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Masked Ball – Financial Controversy Shaping Ethics and Law in Hungarian Health Care[1]

Introduction

If we look at the effective legal regulations, the codes of ethics and recommendations of the health care system in Europe, North America or Australia, we will find that issues of care and treatment are assessed in a sophisticated way. Certainly, it does not mean that all the actions of health care professionals are defined by the legal system or by some kind of ethical guidelines. Nor does it mean that it is always clear when and how the legal and the ethical aspects might or should be implemented in a given situation. It simply means that the legal regulations and standards in ethics usually serve as a good basis for analyzing the problem in question and finding a resolution for it at least in theory. Although many exceptions may exist, we can be confident in general of the overall legal and ethical consequences and implications of a certain act.

The present paper will introduce a health care system where these considerations are not necessarily true. In fact, I will argue that as a consequence of a unique phenomenon in the health care of this country we have good reason to assume that these considerations are not true.

Historical Background

The present notion of ethics and law in Hungary is deeply influenced by its former socialist-communist ideology. It is therefore not possible to understand the impact of law and ethics on health care practice in Hungary without a short review of recent history.

After Word War II communism became the only official acceptable ideology of Hungary. During this time intellectual, artistic, political, scientific and religious activities that did not support and glorify the ruling politics and ideology were persecuted and penalized. The official philosophy of the ruling party was the so-called Marxism-Leninism. The very intensive philosophical life[2] however, was almost entirely restricted to verbatim quotations from Marx's classics and those of his peers (Kovács 1991a, 13). Even Marxist

[1] This paper is a revised version of the following paper: Szebik, I. 2003. Masked ball: ethics, laws and financial contradictions in Hungarian health care. *Science and Engineering Ethics*, 2003/9: 109–124.

[2] Given this recent unfortunate history of philosophy it is not surprising that people, especially those belonging to the middle and older generations have negative or sometimes hostile connotations hearing the word philosophy. It means a forced ideology, the restriction of the freedom of thought that people had to suffer from for a long time. Consequently, physicians and others working in health care also often share these feelings.

opinions or ideas not corresponding to the 'official' trends were persecuted, while philosophers representing these unwelcome ideas were punished by being fired or intimidated by other means.

Still, the political turnover, the introduction of a market economy and pluralism have not resolved many of the enormous problems of the country. Hungary now faces huge unemployment, environmental pollution resulting from the irrational industrialization projects of past decades and the obligation of reimbursement of the misused credits taken from Western countries and their interest rate. Corruption and organized crime became a major factor undermining the well-being of the country.

One of the biggest achievements of the communist regime was access to health care resources for all Hungarian citizens regardless of their financial situation. This might be considered as a big achievement indeed, since due to the poverty level before World War II many Hungarians failed to utilize health care services. Nevertheless, insufficient resources in health care created a controversial situation with regard to the allocation of services. This controversy and its implications will be analyzed later. At the same time, the general state of health of Hungarians today is poor. As of 1994, Hungary has had the highest cardiovascular mortality rate in Europe for people below sixty-five (BLASSZAUER 1995, 1596). Cancer morbidity and mortality, life expectancy, suicide mortality show similar negative characteristics.

Physicians were in a controversial situation. Most of them had private practices before the war, and this fact was an unforgettable sin in an era when the so-called socialist-communist values were exclusively respected. In addition, physicians belonged to the intellectual professions; the official ideology preferred and supported physical workers in the first place, whereas all the others were at least 'suspicious'. In addition to these, some physicians had quite a negative role in the late 30s, when a Physicians' Chamber (Hungarian Physicians' National Association) was established. This organization excluded Jewish physicians. After WW2 physicians were labeled therefore as Fascists, and they were considered as the enemies of the political system (ÁDÁM 1993, 234).

These facts were reflected in policy-making as well. An unskilled physical worker might earn approximately two to three times as much as a physician. In our days, this ratio still exists in certain areas.

TIPPING

One may not understand the present Hungarian health care system without confronting a phenomenon called tipping.[3]

Although less and less Hungarians argue that tipping should not be considered as a problem at all, it is certainly a gross mistake to diminish or even ignore its effects on Hungarian healthcare. It has been widely discussed in Hungary whether tipping is morally acceptable or not, whether it should be eliminated, or even whether it can be eliminated in the near future at all. My point here is not to render a decision about the moral status

[3] In fact this event has a lot of other names in Hungary, like money of gratefulness or parasolventia. The expression 'money of gratefulness', 'money of gratitude' is widely used, meaning that this is the sign of gratefulness of patients towards their physicians. Péter Gaál recommends the expression 'informal payment' for this phenomenon. (Gaál, P. *Informal Payments for Health Care*. PhD. Thesis, January 2004, p. 56.)

of this phenomenon. Rather, I would like to show that the consequences of this kind of payment directly or indirectly influence virtually all acts and decisions in the health care setting in Hungary. Certainly, this influence has moral relevance.

