Surveillance Medicine and the Law

A Critical Legal Study into AI, Ethics, and the Right to Health

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Abstract. Artificial intelligence is quickly becoming embedded in healthcare systems around the world. As this happens, the promise of efficiency, predictability, and personalisation of care is frequently presented as a moral imperative. However, there remains a growing body of evidence that AI-driven healthcare technologies can systematically undermine core principles of medical and legal ethics and, potentially, breach fundamental human rights. This study is an exploration of the deployment of AI in healthcare - specifically predictive algorithms, triage bots, and data-driven diagnostics - and how these risks infringe upon the right to health and the right to non-discrimination.

This study aims, through the lens of critical legal studies, to interrogate how these systems and technologies replicate and automate existing forms of inequality, while hidden by the veil of neutral language and innovation. Drawing upon case studies including UnitedHealth, Babylon Health, and DeepMind, the study demonstrates how algorithmic health tools can exacerbate systemic issues such as racism, gender biases and digital exclusion. It also aims to explore how existing legal systems fail to challenge these harmful effects and perpetually reinforce power dynamics and data commodification under the veil of progress. By critically re-examining the legal governance of AI in healthcare, this study calls for a reassertion of ethical and rights-based principles in emerging health technology regulation, focused not on market efficiency, but on ethical principles like equality, autonomy and human dignity.

Keywords: Medical Law, Artificial Intelligence, Human Rights, Surveillance Medicine, Legal Ethics.

1 Framing the Problem: AI in Medicine and Structural Discrimination

Artificial intelligence (AI) has been discussed as both saviour and disruptor, with promises of efficiency while quietly reconfiguring how bodies are seen, monitored, and valued within medicine and wider society. AI-driven surveillance can be seen to predict outbreaks early, monitor the spread of disease, provide health data in a timely manner, and, overall, improve health outcomes for the general population (Giri & Gupta, 2024).

A. Danielsson et al. (eds.), *Proceeding of The Future of Life - Legal, Scientific, and Geopolitical Challenges (TFOL 2025)*, Advances in Social Science, Education and Humanities Research 1001,
https://doi.org/10.2991/978-2-38476-555-3_7

With recent and ongoing "unparalleled" global health crises (World Health Organization, 2025), the need for efficient, cost-effective healthcare is clear. Not only this, but with the rise in AI, many medical professionals believe the benefits of AI outweigh the risks, with 72.2% of medical leaders demonstrating their support for this (Casassus, 2024).

However, while policy makers and those working in technological advancement celebrate the potential benefits of AI in healthcare, doctors and other healthcare practitioners have demonstrated their concern in relation to the use of AI in medicine. Some of these concerns can be exacerbated by the potential ways in which AI technologies can inadvertently reproduce and amplify existing structural inequalities relating to class, race, ethnicity, and gender. This will be the focus of the study below.

To discuss this issue, it is important to clarify key ideas. Artificial Intelligence in healthcare relates to the AI systems used by medical professionals to enhance their practice to simplify and standardise healthcare, as well as to improve identification of health issues early to allow interventions to begin as swiftly as possible (Bajwa, Minur, Nori, & Williams, 2021). Within this, the use of AI in surveillance medicine, meaning in the monitoring of trends in data to prevent non-communicable diseases and larger health issues within the wider population (Panteli et al., 2025). These issues potentially threaten the right to health of millions across the world. The right to health is, according to the World Health Organisation, a fundamental right enshrined within numerous human rights instruments which grants access to healthcare of an adequate quality, safe food, water, sanitation, and housing, as well as the right to raise issue where health needs are not met (World Health Organization, 2022).

Part of this issue lies in AI itself, as these systems are driven by data and, when human error or bias is present in the data, AI algorithms could amplify and further reproduce these issues (Rich & Gureckis, 2019). There is already concern that these discrepancies in the data have, and will, lead to discrimination within healthcare, with clinical uncertainty and bias potentially leading to inaccurate and damaging outcomes for patients with one or more oppressed/discriminated characteristics (Balsa, McGuire, & Meredith, 2005).

