Governance Brief No. 2
Board Considerations Before Adopting LLM-Based Clinical Tools

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Liability Allocation in AI-Assisted Clinical Decision Making

Purpose

This brief outlines governance considerations related to liability exposure when AI- or LLM-assisted tools influence clinical decision-making.

As documentation and decision-support technologies become embedded in clinical workflows, boards must understand how liability remains structured — and where risk ultimately resides.

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1. The Foundational Principle

In current U.S. legal frameworks, clinical liability attaches to licensed professionals and the organizations that credential and employ them.

Technology vendors typically do not assume responsibility for medical decision-making outcomes.

Even when AI tools provide recommendations, summaries, or diagnostic suggestions, professional judgment remains the legally accountable layer.

Terminology does not change this structure.

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2. Assistive vs. Autonomous Function

Boards should require management to clearly classify AI-enabled tools as:

• Assistive (documentation, summarization, flagging)
• Advisory (suggestive clinical insights requiring review)
• Decision-automating (executing actions without independent confirmation)

Most healthcare systems adopt assistive or advisory tools.

However, workflow design may blur the distinction if:

• Clinicians rely passively on generated outputs
• Productivity pressures reduce independent review
• Documentation auto-populates without meaningful verification

Exposure increases when automation substitutes for oversight.

3. Vendor Contractual Risk Allocation

Boards should review:

• Vendor disclaimers of clinical liability
• Indemnification provisions
• Limitation-of-liability clauses
• Insurance requirements
• Allocation of responsibility in adverse outcome scenarios

In many agreements, vendors limit financial exposure to the cost of the contract itself.

Clinical liability remains with the provider organization.

Understanding this allocation is essential before implementation.

4. Documentation and Defensibility

In malpractice litigation, medical records become primary evidence.

Boards should ensure policies require:

• Clear differentiation between clinician-authored and AI-generated content
• Documentation of independent clinical review
• Retention of system-generated recommendations
• Audit logs reconstructing what was presented to the clinician

If adverse outcomes occur, defensibility depends on demonstrating active professional judgment.

5. Human Verification Requirements

Organizations should define:

• Explicit human sign-off standards
• Prohibited use cases (e.g., high-risk decisions without secondary review)
• Escalation requirements for complex cases
• Monitoring of reliance patterns

If AI is integrated into the exam room, governance must define the boundary between assistance and substitution.

6. Insurance and Risk Management Review

Boards should request confirmation that:

• Malpractice carriers are informed of AI integration
• Coverage extends to AI-assisted workflows
• Risk assessments reflect new technology layers
• Claims tracking includes AI-related contributing factors

Ignoring this step creates blind exposure.

7. Productivity Incentives and Exposure

Liability risk often emerges not from technology itself, but from incentives surrounding it.

Boards should examine:

• Whether AI tools are deployed to increase patient throughput
• Whether review time expectations have shifted
• Whether compensation models reward speed over deliberation

If verification time decreases while system influence increases, risk compounds.

Technology does not create exposure alone.

Incentives amplify it.

8. Strategic Framing

AI-assisted tools may reduce cognitive load and improve documentation consistency.

They may support clinical accuracy.

They may reduce burnout.

However:

Delegation of thought is not defensible.
Augmentation is defensible — if structured.

Boards that define clear verification expectations before implementation reduce downstream exposure.

Closing Observation

In healthcare, accountability is not transferable.

AI may influence clinical reasoning.

It does not absorb liability.

Organizations that align technology adoption with structured human oversight will be better positioned to protect patients, clinicians, and institutional stability.

Liability allocation is not a technical question.

It is a governance question.

Boards evaluating AI-enabled clinical tools may benefit from an independent governance perspective prior to deployment.

A structured external review often surfaces gaps that are easy to miss during implementation planning.