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LAW AND ETHICS AS MECHANISMS OF HEALTHCARE GOVERNANCE: BETWEEN PATIENT AUTONOMY AND RESPONSIBILITY FOR PUBLIC HEALTH

Katarzyna Topolska[1], Kinga Nicer[2*], Michał Kaniowski[3]

[1] Wrocław University of Science and Technology,
Faculty of Information and Communication Technology, Poland
[2] Gabinet Nicer, Czestochowa, Poland
[3] Kaniowscy Clinic, Wroclaw, Poland

Abstract: The Polish healthcare system operates under cost pressure, workforce constraints, and rising stakeholder expectations, which increases the importance of governance and decision accountability. The aim of the article is to develop, from a management perspective, an analytical framework showing how law and ethics jointly shape governance mechanisms in health care, particularly in balancing patient autonomy with responsibility for public health. The study applies a normative-institutional analysis and conceptual synthesis, complemented by mapping core principles onto key management functions: rule and process design, service prioritisation, risk and quality management, compliance control, as well as stakeholder communication. The results indicate that effective governance requires the simultaneous integration of a patient-rights perspective (transparency, equality of access, respect for autonomy) and a stewardship perspective (solidarity, prevention, and the justificatory standards for allocation decisions). The article concludes by proposing a managerial "dual responsibility" model as a basis for developing measurable governance standards that strengthen legitimacy, coherence and trust in decision-making within the healthcare system.

Keywords: governance, healthcare management, health law, machine learning, management ethics, patient autonomy, public health responsibility

JEL Classification: I11, I18, D63

[1] Katarzyna Topolska, PhD, Eng, katarzyna.topolska@pwr.edu.pl, https://orcid.org/0000-0001-9392-9297
[2] Kinga Nicer, MD, kinganicer86@gmail.com, https://orcid.org/0009-0009-6511-1194
[3] Michal Kaniowski, MD, mkkaniowski@gmail.com, https://orcid.org/0009-0008-2610-3282
* Corresponding author: Kinga Nicer, kinganicer86@gmail.com

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Introduction

Healthcare systems currently operate under growing regulatory complexity, cost pressure, and rising stakeholder expectations regarding quality, safety, and equitable access. In this context, legal and ethical issues are no longer merely an external constraint; they become a managerial resource and a binding design parameter that shapes processes, standards, governance arrangements, and organizational accountability.

This is particularly visible in the fundamental values underpinning European healthcare systems, equality of access, solidarity, human dignity, patient rights, and professional ethics, which need to be translated into managerial decisions and internal control mechanisms (Wrześniewska-Wal et al., 2018). At the same time, public health ethics increasingly shifts attention from individual autonomy to responsibility for population health and the institutional consequences of decisions. From a management perspective, this implies aligning clinical and social goals with legality, transparency, and accountability, especially when decisions concern scarce resource allocation, priority setting, health programmes, or preventive interventions (Surmiak, 2020). Organizationally, accountability cannot be reduced to compliance alone; it also involves the quality of justification, learning capacity, and trust-building through consistent standards applied to patients and communities (Włodarczyk & Szetela, 2017).

Recent international research emphasizes that improved health system performance is increasingly linked to governance quality: the transparency of procedures, meaningful stakeholder participation, accountability mechanisms, and procedural fairness in financing and priority decisions (Dale et al., 2023). Evidence also suggests that transparency interventions may reduce selected systemic risks (e.g. corruption, inefficiency, and abuse), yet their sustainability depends on institutional maturity and implementation design, including measurable outcomes and enforceable accountability rules (Gholami et al., 2024). At the organizational level, particularly in hospitals, oversight structures (e.g. boards) are increasingly highlighted as mechanisms that help balance clinical and financial objectives, mitigate tensions between medical professionals and management, in addition embed multidimensional accountability (financial, clinical, and social) (Jalilvand et al., 2024). Meanwhile, reviews of governance interventions indicate that governance arrangements can affect the quality of care, but the evidence base remains fragmented and difficult to transfer across contexts, which complicates the managerial adoption of "what works" solutions (George et al., 2023).