The reason why I discuss the question of tipping is that it is present in practically all patient-doctor encounters. Even if there is no direct money exchange, the mere existence of the possibility of tipping, the potential frustration or anger of physicians triggered by the absence of it or the uncertainty of patients whether they acted right or wrong by not giving money is a relevant factor when we try to understand the behavior of the participants of health care.

The Meaning of Tipping

As mentioned before, the salaries of physicians were held on an artificially low level. This was insufficient to maintain a standard of life required by the medical profession. On the other hand the scarcity of health care resources forced people to find appropriate care for themselves. Other factors like the widespread use of tipping in other areas of everyday life (gas stations, restaurants, etc.) in Hungary or the alleged desire of Hungarians to express their gratitude in this monetary form may provide only some poor explanations.

Patients generally feel very uneasy about how they should manage this problem. In many instances uncertainty, anxiety and fear accompany their whole therapeutic session or the duration of their hospitalization. Uncertainty, because patients often do not know how much they should pay. Overpayment might be as problematic as underpayment. Quite often, one of the main issues of conversation among the patients in a ward[4] is what the appropriate amount for Dr. X. for the given treatment is. They may feel anxious because they do not know how doctors will accept their offer, nor do they know how it will influence their care. Since there is a general pressure on patients in society to give money, those who for different reasons do not want to give, or those who cannot afford to give may have a fear that their care will not be adequate.

The moment of tipping is a peculiar one. It is the only moment in the traditionally quite paternalistic doctor-patient relationship when patients may exercise control over their physicians. Since patients know their doctors rely on their tipping, they may well feel they are in a superior position at least during this short interaction.

Physicians sometimes refuse to accept tips. They have numerous reasons to do so. First, there are some who categorically refuse all kinds of attempts at tipping, but they form only a minority among Hungarian physicians. Generally, physicians do not intend to accept tipping from patients of known low economic status. Furthermore, if the patient suffers from an incurable disease or she is terminally ill, doctors tend not to accept tipping either. Patients may have different feelings in these cases. Some feel that they are refused, and they are frustrated because they assume their doctor considers them

[4] The reimbursement of the cost of the hospitals from the insurance company may depend on the number of days patients spend in the hospital, therefore patients often spend much more time in the hospital than they would in other health care systems. Consequently, patients have 'enough', sometimes too much time to discuss the issue of tipping.

inferior. Others are hurt, while according to my personal experience, only a minority of patients think that their doctor's refusal is the consequence of the doctor's genuine honesty. There is an additional factor that patients consider while musing on the issues of tipping: they may think their doctors refused the money because they feel uncomfortable for some reason. Patients may think that physicians feel uneasy because they have not fulfilled their therapeutic obligations, they acted negligently, they made a mistake, they could not render the best decision regarding the allocation of some scarce resources for their given patient, or they simply did not do their best for the patient. This latter is probably the most common reason patients consider when they think about why their money has been refused.

To avoid their own inner confrontation in dealing with the problem, physicians find that from a moral point of view the refusal of the money may grant them a moral superiority as a compensation for their immoral behavior (i.e. when they accept tipping).

It is no wonder that the refusal of tipping by physicians may further increase the uncertainty and sometimes the anxiety of the patients. Since the reason of the refusal is never made explicit, patients have to guess. This places an additional burden on the shoulder of patients and on the interaction of doctors and patients, which is certainly already loaded by numerous other factors.

The fact that doctors generally do not accept tipping from patients with fatal diseases, like incurable cancer, is well known to patients. Given that physicians in Hungary very often deceive their patients with malignant cancer by not telling them the real diagnosis, the refusal of tipping is often an indirect disclosure of the prognosis of patients. Although we can see here that the superposition of the two, from a moral point of view at least a questionable practice (deceiving patients and tipping), may result in a somewhat acceptable consequence (patients are in this way informed that they have cancer with bad prognosis), no one would argue that this is a required and adequate professional standard of communication.

