Psychiatr. Pol. 2025; 59(5): 843–859
PL ISSN 0033-2674 (PRINT), ISSN 2391-5854 (ONLINE)
www.psychiatriapolska.pl
DOI: https://doi.org/10.12740/PP/195919

Compulsory psychiatric observation under Article 24 of the Mental Health Protection Act – legal and practical problems

Marcin Burdzik

Center of Psychiatry in Katowice
Institute of Law at Faculty of Law and Administration, University of Silesia in Katowice

Summary

The Mental Health Protection Act (MHP) allows for compulsory psychiatric observation of a patient whose behaviour indicates that, due to a mental disorder, he or she is directly threatening his or her life or the life or health of others (Article 24 of the MHP). Hospitalisation is used to determine whether the disorder presented by the patient is a mental illness, within the meaning of the MHP, that is, whether it involves psychotic symptoms (Article 3(1)(a) of the MHP). Current regulations on observation are not complete, which creates numerous dilemmas when applying these provisions in medical practice. The biggest doubts relate to the possibility of reapplying Article 24 of the MHP to a patient who, after being admitted for observation, agreed to stay in the hospital and then demanded to be discharged home before settling concerns about his mental state, or the legal basis for further treatment, it is determined that there are grounds for treatment against his will. The legislator also did not comprehensively regulate the scope of diagnostic measures that can be taken against the patient's will during observation. The purpose of the article is a comprehensive analysis of the title institution with the determination of its axionormative basis, as well as an attempt to resolve the legal and practical dilemmas that arise in the course of applying Article 24 of the MHP in medical practice.

Key words: compulsory psychiatric observation, compulsory hospitalisation of patient with mental disorders, Article 24 of the Mental Health Protection Act

Introduction

Article 24(1) of the Act of 19.08.1994 on Mental Health Protection (Journal of Laws of 2024, item 917; hereinafter: MHP), allows for the admission to a psychiatric hospital of a person whose past behavior indicates that, due to mental disorders, he directly threatens his own life or the life or health of others, but there is doubt as to whether he is mentally

ill. Hospitalization to resolve the aforementioned dilemma cannot last longer than 10 days (Art. 24(2) of the MHP) and cannot be therapeutic in nature (*arg. ex* Art. 33(4) of the MHP). Thus, the analyzed provision refers to a form of "psychiatric observation" used to determine whether a patient is mentally ill (Art. 3(1)(a) of the MHP) [1].

Normative solutions for psychiatric observation are not complete. The major dilemmas relate to the admissibility of the "re-use" of Art. 24 of the MHP, to a patient who, after being admitted for observation, consented to hospitalization and then withdrew it and requested discharge home, if – due to the short time of observation – it has not yet been possible to determine whether he is mentally ill. There are also doubts about the legal basis of further (compulsory) treatment of the patient after the end of the observation, if the prerequisites referred to in Art. 23(1) of the MHP are met. The legislator also did not comprehensively regulate the scope of medical procedures that can be performed on a patient under observation, without his consent. The law is silent, for example, on the possibility of drawing blood samples from the patient, although this procedure may be important for determining the etiology of the symptoms presented (e.g., for assessing the presence of drugs or alcohol in the blood).

The aim of the article is to comprehensively analyze the institution regulated in Art. 24 of the MHP and to attempt to resolve the legal dilemmas that arise when applying this provision in medical practice.

Psychiatric observation and the right to liberty

The right to liberty is one of the individual's fundamental rights, which is guaranteed both by the Constitution of the Republic of Poland (Art. 41(1)) and by international legal acts of fundamental importance to the European axionormative system (Art. 5(1) of the European Convention on Human Rights, Art. 6 of the Charter of Fundamental Rights of the European Union, Art. 9 of the International Covenant on Civil and Political Rights). Nevertheless, this right is not absolute. Deprivation or restriction of liberty may be imposed only by statute (Art. 41(2) Constitution of the Republic of Poland), and only when necessary in a democratic state for the protection of its security or public order, or to protect the natural environment, health or public morals, or the freedoms and rights of other persons (Art. 31(3) Constitution of the Republic of Poland).

An example of this type of limitation is the title psychiatric observation, which is a form of deprivation of liberty, because a patient who is hospitalized under Art. 24 of the MHP loses (temporarily) the ability to freely decide his own whereabouts. The above assumption coincides with the standpoint of M. Szwed [2, pp. 127-128], who rightly assumes that deprivation of liberty is any form of "compulsory confinement of a person in a bounded space, preventing him from moving freely and disposing of his person and subjecting him to supervision".

The content of Art. 24(1) of the MHP leads to the conclusion that interference with the right to personal liberty is, in this case, dictated by the necessity to protect the patient's life or the life or health of others. It should be pointed out, for the record, that

the Constitution's legislature, in the aforementioned Art. 31(3) of the Constitution, does not explicitly refer to "life," but only to "health". However, if an individual's rights can be limited for the protection of health, it should be assumed that they can be limited all the more when there is a need to protect a good of even higher value, i.e., life[1].

Conditions for the administration of psychiatric observation

According to the Art. 24(1) of the MHP, admission to psychiatric observation requires the cumulative fulfilment of four conditions:

1) determination that the patient has a mental disorder within the meaning of Art. 3(1) of the MHP;
2) the existence of doubts as to whether the aforementioned disorders constitute a mental illness within the meaning of Art.3(1)(a) of the MHP;
3) the existence of a state of direct threat to the patient's life or to the life or health of others, resulting from the above disorders;
4) the patient's lack of consent for admission to a psychiatric hospital.