Against this background, a key question emerges: how can the legal-ethical foundations of healthcare be operationalized into coherent managerial instruments, accountability architecture, decision rules, monitoring systems, and reporting mechanisms? The aim of this article is to propose an analytical framework that links the normative dimension (law and ethics) with the execution dimension (management), thereby supporting managers and policy-makers in designing solutions that strengthen transparency, accountability, and trust in healthcare organizations.

Literature review

Healthcare systems operate under persistent tension between efficiency objectives (process performance, cost rationalization, clinical outcomes) and normative requirements that set binding limits for managerial decisions. In the Polish context, the starting point is the constitutional right to health protection, interpreted through the principles of human dignity, equality of access, and solidarity, which together define the "rules of the game" for healthcare organisers and managers. In management practice, this means that organisational goals and performance indicators must capture not only outputs (e.g. service volumes) but also the conditions under which services are delivered, including transparency, respect for patient rights, safety, and professional ethics, as components of service quality and organisational culture.

The development of regulations on patient rights and the corresponding duties of medical professionals and healthcare executives can be viewed as a shift in accountability from the individual to the organisational level, with direct implications for process design, internal control systems, and accountability mechanisms. In this view, compliance is not merely meeting the minimum legal requirements; it becomes a core component of organisational governance, shaping decision-making, the documentation of rationale, risk communication, and the management of adverse events. The literature also highlights the gap between formal guarantees and actual service availability, which, from a managerial perspective, directs attention to managing system constraints, including waiting lists, prioritization, resource allocation, and the patient experience as a stakeholder concern (Wrześniewska-Wal et al., 2018).

Alongside the legal perspective, scholarship on public health increasingly emphasizes an ethical shift: from the primacy of individual autonomy toward responsibility, understood not only as retrospective accountability for outcomes but also as a prospective obligation to prevent foreseeable harm at the population level (Surmiak, 2020). Because public health action often affects individual choices, the justification of interventions requires proportionality, reliable information, and social legitimacy (Holland, 2022; Bernstein et al., 2024; Surmiak, 2020). This orientation has managerial consequences: leaders do not simply "implement a programme" but manage acceptability, trust and public compliance, which demands communication capabilities, stakeholder analysis and systematic risk management (Venkatapuram, Broadbent, 2023; Surmiak, 2020). In the context of scarce resources, procedural justice becomes particularly important. The concept of "accountability for reasonableness" stresses that what matters is not only what is decided but how it is justified: the publicity of reasons, opportunities for appeal and revision, as well as institutional safeguards against arbitrariness (Dastidar, 2020).

In public health management and healthcare delivery, a procedural approach strengthens governance standards by supporting predictability and trust in prioritisation rules (e.g. access to services or crisis response), while also enabling organisational learning through decision audits and policy adjustments (Dastidar, 2020; Venkatapuram, Broadbent, 2023). Recent research published after 2023 extends

this discussion by focusing on instruments and structures of accountable governance in healthcare organisations. A scoping review by Jalilvand et al. identifies four core areas for strengthening accountability in hospitals: inclusive governance, commitment to accountability, accountability planning, and managerial autonomy (Jalilvand et al., 2024). This aligns with the argument that accountability in healthcare has clinical, financial, and socio-political dimensions and therefore requires the simultaneous design of oversight structures, quality systems, and stakeholder involvement mechanisms (Jalilvand et al., 2024). Transparency is treated in this logic as a prerequisite for accountability and for limiting abuse, but also as a lever for improving system outcomes. Gholami et al. show that transparency interventions in low- and middle-income countries are often introduced as responses to corruption and inefficiency and may yield positive yet uneven effects; a major challenge is the sustainability of results and the lack of standardised approaches to measuring impact (Gholami et al., 2024). From a management perspective, this implies that transparency should be designed as a system (data, processes, responsibilities and monitoring) rather than a one-off informational initiative (Gholami et al., 2024).