The above-mentioned tipping system creates tension among doctors of different ages and specialties. Older physicians are in the position to enforce tipping by different maneuvers like reserving themselves the right to see the patient as the last physician at discharge from the hospital, when tipping occurs most frequently. It is evident that doctors working in laboratories of the hospital, radiologists or pathologists will almost never receive tips. The highest rate of tipping occurs among senior manual specialists, like obstetricians and surgeons. As a consequence of these differences jealousy, animosity and anger is not uncommon among doctors with different specialties and of different ages. In light of this it is not surprising to hear a proposal by a professional who is sensitive to moral issues that a resolution of this unfairness and a creation of distributive justice might be achieved by fair allocation of tipping money among physicians. This proposal was not a cynical one. However, it shows how deeply the habit of tipping is embedded in the way of thinking of health care professionals. It shows that it seems to be very hopeless to eliminate the phenomenon itself. Thus we have to find ways that mitigate the negative effects of tipping.

Some argue that the timing of the act itself might have relevant moral and legal consequences. Some patients give the money at the beginning of the visit or before the (invasive) interventions, while others do it at the end of the visit or after the intervention. The argument that those patients who 'express their gratitude' at the end of the visit

or after the interventions are not influencing the physician's decision-making regarding the care of the given patient is often articulated. Giving the money post hoc is therefore legally and ethically acceptable given the present (and aforementioned) financial situation of physicians[5]. At the same time, according to this argument, tipping before the treatment might result in bribery, it may influence the treatment choice of the physician and it may result in privileges for the patient in allocating scarce resources. Consequently, this is corruption, which is illegal and unethical. This way of thinking about tipping is quite widespread among Hungarians. Even the Code of Ethics of physicians finds tipping at the end of the treatment acceptable. However, I would like to challenge this argument by mentioning that the doctor-patient interaction is rarely restricted to one single encounter. Therefore, it is trivial that the mere fact and the amount of money given at the end of the visit/intervention does influence decisions rendered by the physician at the following encounter. As a result of this consideration, generally speaking, tipping is a form of corruption regardless of its timing[6].

Legal and Ethical Aspects of Tipping

The legal status of tipping in Hungary is controversial. Although tipping as a form of bribery is an illegal and punishable act, it is common knowledge that tipping given after the treatments, therefore only as a sign of gratitude, is not against the actual law (Ádám 1993, 183–190). This misbelief is strengthened by the very controversial fact that the money earned by tipping must be declared to tax authorities. Ádám, a lawyer and expert in questions of tipping argues that it is an interesting phenomenon, which he calls 'phantom law'. This means that lay people and often lawyers believe in the existence of such regulations, which never existed and are in contrast with the actual and effective legal regulations. Many people and even professionals, however, are convinced of their existence, they often cite them (without reference), and in this way these phantom-regulations become a relevant part of the professional life and common knowledge (Ádám 1993, 197–199). This is a peculiar sociological and psychological phenomenon. There are also other phantom laws among Hungarian health care professionals, such as:

- It is forbidden to accept tips from a relative of a health care professional.
- Passive euthanasia is not a punishable act.
- Patients with incurable diseases need not be precisely informed about their real condition (Sándor 1997, 23).

These phantom laws often represent the moral desires of professionals. The fact that the effective law is often misinterpreted and is not enforced has an important consequence in my opinion. Although it is possible that some people act in good faith and are convinced about the legality of tipping after the treatment, it is well known that tips are frequently given prior to the interventions to gain benefits, like skipping the waiting

[5] I think the vast majority of physicians would prefer a decent salary, which could result in the honest refusal of money offered by patients. Many rhetoric attempts have been recommended by different government authorities to solve this issue, but nothing changed substantially.

[6] Another twist of tipping is that some private insurance companies cover the amount patients pay as tips in their life insurance package. Biztosítás hálapénzre. *Magyar Nemzet*, 23 March 2000.

list for surgery, or getting a bed in a ward with a single bed instead of getting a bed in a ward with 6-12 beds or lying on the corridor, and so on. The legal status of these latter acts is evidently bribery. The fact that even these forms of tipping remain unpunished undermines the respect and power of legal regulations in general.

To enumerate all the ethical implications of tipping would be beyond the boundaries of this paper. I discuss some of them in other parts of this paper. Here I briefly summarize the statements of the Code of Ethics of the Hungarian Chamber of Physicians effective as of January 1999.