1.1 Methodology

A critical legal methodology is adopted, drawing on Critical Legal Studies and international human rights law as a means of analysing the governance of AI in healthcare. The study employs qualitative case-study analysis of existing AI deployments to explore how legal and regulatory frameworks interact with AI systems, especially surrounding the issue of healthcare. This research is not empirical, and does not offer a technical view of AI, but offers a normative and doctrinal critique of law's adequacy, power, and inequality in the deployment of AI in healthcare. Throughout this study, analysis relies on secondary case studies and published literature, with illustrative examples drawn from the UK and USA, framed through international human rights law.

The paper addresses the following research questions:

- How does the deployment of AI in healthcare intersect with state obligations under the right to health and non-discrimination within international human rights law?
- In what ways does AI in medicine reproduce or amplify discriminatory narratives that can be found in medical literature?
- How can Critical Legal Studies offer a framework for interrogating legal and ethical implications of AI driven discrimination in healthcare?

What legal and ethical mechanisms are necessary to prevent AI-induced harm in medical settings?.

2 Theoretical Framework: Surveillance Medicine and Critical Legal Studies

This section sets out the theoretical foundations that inform the paper's analysis of AI, power, and inequality in healthcare.

2.1 The origins and concerns of surveillance medicine

In the early 1990s, David Armstrong introduced the concept of 'surveillance medicine' as a means of describing the ongoing transformation in medical practice – from diagnosing and treating symptoms and visible conditions, to the monitoring of risk factors across populations, with an aim to understand the spread of disease and factors influencing health conditions (Armstrong, 1995).

Under the extended medical focus, the boundaries between illness, disease and health have been revised and a vision of "total health" has been forged (Earle, Foley, Komaromy, & Lloyd, 2009). This has led to an increase in surveillance of bodies throughout society. Drawing on Foucauldian theory, it is possible to see how AI healthcare monitoring systems can have an impact on the individual. By increasing the medical gaze, Foucauldian discussions are again apparent in relation to constant monitoring, managing and categorising using AI (Octaviano et al., 2024). This is not about simply observing, but about manufacturing systems within which individuals internalise norms and self-regulate under the possibility of constant observation (Foucault & Sheridan, 1995).

In relation to AI-driven healthcare, this manifests itself in algorithms which are responsible for constant monitoring of patient's bodies, risks, and behaviours (Cisney & Morar, 2015). To this end, AI systems monitoring population health do not simply process data, rather, shape understandings of risk, normality and pathology (Panch, Pearson-Studdard, Greaves, & Atun, 2019). Through classification, bodies become legible and, as a result, can be governed, often according to historical norms which have been embedded within medical data.

While frequently justified as objective and preventative, surveillance medicine relies on population-level data which risks reinforcing existing social hierarchies which are

based within datasets which reflect historical exclusion or unequal access to care. Therefore, these AI systems may reproduce discriminatory patterns disguised as scientifically neutral.

2.2 Critical Legal Studies: Law as Embedded in Power Structures

Critical Legal Studies (CLS) grants the opportunity to explore the intersection between law and technology and the impact of this on systems of equality. This theoretical lens argues that legal systems are deeply shaped by economic, political and social factors and power. One of the central tenets of CLS is the idea that law is indeterminate, in that it is open to multiple interpretations, and that structural injustices are often masked by formal language and abstract rights. To this end, CLS helps to reveal how, like with AI in healthcare, algorithmic tools like legal systems can embed and reinforce biases of race, gender and class under the notion of objectivity. By applying CLS to international human rights provisions, this paper will question whether the current frameworks within law are equipped to address the discrimination that can be perpetuated by AI technologies in healthcare systems.

