EXTENDING THE SCOPE OF INVASIVE MEDICAL INTERVENTIONS UNDER HUNGARIAN LAW: CONDITIONS AND JUDICIAL PRACTICE

Judit ZÁKÁNY[*]

ABSTRACT: *Extending the scope of an invasive medical intervention raises a fundamental question about the limits of the patient's right to self-determination. Under Hungarian law, medical interventions are, as a rule, subject to the patient's informed consent. The Health Care Act nevertheless permits, in exceptional circumstances, an intervention already under way to be extended without the patient's separate and contemporaneous consent.*
This study examines the statutory conditions under which such an extension may be permissible and how those conditions are interpreted in Hungarian judicial practice. The article argues that such an extension cannot be understood as a general form of medical discretion or as a broad authorisation to depart from the patient's original consent. Professional necessity, medical expediency, or the technical connection between interventions is not, in itself, sufficient to justify an extension. Rather, the statutory framework recognises a narrowly circumscribed competence to intervene in exceptional situations. On the basis of the relevant case law, the study shows that the permissibility of such extensions is necessarily case-specific and depends on the statutory conditions, the patient's situation, and the consequences of refraining from the additional intervention.

KEYWORDS: *right to self-determination; informed consent; invasive medical intervention; extension of the scope of an intervention; patients' rights; urgent need; disproportionately heavy burden; Hungarian health law; judicial practice*
JEL CODE: *K15*

DOI: **10.62838/cjjc-2024-0080**

1. INTRODUCTION

In Hungary, Act CLIV of 1997 on Health Care (hereinafter: the "Health Care Act") expressly recognises nine distinct patients' rights. Among these, the right to self-determination occupies a central position in the evolution of the doctor–patient relationship from a traditionally hierarchical model towards one based on partnership and cooperation.

[*] PhD, Dr. Senior Lecturer, University of Debrecen, Faculty of Law, Civil Law Department and Part-time Lecturer, University of Debrecen, Faculty of Health Sciences, HUNGARY.

Together with the right to information, this right plays a crucial role in ensuring that the patient is not merely a vulnerable and uninformed recipient of medical care, dependent on decisions made by others. Rather, the patient becomes an autonomous and informed participant who, on the basis of adequate information, is able to make decisions regarding their treatment in accordance with their own interests, preferences, and values. (Zsonda-Fézer, 2016, p. 77.)

The essence of the right to self-determination is reflected in the general principle that any medical intervention requires the patient's consent, given voluntarily, free from coercion, deception, or intimidation, following adequate disclosure of information and in compliance with the formal requirements prescribed for the intervention concerned. (Őri-Feith, 2023, pp. 299-300.) In the context of invasive interventions, however, unforeseen circumstances may arise that necessitate additional medical measures. In such situations, the patient may be unable to express their will at the relevant time, while failure to carry out immediate medical intervention could lead to serious harm to their health or even death.

In exceptional circumstances, the legislature permits the scope of an invasive intervention that has already commenced to be extended without the patient's separate and contemporaneous consent. While the right to self-determination constitutes a fundamental principle governing medical interventions, it is not unlimited. Its restriction, however, cannot be understood as conferring a general freedom of medical discretion. The regulatory framework establishes a narrowly defined decision-making situation, subject to specific conditions, in which consent, professional necessity, and temporal urgency must be balanced in a particular way.

This study examines the legal framework governing the extension of the scope of invasive interventions and, in this context, explores the limits of the right to self-determination. It does so on three interrelated levels: first, by defining the concept of an invasive intervention; second, by examining the statutory conditions governing the extension of its scope; and third, by analysing the questions and boundaries emerging in judicial practice.

2. DEFINING INVASIVE INTERVENTIONS

The definition of an invasive intervention is set out in the Health Care Act. Under this definition, an invasive intervention is a physical intervention that penetrates the patient's body through the skin, a mucous membrane, or a body orifice, excluding interventions that, from a professional point of view, pose only a negligible risk to the patient.[1]

The classification of an intervention as invasive also determines the form in which the patient's consent must be given. In the case of such interventions, formal requirements must also be taken into account. This is not the general rule: as a matter of principle, valid consent may be given orally, or even by conduct implying consent. In the case of invasive interventions, however, consent is valid only if given in writing. (Sáriné Simkó, 2019, p. 11.) In uncertain cases, it may therefore be advisable to request a written declaration of consent. No legal difficulty arises where consent is obtained in writing, even if written

[1] Health Care Act 3. § m).

consent was not strictly required. The converse situation, however, may lead to a finding of liability in the event of a legal dispute.