It states that expressing gratitude is based on an unforced and free decision, whereas the money of gratitude (or tipping) happens when the patient or his relative gives money to the physician after the treatment. A sharp distinction must be made between the money of gratitude and financial offerings given in advance or forced with implied conduct. The latter is considered already as corruption and blackmail. It is unethical for the physician who commits elective abortion to accept money of gratitude or any other financial offering from the patient. According to the Code, tipping is due to the low salary of physicians, which is humiliating for them. Tipping is a result of the dysfunction of the health care system[7]. One could not agree more with the last statement, however, it is a question how dysfunction might be defined, what the underlying causes of this dysfunction are. Furthermore, as I mentioned above, it is also questionable whether the distinction of the moral status of tipping can be based on the timing of the act.

Law and Ethics in Clinical Research on Human Subjects

Hungary is in a specific position regarding clinical research on human subjects. Due to recent democratic changes in the country and the fact that the legal regulation of research conducted on humans also enables foreign companies to meet international standards (like FDA regulations), Hungary became an approachable and accessible place to conduct clinical trials. In addition, low labor-related costs and the relatively developed health care infrastructure favored investment by multinational companies.

Let us see now these facts and their consequences. The legal regulations of clinical research conducted on human subjects indeed meet the requirements of the international guidelines and declarations: voluntary, informed consent is required, research must be done in accordance with the most recent scientific standards, the risk/benefit ratio must be assessed and minimized. The Helsinki Declaration is not only an ethical requirement, it is part of the effective law. So is the case with the Good Clinical Practice of the European Union. Some leaders of governmental institutions and ethics committees are especially proud of this fact and in addition to this, they often mention with pride that legal requirements are even stricter than the European standard. This situation is generally the answer for inquiries about the actual ethical standards of clinical research conducted on humans.

To understand the deeper interactions of law, ethics and practice, we must analyze one major conflict of interest here. Due to the scarcity of resources in research and development, the governmental support of clinical research is very inferior. Since clinical

[7] The Code of Ethics of the Hungarian Chamber of Physicians 1.11.64–66, 69.

trials, such as randomized controlled trials are very costly, it is no wonder that the vast majority of clinical trials are organized and financed by foreign for-profit companies.

On the other hand the 'publish or perish' principle binds also the Hungarian physician-researchers. Their careers largely depend on research activities and publications in internationally recognized journals. Since research is usually very expensive (money acquired from tipping is certainly not nearly enough to cover the costs of research), physicians must find other resources. Practically, the only solution is offered by multinational companies. These find a favorable financial and scientific niche for conducting research in Hungary. Therefore their investment in research has become one of the major factors determining clinical research.

Nonetheless, the allocation of these research funds is slightly controversial. They are not publicly advertised, nor are the criteria made explicit. In the majority of cases a covert pressure is exercised towards physicians to act in accordance with the interest of the profit-oriented companies. Failing to do so may result in lowered or discontinued support, which may mean the end of a scientific career.

The following true case from Hungary will illustrate these conflicts in the interests of companies, physicians and subjects.

Case Discussion[8]

A large international pharmaceutical company organized a clinical trial (phase IIIb) to compare the efficacy and safety of two doses of a trial drug for asthma given together with a long-acting corticosteroid (a drug that mitigates the symptoms of asthma) and a $ß_2$-agonist drug (that mitigates the symptoms of asthma immediately, as it is applied by the patient according to her needs). The trial randomized subjects into 3 arms. Two of them received different doses of the trial drug, the third received placebo. In addition to this, all subjects received the standard asthma therapy. The protocol has been reviewed and approved in many countries. These patients, who are quite seriously ill, need to take this medication also when they do not participate in the trial to achieve good quality of life. According to the trial protocol, no other asthma drug can be used during the trial, which is quite a standard requirement in these trials. In addition, the protocol requires that only patients who have not taken other asthma drugs for a certain time can be included in the trial. The required 'wash-out' varies based on the drug in question. According to our present scientific knowledge, asthma is a multicausal disease, and is best treated with different drugs given together at the same time because different drugs target different trigger pathways leading to asthma attacks. That is why other medications, like theophylline, are frequently given to patients with asthma. This corresponds to the professional standards.

