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Legal Responsibility for the Use of Artificial Intelligence in the Healthcare Sector in Morocco: A Sociological Analysis of the Literature and Legal Texts

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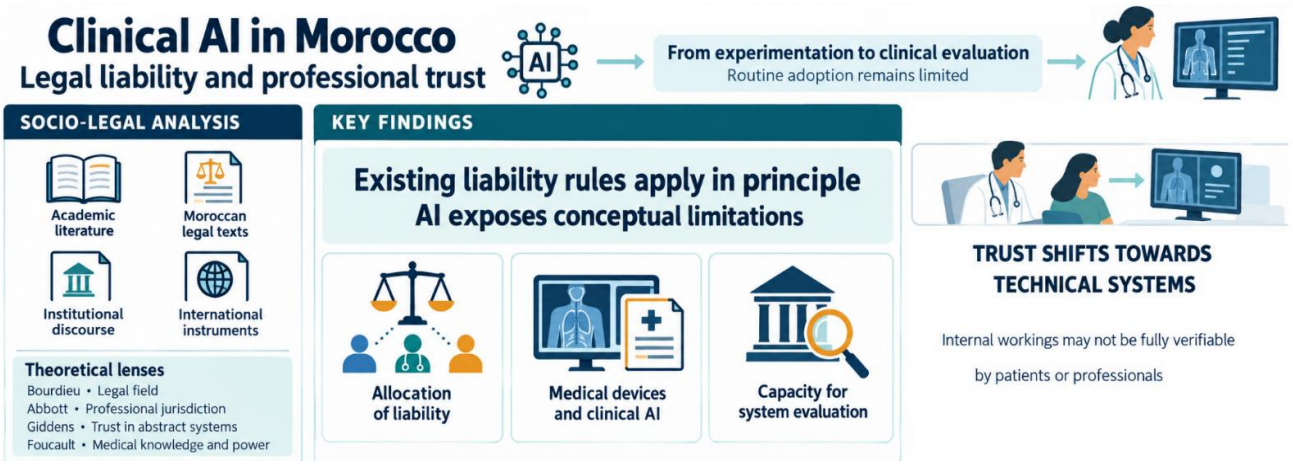
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Graphical Abstract

This article examines the construction and distribution of liability in the Moroccan health sector through a socio-legal analysis informed by Bourdieu, Abbott, Giddens and Foucault. The findings suggest that existing liability rules remain applicable in principle but reveal conceptual limitations when applied to intelligent systems, particularly regarding the allocation of responsibility, clinical AI regulation, institutional evaluation and trust in technical systems.



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Abstract: Recent scientific work on AI in Morocco is moving from algorithmic experimentation towards clinical evaluation, although routine adoption remains limited. This raises questions about legal liability and professional trust when algorithmic systems inform clinical decisions. This article examines the construction and distribution of legal liability in the Moroccan health sector through a socio-legal analysis of academic literature, Moroccan legal texts, institutional discourse and international normative instruments. The analysis draws on Bourdieu, Abbott, Giddens and Foucault. The findings suggest that Morocco does not face a legislative vacuum in the strict sense, as existing liability rules remain applicable in principle, but their application to intelligent systems reveals conceptual limitations. Particular attention is required regarding the allocation of liability, the relationship between medical device legislation and clinical AI, and institutional capacity for system evaluation. The analysis also points to a shift in trust towards technical systems whose internal workings may not be fully verifiable by patients or professionals.

Keywords: *Artificial intelligence, Legal liability, Health law, Trust, Sociological analysis, Morocco.*

Introduction

Artificial intelligence (AI) is increasingly used to analyse health data and support clinical decisions. Its use raises questions about who must validate a system, monitor its performance and answer for harm. These questions concern the organization of care as well as the conduct of individual practitioners [1].

In Morocco, the White Paper on e-Health links digital transformation to improvements in access, coordination and clinical decision support [2]. Bourquia examines the changing role of doctors and the ethical implications of AI in medicine [3]. These sources place AI within wider debates about the development of the health system, professional expertise and patient protection.

Moroccan research includes deep learning for the histopathological classification of breast cancer [4] and machine learning analyses of treatment protocols and cycle counts using hospital data [5]. Studies published in 2026 examine pneumonia detection on chest CT scans and the classification of lung nodules [6,7]. These studies document research and clinical evaluation in particular settings. They do not show that AI use is common across Moroccan healthcare.

International debate addresses failures that have already been observed in evaluations of clinical systems. These findings need to be distinguished from forecasts of future harm and from evidence about use in Morocco. In NBSEH, Brett-Crowther discusses the social and ethical stakes of AI, including control, inequality and the limits of medical applications [8]. Warnings by leading AI researchers, including Hinton and Bengio among the signatories of the Center for AI Safety statement, show that their own work has caused personal alarm [9]. Such warnings are evidence of public concern; they do not establish the frequency of clinical injuries.

AI can connect clinical judgement to decisions made by developers, vendors, healthcare managers and data providers. Errors may arise at several stages, including model development, local deployment and clinical interpretation. This makes the allocation of responsibilities a legal and organizational problem [10,11].

We use ‘liability’ to refer to legally enforceable consequences, and ‘responsibility’ more broadly to include professional, ethical and organizational duties. ‘Accountability’ concerns the obligation to explain decisions and submit them to scrutiny. Participation in an AI system does not automatically entail legal liability.

The sociological question is how these arrangements affect professional jurisdiction, authority and trust. A doctor may remain responsible for a decision while depending on a system that other actors design and control. Our analysis examines how this relationship is represented in legal and

institutional texts and in the selected literature. It does not presume that professional authority has already been redistributed in Moroccan clinical practice.

This study examines how responsibility for AI in healthcare is constructed in the Moroccan legal framework and in relevant scholarly and institutional discourse. We focus on the relationship between legal obligations, control over technical systems and the authority to make clinical decisions. The legal sources examined range from general rules of liability to sector-specific health legislation and data protection legislation, and they are interpreted in the light of international normative standards. Draft Law No. 52.26 on the Integrated National Health Information System, approved by the Council of Government on 22 July 2026, is also currently under way.

Four questions guide the analysis. How do the selected sources allocate responsibility among clinicians, healthcare institutions and technology providers? How do they define authority and trust? What do Moroccan legal provisions and international comparisons reveal about patient protection and the governance of clinical AI? To what extent does Morocco's current legislative framework provide a basis for reconciling technological innovation with the protection of patients' and practitioners' rights?

Moroccan academic literature has begun to explore these matters within managerial, technical and clinical perspectives [12,13], but the legal and sociological dimensions of responsibility and liability remain less apparent. The present study can provide a basis for analysing the allocation and limits of healthcare professionals' liability in use of AI.

