THE PATIENT'S RIGHT TO SELF-DETERMINATION IN HUNGARY

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ABSTRACT: *The aim of the study is to examine, interpret, and explain the Hungarian legal regulations related to the patients' right to self-determination. The right to self-determination is one of the most extensively regulated patient right in the Healthcare Act. This right is of utmost importance, since it – together with the right to information – assists the patients in being able to make responsible decisions regarding their treatment. The article presents what the right to self-determination means, outlines its limitations, and also addresses who is entitled to give consent to healthcare interventions. The examination of the right to self-determination is considered a current topicactual, as evidenced by the legal disputes related to it in the courts.*

KEYWORDS: *right to self-determination, healthcare, civil law liability, patient's rights, right to information, medical intervention, invasive intervention*
JEL CODE: K15

1. INTRODUCTION

The issue of patient rights came into global focus following the civil rights movements of the 1970s in Hungary, the need to regulate them became more important from the 1990s.

In the preceding period, the doctor-patient relationship was dominated by a classical, paternalistic approach, which is entirely different from the practice that has developed in modern times. The characteristic of the relationship was based on a hierarchical structure, where the patient was a vulnerable party of the legal relationship. (Jobbágyi, 2007, p. 32.) This perception was based on the idea that the healer, possessing specialized expertise, like a "good father," always knows what is good for the patient, understands what is necessary for their recovery, and acts in their best interest. As a result, there was no need for the regulation and protection of the rights of the patient. (Jobbágyi, 2007, p. 52.) Thus, the treatment or intervention recommended by the doctor was accepted by patients without any question or information. However, this situation has become untenable in many aspects. We can think of the significant progress in medical science on one hand, and the emergence of large cities on the other hand, leading to the "industrialization" of healthcare.

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In contrast to the earlier, less urbanized society, this development lacked that kind of personal connection, trust, and collaboration that was present before. (Kőszegfalvi, 2001, p. 15.) Furthermore, previously, ethical principles predominated, and a demand for the law to regulate medical activities and patients' rights was emerged. (Jobbágyi, 2007, p. 23.)

The Act CLIV of 1997 on Healthcare (hereinafter: Eütv.) came into effect on July 1, 1998. Departing from the approach of its predecessor, it elevated the patient to the status of an equal party with the healthcare services provider by introducing an extensive catalogue of patient rights. This fundamentally changed the nature of the doctor-patient relationship.

The Eütv. defines nine patient rights. In my view, from the perspective of the transformation of the doctor-patient relationship, two patient rights can be considered cardinal namely the patient's right to information and the right to self-determination. These two rights primarily assist in ensuring that the patient is not a party suffering from a lack of information, not a vulnerable figure in their care, where decisions are made on their behalf by others. Instead, they become "the masters of the case," an informed party capable of deciding about their care in accordance with their own interests and values, armed with the information received.

The Article II of Hungarian Fundamental Law declares the inviolability of the right to human dignity, which is essential in the context of our topic, as the Hungarian Constitutional Court[1] considers the right to self-determination as part of human dignity. The right to self-determination is a dimension of the right to human dignity, thus, it can be stated that that the right to self-determination of the patient has a constitutional basis. (Kovács, 2018, p. 15.)

The significance of the right to self-determination is further supported by the fact that it appears not only as one of the nine patient rights specified in the Health Care Act but is already present among the goals of the act: „the purpose of the act is to create the conditions for all patients to maintain their human dignity and self-identity, and that their self-determination and all other rights remain intact."[2] In addition, it also appears among the principles of the Act (Eütv.): „the personal liberty and right to self-determination of patients may be restricted only in the cases and in the manner specified in this Act, to the extent justified by the patient's health."[3]

2. INTERPRETATION OF THE RIGHT TO SELF-DETERMINATION

When defining the patient's right to self-determination, it is necessary to emphasize that it has several dimensions. If we examine it in the broadest sense, we can actually find elements closely related to the right to self-determination in the content of all nine patient rights regulated in legislation. For example, the right to health care includes the freedom of choosing a doctor, the right of communication includes the possibility of exclusion from

[1] 64/1991 (XII. 17.) Constitutional Court decision
[2] Act CLIV of 1997 1. § c).
[3] Act CLIV of 1997 2. § (1)

visiting, within the right to medical confidentiality, the patient can also decide, for example, who is allowed to be present during the treatment and so on.