In the same way CLS argues legal decisions are shaped by interests outside of the law (such as ideological and institutional interests), AI technologies are shaped by flawed assumptions in the medical field, biased inputs (though these are not always known at the time of inputting), and structural inequalities within society and the healthcare system (Kumar et al., 2024). From a CLS perspective, AI in medicine functions in a similar way to legal systems, within the social context, reflecting the historical assumptions found within the legal and medical literature it draws data from. CLS frames this as, not a data error, but institutionalised bias that has been coded into the decision-making process. However, those designing AI systems claim to minimise, if not eradicate these issues through automation, by removing the flawed human element. On these claims, CLS highlights these issues as political choices, with individuals dictating who counts, which data is reliable, which outcomes are significant enough. This kind of data exclusion has been found to cause potential systematic misinterpretation and therefore can lead to bias and lack of inclusion (Perret, Romanov, Taylor-Sweet, et al., 2025). Therefore, while engaging in discussion surrounding the future of AI in healthcare, the shift from individual bias, which can lead to lower quality of care (Fitzgerald & Hurst, 2017), to structural harm which can lead to adverse health outcomes for minority and oppressed communities (Braveman, Arkin, Proctor, Kuah, & Holm, 2022).

2.3 AI Governance and Accountability

CLS demands clearer and deeper accountability, not only regarding the decisions made by AI, but why decisions are made, what data is used and how do these decisions serve the interests of the patient or other stakeholders. Therefore, governance in this area must confront the histories represented within the data as opposed to hiding them under technical concepts.

3 The Right to Health and Non-Discrimination in International Human Rights Law

This section situates healthcare AI within the legal obligations which are imposed by international human rights law, focussing on the right to health and the principle of non-discrimination.

3.1 International Human Rights and the Right to Health

International human rights requires populations have access to services, information and goods (such as food and water) which are needed to maintain the "highest attainable standard of physical and mental health" (United Nations General Assembly, 1966b). While the right to health exists, World Health Organisation (World Health Organization, n.d.) and within international law set out by the UN, the application of these provisions is limited by failures in enforcement and potential new forms of harm.
Following the ICESCR, the Committee on Economic Social and Cultural Rights issued General Comment No.14 provided for the AAAQ Framework to be adopted by states (Committee on Economic, Social and Cultural Rights, 2000). To this end, and to ensure the right to health is not impeded, AI must therefore not reduce availability or quality of care for all individuals within a state, especially those marginalised and oppressed groups. As well as this, healthcare must be accessible to all, however, current discussions surrounding language bias against non-English speaking patients due to AI's preference toward English, as an example (Ali, 2025).

3.2 The Principle of Non-Discrimination in International Human Rights Law

A number of international rights provisions enshrine the principle of non-discrimination. These provisions provide protections against discrimination in both a broad sense, but also specific provisions dedicated to race, disability and gender, leading to requirements for states to ensure these groups are not unduly impacted, through direct or indirect discrimination. This obligation extends to AI technologies that shape access to medical services.

AI systems can violate these human rights principles by disproportionately disadvantaging certain groups due to flawed proxies, exclusionary design or biased training data. Even where this is not intended, indirect discrimination can still result if legal safeguards do not address discriminatory impacts.

3.3 AI Discrimination in Surveillance Medicine

The promise of AI-driven healthcare collides with the realities of international human rights provision: technologies that should expand the right to health can be seen to reinforce discriminatory patterns which have been prohibited by international legal frameworks and can develop within AI systems (Panch, Mattie, & Atun, 2019). This causes difficulties relating to ethical healthcare, with issues of clinician accountability,

patient autonomy and uncertainty (Grote & Berens, 2020), as well as health inequalities for certain populations within societies (Agarwal, Bjarnadottir, Rhue, et al., 2023). With the prohibition of direct and indirect discrimination being present across a number of national and international legal systems, these inequalities violate human rights legislation across the globe.