A literal interpretation of Art. 24(1) of the MHP dictates that doubts about the mental health condition of a person admitted to the hospital should concern only whether he or she is mentally ill, and not whether he or she has any mental disorder at all [3, 4]. From a slightly different perspective, it can be said that *de lege lata*, Art. 24 of the MHP allows for admission to the hospital of a person with a mental disorder, which – at the time of the decision on admission – does not clearly qualify as a mental illness. If the legislature's intention would be to allow psychiatric observation to resolve doubts about the presence of "any" mental disorder in a patient then the second part of Art. 24(1) of the MHP would state "and there are doubts about whether he or she is a person with a mental disorder," instead of "and there are doubts about whether he or she is mentally ill," as the current provision does.

Extending the subjective scope of the Art. 24 of the MHP would therefore require an amendment to the second part of paragraph 1 of the aforementioned provision. It is worth noting that such a change was planned in the government's project of the MHP amendment of 03/10/2025[2] [5]. The project is, however, at the stage of public

[1] If a patient poses a risk to the life and/or health of others, the condition related to the need to protect the "freedoms and rights of others" within the meaning of Art. 31(3) of the Polish Constitution is fulfilled simultaneously. Both life (Art. 38 of the Polish Constitution) and health (Art. 68(1) of the Polish Constitution) are subject to legal protection.

[2] According to its assumptions, Art. 24(1) of the MHP would allow the admission of a person for psychiatric observation whose previous behavior indicates that, due to a mental disorder, he or she directly threatens his or her own life or the life or health of others, and there are doubts as to whether this threat arises from this disorder because of a significant impairment or loss of the person's ability to perceive and evaluate reality and to control his or her own behavior. Emphasizing the consequences of the observed mental disorder in terms of the person's capacity for proper perception and critical evaluation of reality, as well as the ability to undertake volitional actions, rather than focusing on terminological aspects, should be considered a beneficial approach.

consultation, and it will not be discussed further, as it is unknown whether the proposed changes will ultimately be adopted[3]. In the current state of the law, in Art. 24 of the MHP, the legislator therefore uses two concepts – mental disorder and mental illness – which cannot be treated synonymously.

According to ICD-11, mental disorders are syndromes characterized by a clinically significant disturbance in an individual's cognition, emotional regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental processes that underlie mental and behavioral functioning. These disturbances are usually associated with distress or impairment in personal, family, social, educational, occupational, or other important areas of functioning [6].

The Act on Mental Health Protection divides mental disorders into three categories, distinguishing between mental illness, mental retardation and other disturbances of mental functions which, according to the state of medical knowledge, are classified as mental disorders, if the person requires health services or other forms of assistance and care necessary for living in a family or social environment (Art. 3(1) of the MHP).

Thus, according to the MHP, mental illness is one type of mental disorder [7]. However, this concept has been defined very laconically. The legislator has only indicated that mental illness is a disorder in the course of which psychotic disorders are present (Art. 3(1)(a) of the MHP). The definition of "mental illness" constructed in this way is overly narrow, since the presence of psychotic symptoms does not exhaust the meaning of the term, which was once aptly pointed out by S. Pużyński [8]. Moreover, medical science is abandoning the term "mental illness" due to its pejorative and stigmatizing nature [1].

Regardless of the validity of the aforementioned tendency, the term "mental illness" still functions in legal language[4]. Therefore, correctness of further considerations requires the use of this term despite its "medical" archaicness. At the stage of interpreting a provision, it is not possible, in an arbitrary manner, to change its content, and thus replace concept X with concept Y, especially when non-synonymous concepts are in question. Such an approach would lead to erroneous conclusions.

To conclude the discussion of the first two prerequisites, it should be assumed that, in the current state of the law, the application of Art. 24 of the MHP requires a finding that the patient presents a mental disorder, which creates doubts about its psychotic nature.

The third prerequisite for the application of Art. 24 of the MHP is the identification of a state of direct danger to the patient's life or health, or to the life of others, which

[3] It should be noted that amendments to Art. 24 of the MHP were also planned in the previous government's draft amendment to the Mental Health Protection Act of 30 November 2022 (UD 444), which likewise "stopped" at the stage of public consultation and was never enacted — https://legislacja.rcl.gov.pl/ projekt/12367401/

[4] In addition to the discussed Art. 24 of the MHP, the term "mental illness" can also be found in Art. 13 or Art. 16 of the Civil Code (as a basis for incapacitation) or in Art. 31 §1 of the Criminal Code (as a potential cause of insanity).

results from the patient's mental disorder. The legislator requires that the threat be imminent. The criterion of imminence is met if there is a high probability that at any moment (currently or in the near future) the aforementioned values (i.e., health and/or life) may be violated by the patient [4]. Thus, there needs to be a close connection between the current mental state of the patient and the resulting risk of violating the patient's life or health, or the life of others.

These risks are indicated by "the patient's previous behavior." The latter phrase may refer to behavior that continues over a period of time, as well as a single incident of such intensity that it raises mental health concerns and poses a threat to life or health [9]. The risk assessment is inevitably probabilistic – in the sense that no physician has the ability to determine with absolute certainty how a patient would have behaved in the absence of hospitalization, and thus whether the patient would have committed an attack on the values enumerated in Art. 24 of the MHP. In other words, sufficient prerequisite for the application of Art. 24 of the MHP is a well-founded concern about a state of danger to health or life [10]**.** For example, the immediacy of the threat may be indicated by the presence of suicidal thoughts and intentions, a suicide attempt, or aggressive behavior (including alloaggressive behavior) [1]. This refers both to taking certain actions (such as serious self-harm) and to attempting or making real threats to do so.

