient – forensic psychiatrist called for the hearing, and the doctor initiating the procedure.

399. If the patient does not appear before the court when summoned, the court can order their compulsory attendance. No other coercive means can be applied.\(^1\)

1. *Ibid. Art. 200(5).*

400. If the court rules for the involuntary medical treatment of the patient and the patient does not come within three days from receipt of the legally binding decision to the psychiatric institute referred to in the decision, the doctor initiating the procedure can take necessary steps in order for the patient to be taken to the institute. If necessary the police will help in taking the patient to the institute.\(^1\)

1. *Ibid. Art. 200(6).*

401. The court periodically reviews the necessity of involuntary medical treatment. The patient under involuntary medical treatment has to be released from the institute if their medical treatment is no longer justified.\(^1\)

1. *Ibid. Art. 200(7).*
II. Common Procedural Regulations

402. In the cases related to psychiatric patients the court uses a special legal procedure. The subsidiary law is the 1952 Act III on the Civil Procedure that is applied where there is no specific law.

403. The legal procedures related to detention and termination of psychiatric treatment are free of charge. The involuntary medical treatment procedure takes place at a local court according to the domicile or residence of the patient. The procedure for the review of medical treatment in psychiatric institutions takes place at the local court, according to the seat of the institution.

404. In the court procedure the adequate representation of the patient has to be secured. The patient can be represented upon his/her own authorization or the authorization of his/her legal proxy by the patients' rights representative. If the patient has no legal proxy or durable power of attorney during the procedure the court appoints him/her a guardian.

405. The patient's right representative or the legal guardian who represents patients have the obligation to meet the patient, to inquire about the conditions of the hospitalization and inform the patients about their rights in connection to the procedure. The meeting can also be held outside the court if necessary.

406. The patient and his/her representatives have to be notified about the time of the hearing. An appeal can be made against the decision within eight days of notification. In case of emergency medical treatment the appeal made against the ruling has no delaying force. If during the procedure the court decides to place the patient under guardianship it must notify the Authority of Guardians in charge of the the ruling.1


§3. People with Disability

407. Special rights are listed in the Parliamentary Act on the equal opportunity of the disabled persons. Some of them are applicable in the field of health care. In the course of the health care of the disabled special attention has to be paid to their rehabilitation and social integration.2

2. Art. 12 of the 1998 Act (see above).

§4. The Dying Patient

408. Before 1997 in the Hungarian statutory law euthanasia was mentioned at only one place. According to Article 20 of the Health Minister’s Decree No. 11/1972. (VIII30), euthanasia included the “extinction of life in case of an incurable illness”. The decree mentioned euthanasia as an example of prohibited medical activities, i.e. it suggests – and it only suggests – that the perpetrator may only be a doctor. To cause ‘good death’ anyone can perform an act identical to the prohibited activity, but the scope of euthanasia only covers medical acts.

409. Until 19971 health law was clear about the total ban of any forms of shortening life in case of incurable diseases. According to Article 43 of the 1972 Health Care Act ‘within the given possibilities the patient has to be provided with treatment corresponding with the current status of medicine, with the individual faculties of the patient, as well as with the stage of his disease ... and the most effective therapeutic methods’ have to be applied. Furthermore, ‘a doctor is obliged to treat with utmost care even a patient he regards as incurable.’


410. After 1997, following the legal reform in medical law, all forms of active euthanasia, assisted suicide1 and mercy killing remained serious crimes under the Hungarian law. Nevertheless, some forms of passive euthanasia were legalized by the 1997 Health Care Act by providing explicit rights for competent patients to refuse even life-saving and life-supporting treatment when they have a grievous and incurable disease. Unfortunately the current law does not distinguish between life-saving and life-supporting treatment. The refusal of life-saving or life-supporting treatment has to be respected by doctors if a three-member committee has examined the patient. The committee has to make a decision whether the patient suffers from an incurable disease and has to ascertain that the patient, even when treated with the utmost care would die in a short period of time. The committee has also to verify that the patient was aware of the consequences of his/her decision. Subsequent to the decision of the three-member committee, the dying patient has to re-confirm within three days his/her refusal of the life-saving treatment.

1. Assisted suicide. (Section 168 of the Criminal Code). ‘Anyone, who persuades someone else to commit suicide, or provides assistance in committing it ...’

411. Some experts criticize this bureaucratic procedure, which could be unbearable for a suffering patient.1 Furthermore it may be difficult to justify why it is necessary to investigate the validity of a competent patient’s decision by three doctors, including a psychiatrist. There are no established professional guidelines as to how to assess the competence of a dying patient in making a decision on artificial life-supporting and life-saving treatment.2

1. Albert Takács and Idilko Kmetty filed a petition for the extension of the legal euthanasia in Hungary. The Constitutional Court may examine the constitutionality of euthanasia in October 2002.  
I. Living Will

412. It has become common to write a living will in front of a notary. A living will is a document that governs the withholding or withdrawal of life-sustaining treatment from an individual in the event of incompetence and when the patient suffers from an incurable condition that will result in death within a relatively short period of time. The living will has to be renewed every two years. But even living will statements are not valid without a written opinion of a psychiatrist who has to testify that at the time of making a living will the patient was fully aware of the consequences of his/her decision.

413. Another option under the law is to appoint a durable power attorney by the competent individual in the event of incompetence and incurable disease.\(^1\)

1. Art. 22 (2) of the Health Care Act.

II. Hospice\(^1\)

414. The first law on hospice was a short section in the Health Care Act. The aim of the treatment at the hospice is to offer an alternative for those patients who suffer from an incurable disease. The main purpose of such form of treatment is to relieve pain and to provide comfort and psychological support for dying patients. Unfortunately there are only very few hospices available in Hungary, (six units in Budapest and 12 in the countryside, in addition to that there are five nursing homes).\(^2\)


§5. HEALTH CARE DATA

415. The Constitutional Court in one of its early decision of (No. 15/1991) has interpreted the right to protect personal data as a positive right. The Court argued that personal data could be collected and processed only with permission of the concerned individual. Maybe because data protection was a kind of symbol of the democratization process in Hungary, many citizens perceived this as a clash between data protection and the commercial use of the health care data by insurance companies. Some of them even filed a petition against this practice of the insurance companies by stating that these companies invaded their privacy. The Hungarian Data Protection Commissioner stated in 1999 and in 2000 that insurance companies cannot request an unlimited and general waiver from the medical confidentiality by their clients. This statement followed not only Hungarian laws but also the Directive 95/46/EC of the European Parliament and of the Council of 24 October 1995.

416. Although it is not as common to refer to the right to privacy in Hungary as, for example, in the US, in the field of medical data protection and medical confidentiality it has become an overwhelmingly important right. Data protection in the field of medicine is based on a Parliamentary Act and protected by a special institution called Parliamentary Commissioner on Data Protection. The Parliamentary Act No. XLVII of 1997 of the processing and protecting of health records and connected personal data.

I. Right to Access to Medical Record (Medical Documentation)

417. In the Health Care Act the patient has the right to access the data contained in the medical record concerning them. Parallel to the Health Care Act another important law was adopted, namely Parliamentary Act XLVII of 1997 ‘on the processing and protection of health care data and associated personal data’ (hereinafter: HDP Act)

418. The HDP Act gives a very broad definition of the scope of health care data. Health care data is data related to the individual’s physical, intellectual, or spiritual condition; habits or addictions; to the circumstances of illness or death; causes of death; to any information given to the individual about him/herself, or about any other individual, or any such information seen, heard, observed, examined, measured, imagined or derived. Furthermore, it is also any sort of information (for instance, behaviour, environment, employment, or other data) connected with the above listed categories of information. Under certain circumstances information on sexual habits can also be considered health data.

419. According to the law, identification data comprises family and first name, maiden name, sex, birthplace and time, the mother’s maiden name and first name, home address, location, social security number (hereafter SSN). All this together or some of it may serve for identification until the link between the data and the person can be established.

420. Based upon the law on health care and identity data the following forms of data are considered confidential: data collected or given to the data handler during treatment; information regarding necessary, ongoing, or completed treatment; and other data received in connection with treatment.

421. Data processing can be carried out in pursuit of the following:

- the protection of health or assistance in the maintenance of health;
- the advancement of effective treatment;
- the monitoring of the patient’s state of health; and
- the provision of actions necessary in the interest of public health and epidemic prevention.
Part II, Ch. 2, Physician-Patient Relationship

422. In addition to the goals outlined above, other cases defined by law also exist in which data may be collected for the following reasons: the training of health care specialists; medical-professional or epidemiological testing; medical analysis; the planning of health care provisions; statistical testing; scientific research; social security care, or the determining of social care provision; pursuit of crime; prevention of crime; criminal proceedings; the determination of the ability to work, etc.

423. In the handling and processing of health care and identity data, the security of that data must be assured to prevent involuntary or intentional destruction, alteration, damage, or release to the public, and must be kept secure from unauthorized access.\(^1\) Data-processing for medical treatment is permitted. Anyone who has to collect and process health care data is required to keep medical confidentiality.\(^2\) Exceptions to this are stipulated by law.

1. HDP Act, Art. 6.
2. The Hungarian term for confidentiality is 'medical secret'.

424. In case of the death of the individual concerned, his/her legal representative, immediate relative, and/or descendent may – based upon written request – be given data related to or possibly related to the cause of death, medical treatment before death, physicians’ documentation, and may – at his/her own expense – receive copies of these documents.

425. In addition to the health care provider, the individual’s personally chosen physician, and a legal medical expert, the requirement to keep data confidential also pertains to those providing medical care who have not assisted in medical examinations, identification of illness, or in treatment or operation, unless the release of such data is necessary for the identification of the affliction, or in the interests of the further treatment of the patient.\(^1\)

1. HDP Act, Art. 8.

426. Recording data is part of the treatment. The doctor giving treatment, or the head physician is to decide which data has to be taken in accordance with the law.

427. Health care and identity data may only be used together at a time, and to a degree, that is absolutely necessary in the prevention and treatment of disease, as well as in the interest of public health and the prevention of epidemics.

428. Other than the doctor giving treatment and other staff involved in treatment, only those with the permission of the patient may be present. Others may be present without the permission of the patient because the treatment demands the handling of more than one patient at a time, they are police officials and the individual requiring treatment is being held by the police, they are legal members of the criminal justice system, the patient is serving a prison sentence and the security of those providing treatment must be ensured. If there is a need to prevent escape attempts, the safety of the patient requires it, in the interest of the pursuit of criminals and the patient is in a state in which he/she is unable to state his/her wishes.

429. Others may be present without the patient’s permission if,

- they treated the patient earlier for this particular affliction;
- they have been given permission to be present by the institution’s director, or the individual responsible for data out of personal professional or scientific interest, unless the patient expressly objects to their presence.

II. Processing Data to Protect Public Health and Prevent Epidemics

430. The caregiver is to immediately provide the local ÁNTSZ (State Health and Medical Office) institution – depending on the patient’s home, residence, or workplace – with the patient’s health and identity data if a communicable disease outlined in the law’s appendix is detected, or suspected.

431. Pulmonology clinics, and institutions caring for skin and venereal diseases are to report tuberculosis, or venereal diseases named in this law’s appendix, and – with regard to the danger to other individuals to whom such information should be forwarded because of contact with the patient – the institution is to provide data on the patient’s identity, family name and first name, maiden name, and residence or home address.

