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ARTIFICIAL INTELLIGENCE ADVANCEMENTS AND CONTRACTUAL LIABILITY IN A DOCTOR PATIENT RELATIONSHIP: THE DILEMMA

AUTHORED BY - NARAYANEE AKSHAYAVARSHINI N P[1]

Abstract

The Indian law of medical liability was built for a doctor who makes the clinical decision and can explain it. Artificial intelligence is changing that assumption. When a diagnostic or decision-support tool shapes the outcome, it is unclear who has broken which promise: the doctor, the hospital that deployed the tool, or the developer who sits outside the patient's contract. This paper treats the doctor–patient relationship as a contract and works through the duties of each party, breach, the distinction between contractual liability and medical negligence, informed consent, the standard of care and professional skill, remedies and defences, asking how each applies to AI-assisted care. Drawing on Indian statutes and decisions and on the law of the United Kingdom, the United States and the European Union, it argues that existing doctrine can absorb AI in part but leaves a responsibility gap and gives patients no clear right to know how AI was used. It proposes a layered allocation of duties among doctor, hospital, developer and patient, a patient-facing consent term on AI use, a duty to preserve evidence of the tool's behaviour, and targeted statutory amendment.

Keywords: artificial intelligence, contractual liability, medical negligence, informed consent, standard of care, doctor–patient relationship.

[1]CLA2512, 2nd year LLM(Hons), Department of Criminal Law and Criminal Justice Administration, School of Excellence in Law, The Tamil Nadu Dr. Ambedkar Law University, 9360278970, akshayavarshini2211@gmail.com.

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CHAPTER-I

INTRODUCTION

1.1 Introduction

When a patient consults a doctor in India and the doctor agrees to treat her, a contract comes into being, though neither of them thinks of it in those terms. There is a proposal and an acceptance and, usually, a fee. The doctor undertakes to bring reasonable skill and care to the task, and the patient undertakes to pay and to cooperate. The Supreme Court has confirmed that the relationship rests on a contract for services.[2] Medical law in India has been built on that footing for decades.

Artificial intelligence is altering that arrangement without anyone having renegotiated it. Software now reads radiographs and retinal scans, flags deteriorating patients on hospital wards, suggests drug doses and ranks patients for triage.[3] The doctor who uses such tools still promises skill and care, but part of the work covered by that promise is done by a system the doctor did not build, cannot fully inspect and may be unable to explain. If the system errs and the patient is harmed, it is far from obvious who broke which promise. The doctor relied on a tool; the hospital bought the tool from a developer; the patient has a contract with the doctor or the hospital and none with the developer. That is the dilemma of this paper's title.

The dilemma has two edges. If the law holds the doctor strictly answerable for every output of an AI tool, doctors will avoid useful tools or follow them defensively, and the promise of better care will be lost. If the law excuses the doctor because the machine decided, patients are left with a promise of skill that nobody can be made to keep. This paper looks for a path between the two within the existing Indian law of contract and medical negligence, and asks where that law needs help.

Two points of terminology. "AI" is used here for machine-learning systems that assist clinical decisions, such as diagnostic and decision-support tools, and not for administrative software. "Contractual liability" is used in a wide sense, to cover the express and implied terms of the doctor–patient relationship, the consequences of breaching them, and the way the contract meets the tort of negligence and consumer law, since in India the three are seldom separable in practice.

[2]Indian Med. Ass'n v. V.P. Shantha, (1995) 6 S.C.C. 651 (India).
[3]Eric J. Topol, High-Performance Medicine: The Convergence of Human and Artificial Intelligence, 25 NATURE MED. 44 (2019).

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1.2 Need of the Study

The doctrines that govern medical liability in India were formed for a world in which a human being made the clinical decision. Bolam, Jacob Mathew and Samira Kohli all assume a doctor who chooses a course of action on the strength of training and judgment and who can be asked to explain why.[4] None of the decisions discussed in this paper concerns AI. The regulatory material that does exist in India is soft: guidelines from the Indian Council of Medical Research, a strategy paper from NITI Aayog, and a telemedicine code that tells doctors they remain responsible for their advice. These encourage careful use of the tools. They do not say who pays when a tool fails. There is a second reason, which is specific to contracts. In practice the allocation of risk is being settled in documents that patients never see: the licence between the hospital and the software developer, with its warranties, exclusions and caps on liability, and the consent form the patient signs at admission. If those documents are left to market practice, the party with the least bargaining power and the most to lose will carry the risk. Courts and legislators should look at them now, before AI-assisted care becomes routine and the terms harden.

1.3 Significance of the Study

The study matters to several groups. For patients, it seeks to clarify what they are entitled to be told and whom they can hold to account. For doctors, it addresses a real fear. A doctor who follows an algorithm and is wrong may be accused of abdicating judgment, and a doctor who overrides it and is wrong may be accused of ignoring the best available evidence. The law should say which of the two is the greater risk, and why. For hospitals, the study identifies the contractual terms that matter in procurement. For regulators, it offers a map of what exists and what is missing. For scholarship, it brings together two bodies of law that have mostly been developed apart, the law of medical negligence and the law of contract.

1.4 Review of Literature

The literature falls into five groups. Each is taken in turn below, with the main finding and the difficulty it leaves. Clinical and technical writing establishes both the promise and the risk. Topol argues that AI can raise diagnostic accuracy and relieve clinicians of routine work, provided it is used alongside human judgment and not in place of it.[5]

[4]Bolam v. Friern Hosp. Mgmt. Comm., [1957] 1 W.L.R. 582 (Q.B.) (Eng.); Jacob Mathew v. State of Punjab, (2005) 6 S.C.C. 1 (India); Samira Kohli v. Dr. Prabha Manchanda, (2008) 2 S.C.C. 1 (India).
[5]Topol, supra note 2.

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Obermeyer and colleagues showed that a widely used algorithm for allocating care resources under-served Black patients because it used past health spending as a proxy for need.[6] Together the studies show why AI will be adopted and why its errors may be systematic and not random, which matters for liability.

Legal writing on liability forms the second group. Price considers how the malpractice standard, which is built on what other physicians customarily do, will cope when neither doctor nor patient can see why a system reached its conclusion.[7] Froomkin, Kerr and Pineau warn that a tort regime which punishes doctors for departing from a better-performing machine will push them into over-reliance.[8]

Gerke, Minssen and Cohen survey the legal and ethical questions more broadly, including liability, consent and data protection.[9] Matthias's account of the "responsibility gap" supplies the philosophical frame: when a learning system acts in ways its makers did not foresee and its operators cannot control, the usual grounds for assigning responsibility weaken.[10] The difficult for present purposes is that this work is written mostly from tort and product-liability perspectives and with American or European law in view.