The fourth prerequisite for the application of Art. 24 of the MHP is the patient's lack of consent to hospitalization. It refers both to objections expressed explicitly (verbal communication of lack of consent) and implicitly, i.e., any behavior that indicates a lack of consent to admission (e.g., an attempt to escape from the emergency room).

The scope of medical procedures that can be undertaken for a patient under psychiatric observation without consent

An issue that requires broader discussion is the scope of medical actions that can be taken against a patient hospitalized under Art. 24 of the MHP, against his or her will (i.e., when the patient does not consent to their performance). From a legal point of view, these are health services within the meaning of Art. 2(1)(10) of the Act of 15.04.2011 on medical activity (Journal of Laws of 2025, item 450), i.e., activities aimed at preserving, saving, restoring or improving health as well as other medical activities resulting from the treatment process or separate provisions regulating their performance.

A fundamental principle of the modern health care system is the principle of patient autonomy [11]. The manifestation of this principle is the patient's right to consent to the provision of particular health services, as well as the right to refuse them (Art. 16 of the Act of 6.11.2008 on Patients' Rights and Patients' Ombudsman; Journal of Laws 2024, item 581; hereinafter: PRPO). This right can be restricted only in cases strictly defined in acts of statutory rank (Art. 15 of the PRPO), such as the Act on Mental Health

Protection. The question therefore arises about the scope of the exceptions provided therein, applicable to patients undergoing psychiatric observation.

At the outset of this part of the discussion, it should be pointed out that no therapeutic interventions may be undertaken on a patient hospitalized for psychiatric observation under Art. 24 of the MHP, as explicitly stated in Art. 33(4) of the MHP. This solution remains in harmony with the aim of Art. 24 of the MHP and the "diagnostic" nature of the institution regulated therein. The purpose of hospitalization of a patient admitted to a hospital for psychiatric observation is to resolve whether he or she is mentally ill, i.e., whether he or she presents psychotic disorders [1]. This aim can be achieved through such activities as:

a) assessing the appearance and observing the patient's behavior during conversations with the doctor;
b) assessment of the patient's behavior and the way he/she functions in the unit;
c) analyzing additional information about the patient's previous treatment and the course of disorders presented by him – for example, obtained from family members, social workers, or medical records;
d) conducting additional diagnostic tests, including psychological tests [1].

A functional interpretation of Art. 24 of the MHP leads to the conclusion, which is obvious in its essence, that the above-mentioned activities can be carried out even without the patient's consent [1]. Otherwise, the institution of observation would be illusory. However, it should be remembered that some elements of the psychiatric examination require the active involvement of the patient (e.g., answering questions). Thus, while the patient's consent is not formally required, its absence may in fact exclude or significantly hinder the assessment of some elements of the mental state (for example, when the patient remains silent during conversation with the doctor, or completes a test in a completely random manner, e.g., by ticking "a" for every answer). The law also does not provide for the possibility of applying coercive measures to a patient who does not actively participate in such an examination (*arg. a contrario ex* Art. 18 and Art. 33 of the MHP – for a broader discussion about this issue, see below).

Referring to the aforementioned coercive measures, their application to a patient under psychiatric observation is possible when the patient:

a) commits an attack against the life or health of himself or others;
b) commits an attack against public safety;
c) violently destroys or damages objects in his surroundings;
d) seriously disrupts or prevents the functioning of the medical institution.

In the latter case, coercion may consist only of holding the patient down or the emergency administration of drugs (Art. 18(6)(2) of the MHP). In other situations (items a-c), all forms of coercive measures may be used, including immobilization or isolation (Art. 18(6)(1) of the MHP). Taking into account the prohibition of therapeutic measures resulting from Art. 33(4) of the MHP, it should be assumed that in the case

of emergency administration of drugs, only substances intended to control the patient's agitation and regain self-control can be administered.

Besides the situations defined above, coercion may also be applied to a patient hospitalized under Art. 24 of the MHP in order to prevent him from leaving the psychiatric hospital or ward (Art. 34, second sentence, of the MHP). The legislator did not specify which forms of coercion are meant here. Therefore, it should be assumed that all four of the aforementioned forms of coercion can be used in this case as well (Art. 3(6) of the MHP).

Subsequently, it is necessary to analyze the possibility of taking blood from a patient under psychiatric observation when the patient does not consent. In medical practice, such a procedure can be part of a routine assessment of the somatic state of a patient admitted to the hospital (assessment of basic laboratory parameters). It can also serve to determine the etiology of the disorders presented by the patient (for example, by detecting the presence of psychoactive substances in the blood or excluding somatic conditions that manifest with psychiatric symptoms). Particularly in the latter case, it would seem that this is an element of "observation" and therefore does not require additional consent from the patient. However, in the current legal state, this standpoint should be rejected for two main reasons.

Firstly, there are no explicit norms in the MHP that authorize this procedure to be carried out against the patient's will, which would waive the requirement to obtain the patient's consent arising from Art. 16 of the PRPO[5]. The legal basis for such actions cannot be found in Art. 24 of the MHP itself. This provision permits "only" the admission of a patient to a psychiatric hospital for observation. It does not, however, constitute a general authority to take further medical interventions without the patient's consent.