In contrast, this right could have a narrower interpretation, indeed if we categorize patient rights, we can distinguish a separate group of entitlements closely related to self-determination. This group includes not only the right to self-determination in the narrow sense but also the right to information, which is a prerequisite for it, as well as the right to refuse treatment and the right to leave the healthcare institution.

In an even narrower sense, the right to self-determination, on the one hand, involves giving consent to healthcare and interventions, which can be interpreted as the positive aspect of the entitlement. On the other hand, it also includes the right to refuse treatment, expressing the negative content of the right.

In the narrowest sense, the right to self-determination refers to its positive aspect, as mentioned earlier, which, based on Sections 15-19 of the Eütv., implies several entitlements for the patient. It includes the possibility to decide whether they want to receive healthcare, and if so, to which interventions they consent. It is important that the right also includes the withdrawal of consent, which can occur at any time without any obligation or constraint. The patient also has the opportunity, within the framework of the right to self-determination, to take part in decisions concerning their examination and treatment. The Eütv. divides decisions regarding examinations and applied therapy between the attending physician and the patient. The doctor can choose from scientifically accepted methods of examination and therapy, however, the method proposed by the doctor can only be applied if the patient has validly given their consent to it. Finally, a positive aspect of the right to self-determination is that the patient can designate a person who is entitled to exercise the right to consent on their behalf, and can also exclude certain individuals from this circle.

I primarily focus on the narrowest interpretation of the right to self-determination in my paper, specifically addressing its general implications, without delving into the special aspects of the right to self-determination, such as reproductive procedures.

3. CONSENT TO MEDICAL INTERVENTIONS

Our starting point is that, apart from certain exceptions, the condition for carrying out any medical intervention is the patient's consent, which can be considered the main content of the right. However, it is crucial to consider the manner, content, and form in which consent is obtained.

When examining the content of consent, it is essential that it is given free from deception, coercion or threat. Another important condition for the validity of consent is that it should be based on adequate information. The significant information asymmetry still exists between the two parties, despite the transformation of their relationship into a subordinate one. The doctor possesses expertise and practical experience in a specific field, which requires years or decades to acquire, while the patient is mostly a layperson without specialized knowledge. Therefore, providing information becomes crucial, as it has the potential to offset the information disparities and elevate the patient to a more equal

position. This allows the patient to be in a genuine decision-making position regarding their examination and treatment, moving away from a completely vulnerable situation. The right to information is also detailed in patient rights, and Eütv. prescribes a wide range of information, the patient is entitled personalized and complete information.[4]

In addition, in certain cases, formal requirements must also be considered in the context of obtaining valid consent. However, this cannot be considered the main rule. In general, it is sufficient for valid patient consent if it is given verbally, or it can even be implied conduct, such as lying down on the examination table or making the arm available for blood sampling. (Dósa, 2011, p. 574) However, there are certain medical interventions for which consent is valid only in written form. The following are some examples of this. For example, consent for invasive procedures is one such case where written approval is required. According to the law invasive intervention shall mean physical intervention manifested in penetrating the patient's body through the skin, mucous membrane or body orifice, excluding procedures posing negligible risk for the patient from a medical point of view.[5] Despite the definition, it is not clear in several cases, so the court may need to examine whether the given intervention can be considered invasive. For example, while nasal endoscopy was not,[6] gastroscopy, cystoscopy and tooth extraction[7] were considered invasive. (Hídvéginé Adorján, Sáriné Simkó, 2012, p. 60)

Beyond the mentioned aspects, the law requires written consent for voluntary treatment in the case of psychiatric patients.[8] The patient's written consent is required for the use of any cell, cellular constituent, tissue, organ, or body part removed in the patient's life in connection with the intervention for any purpose unrelated to healthcare.[9] The Eütv. also requires a written consent statement, for example, in procedures related to human reproduction, artificial infertility, or even embryo donation.[10]