The third group is Indian medical-liability jurisprudence. The material is dominated by judicial decisions on the nature of the relationship, the standard of care, consent and compensation. They show a court willing to protect patients while guarding doctors against hindsight, a balance stated most clearly in Jacob Mathew.[11]

Nothing in this body of work considers AI. The fourth group concerns consent. The law has moved from doctor-centred to patient-centred disclosure, from Sidaway to Montgomery in England and from Schloendorff to Canterbury in the United States.[12]

Samira Kohli places India closer to the patient-centred side.[13] How far consent must extend to the use of AI has not been settled anywhere. The fifth group is guidance. International and

[6]Ziad Obermeyer et al., Dissecting Racial Bias in an Algorithm Used to Manage the Health of Populations, 366 SCIENCE 447 (2019).

[7]W. Nicholson Price II, Medical Malpractice and Black-Box Medicine, in BIG DATA, HEALTH LAW, AND BIOETHICS 295 (I. Glenn Cohen et al. eds., 2018).

[8]A. Michael Froomkin, Ian Kerr & Joelle Pineau, When AIs Outperform Doctors: Confronting the Challenges of a Tort-Induced Over-Reliance on Machine Learning, 61 ARIZ. L. REV. 33 (2019).

[9]Sara Gerke, Timo Minssen & Glenn Cohen, Ethical and Legal Challenges of Artificial Intelligence-Driven Healthcare, in ARTIFICIAL INTELLIGENCE IN HEALTHCARE 295 (Adam Bohr & Kaveh Memarzadeh eds., 2020).

[10]Andreas Matthias, The Responsibility Gap: Ascribing Responsibility for the Actions of Learning Automata, 6 ETHICS & INFO. TECH. 175 (2004).

[11]Jacob Mathew, supra note 3.

[12]Sidaway v. Bd. of Governors of the Bethlem Royal Hosp., [1985] A.C. 871 (H.L.) (appeal taken from Eng.); Montgomery v. Lanarkshire Health Bd. [2015] UKSC 11, [2015] A.C. 1430 (appeal taken from Scot.); Schloendorff v. Soc'y of N.Y. Hosp., 105 N.E. 92 (N.Y. 1914); Canterbury v. Spence, 464 F.2d 772 (D.C. Cir. 1972).

[13]Samira Kohli, supra note 3.

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national bodies have stated principles of transparency, accountability, human oversight and respect for patient autonomy.[14] Their findings converge. But they are statements of principle. They create no cause of action and allocate no loss.

1.5 Research Gap

The gap is the contractual one. None of the sources consulted for this paper examines how the doctor–patient contract, with its implied duty of skill and care, its rules on consent and its remedies and defences, should apply when a clinical tool is AI-driven, and the Indian dimension is largely unexplored. The challenges that run through the literature are opacity, the difficulty of proving fault and causation, uncertainty over who owes what to whom, and a lack of data on AI-related harm.

1.6 Research Problem

Indian law treats the doctor–patient relationship as a contract in which the doctor promises reasonable skill and care, and measures that promise against what a competent practitioner would do. AI complicates every part of this. The skill is partly embedded in a tool. The practitioner's ability to explain is limited. The patient's consent may not reflect the tool's role. The party best placed to prevent error, the developer, stands outside the contract. And the remedies and defences developed for human error do not map neatly onto errors made by a system. The research problem is the lack of a coherent account of contractual liability for AI-assisted medical care, and the uncertainty this produces for patients, doctors and hospitals.

1.7 Research Questions

1. How far can the doctor–patient relationship, understood as a contract, accommodate the use of AI tools in diagnosis and treatment, and how do the duties of doctor and patient change when AI is used?
2. How does contractual liability differ from liability for medical negligence where AI is involved, and what standard of care and professional skill should apply when machine output informs the clinical decision?
3. Does the existing Indian law on informed consent, remedies and defences adequately address AI-assisted care, including the allocation of risk among doctor, hospital and AI

[14]World Health Org., Ethics and Governance of Artificial Intelligence for Health: WHO Guidance (2021); Indian Council of Med. Rsch., Ethical Guidelines for Application of Artificial Intelligence in Biomedical Research and Healthcare (2023) (India) [hereinafter ICMR Guidelines].

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developer?

4. What legislative, regulatory, contractual and judicial reforms are needed to give patients, doctors and hospitals a coherent framework of liability?

1.8 Hypothesis

The paper proceeds on the hypothesis that the existing law of contract and medical negligence in India can accommodate AI-assisted care only in part. Its core doctrines, the implied duty of reasonable skill and care, informed consent and the remedies in section 73 of the Contract Act, are flexible enough to apply. But they leave a responsibility gap between the doctor, the hospital and the developer, and they give patients no clear right to know how AI has been used. The null hypothesis is that the present framework is sufficient without change.

1.9 Aim and Objectives

The aim of the study is to examine how the doctor–patient contract and the law of medical negligence apply to AI-assisted care and to propose a framework that allocates responsibility fairly. The objectives are:

(i) to analyse the doctor–patient relationship as a contract and the duties of each party;

(ii) to distinguish contractual liability from medical negligence and show how the distinction works where AI is involved;

(iii) to examine informed consent, the standard of care and professional skill in AI-assisted settings;

(iv) to evaluate the remedies for breach and the defences available to doctors;

(v) to study the approaches of the United Kingdom, the United States and the European Union; and

(vi) to propose legislative, regulatory, contractual and judicial reforms.

1.10 Research Methodology

The study is doctrinal. Primary sources are the Indian Contract Act, 1872, the Consumer Protection Act, 2019, the Bharatiya Nyaya Sanhita, 2023, the Digital Personal Data Protection Act, 2023, the medical ethics regulations and the decisions of the Supreme Court. Secondary sources are books, journal articles and the guidance documents of national and international bodies. The comparative chapter is selective. The United Kingdom is included because Indian law on the standard of care derives from it, the United States because of its developed law on consent and on whether software is a product, and the European Union because it has enacted

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the first comprehensive AI statute. The method is analytical and normative. No field research was undertaken. Citations follow the Bluebook, 21st edition.[15]

1.11 Scope

The study is confined to the relationship between a registered medical practitioner and a patient, with the hospital and the developer considered where they bear on that relationship. It covers clinical decision-support and diagnostic tools used by practitioners. It does not cover administrative AI, autonomous surgical robots or generative chatbots consulted by patients directly. Data protection is considered only as it bears on consent, and criminal liability only briefly.