The Moroccan publications examined here address managerial, technical and clinical questions [12,13], alongside medical and ethical reflection [3]. We contribute a sociological reading of the allocation of responsibility. This observation should not be read as a comprehensive assessment of Moroccan research.

We draw on four interconnected theoretical perspectives. Bourdieu's analysis of the legal field directs attention to how legal categories acquire authority and how competing interests may shape them [14]. Abbott's concept of professional jurisdiction helps examine claims to expertise and responsibility among medical, institutional and technical actors [15]. Giddens' account of trust in abstract systems illuminates reliance on expertise that users cannot independently verify [16]. Foucault's analysis of medical knowledge and power helps examine how the authority to observe, classify and interpret patients' conditions is organized [17]. These perspectives merely guide interpretation.

Accordingly, we read legal provisions as both normative rules and socially situated classifications of actors and duties. We also examine scholarly and institutional writing as discourse that helps

define AI as a public problem. The four perspectives connect the analysis of legal categories to questions of professional boundaries, knowledge and trust.

The article combines a reading of Moroccan legal and institutional sources with selected international instruments and scientific literature. The comparison concerns the functions of safeguards, including oversight, information, consent and accountability. It does not assume that foreign rules apply directly in Morocco.

Our aim is to identify where established legal duties provide a basis for governing clinical AI and where their application needs clarification. We then examine what these uncertainties mean for professional authority and patient trust. The study develops interpretations grounded in documents and identifies where the current framework remains deficient in the light of international normative instruments, notably the UNESCO Recommendation on AI Ethics and the WHO Guidelines on AI Governance in Health.

Materials and Methods

The Nature of the Research and Rationale for the Approach

A qualitative, sociological and documentary approach is used, since the research aims not to measure quantifiable phenomena but to examine how the legal and social meaning of responsibility is constructed in relation to AI in healthcare. The objective is not to establish statistical frequencies, but to analyse the representations, legal categories and discourses through which responsibility is defined, attributed and justified, including the question of who may bear responsibility, to what extent, and on what grounds.

The choice of a documentary approach is also grounded in the available literature and normative material in Morocco. As indicated in the introduction, AI is being integrated with Moroccan healthcare; the available material includes a substantial body of institutional, scientific and legal discourse. Documentary analysis of legal texts, scientific publications and institutional documents can show how issues are being framed. It does not replace field research. Viewed through the theoretical lens – which treats legal texts as social products embodying relations of power and configurations of responsibility and trust – the analysis examines their conditions of production, their underlying categories, and their potential social functions. Legal rules are considered both as normative prescriptions and as particular ways of defining actors, responsibilities, and relationships between professional, institutional, and technological spheres.

Methodological Dimensions

The research adopts a comparative approach, with three interrelated dimensions. The first, *analytical*, consists in examining how legal, professional, and ethical responsibility are conceptualized in the literature on AI in healthcare. The second, *comparative*, identifies convergences and divergences between the Moroccan framework and selected international and European regulatory approaches, with attention to liability allocation, human oversight, data protection, and medical device regulation. The third, *critical*, entails a reflexive reading of legal and institutional discourse, examining how AI may reconfigure professional roles, authority, and trust in the Moroccan context, while distinguishing between what is established by the texts and what constitutes an analytical hypothesis.

Corpus construction

Two criteria guided the construction of the corpus: first, the direct relevance of each source to the issue of legal, professional and ethical responsibility in AI healthcare use; and second, its institutional or scientific standing. Accordingly, the corpus includes relevant legal texts, institutional documents, and scientific publications. Texts addressing AI outside the healthcare context, or lacking sufficient bibliographic traceability, were excluded.

A further distinction was made between the documentary and interpretative levels. On the one hand, we sought to analyse the normative, institutional and scientific content of the sources as shown in the original documents; on the other hand, we identified the sociological interpretation developed by the researcher. Whenever the analysis moved from the description or interpretation of a source to a theoretical or sociological proposition, this transition distinguished what is established by the corpus from what constitutes the researcher's analytical interpretation or hypothesis.

Organization of the Code

The codification comprises 27 identifiable normative and institutional documents, inventoried in Table 1. They are organized into four analytical tiers according to the degree to which the rule is incorporated into the Moroccan legal system. This criterion allows each text to be positioned according to its normative status and binding force within the Moroccan context. The tiers are analytical groupings; they do not constitute a hierarchy of legal force, which is recorded separately for each document in the table.

The first tier comprises general legal foundations: the Constitution (Articles 24 and 31) and the Law on Obligations and Contracts. The second tier brings together sector-specific health legislation and professional regulation, including Law No. 131.13 on medical practice and its implementing decrees, Framework Law No. 06.22, Law No. 07.22 establishing the High Authority for Health and

its implementing decrees, Law No. 84.12 on medical devices, Law No. 08.12 on the National Council of Medical Practitioners, Law No. 28.13 on biomedical research, and the Code of Medical Ethics. The third tier covers data protection and cybersecurity, notably Law No. 09.08 on personal data, Law No. 05.20 on cybersecurity, and the CNDP opinion on cloud outsourcing. The fourth tier includes international comparison and institutional guidance: the EU AI Act, the EU Medical Devices Regulation, the GDPR, Council of Europe Convention 108+ and the Framework Convention on AI, the UNESCO Recommendation on AI Ethics, the WHO guidance on AI for health (2021 and 2024), the IMDRF SaMD risk framework, and the White Paper on e-Health in Morocco.

Each law or decree is counted once, even when several provisions are discussed. The decree amending the telemedicine rules is classified with health regulation. The Code of Medical Ethics is listed separately from the general decree implementing the law on medical practice. The White Paper and WHO's 2024 guidance are included as institutional sources. Broad references to a national roadmap or to unspecified professional statements are excluded from the enumerated corpus because they do not identify a distinct document. European regulations serve as comparative instruments, subject to their own scope and application provisions. International recommendations and technical guidance are not treated as Moroccan legislation. Convention 108 and its modernizing protocol also require separate attention to treaty status: Morocco's accession to the original Convention does not establish that the modernized text applies automatically. The CNDP cloud opinion listed in Tier III concerns credit institutions and is used only as a sector-specific comparison.