If written consent is required, the form of it is an important issue, indeed, there are distinctions among types of written documents, including ordinary private documents, private deed of full probative value,[11] and public deed.[12] The Eütv. uses these concepts without providing specific definitions. Therefore, the provisions of Act CXXX of 2016 on the Code of Civil Procedure are considered as guidelines for these terms. Among the types of documents, an ordinary private document is usually sufficient for obtaining consent for interventions. An unauthenticated private deed is a private document that does not meet the formal requirements of private deed of full probative value.[13] For example, this could be a printed document that is signed by the consenting party. If the patient is unable to do

[4] Act CLIV of 1997 13. § (1)
[5] Act CLIV of 1997 3. m)
[6] Curia Pfv.20.867/2022/18.
[7] Budapest Environs Regional Court10. P. 20.376/2018/38.
[8] Act CLIV of 1997 15. § (5) and 197. §.
[9] Act CLIV of 1997 19. § (1)
[10] Act CLIV of 1997 168. § (4), 187. § and 176. §
[11] Act CXXX. of 2016 325. §
[12] Act CXXX. of 2016 323. §
[13] Act CXXX of 2016 326. §

written statement, but possesses adequate decision-making capacity, for invasive interventions or voluntary medical treatment a statement made in the presence of two witnesses orally or otherwise is sufficient.[14]

In legal practice, the right to information and the right to self-determination go hand in hand, and their violation gives rise to numerous legal disputes, leading to new questions. Therefore, the jurisprudence related to this area is constantly evolving.[15] In the following, I would highlight some examples from judicial practice that contribute to the interpretation of the conditions set forth in the legislation.

In a case forming a legal dispute, the patient suffered a severe allergic reaction during a cardiac catheterization procedure involving contrast agent administration, leading to deterioration despite treatment in the intensive care unit, ultimately resulting in death. The relatives in the lawsuit claimed that the patient's right to self-determination was violated because the deceased did not receive adequate information before the procedure. Additionally, they argued that his death caused harm to their right to live ina complete family. According to Curia of Hungary (as the supreme court, hereinafter: Curia), the patient signed a document titled "Consent Declaration," in which he consented to the procedure detailed in the "Patient Information for Cardiac Catheterization" brochure. The written information clearly stated the possibility of fatal complications and allergic reactions, and it also indicated that the patient received verbal information. During this verbal communication, the patient had the opportunity to ask questions orally in addition to the detailed written patient information form, enabling him to make an informed decision regarding the procedure. There is no legal or professional basis for the claim that if the complications, consequences, and generally the required elements of information for a particular intervention can be generalized and formulated in templates, detailed and procedure-specific information in the form of a document would not be acceptable. It would hinder and make the functioning of the healthcare system impossible if the same information had to be separately written for every patient. This is not expected, and the Eütv. does not contain such a requirement. In this case, the written information met the requirements set forth by the Health Act. Therefore, there was no need to attachsignificance to the question of verbal information.[16]

The following case reinforces the example mentioned earlier, but from the opposite perspective. In this case, the Curia took the position that the healthcare provider's liability for damages can be established if the patient did not receive all essential information, which would have allowed them to make an informed decision regarding consent or refusal of interventions. In this case, the document signed by the patient only mentioned in general the risks and complications of plastic surgical interventions but did not include personalized written information specific to the particular surgical procedure. Furthermore, the healthcare provider could not provide evidence of adequate verbal information. As a result, the patient was not aware of the advantages and disadvantages of

[14] Act CLIV of 1997. 15. § (5)
[15] https://mersz.hu/hivatkozas/YOV0844_164/#YOV0844_164 (Downloading: 2023. december 10.)
[16] Curia Pfv.20.835/2019/7.

the endoscopic surgery, nor did he understand how this surgical intervention differed from traditional surgery. The patient could not properly exercise his right to self-determination due to insufficient information.[17]