1.12 Limitations

The limitations follow from the subject. No reported Indian decision applies contractual or negligence principles to AI-assisted care, so the analysis proceeds by extension from general principles. The regulatory position is changing quickly, particularly in the European Union, and the paper states the position as the author understood it at the time of writing. Contracts between hospitals and developers are confidential, so the clauses discussed in Chapter V are drawn from general contracting practice and not from a survey of actual agreements.

1.13 Chapterisation

1. Chapter I sets out the problem, questions, hypothesis and method.
2. Chapter II describes the international and national framework, including the doctor–patient contract, the duties of each party, breach, the distinction between contractual liability and negligence, informed consent, the standard of care, remedies and defences.
3.Chapter III compares the United Kingdom, the United States and the European Union.
4.Chapter IV examines the role of the Indian judiciary.
5.Chapter V maps duties, consent and contract terms across doctor, hospital, developer and patient.
6.Chapter VI states the findings, suggestions and conclusion.

[15]THE BLUEBOOK: A UNIFORM SYSTEM OF CITATION (Columbia L. Rev. Ass'n et al. eds., 21st ed. 2020).

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CHAPTER II

INTERNATIONAL AND NATIONAL FRAMEWORK

2.1 The Doctor–Patient Relationship as a Contract

A contract exists in Indian law when there is an agreement between competent parties, made with free consent, for a lawful consideration and a lawful object.[16] A patient who engages a doctor and pays, or promises to pay, a fee satisfies these requirements without ceremony. In Indian Medical Association v. V.P. Shantha, the Supreme Court held that medical services rendered for a fee fall within the Consumer Protection Act and treated the doctor's undertaking as a contract for services, as distinct from a contract of service, which is employment.[17] The Court excluded services rendered free of charge by hospitals to all patients, and treated hospitals that charge some patients as providing a service to all of them.

Most terms of the relationship are implied and not written. A person who holds himself out as a medical practitioner implies that he has the skill and knowledge needed for the task and will use them with reasonable care.[18] The doctor does not promise a cure. The undertaking is as to process and not outcome, which is why a poor result does not by itself show breach. Express terms can change this. A doctor who promises a particular result or technique, as happens in cosmetic and fertility practice, adds a term the law will enforce and measure against what was said. So does a hospital that advertises its diagnoses as AI-assisted and highly accurate.

2.2 Duties of the Doctor and of the Patient

The classic statement of the doctor's duties comes from Laxman Balkrishna Joshi. A practitioner owes a duty of care in deciding whether to undertake a case, in deciding what treatment to give, and in administering that treatment.[19]

The Indian Medical Council's ethics regulations add duties to maintain medical records and to keep a patient's confidences.[20] Consent adds a further duty, taken up in section 2.5. When AI is used, each of the three classic duties acquires a new character. Deciding whether to undertake a case includes deciding whether a tool is suitable for this patient. Deciding on treatment includes deciding how much weight an algorithmic recommendation deserves. Administering treatment includes watching whether the tool is performing as expected.

The patient has duties too, though they receive less attention. The patient must pay the agreed

[16]Indian Contract Act, 1872, No. 9 of 1872, §§ 2(h), 10 (India) [hereinafter Contract Act].
[17]V.P. Shantha, supra note 1.
[18]Laxman Balkrishna Joshi v. Trimbak Bapu Godbole, A.I.R. 1969 S.C. 128 (India).
[19]Laxman Balkrishna Joshi, supra note 17.
[20]Indian Medical Council (Professional Conduct, Etiquette and Ethics) Regulations, 2002, regs. 1.3, 2.2 (India).

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fee, give an honest and complete history, follow reasonable instructions and attend follow-up. These duties matter in law because a breach by the patient can reduce or defeat a claim. The Contract Act requires a party who complains of breach to take account of the means of remedying the loss,[21] and the common law reduces damages where the patient's own fault contributed to the harm.[22] With AI the patient's duty of honest disclosure gains a technical side. A tool may depend on accurate inputs, including symptoms, medication history and permission to use data, and a patient who withholds or misstates them may shift some responsibility for an error.

2.3 Breach of Contract

Breach occurs when a party fails to perform a promise, express or implied. For the doctor, three kinds of breach are conceivable. The first is a failure of skill or care, which breaches the implied term. The second is failure to do what was expressly promised, such as use a named technique or deliver a stated result. The third is a failure of disclosure or consent, where treatment goes beyond what the patient agreed to.

The remedy is compensation under section 73 of the Contract Act, which covers loss that naturally arose in the usual course of things from the breach, or that the parties knew when contracting was likely to result from it, and excludes remote and indirect loss.[23]

The difficulty in the medical setting is both evidential and conceptual. Because the promise is one of care, proving breach means proving that care fell short, which is the same exercise as proving negligence. The contract adds little unless the parties have said something more specific.

AI creates room for more specific terms, and this is where contractual analysis can contribute. A hospital that promises human review of every AI output breaches the contract if it fails to provide it, whether or not the omission was careless.

2.4 Contractual Liability and Medical Negligence Distinguished

Contractual liability and liability for medical negligence overlap, and Indian courts often speak of them together, but they are not the same thing. Contractual liability arises from the agreement and the terms the parties made, express and implied. Liability in negligence arises from a duty that the law imposes on a person who undertakes a task of that kind, and it exists

[21]Contract Act, *supra* note 15, § 73 explanation.
[22]Cf. Law Reform (Contributory Negligence) Act 1945, 8 & 9 Geo. 6 c. 28 (UK).
[23]Contract Act, supra note 15, § 73; see Hadley v. Baxendale, (1854) 156 Eng. Rep. 145 (Exch.).

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whether or not there is a contract. English law accepts that a claimant may sue on either basis where both are available.[24] In Indian practice a patient who sues a private hospital typically pleads deficiency in service, negligence and breach of contract together. Table 1 sets out the main differences, together with the third category, criminal negligence.