So was the case of Mr. K., a 58 years old patient, who took steroid, $ß_2$-agonist and theophylline for more than 7 years. His condition was stable, he had no severe complaints. Since he was basically eligible for this trial, the attending pulmonologist, who sees Mr. K. regularly, and who was one of the co-investigators of the trial, approached him to

[8] This is a real case based on the personal experience of the author of this paper. Data are slightly modified for the sake of confidentiality.

participate in this trial. He consented to the participation. Nonetheless, his physician-investigator discontinued ordering theophylline (because with it Mr. K. would not be eligible) and therefore after a week Mr. K. became eligible for the trial. On the 13th day after the discontinuation of theophylline Mr. K. developed a severe asthma attack, he had to be admitted to the ER. He stayed in the hospital for six days to stabilize his condition. The dosage of the steroid had to be raised and theophylline was resumed, so the data of the patient regarding the trial drug was no longer eligible for statistical evaluation.

Thirty-forty percent of the patients had a similar history. Prior to the inclusion they received a therapy which was not allowed for the trial. Therefore, their physicians discontinued these drugs and recruited them to become research subjects. Some other patients also suffered from worsening of their actual asthma symptoms. The majority of them could compensate the lack of theophylline by administering more $ß_2$-agonist, or even the trial drug might have mitigated the symptoms to a certain extent.

The trial wanted to investigate merely the effect of the trial drug vs. standardized therapy. This is why no other asthma medication was allowed, and the 'wash-out' period of these drugs had to be considered. Therefore this requirement of the trial protocol is justifiable from a scientific point of view. Patients on other drugs are not eligible unless these other drugs are discontinued. If researchers do not apply this policy, they most probably are faced with many fewer eligible subjects. This contradiction is resolved in the aforementioned way. But how might it be realized?

The first point we must address is the informed consent of Mr. K. regarding the discontinuation of theophylline. Although the process of information disclosure by physicians towards patients is traditionally paternalistic, physicians and actually those who participate in this trial as co-investigators, surely feel they have to justify somehow why they should stop a certain treatment and that this justification should also be disclosed towards the patients. Physicians acting this way in Hungary may not necessarily consider this step as morally unacceptable. They develop ancillary theories and professional explanations like, 'the less drugs patients take, the less side effects will occur', or 'taking away this drug will not necessarily affect the patient's health, because the trial drug may compensate for it' (note that there is also a placebo arm), etc. Physician-researchers inform their subjects accordingly. The pressure of reseach might be so huge that one can imagine physicians themselves may really be convinced about the validity of these 'auxiliary justifications'. Arguing this way has a long tradition in the country, the acculturation process to accept it begins already in medical schools.

If we look at the research itself from a legal point of view, we will not find any controversies. A voluntary and valid informed consent was obtained, therefore if auditors review this case, they will not report any problems. Research itself, from the time of inclusion was conducted according to the legal regulations.

Still, it is evident that the rights of Mr. K. have been infringed. The Declaration of Helsinki requires that the interest of patients must be the first concern. This means that no therapy modification might be justified merely for the sake of research. One may argue that during the therapy no modification happened, but this is only formally true. Since theophylline is an effective drug, with less severe side-effects than steroids, even if subjects were informed about the modification of the therapy they receive and consented to it, investigators should have considered to refuse this consent since the efficacy of the trial drug is uncertain (it might be placebo as well). It is because the

Declaration of Helsinki also requires that the best available standard therapy must be given to subjects.

Morals and law contradict each other in our situation, confirming the theory that acts that are considered legal are not necessarily morally acceptable[9]. In order to understand the underlying cause for these actions of researchers, let us turn our attention to the motivations whereby the system of research subvention facilitates disrespecting subjects' rights.

It is one of the prime interests of companies sponsoring research to recruit as many subjects as possible. This interest is transferred to the researcher in the form of a very powerful incentive – a per capita payment. The more subjects who are recruited and included, the more money is provided for researchers. Other forms of funding depend also on the collaboration of researchers and one of the best signs of willingness to collaborate is the increasing number of included subjects. As I mentioned earlier, research activities, participation in international conferences, access to expensive scientific resources like different research devices or textbooks is very often just a desire without the direct support of profit-oriented companies. Often the price for these will be paid at the expense of subjects. High standard legal regulations in themselves may not guarantee high level morality. The fragility of the democratic traditions and democratic institutions of health-related organizations of Hungary is certainly a determining factor that contributes to these anomalies[10].

Law and Ethics in Life and Death Decisions

Abortion has a peculiar role in Hungarian health care, which helps us to illustrate the controversial situation of law and morals.

