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EVOLUTION OF JURISDICTION IN MEDICAL MALPRACTICE CASES IN HUNGARY

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In Hungary, in the period before the political transition, in 1989 and in the first years afterwards, a relatively small number of medical compensation lawsuits were initiated. However, the enactment of the Health Act in 1997 has gradually changed this and made the patient from the previous vulnerable position to an equal partner with the healers. As a consequence, we can observe the conscious consumer behaviour of citizens in relation to healthcare services, so recently the quality of health services is more often being questioned.

In the previous judicial practice, the rate of patients winning lawsuits was completely different compared to the current situation, the majority of cases ended with the dismissal of their claims. The reason for this lies in the vulnerable position of the patient which already exists during healthcare and lawsuits as well. Neither the judicial practice nor the legal environment attempted to counterbalance this vulnerability at that time. However, this has gradually changed, and nowadays we can witness a particularly strict judicial practice, the establishment of liability for damages of healthcare institutions is frequent.

The purpose of the article is to demonstrate how the judicial practice of the medical compensation cases has evolved over the past 15-20 years in Hungary, and as a result, what currently observable trends have emerged. To achieve this, it is essential to examine extensively two preconditions of civil law liability for damages, namely causation and fault, as jurisdiction has changed the most in this aspect. Many factors of uncertainty arise in connection with healthcare services due to the uniqueness of the human body. The outcome of lawsuits is significantly influenced by how the court assesses uncertainty factors and which party bears the burden of uncertainty.

Key words: civil law liability, healthcare service provider, patient, medical malpractice lawsuit, rights of patients, causality, fault.

Закані Ю. Трансформація вирішення справ за позовами про відшкодування шкоди, що виникла у галузі охорони здоров'я в Угорщині після падіння комуністичного режиму.

В Угорщині до та в перші роки після падіння комуністичного режиму число позовів про відшкодування шкоди у галузі охорони здоров'я було вкрай малим. Розроблення та прийняття у 1997 році закону про охорону здоров'я це питання поступово змінило і пацієнт на відміну від колишнього положення в якому він був у гіршому становищі, починав ставати рівноправним партнером з лікарем у галузі охорони здоров'я. Внаслідок цього, у громадян підвищилися рівень обізнаності у галузі охорони здоров'я, про свої права при отриманні медичних послуг, збільшилися вимоги до їх якості, через що збільшився і попит на якісні медичні послуги у громадян.

Раніше, число судових справ у яких пацієнти вигравали судові спори у порівнянні із сьогоdnішніми були зовсім іншим, оскільки тоді абсолютно більшість справ ними програвалися. Причина цього була передусім у тому, що пацієнти перебували у вразливій ситуації як при наданні медичних послуг, так і при допущених лікарських помилках. Цю вразливість в ті часи ні правові норми, ні судова практика не намагалася збалансувати. Але це поступово змінилося, тому в сьогоденні ми можемо спостерігати доволі сувору судову практику в даній сфері, лікарські заклади часто притягуються до майнової відповідальності за завдану шкоди.

Мета наукового дослідження полягає в презентації того, як змінилося в Угорщині питання відшкодування шкоди, що виникла у галузі охорони здоров'я в останні 15-20 років і показати останні тенденції, які спостерігаються в цьому напрямку.

Для цього неодмінно необхідно дослідити, обставини цивільно-правової відповідальності за заподіяну шкоду, а саме її передумови, причинно-наслідковий зв'язок та винуватість, оскільки саме у цьому напрямку відбулися найбільші зміни при вирішенні справ. З точки зору ходу розгляду спорів вирішальне значення має те, як тлумачить суд невизначені факти при встановленні ступеня вини та причинно-наслідкового зв'язку та на яку зі сторін лягає тягар доказування невинуватості.

Ключові слова: цивільно-правова відповідальність, працівник сфери охорони здоров'я, пацієнт, позов за лікарською недбалістю, права пацієнтів, причинно-наслідковий зв'язок, винуватість.

Problems in general. In Hungary, in the period before the political transition, at the end of the communist regime in 1989 and in the first years afterwards, a relatively small number of medical compensation lawsuits were initiated. Even a few decades ago, there were fewer attempts that tried to impeach the knowledge of the medical professions and the professionalism of its activities.