Table 1. Inventory of the 27 core normative and institutional documents

Document	Year	Type	Jurisdiction	Normative status	Tier	Analytical relevance
D01 Constitution, Articles 24 and 31 [22]	2011	Constitution	Morocco	Constitutional norm	I	Privacy and access to healthcare
D02 Code of Obligations and Contracts [23]	1913	Code	Morocco	General civil liability rules	I	Fault, causation and custody; cited consolidated version
D03 Law No. 131.13 on medical practice [24]	2015	Law	Morocco	Binding national legislation	II	Medical duties, information and telemedicine
D04 Decree No. 2.15.447 [25]	2016	Decree	Morocco	Implementing regulation	II	Organization of medical practice
D05 Decree No. 2.18.378 on telemedicine [26]	2018	Decree	Morocco	Regulation, subsequently amended	II	Conditions for remote medical care
D06 Decree No. 2.20.675 [27]	2021	Decree	Morocco	Amends telemedicine regulation	II	Changes to the digital care framework

D07 Framework Law No. 06.22 [28]	2022	Frame work law	Morocco	National legislative framework	II	Health system organization
D08 Law No. 07.22 on the High Authority for Health [29]	2023	Law	Morocco	Institutional legislation; implementatio n provisions relevant	II	Health evaluation and institutional jurisdiction
D09 Decree No. 2.24.642 [30]	2025	Decre e	Morocco	Implements Article 32 of Law 07.22	II	Institutional implementation
D10 Decree No. 2.24.643 [31]	2025	Decre e	Morocco	Implementing regulation	II	Appointment of Authority council members
D11 Law No. 84.12 on medical devices [32]	2013	Law	Morocco	Binding national legislation	II	Device definition and clinical software
D12 Law No. 08.12 on the Medical Order [33]	2013	Law	Morocco	Binding national legislation	II	Professional regulation and jurisdiction
D13 Law No. 28.13 on biomedical research [34]	2015	Law	Morocco	Legislative framework; implementing conditions relevant	II	Protection of research participants
D14 Code of Medical Ethics, Decree No. 2.21.225 [35]	2021	Decre e and code	Morocco	Professional regulation	II	Information, consent and professional duties
D15 Law No. 09.08 on personal data [36]	2009	Law	Morocco	Binding national legislation	III	Health data and automated decisions
D16 Law No. 05.20 on cybersecurity [37]	2020	Law	Morocco	Binding legislation within its scope	III	Security and institutional obligations
D17 CNDP opinion D-110-2021 on cloud outsourcing [38]	2021	Regul atory opinio n	Morocco	Banking-sector opinion; not a general health rule	III	Limited comparison of outsourced data governance
D18 EU AI Act, Regulation 2024/1689 [39]	2024	EU regula tion	EU	Binding EU instrument; phased application	IV	Risk classification and oversight comparator
D19 Medical Devices Regulation 2017/745 [40]	2017	EU regula tion	EU	Binding EU instrument within its scope	IV	Medical software regulation comparator
D20 GDPR, Regulation 2016/679 [41]	2016	EU regula tion	EU	Binding within territorial and material scope	IV	Automated decisions and safeguards
D21 Convention 108+ consolidated text [18]	2018	Treaty text	Council of Europe	Modernised comparator; treaty status distinguished	IV	Data protection and transnational norms
D22 Framework Convention on AI, CETS 225 [42]	2024	Conve ntion	Council of Europe	Treaty obligations subject to applicable status	IV	Rights and accountability comparator

D23 UNESCO Recommendation on AI Ethics [43]	2021	Recommendation	International	Non-binding recommendation	IV	Ethical principles and national translation
D24 WHO guidance on AI for health [44]	2021	Guidance	International	Non-binding guidance	IV	Health-specific ethical governance
D25 IMDRF SaMD risk framework N12 [45]	2014	Technical guidance	International	Non-binding technical framework	IV	Software risk categorization
D26 White Paper on e-Health in Morocco [2]	2022	White paper	Morocco	Institutional proposal; not legislation	IV	National discourse on trust and participation
D27 WHO guidance on large multi-modal models [46]	2024	Guidance	International	Non-binding guidance	IV	Generative AI limitations and oversight

Treaty status note: Convention 108 entered into force for Morocco in 2019. This is distinct from the modernizing protocol underlying Convention 108+. The modernized text is used here as a comparator; its application is not presumed [18,19]

Scientific literature as a subject for analysis

The scholarly literature on legal and ethical responsibility in AI healthcare use is included here for two distinct purposes. First, it serves as a reference for the study's theoretical and analytical framework. Second, it is treated as a subject of analysis in its own right. The latter approach aims to map the disciplinary distribution of discourse on this topic, by identifying the actors and disciplines producing knowledge on the issue, the conceptual and disciplinary languages they employ, and the ways in which responsibility is defined, attributed and problematized across these different fields. This choice is supported by studies that have adopted systematic and mapping reviews of the literature on ethics, responsibility and AI in healthcare [10]. Scientific publications are not included in the document count of Table 1; they are listed separately in the bibliography.

Research process

The research was carried out in four stages. The first identified and collected relevant legal and scientific sources according to the criteria outlined above. The second classified these documents – by disciplinary field (medical, legal, ethical, sociological) and, for the normative corpus, by the four tiers defined earlier. The third stage was a qualitative content analysis of these materials, focusing on how responsibility and trust are conceptualized and how roles are distributed among doctors, patients, institutions, and programmers. The final stage related the findings to the specific features of the Moroccan legal and institutional context.

Analytical tools

Three analytical tools were used. Thematic content analysis [41] was used to identify how responsibility is attributed, distributed, and justified across the corpus – addressing the first research

question. Sociological discourse analysis [42] served to uncover the discursive patterns through which authority is constructed, responsibility is assigned or displaced, and power relations are represented – speaking to the second question. Comparative legal analysis examined divergences between the Moroccan framework and selected international instruments, with attention to the scope of existing rules, liability allocation, and safeguards – thereby addressing the third question.

Results and Discussion

The cross-analysis of the sources shows three connected issues that structure our argument. First, the scientific and medical literature reveals a debate on legal liability, oscillating between general law and technological exceptions. Second, the Moroccan legislative corpus shows that AI-related issues have not become connected to a legal arsenal conceived for an analogue world. Third, a more sensitive question appears: AI does not merely modify technical processes; it reshapes relationships of authority and mechanisms of trust between healthcare stakeholders, a cultural shift that texts, medical and legal, do not yet articulate. The discussion places international evidence of system limitations alongside the documentary analysis without treating findings from other countries as observations of Moroccan practice.