Another dimension of governance is social accountability, understood as a set of mechanisms enabling communities to influence service quality and access. A scoping review by Nejatian et al. organised social accountability tools and showed that effectiveness depends on multi-component interventions and fit with the institutional context; it also pointed to typical implementation barriers such as limited resources, insufficient political support and weak enforcement of agreed actions (Nejatian et al., 2024). From a managerial standpoint, this highlights the need to design participation so that it has a genuine pathway of influence over decisions (e.g. priorities, quality standards and investments) rather than a purely symbolic consultative role (Nejatian et al., 2024). Data-driven governance is also gaining prominence, particularly in mixed systems where private providers play a significant role. Faddoul et al. argue that routine data from private providers can support key governance functions (planning, quality oversight, financing, workforce and facility monitoring), but its use remains limited, signalling gaps in institutional capabilities and in standardisation and integration mechanisms (Faddoul et al., 2024). From a management perspective, this underscores the importance of interoperability, data quality policies and accountability for the information lifecycle as part of the decision-making infrastructure (Faddoul et al., 2024). Recent reviews also apply these themes to primary healthcare and UHC objectives, framing governance as a set of functions: policy and plan development, the use of regulatory instruments, generation of "intelligence" (monitoring, benchmarking and evidence-based decision-making), assurance of accountability, in addition to intersectoral coordination and collaboration (Khatri et al., 2025). This strengthens the managerial interpretation of legal and ethical norms: values (fairness, equality of access, protection of patient rights) must be operationalised by means of processes, roles, metrics and oversight mechanisms; otherwise, they remain declarations without practical effect (Khatri et al., 2025; Wrześniewska-Wal et al., 2018). There is also increasing recognition of leadership competencies at the organisational level

as a condition for effective governance. Mondal et al. identify competencies crucial for public health system governance, including systems thinking, policy development and implementation, partnership working, equity and fairness orientation, organisational learning, oversight, the stewardship of resources, as well as the understanding of legal frameworks and organisational ethics (Mondal et al., 2025). From a management perspective, this supports treating law and ethics not as external constraints but as organisational capabilities that can be developed, assessed and embedded within management systems (Mondal et al., 2025). Overall, the literature points to a growing need to integrate three domains: (1) legal norms and patient rights as sources of requirements for healthcare organisers, (2) public health ethics, which provides criteria for justifying interventions and managing population risks, and (3) governance instruments (accountability, transparency, participation and data governance) that enable the operationalisation of values in managerial practice (Jalilvand et al., 2024; Gholami et al., 2024; Nejatian et al., 2024; Wrześniewska-Wal et al., 2018). At the same time, a gap is visible in the limited translation of values and standards into coherent analytical frameworks for managers, frameworks that link the normative level (what is protected) with governance mechanisms (how it is implemented) and outcomes (how to measure effects and unintended consequences). This justifies further work on management models that integrate legality, ethics, and governance into a single architecture of decisions and accountability in healthcare and public health.

Research methodology

The study had a quantitative design and was conducted using the diagnostic survey method. The research instrument was an original questionnaire developed based on a review of the relevant literature, as well as applicable legal regulations and organizational standards governing the functioning of the healthcare system. The questionnaire consisted of a substantive section containing questions related to the analysed research dimensions, as well as a demographic section enabling socio-professional characterisation of the respondents. The study was carried out between March and May 2024. The survey was anonymous, which was intended to increase the sincerity of responses and to limit the influence of social desirability bias. The respondents were informed about the purpose of the study, the voluntary nature of participation, and the possibility of withdrawing at any stage of the research. Participation in the study was not associated with any remuneration or formal consequences. The sampling strategy was purposive. The questionnaires were distributed in electronic form via a dedicated online survey platform, which enabled access to a broad group of respondents and efficient data collection. After the data collection process was completed, the questionnaires were verified for completeness. The collected empirical material was then subjected to analysis using descriptive statistical methods and inferential statistics, in accordance with the stated research objectives and hypotheses.