Secondly, blood collection requires some cooperation from the patient, or at least no active resistance. If the patient actively resists the procedure (e.g., pulling his hand away, tugging, attempting to leave the couch), blood collection without the use of coercive measures will not be possible. Meanwhile, the MHP provisions do not provide for the use of coercion in such cases. In accordance with Art. 34 of the MHP, except for the situations specified in Art. 18 of the MHP, coercive measures may be applied to persons hospitalized against their will only when it is necessary to perform therapeutic procedures – which cannot be administered in the case of psychiatric observation (Art. 33(4) of the MHP) – or to prevent the patient from leaving the hospital without authorization.

[5] For example, such solutions are found in Art. 47(1) of the Act of 26.10.1982 on Upbringing in Sobriety and Counteracting Alcoholism (Journal of Laws of 2023, item 2151) or in Art. 74(2)(2) of the Act of 6.06.1997. – Code of Criminal Procedure (Journal of Laws of 2024, item 37; hereinafter: CCP). According to Art. 47(1) of the Act on Upbringing in Sobriety(…), "if there is a suspicion that a crime or offense has been committed after the consumption of alcohol, the suspect may be subjected to tests necessary to determine the alcohol content in the body, including, in particular, the collection of a blood sample". Pursuant to Art. 74(2)(2) of the CCP, "the accused shall be obliged to (...) submit to the collection of blood, hair or bodily secretions".

Of course, there are no formal contraindications to drawing blood from a patient if he consents. It should be noted that the lack of consent to hospitalization does not exclude the possibility of the patient's consent to particular (some or all of the proposed) health services.

If the patient does not give such consent, under the current legal state, blood draws are possible only in cases of emergency, i.e., when the patient requires immediate medical help and, due to his health or age, he is unable to give consent and there is no possibility to communicate with his legal representative or actual guardian (Art. 33(1) et seq. of the Act of 5.12.1996 on the Profession of Physician and Dentist, Journal of Laws of 2024, item 1287; hereinafter: PPD) [12]. As an example, it refers to a blood draw to determine the causes of sudden and persistent unconsciousness (to rule out intoxication with psychoactive substances or to rule out certain somatic conditions – such as hypoglycemic coma).

In the absence of autonomous regulations in the MHP, Art. 33(1) of the PPD will also serve as the basis for compulsory blood collection from a conscious patient in the case of suspicion of psychoactive substance intoxication, if determination of this fact has clinical significance – for example, for the selection of emergency medications which should be administered to the patient under coercive measures[6]. The literature rightly points out that, for the application of Art. 33(1) of the PPD, it is sufficient to determine that emergency intervention is in the patient's best interest [13], and delay of such intervention "may make its effective performance impossible in the future or prolong the therapeutic process or greatly complicate treatment methods." [12]. Although patients under psychiatric observation are not "treated," as mentioned above, in certain cases, emergency medications may be administered to them (Art. 18(1) in conjunction with Art. 18(6)(1-2) of the MHP). Considering the interactions that may occur between drugs/designer drugs/alcohol and pharmacological preparations, it is in the patient's best interest to obtain information about possible intoxication. If the patient's clinical condition requires immediate action and contact with the patient is significantly impaired despite preserved consciousness (e.g., due to hallucinations, delusions, severe agitation) then the prerequisites for the application of Art. 33(1) of the PPD will be met. Thus, blood may be drawn without the patient's consent.

Regardless of the above considerations, the legislator should introduce a provision into the MHP stating explicitly that persons hospitalized under Art. 24 of this act may have their blood drawn, also without their consent, for the purpose of testing for the presence of psychoactive substances, including alcohol, as well as when this is especially justified in view of their somatic condition (e.g., drawing blood from an elderly person to exclude severe dyselectrolytemia). In order to enable the implementation of the above-mentioned assumptions, in the case of patient resistance, the legislator

[6] For example, when a highly agitated patient in paralogical verbal contact demolishes the ward, thereby meeting the prerequisites for the use of coercive measures (Art. 18(1)(2) of the MHP).

should introduce in parallel the possibility of using coercive measures. Guarantee reasons dictate that the permissible form of coercion in this kind of situation should be limited to temporarily holding the patient. It is worth pointing out that this type of solution will not constitute a novelty in the Polish legal system. The possibility of applying coercive measures for the purpose of performing sanitary-epidemiological examinations is provided for by Art. 36(1) of the Act of 5.12.2008 on preventing and combating infections and infectious diseases in humans (Journal of Laws of 2024, item 924)[7].

Although the postulates formulated above are a manifestation of a paternalistic approach, it should be remembered that they refer to people who were admitted to the hospital because their behavior indicated that, due to mental disorders, they endangered their own lives or the lives or health of others, and doubts about the presence of mental illness have not yet been resolved. These illnesses can significantly impair the ability to reality-test and rationally direct one's own behavior, negatively affecting the decision-making process, also in the context of proposed diagnostic methods. The *conditio sine qua non* of individual autonomy is the ability to understand one's own behavior and decisions, and the consequences associated with them. Lack of such qualities means that the patient's actions will be – to a greater or lesser extent – the matter of chance, and his decision-making autonomy will remain only illusory [7]. In such cases, paternalistic mechanisms are unavoidable.

Admissibility of "reapplication" of Art. 24 of the MHP during the same hospitalization

One of the greatest dilemmas that arise in using Art. 24 of the MHP in medical practice is the question of reapplying this provision to a patient who, after being admitted for observation, agreed to stay in the hospital and then demanded to be discharged home before resolving doubts as to the patient's mental health status (Fig. 1).

