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Healthcare facility manager and patient rights – legal framework and responsibility. A systemic analysis from the public health perspective

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Abstract

Introduction and Objective. The aim of the article is to provide a systematic analysis of the legal framework and various forms of responsibility of the manager of a healthcare facility in Poland in the context of patient rights. It emphasises that effective management in this area is not only a matter of compliance with the law, but is also a fundamental factor determining the health outcomes of the population.

Materials and Method. The study is based on interdisciplinary methodology integrating legal analysis, public health, and healthcare management. Sources included legal acts, case law, and scholarly literature from databases such as PubMed and Google Scholar, selected through key word searches. Methods of analysis and synthesis, deduction and induction, and critical analysis of factual and legal contexts were employed. The study also includes participant observation from the authors' experience, enabling comparison of legal norms with healthcare practice and international approaches.

Results. The analysis reveals that healthcare facility managers bear diverse legal responsibilities (civil, criminal, and disciplinary) arising from key regulations, such as the Act on Patients' Rights and the Patient Ombudsman and the Act on Medical Activity. Organizational culture, internal policy, and teamwork fundamentally influence patient rights, safety, and positive patient experiences, which are crucial for public health. The crucial supervisory role of the Patient Ombudsman is also emphasized.

Conclusions. Effective management implemented by healthcare facility managers, based on a thorough understanding of patient rights and their systemic responsibilities, is crucial for creating a high-quality, safe and patient-centred healthcare environment. This directly contributes to improved public health and increased resilience of the healthcare system.

Key words

public health, patient rights, healthcare system, healthcare management, patient experience, legal responsibility, patient safety culture, healthcare facility manager

INTRODUCTION

Patient rights are treated as an integral part of the right to health and life, as well as a tool for strengthening the quality and safety of medical care. In the Polish legal system, the basis for the protection of patient rights is the Act of 6 November 2008 on patient rights and the Patient Rights Ombudsman [1], which systematises the catalogue of rights to which patients are entitled and creates an institutional framework for supervising their observance.

The starting point for the considerations in this study is the role of the healthcare entity manager in ensuring compliance with patient rights. In the factual circumstances concerned, medical facility managers are not limited solely to supervising the personnel, but bear responsibility for the compliance of the healthcare entity's functioning with applicable regulations. Based on this, the thesis of the study was formulated: the effective management of the healthcare entity manager, in terms of complying with patient rights and improving the quality of care, is linked to their legal as well as organisational responsibility.

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Regulations concerning patient rights are embedded in a broader legal context, including the Act on Medical Activity of 2011 [2], which defines the obligations of entities performing medical activities, and the provisions of the Civil Code [3] and the Criminal Code [4], which provide for civil and criminal liability for violations of patients. personal rights. This framework creates a system in which patient rights are not merely declarative, but binding and enforceable. The key rights include the right to health services in line with current medical knowledge, the right to information, to give informed consent, respect for privacy and dignity, confidentiality of information, and access to medical records [5].

At the European Union level, an important legal act is Directive 2011/24/EU on the application of patient rights in cross-border healthcare [6]. This directive introduces the principle of free access to medical services in other Member States and obliges Member States to provide patients with transparent information on available services, standards of care and the possibility of reimbursement. In practice, this means that Polish patients can seek medical treatment abroad, and healthcare providers in Poland are obliged to accept foreign patients appropriately, which requires not only knowledge of the regulations but also appropriate adjustments to the organisational structure. In this context,

a special role is played by the managers of medical facilities, whose task it is to ensure compliance with EU standards.

In Poland, institutional protection of patient rights is implemented by a number of entities, ranging from the Patient Ombudsman, through common courts, to professional medical associations. The Centre for Quality Monitoring in Healthcare, which develops accreditation standards for medical facilities, also plays a special role. A new approach in these standards is not only the measurement of satisfaction, but also a comprehensive assessment of the patient's experience in contact with the healthcare system – including information, communication, comprehensibility of the diagnostic and therapeutic process, and the degree of respect for patient rights in institutional practice.