Despite the statutory definition, legal disputes often arise even at the threshold stage of determining whether a given intervention qualifies as invasive. It is therefore for the courts to interpret the concept and give it substantive content. The following paragraphs present several cases that illustrate this judicial interpretation.

The first issue to be addressed is the interpretation of the limiting criterion contained in the definition, by which the legislature excludes from the category of invasive interventions those that, from a professional point of view, pose only a negligible risk to the patient.

Blood sampling is an example of this. Although it involves a physical intervention that penetrates the patient's body through the skin, it poses only a negligible risk. Since it does not fall within the conceptual scope of invasive interventions, written consent is not required. At the same time, healthcare institutions must also take into account the possibility of loss of consciousness during blood sampling, which may result in serious injury. Accordingly, if the procedure is performed using a special chair designed for that purpose, in such a way that the patient does not suffer any additional harm in the event of loss of consciousness, the institution will generally be regarded as having met the standard of care generally expected under the given circumstances.[2]

The classification of urinary catheterisation has also raised questions. In that case, the court likewise held that, since the procedure posed only a negligible risk to the patient, it did not qualify as an invasive intervention. Written consent was therefore not required; consent could be given orally or by conduct implying consent, including the patient's cooperation with the procedure.[3]

Another common procedure whose invasive character has been examined is tooth extraction. The patient attended a dental clinic to have their dental prostheses replaced. Within a short period of time, ten of their teeth were extracted and a new prosthesis was made. Prior to the treatment, no written declaration of consent was obtained. The patient disputed whether the treatment had been carried out in accordance with professional standards, particularly the necessity of the tooth extractions. In that case, the court held that tooth extraction qualifies as an invasive intervention. Accordingly, the patient must give their consent in writing, in compliance with the formal requirements applicable to such interventions.[4]

Another illustrative case concerned the classification of nasal endoscopy as invasive or non-invasive. The patient underwent otolaryngological examinations, during which nasal endoscopy was also performed. They later complained that, according to their account, the examination had been carried out without adequate information and consent, and attributed certain health complaints to it. The court found that nasal endoscopy is a diagnostic, non-invasive intervention and, as such, did not require written consent. On the basis of the evidence, it was also considered probable that the patient had received adequate information and had consented to the examination.[5] By contrast, the court held that

[2] Szeged Regional Court of AppealPf. 20.283/2019/6.
[3] Curia Pfv.20326/2020/12.
[4] Budapest Environs Regional Court P. 20.376/2018/38. and Budapest-Capital Regional Court of Appeal Pf. 20.281/2020/8.
[5] Curia Pfv. 20.867/2022/18.

gastroscopy and cystoscopy, both performed through a body orifice, qualify as invasive interventions. (Hídvéginé-Sáriné, 2012, p. 60.)

The case law also includes examples in which the court had to determine whether certain aesthetic procedures, such as hyaluronic acid filler treatment and thread lifting, qualified as invasive healthcare interventions. A company had been carrying out aesthetic procedures without authorisation to operate as a healthcare provider. Proceedings were initiated against it following a complaint after an unsuccessful filler treatment in the eye area, and an official inspection subsequently found that the company was performing invasive treatments. The company sought judicial review of the administrative decision. The court accepted the authority's position that these activities constituted invasive healthcare services and therefore required authorisation to operate as a healthcare provider. Accordingly, the fine imposed by the authority and the prohibition on carrying out the activity were lawful.[6]