[7] According to this provision, "a person who does not submit to (...) sanitary-epidemiological examinations (...) and in whom a particularly dangerous and highly contagious disease is suspected or diagnosed, posing an immediate threat to the health or life of others, may be subjected to a direct coercive measure consisting of restraint, immobilization or forced administration of drugs". The aforementioned sanitary-epidemiological examinations also include laboratory tests for the detection of biological pathogens or confirmation of the diagnosis of an infectious disease (Art. 2(1) of the aforementioned Act on preventing and combating infections and infectious diseases in humans).

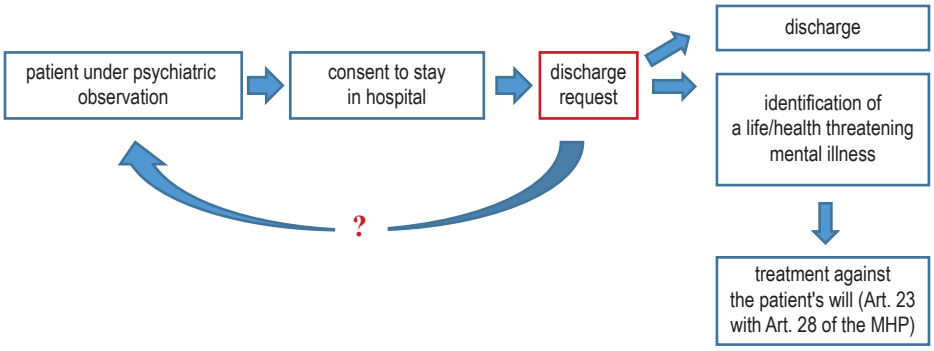

Figure 1. **Procedure for a patient placed under psychiatric observation after the patient consents to stay in hospital and subsequently requests discharge**

Source: author's own graphic – MB

Psychiatric observation is – *ex definitione* – compulsory in nature. Once the patient has consented to further hospitalization, this procedure from Art. 24 of the MHP can no longer be used, on the condition that the guardianship court determines that the patient's consent meets the requirements provided for in Art. 3(4) of the MHP. The court must therefore determine that "the patient was aware of the decision made and the consequences associated with it, and gave his consent freely" [14, 15]. In order to do so, it is necessary that the patient be heard by the court (Art. 26(2) of the MHP). If the patient is deemed to have validly consented to further hospitalization, the proceeding to control the legitimacy of his involuntary admission to the hospital is discontinued (Art. 26(1) of the MHP).

A patient being treated voluntarily may request discharge home at any time. In the current state of the law, such a request must result in discharge unless the patient meets the prerequisites of Art. 23(1) of the MHP. In other words, the patient must be discharged unless his behavior indicates that, due to mental illness, he is directly threatening his life or the life or health of others. Only in the latter case does the law provide for the possibility of continuing to treat the patient against his will (Art. 28 of the MHP).

However, currently there is no possibility of "re-" placement of a patient for psychiatric observation under Art. 24 of the MHP. This standpoint is supported by a literal interpretation of Art. 28 of the MHP. The latter provision allows the continuation of treatment of a patient who has withdrawn consent to hospitalization only if the prerequisites of Art. 23(1) of the MHP exist. Guarantee reasons dictate that this norm must be interpreted strictly [16]. Thus, it is not possible to apply Art. 28 of the MHP in other situations by analogy.

In light of the above considerations, the opinion of A. Rydzewski [17] is unconvincing. This author assumes that Art. 28 of the MHP may also be applied in the case of withdrawal of consent by a patient initially hospitalized under Art. 24 of the MHP,

which is supposed to be supported by paragraph 3. of Art. 24 [17]. Article 24(3) of the MHP refers exclusively to the moment of "admission [of the patient] to the hospital" for psychiatric observation and stipulates that the procedure and rules set forth in Art. 23 of the MHP should be applied then. The content of Art. 24(3) of the MHP "only" allows us to establish that admission of a patient for involuntary psychiatric observation requires compliance with the same procedural requirements as admission of a mentally ill person to a hospital under Art. 23 of the MHP[8]. In the configuration analyzed in this subsection, on the other hand, it is a patient who is already hospitalized and requests discharge. As already mentioned, the latter issues are regulated autonomously by Art. 28 of the MHP. Thus, the norms provided for in Arts. 24 and 28 of the MHP have a different normative scope. The fact that the legislator refers to Art. 23 of the MHP in both of these provisions does not allow support for A. Rydzewski's standpoint, because these cross-references have a different functional context.

Prima facie, in the situation under discussion, one might consider discharging the patient (in accordance with his request) and subsequently admitting him immediately to the hospital again (on the basis of the Art. 24 of the MHP). However, such a practice would constitute a sort of fiction aimed at circumventing the statutory restrictions, and therefore cannot be approved.