While algorithmic bias is present, discrimination can also take place due to the lack of representation within medical research. Examples of this lie within race and gender in medical research. Historical exclusion and underrepresentation of women, racial and ethnic minorities and disabled individuals such as Kanner (1971) and Asperger (1944) has led to knowledge gaps that are still prevalent in modern datasets.
The healthcare implications of this are apparent for individuals and groups within society. However, with the advent of AI in surveillance medicine, the results of underrepresented studies can be perpetuated on a population-wide basis, leading to discrimination and unequal access to healthcare.

4 Case Studies: Discrimination through AI in Healthcare (USA and UK)

While widespread use of AI in surveillance medicine seems to be a thing of the future, existing usage of AI in healthcare leads to greater concerns. This section analyses three contemporary case studies to demonstrate how AI systems in healthcare reproduce structural inequalities in practice. Case studies such as UnitedHealth in the USA, Babylon Health and Google's DeepMind AI in the UK give an insight into the concerns of the future of AI in medicine.

4.1 UnitedHealth and Optum

UnitedHealth, through its subsidiary Optum developed a risk-prediction algorithm which was designed to provide additional care to patients with enhanced or complex health needs. The algorithm used past healthcare spending as an indicator of medical need. Due to black and ethnic minority groups being more likely to suffer lower socioeconomic status, the healthcare spending of these groups led to black patients being highlighted for extra care half as often as equally sick white patients (Heaviside, 2025). Discussing this from the perspective of critical legal studies, it is possible to see that the power dynamics displayed in this case are indicative of a systemic issue. To this end, the cost of healthcare and the power of the legal system allowed Optum's algorithm to be implemented. Cost of healthcare is often considered to be a neutral metric when discussing access to health. While in some instances, this is acceptable, such as while discussing resource rationing (Sloan & Warner, 2021), in other instances, it can lead to misleading conclusions and, in this instance, discriminatory assumptions being

made. Medical neutrality is a key part of international law, combining the principles of non-discrimination and the right to health, however, in this instance, the critical legal approach would argue that the law could have done more to protect individuals in this instance.

4.2 Babylon Health

While the above example demonstrates the issue of resource allocation, the issue of misdiagnosis is also prevalent in AI. Babylon Health developed an AI-driven symptom checker and triage tool which was integrated into the National Health Service. This allowed patients to check their symptoms, and offered remote consultations integrated with the NHS (Iacobucci, 2020). While this system would be a solution to the burdens facing the NHS in the UK, issues of diagnostic bias (such as women's heart attack symptoms being under-prioritised, (Karim, Sharma, & Singh, 2023) as well as concern surrounding linguistic bias. In the instance of Babylon Health's "GP at Hand" application, symptoms which were described in a non-western manner, or non-standard terms, were given poor guidance (Reed, 1999). While women and non-English speakers face disparities in care generally (Terui, 2017; Currie, Lockett, Finn, Martin, & Waring, 2012), AI can replicate and perpetuate biases in traditional medicine, only on a larger scale. These AI tools could deploy to millions of individual patients at one time, emphasising the bias and discrimination which can be exacerbated across populations.

This can also cause concerns relating to regulation, with a lack of accountability for AI and a lack of regulation over its application in medicine with accountability being spread across numerous regulatory bodies. (Karim, Sharma, & Singh, 2023). This lack of central regulation means there is no clear path toward suitable accountability and regulation.

From the perspective of critical legal studies, these issues demonstrate the imbalance of power between the regulators and those patients who are potentially experiencing human rights breaches. Medicine and medical professionals hold significant importance within society. Not only in a Foucauldian sense (in relation to the acquisition of knowledge), but also in relation to interaction between individuals, medicine is powerful and holds significant importance for those experiencing medical concerns. The imbalance of power is apparent, with doctors, nurses, other medical professionals (and to this end, medical AI) holding power through their social position and their status as a medical professional (Cuffee et al., 2013). This power, especially in the hands of a discriminatory AI system, could lead to damaging health outcomes for patients and mistrust in the medical industry (BBC, 2021) potentially widening the divide between minorities and appropriate healthcare.

