

Artificial Intelligence in Medical Malpractice

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Artificial intelligence is all around us and has become part of nearly every industry, including medicine. This creates new challenges for those using it and those judging its use and its users. In a recent episode of the popular TV show “The Pitt” Dr. Al-Hashimi uses an AI app on her phone that streamlines charting but mistakenly documents incorrect medications, pointing out one of the critical considerations for use of AI in medicine—human oversight.

In the March 12, 2026, Journal of the American Medical Association, a survey of AMA members 81% reported using AI in their clinical practices. AI has moved decisively from experimental environments into routine clinical practice. In radiology departments, algorithms now flag suspected intracranial hemorrhage, pulmonary emboli and breast cancer. In inpatient settings, predictive systems estimate the probability of sepsis, clinical deterioration, or need for ICU transfer. In ophthalmology, certain platforms render autonomous diabetic retinopathy determinations without physician



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interpretation. Large language models are increasingly used to generate clinical documentation, summarize records, and even propose differential diagnoses. Pathology departments now have another set of eyes evaluating samples and slides.

The potential role AI plays in contributing to patient injury needs to be analyzed in the specific context of its application in a given specialty. There are different ways that AI errors can happen and become integrated into a clinical decision-making error. The core inquiry remains whether a breach of the applicable standard of care

proximately caused patient injury. Clinical decision making is no longer exclusively human; it is mediated by algorithmic outputs, institutional configuration choices, user-interface design, and regulatory classifications. The new question is what was the role of the AI generated output? These new types of errors at different healthcare touchpoints can negatively affect patient care. There needs to be a framework for evaluating AI-related injury.

Many AI systems are simply assistive. Computer-aided detection and diagnosis tools in radiology are commonly being used to flag abnormalities or provide probability estimates while leaving interpretive authority with the physician. Computer-assisted detection (CAD) in mammography uses AI algorithms to analyze digital breast images, to highlight potential abnormalities like masses or calcifications in order to assist radiologists in not overlooking signs of possible breast cancer. The algorithm is designed to put various markers on the breast images that represent areas of concern that it brings to the radiologist's attention. Both false positive and false negative CAD findings can cause patient injury. A false positive occurs when the system incorrectly flags a benign or normal breast area as suspicious, prompting further evaluation by a radiologist, which can lead to unnecessary recalls, additional imaging, or biopsies. Traditional CAD systems typically produce 2 to 5 false positive marks per 4-image case, contributing to higher overall recall rates (around 10 to 11%) compared to radiologist-only readings. Radiologists are more likely to

have a bias to confirm a false positive lesion if it is flagged by AI. Going against AI creates a risk for the radiologist if a missed finding leads to patient harm and malpractice liability, with studies showing jurors perceive 72.9% liability for radiologists in AI-disagreement cases involving brain bleeds. This is one form of AI intimidation leading to overtreatment.

These are examples of where AI acts in an advisory role and not a diagnostic role. Conversely, physicians need to remain aware that AI's failure to identify a finding that is present and should have been identified is not a defense in a malpractice case. Similarly, sepsis alerts or early warning scores are advisory in nature. In these situations, the physician remains in the role of the final decision maker. The AI output is designed to provide additional information within the clinical environment, not to be a substitute for professional judgment.

By contrast, certain AI systems are designed to operate autonomously. Some diabetic retinopathy screening platforms provide diagnostic determinations without requiring physician interpretation. In such cases, the physician's role shifts to appropriate ordering, ensuring that patient eligibility criteria are met, and responding to the output and not interpretation.

Other AI systems influence workflow rather than diagnosis directly. For example, AI triage algorithms can elevate suspected intracranial hemorrhage cases on a radiology worklist, thereby affecting the timeliness of the study and not interpretation. When injury

arises in this setting, a question may center on delay rather than misdiagnosis. Whether the algorithm did not run as designed or necessary information was not provided are the types of questions that arise. However, the physician who is managing a critical stroke patient must remain diligent on the timeliness of treatment even if AI erroneously does not give that correct prioritized imaging status.

Many large language model-based tools, which are not regulated as medical devices, generate medical summaries, documentation, or diagnostic suggestions. Errors in the summaries generated or care suggestions can have a pervasive influence on diagnostic care even though they do not render a formal diagnosis. Whether AI makes an entry error such as with a medication, because of an optical character recognition or speech to text error, such misinformation can cause serious injury and death, if not recognized by reviewing providers and corrected. The role of the AI error in its contribution to an adverse patient outcome may be substantial.

The most important area where error can occur is at the human-AI interface. Physicians can easily over-rely on algorithmic output, a phenomenon often described as automation bias, and provide incorrect treatment despite contradictory clinical indicators. Conversely, physicians may disregard AI alerts without adequate evaluation. Excessive false-positive rates can produce alert fatigue, diminishing responsiveness even to accurate warnings. Incorrect information entered into the

patient's record by AI may be the result of faulty voice-to-text transcription when dictating history or medications. AI systems easily lead physicians to misinterpret the information when they interpret AI's results as a diagnostic certainty rather than probabilistic assessment. The fundamental question in such a situation is whether a reasonably prudent physician, exercising professional judgment under similar circumstances, would have acted differently if the physician made an independent co-assessment. AI assistance is just that—assistance not diagnosis.

AI-related malpractice cases must include the physician who will likely bear some or all of the liability for the injury, because the physician ultimate bears responsibility for any unreasonable reliance on or disregard of AI output. The possibility exists that the institution may bear responsibility for unsafe implementation or failure to monitor, or the manufacturer may have liability for design defect or failure to warn. However, institutional liability and manufacturer liability are harder to establish, because the learned intermediary doctrine likely plays a role, particularly in assistive systems where physicians retain ultimate decision-making authority. However, the diffusion of responsibility inherent in AI deployment complicates traditional fault allocation.

Depending on the specifics of the care at issue, discovery may require production of model version history, update logs, validation datasets, and institutional monitoring records. Alert override logs may reveal patterns of

clinician response or lack thereof. Training materials and policy documents can illuminate expectations placed upon users. Expert testimony will be required to disentangle algorithmic limitations from implementation flaws from clinical error.

Artificial intelligence does not alter the fundamental elements of malpractice law, but it complicates the path by which liability and causation are traced. The standard of care still remains anchored in reasonable professional conduct, which requires awareness of the risks presented by AI integration in healthcare decision making. The novelty of AI lies not in the legal doctrine, but in the complexity of decision-making systems through which clinical decisions are now filtered.

Responsibility still lies with the clinician signing off on the chart, but additional liability may eventually lie in algorithmic design and institutional implementation. With a coherent framework to help understand and separate the intertwined responsibilities between physicians and AI, liability analysis of adverse health care outcomes can be properly done. For the moment, the questions need to be:

- Was the patient's care guided by AI?
- If so, what specific AI tool was used?
- How was it used?

- Is the AI incorporated into your healthcare system network?
- If not, how was the specific tool chosen and vetted?
- What were the provider's differential diagnoses before using AI?
- What information did AI provide?
- Did the AI Information impact the differential?
- Did the provider follow suggestions provided by AI?
- Did the provider reject suggestions provided by AI?
- Where and how is the use of AI documented?

More such questions will follow, but for now, malpractice lawyers must recognize the potential for AI to have a role in today's cases and adjust their inquiries accordingly.

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