However, the rapid increasing of information and the enactment of Health Act in 1997 has gradually changed this, and made the patient from the previous vulnerable position to an equal partner with the healers. As a consequence we can observe the conscious consumer behaviour of citizens in relation with healthcare services, so the quality of health services is more often being questioned. The tolerance level for services that are considered inappropriate has decreased.

In the previous judicial practice, the rate of patients winning lawsuits was completely different compared to the current situation, the majority of cases ended with the dismissal of their claims. The reason for this lies in the vulnerable position of the patient, which, previously, neither the judicial practice nor the legal environment attempted to counterbalance. The vulnerability already exists during health care, as medicine is an activity requiring specialized knowledge that the common citizen does not possess at all. So, the patient is compelled to trust the doctor who has the knowledge. The vulnerability is increased if a problem arises during the treatment and the patient would like to initiate a lawsuit to enforce his rights. In Hungary, in order to establish liability for damages, four conditions must be met: the damage, the unlawfulness, the causal link between the two, and finally the fault. So, it is necessary that the injured party suffered harm caused by unlawful conduct, and the fault of the tortfeasor is also indispensable. In a lawsuit, it is the responsibility of the plaintiff to prove three of the four preconditions of liability, while the healthcare provider must prove that they were not at fault. Many factors of uncertainty arise in connection with healthcare services due to the uniqueness of the human body and the unpredictability of its reactions. The occurrence of harm is often not attributable to a single cause, and it cannot be determined with absolute certainty how much the medical intervention influenced the occurrence of the adverse outcome or how different the outcome would have been if a different treatment had been applied. Therefore, much depends on whether the court assesses these factors of uncertainty on the side of the plaintiff or the defendant. If the court adjudicates them within the scope of causation, then the burden of proof is on the patient, if it pertains to the exemption from fault, then it rests on the healthcare provider. In connection with this, there has been a change of approach in Hungary that fundamentally changed the judicial practice in medical malpractice cases over the past 15 years.

Researches and publications in this topic. Several researchers in Hungary are dedicated to studying the practice of medical compensation lawsuits. I would like to highlight and reference the works of Ágnes Dósa, Zsombor Kovácsy, László Pribula, Éva Kereszty, and Péter Havasi.

The purpose of the article is to demonstrate how the assessment of liability preconditions has changed in medical compensation lawsuits over the past 15 years in Hungary, and as a result, what currently observable trends have emerged. Firstly, the study explores which liability rules of civil law should be applied in medical compensation lawsuits, and then the writing examines the liability prerequisites, with a particular focus on causation and fault. Afterward, the paper describes how the assessment of these two liability prerequisites has changed in these procedures. Finally, I will address the rules of privileged case of inability to allege and the rules of privileged case of inability to prove, which are new legal institutions in Hungarian civil procedural law and which can explain the current trends in medical compensation lawsuits.

The main research material. Before delving into a more detailed examination of liability preconditions, it is important to clarify which liability rules are applied by the courts in medical compensation lawsuits. One of the options, and perhaps the most obvious one, is to apply the rules of liability for breach of contract considering that there is a contractual relationship between the healthcare provider and the patient. [1, p. 7] This was the case, as Section 244 of Act CLIV of 1997 on Health Care (hereinafter: Eütv.) originally ordered the application of the contractual liability rules from the previous Hungarian Civil Code (Act IV of 1959) to the liability of healthcare providers based on the contractual relationship. However, with the entry into

force of the new Hungarian Civil Code (Act V of 2013) the referred section of Eütv. was modified, and now it refers to the extra-contractual liability rules of the current Civil Code. The reason for this can be found in the fact that in the previous Civil Code (Act IV of 1959) had a broader scope of parallel rules regarding both contractual and extra-contractual liability. The section 318 of the Civil Code ordered the application of the extra-contractual liability rules on liability for breach of a contract and the amount of damages. The current Civil Code (hereinafter: Ptk.) brought fundamental changes in the assessment of liability issues, and it raised serious concerns considering the established judicial practice regarding the liability for damages of healthcare providers. Exculpation of the healthcare provider was already difficult in the extra-contractual liability system and the new regulations of liability for breach of a contract would have been excessively strict for this special legal relationship. The contractual relationship between healthcare service providers and patients is a specialized area where some rules of business law cannot be applied completely. As an example, we can mention the regional service obligation of healthcare service providers where institutions do not have the discretion to decide whether to enter into a contract with the patient and they cannot be exempted from the obligation to provide care. [2, p. 620] This is a significant difference compared to business contracts, where taking a contractual risk is a voluntary decision, thus increased liability can be justified.