3. THE STATUTORY FRAMEWORK GOVERNING THE EXTENSION OF THE SCOPE OF INVASIVE INTERVENTIONS

In relation to invasive interventions, the right to self-determination may be limited in two respects. First, where specific conditions are met, the patient's consent may not be required at all for the performance of an invasive intervention; in such cases, consent is presumed. One of these conditions is that the patient is not in a state that would enable them to give the consent required for the intervention. (Lomnici, 2007, p. 183.) In such cases, as a general rule, the substitute decision-maker designated by the patient must be contacted. In the absence of such a person, and where an invasive intervention is concerned, contact must be sought with a statutory substitute decision-maker from among the persons specified by law. The second conjunctive condition is that obtaining the declaration of the designated or statutory substitute decision-maker would cause delay. Efforts must be made to contact the person entitled to make the declaration, and the presumption of consent may be relied on only if those efforts are unsuccessful. (Kőszegfalvi, 2001, p. 58.) The third condition for performing an invasive intervention without consent is that the delay involved in obtaining the declaration of the substitute decision-maker would result in serious or permanent harm to the patient's health.[7]

The other category, which lies at the centre of this study, concerns the extension of the scope of an invasive intervention. This refers to situations in which circumstances arising during the course of the intervention indicate that its scope should be extended beyond what had originally been planned. In other words, it becomes necessary to perform an additional intervention that was not foreseeable in advance and therefore did not fall within the scope of the patient's original consent. As a general rule, such an intervention may not be performed without seeking the patient's consent. In practice, this may be extremely difficult where the patient is unable to make a declaration, for example because they are under anaesthesia. Requiring consent in such circumstances would also impose a significant additional burden on the patient. (Ungváry, 2024, p. 9.)

[6] Budapest Environs Regional Court K. 700.191/2023/11.
[7] Health Care Act 17. § (1) b)

In two exceptional cases, however, the extension of the scope of the invasive intervention and the performance of the further necessary intervention without consent are permitted. The first is the case of urgent need, which refers to a change in the patient's state of health whereby, in the absence of immediate healthcare, the patient's life would be directly threatened, or they would suffer serious or permanent impairment of health.[8] The second statutory ground is considerably less clear. The Act defines it as a situation in which failure to perform the intervention would impose a disproportionately heavy burden on the patient. The situation is even more specific where the extension would lead to the loss of an organ or body part of the patient, or to the complete loss of its function. Such an extension may be justified only by the disproportionately heavy burden referred to above, or by the existence of a direct threat to life.

In some cases, the difficulties associated with extending the scope of an invasive intervention may be addressed in advance. The physician may inform the patient before the intervention of the ways in which the intervention may most commonly need to be extended, provide adequate information on these possibilities, and seek the patient's prior consent. In this way, the situation described above may be avoided. This, however, cannot amount to a general declaration authorising the extension of the intervention, since in that case the patient would not have received adequate information regarding the specific possibilities. Nor can it provide a solution for unexpected and rare situations. (Kőszegfalvi, 2001, p. 60.)

4. THE EXTENSION OF THE SCOPE OF INVASIVE INTERVENTIONS IN JUDICIAL PRACTICE

An examination of judicial practice is of particular importance, since court decisions give concrete content to statutory conditions, which are formulated as framework rules, and delineate the boundaries within which the extension of the scope of an invasive intervention may be regarded as permissible under the statutory framework. The following analysis presents selected cases, organised around recurring legal questions, in order to show how courts interpret and apply these statutory conditions. It includes cases in which the extension was accepted, as well as cases in which the courts found that it could not be justified.

In relation to the extension of the scope of an invasive intervention, a key issue is whether care regarded as professionally justified may, in itself, be sufficient to establish the permissibility of the extension. The legal dispute discussed below centred on whether professional necessity can justify an intervention going beyond the patient's original consent where the statutory conditions for extending its scope are not met.[9]

The patient was admitted to the gastroenterology department with cholelithiasis, for which surgery was recommended. Twenty-three years earlier, the patient had suffered severe acute pancreatitis, following which an extremely large pancreatic pseudocyst had developed; however, it caused them no symptoms. Nevertheless, it was also recommended that the pseudocyst be removed by a combined laparoscopic-endoscopic approach, at the same time as the surgery for cholelithiasis. During the intervention, the surgeon

[8] Health Care Act 3. § i)
[9] Debrecen Regional Court of Appeal Pf.20409/2017/8.

encountered resistance at the wall of the pseudocyst and observed that it was calcified. The procedure was therefore converted to open abdominal surgery. At that point, it became clear that the wall of the pseudocyst was so extensively calcified and ossified that it could not be sutured, and the intervention could not be performed as originally planned. It would still have been possible, without endangering the patient's life, to complete the surgery after addressing the cholelithiasis and to refrain from any further intervention. This, however, did not occur. Instead, the scope of the operation was substantially extended. The pseudocyst was removed, but this led to significant bleeding, and it also became necessary to remove substantial parts of the stomach and pancreas. The patient was subsequently treated in an intensive care unit, and further abdominal surgeries became necessary. The patient later died following complications, including internal bleeding and cardiac arrest.