In 1953 a very strict abortion law was introduced, threatening physicians committing induced abortion with very severe punishment (Kovács 1991a). This situation was drastically changed in 1956, when abortion became legalized and virtually all women who wanted to terminate their pregnancy could do it. Although a committee was established to review and authorize all requests, this committee had only a formal role and served only as a tool of the political system to humiliate women. The result of this liberal

[9] If we look at this from a wider perspective, it is certainly true that the consent for the discontinuation of the therapy prior to the research was in itself invalid and therefore illegal. However, strictly taken, this does not affect the legal status of the research.

[10] There are numerous factors present which allow these morally questionable policies to happen. These include: 1. the formal role of Hospital Ethics Committees, and their inadequacy in terms of direct impact to follow-up research activities and subjects' rights; 2. lack of adequate audit of governmental authorities like National Institute of Pharmaceutics or Central Research Ethics Committee; 3. lack or weakness of patients' or research subjects' support groups.
Difference between the Western and Hungarian professional standards concerning the treatment of asthma might also be a theoretical possibility. This would mean that in those countries where the protocol, its inclusion and exclusion criteria have been designed, there are proportionally more patients eligible for the given trial. In Hungary the standard of practice might differ from that of the country where the research protocol was written (due to special reasons, like differing reimbursement policies of insurance companies, financial shortage, differing marketing strategies of pharmaceutical companies, etc.). Therefore, if researchers want to comply with the requirements of the companies with regard to the required number of included subject, often they are forced to decline from the legal or moral standards.

regulation was an unprecedented increase of the number of abortions. Between 1959 and 1973 the number of abortions outweighed the number of live births[11]. All pro-life (mainly religious) arguments were silenced till the end of the 1980s. Even gynecologists who had personal value conflicts were forced to commit abortions by their supervisors if they wanted to remain in practice. The new bill called 'Bill for the protection of the Fetus'[12] in 1992 continued to provide wide possibilities for social indication for abortion till the 12th week of pregnancy. Physicians are no longer forced to participate in elective abortions against their will. This right is mentioned in the Code of Ethics of the Hungarian Chamber of Physicians (Code of Ethics) as well[13].

Tipping is very common in the gynecology-obstetrics practice. Actually, gynecologists benefit perhaps the most from the tipping system. It is very interesting, however, that the actual Code of Ethics states: 'It is unethical if the physician committing elective abortion accepts money of gratitude or any other offering'[14]. I think this statement of the Code of Ethics reflects the uncertainty, cloudiness and confusion existing in the present practice of medicine in Hungary.

Although tipping is an uncomfortable phenomenon, it might not be eliminated promptly. It is the result of the dysfunctional health care system. This fact is reflected in the Code of Ethics (as mentioned earlier) by acknowledging the presence of tipping without any comment or moral judgment. Therefore accepting money from patients cannot be morally wrong in this situation if one adheres only to the Code of Ethics. On the other hand, elective abortion is legally permitted under certain circumstances, but the Code of Ethics does not state that it is morally unacceptable. The only obligation physicians have is to 'argue for continuing the pregnancy'[15]. This shows that there is a slight uncertainty about the moral status of elective abortion in the Code of Ethics, however, it does not state that it is immoral. Gynecologists often use a similar, but certainly contestable argument to justify their action: it is better not to be born than to be born as an undesired child.

It is interesting that these two actions (accepting tipping and committing elective abortion) have been implicitly considered as acceptable actions from a moral point of view, if they occur separately. Nevertheless, when they occur together they become immoral. Although the intention in the standpoint of the Code of Ethics is probably the prevention of physicians' undue encouragement of women to ask for elective abortion, the contradiction is obvious. Once tipping is the consequence of dysfunctional health care and a contribution to the salary of physicians, why should they refrain from accepting it for abortion? What if a gynecologist's task is restricted to undertaking elective abortion for a period of time? Furthermore, if elective abortion is not immoral (as the Code implicitly assumes), what is the difference between accepting money for a face-lift and accepting money for elective abortion? This confusion of the effective law and the morals is not reflected only in the Code of Ethics but also among physicians and others.