III. Data on HIV

432. When screening for HIV an individual is not required to provide identity data to the health provider. However, if the test is positive the individual concerned must provide personal identity data to the health provider. The patient should be made aware of this requirement prior to screening. Mandatory disclosure of identity after the positive test is currently being contested by civil rights organizations.\(^1\) After completing this monograph and before the date of its publication, a new law was adopted that guarantees full anonymity in AIDS testing in cases where testing is not mandatory. (Parliamentary Act No. LVIII of 2002, on the amendment of some health and social insurance laws.)

1. Constitutional Court in its decision No. 27/2002(VI. 28) invalidated the law on AIDS prevention and screening. As a consequence of this decision the law No S/ 1988, (V. 31) SZEM r. will not be enforced from January 2003. The petitioner stated that the law violates human dignity and the law discriminates between individuals who have been infected by transfusion and those who have been infected in sexual relationship. The Constitutional Court considered the entire law unconstitutional as it regulates basic human rights in a Ministry Decree. Under Section 8 (2) of the Constitution norms that effect basic rights should be adopted in a Parliamentary Act.
IV. The Registration of Congenital Birth-Defects

433. In as much as the affected newborn suffers from a congenital birth defect (according to the International Classification of Diseases), the health care provider may forward the patient's identity and health data, as well as the name and address of his/her legal representative to the National Registry of Congenital Birth-Defects at the 'Johann Béla' National Health Institute.

V. Access to Health Care Data

A. Access to Health Care Data to Help Train Health Care Professionals

434. In their training health care professionals may be present during treatment with the permission of the patient (or his/her legal representative). Such professionals are doctors, medical students, health care professionals, students and teachers at health care colleges, professional schools, or health care middle schools.

435. One of the most highly questionable exceptions allowed by law is that if institutions designated for the training of health care professionals, the permission of the patient (or his/her legal representative) is not required.¹

1. HDP Act, Art. 17(20).

B. Epidemiological Study and Analysis

436. In case of the detection of tumours or cancer-related illness, the health care provider is to forward the patient's health and identity data to the National Cancer Registry. The National Cancer Registry is run by the National Oncology Institute.

C. Processing Health Care Data for Statistical Purposes

437. A patient's health data may be used on occasion for identification purposes.¹ Identity and health data may be disseminated with the written permission of the individual in question.

1. HDP Act, Art. 20(1).

438. In the case of birth or death, health care and identity data is to be sent to the Central Statistical Office through the official registrar at the place of birth, or death.

D. Processing Health Care Data for Scientific Research

439. With the permission of the institution's director, or the individual in charge of data protection, access may be provided to stored data for the purpose of scientific research. Health care and identity data may not, however, be used in scientific reports in such a way that the patient's identity may be discovered. In the course of scientific research copies of documents containing identity data may not be made.¹

1. HDP Act, Art. 21(1).

E. Access to Health Care Data by Health Insurance

440. The Directorate of the State Pension Plan, and the State Health Insurance Fund, as well as their directing bodies (hereafter commonly referred to as health insurance directing organizations) may also be given health and identity data in compliance with legal regulations.¹

1. HDP Act, Art. 22.

441. Pharmacists have to maintain a registry of all those involved who request opiates by medical prescription.

442. Health records must be preserved for at least 30 years from its registration. The hospital discharge records have to be preserved for 50 years. Following the required storage time, data may be further preserved in the interest of health or scientific research. If the further storage of data is not justified the registry is to be destroyed.¹

1. HDP Act Art. 30(1).

443. In as much as health documentation is of scientific value, following the compulsory storage time such data is to be entrusted to the Semmelweis Medical History Museum's Library and Archives.

444. Pharmacies have to keep prescriptions for three years - with the exception of those for drugs containing opiates or psychotropes. Prescriptions for opiates or psychotropes are to be stored for five years. Prescriptions must be destroyed following the compulsory storage period.¹

1. HDP, Art. 30(7).

445. Incorrect health data in health documentation — following the collection of data — is to be corrected or erased so that the originally collected data cannot be detected.

VI. Health Care Data Commissioners at Health Care Institutions

446. Health data protection officials are to be trained physicians, or individuals with at least two years of legal practice and holding legal degrees, or individuals with other university degrees who have at least two years of practice in health data handling.¹

1. HDP Act Art. 32(4).

447. In case of transmission of health data abroad, the regulations outlined in
VII. Genetic Data

448. According to Article 6 of the 95/46 EU Directive, personal data has to be processed fairly and lawfully collected for a specified, explicit and legitimate purposes and not processed in any other way that would be incompatible with those purposes.

449. The data has to be adequate, relevant and not excessive in relation to the purposes for which they are collected and/or further processed. The problem with medical data is that it is often used for research and other purposes that may be regarded by health care professionals as the same purpose though legally speaking these are different purposes.

450. The legal framework on genetics must react to both the advantages and disadvantages of prediction tests and has to assess the potential abuses of the gradually growing genetic information. This preventive motivation explains why, though at the moment there are very few relevant and accurate genetic tests available, in recent years many states, including Austria, Belgium, Denmark, France, Norway and the Netherlands have enacted legislation to control the acquisition of genetic information by insurers. Many countries responded by introducing moratoria on the use of genetic information. Within the model of voluntary moratoria, two forms have been developed: it can either be indefinite, such as in Finland, or for a limited number of years such as in France. In Hungary insurance companies have not yet declared a moratorium on the use of genetic data, nevertheless Hungary ratified the Oviedo Convention (see Article 12 of the Convention).

451. Genetic information is a complex notion, biologically, medically, and legally. It includes DNA and chromosome analysis, and certain clinical tests, as well as traditional sources of genetic information, such as family history. Ethical considerations have developed around genetic information partly because genetic anomalies have special characteristics. Some of these characteristics are regarded as irreversible and more or less objective conditions. There can be a threat of developing symptoms affecting the individual’s life, especially in case of late-onset diseases. Furthermore, genetic anomalies may be inherited by the offspring, affecting the afflicted individual’s carrier and his or her spouse’s chances of having a healthy child. In terms of causality, one may make a distinction between genetic information such as genetic tests for monogenic recessive or dominant conditions where degrees of risk are high and between the genetic information that can be derived from testing as susceptibility data. In this latter case genetic information is not only an indicator of an individual’s current state of health; it is also an indicator of that individual’s likely future health. For medical conditions controlled by a single gene

452. Another relevant distinction should be made between physical samples taken from the individual and the genetic information derived from these samples. If insurers may take account of the existing genetic test results, it can be done only when their reliability and relevance to the insurance product has been established.

453. We do not yet have a coherent analysis on the legal status of various kinds of genetic information. Nor do we know how often people neglect to inform their insurer about medical problems or conceal health information from them. Even if the genetic information is available, whether it has the same relevance in non-medical use as in the biomedical research is not clear. Fear of discrimination already exists and it may discourage individuals at risk from undergoing medically indicated genetic testing. As a consequence non-medical use of genetic information may significantly affect the medical use of such information.

454. The informational exposure in the field of genetic information may in the future reduce the uncertainty about future events relevant to various kinds of insurance. Genetic information may provide a more accurate assessment of certain future events, such as having a heart attack, suffering from a cancer or dying within a certain time period.

§6. Hospital Ethics Committees

455. Under the Health Care Act directors of each hospital have to establish a local ethics committee. The role of the local ethics committee is to decide ethical disputes that occur in health care institution. The local Ethics committees have a role in the enforcement of patients’ rights, as well as, in the decisions on transplants. The Committees have about 5–11 members selected on multidisciplinary basis.

I. Regional Ethics Committees

456. There are almost a dozen regional research ethics committees that are mostly based at medical faculties. There are no clear guidelines on the selection criteria. Most members have no training in ethics or ethical review.1

Chapter 3. Specific Activities

§1. BIOMEDICAL RESEARCH

457. The main ethics review body at the national level is the Scientific and Research Ethics Council (with the Hungarian acronym: EITT). Recently a study by Antal Ferenczy revealed that it might be one of the oldest ethics review bodies in the world. The history of the Commission can be traced back to 1868 when the Hungarian National Public Health Commission was set up. The present model was first adopted in 1951 when the ‘Egészségügyi Tudományos Tanács’ (EITT) was established.\footnote{In Hungarian: ‘Egészségügyi Tudományos Tanács’. In 2001 the president of the Council was Prof. Szilveszter E. Vizi, in 2002 Prof. Péter Sólyom.}

1. Manuscript of Prof. Antal Ferenczy, medical doctor, bioethicist.

458. On the most recent laws on the Health Science Council [16/2001 (IV. 28)], EüM decree specifies five Commissions of the Council: Scientific and Research Ethics Commission (with the Hungarian acronym: TUKEB), the Clinical Pharmacology Ethics Commission, the Forensic Commission, the Human Reproduction Commission and the Medication Commission.

459. TUKEB plays a principle role in ethical review of new medical technology based on the protocol submitted to the Council. Most members of this Commission are prominent medical professors. Members of the Council and Commissions are appointed by the Minister for Health. There is no rotation though the appointment is a fixed term.\footnote{The head of the Commission is Prof. Zoltán Papp, gynecologist, obstetrician. There are two lawyers who are members of this Commission: Ágnes Déva and Judit Sándor and there is one in-house lawyer, Dorottya Mogorósi, who is delegated by the Ministry.}

460. Biomedical interventions can only be carried out with authorization and with the research purpose of developing diagnostic, therapeutic, preventive and rehabilitation procedures, for working out new procedures, and for a better understanding of the etiology and pathogenesis of illnesses.

461. Within the meaning of this decree biomedial intervention is:
- human genetic research carried out on living human beings and human genetic material, or other human genetic research;
- trying new, not yet applied, medical and treatment procedures, interventions, tools, equipment, applying medicines on the basis of new recommendations, or using other substances;
- for public health, i.e., epidemiology and environmental health care research carried out on human beings; and
- research carried out on embryos and still-born foetus.

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Part II, Ch. 3, Specific Activities

462. Biomedical intervention has to be based on appropriate and satisfactory laboratory and animal experiments and the deep understanding of relevant professional literature.

463. Biomedical intervention can only be carried out in the institutions defined in the Health Care Act.

464. In the biomedical intervention process the scientifically well-grounded diagnostic and therapeutic procedures (i.e., accepted practice extended to all patients) shall be extended to the persons participating in the intervention as well as to the persons controlling the intervention.

465. The biomedical intervention - including interventions not carried out for therapeutic and preventive reasons - can only be carried out within the framework of chapter VIII of the Health Care Act (Act CLIV of 1997) if:
- it is in the public interest and is scientifically sustainable;
- the expected results can be verified; and
- the professional, personal and material circumstances necessary for careful preparation and the verification of the evaluation are satisfied.

466. The health and the personal rights of the healthy person or the person under medical treatment involved in the biomedical intervention (i.e. the person involved in the research) shall be protected. The biomedical intervention cannot endanger without justification the health condition of the person involved in the research.

467. The head of the research has the obligation to put together a detailed research plan and individual data-files about all the persons involved in the research. The data-file has to contain all data, facts and events that are connected to the intervention which can respectively influence the outcome of the research. The head of the research will send the research plan and the data-file to the director of the institute; non-affiliated doctors to the research will send the data to the director of the capital or county hospital in charge territorially.