In its defence, the healthcare provider argued that removal of the pseudocyst had been medically indicated and that the operation had been performed in accordance with professional standards. The expert officially appointed in the proceedings, however, stated in their opinion that neither urgent need, nor a disproportionately heavy burden on the patient, nor a direct threat to life justified the substantial extension of the primary operation without the deceased patient's consent. In such circumstances, the extension of the operation entailed unforeseeable and unassessable risks that exceeded the risks associated with refraining from the intervention.

According to the court's decision, the fact that the extension of the scope of an invasive intervention is medically justified is not, in itself, sufficient to establish its permissibility. One of the conditions laid down in the Health Care Act must also be met. Where no statutory condition is fulfilled, the extended intervention may not be performed. The patient must be adequately informed and their written consent must be obtained; otherwise, their right to self-determination is violated.

In practice, the key issue is often whether the professional relationship between different interventions, the practical advantage of performing them together, or their technical connection may provide a sufficient basis for extending the scope of an invasive intervention and for interpreting the patient's consent broadly. The case arose from medical care provided in connection with the treatment of a haemangioma in the vulvar region.[10] Two professionally related invasive interventions were performed on the patient: an angiographic examination followed by embolisation. Before undergoing the angiographic examination, the patient had received adequate information and had given written consent to that procedure. However, no written declaration of consent was obtained for the embolisation subsequently performed as part of the same procedural sequence. The embolisation led to serious complications, including tissue necrosis, permanent scarring, sensory loss, and significant psychological harm.

On the basis of the expert opinions obtained in the proceedings, no breach of professional standards could be established. The harm to the patient's health was a known, albeit rare, complication of the intervention. The legal dispute therefore centred not on a breach of professional standards, but on the patient's right to self-determination and, more specifically, on the extension of the scope of the invasive intervention. The court emphasised that embolisation, like angiography, qualifies as an invasive intervention and therefore requires separate written consent under the Health Care Act. The mere fact that,

[10] Curia Pfv.20033/2023/4.

from a professional point of view, it was expedient to perform the two interventions during the same procedure could not substitute for the patient's express consent. Nor did the court accept that the patient's oral statement made during the operation could be regarded as valid consent. The decision also makes clear that an extension of the scope of an intervention can be justified only by unforeseeable circumstances that do not permit delay; it cannot cure the absence of consent for an intervention that had been planned in advance.

The statutory formula of a "disproportionately heavy burden on the patient", which may make the extension permissible, is an open-textured normative category whose precise content cannot be defined in abstract terms. Its concrete application is therefore necessarily a matter for the courts. Judicial practice gives content to this statutory condition on a case-by-case basis, by assessing the circumstances of the intervention, the nature of the burdens imposed on the patient, and the consequences that would follow if the intervention were not performed.

Some decisions have accepted reliance on this condition and found the healthcare provider's conduct to be permissible under the statutory framework. The patient underwent mitral valve-sparing surgery. During the operation, the surgeons observed that silicone from a ruptured breast implant was leaking through the tissue into the left atrium. In order to save the patient's life, they arranged for the damaged implant to be removed. This extension of the intervention was clearly justified by the life-threatening condition.

At the same time, a plastic surgeon was asked to insert a new implant. This, however, was no longer directed at averting the life-threatening condition, and professional ethics proceedings were therefore initiated against the physician who had performed the intervention. It could be established that, during the operation, the patient had been in a situation in which the new implant could be inserted without any additional trauma. By contrast, if this had not been done, a further surgical intervention would have been necessary, together with all the burdens and risks that such an intervention entails. Accordingly, the healthcare provider successfully argued that the performance of the intervention without consent may also be justified where failure to perform it would impose a disproportionately heavy burden on the patient. The position taken by the healthcare institution was based on an entirely acceptable, realistic, and logical conclusion: if the operation had been stopped after removal of the old implant and the leaked silicone, this would have caused particularly serious trauma to the patient and, in addition, she would have had to undergo a further operation.[11]