Table 1: Three kinds of liability compared

Feature	Contractual liability	Negligence (civil and consumer)	Criminal negligence
Source of duty	Agreement; express and implied terms	Duty imposed by law on one who undertakes the task	Statute (BNS s. 106)
Standard	As promised; implied reasonable skill and care	Reasonably competent practitioner (Bolam, Bolitho)	Gross negligence or recklessness (Jacob Mathew)
Who may claim?	Parties to the contract	Anyone owed the duty; consumers under the CPA	The State, on complaint or report
Remedy	Damages under Contract Act s. 73; refund of fees	Compensation; consumer relief under CPA s. 39	Up to two years' imprisonment for registered practitioners, and fine
Effect of AI	Terms can fix AI's role and human review; developer outside the contract	Standard must say how far reliance on AI is reasonable	Good-faith reliance with due care shelters the doctor; blind reliance does not

Criminal negligence needs a word. Under section 106(1) of the BNS, causing death by a negligent act not amounting to culpable homicide is punishable, and a proviso reduces the maximum to two years where the act is done by a registered medical practitioner in the course of a medical procedure.[25] In Jacob Mathew the Supreme Court held that criminal liability

[24]Henderson v. Merrett Syndicates Ltd., [1995] 2 A.C. 145 (H.L.) (appeal taken from Eng.).
[25]Bharatiya Nyaya Sanhita, 2023, No. 45 of 2023, § 106(1) (India) [hereinafter BNS].

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requires gross negligence or recklessness, and not the lack of reasonable care that suffices for civil liability.[26]

The distinction matters for AI in three ways. First, express terms about the tool can raise the standard the hospital must meet, as noted above. Second, the developer is outside the contract. A patient has no contract with the developer, and Indian law adheres to privity, subject to limited exceptions such as trusts and certain beneficiary claims.[27] Any claim against the developer would have to lie in tort or under the product-liability provisions of the Consumer Protection Act, 2019, and it is unclear whether software that assists a diagnosis is a "product" or a "service" for those purposes.[28] Third, remedies and limitation periods differ, so the route a patient takes can decide the outcome.

2.5 Informed Consent

Consent is where contract and medical ethics meet, and it has two faces.

In contract, free consent is the basis of every agreement, and consent obtained by fraud or misrepresentation makes the contract voidable.[29] Fraud includes the active concealment of a fact by one who knows it, and silence amounts to fraud where the circumstances impose a duty to speak.[30] In medicine, consent is the patient's authority for the doctor to touch her at all. Justice Cardozo put the principle in 1914: every adult of sound mind has a right to determine what shall be done with his own body.[31] The duty to disclose links the two. A patient who has not been told what she needs to know has not freely agreed to the contract of treatment.

Samira Kohli v. Dr. Prabha Manchanda is the leading Indian authority. The Court held that a doctor must obtain the patient's real consent before treatment, that consent must be given by a competent adult voluntarily, and that to be real it must follow disclosure of the nature of the procedure, its purpose, its substantial risks and the alternatives to it.[32] Consent to a diagnostic procedure does not extend to a surgical one, and a doctor who goes beyond the consent given is liable unless there is an emergency.[33] The Court later tied patient autonomy to Article 21 in Common Cause v. Union of India.[34]

Three layers of consent now overlap. The first is consent to treatment, as before. The second is

[26]Jacob Mathew, supra note 3.
[27]M.C. Chacko v. State Bank of Travancore, (1969) 2 S.C.C. 343 (India).
[28]Consumer Protection Act, 2019, No. 35 of 2019, §§ 2(11), 2(33), 2(42), 82–87 (India) [hereinafter CPA].
[29]Contract Act, supra note 15, §§ 13–14, 17–19.
[30]Id. § 17 & explanation.
[31]Schloendorff, supra note 11.
[32]Samira Kohli, supra note 3.
[33]Id.
[34]Common Cause v. Union of India, (2018) 5 S.C.C. 1 (India).

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consent to the use of an AI tool in the patient's care, which no Indian authority yet requires in terms. The third is consent to the processing of the patient's data, which the Digital Personal Data Protection Act, 2023 regulates through its requirements of notice and consent.[35] The second layer is the contested one. Under Montgomery, a doctor must tell the patient of any material risk and of reasonable alternatives, and a risk is material if a reasonable person in the patient's position would be likely to attach significance to it.[36] It is hard to say that a patient would not want to know that a diagnosis was produced by a system that performs less well for her demographic group, or that no human reviewed its output. Where AI's role is clerical, disclosure may not be needed. Where it materially influences diagnosis or treatment, the better view is that disclosure is part of the duty. It should cover the fact that a tool is used, what for, whether a human reviews its output, its known limitations and the alternatives.

2.6 Standard of Care and Professional Skill

In England the standard is stated in Bolam: a doctor is not negligent if he acts in accordance with a practice accepted as proper by a responsible body of medical opinion skilled in the particular art, even though another body would take a different view.[37] Bolitho qualified this by requiring that the body of opinion withstand logical analysis.[38] The Indian Supreme Court has adopted the same approach and expressed it in terms of professional skill. In Jacob Mathew the Court said that a doctor is expected to possess the skill of an ordinary competent member of the profession and to exercise it with reasonable care, that the standard is neither the highest nor the lowest degree of skill, and that an error of judgment is not necessarily negligence.[39] A specialist is judged by the standard of a specialist in the field. In Arun Kumar Manglik v. Chirayu Health & Medicare (P) Ltd. the Court applied Bolam and also required that the practice relied on withstand Bolitho scrutiny.[40]

AI raises two questions about the standard. The first is whether a doctor who follows an AI recommendation acts within accepted practice. Where a tool has been validated, approved by the regulator and widely adopted, reliance on it is likely to be accepted practice, but only if the doctor uses it with the care any competent user would bring, including noticing when an output is implausible. The second question is the reverse: whether a doctor who fails to use an

[35]Digital Personal Data Protection Act, 2023, No. 22 of 2023, §§ 5–7 (India).
[36]Montgomery, supra note 11.
[37]Bolam, supra note 3.
[38]Bolitho v. City & Hackney Health Auth., [1998] A.C. 232 (H.L.) (appeal taken from Eng.).
[39]Jacob Mathew, supra note 3.
[40]Arun Kumar Manglik v. Chirayu Health & Medicare (P) Ltd., (2019) 7 S.C.C. 401 (India).