The legislator fortunately has recognized and remedied the issue by amending Section 244 of Eütv., which provides the application the extra-contractual liability regulations of Ptk. based on fault for the liability of healthcare providers.

In Hungary, in order to establish liability for damages, four conditions must be met: the amage, the unlawfulness, the causal link between the two and finally the fault. Among the liability preconditions, the paper focuses mainly on fault and causation, as these two are closely related, and there are some noticeable changes in the judicial practice related to them. To establish the liability for damages of healthcare service providers, it is not sufficient to prove that the conduct is unlawful, it is also necessary to determine the fault of the conduct, since these claims are not judged based on objective liability rules. Fault, unlike culpability, does not focus on the actor's own conduct but rather assesses the harmful behaviour based on an objectified and standardized measure.

In civil law relations, one shall proceed with the care that is generally expected under the given circumstances otherwise that person is at fault. The expression "generally expected under the given circumstances" means that the activity is measured by an objective standard in civil law, however, it does not imply a universally applicable, entirely objective requirement for all situations. The requirement of "generally expected under the given circumstances" relativizes the objective standard, typifying the conduct based on specific activities, the context of behaviour and the circumstances. [3, p. 109] From the perspective of the study, it is relevant to examine what rules determine the generally expected conduct in the context of medical activities. According to Section 77 of Eütv.: all patients shall be treated with the care expected of the personnel involved, and in due compliance with professional rules, rules of conduct and guidelines, irrespective of entitlement to receive treatment. The other fundamental legal provision is the Act LXXXIV of 2003 on certain issues related to the performance of healthcare activities (hereinafter: Eütev.). In accordance with Section 5 and Subsection 1 of Eütev., healthcare professionals have to provide healthcare activities with the care generally expected in medical activities within the framework of professional requirements, adhering to ethical standards, to the best of their knowledge and conscience, at the level determined by the available material and personal conditions, and in line with their professional competence. Despite the changes in the legislation, a heightened standard of care still applies to doctors, given the importance of the right to life, physical integrity, and health. However, the requirement for this increased care should be based on the activities of a doctor with an average level of education, expertise and competencies in the specific field. [4, p. 272]

What is considered generally expected conduct in relation to medical activities is determined by written and unwritten professional rules. Among the written professional rules, the professional protocols, methodological letters and guidelines compiled by professional bodies are the primary ones. If there is no aforementioned written guideline on a specific question, then the textbook constituting the curriculum for the medical specialty exam should be considered as the written source. In the absence of a written source, the unwritten rules of the profession set the guidelines to be followed. [5, p. 675] Professional standards are often not clear instructions, they only establish the scope of the activity, so they may need interpretation in the context of a specific problem and the possibility of deviation can be permitted when it is justified.

We can find several examples in judgments where the healthcare provider did not violate professional rules with their activities, but at the same time, the healthcare institution was held responsible by referring to the failure of the generally expected standard of care. The study agrees with the standpoint that does not

approve of separating the requirement of the expected standard of care from compliance with professional regulations. [6, p. 104] The different evaluation of behaviour from medical and legal perspectives generates uncertainty and an unpredictable set of conditions, which expands the boundaries of liability.