The documentary corpus comprises 27 normative and institutional documents, organized into four analytical tiers according to their degree of incorporation into the Moroccan legal system. The first tier consists of general legal foundations: the Constitution (Articles 24 and 31) and the Code of Obligations and Contracts. The second tier brings together sector-specific health legislation and professional regulation, including Law No. 131.13 on medical practice and its implementing decrees, Framework Law No. 06.22, Law No. 07.22 establishing the High Authority for Health and its implementing decrees, Law No. 84.12 on medical devices, Law No. 08.12 on the National Council of Medical Practitioners, Law No. 28.13 on biomedical research, and the Code of Medical Ethics. The third tier covers data protection and cybersecurity, notably Law No. 09.08 on personal data, Law No. 05.20 on cybersecurity, and the CNDP opinion on cloud outsourcing. The fourth tier includes international comparison and institutional guidance: the EU AI Act, the EU Medical Devices Regulation, the GDPR, Council of Europe Convention 108+ and the Framework Convention on AI, the UNESCO Recommendation on AI Ethics, the WHO guidance on AI for health (2021 and 2024), the IMDRF SaMD risk framework, and the White Paper on e-Health in Morocco. Scientific literature is not counted among these 27 documents.

The Scientific and Medical Literature's View of Legal Liability

Observed limitations of clinical AI

Wong *et al.* evaluated a widely implemented proprietary sepsis prediction model using hospital records. At the studied threshold, the model failed to identify 67% of sepsis cases, but 18% of hospitalizations would have triggered an alert [47]. The analysis documented a performance problem and a potential alert burden. It was a retrospective evaluation with hypothetical alerts, not a demonstration that model use caused those patients' injuries.

Hager *et al.* evaluated large language models in a simulated decision-making environment built from 2,400 real patient cases. The tested models showed problems in diagnosis, adherence to clinical guidance and interpretation of results [48]. These are observed limitations under the study conditions. They cannot be generalized to every AI system or interpreted as a trial of current routine care in Morocco.

WHO's guidance on large multi-modal models addresses inaccurate outputs, automation bias and the need for evaluation and oversight [46]. Together, these sources show why general promises of accuracy are insufficient. Decisions about validation, monitoring and responding to failures should be assigned to identifiable actors across the system's lifecycle.

Clinical duties and organizational control

Civil liability addresses compensation for harm. Criminal and disciplinary responsibility concern different grounds and procedures. Healthcare has long involved several potentially responsible actors, including practitioners, institutions and manufacturers. AI adds questions about data quality, model design, procurement, local validation and monitoring; it does not create distributed responsibility from nothing [1,11].

Errors may arise from defective data, poor model performance, unsuitable deployment or a clinician's interpretation of an output. A sociological analysis needs to consider who controls each stage and who has access to evidence when harm is alleged. Responsibility cannot be inferred solely from the fact that a doctor used an AI tool [1,11].

Price *et al.* show how AI recommendations can complicate the assessment of professional conduct under the US standard of care [49]. Their 2019 discussion can identify a legal problem, but it cannot establish current clinical safety or Moroccan judicial practice. It should be read alongside subsequent empirical evaluations and governance guidance. Their analysis highlights a daunting

paradox for the physician: clinicians risk liability in two symmetrical scenarios – if they ignore a relevant AI recommendation that was nevertheless consistent with good practice, or if they follow an erroneous recommendation that deviated from that same practice. In both cases, the professional standard of care remains applicable.

This situation carries a weighty sociological implication. By evaluating the physician's liability solely according to his or her individual conduct, the current legal framework may encourage a defensive use of AI: it is employed to confirm a diagnosis already well established, but clinicians are wary of relying on it when it suggests an unusual path or departs from standards. The broader question is this: under what conditions can AI become a tool for clinical decision-making, particularly when it challenges established standards?

These studies direct attention to the conditions under which reliance on an output is reasonable. Institutions make choices about purchasing, workflow integration and training, and suppliers control aspects of development and documentation. Our interpretation is that evaluating only the clinician's final decision can leave these organizational contributions insufficiently examined. The legal consequences remain dependent on the applicable rules and the facts of each case.

Brett-Crowther extends concern beyond technical error to human control and unequal access to benefits [8]. In the Moroccan analysis, these concerns can be related to three questions: whether institutions can independently assess the systems they procure; whether patients and practitioners can obtain evidence needed to question an output; and whether oversight reaches the organizations that control the technology. This connection gives the international debate a specific socio-legal focus without treating every forecast of severe risk as an established clinical outcome.

The responsibility gap and the selected Moroccan literature

Matthias' concept of a responsibility gap describes difficulties in attributing responsibility when learning systems behave in ways their designers or users cannot fully anticipate [50]. It provides a conceptual starting point. Whether a particular case creates an unresolved legal gap requires examination of the relevant duties, evidence and remedies.

Morley's mapping review documents the range of ethical questions raised by AI in healthcare [10]. The vocabulary varies with the discipline. Legal scholars frame the issue in terms of attribution and compensation; ethicists prefer transparency and autonomy; technologists reach for interpretability and verifiability. Each field defines the problem in its own way. Abbott's framework helps us interpret disputes over which expertise should define and address such questions [15]. Medical, legal and technical perspectives may emphasize different duties.

The selected Moroccan publications include work on hospital management, healthcare delivery and clinical applications [4-7,12,13]. Bourquia adds a medical and ethical discussion of the doctor's role [3]. Within this selection, the allocation of legal responsibility features less than technical or managerial questions. This suggests that, within the body of Moroccan literature, the question of AI liability has not yet become very apparent. This is not evidence of an absence of legal or sociological concern across the country. Rather, it is a characteristic of the specific academic corpus surveyed – a blind spot in the literature.

This finding concerns the materials examined. Because the literature selection is purposive, we cannot infer the relative size of disciplinary fields or conclude that AI liability is absent from Moroccan public debate. The corpus identifies a need to connect technical evaluation with socio-legal investigation.

A Sociological Reading of Moroccan Legal Texts

General rules and sector-specific provisions: the limits of a concept developed in a different context

At the heart of Moroccan civil liability lies Article 88 of the Code of Obligations and Contracts. It establishes the custodian's liability for damage caused by objects in their custody, provided that a direct causal link can be proven. The custodian may, however, escape liability by demonstrating that he, she or it took all necessary precautions, and that the damage resulted from a sudden accident, force majeure, or the fault of the injured party [23].

So far, so straightforward. But the provision says nothing about the nature of the object in custody, let alone its degree of autonomy. Apply it to an intelligent system, and two immediate difficulties arise. First, the notion of custody itself. Legal doctrine has traditionally defined custody through three elements: use, direction, and supervision. Yet in the case of an AI system, the physician uses the system without directing its inferential reasoning, and the designer has directed the design but is not in control of its use. Custody thus becomes distributed across multiple actors, with no statutory criterion to determine who holds it. Second, the grounds for exemption produce a perverse effect in this context. A user who faithfully complies with the terms of use can reasonably argue that he or she has exhausted all reasonable efforts. The result? A lack of transparency—which ought to be a basis for accountability—paradoxically becomes a ground for exemption, leaving the aggrieved party potentially without effective redress. Article 88 does not establish an AI-specific allocation of responsibility. Its application to a particular system requires legal analysis of custody, causation and the circumstances of the harm.