A recent case of abortion helps to illustrate the controversial situation of ethics (or

[11] Baló, Gy. – Lipovecz, I. (eds.). *Tények Könyve '89* cited In Kovács 1991a.
[12] Act N°79 of 1992 of the Hungarian House of Parliament for the Protection of the Fetus (Magzatvédő törvény, 1992. évi LXXIX törvény).
[13] The Code of Ethics of the Hungarian Chamber of Physicians 1.12.70.
[14] The Code of Ethics of the Hungarian Chamber of Physicians 1.12.76.
[15] The Code of Ethics of the Hungarian Chamber of Physicians 1.12.72.

presumed morals) and law in this country as well. A 13-year-old girl lied to her friend by stating that she was 16. She had sexual intercourse with him and became pregnant. She wanted to have abortion and her mother agreed with her. The girl, however, visited a priest, who declared her planned abortion to be murder. It is unclear whether the girl became uncertain and notified an organization to help her against the will of her mother, or whether the priest himself wanted to preserve the life of her fetus. What is sure is that a Pro Life organization stepped in as an advocate of the fetus and asked the court to inhibit the abortion. The court decided on the first level that the right of the fetus outweighed the right of the girl for self-determination[16]. This decision triggered passionate debates, and even some lawyers questioned whether this decision was in accordance with the effective Hungarian law and the constitution. Many other issues were raised concerning this case, one of which is especially interesting. The minister of health stated that since the court's verdict is not effective (it might be appealed, which was true at that time), and it did not explicitly prohibit the abortion, the abortion was allowed to be performed[17].

This statement excellently reflects the overall attitude of Hungarian health care toward the law. It is implied here that once moral judgments (or an alleged majority moral attitude which allows elective abortions) happen to contradict a decision of the court, then let us ignore it. The law is only a tool, and if one thinks that her morals are in conflict with the law then it is the person's choice to render a decision according to her values.

Why is this case worth mentioning here? A minister in a democratic country, where the different branches of power are separated, is responsible for executing and safeguarding the law constituted by the members of parliament, while jurisdiction is the task of courts. When a minister interferes in jurisdiction, and declares his opinion in a certain case, then he overrides his task. However, moral considerations are often thought to have priority over legal requirements.

This might be the reason why the minister of health made such a statement. Since it is assumed that the majority opinion in Hungary is that the right to abortion overrides the right of the fetus to life, the decision of the court should be disregarded. It is not the legal procedure of appealing that should be prioritized. I think these considerations are partly the consequence of tipping as well. Once tipping is illegal, or at least its legal status is strongly ambiguous, and at the same time it is tolerated and not debated from a legal point of view, the power and respect of law is undermined. Therefore, in questions posed like that above, there is often an attempt to bypass law.

Questions and moral problems regarding withdrawing and withholding treatments, futility or respecting the patient's autonomy were ignored during the last decades in Hungary. Although the doctor's duty was to do the utmost for their patients (Balasszauer 1995, 1598), passive euthanasia was and still is a standard but unpublished and unacknowledged practice in the country. Decisions at the end of life are often masked as strictly medical decisions or disguised forms of resource allocation (Kovács 1991b).

The following case will help us to concentrate on the peculiar problems existing in Hungary.

[16] *Magyar Hírlap*, 24 March 1998.
[17] *Magyar Hírlap*, 24 March 1998.

The four-day-old infant was being maintained on a respirator due to severe respiratory deficiency. While there had not been time for chromosomal analysis by karyotype, all evidence pointed to a diagnosis of Trisomy 18, a genetic disorder leading to severe mental retardation, growth failure, and numerous anatomical abnormalities. While there have been scattered reports of patients with the anomaly living to adulthood, 87% die within the first year of life. A conference was held to decide what to do with the infant.

The Chief of Pediatrics reported several conversations with the father, who had said, 'If you cannot guarantee that my child will be normal, I don't want you to do anything for it.' The Chief said that he shared the sympathies of the father and had told him, 'I promise to do everything in my power to see that your wishes are carried out.'

A psychiatrist also had several conversations with the father and felt that the father was in a state of acute denial at the time; however, if the respirator were turned off at the father's initiative, later feelings of guilt could create psychiatric problems for him. He also noted that parents who bring a retarded child home only to have it die later might well suffer guilt over that also.

The psychiatric social worker contradicted the psychiatrist and stated that she felt that the family would be put under extreme stress if the infant were brought home.

At this point, the nurse who had been most directly responsible for the care of the infant interrupted with an obvious sense of outrage. She insisted that the infant had every right to live and could not be allowed to die by the hand of man. In fact, if necessary, she said she was willing to try to adopt the infant and care for it herself.