We can mention a case where a patient underwent the same type of surgery, a right-sided neck rib procedure 9 years apart at the same institution. The issue arose because during the second surgery, the patient did not receive detailed information but was merely referred to the first intervention, with the explanation that the same principles applied as in that case. Unfortunately, as a complication of the second surgery, brachial plexus damage occurred, and its symptoms persisted in the long term. The Curia determined that the plaintiff did not receive personalized, detailed information in accordance with the Eütv. Without such information, the plaintiff did not have sufficient knowledge to provide informed consent or to refuse the intervention, thereby being unable to exercise their right to self-determination. In the absence of informed consent, the healthcare institution is also responsible for the complication arising from the surgery, which would not have occurred without the performance of the procedure.[18]

In another disputed case, the issue arose from the fact that the patient, was informed before the intervention regarding a complication that this could be persistent. However, the patient developed permanent health damage, which was not mentioned. The Curia determined that the doctor should provide information about the surgical risks and expected complications in order to patient can exercise their right to self-determination. This requirement is met by mentioning the possibility of paralysis in general among the possible complications. But the duty of the healthcare provider to inform the patient should not extend to giving a prognosis priorly about whether this will certainly occur and, if so, what its severity or duration will be.[19]

4. LIMITS OF THE RIGHT TO SELF-DETERMINATION

The right to self-determination is not unlimited similarly to other patient's rights. However, it is important to note that since it is based on constitutional foundations, the essential content of it cannot be restricted, and otherwise, it can only be limited in specific cases and manners as defined by law. (Hídvéginé Adorján, Sáriné Simkó, Ohár, 2020, p. 170)

A general limitation of this right is that it must be exercised in compliance with the relevant regulations and the operational rules of the healthcare provider, as well as the rights of healthcare workers and the rights of other patients.

The Eütv.sets out three specific limitations regarding the right to self-determination, namely presumed consent, interventions that can be performed without consent, and the issue of extending invasive interventions. We will review these in the following.

[17] Curia Pfv.21.053/2016/10.
[18] Curia Pfv.22.569/2017/7.
[19] BH2013. 219.

One of the specified limitations of the right to self-determination is represented by situations where the law presumes consent. In these cases, the intervention can be legally performed even if neither the patient nor others have given explicit consent for it. The presumption of consent can be applied when several conditions are met together. (Lomnici, 2007, p. 183)

The first condition is that the patient is not in a state to give consent to the intervention. In such cases, as a general rule, the patient's authorized substitute decision-maker should be informed. If there is no such person, the law designates a circle of substitute decision-makers for invasive interventions, and one of them must give consent. However, there may be a situation, and this is the second conjunctive condition, where obtaining a statement from the authorized or legal substitute decision-makers would cause a delay. This does not mean that in such cases, there should be no attempt to obtain consent. It is necessary to try to reach the person authorized to make the statement, and if it is unsuccessful, then consent can be presumed. (Kőszegfalvi, 2001, p. 58)

In the case of invasive interventions, there is a third condition. Consent can be presumed for this type of intervention only if the delay caused by obtaining a statement from substitute decision-makers would lead to serious or permanent impairment of the patient's health.[20]

The absolute legal limitations to the right to self-determination are situations where no consent is required for the intervention, neither from the patient nor from anyone else. However, the right to information is still applicable to the patient in these cases as far as possible.

Consent is not reqiured when the patient's life is in immediate danger and the primary consideration is to provide care as quickly as possible. We note that in special situations, life-saving interventions cannot be performed if the patient, meeting the legal conditions, validly refused it.[21]

The patient's consent is not required if failure to carry out the given intervention or measure seriously endangers the health or physical integrity of others. For example, the patient's consent is not required for the implementation of mandatory epidemiological measures.[22]In the case of a screening test carried out for epidemic reasons, epidemiological surveillance, or even compulsory home quarantine, but any epidemic measure could be mentioned, the public interest takes precedence over individual autonomy.