AI can make those questions difficult because use and control may be divided. A clinician may operate a tool whose training, updates and technical documentation remain controlled by a supplier. A healthcare institution may determine procurement and deployment without developing the model. These configurations invite analysis of the duties of each actor. Opacity may make it harder for an injured patient to identify the source of an error or obtain evidence. But, compliance with instructions or inability to explain a model does not itself establish exemption from liability. Our hypothesis concerns an imbalance in access to information and control. Its legal effects would need to be assessed through case law and the facts of individual disputes.

The same logic extends to sector-specific legislation. Law No. 131.13 grounds medical practice in professional judgement and patient rights. Article 2 requires practice free from improper influence, and Article 3 addresses scientifically established techniques [24]. The telemedicine provisions retain a central role for medical professionals while regulating remote care [24-27]. These rules should not be read as applying identically to every AI application. Abbott's account of jurisdiction helps identify the formal place of professional expertise; Foucault's approach draws attention to the relationship between diagnostic knowledge and authority [15,17]. Neither framework establishes how these provisions operate in practice. Viewed through Foucault's lens, the law still speaks as if the doctor were the sole master of the clinical encounter, reproducing a vertical, hierarchical relationship now transposed into digital space. It seems that technological modernization does not transform the underlying patterns of power.

Consider now Law No. 09.08. Article 11 is devoted to the neutrality of effects. It stipulates that no judicial decision concerning an assessment of a person's behaviour may be based on automated processing of personal data intended to evaluate certain aspects of their personality. Nor may any other decision producing legal effects be taken solely on the basis of such automated profiling [36]. The provision therefore establishes a safeguard—it does not leave the matter entirely unregulated. Yet its scope in relation to clinical artificial intelligence is open to question. An intelligent diagnostic system is typically designed to assess a patient's physiopathological condition, not the personality. And a treatment recommendation does not constitute a decision producing legal effects in the strict sense. So the safeguard’s material reach is ambiguous. Its application to clinical AI depends on the type of processing and decision. A tool that supports a clinician differs from a process that makes a decision solely through automation. These are issues of scope and interpretation rather than evidence that all medical AI falls outside the law.

This is why comparisons with the European framework should be framed with care. The issue is not the presence versus absence of a rule, but rather the level of safeguards provided. Article 22(3) of the General Data Protection Regulation lays out explicit procedural guarantees: the right to

obtain human intervention, the right to express one's point of view, and the right to contest the decision [41]. Article 11 of Law No. 09.08 contains no equivalent explicit set of procedural guarantees. At the same time, the Moroccan provision expressly excludes from the category of automated decisions certain decisions taken in the context of concluding or performing a contract—provided the data subject has had the opportunity to present his or her observations—as well as decisions that satisfy the data subject's request. The real issue, then, is not the absence of a safeguard, but rather the material and procedural limits of the safeguard that does exist when it comes to clinical AI. These guarantees cannot be treated as applying to every clinical algorithm. The comparison highlights questions for Moroccan patient protection without assuming equivalent legal coverage.

A normative paradox emerges here. In 2009, Moroccan law explicitly shielded judges from having their discretion delegated to machines. Yet the law did not then establish an equally explicit safeguard addressing the use of automated processing in medical decision-making. Our hypothesis is that this disparity reflects a difference in the capacity for symbolic mobilization between the two fields at the time the text was drafted [14,15]. The differences between these provisions also invite sociological inquiry. Bourdieu and Abbott help formulate questions about which actors participate in defining legal categories and whose concerns receive institutional recognition [14,15]. The wording of a statute alone cannot demonstrate that one professional group had greater influence during its preparation. Legislative records and interviews would be needed to examine that hypothesis. They may not be available to a researcher.

Finally, Law No. 84.12 includes, within its definition of a medical device, the software for its operation [32]. But this matter turns on the specific location of the software within the device and its intended purpose and configuration. This opens up a research hypothesis regarding adaptability, rather than yielding a definitive legal conclusion. By contrast, the European Article 6(1) of Regulation 2024/1689 links the classification of specified AI systems to product legislation and third-party conformity assessment requirements [39,40]. It does not make all medical AI high-risk. The comparison identifies a question about the coordination of regulatory regimes.

We must distinguish the limitations from the substance of the texts. What these provisions reveal when applied to intelligent systems is not a flaw in legislative craftsmanship. It is, rather, a historical imprint: they were constructed at a time when the question of the distribution of agency between human beings and machines had not yet become a social problem requiring regulation. We are not facing a legislative vacuum, nor an absence of applicable rules. The selected Moroccan provisions provide a legal starting point for AI-assisted care [23,24,32,36]. They do not resolve all questions about the allocation of duties across developers, suppliers, institutions and users. We lack

provisions specifically adapted to the distributed agency and responsibility created by intelligent systems. This aligns with Bourdieu's view of the legal text as a provisional crystallization of the balance of power that existed when it was produced [14]—a snapshot of a world that no longer quite exists.

Institutional jurisdiction and regulatory change

Law No. 07.22 establishes the High Authority for Health and assigns it functions relating to evaluation and quality in the health system [29]. Its implementing decrees provide further elements of institutional organization [30,31]. The law confers upon the Authority a broad and weighty portfolio: assessing the quality of services provided by healthcare institutions, periodically evaluating medicines and health products, scrutinizing professional practice, and delivering expert opinions on health policies. It is an ambitious mandate. Yet it contains no provision to evaluate or approve clinical AI tools, none. The law does not set out a detailed approval pathway specifically for clinical AI. This leaves questions about how broader health evaluation functions intersect with medical device regulation, data protection and institutional duties.

This omission should not, however, be mistaken for institutional paralysis. The Authority's Chair was appointed in 2024, and the implementing decrees followed in 2025. Moreover, the Law's entry into force is conditional upon the publication of all its implementing provisions. A lack of AI-specific wording does not show that no authority can act. The relevant question is which institution is competent for a particular activity, upon which legal basis and with what procedures. The gap we have identified is the absence of an explicit institutional mandate relating specifically to the governance of clinical AI. Assessing operational capacity or the present implementation of all provisions would require additional institutional evidence.

This is sociologically significant—and for a very particular reason. The High Authority for Health is itself an institution whose organizational and regulatory boundaries are still being drawn. Yet the question of clinical AI governance is now urgent. The current moment is thus a rare opportunity to observe how institutional jurisdictions are defined and negotiated between actors, rather than simply deduced from the wording of a finished legal text [15]. Abbott's concept of jurisdiction directs attention to how these functions are allocated and coordinated [15]. For clinical AI, the boundaries between professional oversight, technical assessment and institutional management may become consequential. The documentary analysis identifies these boundaries as subjects for investigation; it does not establish an observed conflict between the institutions concerned.