468. If the authorization for the biomedical intervention\footnote{Health Care Act, §161(4).} has not been had by the director of the institution, then the intervention cannot proceed.

469. Biomedical intervention – unless laws provide differently – can only be carried out on patients or healthy persons who undertake the research voluntarily. Carrying out biomedical intervention requires the preliminary written consent of the person involved in the research.

470. Biomedical intervention can, even if it receives ethical-professional support, only proceed if the person involved in the research, or their legal representative has been informed in detail, by the director of the research or based on their
authorization by another doctor participating in the research, about all facts, circumstances or events that are connected or can be connected to the intervention.

471. Information has to be provided about the purpose and the course of the research, the interventions necessary for the research, the frequency of the interventions, the possible and expected effects and side effects connected to the research and the possible advantages, risks and possible consequences. Information shall also be given concerning the fact that the consent to participate in the research can be withdrawn at any time, orally and that in case of any damage to their health condition they may ask for compensation. Information has to include the explanation of medical terminology.

472. Such information has to be included in the document referring to the consent. The withdrawal of consent has to be included in the medical documentation. The reimbursement of expenses can be given to the person involved in the research – unless the intervention was made with therapeutic purposes.

473. The interests of the persons involved in the research shall be represented – for medical purposes – by a doctor, who is not participating in the research, and is appointed by the director of the institution (appointed doctor of the institution). If more than one doctor is needed he/she can be appointed. In selecting the appointed doctor of the institution the preference of the patient has to be considered.

474. The appointed physician of the institution has to be informed regularly – without special request – about the status of the biomedical intervention, and any occurring problems. Information must be immediately given upon request of the appointed doctor.

475. It is the task of the appointed physician of the institution to monitor the health condition of the person involved in the research. For this purpose the physician must:
- keep in touch regularly with the persons involved in the research, provide information for them, offer professional help;
- examine the person involved in the investigation regularly and in case of complaint notifies immediately, the director of the institution if necessary;
- take part in the supervision and evaluation of the research.

I. Ethical Supervision

476. Biomedical intervention is continuously supervised from a professional, scientific and ethical point of view by the director of the institution and by the chief doctor of the department professionally in charge. The appointed doctor of the institution has to be involved in the supervision.

477. The health condition of the person involved in the research has to be observed and carefully documented before starting the research, continuously during the research and after the research.

II. Informed Consent Process

478. Information required under the decree should include the following elements:
- data of the research, the experimental character of the research;
- object of the research, expected duration of the research, the number of research subjects, biomedical interventions and its frequency;
- other possible available treatments, information about the change of the therapy and its impact on the research subjects' health;
- expected consequences of the research;
- benefits of the research;
- if no benefit is expected then it has to be mentioned why the research is necessary;
- the method of selecting different research groups;
- compensation for potential damages;
- a statement describing any compensation for study participation (including expenses and access to medical care) to be given to research participants;
- data protection; and
- the name of the ethics review committee


A. Minimal Content of the Consent Form

479. The written consent form that should be signed by each of the research subjects should include at least the following elements:
- the name of the health institute where the research will be conducted
- the name of the head of the research and names of the staff members who will provide information on the research;
- personal data of the research subject (name, mothers' name, date and place of birth, social security number, address);
- statement of the consent;
- date of the signature;
- signature of the researcher who provided the information; and
- research already conducted on animals.

1. Art. 4(5) of the 23/2002/(V.29.), EU&M r.
III. Termination of Medical Research

480. The researcher has to stop the biomedical intervention immediately if he/she perceives that continuing it could be damaging to the person involved in the research.

481. Where a non-desired side effect occurs that justifies the interruption of the biomedical intervention, or an important change occurs in the circumstances relating to the ethical-professional opinion, the director of the institution immediately suspends the intervention and notifies the committee which has given their ethical-professional opinion of this.

482. The director of the institution must suspend the research if more than one fifth of the persons involved in the research withdraw their consent.1

1. Ibid. Art. 15(1).

IV. Special Cases: Reproductive and Genetic Research

483. While medical science and bio-technology supply reproductive medicine and genetics with more advanced procedures, politics, ethics and the law offer the same old 'solutions' time and time again: 'human rights', 'human dignity', 'respect for life', 'the principle of non-maleficence', 'informed consent', 'freedom of research'. The normative responses to genetic discoveries, which may appear to be dull, nearly always lead to bitter debate. The public is either unable to decide or is strongly divided on the issues, and even positions reached after difficult deliberation are not always consistent.

484. Nowadays the doctrine of informed consent is challenged in terms of how much an individual-based right can encompass the difficult problems of reproductive choice, learning and how genetic information can be used.

485. Information is strongly related to the legal concept of confidentiality and privacy. Right to privacy usually refers to the control over one’s own personal information. Genetics has opened a vast field of investigation into individual genetic characteristics. Protocols of the proposed research have to go through a review of ethics boards. Ethics boards both at the institutional and at the national level serve dual functions; they evaluate the protocols based on scientific merits and based on ethical considerations. The composition of the ethics committees therefore is mixed, but still the main influence is from the medical profession.

486. Genetic research undermines the individuals informed consent in at least two respects: genetic research on one individual affects family members and often relatives who do not even have regular contact; they might live in distant places, may have different religions and different levels of education and even be living in different communities.

5V. Special Cases: Cloning

487. Genetic research may not offer any benefit for the research subjects involved. After the results of the testing or screening are disclosed, treatment of genetic disorders may be useless.

488. International and national norms of research carried out on humans are based on the informed consent of the concerned person. Thus persons who due to their status cannot give their informed consent cannot be the subject of research. This is why law forbids research carried out on prisoners. Children may be research subjects only in exceptional cases. According to the Health Care Act in such cases research can only be carried out if the results achieved throughout the research will directly further the health of the child and the particular research cannot be replaced with research carried out on another, legally capable person. Another general principle is that the research can only be continued if there is no other alternative to the research conducted on human beings. If all conditions specified in laws and decrees are fulfilled and research on a child is to be carried out, consent to the research can be given by the legal representative but in most cases it is the parent of the child.

489. Thus it can be stated, therefore, that research on embryos can hardly fit into the framework drawn up for research on humans. In biomedical research the concerned individual should provide consent, in case of minors, parents may substitute consent if additional legal guarantees are met. In respect to research on the embryos the law usually requires the couple’s consent who requested for the creation of the embryo. However, in most cases the research does not serve the interest of the embryo and it is not completely clear on what basis the ‘parents’ can provide their consent: are they parents or owners of the embryo? The other problematic element of the law that it requires that the embryo that has been a research subject could not be implemented into the mother’s body. Thus Section 181 of the Health Care Act states similarly to regulations in many other European countries that research on the embryo can only be carried out until the 14th day following conception. The embryo has special status according to European legal thinking, it differs from rules referring to research on human beings, but also from the status of cells, tissues and genes originating from human beings.

490. Even though there is no research on human embryos conducted in Hungary, if such research were carried it would create a problem under the Human Reproduction Commission law (Section 185, paragraph 2/b), i.e., the control on reproductive institutions authorized to carry out research on embryos and gametes, has not yet been set up.

491. Conditions for the freezing of embryos are regulated by the Fourth appendix of Ministry Decree 30/1998 (IV. 24). There is no reference to research here in this law. In the same law the declaration for disposal of embryos is regulated, however the type of research here is not specified.
492. Paragraph (3) of Section 183 of the Health Care Act which provides that cells of the embryo can only be separated with the purpose of establishing the possible illnesses which the child yet to be born will face or the deficiency of the embryo, this leaves room for some interesting interpretations. This points to the possibility of genetic research in the pre-implantation period.

493. The Additional Protocol to the Convention on Human Rights and Biomedicine on the Prohibition of Cloning Human Beings of Oviedo contains only one substantive provision: according to the first section it is forbidden to carry out interventions if their aim is the creation of human beings that are genetically similar to either living or dead human beings. According to the Additional Protocol two human beings can be considered genetically similar if genetically their nucleus can be considered as identical.

494. It is clear that the solution for the problem is closely dependent on the legal status of the embryo. We must mention here that the title of the Chapter VIII of the Health Care Act only refers to medical research conducted on human beings. In Hungarian law, for example in Act LXXIX of 1992 on the protection of foetal life or in the Criminal Code (the law distinguishes between the human genome, the genetic material of the embryo, and changes in the genetic make-up of the embryo) but in the Oviedo Convention the legal protection provided for the embryo or the foetus is special and distinct from the legal protection provided for the living human being.

495. Let us suppose that in some countries research with non-reproductive purposes conducted on pre-embryos will spread. In this case in vitro clinics will become interested in the production of surplus of embryos. It is hazardous to connect a mainly palliative type of service with research and transplantation interests.

496. If an individual has a right to decide their own genetic make-up, as distinct from their parent then it will probably be impossible to prohibit the use by the parents of organs and tissues produced from the pre-embryo with cloning for their own medical treatment.

497. In Hungary the 1997 Health Care Act catches up on a loss of several decades in the field of health care legislation, but due to its framework character it could not make detailed rules. It is also true that at the point of entering the century of biotechnology the three years passed since the promulgation of the law are a very long period considering the dynamic progress of biomedicine.

498. For the process of biomedical intervention, see paragraph 467 above.

499. The reason behind the ban of cloning with the purpose of reproduction is the protection of personal rights and dignity. The question still remains, how much this argument can be used for therapeutic cloning?

500. From July of 2002 the Health Minister's Decree No. 23/2002 (V. 9) provided a detailed definition of biomedical research, including the genetic research on human beings.1 Research ethics committees will have three different levels, the institutional ethics committees: Institutional Ethics Board (IEB) Regional Research Ethics Board (RKEB) National Scientific and Research Ethics Board (TUBEK).

1. There is a special law on licensing and registration of human pharmaceutical products: 12/2001. (IV. 12). Health Ministry Decree (El nemedelet) and the clinical trial at products for human use and on Good Clinical Practice 24/2002 (V. 9). Health Ministry Decree (El nemedelet).

501. Under the new law all documentation required for a thorough and complete review of the ethics of proposed research should be submitted by the applicant. The investigator has to submit the protocol of the proposed research, together with supporting documents and annexes. The project documentation should include the investigator's curriculum vitae, the material used (including advertisements) for the recruitment of potential research participants; a description of the process used to obtain and document consent; the informed consent form (clearly identified and dated) in the language(s) understood by the potential research participants and, when required, in other languages.

502. All properly submitted applications should be reviewed in a timely fashion and according to an established review procedure.

503. Elements of the Review: The primary task of an ethics committee lies in the review of research proposals and their supporting documents, with special attention given to the informed consent process, documentation, and the suitability and feasibility of the protocol.

VII. Research on Animals

504. Research on animals is regulated by the 1998 Parliamentary Act on the protection and care of the animals. The law deals with the experiments on vertebrates. Experimentation on animals can be conducted only at licensed research institutions.1 Experimentation cannot serve the purposes of the cosmetic or the tobacco industry nor as a trial for weapons. There are universities that operate a special animal protection ethics committee. Some of them have developed detailed regulations about handling animals in humane ways.2

1. Act XXVIII of 1998 on the Protection and Care of Animals, §25(2)
2. See also Governmental Decree No. 243/1998 (XII. 31) Korm. r. [amended by the Governmental Decree No. 103/2002 (V. 10)].