A pediatric resident called attention to a patient of his own who had a slight respiratory difficulty but could not be put on a respirator because the Trisomy 18 infant was using the last available machine. Without the respirator, the other infant, who was otherwise healthy, may have run a 50% risk of some brain damage[18].

This case was reported in North America, but it could certainly have been reported in Hungary as a typical case as well. It helps to illustrate the fundamental difference of the two systems, and to focus on the very nature of the present Hungarian way of thinking.

A decent bioethicist would start to analyze the case at this point, describing how the different interests and values are confronting each other, what the relevant medical facts are, what the effective legal regulation in the given country is, what kind of solutions are acceptable here, how the different parties would accept that, and so on.

In fact, we could do that in the Hungarian context also for a second to highlight the controversy. As mentioned, all forms of euthanasia are illegal and the Code of Ethics declares them as morally unacceptable. On the other hand, according to a survey, seventy-nine percent of physicians working in neonatal intensive-care units in Hungary do not believe that every possible effort should be made to sustain life in all circumstances[19]. Furthermore, we should ask what the chief pediatrician, the father, the nurse and the resident exactly thought about the case, and why they though what they thought, and what is the difference between passive euthanasia and futile treatments.

[18] Case by Robert Veatch, personal communication.

[19] SCHULTZ, K. 1995. A Report from Hungary: Hungarian Pediatricians' Attitudes Regarding the Treatment and Non-Treatmen of Defective Newborns. A Comparative Study. *Bioethics*, 1995/1: 41–56, cited In BLASS-ZAUER 1995, 1598.

However, all these considerations fail. They fail, because a hidden factor may influence the whole scenario to the extent that it may become not only totally incomprehensible, but also often unresolvable in a correct way.

This hidden factor is the tipping.

When we try to analyze the case, we will come to points where it becomes cloudy enough to stop us from going further. The first such point is the fact that the chief pediatrician 'shared the sympathies of the father'. What does that mean exactly? First, it may mean that the pediatrician has been offered tipping, so she feels obliged to fulfill the requests of the father. Second, it may mean that he has not received yet anything, but there is a good chance that if she influences the outcome of the case in that way that it will be favorable for the father then she will receive a tip. In both cases the uncertainty is outrageous. In the place of the nurse or the shocked mother, who may feel for the child as well, one would be deeply biased whether the assessment of the present medical condition and the future prospects of the baby by the chief pediatrician is objective. Whether it is unduly influenced to favor the father or not. Third, it may certainly represent the honest feelings and professional judgment of a health care professional, which are probably influenced by some personal values as well.[20]

Since, however, tipping is an existing, but hidden reality occurring rather frequently in Hungary, one can never know which of the these possibilities are present in the given clinical cases. Even the father, who knows about the existence or absence of tipping may not be aware of the existence of potential hidden motivations of the chief pediatrician's sympathy: to be honest, to get more or to favor?

Since health care professionals and especially physicians always have to navigate very cautiously between the well-defined objective facts, the parameters of Scylla and the uncertainty and subjectivity of Carybdis regarding the interpretation of the facts in an actual case, the existence of tipping may easily, although unduly or unconsciously, influence even the most honest personalities.

These considerations might be continued by further analysis of the case. What about the evaluation of the needs of the resident's own patient? Does the child really need the respirator, or is it just a measure to ensure maximal safety for a child of well-paying parents? What does the 50 % risk of some brain damage mean? How was it assessed? Is the chief pediatrician's shared sympathy toward the father just a way to facilitate allocation of scarce resources? Or is this sympathy the consequence of the fact that he was tipped by the parents of the other child? Biases like this are virtually endless.

And here is the point when a lot of my colleagues in Hungary would say, let us stop for a while. They would argue that no physician would accept tipping in a situation like this, when it is about the life of a seriously defected newborn baby. And even if someone would, she would never be influenced by that fact. Maybe it is true. Nevertheless, my argument is that one can never be sure about assessments and decisions, whether they are based on scientific evidence combined with experience of long practice or whether they are in a situation of conflict of interest. Therefore the interrogation of the basis of statements and assessments is theoretically always justifiable. This uncertainty, however, leads to the sad and often tragic fact that clinical cases might not be understood and

[20] Certainly, there exist combinations of these variations. Nevertheless, these represent probably the most important ones, and are sufficient here to illustrate my point.

analyzed fully, since the hidden facts may not be unraveled until the unfortunate system of tipping is maintained. Health care in the country is a masked ball. Law and ethics are just masks to hide the essence that governs them.

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