The same question arises in relation to Bill No. 52.26, on the integrated national health information system, which was approved by the Council of Government on 22 July 2026. According to the government communiqué, the Bill aims to establish a national digital health information system—a centralized platform for collecting, managing and exchanging health data, alongside a shared medical record, a national health identifier, and a unified public hospital information system. Because the Bill remains at the drafting and adoption stage, it offers an exceptional opportunity: the chance to observe a regulatory framework while its positions and institutional boundaries are still being actively negotiated. We can thus see the law being born—rather than retrospectively reconstructing the distribution of power and jurisdiction from a completed, polished legal text [14]. Changes in digital health legislation offer a further opportunity to examine the allocation of responsibilities for health information systems.

Legislative provisions can be studied through successive drafts, explanatory documents and documented interventions by professional organizations [14]. Such material may permit analysis of how competing definitions of responsibility enter or disappear from a final text. It cannot be replaced by an inference from the enacted wording alone. We therefore propose that the final form of the Bill—particularly with regard to the obligations it imposes on professionals and the nature of the sanctions attached to their breach—may indicate the respective positions of the actors involved in this field. The allocation of responsibilities in the final version may reveal which interests have successfully made their way into the emerging regulatory framework. A future investigation could compare draft and adopted provisions, identify participating actors and examine how their proposals affect duties, sanctions and access to remedies. The present corpus does not provide a documented legislative history of those negotiations. But one must recognize that the main question is how the law governs the use of AI.

The main issues identified in the selected provisions concern the allocation of duties across the AI lifecycle, the classification of clinical software and the coordination of evaluation and oversight. General liability rules, medical obligations and data protection safeguards remain relevant [23,24,32,36]. Their application requires attention to the system's function and the relationships among the actors involved. Developing a clearer framework would require consideration of procurement, local validation, documentation, incident reporting and patients' access to explanations and remedies. These are implications of our comparison; not findings that particular Moroccan institutions have failed to fulfil a legally established duty.

We interpret this situation as a possible mismatch between the pace of technological change and the rhythm of legal adaptation. The existing framework tends to address new technological situations, by applying pre-existing legal categories. Yet clinical AI raises questions that these

categories never contemplated—particularly concerning the identification of the relevant actor, the distribution of agency, and the attribution of responsibility. The issue, then, is not strictly a legislative vacuum in the technical sense. Now, existing categories confront forms of technological agency that push them to their very limits.

Patient information and consent

The practical question is what a patient should be told when a technical system contributes materially to a clinical recommendation, and who must provide that information. The duty to inform and secure consent rests on a quiet, often unspoken premise: that the doctor is able to explain the basis of the proposed intervention, and that the information provided reflects a professionally grounded clinical assessment. This assumption has long been woven into the fabric of Moroccan medical law.

Law No. 131.13 affirms the patient's right to receive such information as a fundamental principle. Article 2 grants the patient—or, where applicable, the guardian or legal representative—the right to be informed of the diagnosis, possible treatment options, the prescribed treatment and its potential effects, as well as the consequences of refusing treatment. This information must also be recorded in the patient's medical file [24]. Article 101 goes a step further: it stipulates that any telemedicine act requiring the patient's participation may only be carried out with the patient's explicit, free and informed consent, expressed in writing, including by electronic means [24].

The Code of Medical Ethics, annexed to Decree No. 2.21.225, reinforces and refines these obligations. Article 42 requires the patient's consent for any preventive, diagnostic or therapeutic procedure. Article 43, in turn, places a positive duty on the doctor to provide impartial and appropriate information about the patient's condition, using clear language suited to the patient's capacity for understanding. This information must cover, in particular, the diagnosis, examinations, risks, proposed treatment, alternative options, and their expected effectiveness [35]. Decree No. 2.18.378 of 25 July 2018, specifically Article 12, elaborates on the modalities of consent in telemedicine: consent may be given in writing or by any means allowing it to be recorded, including electronic means, after the doctor has provided comprehensive information concerning the patient's medical condition, the nature of the remote intervention, its expected outcomes, the available treatment options, and the anticipated risks and benefits—as well as the consequences of refusing consent [26,27]. These provisions supply an existing framework for examining the use of technology in care.

The integration of intelligent systems poses a question that the existing Moroccan legal framework does not answer: does the duty to inform extend to disclosing to the patient that an automated or AI-based system has been used in the diagnosis or in determining the treatment protocol? We have found no provision that expressly imposes such a duty. These obligations concern the clinical relationship and are not confined to decisions made without technical assistance. Their application to AI requires interpretation of the information material to the patient's decision, including the system's role and relevant limitations. The selected provisions do not set out a general, explicit AI-specific disclosure rule. This does not imply that established information duties cease to apply. It raises the question of how those duties should be fulfilled when a recommendation depends partly on a system whose operation is difficult to explain.

Article 11 of Law No. 09.08 offers a related, but significantly narrower, legal reference. Entitled "Neutrality of effects", it restricts certain decisions producing legal effects on an individual when they are based solely on automated processing of personal data—particularly where such processing is intended to define the individual's profile or assess aspects of the personality [36]. Yet the provision does not establish a general duty to inform an individual that automated processing has been used, nor does it specifically regulate automated decision-making within the therapeutic relationship. Its relevance to the use of AI in healthcare remains indirect. It should be considered alongside the law's other data protection requirements and the duties attached to clinical care. The automated-decision safeguard is not a complete substitute for a framework governing information and consent in AI-assisted treatment.

By way of comparison, Article 22(3) of the General Data Protection Regulation provides, in the circumstances covered by that provision, explicit procedural safeguards: the right to obtain human intervention, the right to express one's point of view, and the right to contest the decision [41]. No equivalent provision on these safeguards in the context of AI-assisted clinical decision-making appears to exist in the Moroccan legal framework. The issue is how patients can obtain an explanation, seek review and question the use of a system. The existence and scope of any specific right must be established from the applicable legal provisions.

Yet this procedural gap raises a deeper question. The duty to inform presupposes an agent who is capable of interpreting and explaining the basis of the proposed intervention. When an element of the reasoning underlying a clinical recommendation becomes difficult—or even impossible—to interpret, the very nature of the duty shifts. The doctor is no longer communicating solely a professional assessment; he or she is also mediating trust in an abstract system whose internal operations may be opaque.