Contemporary protection of patient rights is an element of quality and safety management in healthcare and, at the same time, a mechanism for building trust in the healthcare system. Responsibility for its implementation extends across many levels – from individual decisions made by medical staff, through management supervision, to the shape of systemic control mechanisms and institutional accountability. Given the interdisciplinary nature of the issue, a qualitative and interpretative approach was employed to integrate normative legal analysis with insights derived from practical experience in healthcare management.

Patient rights and their protection – legal and institutional perspective. Patient rights are part of medical law, which comprehensively regulates relations in healthcare. Medical law is a branch of law evolving before our very eyes, covering issues related to medical treatment [7]. This concept has long functioned in legal language, but this law has been separated as a new branch of law only recently [8]. The process of its separation is exceptionally fast, just as fast as the contemporary development of medicine itself. It is not codified, and the provisions are scattered in various places: in the constitution, international conventions, codes, and acts [7].

The basic idea behind these rights is to treat the patient as an entitled person, which is a relatively new approach historically. The concept of the patient as a subject of rights only emerged during the Enlightenment, and in practice – mainly in the 20th century. Since 2008, patient rights have been regulated by the Act on Patient Rights and the Patient Rights Ombudsman.

The contemporary approach to protecting patient rights focuses on strengthening patient autonomy and participation in decisions regarding medical care, which is crucial from a public health perspective as a factor in building trust in the healthcare system.

Article 68 of the Constitution of the Republic of Poland guarantees citizens a number of fundamental rights which shape the framework for healthcare and patients' rights, which reads: 'Everyone has the right to health care, and public authorities are obligated to ensure equal access to publicly funded healthcare services for all citizens, regardless of their financial situation'[9]. These rights go beyond ordinary legal entitlements, shaping the ethical dimension of the doctor-patient relationship and influencing the overall quality of services provided. The catalogue of these rights also reflects other constitutional values, such as human dignity (Art. 30) or the protection of private life (Art. 47). Thus, patient rights are a specialised form of realising constitutional guarantees

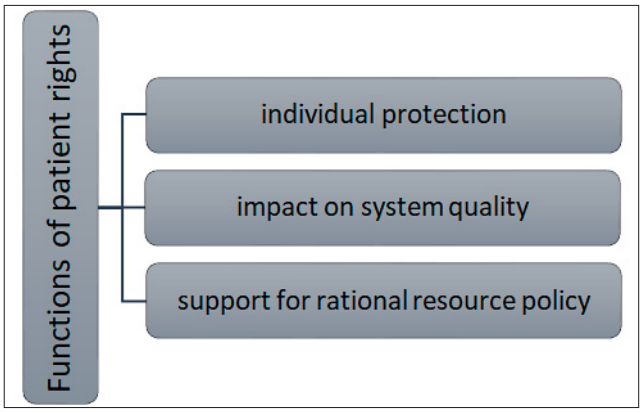

Figure 1. Patient rights in the context of public health

in the context of the patient-healthcare system relationship.

In Poland, the legal foundation is the Act of 6 November 2008 on Patients' Rights and the Patient Ombudsman [1], which establishes a set of personal rights (to healthcare services, information, consent, respect for dignity and privacy, access to medical records, and objection to a physician's opinion) and creates the institution of the Ombudsman responsible for their protection and enforcement. A significant extension is the Act on Medical Activity [2], which specifies the organizational and management competencies of the facility manager, including responsibilities regarding procedures and the quality of services.