The court likewise found the extension of the intervention to be justified in a case in which the patient underwent surgery for an ovarian cyst, but the operation was extended after more extensive tumorous lesions were found. As a result, both of the patient's ovaries, the fallopian tubes, and the uterus were removed. The surgical consent form covered only the planned intervention, and the patient had not been informed in advance of the possibility that the scope of the procedure might be extended. In the proceedings, the plaintiff argued that the physicians of the healthcare provider had violated her right to self-determination and her right to health, had failed to comply with their duty to provide information, and had removed her ovaries and uterus without consent. The plaintiff further argued that the intervention had been unnecessary and had resulted in the loss of her ability to have children.

[11] Curia Kf.39.095/2020/5.

The court found that the patient had indeed not consented to the removal of her uterus and had not been informed in advance of that possibility. Nevertheless, the statutory conditions for extending the scope of the intervention were met, since failure to perform the extended intervention would have imposed a disproportionately heavy burden on her. The lesion, which was later classified as a borderline tumour, had appeared clinically malignant, both in its appearance and in its extent. Accordingly, removal of the organs was necessary in order to prevent its spread and to avoid the risks associated with a possible further operation. At the same time, following the operation, the pathologist failed to exercise the care generally expected under the given circumstances when diagnosing a malignant tumour. As a result of this erroneous diagnosis, the patient underwent cytostatic treatment, that is, chemotherapy, which placed a considerable burden on her. In this respect, the healthcare provider's liability for damages could therefore be established.[12]

By contrast, the Budapest-Capital Regional Court of Appeal did not find the extension of the intervention permissible in a case concerning sterilisation performed during a caesarean section.[13] During the operation, the operating physicians observed that, due to the condition of the patient's uterus, carrying a future pregnancy to term could entail serious, potentially life-threatening complications. In light of this, the physician performing the intervention informed the patient during the caesarean section of the possibility of sterilisation. The patient gave oral consent, and the sterilisation was therefore carried out immediately. The written declaration of consent, however, was signed by the patient only on the day following the operation and was backdated to the day of the procedure. The patient and her partner argued that they had not had sufficient time to consider and weigh the consequences of sterilisation. They therefore based their claim on the violation of the patient's right to self-determination and right to adequate information. The court pointed out that, for sterilisation to be performed, the law requires a request complying with heightened formal requirements, which cannot be substituted by oral consent. No such request, set out in a public document or in a private document with full probative force, was available in the case at hand.

The court then examined whether there were any exceptional circumstances that could have rendered the performance of the intervention without consent legally permissible. It found that no direct threat to life had existed, since such a threat could have arisen only in the event of a possible future pregnancy. Nor did the court consider the statutory condition of a "disproportionately heavy burden" to have been established. The mere fact that sterilisation performed during the caesarean section would have involved a lower health risk than a separate operation at a later date was not sufficient to justify the extension of the intervention.

The three cases discussed above illustrate that the statutory condition of a "disproportionately heavy burden" is one of the most difficult and discretion-sensitive elements in assessing the extension of the scope of an invasive intervention. In this context, judicial practice primarily examines what consequences would follow if the intervention were not performed. These may include additional health risks, the burdens of repeated surgery, or a significant deterioration in the patient's condition. The decisive question is whether such consequences justify an intervention going beyond the patient's original

[12] BDT2008. 1884.
[13] Budapest-Capital Regional Court of Appeal Pf. 21.020/2016/6.

consent. At the same time, the case law also shows that the mere fact that a later intervention would be more burdensome or involve greater health risks is not, in itself, sufficient to establish that the extension is legally justified.

The next two decisions address a specific issue within the broader question of extending the scope of invasive interventions: cases in which the extension would lead to the loss of an organ or body part of the patient, or to the complete loss of its function.