This dynamic can be illuminated by Giddens's analysis of trust in abstract systems [16]. A clinician may be expected to explain a recommendation while relying on evidence and technical processes that he or she cannot fully verify personally. Significant information need not reproduce the model's internal calculations. It should address the clinical relevance of its output, its limitations and the human decisions surrounding its use. Informed consent, in this new context, may increasingly mean consent to a therapeutic decision whose technical basis neither the doctor nor the patient can wholly apprehend. The issue is not simply whether the patient has formally ticked a box, but whether the conditions under which that consent is obtained remain compatible with the informational assumptions that underpin the very concept of informed consent.

This observation also connects directly to our earlier analysis of Article 88 of the Code of Obligations and Contracts [23]. The opacity of an AI-based system may have a twofold effect on the patient's position. On the one hand, it may provide the professional or system operator with an argument concerning the limits of what could reasonably have been anticipated or controlled—a shield against liability. On the other hand, it complicates the practical fulfilment of the duty to inform, by making the technical basis of the decision difficult to explain in clear, accessible terms. The patient may consequently bear the burden of a form of technical ambiguity, with little capacity to exercise control.

This dependence also raises questions about access to evidence. If the supplier holds technical records and the institution controls deployment information, the patient and clinician may lack material needed to understand an error. Our analysis connects this informational imbalance to the attribution of responsibility; it does not establish that opacity itself excuses liability under Article 88 [23]. We present this as an analytical hypothesis—one that will require verification through field research and examination of judicial practice. Further research should examine the information provided in actual consultations, the documentation retained by institutions and suppliers, and how complaints or disputes are handled. These data would allow the documentary interpretation to be tested against practice.

New Manifestations of Authority and Trust in AI-Driven Healthcare Practices

Medical knowledge and reliance on technical expertise

Foucault's account of the medical gaze helps examine the authority attached to observing, classifying and interpreting illness [17]. For clinical AI, this directs attention to the data and categories through which a patient's condition becomes an object of knowledge. It also raises questions about who can inspect or contest those categories. In a context where the intelligent system emerges as a new actor on the clinical stage, this dynamic undergoes a quiet but significant

transformation. Authority is no longer concentrated in a single pair of hands. The doctor is now called upon to balance his or her expertise against the outputs of the machine.

AI can introduce additional technical expertise into the production of a clinical judgement. Bourquia's discussion of the doctor's changing role offers a medical perspective on this development [3]. We interpret it as a question about the relationship between professional authority and technical dependence. Bourquia has captured this shift with the evocative concept of "added technical authority": the doctor is no longer the sole authority; responsibility now extends to other actors involved in the design and operation of the technology, including programmers. In the present research, we understand this proposition as an interpretive framework—a way of seeing the landscape—rather than a claim of empirical verification. The selected texts cannot establish how that relationship is negotiated in Moroccan consultations.

Trust may concern the clinician, the system and the institution responsible for its deployment [51]. In digital medicine, trust operates across several interrelated levels: trust in human intent (i.e., in the doctor); trust in technology (i.e., in the intelligent system); and trust in the institution (i.e., in the legal and regulatory framework). Shevtsova *et al.* identify several factors affecting trust and acceptance, including properties of the technology, healthcare professionals and the context of use [52]. These findings support an analysis that distinguishes the object of trust and the conditions under which it is granted.

Giddens' framework makes this dependence on external expertise sociologically intelligible [16]. Both patients and clinicians may rely on systems that they cannot independently audit. Trust, Giddens argues, shifts from familiar individuals to technical systems whose inner workings the ordinary agent has no means of verifying. Applied to clinical artificial intelligence, this framework applies to both patient and doctor. The physician may be in the unfamiliar position of placing trust in a system whose logic he or she cannot fully interpret—a reversal of the traditional epistemic order, in which the doctor was the one who knew, and the patient was the one who trusted.

The relationship between patient and doctor can thus be mediated by a wider set of technical and organizational relationships. This creates a possible tension between the clinician's formal responsibility and his or her practical control over the system. Responsibility should be examined alongside the institutional arrangements that make such reliance reasonable, including evaluation, training and access to review. Examining that tension is more helpful than assuming that AI replaces medical authority.

Professional concerns and the economic use of data

Concerns about professional autonomy can be interpreted through Abbott's account of jurisdiction [15]. Questions about who may define a diagnosis, recommend treatment or certify a system's reliability concern different forms of expertise. When a new actor enters the field—whether human, technological, or algorithmic—previously stable boundaries must be renegotiated. Whether these claims produce conflict, collaboration or new forms of dependence requires empirical investigation.

The ethical literature discusses ambiguity in responsibility and the relationship between medical judgement and AI [53,54]. Attar *et al.* argue that the ambiguity surrounding the distribution of responsibilities between doctor and intelligent system may generate real tensions in professional practice—particularly when an error occurs in diagnosis or treatment [53]. Farhud and Zokaei reinforce this point, emphasizing the ethical and professional implications of the interaction between human medical judgement and artificial intelligence, including the thorny questions of responsibility and accountability that arise [54]. Mahomed examines related ethical, social and legal questions in an African context [55]. Ezzerouali *et al.* consider privacy protection under Moroccan law more broadly [56].

Economic arrangements also matter because technical expertise and access to data may be controlled by commercial organizations. The terms governing access, reuse and disclosure of data can affect both professional autonomy and patient trust. Zuboff's analysis of surveillance capitalism offers a framework for questioning the commercial use of data [57]. It does not establish that particular extractive practices occur in Moroccan healthcare. Applied here, it prompts questions about who controls health information, who benefits from its reuse and what mechanisms allow patients or public institutions to challenge those arrangements. Zuboff's framework provides a broader analytical lens through which to examine the economic dimension of data in the development of digital and intelligent systems in healthcare. It draws our attention to a structural tension—a fundamental incompatibility, perhaps—between the economic valorization of data and the ethical principles that have long governed the handling of health information.

Institutional discourse and participation

The Moroccan White Paper presents trust and participation as concerns for digital health development [2]. The document's stated aspirations do not demonstrate either effective participation or the exclusion of patients from decisions. We propose a sociological reading of this text, arguing that it quietly reproduces the existing epistemological hierarchy within the medical field. Technical knowledge remains largely monopolized by healthcare professionals and digital experts, and citizens are cast as subjects of assessment rather than partners in decision-making.