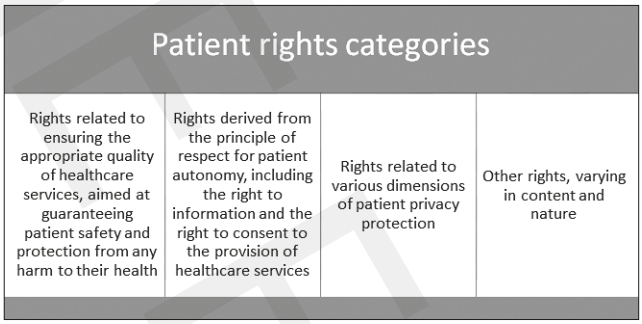

Figure 2. Categories from the catalogue of patients' rights

The protection of patient rights is also associated with civil liability and criminal liability (Criminal Code), which provide sanctions for the violation of a patient's personal rights, life, health, or dignity [10, 11]. This integration of legal norms ensures the effective enforcement of patient rights and enables the pursuit of claims against individuals or institutions. Civil liability (Art. 444–445 of the Civil Code) performs a compensatory function, enabling the patient to seek compensation and redress for the damage suffered. Criminal liability (Art. 160 §2 and Art. 231 §1 of the Criminal Code) is penalising and applies when the violation of patient rights constitutes a crime. In the context of medical errors, they may concern both medical staff and, in specific situations, unit managers who are responsible for organisation and supervision (Art. 34 of the Labour Code) – the so-called organisational error. At the EU level, a key role is played by Directive 2011/24/EU on the application of patients' rights in cross-border healthcare, which establishes the patient's right to use services in other EU Member States, the right to information about available services, reimbursement mechanisms, and the protection of the quality and safety of

services [12]. Implementation of these principles requires Polish facilities to adapt organizational, information, and communication procedures – which is the responsibility of the healthcare facility manager.

At the same time, there are non-statutory standards that are nevertheless relevant to quality policy and public health. The European Charter of Patients' Rights, formulated by the Active Citizenship Network, contains 14 fundamental rights, such as information, consent, safety, participation, and respect for the patient's time [13]. In addition, the WHO and the OECD promote a model of people-centred care, in which the patient experience is central as an indicator of quality and an element of system monitoring [14].

The healthcare facility manager and patient rights – between management and responsibility. The responsibility of the manager goes beyond purely administrative or financial management, encompassing direct supervision and practical implementation of patient rights throughout the organisational structure. On the one hand, he/she is obliged to ensure that the facility's activities comply with Art. 68 of the Polish Constitution, the Act on Medical Activity and EU directives and, on the other hand, to implement organisational procedures that translate patient rights into everyday medical practice. The manager is responsible for ensuring that the entity's activities comply with the legal requirements concerning patient rights. This legal provision establishes the manager as the main point of responsibility for the entity's compliance with patient rights.

The manager also has the legal right to restrict certain patient rights (e.g. contact with other people) in strictly defined legal circumstances, such as an epidemic threat, patient health safety considerations, and, in the case of certain rights, also due to the organisational capabilities of the facility. This ability to restrict rights, although legally defined, carries a significant ethical burden and requires transparent justification to prevent arbitrary restrictions. The manager must therefore maintain a complex balance between the individual rights of the patient and the broader public health or operational needs of the institution, always requiring justification and documentation in the medical records [5]. This situation creates a critical tension in which the manager must navigate ethical and legal complexities, balancing the autonomy of the individual patient with broader public health imperatives or institutional constraints.

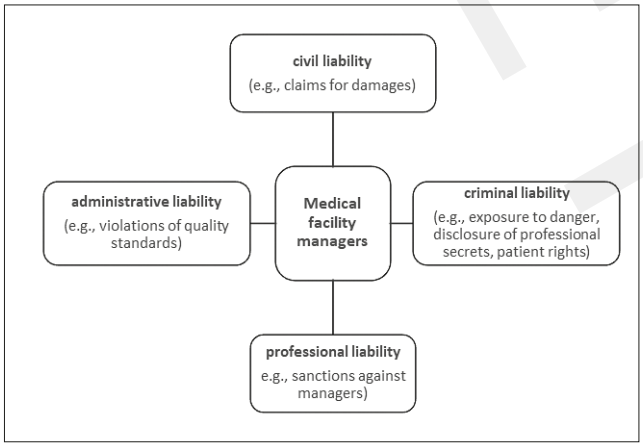

Figure 3. Responsibility of the manager of a healthcare facility for violations of patient

Medical facility managers bear real responsibility for violations of patient rights. Errors or failure to implement procedures may result in liability (Fig. 3).