In the analysis related to fault, it is worth mentioning the concepts of complication and risk, as well as their legal evaluation. If it can be proven that the occurred adverse outcome falls into these categories, it leads to the providers' exemption from liability. To achieve this, two important conditions must be met. One of them is that the patient must be properly informed about the possible risks and complications of the intervention. The other condition is that the occurrence of these risks and complications is acceptable only if they develop despite the demonstration of expected care and prudence. The concept of risk can be defined as the possibility of the occurrence of danger associated with the execution of medical activities. A complication refers to the development of another illness during the course of the activity or the occurrence of a disruption in the functioning of the organism. [7, p. 13] The category of these harmful outcomes has been narrowed by the judicial practice. An adverse event caused by faulty behaviour cannot be recognized as a risk. For instance, the court no longer accepts the retention of a foreign body in the body cavity as a surgical risk because its occurrence is not possible with the demonstration of expected care. It is important to mention the concept of side effects as well. Side effects are considered to be the harmful and undesired effects that arise from the normal dosage and usage of medications according to the marketing authorization. Side effects also include those resulting from medication errors and from usage not specified in the marketing authorization.

The causal connection between unlawful, faulty conduct of the person causing damage, and the damage are indispensable precondition for civil law liability. Causality is one of the most debated elements among the preconditions of liability, both in theory and in various fields of legal application, including incidents related to healthcare services. Theories were based on the principle of condition sine qua non, which states that all antecedents must be considered as causes, regardless of their degree of involvement in the occurrence of the damage. [8, p. 1267] This natural scientific approach of causation is not appropriate for the legal evaluation of behaviours, whereas it requires us to identify the legally relevant causes among the factors influencing the occurrence of the damage.

There are theories of causation that introduce a subjective element into the objective causation process represent the next level of development. According to these theories, the court decides which factors should be included within the scope of causation in the evaluation of the adverse event. In terms of civil law, the causes that should be considered relevant are those that can be affected by compensation measures and are related to the achievement of the preventive purpose of compensation. [9, p. 271] In light of this, only factors that could be foreseen under the given circumstances can be taken into consideration. [4, p. 279] The Ptk. sets a limit to the compensable damages by the foreseeability rule. No causal link shall be established in connection with any damage which the person causing damage could not foresee and should not have foreseen. Foreseeability is an objective requirement, implying that all damages must be compensated that a person in the same circumstances of the liable party should have foreseen.

In accordance with Section 265 of Act CXXX of 2016 on the Code of Civil Procedure (hereinafter: Pp.) the relevant facts in a case shall be proved by the party having an interest in the fact being accepted by the court as the truth (hereinafter: "interest to prove"), and the consequences of not proving or unsuccessfully proving such a fact shall be borne by the same party. In the practice of medical compensation lawsuits, this implies that the injured party is required to prove the unlawful conduct, the occurrence and extent of the damage, as well as the causal link between the damage and the unlawful activity. On the other hand, the healthcare service provider needs to exculpate themselves and prove that neither their behaviour was neither unlawful nor they were at fault. Proving and establishing causation is particularly difficult in cases of adverse events related to healthcare services. Therefore, in the civil procedure on these matters proving the probability is sufficient. [10, p. 96] In many cases it cannot be determined with absolute certainty how much the medical intervention influenced the occurrence of the adverse outcome or how different the outcome would have been if a different treatment had been applied. On the one hand, there are numerous uncertainties related to medical activities and individual reactions of the human body, even the scientific causation can be uncertain. Furthermore, it is common that the harm cannot be attributed to a single cause, besides the activities of healthcare providers, the patient's condition, the nature of their illness, and lifestyle can also influence the outcome. [4, p. 385] Examples falling into this category include claims related to the loss of chance of recovery where the patient's health condition and the nature of their illness also play a role in the occurrence of the outcome, apart from the misdiagnosis and delayed treatment. On the other hand, it is also possible that the damage occurred in causal connection with the conduct of several persons for example,

when more healthcare institutions are involved in the patient's treatment, or the injury caused by a third party completely independent of the healthcare services provider. In such situations, it is common to establish joint liability among the wrongdoers, but we can also find instances where the obligation to pay compensation obligation is divided in percentages. [6, p. 118]

The outcome of the procedure largely depends on whether the court assesses these factors of uncertainty on the side of the plaintiff or the defendant. Probably the judicial practice has changed the most in this aspect in the last 15 years. Proving causation and proving the absence of fault are closely related issues. The latest judicial practice requires the healthcare service provider to prove several facts that previously had to be proven in establishing causation, but now it is expected from the defendant to verify these facts.