We can mention as an example the emergency medical treatment or forced medical treatment of psychiatric patients. Emergency medical treatment is needed if a psychiatric patient exhibits imminently harmful conduct, and his or her admission to a psychiatric institution for treatment is the only way to prevent it.[23] Forced medical treatment is warranted if the psychiatric patient exhibits harmful conduct, however, his or her

[20] Act CLIV of 1997 17. § (1) b).
[21] Act CLIV of 1997 20-23. §
[22] Act CLIV of 1997 56. § (3)
[23] Act CLIV of 1997 199. §

emergency medical treatment is not justified.[24] As long as the patient's harmful conduct and imminently harmful conduct persists, the patient does not need to give consent to the restrictions necessary to avert it.

The law draws attention to a specific set of cases, as it mentions fetuses that have reached the 24th week, distinguishing them from the general category of "others". If failure to carry out the given intervention or measure seriously endangers the health or physical integrity of a 24th-week fetus, there is no need to consent from the mother, so she cannot refuse the intervention. (Kaszás, 2013, p. 220) Based on this, the mother's right to self-determination is subject to absolute limitation in order to protect the life and physical integrity of the fetus that has reached the 24th week.

The third specified limitation of the right to self-determination is the possibility of extending invasive interventions. This refers to extending the intervention based on circumstances arising during invasive interventions. It means that the intervention should be extended beyond what was originally planned, performing procedures that were not foreseeable initially and, therefore, not covered by the original consent. The general rule is that even in such cases, the intervention cannot be performed without the patient's consent, their approval is necessary. However in two exceptional situation the extension of the invasive intervention is permitted without additional approval and further necessary interventions can be carried out. One of these exceptional situation is the so-called urgent need, which means a change in health status that, in the absence of immediate medical care, would put the patient's life in immediate danger or cause serious or permanent damage to health.[25] The extension of invasive intervention can be carried out too if failure to do so would mean a disproportionately greater burden for the patient.[26] The meaning of disproportionately greater burden is not defined by the legislation, so decisions must be made on a case-by-case basis through individual consideration. The situation becomes even more specific when, as a result of the extension, the patient would lose an organ, body part, or its function, as this can only be justified by the aforementioned disproportionately greater burden or if the patient’s life is in imminant danger.

Regarding the legality of the extension of the intervention, the courts have taken a stance in numerous cases. In some situations, they deemed the extension-related medical decision lawful, while in other circumstances, it was considered unlawful.

For example, in the case when a surgery is performed to remove an anomaly found during a gastroscopy and it ultimately leads to the removal of the entire stomach, the Curia found the decision to extend the intervention justified.[27] Physicians of the defendant removed the entire stomach because the histopathological examination conducted through a quick-freezing procedure following exploration confirmed the presence of malignant tumor cells. The surgery resulting the complete loss of the stomach, in the absence of consent, can only be performed under the Eütv. if its omission would represent a

[24] Act CLIV of 1997 200. §
[25] Act CLIV of 1997 3. § i)
[26] Act CLIV of 1997 18. §
[27] Curia Pfv.21.447/2019/6.

disproportionately greater burden for the patient or if their life is in imminant danger. The opinion of the expert refused the existence of an imminant life-danger condition. However, it established that the double surgical burden and the double expected complications, taking into account the patient's relevant conditions, would have represented a disproportionately greater burden. Therefore, the extension of the intervention was considered lawful. However, a diagnostic error also occurred in this case. Subsequent histological examinations after the removal revealed that there was no need for the removal of the stomach. The court examined the diagnostic error independently of the right to self-determination. The patient's right to self-determination was not violated however, the healthcare provider did not act with the expected care in establishing the diagnosis. Therefore, their liability for compensation was established finally in this case.

The Budapest-Capital Regional Court of Appeal did not find the extension of the intervention justified in the case where a sterilization procedure was performed simultaneously with a caesarean section. During the surgery, the doctors observed that the uterus was in a condition where carrying another pregnancy to term could lead to a severe, life-threatening condition, or even death. The physician performing the intervention informed the patient about this during the caesarean section, and the patient verbally consented to the performance of sterilization, which was promptly carried out. The patient signed the written consent the next day, backdated to the day of the surgery. At that point, the plaintiff and her husband realized that they did not have the opportunity to contemplate the issue of sterilization. Consequently, in the lawsuit, they based their claim on the violation of the right to information and self-determination. The court determined that the relevant legislation requires a request presented in private deed of full probative value, or public dees for sterilization, and this cannot be substituted with verbal consent. However, no such request was submitted. Subsequently, the court had to determine whether there were circumstances that could justify the performance of the sterilization without the consent of the patient. The sterilization could have been performed in a life-threatening condition, which did not exist, it could have been possible in a future pregnancy. On the other hand, the extension of the intervention could have been deemed lawful if its omission would have represented a disproportionately greater burden for the patient. This situation did not apply either, it could only be established that the risks associated with the sterilization procedure performed concurrently with the caesarean section were lower than the risks that would have been present in the later, planned sterilization surgery.[28]