In the first case,[14] the patient was admitted to hospital with anxiety-related complaints, but soon developed fever, pain in the area of the left kidney, and sepsis. After the initial examinations had revealed no significant abnormality, an ultrasound examination later identified a large abscess around the left kidney. The patient's condition became life-threatening, and emergency surgery was performed. During the operation, the abscess was opened and drained, but it became apparent that the inflammation had extended to the kidney in several places. The physicians therefore extended the scope of the intervention and removed the patient's left kidney. The patient later brought an action for damages, arguing that the condition of the kidney had not been serious enough to justify its removal. Since they had not consented to the removal, they claimed that the extension of the intervention had violated their right to self-determination. They also argued that the loss of the kidney had caused permanent physiological impairment, adversely affecting their subsequent way of life.

Where the extension of the scope of an invasive intervention would lead to the loss of one of the patient's organs, it may be justified under the Health Care Act[15] only if there is a direct threat to life or if failure to perform the intervention would impose a disproportionately heavy burden on the patient. The expert officially appointed in the proceedings found that the healthcare provider had treated the patient with the care generally expected under the given circumstances and in accordance with professional standards. The abscess had developed despite appropriate antibiotic treatment and was attributable to the underlying inflammatory process, rather than to any medical error. The operation was also performed in accordance with professional standards. The physicians correctly decided during the procedure to remove the left kidney, as this was the only available way to prevent the further spread of the inflammation. Both the operation and its extension, including the removal of the kidney, were life-saving in nature. Without the intervention, the plaintiff's life could not have been saved.

In another case, the Curia accepted the extension of the intervention where surgery performed because of an abnormality detected during gastroscopy, that is, stomach endoscopy, ultimately led to the removal of the patient's entire stomach.[16] During the operation, after the surgical area had been opened, a rapid tissue examination carried out during the operation indicated the likely presence of malignant tumour cells. The operating physicians therefore decided to remove the stomach in its entirety. The court pointed out that the removal of the entire stomach is a major intervention which, in the absence of the patient's prior consent, may be performed only if the conditions laid down in the Health Care Act are met. The expert opinion obtained in the proceedings excluded the existence of a direct threat to life. At the same time, it found that, in view of the patient's underlying

[14] Budapest-Capital Regional Court of Appeal Pf. 21.555/2013/5.
[15] Health Care Act 18. § (2)
[16] Curia Pfv.21.447/2019/6.

diseases and general condition, the need for a further operation, together with the risks of undergoing surgery twice and the associated risk of complications, would have imposed a disproportionately heavy burden on the patient. On that basis, the court found the extension of the intervention to be permissible under the statutory framework.

The two cases discussed above show that assessing the extension of an intervention becomes particularly sensitive where it results in the loss of one of the patient's organs or in the permanent loss of its function. In such cases, judicial practice accepts the extension only where it is linked to averting a direct threat to life or to preventing a disproportionately heavy burden on the patient.

In the following cases, the courts did not accept the extension of the intervention as permissible under the statutory framework, as there were no exceptional circumstances that would have warranted a restriction of the patient's right to self-determination. What these decisions have in common is that the interventions were extended in the absence of the statutory conditions and went significantly beyond the scope of the patient's original consent.

The patient and the healthcare provider entered into a contract for vulvar plastic surgery. The purpose of the intervention was for the defendant to remove the pigmented, protruding parts of the plaintiff's inner labia, with the lower parts of the labia minora being reduced, while their upper parts would remain unaffected. During the operation, however, the healthcare provider completely removed the left inner labium and partially removed the right one. As a result of the surgery, asymmetry developed in the area of the labia minora, and the urethral and vaginal openings became partially exposed. The patient also developed sensory disturbance in the vulvar area, resulting in both aesthetic and functional impairment. The Curia held that, in performing the medical intervention, the healthcare institution had failed to comply with the required standard of care. It had extended the operation beyond the agreement of the parties, without any medical indication, thereby violating the plaintiff's right to self-determination.[17]

The Curia likewise found that the extension of the intervention could not be accepted under the statutory framework in a case in which twelve teeth were removed during a single dental treatment. The patient had previously lived with an upper fixed dental bridge and sought treatment because of pain and problems affecting the bridge. Before the intervention, the dentist recommended the removal of two teeth in order to ensure stability, and the patient consented to this. In the course of treatment, however, twelve teeth were ultimately removed.