The problem of the impossibility of reapplying Art. 24 of the MHP in order to "finish the observation" is not just theoretical. It is possible that a patient initially admitted for psychiatric observation agrees to remain in the hospital, and then requests discharge as early as the first day of hospitalization. In such a case, the actual period of observation will be dramatically reduced. The patient's temporary stay in the ward will not allow the realization of the purpose of Art. 24, i.e., determining whether the patient presents psychotic disorders (mental illness within the meaning of the MHP). The current legal state is highly unfavorable. In the situation described here, the doctor faces a serious dilemma. Discharging a patient while doubts about mental illness remain unresolved may pose a threat to the patient's life or health. In turn, hospitalization based on a reapplication of Art. 24 of the MHP does not have a sufficient normative basis and is therefore contrary to the law. In both cases, the doctor exposes himself to legal liability. The first scenario may lead to allegations of exposing the patient to imminent danger of loss of life or grievous bodily harm (Art. 160 §2 of the Act of 6.06.1997 – Criminal Code, Journal of Laws of 2025, item 383; hereinafter: CC). In the second scenario, the doctor may face an allegation of violating the patient's

[8] Thus, in the case of admission of a patient for observation under Art. 24(1) of the MHP: admission for observation is decided by the physician after personally examining the patient and consulting, if possible, with a second psychiatrist or psychologist (Art. 23(2) of the MHP); the physician must explain to the patient the reasons for admission to the hospital without consent and inform him of his rights (Art. 23(3) of the MHP); admission requires approval by the head of the department (the physician in charge of the department) within 48 hours of admission and notification of the guardianship court by the head of the hospital, within 72 hours of admission (Art. 23(4) of the MHP) and documentation of these circumstances in the medical records (Art. 23(5) of the MHP). So, the provision of Art. 24(3) of the MHP serves to avoid repetition of identical normative content by using a reference to another standard (in this case, to Art. 23(2-5) of the MHP).

rights, along with a resulting claim for compensation for harm suffered as a result of unlawful hospitalization (Art. 4 of the PRPO in conjunction with Art. 448 of the Act of 23.04.1964 – Civil Code, Journal of Laws of 2024, item 1061) [10]. "Renewing" psychiatric observation may also be considered in the context of the criminal act typified by Art. 189 of the CC (unlawful deprivation of liberty) [18, 19].

The current legal state is also unsafe for patients. It creates a risk of misuse of Art. 23(1) (in conjunction with Art. 28 of the MHP), by "aprioristically" assuming that a patient is mentally ill, even if, at the time of the discharge request, doubts in this regard have not yet been definitively resolved.

It seems reasonable to expand Art. 28 of the MHP by introducing an appropriate reference to Art. 24 of this Act. Such a solution would allow for the legal "completion" of psychiatric observation. Of course, for guarantee reasons, it would be necessary to introduce a parallel provision stipulating that the total duration of observation (both the initial and the repeated one) may not exceed 10 days, including the period of hospitalization carried out "with the consent" of the patient. From a practical standpoint, the latter limitation should be introduced into Art. 24 of the MHP, as an additional (fourth) paragraph of this provision.

Regardless of the above considerations and postulates, it should not be lost sight of the fact that the doctor who decides on the patient's further hospitalization is a guarantor of the patient's health and life. If, in the doctor's assessment, these values are directly threatened, and the short period of psychiatric observation did not allow this threat to be excluded, the doctor who decides to continue hospitalization – in accordance with the principle of *salus aegroti suprema lex esto* – should be regarded as acting in a state of superior necessity within the meaning of Art. 26 §1 of the Criminal Code, in the event that criminal charges are brought against him. Health and life constitute *summa bona* in contemporary axionormative systems and undoubtedly represent superior values to an individual's decision-making autonomy. Although this autonomy is an emanation of human dignity [20], the necessity to save human life may, in certain cases, justify its restriction. An exemplification of this assumption are, among others, the compulsory psychiatric hospitalization modes discussed in this article. Their application involves overriding the patient's autonomy (as to his will to remain in the hospital) in order to save his life or to protect the health or life of others. It should also be borne in mind that Art. 24 of the MHP applies to situations in which doubts remain unresolved as to the presence of psychotic symptoms (i.e., mental illness within the meaning of the Act). The latter may result in the loss of the ability to test reality and rationally direct one's actions, rendering decision-making autonomy merely illusory.

The state of superior necessity under civil law has a narrower subjective scope (Art. 424 of the Civil Code)[9] [21]. Therefore, this institution will not be applicable

[9] The provision of Art. 424 of the Civil Code states: "Whoever destroys or damages another's property, or kills or injures another's animal, in order to avert a danger directly threatening themselves or others, shall not be liable for the resulting damage, provided that the danger was not caused by them, could not have been otherwise prevented, and the good being protected is clearly more important than the good violated."

to potential civil claims against the doctor on the basis of Art. 4 of the PRPO in conjunction with Art. 488 of the Civil Code, in connection with allegations of violation of patient rights.

Procedure in case of confirmation of the patient's psychotic disorder (mental illness within the meaning of the Act)

Similar to the problem outlined above is the question of how to proceed when a patient under psychiatric observation is diagnosed with psychotic symptoms (mental illness according to the MHP) and does not consent to further treatment. If the doctors determine that – despite the presence of the illness – the patient does not pose a direct threat to his life or to the life or health of others, the discharge request should result in the termination of hospitalization. From a medical standpoint, there is no doubt that if the opposite finding is made – i.e., if the patient is considered to pose a direct threat to his life or to the health or life of others – there is a need for compulsory treatment [1]. From a legal perspective, however, the question remains as to the legal basis for further hospitalization (Fig. 2).