5. EXERCISING OF THE RIGHT TO SELF-DETERMINATION

In the context of the right to self-determination, it is necessary to review who is entitled to make decisions regarding healthcare interventions for individuals belonging to different categories of capacity to act. Capacity to act means the ability to make legal statements validly: any person whose competency is not limited can acquire rights and assume obligations of their own will and on their own behalf. (Méhes, Varga, 2021, p. 13) The

[28] Budapest-Capital Regional Court of Appeal Pf. 21.020/2016/6.

Eütv. uses the concept of capacity to act and its categories, but it does not provide definitions. Therefore, we refer to the regulations of Act V of 2013 on the Civil Code (hereinafter: Ptk.) as the guiding framework. (Fridli, 2001, p. 105)

A patient who has full capacity to act can makes decisions regarding their healthcare interventions on their own. The healthcare provider acts negligently if they do not sign the consent statement with the adult patient has full capacity to act, but instead have it signed by the patient's mother.[29] According to the Act of CLV of 2013 in supported decision-making if the patient has a supporter for decisions related to healthcare, it must be ensured, that the supporter can be present during the giving of consent, consult with the patient, but the absence of the attendance of supporter does affect the validity of the consent. (Kőrösi, 2017, p. 90)

A patient who has a full capacity to act may also decide to designate another person who has full capacity to act too, who is authorized to exercise the right of consent on their behalf (authorized substitute decision-maker). This statement can be made in a public deed or in private deed of full probative value and if the patient is unable to write, in the presence of two witnesses.[30] In addition, a patient with full capacity to act may issue a statement to exclude persons from exercising the right of consent and refusal on their behalf. The authorized substitute decision-maker plays a key role even if the patient loses their capacity, as they will be the first in the legal order to exercise the right of consent on behalf of the patient. It needs to emphasize that the option to designate an authorized substitute decision-maker is available not only for individuals have the full capacity of act, but also extends minors reached the age of 16 with limited capacity of act.

This legal option is particularly significant because, in this way, the validity of the healthcare declarations of the minor, who is considered limited capacity of act, does not require the consent of the minor's statutory representative but relies on the consent of the substitute decision-maker (such as an adult friend, or a parent without parental custody rights).[31]

According to the Ptk. the legalstatements of an adult having no capacity to act shall be null and void, only a few exceptions exist, and these do not include consent for medical interventions. Thus, consent can be given on their behalf by the persons specified by the Eütv. The legislation outlines a gradual system that applies not only to the right to self-determination but also to right to refuse the treatment and the right to information. If the patient does not have capacity to act, primarily the authorized substitute decision-maker exercises the right to self-determination on their behalf, who was designated while the patient was still had capacity to act. The consent of the designated substitute decision-maker must be obtained for all medical interventions (both invasive and non-invasive).

If the patient does not have a designated substitute decision-maker, the Eütv. appoints legal substitute decision-makers. The first in the order of them is the statutory representative. However, not every incapacitated person has a statutory representative, for