§2. Reproductive Rights

505. Reproductive health implies that people have the capacity to reproduce and
the freedom to decide if, when and how to do so. Reproductive rights embrace certain human rights that are already recognized in national laws, international and human rights documents and other consensus documents. These rights rest on the recognition of the ‘basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children, and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health’.

506. International legal documents interpret reproductive rights and rights in respect to reproductive health as negative rights. Negative rights guarantee a free decision and non-interference in the questions of contraception, sterilization and abortion (individual choice against coercive abortion). Similarly, the concept of women’s reproductive health outlaws female genital mutilation and female circumcision.

507. Among the rights which have been enumerated to comprise the totality of reproductive rights, the rights to found a family and decide freely and responsibly on the number of children most directly address the rights of infertile individuals and couples. What does the right to found a family mean if the couple cannot become pregnant through ‘natural’ methods? How can one decide ‘freely’ on the number of children if one cannot conceive a child in the first place?

508. It might be supposed that reproductive rights should confer a right to choose: that everyone should be able to choose whether to have or not to have children. Certain language from the Cairo Programme would support such a view:

'Reproductive health implies that people have the capacity to reproduce and as it follows reproductive health care is defined as the constellation of methods, techniques and services that contribute to reproductive health and well-being by preventing and solving reproductive health problems.'

So, it could be argued that reproductive rights are predicated on reproductive health.

509. The ability to procreate should not be conditioned on an individual or couple’s biological capacity if medical interventions exist that can ameliorate any shortcomings. In other words, reproductive rights should include infertility treatment and assisted procreation. Despite the logic of such reasoning, there is no basis in international human rights law to interpret reproductive rights as including the right to infertility treatment. The actual language of the applicable treaties is silent, the travaux preparatoire give no evidence of such consideration, and the policies of requiring states to underwrite expensive and experimental technologies is impractical.

510. Doctrinally there is no right to infertility treatment. Conversely, there is no barrier to advocate for an extension of reproductive rights to include infertility treatment. Nothing, moreover, in the general human rights framework, nor in the specific language of ICPR prevents a state from providing infertility treatment to couples or individuals who so desire it. To this extent then, it can be said that Hungary’s legislation in the area of assisted procreation is precedent, and might be used to extend the eventual purview of reproductive rights.

I. Laws on Assisted Reproduction

511. Assisted procreation, has been practised in Hungary for about 10 years, yet it had not been regulated before 1997, except by a Ministerial decree on artificial insemination and some insurance laws on in vitro fertilization. First successful GIFT was made in 1987 in Pécs and the first in vitro baby was born in 1989 in Hungary. Since then numerous private and public medical centres have already provided biomedical assistance for infertile couples in Hungary. Currently 11 in-vitro centres are in operation. (five public and six private clinics).

1. Gamete intra – fallopian transfer.

512. The new codification had set up a working group on reproductive law policy, which had to bring a proposal in a short period of time in order to include it in the Health Care Act. The Health legislation process that had also been motivated by political reasons was supported by the Socialist-Liberal Governmental Coalition. In December 1997, the Health Bill which was contested by Conservatives and the Hungarian Medical Chamber was adopted as (Act No. CLIV) by the Parliament. Nevertheless the Act only came into force in July 1998 during the reign of the new, Conservative-Christian coalition. At the same time a Ministerial decree has come into force, as well, (30/1998 (VI. 24) NM. In the future some changes may be expected in the Health Care Act, nevertheless the trends toward a patients’ rights oriented health care system has become irreversible.

513. Although the new Act has come into force in July 1998, there was no follow up to evaluate the effects of this legislation.

514. The 1997 Health Care Act included a chapter on assisted procreation which provided the main rules for access and the condition for the different forms of assisted procreation. The 1997, CLVI, Parliamentary Act on Health Care in the Chapter IX, (Arts. 165–187) regulates the ‘extraordinary treatments of human reproduction, research on human embryos and gametes, and also sterilisation’.

515. This law also established the main controlling and licensing agency: the Human Reproduction Commission. Although since 1998 the Commission existed de jure, it only started to operate in 2001. The first head of the Commission is György Koszolcsányi. One of the main task of the Commission is to monitor the practice of reproductive clinics in Hungary.

1. The author is a member of the Hungarian Commission on Reproduction.
516. The laws that have to interpreted here are the parliamentary Act No. LXXIX of 1992 on the protection of the foetus’s life, Parliamentary Act CLIV of 1997 on Health Care Chapter IX, (Arts. 165–187) and the 30/1998 (VI. 24) NM. r. on extraordinary procedures of human reproduction, the treatment of embryos, gametes and their storage.

517. Before the 1997 Health Care Act of the Hungarian Parliament, no attempt had been made to provide a statutory solution for the ethical and legal problems raised by new bio-techniques. Since the new Act came into force on 1 July 1998 and parts of it in 2000 (e.g. provisions on surrogacy) it is still difficult to predict its effects.

II. Reproductive Services

518. The main source of the legal norms on medically assisted reproduction can be found in a specific chapter in the Health Care Act. The drafting group had to solve many problems. First of all before this Act only a decree on artificial insemination and another one on sterilization existed. So there was no legal terminology to describe various forms of assisted procreation and there was no consensus on what should be the scope of these medical services. The term medically assisted procreation had no equivalent in the colloquial language and therefore a complicated title was given to the chapter on assisted procreation: ‘Extraordinary Treatments of Human Reproduction, Research on Human Embryos and Gametes, Sterilisation’.


519. It was also very hard to reach a consensus on definitions. An embryo was defined as every living human embryo following the completion of the fertilization until the 12th week of the pregnancy. The foetus: the human being developing within the uterus after the 12th week of the pregnancy. If one reads these definitions carefully it is clear that the clone-embryo does not fit in the definition of the embryo since it is not conceived by fertilization. But (hypothetically) if a clone-embryo is transferred into a women’s womb then it is regarded as a foetus (human being developing in utero). Of course, the drafters of the law did not think of the possibility of reproductive cloning that later became a criminal offence in the Hungarian law.

III. General Conditions of Medically Assisted Procreation

520. Medically assisted human procreation (here after referred to as MAP) can be applied to married persons, or persons in civil law marriage with parties of a different sex while unmarried, who due to medical reasons (infertility) in any parties, where there is a high probability that in vitro fertilization will not occur. If the fertilization of the ovum has been completed and then the couple file for divorce or the spouse dies, the women can ask for the continuation of reproductive services. How-

521. MAP procedures cannot be carried out by the request of the divorced or widowed woman if continuation was previously excluded by a common written declaration made before a health care provider by the couple in question.

1. Health Care Act, §167(1).

522. MAP can only be applied if other methods of treatment of infertility have proven to be unsuccessful and if there is a fair, medically sustained, chance that the applied method will lead to the conception and delivery of a healthy child. Assisted reproductive technology can be applied if suggested by a specialist, at the health care providers authorized in their licence to carry it out.

523. Under Article 1668(1) of the Health Care Act only the following forms of assisted procreation techniques may be carried out: in vitro fertilization and transfer; artificial insemination using the sperm of the spouse or donated sperm; gamete donation; embryo donation; other methods promoting the fertilization or potential fertility of the egg and the adhesion and development of the fertilized egg (micro manipulation).

524. The MAP procedures can be carried out, or continued in case of single women, at the common written request of the couple or of the single woman. The request has to be enclosed in a notarized document or in a private document having full legal effect. Before the procedure, the doctor or team of doctors which will carry out the procedure informs the requesting couple or woman about the MAP procedure to be carried out in writing and verbally.

524. Hungarian law established a unique reproductive right by creating the ‘right to continuation of the infertility treatment’. This right can be enforced exclusively by women who become widows or divorced after the medically assisted fertilization had been achieved. Medical staff have to notify the couple about this law when the couple initiate the medically assisted procreation. The couple, nevertheless, can make a written agreement in which they restrict the woman’s right to continuation of the treatment beforehand. But if there is no previous agreement a woman who undergoes hormonal therapy and conceives embryos and her husband dies afterwards or files for a divorce she can have unilateral access to embryos in order to carry on with the pregnancy. It follows from this regulation that Hungarian law recognizes the different nature of the contribution by women (invasive and potentially risky medical interventions) and men (sperm ‘donation’) in the assisted procreation treatment. In the case of divorced women the potential problems in respect to family law have not yet been elaborated on because of the lack of judicial cases.


525. Because of the continuity of the various forms of assisted procreation a special informed consent procedure can be followed. The information provided should include:
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526. The information should extend to all possible applicable methods, and should also contain the medical indication referring to the procedure to be applied.

527. Assisted reproduction procedures can only be started on the basis of the common written consent of the couple (in the case of couples), or the written consent of the woman made after they have been informed.

528. Licence for carrying out MAP procedures can only be given to health care providers which have the professional conditions for storing both gametes and embryos, conditions defined in a separate Act.

529. In the Ministry Decree No. 49 of 1997 on the financing of assisted procreation criteria have been set for free of charge assisted procreation granted by the national health care system. In the decision No. 18 of 2001 the Hungarian Constitutional Court had to make a decision on some of the provisions of this decree. The petitioner challenged the rule provided by Point a) of Subsection 2 of Section 2/A of the Procreation Decree, by which the lawmaker excluded males over 60 years from taking advantage of the free of charge procedures concerning some forms of assisted procreation available in the national health care system.

1. The decision was translated by Jókai Takács.

530. The petition required the Constitutional Court to declare this rule unconstitutional and to annul it. In his statement the petitioner stated that the objected rule violated the right to social security declared by Subsection 2 of Section 70/E of Act XX of 1949 on the Constitution of the Republic of Hungary infringed the prohibition of discrimination declared by Subsection 1 of Section 70/A of the Constitution, was contrary to the rule ensuring all Hungarian citizen the general legal capacity set forth by Section 56 of the Constitution and contradicted with the protection of the institution of marriage and the family, which was declared by Section 15 of the Constitution. Concerning the argument of the discrimination the petitioner's reasoning was that this unconstitutional rule detrimentally discriminates on the basis of age in two aspects. First, according to this rule the availability of the free of charge national health service assisted reproduction depends not only on the biological capacity of males but on their age as well. Thus, this provision directly discriminates against sterile males on the basis of their age. Secondly, this provision indirectly discriminates against infertile women with husbands (partners) who are older than 60.

531. The Constitutional Court declared the segment of law unconstitutional and annulled it with a retrospective effect. The Court based its decision on the second argument of the petitioner, namely that the referred rule infringed the constitutional prohibition of discrimination, which was declared by Subsection 1 of Section 70/A of the Constitution. This provision set forth:

'The Republic of Hungary shall respect the human rights and civil rights of all persons in the country without discrimination on the basis of race, color, gender, language, religion, political or other opinion, national or social origins, financial situation, birth or on any other ground.'

The court supported its reasoning with the fourth argument of the petition, which refers to the constitutional protection of the institution of marriage and the family. The other arguments were not accepted by the Court. Pursuant to the resolution of the Court the Health Care Act, which contains the general rules of human reproduction treatments, entitles males over 60 years to use certain reproduction techniques, on condition that theese treatments are medically necessary for one or both members of the applying couple. Only the free of charge application of this health service for males over the age 60 was prohibited by the referred rule of the Procreation Decree.