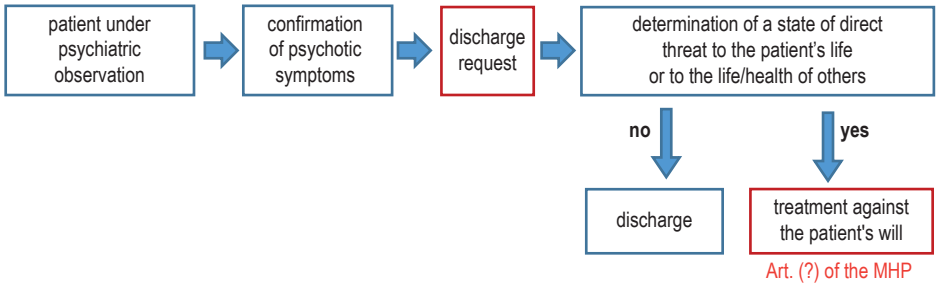

Figure 2. **Procedure for a patient under psychiatric observation following the diagnosis of mental illness and lack of consent for further hospitalization**

The problem that arises here stems from the inconsistency of the legislator, who did not regulate this issue in the Mental Health Protection Act. The provision of Art. 23 of the MHP refers to the "admission [of a patient] to a psychiatric hospital." In contrast, Art. 28 of the MHP applies to persons who are hospitalized in a hospital with their consent and subsequently withdraw that consent. In the discussed case, on the other hand, it concerns a patient who is already forcibly hospitalized (Art. 24 of the MHP) and who "still" does not consent to further treatment after the end of observation. *Prima facie*, there is no legal provision applicable to manage this kind of situation. Since the patient has never been in the hospital "with his consent," Art. 28 of the MHP cannot be applied.

The literature indicates that the only course of action, in such a case, is to discharge the patient, with his subsequent immediate admission on the basis of Art. 23 of the

MHP [22]. Although the above approach may be somewhat justified from the point of view of the strict interpretation of the MHP provisions and the search for a way out of the impasse, it raises ethical questions. After all, the implementation of the above-mentioned assumption comes down to the creation of a peculiar "fiction of discharge," which serves only to bring further medical treatment into line with the strict wording of Art. 23 of the MHP. In fact, the patient will not be released from the psychiatric hospital (which is a natural consequence of discharge). Thus, he will not regain the right to decide on his own location and will still be deprived of his liberty. So, the "discharge" will be no more than a formal and apparent action.

Theoretically, the basis for the continuation of the forced hospitalization of the patient in discussion here can be derived from Art. 28 of the MHP by using an *a fortiori* interpretation. This inference can be justified as follows. If, in the case of the occurrence of the prerequisites of Art. 23(1) of the MHP, the legislator allows for detaining in the hospital a person who was there voluntarily (with his consent), then all the more it is allowed to further detain in the hospital a person who is already there against his will (i.e., a patient primarily subjected to compulsory psychiatric observation).

Nevertheless, it should be remembered that Art. 28 of the MHP (as well as Arts. 23 or 24) are competence norms. These provisions grant the hospital certain powers of public authority, the application of which results in interference with the patient's constitutional right to personal liberty and allows his forced hospitalization. Competence norms must be interpreted strictly, which results from Art. 7 of the Polish Constitution and the principle of legalism expressed there [23, 24]. Therefore, competences cannot be presumed or extended beyond those that arise directly from the provision. Article 28 of the MHP, in its current wording, allows "only" for the detention of a patient who has previously been in the hospital with his consent. So, it does not apply to a patient under compulsory psychiatric observation. The problem of the legal basis legitimizing the patient's continued treatment in the hospital if it is determined during psychiatric observation that he is "mentally ill" remains unresolved.

This legal loophole should be assessed unequivocally negatively. In order to bridge this loophole, the legislator should introduce provisions in the MHP that precisely regulate the issue. It seems sufficient to expand Art. 24, paragraph 2, of the MHP by a second sentence, so that the provision assumes the following wording: *The stay in the hospital referred to in paragraph 1 cannot exceed 10 days. If, during this stay, the circumstances referred to in Art. 23, paragraph 1, are found, the provision of Art. 28 shall apply accordingly*.

Conclusion

The provisions on psychiatric observation, as provided for in Art. 24 of the MHP, are not complete. The current state of the law is the cause of many doubts arising in the application of this institution in medical practice. As a result, medically obvious actions do not always find a direct basis in the norms of the MHP, which exposes doc-

tors to legal liability. These deficiencies make psychiatric observation an institution of limited utility. Concluding the conducted considerations, it is worth highlighting three fundamental issues.

Firstly, in the current state of the law, it is impossible to "reapply" Art. 24 of the MHP in order to "complete" the psychiatric observation of a patient who, after being forcibly admitted to the hospital, consented to further stay and then withdrew this consent and demanded discharge home (no reference to Art. 24 in Art. 28 of the MHP). It would be advisable to expand Art. 28 of the MHP with an appropriate reference to Art. 24 of the MHP, with the limitation that the total duration of observation (initial and repeat) may not exceed 10 days, including the period of the patient's stay in the ward with his consent.

Secondly, doubts may concern the legal basis for further treatment of a patient under observation, once it has been established that he presents a psychotic disorder (mental illness within the meaning of the MHP) that threatens his life or the life or health of others, if the patient does not consent to such treatment. Article 24 of the MHP does not autonomously regulate this issue, while Art. 28 refers to a generically different situation. Thus, in the current state of the law, the issue remains unresolved.

Third, the lack of regulations defining the scope of medical (other than therapeutic) actions that can be taken against a patient under psychiatric observation if the patient does not consent to them should be assessed negatively. Particularly important seems to be the question of the permissibility of drawing blood from such a patient. This procedure may be important for establishing the etiology of the presented disorder (e.g., by excluding a state of intoxication with psychoactive substances), and thus to achieve the primary goal of the observation. Nevertheless, in the current state of the law, the collection of blood from a patient, as a rule, requires his consent, including when he is under psychiatric observation. In view of the aforementioned lack of separate provisions in the MHP, blood sampling without consent is possible only in emergency situations, in accordance with the procedure set forth in the Law on the Profession of Physician and Dentist (Arts. 33 and next). It seems reasonable to introduce into the Mental Health Protection Act an autonomous provision that allows explicitly to draw blood from a patient under psychiatric observation, also "beyond" the state of emergency, when it is necessary for diagnostic purposes, and therefore for the resolution of doubts referred to in Art. 24 of the MHP. The absence of such a regulation undoubtedly hinders the effective conduct of psychiatric observation.