The study included 210 respondents, whose socio-professional characteristics were described based on the data collected in the demographic section of the questionnaire. In terms of gender structure, women predominated, accounting for 61.0% of the study sample (128 individuals), while men represented 39.0% (82 individuals). This indicates a clear predominance of women among the respondents. The analysis of the age structure shows that the largest group consisted of respondents aged 40-49 years, comprising 64 individuals (30.5%), which suggests a predominance of middle-aged participants with substantial professional experience. The next most numerous group included respondents aged 30-39 years, with 56 individuals (26.7%). Respondents aged 50-59 years accounted for 42 individuals (20.0%), while the youngest group, aged 18-29 years, consisted of 34 individuals (16.2%). The least numerous group comprised respondents aged 60 years and above, totalling 14 individuals (6.6%). With regard to educational attainment, the study sample was dominated by individuals with a master's degree, who accounted for 41.0% of the respondents (86 individuals). A bachelor's or engineering degree was reported by 62 respondents (29.5%), while 48 individuals (22.9%) declared secondary education. The smallest group consisted of respondents with doctoral or higher education, comprising 14 individuals (6.6%). The analysis of occupational status revealed that the largest proportion of the sample consisted of healthcare professionals, totalling 96 individuals (45.7%). The second largest group was managerial and administrative staff, comprising 42 individuals (20.0%). Academic and teaching staff accounted for 28 respondents (13.3%), while individuals representing other professions totalled 44 respondents (21.0%), indicating a diverse occupational profile of the study participants. In terms of length of professional experience, the most numerous group included respondents with 11-20 years of work experience, comprising 66 individuals (31.4%). Participants with more than
20 years of experience accounted for 54 individuals (25.7%), while 52 respondents (24.8%) reported 6-10 years of professional experience. The least numerous group consisted of individuals with up to 5 years of work experience, totalling 38 respondents (18.1%), which confirms the predominance of participants with well-established professional experience. Considering the type of institution in which the respondents were employed, the majority were affiliated with public institutions, totalling 138 individuals (65.7%). Private institutions employed 56 respondents (26.7%), while 16 individuals (7.6%) indicated another or mixed type of institution. This structure reflects the dominant role of the public sector within the studied population. The primary aim of this study was to identify and assess the key determinants influencing the level of legitimacy and stakeholder trust in managerial decision-making within the healthcare system. The research sought to examine how legal-operational, ethical-social, and managerial-resource dimensions jointly shape stakeholders' acceptance and perceived credibility of decisions made under conditions of limited resources. A further objective was to evaluate the predictive power of these determinants using a nonlinear machine learning approach, specifically Support Vector Regression (SVR), in order to capture complex

and potentially nonlinear relationships between decision-making processes and perceived legitimacy.

The main research question guiding this study was formulated as follows:

To what extent, and through which dimensions, do legal-operational, ethical--social, and managerial-resource factors influence the level of legitimacy and stakeholder trust in managerial decisions in the healthcare system?

Independent variables

Legal and operational dimension (compliance and processes):

1. Degree of compliance fulfilment – the level of implementation of patient rights protection procedures and legal standards.
2. Transparency of allocation procedures – clarity of the criteria applied in establishing waiting lists and prioritizing healthcare services.
3. Quality of justification documentation (accountability for reasonableness) – the standard of substantive justification of decisions in situations of resource constraints.

Ethical and social dimension (stewardship):

1. Level of patient autonomy protection – the extent to which patient subjectivity and rights are respected in medical processes.
2. Effectiveness of preventive and prophylactic actions – fulfilment of responsibility for population health (stewardship perspective).
3. Scope of stakeholder participation – the real influence of patients and communities on decision-making processes and quality standards.