4.3 Google DeepMind

DeepMind, Google's AI form, was given access to the personal records of 1.6million patients within the UK at the Royal Free London NHS Foundation Trust without patient consent (Iacobucci, 2017). While this was justified through "implied consent", This "inappropriate" arrangement led to concerns regarding confidentiality, transparency and trust (Iacobucci, 2017).

One issue lies within the General Data Protection Regulations (GDPR), within which lawfulness, transparency and confidentiality of personal data are paramount. From a critical perspective, this case demonstrates how data can be transformed into tools of governance through administrative processes of categorisation and surveillance (Foucault, 1973). The absence of meaningful consent reflects power imbalances between individuals, public institutions, and private organisations. As well as this, considering the purpose of DeepMind's predictive tools in terms of their aim to manage risk across populations, this is Foucault's biopolitics (the management of life itself) in action. Through statistical prediction and continuous monitoring, life can be governed and surveilled more effectively (Foucault, 1976).

5 Legal and Ethical Imperatives for Reform

This section outlines reforms to align healthcare AI with human rights obligations.
First, human rights impact assessments (HRIAs) should be implemented for healthcare AI, not only as a practical safeguard which ensures the specific risks that AI poses are addressed, but also as a legal obligation to ensure the right to health and the right to non-discrimination is safeguarded, and will identify any discriminatory impacts prior to deployment of any AI system.
As well as this, there should be mandatory standards for transparency and explainability of these systems prior to deployment. In some black-box models of AI, it can be extremely difficult for transparency, with some AI designers being unable to translate the true nature and workings of the AI system (Hassija et al., 2024). Systems must be able to offer reasons for individual outputs, such as highlighting key variables which has determined the output, which would allow clinicians to evaluate the effectiveness of the output for the purposes of explainability, as well as to support public reporting, and regular independent audits of the systems themselves.
Also, incorporating affected communities into the development of medical surveillance AI systems would help to identify any blind spots within which underrepresented experiences can be identified and explored further within datasets. This will build legitimacy and trust within the systems, especially if they have had a voice in its development. Participatory design should be incorporated to include these groups to foster legitimacy and trust.
Finally, accountability mechanisms should be clarified for AI-induced harms. Independent auditing bodies should be incorporated into existing governance structures to ensure AI performance, bias, and patient outcomes are monitored over time. Existing tort and malpractice frameworks should be amended, or new frameworks developed to ensure clinicians, hospitals, and AI developers can be held liable if AI leads to misdiagnosis, improper treatment, or denial of care.
Together, these reforms address three dimensions of AI governance, legal accountability, regulatory oversight, and participatory design. By moving away from technical

compliance and risk mitigation, structural inequalities and social harms that exist within medicine can be addressed and should not be perpetuated by AI healthcare systems.
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6 Conclusion

To summarise, this paper examined how AI in healthcare, while often presented as neutral and efficient, can violate human rights by reproducing and amplifying structural inequalities, undermining the rights to health and non-discrimination. Through the lens of surveillance medicine and Critical Legal Studies, the analysis demonstrates that medical AI is embedded in power relations that shapes whose lives are prioritised and whose risks are rendered invisible.

Exploring case studies reveals regulatory gaps and highlights the limitations of existing legal frameworks in addressing algorithmic harm. By implementing appropriate regulatory measures, it will be possible to shift away from technical compliance toward a system which regulates and addressed structural inequalities which have been apparent in AI medical surveillance systems.

By situating healthcare AI within international human rights law and critical legal theory, this paper contributes to broader debates on the ethical governance of emerging technologies. As AI continues to shape medical decision making, ensuring these systems promote equality, dignity, and justice will be paramount to the future of healthcare.

Disclosure of Interests. Generative AI tools were used in this paper solely to support language editing of author written text. No confidential, sensitive, or identifiable personal data were entered into these systems. All content was reviewed and verified by the authors, who remain fully responsible for the content of the manuscript.

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