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available tool falls below the standard. Judge Learned Hand's warning in The T.J. Hooper, that a whole industry may lag behind and that custom does not settle what reasonable care requires, applies here.[41] If an AI tool becomes markedly more accurate than unaided judgment for a given task, a court may one day hold that not using it is negligent. Professional skill will then include a working understanding of the tools in use: what they were trained to do, where they are likely to fail, and when to override them.

The doctor's task is changing from making every judgment to supervising judgments made partly by machines. The law should not ask for more than is possible. It cannot ask a doctor to audit an algorithm's internal reasoning, which the doctor cannot see. It can ask for reasonable verification: checking outputs against clinical findings, knowing the tool's validated scope, and recording why a recommendation was followed or set aside.

2.7 Remedies for Breach

The principal remedy is damages. Under section 73 of the Contract Act the injured party is entitled to compensation for loss that naturally flows from the breach or was within the parties' contemplation, subject to the requirement to take account of ways of remedying the loss. In the medical context this covers the cost of corrective treatment and loss of earnings and, as the consumer fora have been willing to recognise, mental agony and loss of amenity.[42] Under the Consumer Protection Act a Commission may direct the service provider to remove the deficiency, refund the fee, pay compensation and, in some cases, punitive damages and costs.[43] A complaint must be filed within two years of the cause of action.[44]

Other remedies are less useful. Specific performance cannot be used to compel a doctor to treat a patient or to treat her better, since such a contract depends on the personal qualifications of the parties and needs continuing supervision.[45] Disciplinary proceedings before a State Medical Council or the National Medical Commission may lead to suspension or removal from the register, but they give the patient no compensation.[46] Criminal prosecution is rare and limited by the standard in Jacob Mathew. In practice damages and consumer relief carry nearly the whole burden. In an AI setting the question is who pays. A hospital that is vicariously liable for its doctors can be expected to answer for tools it chooses to deploy, and may seek indemnity

[41]The T.J. Hooper, 60 F.2d 737, 740 (2d Cir. 1932).
[42]Balram Prasad v. Kunal Saha, (2014) 1 S.C.C. 384 (India).
[43]CPA, supra note 27, § 39.
[44]Id. § 69.
[45]Specific Relief Act, 1963, No. 47 of 1963, § 14 (India).
[46]National Medical Commission Act, 2019, No. 30 of 2019 (India).

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from the developer under their own contract. The patient should not have to untangle that chain.

2.8 Defences Available to Doctors

1. Accepted practice

A doctor who acted in accordance with a practice accepted by a responsible body of medical opinion, which withstands logical scrutiny, has not breached the standard. Documented use of a validated tool within its intended scope supports this defence in an AI case. Error of judgment. A reasonable decision that turns out wrong is not negligence.[47] A reasonable decision to follow, or to depart from, an AI recommendation is covered in the same way.

2. Consent and necessity

Where the patient was properly informed and agreed to a risk that then materialised, the duty of disclosure has been met. The BNS shelters acts done in good faith, with consent and for the patient's benefit, that were not intended to cause death, and acts done in good faith for the benefit of a person who cannot consent, such as in an emergency.[48] The shelter depends on good faith, which the Sanhita defines as requiring due care and attention.[49] Careless reliance on an AI output would therefore weaken it.

3. Contributory fault and failure to mitigate

The patient's own conduct, such as withholding history or ignoring advice, can reduce damages, as noted in section 2.2. Causation. The patient must show that the harm resulted from the breach. Where the result would have been the same, there is no liability, although the House of Lords relaxed the rule in a consent case in Chester v. Afshar.[50] Limitation. A consumer complaint filed after two years from the cause of action will not ordinarily be admitted.

4. Exclusion clauses

Hospitals often put clauses in admission forms disclaiming liability. A clause that purports to exclude liability for negligence is unlikely to survive scrutiny under section 23 of the Contract Act, which voids agreements whose object is opposed to public policy, or under the unfair-contract provisions of the Consumer Protection Act.[51] A patient admitted in distress has no real power to bargain. The same reasoning should apply to clauses that try to shift the risk of AI error to the patient.

[47]Jacob Mathew, supra note 3.
[48]BNS, supra note 24, §§ 26, 27, 30.
[49]Id. § 2(11).
[50]Chester v. Afshar [2004] UKHL 41, [2005] 1 A.C. 134 (appeal taken from Eng.).
[51]Contract Act, supra note 15, § 23; CPA, supra note 27, § 2(46).

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2.9 Regulatory Framework for Medical AI

International guidance is non-binding.

The World Health Organization's 2021 guidance on the ethics and governance of AI for health sets out six principles, including protection of autonomy, transparency and explainability, and accountability.[52]

The UNESCO Recommendation on the Ethics of Artificial Intelligence and the OECD AI Principles say similar things in general terms.[53] The European Union's AI Act, discussed in Chapter III, is the first binding comprehensive statute.

India has no statute on AI. The relevant material is scattered. NITI Aayog's 2018 national strategy identified healthcare as a priority area.[54] The ICMR's 2023 guidelines address AI in biomedical research and healthcare and stress human oversight, accountability, consent and data protection.[55] The Telemedicine Practice Guidelines, 2020 state that AI-based platforms may not counsel patients or prescribe medicines and that the registered medical practitioner remains responsible for the advice given.[56] Software intended for diagnosis may be regulated as a medical device under the Medical Devices Rules, 2017.[57] The Digital Personal Data Protection Act governs health data, and the Consumer Protection Act supplies the remedy. None of these instruments allocates liability among the doctor, the hospital and the developer.

2.10 Assessment

Read together, the framework gives a patient harmed by AI-assisted care the remedies she would have had if the doctor alone had erred, and that is a strength. But it rests on the assumption that the doctor's mind produced the decision. Four points show where the assumption fails. The standard of care has nothing to say about reliance on AI. The law of consent does not mention it. The developer sits outside the contract. And nobody is under a duty to preserve evidence of how the tool behaved. The remaining chapters ask whether comparative law and the courts offer ways of closing these gaps.

[52]World Health Org., supra note 13.
[53]U.N. Educ., Sci. & Cultural Org. [UNESCO], Recommendation on the Ethics of Artificial Intelligence, UNESCO Doc. 41 C/73 (Nov. 23, 2021); Org. for Econ. Co-operation & Dev., Recommendation of the Council on Artificial Intelligence, OECD/LEGAL/0449 (May 22, 2019).
[54]NITI Aayog, National Strategy for Artificial Intelligence: #AIforAll (2018) (India).
[55]ICMR Guidelines, supra note 13.
[56]Bd. of Governors in Supersession of Med. Council of India, Telemedicine Practice Guidelines (Mar. 25, 2020) (India).
[57]Medical Devices Rules, 2017, G.S.R. 78(E) (India).