Managerial and resource dimension:

1. Level of maturity of supervisory structures (Supervisory Boards) – effectiveness of mechanisms balancing clinical and financial objectives.
2. Quality of data governance – the extent to which reliable data are used in the planning and monitoring of healthcare services.
3. Leadership competencies in ethics and systems thinking – the level of managers' preparedness to understand legal and ethical frameworks.
4. Effectiveness of risk and quality control mechanisms – the efficiency of systems monitoring safety and adverse events.

Results

To provide a comprehensive and methodologically robust answer to the research question, a complementary analytical strategy was adopted that combines Spearman's rank correlation analysis with Support Vector Regression (SVR). Spearman's correlation was employed to identify and assess the direction and strength of monotonic relationships between the independent variables and the level of legitimacy and stakeholder trust in managerial decisions. This nonparametric method is particularly appropriate for social and organizational data as it does not require assumptions of normality and is robust to outliers and ordinal measurement scales.

Building on the insights gained from the correlation analysis, Support Vector Regression was applied to model the combined and potentially non-linear effects of the independent variables on the dependent construct. The SVR approach enables the estimation of complex functional relationships and provides strong predictive performance even in the presence of multicollinearity and high-dimensional feature spaces. By integrating correlation analysis with SVR modelling, the study is able not only to identify which factors are associated with legitimacy and trust, but also to determine their relative importance and predictive contribution within an integrated model. Consequently, the use of these methods allows a direct and empirically grounded response to the research question by linking theoretical constructs to observed patterns in the data and by quantifying their joint influence on managerial decision legitimacy in the healthcare system.

The results of the Spearman's rank correlation (Table 1) analysis reveal a consistent pattern of positive relationships between all the examined independent variables and the level of legitimacy and stakeholder trust in managerial decisions within the healthcare system. The strength of these relationships varies across dimensions, providing important insight into the relative importance of legal--operational, ethical-social, and managerial-resource factors.

Table 1. Spearman's rank correlation matrix between independent variables and dependent variable "Level of legitimization and stakeholder trust in managerial decisions"

No.	Independent variable	r (Z1)	Strength of correlation	Theoretical justification
1	Degree of compliance with regulatory requirements (compliance)	0.62	strong	Compliance with law and patient rights constitutes a fundamental condition for institutional legitimacy.
2	Transparency of allocation procedures	0.68	strong	Clear decision-making criteria increase perceived fairness and social acceptance.
3	Quality of documenting justifications (A4R)	0.72	strong	Providing decision justifications is a key mechanism for building procedural trust.
4	Level of protection of patient autonomy	0.55	moderate	Respect for patient agency strengthens the moral legitimacy of decisions.
5	Effectiveness of preventive and prophylactic measures	0.44	moderate	Population-level health outcomes enhance trust indirectly over the long term.
6	Scope of stakeholder participation	0.70	strong	Co-participation in decision--making increases social

No.	Independent variable	r (Z1)	Strength of correlation	Theoretical justification
				acceptance and sustainability of decisions.
7	Maturity level of oversight structures	0.58	moderate	Oversight ensures coherence and a balance of interests but is less visible to patients.
8	Quality of data governance	0.50	moderate	Data support decision rationality, yet their impact on trust is indirect.
9	Leadership competencies in ethics and systems thinking	0.65	strong	Ethical leadership is directly associated with the credibility of decisions.
10	Effectiveness of risk and quality control mechanisms	0.57	moderate	Safety and quality are prerequisites for maintaining trust, although often reactive in nature.