[29] Curia Pf.VI.20.222./2013/6.
[30] Act CLIV of 1997 16. § (1).
[31] Act CLIV of 1997 16. § (6)

example, a person who temporarly, when making legal statement completely lacks the ability required to take care of his own in cases, or a person who permanently and completely lacks the ability required to take care of his own affairs but the court has not placed under custodianship fully limiting his capacity to act yet. (Sáriné Simkó, 2019, p. 11) If there is no statutory representative or they cannot be reached, primarily, the cohabitant relatives with full capacity to act in order specified by the law are entitled to exercise the right to self-determination on behalf of the patient.[32] If these relatives are also absent or cannot be reached, then relatives with full capacity to act who do not live in the same household with the patient may exercise the right to self-determination on behalf of the patient in a specified order.[33] Legal substitute decision-makers only exercise the right to self-determination on behalf of the patient within defined limits. This is a significant difference compared to substitute decision-makers designated by the patient, whose consent must be sought for all treatments. One of the limitation in the case of legal substitute decision-makers is that their consent is only required for invasive interventions.[34] In the case of non-invasive interventions, the paternalistic approach of previous years is emerging. In such cases, the doctor assesses and decides on behalf of the patient, as the patient, due to their lack of decision-making capacity, cannot do so themselves, and the law does not require the consent of legal substitute decision-makers for non-invasive interventions. On the other hand, the law also protects the interests of the patient by stipulating that apart from the risks inherent in the intervention, the consent for invasive interventions given by relatives may not have an adverse effect on the patient's health, in particular, it may not lead to serious or permanent impairment of the patient's health.[35] Therefore, relatives cannot make a decision that the physician deems detrimental to the patient. Thus, the doctor's assessment plays a crucial role, and in specific cases, they may override the decision of the relatives, especially concerning invasive interventions. (Dósa, Hanti, Kovácsy, 2016, p. 55)

The third category of capacity to act encompasses patients with partially limited capacity to act. For legal statementof people having limited capacity to act to be valid, the consent of the statutory representative shall be required. That is why in the case of patients with limited capacity to act, both the declarations of patient's and the statutory representative's may be necessary to exercise the right to self-determination. However, there is a significant difference between minors and adults with limited capacity to act. Since statutory representative is entitled to make legal statementon behalf of minors,[36] and this also applies to healthcare declarations too. (Kovácsy, 2009, p. 440) However, it is important to emphasize that a minor who has reached the age of 16 with limited capacity to act can also have an authorized substitute decision-maker, who is entitled to exercise the right to consent to healthcare on their behalf, preceding the statutory representative in

[32] Act CLIV of 1997 16. § (2) b)
[33] Act CLIV of 1997 16. § (2) c)
[34] Act CLIV of 1997 3. § m) pont
[35] Act CLIV of 1997 16. § (4)
[36] Act V of 2013 2:12. § (4)

the order. In the case of adults, the statutory representative can make legal statementindependently in exceptional situations, if the protection of the interests of a person having partially limited capacity to act or his protection from any damage requires immediate action.[37]

Another difference between minors and adults with limited capacity to act is that minors do not have specific categories of affairs, their limited decision-making capacity is general. However, adults with partially limited decision-making capacity can make valid legal declarations independently in those categories of affairs not covered by the restriction of their decision-making capacity. Therefore, adults with partially limited capacity to act can independently make healthcare declarations if those declarations are not included the categories of the restriction.

6. CONCLUSION

Among the nine patient rights outlined in the Eütv., the right to self-determination can be considered crucial, especially in the transformed doctor-patient relationship. Right to self-determination and right to information assists patients in giving their consent by ensuring they possess adequate awareness, thus enabling them to make informed decisions. The purpose of the study is to subject the right to self-determination in the narrowest sense to a comprehensive examination. Beyond the legal content of the right, we also aimed to provide examples from the recent years' judicial practice and highlight the significant findings presented in these cases. After introducing the topic, we reviewed the substantive and formal requirements considered central to the right to self-determination, particularly concerning consent to healthcare interventions, supported by examples from legal practice. Subsequently, we addressed the limitations of the right, cases where the patient's consent is not required, or it must be presumed, and practical questions arise regarding the extension of interventions.

Considering that, according to the rules of civil law, individuals can be either with full capacity to act or limited capacity or incapacity to act,so it is essential to review who exercises the right to consent on their behalf and to explore the differences and limitations that may arise about substitute decision-makers.

Overall, it can be stated, that the examination of the right of self-determination is current and necessary, since the legal disputes related to this are still present nowadays, and the case law is constantly evolving in this area.

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