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CHAPTER III
COMPARATIVE STUDY

The three systems below were chosen for what each can teach. The United Kingdom supplies the common-law doctrines from which Indian law on the standard of care and consent descends.

The United States has the most developed debate on whether software is a product and on how regulation shapes the clinician's role. The European Union has enacted legislation written for AI. The comparison is meant to suggest what India might adapt, not to propose copying any one system.

3.1 The United Kingdom

English law treats the doctor's duty primarily as one in tort, though it accepts concurrent contractual liability.[58] The standard of care comes from Bolam and Bolitho. On consent, Montgomery replaced professional custom with a patient-centred test of material risk, and described the doctor's role as a dialogue in which the patient is treated as an adult capable of weighing risks.[59] That reasoning transfers readily to AI. If a reasonable patient would attach significance to the fact that an algorithm shaped her diagnosis, Montgomery requires that she be told.

The English approach has a strength and a weakness for present purposes. The strength is flexibility: courts can extend established doctrines to new technology case by case. The weakness lies in Bolam itself. If the test is what a responsible body of doctors would do, then widespread adoption of an AI tool may make reliance on it self-validating, whatever its real merits. Bolitho is the answer, since it permits a court to ask whether the practice is logically defensible, but it puts a heavy load on expert evidence. So far as the author is aware, England has not legislated specifically for liability for AI in healthcare.

3.2 The United States

American law supplies two points of comparison. The first concerns the nature of the claim. Malpractice is treated mainly as a tort, and contract claims are narrow. In Sullivan v. O'Connor the Massachusetts court allowed a patient to sue on a doctor's promise of a particular result but limited recovery to the patient's out-of-pocket reliance losses, as distinct from the value of the

[58]Henderson, supra note 23.
[59]Montgomery, supra note 11.

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promised result.[60] The decision shows how courts have hesitated to turn the medical relationship into an ordinary commercial bargain, and the hesitation is relevant where hospitals make express claims about AI accuracy.

The second concerns whether software is a product. Strict product liability applies to products, and the Restatement (Third) defines a product as tangible personal property distributed commercially.[61] Courts have been reluctant to treat information as a product, although one federal court of appeals observed that computer software might be analogous to a tangible product.[62] The question remains unsettled for clinical AI. The federal regulator has partly answered it through regulation. Congress excluded from the statutory definition of a medical device certain clinical decision-support software, provided that the clinician can independently review the basis for the software's recommendation.[63] This design shapes liability. If the clinician must be able to review the basis for the recommendation, the clinician is expected to do so, and responsibility for acting on it stays with the clinician.

3.3 The European Union

The European Union has gone furthest. The AI Act classifies as high-risk those AI systems that are, or are safety components of, products such as medical devices that require third-party conformity assessment.[64] Providers of high-risk systems must manage risk, keep records of the system's operation, give deployers instructions that allow them to interpret outputs, and design the system for effective human oversight.[65] Deployers, which include hospitals, must assign oversight to competent people and keep the logs the system generates.[66] A person affected by a decision based on a high-risk system has a right to a clear explanation of the system's role in it.[67] The obligations are phased in, and those for high-risk systems embedded in regulated products such as medical devices apply from August 2027, subject to any later adjustment. The revised Product Liability Directive adds the civil side. It treats software as a product, makes the manufacturer liable for damage caused by a defect, including one arising from updates or continued learning after the product is placed on the market, and eases the claimant's burden

[60]Sullivan v. O'Connor, 296 N.E.2d 183 (Mass. 1973).
[61]Restatement (Third) of Torts: Prods. Liab. § 19 (Am. L. Inst. 1998).
[62]Winter v. G.P. Putnam's Sons, 938 F.2d 1033 (9th Cir. 1991).
[63]21 U.S.C. § 360j(o)(1)(E); see also U.S. Food & Drug Admin., Artificial Intelligence/Machine Learning (AI/ML)-Based Software as a Medical Device (SaMD) Action Plan (Jan. 2021).
[64]Regulation (EU) 2024/1689 of the European Parliament and of the Council of 13 June 2024 Laying Down Harmonised Rules on Artificial Intelligence, 2024 O.J. (L 1689) 1, art. 6 [hereinafter AI Act].
[65]Id. arts. 9, 12–14.
[66]Id. art. 26.
[67]Id. art. 86.

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by allowing courts to order disclosure of evidence and to presume defect or causation where the technical complexity makes proof difficult.[68] Member States must transpose it by December 2026. The Commission's 2022 proposal for a separate AI Liability Directive had not been adopted at the time of writing, and its future was uncertain. Medical liability itself remains a matter for national law.

3.4 Lessons for India

Four lessons stand out. First, the patient-centred test of consent in Montgomery can be extended to AI without legislation, and Indian courts can reach the same result from Samira Kohli. Second, regulation should say what is expected of the clinician. The American requirement that clinicians be able to review the basis for a recommendation is one way of doing so, and the European requirement of human oversight by competent persons is another. Third, evidence is the real problem in AI cases. The European provisions on logging, disclosure and presumptions show how the law can respond without requiring claimants to open the black box themselves. Fourth, the developer must be reachable. Treating software as a product, as the European directive does, gives the patient a defendant who is otherwise outside the contract. India has none of these provisions, but each can be introduced by rules, regulations or limited amendment, without remaking the law of contract.

CHAPTER IV

ROLE OF THE JUDICIARY

4.1 Characterising the Relationship

The Supreme Court's first contribution was to characterise the relationship. V.P. Shantha brought medical services within consumer law and, with that, within a forum designed for speed and low cost, and made the patient a consumer entitled to relief for deficiency in service.[69] Spring Meadows Hospital v. Harjol Ahluwalia held a hospital answerable for deficiency in the service provided through its staff.[70] Taken together, these decisions mean that a hospital cannot hide behind the individual doctor. They are the natural foundation for treating a hospital as answerable for tools it chooses to deploy, since a tool is as much part of the service as a nurse is.

[68]Directive (EU) 2024/2853 of the European Parliament and of the Council of 23 October 2024 on Liability for Defective Products, 2024 O.J. (L 2853) 1, arts. 4, 7, 9–10 [hereinafter PLD].
[69]V.P. Shantha, supra note 1.
[70]Spring Meadows Hosp. v. Harjol Ahluwalia, (1998) 4 S.C.C. 39 (India).