Source: Own elaboration

The results indicate that legitimacy and trust in healthcare decision-making are most strongly associated with procedural factors. The highest correlations are observed for the quality of documented justifications (r = 0.72), stakeholder participation (r = 0.70), transparency of allocation procedures (r = 0.68), ethical leadership competencies (r = 0.65), and compliance with legal and regulatory requirements (r = 0.62). These findings confirm the central role of procedural justice, transparency, and reason-giving in building institutional legitimacy. Moderate correlations are identified for supervisory and oversight structures (r = 0.58), risk management and quality control (r = 0.57), protection of patient autonomy (r = 0.55), data governance quality (r = 0.50), and the effectiveness of preventive and public health actions (r = 0.44). These mechanisms contribute to trust more indirectly, reinforcing credibility and coherence over time rather than shaping immediate perceptions of legitimacy. Overall, the correlation analysis demonstrates that transparency, justification, participation, and ethically grounded leadership are the primary drivers of legitimacy and stakeholder trust, while operational and preventive mechanisms play a supportive role. These findings provide a robust empirical basis for subsequent multivariate modelling using the SVR regression approach Table 2.

SVR Model parameters:

- Algorithm: SVR (RBF kernel)
- Feature standardization: yes
- Number of observations: 300
- Number of independent variables: 10
- Data split: 70% training / 30% testing.

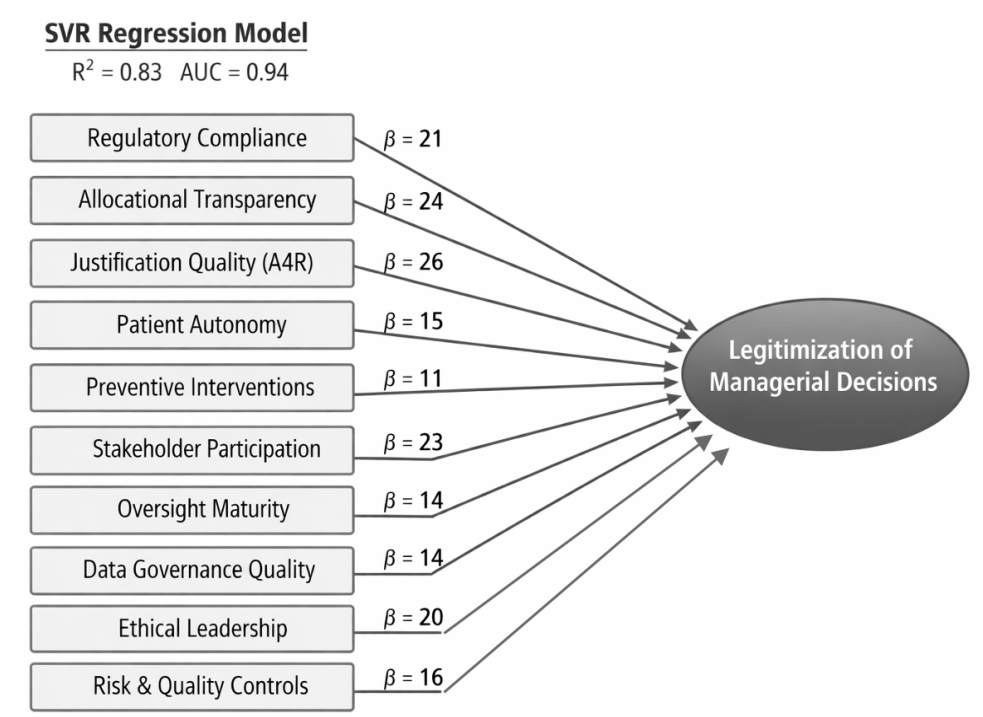

Figure 1. SVR Regression Model

Source: Own elaboration

Table 2. Model coefficients

Metric	Value	Interpretation
RMSE	0.763	Low prediction error given a moderate variance of the dependent variable
MAE	0.623	Moderate mean absolute error
R^2	0.834	Very good model fit (83% of the variance explained)

Source: Own elaboration

The regression model based on Support Vector Machines (SVM) demonstrated high predictive performance ($R^2 = 0.83$) (Table 2). In addition, to assess the model's ability to discriminate between the levels of the legitimization of managerial decisions, ROC analysis was applied to the discretized dependent variable, yielding an AUC value of 0.94, which indicates very good discriminative validity of the model (Figure 2).