532. In its reasoning the Court referred to an earlier decision (No. 750/B of 1990) in which the Court stated that 'The procedures concerning assisted reproduction, as a health service, can be conditional, provided that these conditions are in line with the basic principles of the Constitution.' Thus the use of assisted procreation techniques is not a basic right available for everyone without discrimination. While creating a rule that can result in discrimination, however, the lawmaker has to consider that these individuals affected by the law have equal human dignity. In this case the Court examined the latter, in line with the prohibition of discrimination on 'any other ground' provided by Subsection 1 of Section 70/A of the Constitution, whether the lawmaker considered the affected individuals as having equal human dignity, when it declared that males over the age of 60 were not entitled to use the free of charge assisted procreation treatments.

533. On the one hand the objected rule excludes sterile males over 60 years from exercising the right to use the free of charge treatments of assisted procreation. In this case according to the reasoning of the Court, infertility is not an illness that has to be cured, but a natural consequence of aging. Furthermore, from the point of view of the society it is exceptional to start a family at that age. The Constitutional Court stated, that the contested law did not discriminate neither the sterile men reached the age of 60 years nor the younger men with sterility problems.

534. On the other hand pursuant to the objected regulation sterile wives of males having completed their 60 year were not eligible for the free of charge health service concerning assisted procreation either. In that case, taking into considera-
IV. Donation and Deposit of Gametes

535. In the section of the Health Care Act where the deposition of gametes are mentioned the law applies a language that is alien to family law but much closer to property law.

536. Only human gametes and embryos can be used for fertilization and embryo implantation in MAP procedures. Gametes originating from corpses and from dead embryos cannot be used in MAP procedures.

1. Health Care Act, §166(2)

537. Gametes can be donated for MAP procedures and for medical research purposes. The purpose of donation, however, cannot be changed. Gametes can be used only for the purpose for which they were donated. No compensation can be requested or provided for for the donation of gametes. The necessary and certified costs and loss of income of the donor that occurred connected to the donation should be remunerated according to the conditions and the extent defined in the decree of the Minister of Welfare.

538. Gametes can be donated for the purposes of MAP procedures by competent persons who are less than 35 years old, and who conform to the conditions defined in a separate Act. Gametes can be offered and donated directly to health care providers and research institutes authorized to carry out MAP procedures. Persons, legal persons or organizations without legal personality that are not authorized to carry out MAP procedures and research cannot procure or receive human gametes donated to them or to someone else.

539. The donation is based on a written statement by the donor to the health care provider or the research institute. The written donation has to contain – in case of donation for the purpose of a MAP procedure – the name of the donor (first name, family name, maiden name), the maiden name of their mother, permanent address, date of birth, sex, race, and any illnesses known to the donor.

540. The health care provider receiving the donation carries out the medical examination of the donor who comes personally to the institution before the removal of the gametes for MAP procedures, and informs the donor verbally about the purpose and conditions of the donation. When visiting the institute, the donor has to certify the accuracy of the personal data provided.

541. The health care provider or the research institute authorized to receive donated gametes can refuse the offer without providing an explanation for the refusal. Donations made for the purposes of MAP procedures have to be refused if:

- the donor has an illness which excludes the possibility of donation;
- the donor refuses to provide the personal data prescribed by law and there is no other reliable way to obtain the relevant information;
- the donated material containing the gametes is not the one removed by the institute, provided for in the written donation, on the occasion of the donor visiting the institute.

542. During the data processing personal and special data can be provided for other health care providers authorized to carry out MAP procedures or for people eligible for MAP procedures within some legal limitations.

543. Research institutes can exclusively process from the data they obtained in connection to gamete donation those data which refer to the health condition and the illnesses of the donor. The right to data processing provides for the processing of legally processable data, which does not permit the personal identification to be revealed when forwarding and publicizing the purpose of medical research and in communication of results of the medical research.

544. The health care provider can only forward the gametes, which were donated for the purposes of MAP procedures, for procedures carried out on its premises or in other health care providers authorized to carry out MAP procedures or for the purpose of applying for a MAP procedure and to the extent necessary for the intervention within the limits set in paragraph Health Care Act.

545. Before making the donated gametes available, the health care provider that stores gametes has to ensure the gametes can be used in the respective MAP procedure, that there is no biological incompatibility. All the personal identification data necessary for the examination should be provided for the examiner.

546. The health care provider which stores the gametes cannot provide, forward or make public information about the provision of gametes or the data of the people involved in the utilization of the gametes.

547. Research institutes can provide gametes only for the purpose of medical research, exclusively for health care providers and research institutes authorized for receiving gametes.
548. The health care provider stores the donated and received gametes until they are used. The storing of gametes can be excluded, or limited in time on the basis of conditions defined in a separate Act in another law. The gametes which can only be stored for a limited period have to be destroyed after the end of their time limit.

549. Following a request based on medical reasons and supported by the opinion of a specialist or another justified claim, gametes can also be received from competent persons for the purpose of depositing them for later use by the donor (depositing gametes). Only the personally provided gametes of the donor can be accepted for storage.

550. The deposited gametes can be made available on the basis of a written instruction from the depositing person to the health care provider carrying out the MAP procedure. At the written request of the depositing person the gametes can be destroyed before the end of the depositing period.

551. It goes without saying that gametes from different donors or from the same donor but donated on different occasions as well as gametes donated for different purposes and gametes which are deposited should be stored separately to avoid a mix up.

552. Records should be kept about the stored gametes, their delivery, utilization and destruction. For the sake of the maintenance of evidence the storage units of the gametes have to be provided with identification codes suitable for personal identification. In the case of storage for research purposes, personal identification is not necessary.1


553. The professional rules and conditions of gamete donation and storage will be laid down in a decree of the Minister of Welfare.

V. Embryo Donation and Deposit

554. Decisions regarding in vitro embryos created in MAP procedures but not implanted are made together by the persons who created the embryo – irrespective of the changes that occurred in their marriage or the relationship of unmarried persons until the death of one of the parties. However each of the parties can renounce his/her right to decide over the embryo in a notarized document or a private document with full legal effect. In case of disagreement, the declaration of the party providing the egg is decisive.

555. The right to decide over the embryo includes the decision to deposit the embryo for eventual later use for own purposes (embryo deposit), offering it for MAP procedures carried out on other persons (embryo donation), or offering it for the purpose of medical research. Upon lack of adequate instructions – or lack of

556 - 561 information about the existence of such instructions – the deposit of the healthy embryo has to be assumed.

556. The donation of the embryo can be made by written statement of those who have the right to decide over the embryo. The written statement has to contain the purpose of the offer, and – in the case of embryo donation – the age, race and any hereditary illness known to the declaring party or of the known persons who created the embryo.1

1. Ibid. Art. 176(1).

557. The health care provider or research institute referred to in the written statement can refuse the offered embryo if it cannot utilize the embryo for the purpose declared within the allowed time span. However, it has to provide for the keeping and storage of the embryo until its utilization in accordance with paragraph (4). The offer of donation has to be refused if it is not certain that a healthy child will develop from the embryo.

558. The health care provider or research institute has to process the personal and special data received in connection with embryo donations and the offer of embryos for research purposes in accordance with the dispositions of this law referring to data processing in connection to donation of gametes, so that only the data enumerated in paragraph (1) of Health Care Act Art. 176(1) can be processed.

559. In the procedure of embryo donation, data processing through the association of data received legally by the health care provider in connection with donations of embryos and gametes and personal and special data which can be processed in any procedure, cannot be considered illegal.

VI. Research on Embryos, Examinations and Interventions that can be carried out on Embryos

560. Research on embryos can be carried out on the basis of an authorization of the Hungarian Reproduction Commission. The research proposal must be approved simultaneously at a health care provider or a research institute having the appropriate professional conditions. Embryos can only be used for research purposes and experiments can only be made on embryos for the research purposes that the Health Care Act sets with regard to medical research.1


561. Embryos cannot be created for research purposes, only embryos created in MAP procedures can be used for research and experiments, either on the basis of the decision of those entitled to decide or if the embryo is damaged.1

1. Ibid.
562. The embryo cannot be implanted in animal bodies and human and animal gametes cannot be fertilized with each other.\(^1\)

1. *Ibid. Art. 180(4).*

563. The embryo cannot be used for creating more embryos or with the exception set in the Health Care Act for the creation of beings having attributes different from the ones developed by the fertilization or for creating further attributes.\(^1\)

1. *Ibid. Art. 180(5).*

564. The embryo on which experiments were carried out cannot be implanted into the human body, and cannot be kept alive for more than 14 days – the period of storage not included – starting from the commencement of the experiment to its duration.\(^1\)

1. *Ibid. Art. 181(1).*

565. Procedures directed at influencing the sex of the child before birth can only be applied where there is recognition of a sex dependent hereditary illness, so as to prevent the development of such illness.\(^1\)

1. *Ibid. Art. 182(1).*

566. Genetic characteristics of the embryo can only be changed in the case of absolute necessity and to the extent that is necessary for preventing or treating the expected illness of the child yet to be born. For the unique purpose of establishing the probable illness of the child yet to be born or damage to the embryo, separation of the cells of the embryo is allowed.

567. Although Parliament in 1997 voted in favour of altruistic surrogacy, nevertheless the application of the laws on surrogacy were suspended until the year 2000. In 1999 the Parliament re-examined this issue and outlawed the provision on surrogacy. As a consequence it has become illegal since 2000.

VII. Surrogacy\(^1\)

568. Under the 1997 law *in vitro* embryos created from the gametes of spouses living in marriage or parties living outside marriage, can be implanted (surrogacy) in the uterus of another woman (surrogate mother) for the purpose of delivery in favour of the creating couple, if the woman providing the egg:
- is incapable for physical reasons of delivery, or
- where delivery of the child would endanger her life or bodily integrity, or
- where a high probability exists that no healthy child would be born from the embryo in case of implantation in her body.

1. Since the year of 2000 is not valid.

569. Under the 1997 law a surrogate mother had to be a close relative of one of the persons creating the embryo, who was competent, fit for the delivery of a healthy child, who at the moment of the implantation was already 25 years of age and not yet 40 years of age and had previous experience at giving birth.

570. If the woman delivering the child (surrogate mother) was in a marital relationship (or has a spouse outside marriage, i.e. a civil law husband), the general consent of her spouse is also needed for authorization.

VIII. Reduction of the Number of Embryos in Multiple Pregnancy

571. In case of multiple pregnancy, if it is medically probable that some of the embryos will show developmental disorders implying non-viability, or will be viable but with serious handicap, the pregnancy can be reduced, with intervention within the uterus, to the delivery only of the healthy embryos.\(^1\)

1. Art. 185(1) of the Health Care Act.

572. The number of embryos to be delivered in multiple pregnancy can also be reduced even when all embryos are healthy, if for the purpose of carrying a child to term, of delivering a healthy child or children, or the purpose of a safe delivery of the embryos, which does not endanger the life or physical condition of the mother.

573. In case of multiple pregnancy and severe disability of the embryos the number of embryos to be delivered can be reduced – based on the opinion of a genetic counselor – until the 20th week of the pregnancy or in the cases when the medical examination had been prolonged until the 24th week of the pregnancy.