In the proceedings, it was established that the healthcare provider's records did not accurately reflect the treatment and had not been prepared contemporaneously, but only afterwards. Consequently, the parts of the documentation concerning the information provided to the patient and her consent could not be relied on. This prevented the healthcare provider from proving that the intervention had been performed on the basis of the patient's informed consent and that her right to self-determination had not been violated. The patient's consent extended only to the removal of two teeth. Owing to her panic disorder and her trust in the dentist's professional expertise, she was unable to object during the treatment.[18]

[17] Curia Pfv.20.753/2011/7.
[18] Curia Pfv. 20.761/2019/13.

The exercise of the right to self-determination in healthcare is particularly sensitive in the context of anaesthetic care, as such situations often require rapid decision-making and may necessitate changes to the originally planned course of care. Even in this context, however, the scope of the patient's consent and the permissibility of extending the intervention must be assessed by reference to the narrow statutory conditions laid down for such cases.

The patient was admitted to the healthcare institution for knee ligament surgery. Apart from the injury, their general state of health was good, and they had no serious pre-existing medical conditions. The patient signed consent forms for both the knee surgery and the anaesthetic intervention. Among the anaesthetic techniques listed, they consented to spinal anaesthesia. During the preparation for surgery, the spinal anaesthesia did not produce complete loss of sensation, and the patient developed involuntary muscle movements for reasons that could not be precisely identified. The situation was assessed as inadequate spinal anaesthesia, and the physicians switched to general anaesthesia without the patient's prior written consent.

After the knee surgery had been completed, the patient could not be awakened. They suffered seizures and made abnormal movements with their upper limbs. Since they did not regain consciousness, they were transferred to another healthcare institution providing intensive care. The patient's blood pressure, pulse, body temperature, and carbon dioxide levels rose significantly, while their oxygen saturation decreased. The symptoms raised the possibility of malignant hyperthermia, a severe reaction associated with anaesthesia, and the appropriate medication was started. After the first dose, however, treatment could not be continued in time because no further supply of the medication was available at the institution. The next dose was administered only after a significant delay, and the patient died shortly afterwards.

The court found both healthcare providers liable. The provider performing the surgery was held liable, first, because the intervention was not interrupted after the onset of seizure-like symptoms following spinal anaesthesia, even though those symptoms went beyond inadequate anaesthesia and required clarification. Secondly, the patient had consented only to spinal anaesthesia, not to general anaesthesia. General anaesthesia during surgery requires written consent, which had not been obtained. Nor were the exceptional statutory conditions for extending the scope of an invasive intervention without separate consent met: there was no urgent need, and failure to proceed in that manner would not have imposed a disproportionately heavy burden on the patient. The extension of the intervention was therefore contrary to the statutory framework.

The liability of the provider responsible for intensive care was established because, despite the poor prognosis associated with malignant hyperthermia, continuous drug treatment was not ensured. Such treatment would have significantly increased the patient's chances of survival.The decision makes clear that consent given in the context of anaesthetic care cannot be construed as a general authorisation to use other methods of anaesthesia. Where the statutory exceptions are not met, changing the method of anaesthesia without the patient's separate consent violates the right to self-determination.[19]

[19] Győr Regional Court of Appeal Pf. 20.280/2017/9.

5. CONCLUSIONS

With respect to invasive interventions, the Health Care Act exceptionally allows healthcare providers, in the patient's interest, to extend the scope of an intervention and to perform an additional intervention whose necessity could not have been foreseen and to which the patient had therefore not given prior consent. This possibility is undoubtedly necessary, since unexpected situations may arise in everyday medical practice in which there is no opportunity to inform the patient and seek their consent, for example because the patient is under anaesthesia. As a general rule, information must still be provided and consent obtained. However, in cases of urgent need, or where failure to perform the intervention would impose a disproportionately heavy burden on the patient, the additional intervention may be performed without separate consent. Where the extension would lead to the loss of an organ or body part of the patient, or to the complete loss of its function, the legal scope for doing so is even narrower: such an extension may be justified only by the disproportionately heavy burden referred to above or by the existence of a direct threat to life.

The possibility of extending the scope of an invasive intervention does not displace or replace the requirement of consent as a general rule. Nor does it confer a general authorisation on the physician to modify the intervention freely. Rather, it creates an exceptional decision-making situation in which medical discretion may be exercised only within the limits defined by law. The legislature therefore does not allow physicians simply to pursue the professionally optimal course of action; it recognises a legally circumscribed competence to intervene in situations of necessity.