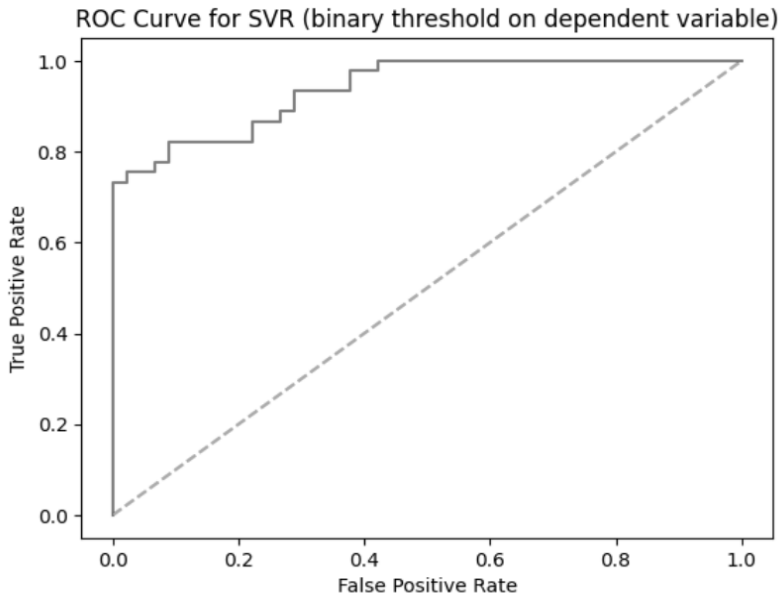

Figure 2. Matrix ROC

Source: Own elaboration

Table 3. Model coefficients

No.	Exogenous variable	Standardized β	Effect direction	Relative contribution	Interpretation
1	Degree of regulatory compliance (compliance)	0.21	positive	high	Higher regulatory compliance significantly increases the perceived legitimacy of managerial decisions.
2	Transparency of allocation procedures	0.24	positive	very high	The strongest predictor – transparency of decision criteria directly enhances stakeholder trust.
3	Quality of decision justification documenta-tion (A4R)	0.26	positive	very high	A key procedural determinant – systematic justification of decisions substantially reduces the trust deficit.

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No.	Exogenous variable	Standardized β	Effect direction	Relative contribution	Interpretation
4	Protection level of patient autonomy	0.15	positive	moderate	Patient autonomy contributes to moral legitimacy, although its effect is weaker than that of procedural determinants.
5	Effectiveness of preventive and prophylactic interventions	0.11	positive	moderate	An indirect and long-term effect – population-level outcomes translate into trust over time.
6	Stakeholder participation intensity	0.23	positive	high	Participatory decision-making significantly increases the acceptance and sustainability of system-level decisions.
7	Maturity of oversight and governance structures	0.14	positive	moderate	Oversight mechanisms enhance decision stability, though their effect is less directly observable.
8	Data governance quality	0.12	positive	moderate	Data-driven rationality improves decision credibility but does not independently generate trust.
9	Ethical and systems leadership competencies	0.20	positive	high	Ethical and system--oriented leadership is strongly associated with perceived decision credibility.
10	Effectiveness of risk and quality control mechanisms	0.16	positive	moderate	Ensuring safety and quality is necessary for trust maintenance, primarily through reactive mechanisms.

Source: Own elaboration

The results indicate that legitimacy and stakeholder trust in healthcare managerial decisions are primarily driven by procedural transparency and participation. The Support Vector Regression model with an RBF kernel demonstrated very strong predictive performance ($R^2 = 0.834$), explaining over 83% of the variance, with low prediction errors (RMSE = 0.763; MAE = 0.623), confirming model robustness. The correlation analysis showed positive relationships for all the predictors, with the strongest effects observed for documented decision justifications, the transparency of allocation procedures, stakeholder participation, and compliance with legal and regulatory requirements. These findings suggest that trust under conditions of resource scarcity is built mainly through clear criteria, justification mechanisms, and inclusive decision-making. The SVR results further confirmed the dominant role of procedural and deliberative factors, which outweighed operational and quality--control mechanisms. Ethical and system-level leadership also showed a substantial positive influence, while patient autonomy, preventive actions, data governance, and risk control exhibited moderate, more indirect effects. Overall, the findings highlight transparent, well-justified, and participatory processes as the core determinants of legitimacy and trust in healthcare governance.