International research and literature emphasize that effective management of patient rights requires a modern organizational culture based on transparency and a culture of learning. The concept of *'no-blame culture'*, promoted by *The Institute of Medicine* in its report *To Err Is Human*, assumes that employees should not be punished for errors but rather analysed for the systemic causes of events [15]. The author of the book *To Err Is Human* argues that the problem is not bad people employed in healthcare, but good people employed in bad systems that need to be improved in terms of safety. Nevertheless, newer concepts, such as '*just culture*', emphasize the need to balance individual responsibility with systemic analysis of events – even if this means responsibility for predictable and preventable errors [16]. In the Polish medical environment, where a culture of formal responsibility often prevails, implementing a transparent and supportive management atmosphere can significantly improve the quality of medical services and patient rights. Empirical studies confirm that in a blame culture, as many as 42% of error reports directly blamed a specific individual, significantly limiting the educational and corrective dimension of the patient safety system [17]. Furthermore, the results of a study conducted in the nursing environment showed that a developed just culture fosters open incident reporting, increases employee trust, and subordinates responsibility to the clear principle of proportionality [18]. Similar conclusions are drawn in other analyses conducted at the medical and management levels – systems equipped with clear rules and leadership support the promotion of incident reporting, which fosters more effective learning [19].

In the context of management, *psychological safety* also plays a key role, meaning the sense of the psychological safety of a team, enabling them to report errors without fear of repercussions. A study published in the *Journal of Patient Safety* demonstrated that collaborative leadership, shared responsibilities, and a feedback system, are crucial for building a culture conducive to reporting problems [20]. In turn, analysis of NHS and WHO data emphasizes that healthcare institutions should strive for transparency and the creative use of errors as a source of systemic learning [21].

Recent evidence suggests that public health structures not only promote but actually require health institution managers to shift from an administrative to a quality-oriented approach through the active implementation of complaint systems, monitoring, internal training, and transparent audits [21]. In this context, leadership involves implementing policies that enable both the prevention of errors and their constructive explanation. Thus, Polish law, through the Act on Quality, introduces all these principles into Polish hospitals.

An effective adverse event reporting system is the foundation of patient safety. In Poland, pursuant to the Act of 16 June 2023 on quality in healthcare and patient safety, all entities providing medical services are required to establish an internal quality and safety management system by 30 June 2024. This Act imposed an obligation on managers of healthcare entities to keep a register of adverse events, but this obligation does not only mean creating a registration system, but also ensuring that root cause analyses of each incident are carried out, implementing systemic changes, and monitoring

the effectiveness of the measures introduced. The obligation to publish quality reports is of systemic importance: it enables the comparison of facilities and the use of data for public health policy [22].

The manager of a healthcare entity occupies a key position between law and practice: they must ensure that the activities of the entity comply with applicable regulations, while at the same time creating a culture of responsibility ('*just culture*') that enables the reporting of errors, learning lessons, and real improvements in the quality of care. Managers of healthcare entities play a key role in promoting this approach – through training, continuous feedback and supportive leadership [23] proportional response, which is an essential condition for effective public health policy. These issues were included in the Act on Quality in Healthcare and Patient Safety [24] and the Announcement of the Minister of Health of 6 September 2024 on accreditation standards for medical activity in the nature of 24-hour and stationary hospital healthcare services [25].

From a public health perspective, patient rights and the responsibility of healthcare managers are not isolated legal concepts, but integral components that influence the safety, quality and equality of healthcare services for the entire population [26].

Protecting individual patient rights is not merely an ethical or legal obligation. It is a crucial early intervention in public health that promotes a healthier population. When patient rights, such as the right to information, informed consent and privacy, are consistently and effectively respected, patients are more likely to actively participate in the medical treatment process and adhere to therapeutic recommendations. This increased engagement and adherence directly contribute to improved individual health outcomes, such as higher cure rates and better long-term health outcomes [27]. The accumulation of these positive outcomes at the individual level translates into significant public health benefits.