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4.2 Setting the Standard and Allocating the Burden

Laxman Balkrishna Joshi set out the duties and the standard of reasonable skill.

It held that the standard is that of an ordinary competent practitioner, that a mere error of judgment is not negligence, and that a doctor should not be prosecuted for criminal negligence unless a competent medical opinion supports the charge.[71] Kusum Sharma v. Batra Hospital collected the principles and stressed that a doctor is liable only where conduct falls below the standard of a reasonably competent practitioner in the field.[72]

The proof of negligence has been less steady. Martin F. D'Souza v. Mohd. Ishfaq required expert opinion before a doctor could be proceeded against, V. Kishan Rao v. Nikhil Super Speciality Hospital held that expert evidence is not needed in every case and applied the maxim res ipsa loquitur where the facts speak for themselves, and Harish Kumar Khurana v. Joginder Singh returned to the importance of expert evidence while allowing that the maxim may apply in an appropriate case.[73] This matters for AI. If the claimant must produce expert evidence about what a competent doctor would have done with the tool, the claimant needs an expert who understands the tool, and few exist. If res ipsa loquitur is available only where the error is obvious, it will help only in clear cases, such as an output that no clinician would have accepted at face value.

4.3 Consent and Compensation

On consent, Samira Kohli is the principal authority, and Nizam's Institute of Medical Sciences v. Prasanth S. Dhananjaya treated a failure to explain a serious risk before surgery as a deficiency for which the hospital answered.[74] The reasoning in these cases is patient-centred. It would be natural to extend it to a requirement that the patient be told when an AI tool materially shapes the decision, though no court has yet said so.

On compensation, the decisions in Malay Kumar Ganguly v. Dr. Sukumar Mukherjee and Balram Prasad v. Kunal Saha show that where negligence is proved the awards can be very substantial.[75] That is a reason for hospitals and doctors to pay attention to who will bear the loss if an AI tool is at fault, and a reason for the law to settle the allocation before large claims arise.

[71]Jacob Mathew, supra note 3; see also Dr. Suresh Gupta v. Gov't of N.C.T. of Delhi, (2004) 6 S.C.C. 422 (India).
[72]Kusum Sharma v. Batra Hosp. & Med. Rsch. Ctr., (2010) 3 S.C.C. 480 (India).
[73]Martin F. D'Souza v. Mohd. Ishfaq, (2009) 3 S.C.C. 1 (India); V. Kishan Rao v. Nikhil Super Speciality Hosp., (2010) 5 S.C.C. 513 (India); Harish Kumar Khurana v. Joginder Singh, (2021) 10 S.C.C. 291 (India).
[74]Nizam's Inst. of Med. Scis. v. Prasanth S. Dhananjaya, (2009) 6 S.C.C. 1 (India).
[75]Malay Kumar Ganguly v. Dr. Sukumar Mukherjee, (2009) 9 S.C.C. 221 (India); Balram Prasad, supra note 41.

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4.4 Reading AI into the Case Law

The case law does not mention AI, but it offers five propositions that can be extended. First, the relationship is a contract for services, the patient is a consumer, and the hospital answers for the service it provides, which should include the tools it deploys. Second, the standard of care is that of a reasonably competent practitioner, and under Bolitho reasoning a court may examine whether reliance on a tool was logically defensible and need not accept the developer's claims or the profession's habits. Third, consent must be real, and a reasonable patient would, in many cases, want to know of the tool's role. Fourth, criminal liability needs gross negligence, and the BNS makes good faith depend on due care and attention, so that thoughtful reliance on a validated tool is protected and blind reliance is not. Fifth, a doctor is not an insurer, and an error of judgment made with reasonable care remains defensible, whichever way the judgment went in relation to the AI output.

The limits are equally clear. The courts cannot create a duty on the developer where there is no privity and the statute does not reach the product. They cannot compel logging of the system's behaviour or the preservation of its versions. They cannot supply experts who understand the tools. Their ordinary processes are slow, and consumer commissions often rely on expert boards whose competence in AI is untested. These limits explain why the next chapter proposes steps that go beyond judicial interpretation.

CHAPTER V

A LAYERED RESPONSIBILITY MODEL: MAPPING DUTIES, CONSENT AND CONTRACT TERMS

5.1 Purpose of this Chapter

The preceding chapters have gathered the law. This chapter organises it around the four research questions and proposes a way to allocate responsibility among the four parties involved: doctor, hospital, developer and patient. The model is "layered" because each party owes something different, and because the law should ask each to do what it is best placed to do. The doctor is best placed to exercise clinical judgment, the hospital to select and monitor tools, the developer to know how the tool works, and the patient to give an honest account of her own condition.

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5.2 Who Owes What?

Table 2: Duties of the parties in AI-assisted care

Party	Core duty	Present source	Gap
Doctor	Reasonable skill and care in using the tool; verify outputs against clinical findings; disclose; record reasons	Implied term; Jacob Mathew; Samira Kohli	No guidance on weight to give AI output; AI literacy not required
Hospital	Select, validate and monitor tools; train staff; keep logs; answer for the service	V.P. Shantha; Spring Meadows; CPA	No procurement standard; no duty to preserve logs
Developer	Safe and accurate within stated scope; disclose limits; update; assist investigation	Tort; CPA product liability (uncertain); contract with hospital	Outside patient's contract; status of software unclear
Patient	Honest history; follow instructions; mitigate loss	Contract Act s. 73; common law	Scope of data consent unclear
Regulator	Approve, monitor and publish adverse events	Medical Devices Rules, 2017; NMC; ICMR (non-binding)	No binding AI-specific clinical standard

5.3 Five Principles

1.The clinical decision remains the doctor's.

A doctor cannot say "the machine decided". But the duty is one of reasonable verification, not omniscience. The doctor should know the tool's validated scope, check its output against the clinical picture, and record why the recommendation was followed or set aside. A doctor who does these things has met the standard even if the tool later proves wrong.

2.The hospital is the pivot.

The hospital chooses the tool, decides where and for whom it is used, and trains the staff who use it. It is already liable for its service. The law should make explicit that the duty extends to selection, validation and monitoring, as it does for any other equipment, and that the hospital

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must keep the system's logs and version records for a fixed period. The hospital can then seek indemnity from the developer, and the patient need not.