Previously, the scientific uncertainty fell on the plaintiff's burden of proof, often resulting in the dismissal of the claim as can be observed from the following example. In that case in 1997 (41.Pf. 26.287/1997.) the plaintiff's child was born in a state of oxygen deficiency and died a few days after birth. On the day of delivery, the CTG (cardiotocography) examination showed rapid heart rate at the upper limit of normal and significantly narrowed oscillation with mild contraction activity. These symptoms, according to the opinion of the expert, could indicate the oxygen deficiency of the fetus. According to the Budapest-Capital Regional Court it cannot be determined and proven that if the caesarean section is performed earlier, the damage of the fetus would not occur. The damage could have been caused by various reasons, including the entanglement of the umbilical cord. It cannot be established with absolute certainty that the fetus's oxygen deprivation was caused by the omission and activity of the defendant, so the claim of the plaintiff was dismissed in the second instance.

Recent judicial practice separates scientific and legal causation and considers the latter to be decisive in the jurisdiction. [11, p. 3] If there is any default on the part of the hospital, the court grants the claim even if the damage is not certainly caused by the activity or omission of the healthcare service provider. The range of facts that need to be proven in the causal link has been narrowed, and the uncertainty factors must be taken into account by the defendant in the context of the exemption from fault. If the patient can prove that their injury occurred during or after the treatment, the court will accept the existence of causation. [8, p. 1274] So essentially, the burden of proof has reversed since it is no longer the patient's task to substantiate causality. Instead, the healthcare provider must prove its absence in the exemption from fault. The healthcare institution can exculpate itself only by proving that it acted with the highest level of care and prudence or that the damage would have occurred inevitably even with such a course of action.

The following case (Pfv.III.21.212/2008/5.) is a good example to demonstrate the new mindset of judicial practice. The plaintiff delivered a newborn baby with health impairment at the defendant's healthcare institution. According to the plaintiff, the doctor violated the duty of care prescribed in the Eütv. when he did not perform a caesarean section, even though several factors justified it. According to the defendant, there was no indication of a caesarean section, and the CTG did not show any abnormal results. Additionally, the amniotic fluid was clear which argues against the presence of oxygen deficiency. The oxygen deficiency could have developed when the head of the fetus passed through the pelvic inlet, and at that moment, there was no longer an opportunity to perform a caesarean section. In the review procedure, the Supreme Court concluded that the defendant inadequately documented the process of childbirth, resulting in their inability to exculpate themselves from fault. Because of the deficiencies in the documentation, the defendant was unable to demonstrate that they acted with the care expected of the personnel and performed all the relevant examinations justifying the decision for vaginal delivery.

The adjudication of claims related to the loss of chance of recovery has also undergone a transformation. Assessing the involvement of the healthcare provider's fault, such as incorrect diagnosis, delayed diagnosis, or delayed treatment, in relation to the illness or death, and determining how much the same outcome would have occurred without it, entails significant uncertainties. [6, p. 179] In the past, the uncertainty factor was adjudicated within the context of causation, placing the burden of proof on the plaintiff. If the plaintiff could not prove that he would have definitely recovered or survived with appropriate diagnosis and timely treatment, the case typically ended with the dismissal of the claim. According to the new trends, the uncertainty related to the loss of chance of recovery is now adjudicated within the scope of the defendant's exemption from liability. If the healthcare provider is unable to demonstrate that there was no chance of recovery even in the absence of errors, they cannot fulfill their obligation of exculpation, and the case will result in granting the claim. The following justification (Pfv.III.20.799/2010/6.) illustrates the change in judicial practice as well. The paramedics transported a resuscitated and ventilated patient to the defendant's hospital and handed over the patient at the admission department. The patient had ventricular fibrillation which was confirmed

by the EKG report conducted at the hospital. This clearly required the doctors of the defendant to initiate resuscitation, but it was not performed. If resuscitation had been performed, it still cannot be certain that there would have been a chance for the patient to survive. However, in the absence of it, the opportunity for survival was lost, which constitutes harm. According to the Supreme Court, the defendant unfoundedly referred to the lack of causal relationship in the review application. In order to be liable for the damages, the causal link should not be established between the doctor's default and the patient's death, but between the omission and the possibility of survival if the resuscitation had been performed. The exemption is only possible if the hospital proves that the patient would have died even if resuscitation had been started immediately. If the doctors attempted resuscitation of the patient but it was unsuccessful, the defendant could have been exempted from liability for damages. [7, p. 13]