574. Throughout the procedures of intra-uterus reduction the number of embryos according to the dispositions of Act LXXIX of 1992 on the protection of the foetus’s life are decisive for the problems not regulated in this law. The dispositions included in this law do not concern the possibility of reducing the number of embryos, according to the Mtv. 1992 Act on the basis of other conditions that can be taken into account as reasons for abortion.\(^1\)

1. Art. 185(4) of the Health Care Act.

IX. Human Reproduction Commission

575. The Human Reproduction Commission (herefore referred to as the Commission) functions as a counselling, executive and supervising body to the Minister of Welfare in the field of MAP procedures and medical research on human embryos.\(^1\)

1. Health Care Act, Art. 186(1).
576. The Commission performs the duties defined in this Act and in a separate law. The duties of the Commission, and the detailed rules of its functioning and composition are defined in a decree of the Minister of Welfare.

577. The tasks of the Commission include especially:

- preliminary provision of opinions on the authorization for functioning of health care providers authorized for carrying out MAP procedures and for storing gametes, permanent supervision of such institutions, if necessary provision of suggestions for the health care provider, or for the supporting and supervising medical authority to bring defined measures;
- authorizing medical research on embryos on the basis of the submitted research proposal;
- providing opinion on the Acts and professional rules connected to MAP procedures, suggestion for the framing or amendment of these;
- continuous evaluation of the domestic and international practice of MAP procedures, and of the observations of research on embryos.

578. Any member of the Commission can enter the premises of a supervised health care provider, examine documentation referring to individual interventions and request further information concerning the examined activities.¹

1. As a result of the parliamentary Act No. XXXIV of 2001 since 1 January 2002 this subsection is not enforced.

579. Certain members of the Commission are nominated by the Minister of Welfare, from doctors specialized in gynaecology and obstetrics, who have specialist knowledge and from persons with legal education. Other members are delegated by associations and scientific bodies carrying out of MAP procedures.

X. Sterilization

580. Sterilization preventing fertilization or procreative capacity can be carried out upon the advice of a specialist and at the written request of the woman or man for family planning reasons or for medical reasons.¹


581. Persons entitled to request sterilization are those who are competent or partially competent and who have turned 35 or have three children. In order that the request of a partially competent person be valid, the assent of his or her proxy and of the Authority of Guardians is needed.¹

1. Ibid. Art. 187(2)

582. Sterilization for family planning reasons can only be carried out on a Hungarian citizen, having domicile or residence in Hungary.

583. Sterilization can be carried out within three months of the submission of the request, except if because of Caesarean Section or any other operation makes earlier intervention justified. Before proceeding with the intervention the appointed doctor of the health care provider carrying out the intervention informs the requesting party — if married, or having spouse without marriage (i.e. a civil law husband) and the spouse — about other methods of contraception, about the character of the intervention, its possible risks and its consequences.¹

1. Ibid. Art. 187(5).

§3. LAW ON ABORTION

584. Since the 19th century, very few changes have occurred in the legal concept of the foetus in Hungary. The law still applies a condition of suspense until the birth.¹


585. When the Constitutional Court has faced the problems of abortion, it usually applies a form of balancing test between right to life and human dignity. 'In the Hungarian Republic everyone has an inherent right to life and human dignity from which no one shall be deprived.' (Constitution 54 § (1)). This general protection of the personality, in the interpretation of the Constitutional Court,¹ is a subsidiary provision when there is no concrete special provision for the given violation of personal autonomy.

1. 8/1990, (IV. 23), AB h. and also 64/1991(XII. 17) AB h. in Magyar Közlöny 139/1991 p. 2811.

586. The Constitution does not rank rights, nor does it specify the justification for limitations on these rights. Therefore, basic rights and obligations are ensured and imposed on ‘everyone’ (in case of the respect of right to life and human dignity on every person). Since the present national and international laws and conventions apply the notion of ‘human beings’, ‘persons’ and ‘everyone’, these words have become legal synonyms and ‘human being’ has become a legal normative conception.¹ Although the constitution does not provide a definition for persons, it is clearly defined in the Hungarian Civil Code. Under the Hungarian Civil Code (Art. 9) only individuals born alive are considered as persons under the law. Foetuses however, possess certain legal rights from the moment of conception.

587. Although the Hungarian Act on the Protection of the Foetus's Life represents generally a liberal approach towards abortion, there are still several articles where some more or less implicit guarantees serve the protection of the foetus's life.

I. The First Abortion Case

588. At the end of 1991 the Hungarian Constitutional Court issued a decision on Regulations 76/1988 (XI. 3) and 25/1988 (XII. 15) SZEM, which were based upon the Health Care Act (Act II of 1972) which deals with the termination of pregnancy.

589. In this case the Court did not examine nor resolve the substantive question of whether the regulations on abortion were unconstitutional. Instead, the Court found these laws unconstitutional for procedural reasons. The Court stated clearly that the mentioned regulations violated Section 8 (2) of the Constitution that requires that all basic human rights should be regulated by a Parliamentary Act. Instead of declaring the challenged regulations immediately unconstitutional, the Constitutional Court provided a period of one year for the parliament to pass new regulations. It should be mentioned here that the Hungarian Constitutional Court has extremely broad jurisdiction. Complaints are not limited to contesting the constitutionality of existing laws and administrative regulations, they even extend to allegations of negligence against the legislature for not having passed a law, if the absence of such a law creates an unconstitutional situation. If the Constitutional Court concludes that lawmakers should have passed such a law, parliament is given a limited period of time in which it has to pass the required legislation. That was the case with the abortion law since there was no regulation at the Parliamentary level (except the short clause in the Health Care Act).


A. The 1992 Law on Abortion


592. However, due to the political compromises and notwithstanding various restrictions, abortion remains largely available under the new Act. As the preamble clearly expresses, the Act is based on two different principles:
   1. The prenatal life enjoys respect and protection from the moment of conception, and abortion cannot be considered as a contraceptive method.¹

2. The Act recognizes the right to family planning as the right of the parents and it emphasizes that this right involves the duty to protect the foetus's life.²
   2. Ibid.

593. Articles 2–4 deals with several means of protecting the foetus, such as education on family planning, free medical care for pregnant mothers, and financial support for pregnant women. Articles 5–13 regulate the conditions and procedures for performing an abortion.

594. The Act regulates the availability of abortion through different time limits. An abortion may be performed up to the 12th week of pregnancy if:
   - there is a grievous threat to the mother's health;¹
   - the foetus has a grievous handicap or injury according to medical science;²
   - pregnancy is the result of crime;³ or
   - there is a grievous crisis in the mother's life
     2. Ibid. Art. 6(1)(b).
     3. Ibid. Art. 6(1)(c).

595. An abortion may be performed up to the 18th week of pregnancy if the pregnant woman is incompetent (the law makes distinctions between three categories of competence based on age and mental state) and if the pregnant woman did not recognize her pregnancy for a reason outside her competence, medical misdiagnosis or the failure of any health institute or other authority to act as required by the law.

596. Pregnancy may be terminated up to the 20th week of pregnancy or if a diagnostic procedure has been postponed, up to the 24th week if the probability of genetic or teratological damage/defect is more than 50 per cent.

597. Pregnancy may be terminated at any time
   - if there is a grievous medical threat to the mother's life, or
   - if the foetus has such a grievous malformation that the child physically cannot lead a normal life.

II. Procedural Requirements

598. If there is no medical reason for the termination of pregnancy, it may be performed upon the written request of the mother. The pregnant woman has to personally deliver her written request, together with the medical evidence of pregnancy to a staff member of the Family Protection Service (FPS).

599. Under Article 9(1) of the Act women with restricted capacity may request

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an abortion only with the consent of their guardian, natural or otherwise. For women who are not competent, only the guardian can request the abortion.

600. The member of the FPS preferably in the presence of the father of the foetus, will provide information to the pregnant woman about:¹
- the laws on the termination of pregnancy;
- possibilities of material and other support for maternity care provided by state and non-governmental organizations;
- institutions and organizations that may provide material and moral support for mothers;
- possibilities of adoption;
- methods of abortion;
- institutions where abortions are performed; and
- contraceptive methods with special consideration of the person.

1. Ibid. Art. 9(1).

601. After distributing the information, the FPS member will fill in the request form.

602. Within eight days the pregnant woman should go to the chosen health institute (one mutually agreed upon by the woman and the staff member). Should the woman fail to go within eight days, the request form required for the abortion is no longer valid. Abortions may not be performed until three days after the date the request form was filled out.¹

1. Ibid. Art. 10(1).

603. If the doctor of the health care institute recognizes that the request for the termination of pregnancy is not within the time-limit fixed by the law or that performing the abortion would threaten the pregnant woman's life, he may refuse to perform the abortion. The pregnant woman must then be informed about the possibility of requesting and obtaining a supervisory opinion.

604. By cancelling the specifically enumerated criteria for abortion (lone mother, no home, older than 35, having more than two children, etc.) of the previous law (16/1988 XII. 15. SZEM r.), and introducing a general category of 'grievous crisis', the Act has radically changed the conditions under which abortion may be obtained. Article 12 (6) of the Act defines a 'grievous crisis' as a state that causes either physical or mental crisis or social impossibility and, because of those reasons, threatens the foetus's life. The previous system of enumeration was subject to much criticism because it was discriminatory and provided easier access to abortion for the poor and young couples who had no accommodation. However by applying the definition of 'grievous crisis', the current Act presents other difficult questions. The definition of 'grievous crisis' itself is ambiguous since it is not clear whether it is intended to protect mainly women in crisis or the foetus's life.

III. Second Abortion Case

607. The Second Abortion Case was heard by male justices and based on petitions submitted mainly by pro-life male activists. There is no doubt that the definition of grievous crisis situation is a poor piece of legislative drafting, nevertheless there is no indication that introducing one subjective criteria in such an intimate decision such as reproduction, sexuality and child bearing would compromise the overall control over reproduction. The 1992 Act introduced the mandatory consultation and mandatory waiting period of three days after the decision to abort was made.

608. Although reference to demography was not an explicit concern in the 1998 abortion debate associated with the Baja Court case and the Second Abortion Case it still indicates that we have never resolved the legacy of the past when women were in a controversial situation being blamed for the decreasing population in Hungary on the one hand and being encouraged to 'solve' socio-economic problems of their family discretely on the other. The abortion debate is a dominant topic in the Hungarian medico-legal literature.¹ This topic occupies almost one third of the recently published articles on medical law.

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609. In November 1998 the Hungarian Constitutional Court wanted to issue a cool-minded, strictly constitutional response to pro-life petitions that demanded more protection for the foetus by challenging the subjective grievous crisis as a ground for the abortion request. The Court could not resist dealing with the petitions, however, it did not dare to reveal its sentiment towards the restrictions either. As a consequence it stopped half-way by giving just a gesture to the pro-life approach. Judges, we know that too well since the Baja case, do not have too much sense on symbolic gestures, expressing vague sympathies may be harmful when individuals’ rights are at stake. The half-way, compromised change initiated by the Court therefore created uncertainty around abortion laws. That was eliminated by a Parliamentary Act at the end of 1999.

A. Amendment of the 1992 Law

610. The Parliamentary Act No. LXXXVIII of 2000 amended the 1992 Parliamentary Act. Women may still request the termination of pregnancy up to the end of the 12th week if they confirm that they are in a grievous crisis. However, the mandatory consultation process has been significantly changed.