3.The developer must be reachable

Whether through amendment of the product-liability provisions of the CPA or through contract-based indemnities that sit behind the hospital's liability, the developer should bear the loss caused by defects in the tool that the hospital and the doctor could not reasonably have detected. A developer who is outside the patient's contract and also outside the statute is a developer who has no reason to care what happens to the patient.

4.Consent to AI use should be a term of the contract

A patient-facing clause should disclose that an AI tool is used, in what role, whether a human reviews every output, the tool's known limitations, and the patient's right to ask for a human-only assessment where practicable. It should not be buried in a general consent form. It should be accompanied by the usual statement of the risks of the treatment.

Evidence must be preserved

The greatest practical obstacle to a claim is that nobody can say what the tool did. Hospitals should be required to preserve the inputs, outputs and version of the tool for each use in a patient's care. Where a hospital fails to do so, the court should be able to draw an adverse inference. This is the Indian analogue of the European presumptions and costs little to administer.

5.4 Contract Terms

Two sets of terms deserve attention. In the contract between hospital and patient, the terms are those just described, together with a statement that nothing in the form limits liability for negligence. In the contract between hospital and developer, the hospital should insist on a warranty that the tool performs as stated within a defined scope, an indemnity for loss caused by defects, a right to audit and to obtain the logs, a duty on the developer to notify the hospital of known faults and updates, clear rules on data use, and adequate insurance. These are drawn from general contracting practice and have not been tested against actual agreements, which are confidential. They are offered as a checklist and not as a model contract.

5.5 Guarding against Over-deterrence

A framework that makes doctors liable for every error of a tool will drive them to avoid it, or to follow it without thought. The model therefore includes a safe harbour. A doctor who uses a validated tool within its intended scope, verifies its output reasonably, and records the

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reasoning behind a decision to follow or depart from it has acted within the standard of care. This protects the doctor who does what a competent colleague would do and leaves the patient with a claim against the hospital and the developer if the tool itself was defective. It places responsibility where it belongs and keeps doctors willing to use tools that improve care.

CHAPTER VI
CONCLUSION

6.1 Findings

The doctor–patient relationship can accommodate AI. It is a contract for services with an implied term of reasonable skill and care, and the three classic duties of the doctor, in deciding whether to treat, in choosing treatment and in administering it, extend naturally to the selection, use and monitoring of a tool. The patient's duties of honesty and mitigation continue to apply and acquire a technical dimension. The contract is silent, however, on the role of the tool, and express terms about AI are rare.

Contractual liability and medical negligence overlap but differ in source, standard, parties and remedy, and the difference matters because the developer is outside the contract and the patient's route against it is uncertain. The standard of care, expressed through Bolam, Bolitho and Jacob Mathew, can absorb AI by asking whether reliance on a tool was reasonable and whether failure to use it was unreasonable. Professional skill will come to include an understanding of the tools in use.

Informed consent under Samira Kohli is capable of extending to AI, but no authority yet requires disclosure of the tool's role. Remedies are adequate in form, being damages and consumer relief, but the question of who pays is unresolved because there is no allocation among doctor, hospital and developer. The defences are well established and apply to AI cases without difficulty, with the qualification that good faith under the BNS depends on due care and attention. Exclusion clauses are unlikely to protect either doctor or hospital against negligence.

Reform is needed in four places: the status of software under the Consumer Protection Act; a duty to disclose AI use; a duty to preserve evidence of the tool's behaviour; and the terms of the contracts between hospital and developer. The comparative material shows that each has a workable precedent, and the judiciary can contribute by extending existing doctrine.

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6.2 Suggestions

Legislative and regulatory

1. Amend the Consumer Protection Act, 2019 to clarify that software, including AI used in healthcare, is a product for purposes of product liability, or that its provider is a product service provider, and add provisions for disclosure of evidence and presumptions of defect where technical complexity makes proof unreasonably difficult.
2. Amend the medical ethics regulations to require a registered medical practitioner to inform the patient when an AI tool materially influences diagnosis or treatment, what it is used for, whether its output is reviewed by a human, and what alternatives exist.
3. Require, under the Medical Devices Rules, 2017 or a successor, that clinical AI used in India log its inputs, outputs and version for each use, and that hospitals retain the logs for a fixed period.
4. Provide by statute or binding guidance that clauses in hospital admission forms excluding liability for negligence, including AI-related error, are unenforceable.
5. Establish a system for reporting adverse events involving clinical AI and require publication of aggregate data.
6. Include training in the capabilities and limits of AI tools in medical education and continuing medical education.

Institutional and contractual

7. Hospitals should adopt procurement standards for AI tools, set up clinical governance committees to validate and monitor them, and require doctors to record reasons for following or overriding AI recommendations.
8. Hospitals should include in contracts with developers a performance warranty tied to the validated scope, an indemnity, audit and log-access rights, duties to notify faults and updates, and insurance.
9. Hospitals should adopt a patient-facing consent clause on AI use that is separate from the general consent form and states that it does not limit liability for negligence.

Judicial

10. Courts should extend the patient-centred reasoning of Samira Kohli, in the light of Montgomery, to hold that disclosure of an AI tool's material role is part of informed consent.

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11. Courts should apply Bolitho scrutiny to claims that reliance on, or failure to use, an AI tool was accepted practice, and should not treat widespread adoption as conclusive.
12. Consumer commissions and courts should appoint expert panels with competence in clinical AI, accept res ipsa loquitur where an output is plainly implausible, and make interim orders for preservation of logs and version records.
13. Courts should read the Consumer Protection Act purposely so that software used in a clinical setting is not left outside the scope of product liability by reason of its form.

These steps share one aim, which is to keep the patient's promise of skill and care from losing its meaning as the skill moves partly into machines.

6.3 Conclusion

The hypothesis stated in Chapter I is borne out. The law of contract and medical negligence in India is flexible enough to apply to AI-assisted care and gives a harmed patient familiar remedies. But it was built on the assumption that a human mind made the decision, and it leaves a responsibility gap between doctor, hospital and developer. The dilemma of the title is real. It is not resolved by holding the doctor to account for everything or for nothing. It is resolved by giving each party the duties it is best placed to perform, by making the role of the tool visible to the patient, and by ensuring that evidence of the tool's behaviour survives to be examined. Most of this can be done through regulations, hospital practice and contract terms. A small number of statutory amendments would complete it.

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