Responsibility for protecting patient rights – practical, systemic and institutional challenges. Patient rights and the responsibility of the head of a healthcare facility are not isolated legal or managerial concepts, but are deeply integrated into the functioning of the entire healthcare system. The manager of a healthcare entity bears diverse legal responsibilities arising from their managerial and supervisory role in a medical institution. These responsibilities are civil, criminal, disciplinary and employment-related, and their attribution depends on the circumstances and nature of the violation. Liability for medical errors is multifaceted and encompasses four main regimes: civil, criminal, disciplinary and employment. Under civil liability, the healthcare entity – as an employer or direct service provider – is liable for damage caused to the patient. If a patient suffers damage as a result of an action, omission or negligence on the part of the staff, they are entitled to civil claims in the form of compensation (Art. 444 of the Civil Code), a pension (Art. 446 § 1 of the Civil Code), compensation (Art. 445 of the Civil Code) and reimbursement of treatment and rehabilitation costs.

As a rule, a lawsuit is brought against the healthcare entity and not against specific managers, unless their personal fault has been proven. An example is the judgment of the Court of Appeal in Łódź (Case File No. IACa 621/14) in which it was found that the infection sustained by the plaintiff during her hospital stay resulted from the failure of the medical staff to exercise due diligence in ensuring adequate sanitary conditions [28].

Criminal liability is based on the principle of fault and does not automatically result from an undesirable outcome of treatment. In order for it to apply, the act must be socially harmful and prohibited under penalty of law. The issue of the so-called organisational error is a significant category from the perspective of management staff's liability which often coexists with medical errors. In the judgment of the District Court in Zgorzelec of 13.03.2013 (Case File No. II K 63/10) the court noted that: 'an organisational error is not a case of medical malpractice, although it may be associated with a technical, therapeutic, or diagnostic error'. An example is the case of the director of the Hospital in Słupsk, who was accused of exposing patient M. S. to the direct danger of loss of life or grievous bodily harm as a result of improper work organisation in the Hospital Emergency Department and the Gynaecology and Obstetrics Ward. It was alleged that by failing to employ a doctor specialising in gynaecology and lacking 24-hour diagnostic capabilities, he allowed a situation to arise that led to life-threatening haemorrhagic shock for the patient, thereby meeting the elements of the act defined in Art. of the Criminal Code. However, analysis of the facts led the Court to the conclusion that the accused acted within the framework of applicable regulations and within the limits of his competences. He was acquitted by the District Court in Słupsk (Case File No. XIV K 54/15, Judgement of the Court, 5 December 2017).

The third form of liability is disciplinary liability, concerning violations of professional ethics and deontology, and taken into consideration by professional self-regulatory bodies, such as Medical Courts. This type of liability has a direct impact on the professional status of a doctor, as well as on persons holding managerial positions, provided that they are licensed to practise medicine.

The last type is employee liability, which is an internal accountability mechanism which can be applied to employees who have made mistakes, violated internal regulations, or demonstrated inappropriate professional conduct. Sanctions in this regard may take the form of a warning, a reprimand entered in the employee's file, or, in the case of more serious violations, termination of employment. According to Art. 108 of the Labour Code, employee liability is limited to the employee bearing disciplinary liability for a culpable violation of work order or organisation. Art. 114–127 of the Labour Code specifies the permissible penalties: warning, reprimand, or a fine, defined in regulate material liability, including for damage caused by unintentional fault (limited to 3-months' remuneration) or intentional fault (in full amount), applied only for the most severe offences.

The complexity of the medical treatment process and the interaction of many people often leads to difficulties in precisely assigning responsibility for medical errors [29]. It is crucial to distinguish between individual medical errors and systemic organisational failures, which affects the assignment of responsibility to the manager.

Although the regulations [30] clearly indicate that in civil liability cases it is usually the hospital that is sued, and not the director personally, Art. 46(1) of the Act on Medical Activity introduces an important nuance: the manager of a medical entity bears 'full responsibility for management', which may extend to criminal and civil liability. This means

that although the institution bears direct civil liability for the mistakes of its employees, the personal liability of the manager (especially criminal or disciplinary) may result from his or her managerial negligence, i.e. failure to establish or maintain appropriate systems, policies or supervision that contribute to errors or violations of patient rights. This distinguishes responsibility for direct clinical actions from responsibility for systemic management.