Regarding informational deficiencies, we can also witness similar changes. Previously, patients were expected to prove that if they had been informed about the possibility of a certain risk or complication, they would not have consented to the intervention. In a legal case (32.P.88.813/1991.) the plaintiff referred to the lack of information about the nature, risks and consequences of the surgical intervention. He stated that he did not receive adequate information about the surgical procedure, therefore he could not make an informed decision. The court's standpoint in the case was that the plaintiff should have proven the facts that he alleged.

Recently, the healthcare service provider is expected to prove that the information provided was in accordance with the legal requirements, or that the patient would have consented to the intervention even with knowledge of the risk factors. We can also mention a case as an example (BH2003.453.) where the plaintiff underwent surgery due to bunions on both of their feet. On one foot, a Schede-type procedure was performed, while on the other foot, a Mayo-type surgery was conducted. A defendant was obligated to inform the plaintiff about the necessity of performing the Mayo-type surgery and the reasons for both types of surgeries, as well as their common consequences, as the patient's fundamental right is to decide whether to undergo the procedure considering the known risk factors. Based on the evidence presented in the lawsuit, it cannot be determined whether the plaintiff received any information regarding consequences, risks, or complications. The defendant also failed to prove that the plaintiff received detailed information, including potential negative outcomes, prior to the surgery. Based on these, the Supreme Court concluded that the court of second instance made the right decision when establishing the defendant's liability for damages due to the omission of proper preoperative information, in accordance with the law. [6, p. 250]

In the opinion of the author, the judicial practice is inappropriate in the adjudication of issues such as the loss of chances of recovery, omissions regarding the obligation to provide information and documentation deficiencies. That kind of approach is incorrect which states that uncertainties arising from documentation errors, omissions in providing information, or delayed recognition of illnesses are burdens on the defendant's side. There is no doubt these are considered errors on the part of the healthcare provider, but often the harmful outcome, for which liability for compensation is determined, does not arise in direct causation with these errors. Thus, it is possible that the damage occurred as a complication of the treatment and not due to professional error. [12, p. 37] However, the incomplete documentation is adjudicated by the court in a way that the healthcare provider has excluded the possibility of exemption from fault and they are fully liable for damage. In such cases, the only proven omission is the deficiency of the documentation which is certainly not causally related to the occurred damage.

Of course, there is no need for a change that would allow the hospital to use a documentation deficiency to its advantage and be exempt from liability due to lack of evidence. A more fair and rational adjudication of uncertain factors would be appropriate. The study agrees with the viewpoint that in cases of loss of chance of recovery a suitable solution could be that the injured party receives compensation in proportion to the probability that the harm was caused by the fault conduct of the healthcare services provider. In fact, this represents a form of shared responsibility in such cases, the damage is partly caused by the natural course of the disease and partly by the actions of the healthcare provider. Thus, the healthcare provider is only liable for the damage that can reasonably be attributed to their own actions. [10, p. 98]

In the case of documentation deficiencies, this solution may be more difficult to apply, indeed, there are cases when it might be reasonable for the court not to place the entire uncertainty on the healthcare provider's responsibility. The following case (EBH.2008. 1867.) is a great demonstration of this, as the author would consider the percentage-based assessment to be applicable. The child was born with a limb developmental disorder which, according to expert opinions, is difficult to recognize, and there are no definitive methods for it. The probability of recognition is estimated at 30%. The documentation did not contain any data regarding the examination of the limbs during the ultrasound control, and the institution could not provide evidence of

its occurrence. According to the court's reasoning, the hospital excluded itself from the exemption of liability by this documentation deficiency. Even if the necessary examination was performed and documented as well, there would still have been a 70% chance that the limb malformation would not have been detected. It is not reasonable to solely burden the healthcare provider with complete uncertainty and impose full liability for compensation in such a case.