611. Since the new Parliamentary Act has introduced mandatory consultation in two phases the fee for abortion has also been raised. Currently it is 20,433 HUF (roughly a half of the minimum wage in Hungary). Though the number of abortions has decreased, nevertheless the figure is relatively high 56,000 per year. The contra-

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612. Late term abortions, performed in response to a growing number of medical and genetic indications, are not raising public attention, yet. Early stage abortions, and the ground of ‘grievous crisis’ continue to dominate public attention, even though foetuses’ lives are being terminated at more advanced stages of pregnancy, when the risks to women’s health are necessarily greater.

613. Despite the on-going abortion debates no attention has been given to the medically ‘indicated’ late-term abortions; 1 reproductive health of women, medical abortion (such as mifepristone, RU 486), psychological support after abortion, woman’s health etc. Some arguments were consistently missing from the legal debate, as well. Reference to equal treatment and the prohibition of discrimination on the grounds of sex and pregnancy e.g. were almost entirely absent from the debate. 2 Dignity as an evident legal category in the Hungarian constitutionalism has never gained a special meaning in terms of guarantees for women’s dignity.

1. If severe fetal disease manifests in a later stage of the pregnancy

614. Women’s dignity is not yet interpreted in the context of reproductive rights. Promotion of right to life is undoubtedly an important state interest which, in case of pregnancy, should always be ‘external’, help for women to improve their circumstances, conditions by creating a more favourable social, medical environment for child birth. In other words protection should be supportive and not coercive.

615. One can easily notice that the abortion debate in Hungary serves also as a substitution for discussion of many unsolved problems derived from the disrupted emancipation process after the transition. Since other topics are still regarded as taboo, abortion seems to channel other hidden concerns, such as problems of dealing with unemployment, status of the social welfare rights, reproduction and women’s reproductive health, sexuality of minors, mutual family planning etc.

616. There was no public debate about the effects on women’s health of considering abortion as a family planning method and offering only surgical methods until very recently. Information about the technique of abortion was given to women only since 1992 but this consultation offers information just a couple days before the abortion. It is very unlikely that women being in any form of crisis, that led them to request termination of pregnancy will be able to absorb information in that difficult moment. The Constitutional Court built concerns for life protection by strengthening the grievous crisis. However, if abortion is accessible but the applicant has to prove something which usually cannot be ‘proven’ then it leads to the situation of mercy and discretion.

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617. Discussion of reproductive rights has had little impact, so far at least, on the legal debates about abortion and infertility treatment in Hungary. Unlike the right to life, which has a well-established history of interpretation here, women's specific privacy rights have still not gained general legal recognition.

618. Women's views, experience and concern to humanize health care, though articulated only sporadically so far, in the future would deserve more influence in health policy and in the practice of the hospitals and in respect to home birth women's movement was already very effective.

§4. Tissue and Organ Transplantation

619. Under the Health Care Act tissue is defined as any part of the human body, except the sperm, and ovum, the embryo and the foetus, blood and blood components. Under the law an organ is defined as a part of the human body which forms an integrated tissue entity with a certain structure, and which - if dissected in its whole - cannot be regenerated by the human organism. Organ and tissue transplantation is understood as the removal of organs or tissue from the human body and its implantation into the body of another living person. Brain death is understood as the complete and irreversible termination of brain (including brain stem) functions; while death is regarded as the moment when the irreversible decomposition of the human organism commences, due to the complete termination of breathing, blood circulation and brain functioning.

620. In transplantation policy priority is given to the use of the body of a deceased person by removing an organ or tissue part from it for purposes of transplantation. Under Hungarian law it is prohibited to advertise human organs or tissue parts for any purpose of use. Organs or tissues removed from the body of living or deceased persons shall be stored in an organ and tissue bank. If it is possible to conserve them and use them for purposes of transplantation. Removed organs or tissue parts may be stored and transplanted exclusively in medical institutions that have a special license for these operations issued by the Minister of Health. The Minister of Health issued a decree to provide detailed regulations for the storage and transplantation of organs and tissue parts.

1. 1998. (XIII. 27) EúM rendelet az egészségügyről szóló 1997. évi CLIV. törvénynek a szerv- és szövetátvitelére, valamint-tárolásra és egyes képződési vizsgálatokra vonatkozó rendelkezései végrehajtásáról. (In English: Ministry Decree on organ and tissue transplantation, on autopsy, and on storage of organs and tissues.)

621. As a general rule any organ or tissue removed from the body of a living person shall be subjected to pathological [organ and tissue] sampling. However, pathological [organ and tissue] sampling is not necessary:
- if the purpose of [organ or tissue] removal is transplantation into the body of another person;
- if the purpose of removal is to conduct a special diagnostic examination;
- in cases of organs and tissues determined by the decree of the Minister of Health.

1. Health Care Act Art. 204(1).

622. For the purpose of transplantation, only the following organs or tissue parts may be removed:
- one half of a paired organ, if its removal does not cause severe and permanent deficiency;
- the segment of an organ, if after its removal, the organ does not suffer significant functional loss; or
- a tissue part that regenerates itself.

1. Health Care Act Art. 205(1).

623. Only legally competent persons may donate organs or tissue parts. In exceptional cases when the recipient is related to the donor, bone marrow, haemopoietic parent cell, or any self-regenerating tissue part may be donated. In these cases the consent of the legal representative of the minor becomes valid with the approval of the ethics committee of the hospital.


624. A person with restricted legal capacity may make this donation only if the donor is related to the recipient as,
- direct descendant;
- a sibling of a direct descendant;
- a sibling;
- a direct descendant of the recipient's sibling.


625. A minor may be a donor if, before making a decision, the ethics committee of the hospital interviews the minor, and finds assurances that he/she will undergo the process free of constraint, threat or deceit.

626. The donation of organs and tissue parts must be made without any monetary compensation. The donor has the right to claim reimbursement of his/her costs, such as lost income as a result of the donation and any costs that are related to making the donation statement or travelling expenses that are not covered according to the contract with the health care system. These costs are paid by the state.

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627. Before transplanting an organ or tissue part, the medical doctor who performs the transplantation must ensure that the conditions of the donor are favourable for removing the organ or tissue part, the transplantation is not contraindicated, it is justified for the recipient, the conditions of the recipient are favourable for the implantation, and the organ is suitable for transplantation.

628. Before transplanting an organ or tissue part, the donor must be informed in detail, verbally and in writing about all significant factors related to the intervention/operation, with a special attention to the long and short term consequences of the removal and lack of the organ or tissue part, and to the rule that in case of the death of the donor, he or she will be subject to a mandatory autopsy. The donor shall be informed by a doctor who is not directly involved in the transplantation.

629. In the case of donating an organ, the donor’s consent must be recorded in an official document. Beyond the general conditions of the consent, the official document must include the donor’s statement that the donation is made free of constraint, threat or deceit, without monetary compensation, and that the donor accepts that his/her body undergoes autopsy after his or her death.

630. In the case of donating tissue, the donor’s consent must be recorded in a private document with full power of evidence.

631. The donor may withdraw his or her decision, without any formally binding regulation, before the organ or tissue part is removed. Even in case of valid agreement on the donor’s part, the physician cannot continue the intervention involving the removal of an organ or tissue part, if new circumstances arise, which threaten the life of the donor or may lead to health impairment.1

1. Ibid. Art. 209(1).

632. The recipient must be informed about all significant circumstances concerning the intervention, with special attention paid to:
- the consequences on the health condition of the donor resulting from the donation of an organ;
- the fact that the recipient is subject to autopsy in case of his or her death; and
- the origin of the organ or tissue to be transplanted into his or her body.

The agreement of the recipient participating in the transplantation must be put in written form.

633. If the donor’s health or physical fitness is impaired – beyond the foreseeable impairment that directly follows from the removal of the organ or tissue part – the donor becomes disabled or dies, and the physician and health worker conducting the intervention cannot be made liable, then the state indemnifies the donor and his or her relatives for all damages that are not covered on the basis of the legal relations with the social security system.

II. Removal of Organs and Tissue Parts from a Deceased Person

634. It is possible to remove an organ or tissue part from a corpse/deceased person unless the deceased person made a statement prohibiting against this during his or her life.1 The legally competent person may make a prohibiting statement in written form (in an official document or private document with full power of evidence) or – in case the person is unable to make a written statement or only with significant difficulty – in oral form to the physician responsible for his or her treatment.2 A person with restricted legal competence may make a prohibiting statement without the active contribution of his or her legal representative. A person without legal competence may make a prohibiting statement through his or her legal representative, (the representative may make the statement instead of the person without legal competence).

1. Opting-out model.
2. Health Care Act Art. 211(1).

635. The physician responsible for the patient’s treatment is obliged to ascertain, within the time available for the removal of the organ or tissue part, whether the deceased person has left behind a prohibiting statement. If the written statement cannot be found within the available time for the removal, or such statement is not given to the physician, it shall be presumed that the statement does not exist.

636. If the deceased person is a minor, and the statement prohibiting organ or tissue removal cannot be found, the process can only be initiated after the legal representative submits a written statement of approval.

637. The removal of the organ or tissue part may begin only after a three-member committee of physicians (here after: the committee) pronounces brain death, forming their unanimous opinion independent of each other, and according to the procedure set forth by the decree of the Minister of Health. The members of the committee are assigned to this task by the director of the health institute, and they must be physicians with sufficient experience who have completed the necessary training to fulfil this task. The physician, who participates in the work of removing or transplanting an organ or tissue part or in the medical treatment of the recipient, may not be a member of this committee.

638. The committee records in an official report the results of clinical and technical tests and the probable cause of death. After brain death is pronounced, mechanical respiration or the artificial maintenance of any other organic bodily functions is justified only if it is in the interest of maintaining the functionality of the organs or tissue parts intended to be used in transplantation.

639. The organs and tissue parts that are removed from the deceased person but not used in transplantation are subject to pathological examination.

640. Unless it is regulated differently by law organs and tissue parts may be
removed from the bodies of crime victims, but only if the authorities of investigation have given written consent in advance. In this case, only abnormalities occurring during the intervention must be documented in detail.

III. Implantation of Organs and Tissues

641. The patients for whom transplantation of an organ or tissue is medically justified, shall be included on a national waiting list determined by the types of organs or tissue parts. The inclusion of the patients on these lists shall be initiated by the health institute that indicates the necessity of organ or tissue transplantation. The patient shall be informed about all significant circumstances concerning his/her inclusion on the waiting list. The selection of recipients from the waiting lists shall be made exclusively according to professional rules. The health authority shall conduct the professional supervision of the process of putting patients on the waiting list, selecting them from it, and eventually investigating any patient’s complaint.

IV. Xenotransplants

642. Though xenotransplants were already performed in the 1960s in the United States,¹ I have not found any data about similar experiments in Hungary. Some European countries have voluntary moratorium on xenotransplants. It follows from the Hungarian legal definition on organ and tissue transplants that it relates exclusively to the use of human organs and tissues.