Furthermore, the existence of separate forms of liability – civil, criminal, disciplinary and employee liability [29, 30] – is not accidental. Each one serves a different purpose: civil liability provides financial compensation to patients, criminal liability refers to serious violations of the law with social consequences, disciplinary liability upholds professional standards, and employment liability allows for internal organisational control. These diverse paths, although governed by different legal principles and procedures, together form a comprehensive system designed to deter misconduct and ensure accountability at various levels of the healthcare system.

The ability of the Patient Ombudsman to initiate proceedings in cases of violations of collective patient rights acts as a trigger, potentially leading to investigations that may result in various forms of accountability for the entity or its manager, thereby strengthening the interconnections. An example is the judgment issued in 2017, where the Supreme Administrative Court (II OSK 2619/16) upheld the decision of the Patient Rights Ombudsman to impose a fine of PLN 210,000 on a hospital for violating the collective rights of patients, confirming the judgment of the Provincial Administrative Court in Warsaw (VII SA/Wa 2697/16). The violations concerned, among others, charging fees for basic services, lack of individual therapeutic programmes, incorrect documentation, and improper ensuring of patient privacy.

The planned regulations impose a specific personal sanction on the healthcare entity manager in the form of Art. 69b of the Draft Act amending the Act on Patient Rights and the Patient Rights Ombudsman and the Act on the emergency notification system (RCL UD207). The planned Aricle. 69b provides for the possibility of imposing a fine up to 20 times the average remuneration directly on the natural person performing a managerial function (e.g., hospital director) from their personal assets, if that person, in the course of performing their function, through their action or omission, allowed a violation of the prohibition specified in 59 section 2 or failed to perform actions necessary to discontinue a practice violating the collective rights of patients. The justification indicates that the new power of the Patient Rights Ombudsman is analogous to that held by the President of the Office of Competition and Consumer Protection. Commentary on the provision of Art. 106 section 1 of the Act of 16 February 2007 on competition and consumer protection, which is analogous to the planned Art. 69b of the Act on Patient Rights and the Patient Rights Ombudsman:

> The purpose of the regulation discussed is to ensure the greatest possible effectiveness of the provisions of the Act. It can be assumed that the risk of punishing the entrepreneur will only in some cases be sufficient to discipline natural persons and encourage them to adopt behaviours desired by the legislator. Personal liability may be a significantly more effective means of pressure in this context, prompting those responsible for managing the entrepreneur to take actions in accordance with the law.'

At the same time, it should be indicated that regardless of the legal form (SPZOZ, commercial law company), the healthcare entity manager is obliged to respect patient rights and implement statutory regulations.

The performed examination of the scientific literature using the key words: 'responsibility', 'Healthcare facility manager' indicates that this issue is only beginning to gain importance in scientific research. Among the available studies, publications concerning the formal aspects of serving as a healthcare entity manager and the organisation of the healthcare system prevail, while issues of their *legal* liability remain marginally discussed. The position presented by A. Słowińska [31], M. Serwach [32], M. Gornowicz [33] and R. Pankiewicz [34] seems worth considering, as they indicate that the liability regime of the healthcare entity manager is multifaceted and functionally connected to their key managerial role in the healthcare system. In scientific discourse, it is emphasised that this issue is further complicated by the discussion of insufficient managerial qualifications, the lack of which may constitute negligence, hence forming the basis for holding the director liable for improper conduct of the affairs of a healthcare entity.

CONCLUSIONS

This study is not of a purely dogmatic and legal nature, but rather synthesizes analysis of patient rights and various forms of liability with a perspective on public health. It is argued that while the Polish legal framework, supplemented by EU directives, provides a solid foundation for patient rights, their practical implementation and effectiveness, and consequently their impact on public health, are deeply dependent on the management and leadership capabilities of healthcare providers. Accountability in healthcare extends beyond individual medical errors to encompass systemic shortcomings in management, organizational culture, and resource allocation. The function of a healthcare entity manager therefore requires balancing economic efficiency with the norms of medical law, which makes their liability regime one of the most extensive in the healthcare system, indicatuing the need for in-depth theoretical and legal analysis in this area.