The established judicial practice can be explained with statutory provisions, as Pp. regulates privileged case of inability to allege and privilege case of inability to prove. According to Section 4 and Subsection 2 of Pp.: unless otherwise provided by an Act, the parties shall bear the burden of presenting the relevant facts of the case and the supporting evidence. In accordance with Section 265 of Pp. the relevant facts in a case shall be proved by the party having an interest in the fact being accepted by the court as the truth. However, informational asymmetry emerges in many legal relationships, and to counterbalance this, two legal institutions, privileged case of inability to allege and privileged case of inability to prove, have been established. This informational asymmetry can be observed in the relationship between healthcare service providers and patients. During such proceedings, the patient is in a vulnerable position due to his lack of specialized expertise or access to documentation. In the early stages, neither the judicial practice nor the legal environment attempted to counterbalance this, leading to a significant number of claim dismissals. In the absence of specialized expertise, it cannot be expected from the patient to identify the unlawful conduct. Additionally, it also cannot be expected from the patient to prove the causal relationship between the conduct of the healthcare service provider and the occurred harm. Consequently, the plaintiff is not required to make a medically detailed statement regarding the activities performed during healthcare service.

A party shall be deemed to be in a privileged case of inability to allege if he substantiates that the information necessary to prove a specific fact is held exclusively by the opposing party, he certifies that he took the necessary measures to obtain and keep such information, the party with opposing interests does not provide the information despite being called upon to do so by the court, and the party with opposing interests does not substantiate the opposite of previously mentioned facts (Section 184 of Pp.). The consequence of privileged case of inability to allege is the statement of fact concerned (the causal link in medical malpractice cases) may be accepted by the court as the truth if it does not have any doubt regarding its veracity.

A party shall be considered to be in a privileged case of inability to prove under four conditions. First of all, he has to substantiate that the data indispensable for his motion for evidence are in the exclusive possession of the party with opposing interests. Secondly, he has to certify that he took the necessary measures to obtain such data, it is not possible for him to prove a statement of fact, but it can be expected that the party with opposing interests will supply evidence of the non-existence of the facts stated, or the success of taking evidence was frustrated due to the fault of the party with opposing interests, and the party with opposing interests does not substantiate the opposite of previously mentioned facts (Section 265 Subsection 2 of Pp.).

A party shall be considered to be in a privileged case of inability to prove, if he substantiate that the data is indispensable for motion for evidence are in the exclusive possession of the party with opposing interests. He is also in a privileged case of inability to prove, if he is unable to prove the facts but it can be expected that the opponent will supply evidence of the non-existence of the facts stated. (Section 265, Subsection 2 of Pp.)

Since healthcare institutions are obligated to maintain documentation, these conditions are often met in medical compensation lawsuits. As a result, the plaintiff is not only exempt from stating expressly the unlawful conduct but also does not have to prove it, shifting the focus onto the healthcare service provider's exemption from liability. [13, p. 6]

Conclusions. It can be concluded that the judicial practice has significantly changed in medical compensation cases in Hungary in the past 15-20 years. The essence of the process of change lies in the assessment of causation and exemption from fault. Causation is the most uncertain element among the preconditions of liability, and proving it is particularly challenging in medical malpractice cases. Therefore, much depends on whether the court adjudicates these factors of uncertainty on the side of the plaintiff or the defendant. If the court assesses them within the scope of causation, then the burden of proof is on the patient, if it pertains to the exemption from fault, then it rests on the healthcare provider. The range of facts that need to be proven related to the causal link has been narrowed, and the uncertainty factors must be taken into account by the defendant in the context of the exemption from fault. This is especially true in cases related to the loss of chances of recovery, as well as in cases involving informational and documentation deficiencies.

Where we started after the end of the communist era was also inadequate, but the cases, where the healthcare service providers are found liable for damages, has significantly increased due to the recent jurisdiction. It is not appropriate if we ignore the informational asymmetry and vulnerable position of patients. It is

recommended for the court to take these circumstances into account and ease the burden of proof on the plaintiff's side. However, it is also not acceptable to burden the other party with all uncertainties. A more fair and rational sharing of uncertainty factors would be expedient between the plaintiff and the defendant.

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