References

1. Gałecki P, Bobińska K. *Komentarz do art. 23-24*. In: Gałecki P, Bobińska K, Eichstaedt K. *Ustawa o ochronie zdrowia psychicznego. Komentarz.* Warszawa: Wolters Kluwer; 2016. pp. 143-155.
2. Szwed M. *Przymusowe umieszczenie w zakładzie psychiatrycznym w świetle współczesnych standardów ochrony praw człowieka.* Warszawa: Wolters Kluwer; 2020.
3. Heitzman J, Markiewicz I. *Przyjęcie do szpitala psychiatrycznego.* In: Wciórka J, Pużyński S, Rybakowski J, eds. *Psychiatria. Vol. 3: Metody leczenia. Zagadnienia etyczne, prawne, publiczne, społeczne.* Wrocław: Edra Urban & Partner; 2012. pp. 484-485.
4. Dmuch M. *Komentarz do art. 24.* In: Drembkowski P, Kmieciak B, Tymiński R, eds. *Ochrona zdrowia psychicznego. Komentarz.* Warszawa: Wolters Kluwer; 2023. pp. 590-601.
5. The government's project of amendments to the Mental Health Protection Act of 30/11/2022 (source: https://legislacja.rcl.gov.pl/projekt/12367401).
6. World Health Organization. *International Statistical Classification of Diseases and Related Health Problems, 11th Revison.* (source: https://icd.who.int/en/).
7. Burdzik M. *Osoba z zaburzeniami psychicznymi jako uczestnik postępowania karnego.* Warszawa: Wolters Kluwer; 2024.
8. Pużyński S. *Choroba psychiczna – problemy z definicją oraz miejscem w diagnostyce i regulacjach prawnych.* Psychiatr. Pol. 2007; 41(3): 299–308.
9. Supreme Court decision of 12.10.2018, V CSK 166/18, LEX database no. 2575852.
10. Supreme Court decision of 4.08.2020, IV CSK 51/20, LEX database no. 3063048.
11. Karkowska D, Kmieciak B. *Komentarz do art. 16.* In: Karkowska D, ed. *Prawa pacjenta i Rzecznik Praw Pacjenta. Komentarz.* Warszawa: Wolters Kluwer; 2021. pp. 564-574.
12. Malczewska M. *Komentarz do art. 33.* In: Zielińska E, ed. *Ustawa o zawodach lekarza i lekarza dentysty. Komentarz.* Warszawa: Wolters Kluwer; 2022. pp. 830-836.
13. Świderska M. *Zgoda Pacjenta na zabieg medyczny.* Toruń: Dom Organizatora TNOiK; 2007.
14. Eichstaedt K. *Komentarz do art. 26*. In: Gałecki P, Bobińska K, Eichstaedt K. *Ustawa o ochronie zdrowia psychicznego. Komentarz.* Warszawa: Wolters Kluwer; 2016. pp. 163-164.
15. Tymiński R. *Komentarz do art. 26.* In: Drembkowski P, Kmieciak B, Tymiński R, eds. *Ochrona zdrowia psychicznego. Komentarz.* Warszawa: Wolters Kluwer; 2023. pp. 616-624.
16. Komarnicka-Boberska K, Ulman M. *Komentarz do art. 28*. In: Drembkowski P, Kmieciak B, Tymiński R, eds. *Ochrona zdrowia psychicznego. Komentarz.* Warszawa: Wolters Kluwer; 2023. pp. 628-631.
17. Rydzewski A. *Problematyka skuteczności i wykonalności orzeczeń sądu wydanych na podstawie ustawy o ochronie zdrowia psychicznego.* Rejent 1998; 1(81): 82-99.
18. Judgment of the Court of Appeals in Cracow of 12.12.2012, II AKa 220/12, LEX database no. 1254370.
19. Mozgawa M. *Komentarz do art. 189.* In: Mozgawa M, ed. *Kodeks karny. Komentarz aktualizowany.* Warszawa: el.LEX; 2025.
20. Judgment of the Polish Constitutional Tribunal of 11.10.2011, K 16/10, LEX database no. 992832.
21. Długoszewska-Kurk I. *Komentarz do art. 424*. In: Załucki M, ed. *Kodeks cywilny. Komentarz.* Warszawa: CH Beck; 2019. pp. 992-993.

22. Ciechorski J. *Przyjęcie osoby bez jej zgody do szpitala psychiatrycznego na podstawie ustawy o ochronie zdrowia psychicznego – uwagi w świetle Europejskiej Konwencji Praw Człowieka.* Europejski Przegląd Sądowy 2018; 4: 13–24.
23. Florczak-Wątor M. *Komentarz do art. 7*. In: Tuleja P, ed. *Konstytucja Rzeczpospolitej Polskiej. Komentarz.* Warszawa: Wolters Kluwer; 2023. pp. 46-49.
24. Judgment of the Polish Constitutional Tribunal of 27.05.2002, K 20/01, LEX database no. 54068.

Corresponding author: Marcin Burdzik
e-mail: marcin.burdzik@us.edu.pl