Currently, the protection of patient rights constitutes not only the ethical and legal foundation of the healthcare system but also, increasingly, an area of risk management, oversight, and accountability. As demonstrated in this study, the manager of a healthcare facility becomes not only an enforcer of regulations but also the recipient of institutional, organizational, and axiological expectations. The scale of these responsibilities – coupled with the lack of symmetrical support mechanisms – raises questions about the sustainability and fairness of the healthcare system.

Discussions concerning the protection of patient rights also require consideration of the obligations of public authorities arising from Art. 68 of the Constitution of the Republic of Poland, both in terms of providing healthcare services and responsibility for their quality and accessibility. This

provision constitutes the constitutional foundation of the responsibility of the State for protecting the health of its citizens, which also requires ensuring mechanisms for enforcing patient rights. Currently, however, responsibility for system failure is often shifted to managers, physicians, and staff, without considering actual conditions such as staffing shortages, unrealistic organizational standards, or inadequate risk management instruments.

The Patient Rights Ombudsman serves a significant and necessary protective function, but his or her actions, focused almost exclusively on the best interests of the patient, often overlook the true complexity of clinical and institutional relationships. Ignoring the degree of patient co-responsibility for the medical treatment process (e.g., through non-compliance with medical recommendations) leads to a situation in which all responsibility rests with staff and managers, regardless of intentions, context, or realistic possibilities for preventing violations. Such a system promotes reactivity, not prevention.

In the face of these challenges, the idea of transitioning from a "*no-blame culture*" to a '*just culture*' becomes not only a modern approach to quality management, but a systemic necessity. Promoting such a model, especially in the view of the existing statutory adverse event reporting system, can create conditions for genuine improvement in care, without resorting to repression or scapegoating.

Despite the institutional changes introduced in recent years, the Polish legal system still fails to ensure balance in the protection of the rights of individual participants in the healthcare system. In 2010, the Bureau of Doctors' Rights was established within the structure of the Supreme Medical Chamber, and the function of the Doctor's Rights Ombudsman was entrusted to the body responsible for protecting the dignity of the profession and defending the collective interests of doctors [35]. In individual cases, the relevant bodies are the Doctors' Rights Ombudsmen operating at the Regional Medical Chambers. Their competences include intervening in cases concerning the violation of doctors' personal rights, and cases of inadequate preventive measures being applied during criminal proceedings [36]. The situation of nurses and midwives is different. The tasks of the Regional Professional Liability Ombudsman focus on conducting proceedings in cases of violation of professional practice rules and professional ethics [37]. This protection is primarily corporate in nature.

The least protected group are healthcare facility managers, for whom no forms of organised legal protection have been foreseen. As a result, a persistent imbalance can be observed in the Polish healthcare system: while patients and, to a certain extent, doctors and nurses benefit from institutional protection mechanisms, the management staff of healthcare entities remain deprived of analogous tools to secure their rights and interests.

It is also worth noting that the healthcare entity manager, although liable as a public official according to the provision of Art. 231 of the Criminal Code, they do not benefit from the adequate legal protection provided for in Art.s 222 and 226 of the Criminal Code, which raises serious axiological doubts. Case law, including the established positions of the Court of Appeal in Kraków (II AKz 2/00), the Supreme Court from 2001, and the District Court in Radomsko (VI K 38/16), consistently refuses to classify the hospital director as a public official under Art. 115 § 13 k.k. of the Criminal Code.

The conclusion that suggests itself in light of the facts cited is the need to regulate this area, if only by statutory clarification of the status of managers of SPZOZs (Public Healthcare Entities) in relation to the criminal law system, or *de lege ferenda*, by introducing criminal protection analogous to that afforded to public officials. Otherwise, these individuals will continue to operate under conditions of axiological imbalance.

In a comparative context, it is worth citing the French solutions in which the function of a hospital director has been fully professionalised and institutionally supported. In France, the training and professional development of healthcare facility managers is carried out by the National Management Centre (Centre National de Gestion), which is responsible for both the recruitment and training of directors within a specialised school in Rennes. Completion of this programme is a prerequisite for taking a managerial position and constitutes an element of the planned policy of the State for the professionalisation of public health management. The hospital director in France bears full responsibility for the functioning of the hospital. The director's work is subject to an annual, formalised evaluation conducted by the National Management Centre, which analyses the achievement of objectives, managerial competences, and management effectiveness. In the event that required standards are not met, sanctions are not applied; instead, developmental support mechanisms are implemented, such as advanced training, managerial coaching, or temporary transfer to another position.