Conclusions

The article's perspective demonstrates that law and ethics should not be treated merely as "external" constraints on healthcare management, but as the core of a governance architecture; they set the boundaries of permissible decisions while simultaneously providing criteria for justifying, communicating, and holding those decisions to account. In practice, this means the constant need to reconcile two orders of responsibility, toward the individual (autonomy, patients' rights, equality of treatment) and toward the community (solidarity, prevention, protection of population health). Understood in this way, "dual responsibility" is not only a normative dilemma but also a managerial task that requires tools: clear rules for prioritization, standards for justification, mechanisms for stakeholder involvement, and measurable procedures for oversight and quality control. The empirical analyses support the claim that enduring trust in managerial decisions is built primarily through process quality, transparency, the ability to understand the logic of decisions, as well as genuine participation and only secondarily through "hard" operational instruments. This points to the need to shift the emphasis from formal compliance alone to mature legitimacy management, one that can integrate legal requirements, ethical standards, and organizational efficiency into a coherent system of rules, roles, and accountability. From a managerial standpoint, this entails, among other things, designing allocation procedures as auditable processes (with clear documentation of premises), strengthening the ethical and systems competencies of leadership, and developing solutions that enable stakeholders to shape quality standards and priorities, not merely in a consultative way, but in a manner that is meaningfully connected to decision-making.

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AI Declaration: The authors confirm that no AI tools were used in the creation of this paper.

PRAWO I ETYKA JAKO MECHANIZMY ŁADU ZARZĄDCZEGO W OCHRONIE ZDROWIA: MIĘDZY AUTONOMIĄ PACJENTA A ODPOWIEDZIALNOŚCIĄ ZA ZDROWIE PUBLICZNE

Streszczenie: Polski system ochrony zdrowia funkcjonuje w warunkach presji kosztowej, ograniczeń kadrowych oraz rosnących oczekiwań interesariuszy, co zwiększa znaczenie ładu zarządczego i rozliczalności decyzji. Celem artykułu jest wypracowanie, w perspektywie zarządzania, ram analitycznych pokazujących, jak prawo i etyka współtworzą mechanizmy governance w ochronie zdrowia, szczególnie w obszarze równoważenia autonomii pacjenta z odpowiedzialnością za zdrowie publiczne. Zastosowano analizę normatywno-instytucjonalną oraz syntezę koncepcyjną, uzupełnione mapowaniem zasad na funkcje zarządcze: projektowanie reguł działania, priorytetyzację świadczeń, zarządzanie ryzykiem i jakością, kontrolę zgodności (compliance) oraz komunikację z interesariuszami. Wyniki wskazują, że skuteczny ład zarządczy wymaga jednoczesnego uwzględniania perspektywy praw pacjenta (transparentność, równość dostępu, poszanowanie autonomii) i perspektywy stewardingu (solidarność, prewencja, uzasadnialność decyzji alokacyjnych). Artykuł kończy propozycja menedżerskiego modelu „podwójnej odpowiedzialności" jako podstawy budowy mierzalnych standardów zarządzania, które wzmacniają legitymizację, spójność i zaufanie do decyzji w systemie ochrony zdrowia.

Słowa kluczowe: ład zarządczy, zarządzanie w ochronie zdrowia, prawo medyczne, uczenie maszynowe, etyka w zarządzaniu, autonomia pacjenta, odpowiedzialność za zdrowie publiczne