The basic rationale underlying the regulation is that, in certain intraoperative situations, the patient lacks the actual capacity to make a decision, while failure to perform the necessary intervention would entail disproportionate risks or further serious harm to the patient's health. The extension of the intervention can be regarded as permissible under the statutory framework only if the applicable statutory conditions are met and the extension is attributable to an unforeseeable circumstance arising during the intervention.

The statutory framework thus addresses a dual tension: on the one hand, the primacy of the right to self-determination and, on the other, the need to ensure the continuity and effectiveness of healthcare. It does not amount to a general override of the right to self-determination, but rather to an exceptional and conditional limitation of that right, the scope of which requires a narrow interpretation of the statutory conditions. Where the extension is carried out in accordance with those criteria, it excludes the unlawfulness of the intervention and, consequently, the violation of the patient's right to self-determination. Such situations may therefore be understood as legally recognised limits to that right.

The case law also confirms that professional necessity, medical expediency, or the technical connection between interventions cannot, in themselves, substitute for the statutory conditions. Where the possible extension of an intervention is foreseeable in advance, the patient must be informed of that possibility and their consent must be sought before the intervention begins. The exceptional rules on extension therefore cannot be used to legitimise a departure from the patient's original consent in relation to an intervention that was, or could have been, anticipated.

The statutory conditions governing the extension of an intervention are themselves formulated as framework rules, the concrete content of which is determined through judicial application. Accordingly, the lawfulness of extending the intervention cannot be assessed in abstract terms, but must be examined on a case-by-case basis. Judicial practice provides examples in both directions. In some cases, the courts accepted the extension as permissible under the statutory framework. In others, they held that the extension had been unnecessary and established both a violation of the patient's right to self-determination and the liability of the healthcare provider.

REFERENCES

Books and Articles:

Hídvéginé Adorján Lívia – Sáriné Simkó Ágnes (2012): A betegek jogairól. Budapest. Medicina, 338 p. ISBN: 9789632263755

Ifj. Lomnici Zoltán (2007): A tájékoztatáson alapuló beleegyezés intézményének felelősségi kérdései a hazai joggyakorlat tükrében. Iustum Aequum Salutare, 3. évf. 3. 179-190.

Kőszegfalvi Edit (2001): Egészségügyi és betegjogi kézikönyv. Budapest, KJK Kerszöv. 479 p. ISBN: 9632245733

Őri Adrienn, Feith Helga Judit (2023): „Ha tudtam volna…" A tájékoztatáshoz való jog, mint betegjog aktuális kérdései és jogtörténeti perspekítvái. Kaleidoszkóp, 13. évf. 27. 298-309.

Sáriné Simkó Ágnes (2019): Betegjogok az egészségügyi törvény és a Polgári Törvénykönyv összefüggései alapján. Gazdaság és Jog, 27. évf. 6. 7-13.

Ungváry Botond (2023): Sürgős! Az orvos mentesülése egyes betegjogok figyelembe vétele alól sürgősségi helyzetekben. Med et Jur, 14. évf. 2. 4-11.

Zsonda László – Fézer Tamás (2016): Betegjogok. Budapest, Egészségügyi Nyilvántartási és Képzési Központ. 111 p. ISBN: 9789639661080

Legal Sources and Judicial Decisions

Act CLIV of 1997 on Health Care
BDT2008. 1884.
Budapest Environs Regional Court K. 700.191/2023/11.
Budapest Environs Regional Court P. 20.376/2018/38.
Budapest-Capital Regional Court of Appeal Pf. 20.281/2020/8.
Budapest-Capital Regional Court of Appeal Pf. 21.020/2016/6.
Budapest-Capital Regional Court of Appeal Pf. 21.555/2013/5.
Curia Kf.39.095/2020/5.
Curia Pfv. 20.761/2019/13.
Curia Pfv. 20.867/2022/18.
Curia Pfv.20.753/2011/7.
Curia Pfv.20033/2023/4.
Curia Pfv.20326/2020/12.

Curia Pfv.21.447/2019/6.
Debrecen Regional Court of Appeal Pf.20409/2017/8.
Győr Regional Court of Appeal Pf. 20.280/2017/9.
Szeged Regional Court of Appeal Pf. 20.283/2019/6.