The French model, based on a balance between responsibility, protection, and support, serves as an example of a coherent system for managing managerial staff that could inspire the Polish legislator in the context of strengthening the status and legal security of healthcare entity managers. Therefore, the further development of standards for the protection of patient rights should be supplemented with systemic reflection: not only in terms of expanding the set of rights, but also in the context of realistic possibilities for their implementation, the distribution of responsibility, support mechanisms, and institutional symmetry. Otherwise, there is the risk of not only distorting the concept of patient protection, but also eroding trust in the entire system – on the part of those who create it from the inside.

A thorough analysis of the Patient Rights Ombudsman's activities reveals a diverse structure of incoming complaints. Alongside many legitimate reports based on actual violations, a significant portion stem from subjective dissatisfaction, a sense of injustice, or a need to attract attention. The current design of the system allows patients to submit a complaint without stipulating the specific provision that was allegedly violated, without providing justification or reference to the consequences of the alleged violation. As a result, the complaints process can be treated as a space for expressing general dissatisfaction, compensating for life's frustrations, and even – in extreme cases – giving meaning to one's daily life through the repeated act of blaming the system. Consequently, we are faced with an overabundance of complaints which, instead of serving to improve the quality of the system, burden it procedurally and distract from actual violations. Reports of situations can be highly subjective – as in the case of the description of 'psychological trauma' after a scratch during a blood draw – without considering the context of the incident or the possibility of patient

complicity (e.g., a sudden hand movement). Although from a public health perspective, concerns for mental well-being are unquestionable, in the case of complaints based solely on declarative experiences, often impossible to verify, there is a risk of instrumentalization of suffering, in which 'harm' becomes an element of the relational game with the system, and not an objective problem.

In this context, it seems reasonable to consider introducing a structured, uniform procedure for reporting violations of patients' rights, which would require the complainant to indicate:

1) the specific law or regulation being reported;
2) a description of the facts supporting the allegation;
3) information on the potential consequences of the violation;
4) how the patient attempted to clarify the situation at the facility level.

Such a model would not be barrier-like; it would not prevent vulnerable, less informed, or health-impaired individuals from making complaints, but would require a minimum level of legal and factual reflection, which would promote both the quality of analysis by supervisory institutions (including the Office of the Patient Ombudsman) and development of the legal awareness of the patient. The current lack of such a structure favours a flood of complaints that are imprecise, general, or based solely on feelings. This procedure could function as part of an electronic reporting system, with appropriate informational and educational support, and its implementation would positively impact both the quality of patient rights protection, and relieve public institutions of the burden of unjustified reports.

Despite a rich set of patient rights, Polish law still lacks a coherently defined set of patient obligations. The only obligation frequently cited in practice is the cancellation of an appointment, which does not stem from the law but from the organizational recommendations and carries no real sanctions. Meanwhile, due to a growing number of incidents of verbal and physical aggression against healthcare workers, the dignity and safety of medical personnel should be recognized as areas requiring protection, in parallel to that provided to patients. It is worth noting that some patient rights – such as the right to respect for dignity, information, and effective communication – should in fact be reciprocal and operate in a two-way relationship, also with respect to doctors, nurses, and other medical staff. Unfortunately, the current model, focused almost exclusively on unilateral patient protection, can in practice destabilize therapeutic relationships and lead to the collapse of the healthcare system. It is therefore necessary to create a balanced system that takes into account both the rights and obligations of patients – including the obligation to respect staff and to share responsibility for the medical treatment process – as an essential part of modern public health. From a public health perspective, effective protection of patient rights should not be limited solely to reactive complaint resolution but should be part of a broader strategy for quality care, building trust, and rational risk management. Only a balanced system that considers not only patient rights, but also staff accountability and safety, can truly support population health and the sustainable development of the healthcare system.

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