1. In 1963–1964 six patients received kidneys from chimpanzees and a further six from baboons.

Part III. The Physician in Relation to the Health Care System

Chapter 1. Collegial Relationships

§1. HUNGARIAN MEDICAL CHAMBER¹

643. The development of the Law on Chambers passed in 1994 was preceded by lengthy debates. According to the law the Hungarian Medical Chamber is to act as a self-regulating body of the professional practitioners of medicine. This professional body was established to enable the society of physicians to take care of its own affairs, both directly and, through its elected representatives, indirectly and independently. This chamber covers physicians’ professional, ethical, economic, and social interests, and enables them to participate in the transformation of medical policies and the improvement of health care, to an extent justified by physicians’ social and intellectual power. The Hungarian Medical Chamber (HMC) is the public interest group of self-governing physicians and dentists (physicians).

1. Parliamentary Act No. XXVIII of 1994 on the Hungarian Medical Chamber.

644. The HMC’s most important tasks are the following:

- to represent physicians in issues related to professional practice and medical activities,
- to protect physicians’ authority, the interests of their organizations and members, to protect physician’s rights and – within separately legally defined limits – to ensure the realization of these rights in individual cases;
- to develop its Basic Operating Rules;
- to establish regulations on professional behaviour, medical ethical standards, and ethical statutes, and to pursue ethical cases against individual physicians as determined by these regulations;
- to operate professional physicians residencies;
- to take part in the development of general terms in contracts between medical practitioners and health insurance entities; to ensure the recognition of medical degrees garnered in foreign higher-education institutions, or to make determinations on requests to be allowed to carry out medical work without the post-valuation of such degrees;
- to offer opinions in issues directly influencing the professional practice of medicine, or its material support, and in the establishment of all regulations
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affecting medical affairs, as well as professional competence;
- to make suggestions as to the minimum charges established for the carrying out of certain medical procedures, or services;
- to maintain a list of members, and a list of practising physicians;
- to establish the mandatory further education of members,
- to establish uniform principles and programmes, and to regularly check on the fulfillment of requirements and further training programmes based upon the opinion of professional residencies;
- to carry out conciliatory procedures at the behest of those involved in debated issues of medical practice.  

1. In 1997 the Constitutional Court invalidated some elements of the parliamentary Act of the Hungarian Medical Chamber (Decision No. 91/1997, (VII. 1) AB). The Court argued that rights and licences of the Hungarian Chamber have to be based on the parliamentary Act.

645. National administrative organizations within the Hungarian Medical Chamber are: The Board of Ethics, The Board of Oversight, The Ethical House, and other boards as established in the statutes.

646. Anyone can be a member of the HMC who is a resident in Hungary, has acquired a medical or dental degree from a Hungarian University, or who has a post-validated medical degree from a foreign university, or whose professional qualifications are generally acknowledged, is included in the national list of physicians or – following its establishment – in the proper registry, has performed, is performing or wishes to perform work related to a medical degree within the territory of Hungary, can carry out chamber duties as established in the organization’s statutes. Members should acknowledge and accept the compulsory nature of the organization’s statutes.

647. Those wishing to carry out related medical activity may only do so if, in addition to other conditions established by law they are a member of the HMC, however those who have a post-validated medical degree awarded by a foreign institution, gained recognition of professional qualifications, or garnered a degree awarded by a Hungarian university in the framework of education in a foreign language, must successfully pass a professional Hungarian language exam.

§2. Professional Colleges

648. Professional standards are monitored and developed by the Professional Colleges.

1. 52/199, (XL. 12), EiM rendelet az orvosi szakmai kollegiumokról.

649. There are 38 professional colleges operating in the field of anaesthesiology, internal medicine, dermatology and sexually transmitted diseases, neonatal and paediatric care occupational health dentistry stomatology, oto-rhino-laryngology, gastroenterology, geriatrics, paediatric surgery, family doctors, neurology, infectology, cardiology, clinical immunology and allergiology, preventive medicine, nuclear medicine, medical laboratory, microbiology, orthopaedics, forensic medicine otorhinology, pulmonology, psychiatry, radiology, rehabilitation, rheumatology and physiotherapy, surgery, sport medicine, radio-therapy and oncology, ophthalmology, obstetrics and gynaecology, transfusiology, traumatology, pulmonology, and urology.

650. Members of the professional colleges are nominated by the Hungarian Medical Chamber, scientific councils operating on the particular domain of medical profession and medical schools. Only those doctors that have a professional license and have an outstanding professional activity for at least 10 years can be nominated.
Chapter 2. Relationship with other Health Care Providers

§1. PHARMACISTS

651. Pharmacists must complete a university degree. Pharmaceutical studies comprise ten semesters, or a minimum of 4,800 hours. There are currently 2,080 pharmacies in Hungary. A new system of state pharmaceutical subsidy became effective in November 1999. Pharmacies are reimbursed by the state only for the actual sale of the medication.

652. Under the Parliamentary Act No. LI of 1994 the Hungarian Chamber of Pharmacology is the professional, autonomous, self-governing body of pharmacists and their groups. Through the elected delegates of this body, the society of pharmacists is able to represent their professional and economic interests in front of legal and political authorities. The Chamber may represent the case of individual pharmacists even by providing legal service to them. The Chamber is organized according to the territorial principle and it has branches in Budapest as well as in county seats.


§2. INSTITUTE OF NATIONAL PUBLIC HEALTH AND MEDICAL OFFICER SERVICE

653. The National Public Health and Medical Office is a state agency. It has been established by the Parliamentary Act No. XI of 1991. This Service formulates public health programmes and monitors their implementation. It also evaluates the statistical figures on public health, one of its most well known tasks is perhaps the measures which can be taken in the case of infectious diseases.

1. Hungarian Acronym is: ANTSZ.

§3. THE CENTRE FOR HEALTH CARE INFORMATION OF THE MINISTRY OF HEALTH


§4. INSTITUTE FOR BASIC AND CONTINUING EDUCATION (ETI)

655. This Institute has an important role in the field of education and development. By developing numerous requirements for extension courses and by design-
Chapter 3. Relationship with Health Care Institutions

658. The de-centralization of health care is well illustrated by looking at the number of beds run by national institutes. In 1980 there were about 10,000 beds at national institutes this number dropped to 6,105 in 2000. Churches can claim back their nationalized properties and as a result of this there are about 1,600 beds operated by them.1


659. The Hungarian Medical Chamber, the Professional Colleges, the Hungarian Hospital Association and the National Institutes all play an important role in representing the interests of the medical profession and also in co-ordinating the professional standards.

660. The Hungarian Hospital Association was established in 1931. It is an independent voluntary self-governing organization. Its main task is to represent the interest of the Hungarian in-patients institutions and hospitals.

Chapter 4. Health Insurance

661. Insurance reform after the political transition started with the separation of the single Social Insurance Fund into two different funds; The Pension Fund and the Health Insurance Fund. In 1992 this made it possible to establish a relative independence of the Funds and some financial control over health care expenditure. The next step was to reform the primary care system. The general practitioners (közcél orvosok), who had simply referred patients to the level of specialized outpatient care in the previous health care system, like some 'postmen', now became the gatekeepers of the new system, in which they are supposed to act as primary care physicians and to start performing medical services themselves.


662. The basic rules of health insurance are incorporated in Parliamentary Act No. LXXX of 1997. The general principles of social insurance is the principle of solidarity as is stated in Article I of this Act.

1. And also in 195/1997 (XI. 5) Government Decree.

663. The social security pay-roll tax is currently 29 per cent, which includes 18 per cent retirement insurance and 11 per cent health insurance. In addition, each employer pays a fixed amount of health insurance contribution, which amounted to 4,500 HUF in 2001. Since 2001, emergency service when abroad is covered by health insurance.

664. The specific services performed under the coverage of compulsory health insurance are listed in the Parliamentary Act LXXXIII of 1997 on the health care based on the compulsory health insurance.

665. Although a significant proportion of the population pays for dental care in cash and out of their pocket as an addition to their health contribution, since 2001 a part of dental care, the preservation of tooth is free of charge, irrespective of the age of the insured citizen.

666. Primary care is accessible for all insured patients and that includes prevention, consultation, and health care. Outpatient care is also covered by the compulsory health insurance. Without a special medical referral a patient can turn directly to the dermatologists, gynaecologists, general surgeon, traumatologist, oncologist, psychiatrist, pulmonologist and urologist specialist doctor.

667. In-patient care is free of charge for the insured patient if there is a medical indication for the necessary treatment. Outpatient care is also covered by the com-
Chapter 5. Conclusions

670. Most probably this is the first comprehensive introduction to the Hungarian health and medical law in the English language. In order to provide accurate information I have tried to provide a general overview of the current legal norms. However, Hungarian legal terminology is rather different from English legal terminology, and therefore I often hesitated on how far I should provide an English equivalent for a term that may not have exactly the same meaning. At the time of completion there was no usable and available translation for Hungarian health care laws so I had to, for example, provide a meaningful translation for the biomedical legal norms and also provide explanations and analysis of those norms.

671. As I emphasized previously, 1997 was a historic demarcation line between the old paternalistic legal norms, which often appeared only at the lower levels of regulation and the new forms of legislation that incorporated patients’ rights at a higher level of legal norms, such as the Parliamentary Act. Although the 1997 health law reform grew almost spontaneously and without an adequate policy assessment, it nevertheless provided a new legal scheme. Hundreds of new institutions have since been introduced, and many health care services were regulated for the first time. Not surprisingly this legal reform provoked a great deal of debate.

672. The controlling mechanism of the patients’ rights representatives, and the requirement to provide detailed information for the patients required a new legal environment.

673. One challenge in the coming years is to introduce a system which monitors medico-legal norms and provides a routine procedure for ascertaining the impact of these norms. However, besides creating favourable legal conditions it is also important to improve working conditions in heath care. Some old problems also remain unsolved, such as providing tips for doctors and health care personnel. The salaries of the health care staff are still much lower than in the countries of the European Union.

674. At the end of the monograph I would like to refer to some areas where further elaboration is needed in the near future.

675. Hungary does not yet have a law on human genetics, no legal norms on accessibility of genetic testing and screening. It would also be desirable to draft a law on tissue and organ data banks, and on stem cell research. In Hungary the 1997 Health Care Act recovered a loss of several decades in the field of health care legislation, but due to its framework character could not make detailed rules. It is also true that the five years that have passed since the promulgation of the law represent a very long period in the dynamic progress of biomedicine.
676. At the time of concluding the manuscript two important events occurred in Hungarian medical law. One is that by Parliamentary Act No. VI, of 2002 Hungary has ratified the Convention for the Protection of Human Rights and Dignity of the Human Being with regard to the Application of Biology and Medicine (Convention on Human Rights and Biomedicine).

677. There are numerous legislative plans. Within the framework of the National Council for Health and Science (ETT) a committee has been established with the tasks of drafting guidelines on genetic data, genetic data banks and tissue banks.¹

1. The committee is chaired by György Kosztolányi and the author of this book is a member of the committee.

678. A new Government has been elected and a socialist Minister for Health was nominated.¹ The other important event is the forthcoming referendum on our membership within the European Union. During the next three years the new government is planning to improve the circumstances of the health care workers and introduce health care reform. Constitutional Amendment is under preparation in order to facilitate accession to European Union.²

1. The new name of the Ministry is Ministry for Health, Welfare and Family Affairs.
2. The research on Hungarian medical law was supported by a research fellowship of the Center for Policy Studies of the Central European University.

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