Wynne's work challenges accounts that reduce public reservations about expertise to a deficit of information [58]. Institutional discourse of this kind tends to assume that public reservations about technology stem from a simple lack of information. The remedy, accordingly, is informational and educational—not participatory. Wynne has shown, however, that this assumption overlooks a crucial dimension: the capacity of non-specialists to reflect critically on their relationship with experts and on the epistemological value of their own local knowledge. Trust in science, he argues, depends on the social connections that individuals perceive as relevant to scientific knowledge, rather than simply on the quantity of information available to them. Callon *et al.* examine arrangements through which experts and affected publics can participate in decisions under uncertainty [59]. These views suggest questions for digital health governance: who helps define the problem, whose experience is recognized, and what opportunities exist to contest a proposed solution? This latter approach—bringing together experts and non-experts in the formulation and discussion of technical decisions—is what Callon *et al.* have termed "hybrid forums."

The UNESCO Recommendation provides an international statement of ethical principles [43]. Its existence does not establish that those principles have been incorporated into Moroccan law. Merry's analysis of the local translation of international norms helps frame this question [60]. Transnational norms are not automatically transferred to local contexts; rather, they pass through intermediaries who translate and reformulate them for local use. These intermediaries are, at the same time, knowledge brokers and actors susceptible to co-optation by states and interest groups. For clinical AI, examining translation would require tracing connections between international guidance, national rules and institutional procedures. A reference to the UNESCO Recommendation tells us little, in itself, about what will actually be incorporated into the Moroccan system.

We therefore treat the possible legitimizing role of ethical discourse as a hypothesis. International mappings of AI ethics guidelines show the importance of examining the relationship between principles and their implementation [61]. In Morocco, assessing that relationship would require evidence about monitoring, enforcement, procurement and remedies. The gap between an institutional discourse that adopts the vocabulary of ethics, sovereignty and universality, and a legislative reality that lacks a specialized framework for the distribution of responsibility, may point to a legitimizing function. Such discourse may precede binding legal norms, or act as a temporary mechanism for framing a field whose regulation has not yet been fully established.

This hypothesis rests on theoretical foundations that predate the critical literature on AI. Meyer and Rowan demonstrated, decades ago, that organizations incorporate prevailing institutional norms as "myths" that confer legitimacy and resources upon them [62]. Crucially, this incorporation may be

accompanied by a separation of formal structures from actual activities—such that institutional legitimacy may substitute, at least in part, for direct coordination, inspection and evaluation. DiMaggio and Powell similarly showed that organizations within a given field tend to conform to dominant models in response to normative and mimetic pressures, rather than solely out of considerations of efficiency [63]. These two analyses allow us to refine our hypothesis: the point is not that ethical discourse is false or insincere, but rather that its adoption may fulfil a legitimizing function independent of the extent to which it is translated into binding rules and effective accountability mechanisms. This proposition can be examined by comparing normative discourse with the monitoring, enforcement and accountability mechanisms that accompany it.

This hypothesis finds a parallel in the international literature under the concept of "ethics washing"—a term that captures situations in which ethical principles, guidelines or discourse are mobilized in ways that respond to public concerns about technology without necessarily producing equivalent regulatory constraints or effective accountability [64,65]. Wagner analyses ethics as a potential escape from regulation, particularly through the processes of "ethics-washing" and "ethics-shopping" [64]. Van Maanen extends this discussion specifically to AI ethics, arguing that ethical frameworks may be susceptible to appropriation by dominant actors when they remain focused on principles and discourse without sufficiently addressing the political and social conditions of technological development [65-67]. We present this as a research hypothesis requiring further empirical validation—rather than as a conclusive finding about the Moroccan context. The present analysis cannot establish such a separation within particular Moroccan organizations. It identifies a proposition that could be examined through organizational research.

Conclusion

This study examines responsibility for AI-assisted healthcare in Morocco through four sociological perspectives. It draws on legal texts, academic literature and institutional statements, and treats legal provisions as both normative rules and socially situated classifications of actors and duties. The central sociological issue is the relationship between formal responsibility and practical control over the knowledge, data and infrastructure used in care.

The literature review shows that the idea of distributed liability remains largely theoretical rather than an established practice, with physicians continuing to bear the main burden of responsibility under existing standards of professional care. In Morocco, academic work on the subject has focused on managerial, technical and clinical aspects, and legal and sociological dimensions have received less attention. This suggests that the issue has not yet been seen as a distinct legal problem in Morocco. International evaluations show that failures in performance and reliability are already

observable, although the evidence must be interpreted according to study design and setting. Public warnings and ethical debate reinforce the need for scrutiny. For Moroccan healthcare, local validation, traceability, institutional responsibility and access to review are therefore central questions for governance.

It appears that the Moroccan legal system does not face a legislative vacuum in the strict sense. Civil, professional and medical liability rules are applicable in theory, but their enforcement in practice becomes more complex when medical decisions hinge on AI-based systems. These rules were developed for a model in which responsibility could be attributed to identifiable human actors, whereas AI systems introduce a more complex relationship between human decision-making and technological systems. The selected legal and institutional sources provide existing duties and safeguards, while leaving questions about their application to particular AI systems. Three areas require particular legislative clarification: the allocation of liability among the different actors involved in the development, deployment and use of AI systems; the relationship between the legislation governing medical devices and the clinical use of AI; and the institutional responsibility for assessing and overseeing such systems. A further issue concerns the requirements of information and informed consent. Although these requirements are addressed in the context of telemedicine, the existing framework does not address situations in which an AI system contributes to the development of a diagnosis or therapeutic decision. These implications concern the selected provisions and do not suggest that there is a comprehensive absence of safeguards in Moroccan law.

The analysis of legal and institutional discourse does not suggest that AI is displacing the physician's authority. Rather, it points to a transformation in the conditions under which that authority is exercised. Existing regulatory frameworks, including digital healthcare, continue to place the physician at the centre of clinical decision-making. Technological modernization therefore does not necessarily imply a corresponding redistribution of professional authority. Concurrently, the basis of trust between physicians and patients is being reshaped. The literature points to situations in which physicians may have to rely on systems whose internal processes they cannot fully understand or verify. This poses significant challenges to a legal framework that continues to assume that responsibility can ultimately be attributed to a human decision-maker. The concerns expressed by physicians in the literature can also be understood as reflecting tensions over professional jurisdiction, as the introduction of AI may challenge boundaries that have previously been relatively stable. Trust depends on the arrangements that support justified reliance and allow decisions to be challenged.

This analysis focuses on the normative and discursive construction of responsibility, rather than on its empirical negotiation and management within healthcare institutions. This delimitation suggests three priority areas for further research: qualitative studies with healthcare professionals on how they perceive and allocate responsibility; scrutiny of the parliamentary development of Bill No. 52.26; and testing whether ethical discourse serves to legitimize emerging forms of AI governance in healthcare. Future research should also examine clinical and procurement practices, legislative negotiations and patients' experiences. The study's limits follow from its documentary design and purposive selection: it does not measure routine adoption, patient injuries, professional attitudes or judicial outcomes in Morocco.

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