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SUBMISSION

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AMA submission on the House Standing Committee on Employment, Education and Training inquiry into the digital transformation of workplaces

Introduction

The AMA is the peak body representing medical professionals in Australia. This submission focuses only on aspects of the terms of reference we believe directly relevant to the public hospital doctor workplace in the context of “*digital transformation of workplaces*” meaning artificial intelligence (AI) in public hospitals.

The [AMA’s Position Statement on Artificial Intelligence in Healthcare](#) provides relevant detail, particularly at its Items: 2.6-2.9, 2.13, 3.10-3.11, and 4,2(c).

Public health sector AI can speed up operationalisation of pharmaceuticals and medical devices, individualise patient diagnosis, treatment and care, take clinical notes, answer clinical questions, create patient management plans, and assist optimising invasive treatment outcomes.

Artificial intelligence can free up doctors’ time enabling an improved patient-focus or removing the requirement to recall patient information. Artificial intelligence can avoid delayed, missed or inaccurate diagnoses, which might reduce patient claims for negligence.

Artificial intelligence has immense potential to help improve the delivery of public health care, support doctors and improve patient outcomes. However, from a doctor workplace perspective, AI will likely have broad implications requiring response including (mainly relates to the content of the Australian Salaried Medical Officers Federation (ASMOF’s)¹ / AMA’s industrial instruments and agreements):

- clinical engagement (doctor control / (or at least) genuine influence)
- AI specific change consultation requirements
- remuneration (compensating new/different tasking (allowances & penalties) and work value changes)
- imposition on doctors during non-working hours or move to a 24/7 model of patient care
- clinical task substitution
- medico-legal implications.

¹ “ASMOF”, the Australian Salaried Medical Officers' Federation, is the registered trade union representing salaried doctors.

c. the risks, opportunities, and consequences for the nature of work. Including effects on hiring, rostering, work intensity, job design, wage setting, monitoring, surveillance and job quality

Artificial intelligence may change (at least) clinical decision-making processes, and disease detection, and may mainstream information technology (IT) and machines for surgery assistance, precision medicines development, and remote patient monitoring. There may be a change in the way doctors interact with patients, collaborate with peers, how they undertake clinical assessments and make therapeutic or diagnostic recommendations, conduct certain treatments and procedures, manage administrative tasks, and deliver health services.

Public health administration and management systems may change, for example: patient triage, workforce planning, and resource allocation. Artificial intelligence may facilitate efficiency because of high diagnoses/treatment accuracy, reducing error rates, and improving cost-effectiveness freeing up existing resources (though not necessarily by increasing costs). Public hospital activity can be enabled to expand to a genuine 24/7 model (partly because of AI being introduced).

Doctor related workplace pay, and conditions frameworks are not necessarily organised to respond to AI induced fast-emerging change. Current remuneration systems do not necessarily account for time, value, and style of different forms of work arising through AI, including time spent on preparation and post consultation / other clinical or managerial engagement.

Managing the integration of AI is a new challenge for which doctors (and public hospitals) are not necessarily equipped (in a managerial / administrative competency and skill sense). Artificial intelligence will likely change behaviour which brings with it a new set of requirements to coordinate new systems of work and to guarantee effective communication between the doctor, the new technology and its implications for teams and administration.

Therefore, public hospital employers will need to support development of skills and ensure early, genuine, dialogue amongst its doctors to ensure there is careful introduction of the new ways of doing things (includes increased need for upskilling and clinical informatics trained doctors); this so that patient care is not undermined.

To effectively respond and to emphasise and maintain the role of the doctor in patient safety and quality, a mandated more inclusive and targeted approach to consultation is required. Well in advance of any decision to use AI, complex and nuanced engagement with doctors should occur to limit perverse or unworkable outcomes. There should also be mandated feedback and measurements to inform continuous improvement.

Key workplace challenges for doctors arising from AI

- Ensuring that evidence-based practice norms continue where clinically appropriate, and AI generated change is not simply pursued for the sake of change.
- Defining the concept of “useful” change as related to AI. This “useful” concept partially relates to the gap between theoretical and empirical benefits and partially relates to tension between priorities given limited (financial) resources.
- Maintaining significant doctor ownership over useful change. This to guarantee patients benefit, effective and efficient implementation / integration and to ensure medicine remains a safe and useful career. This includes careful consideration of professional accountabilities / liabilities for patient safety intersecting with a balance between the level to which technology is operational or adjunct /

supportive of clinical practice, and the level to which the medical profession holds interpretation and application responsibility.

- Negotiating / enforcing employment rules to keep pace with rapid change. The introduction of AI can be anticipated to expand work obligations and commitments. Having AI intended to create quality and efficiency can have unforeseen and perverse implications for the way doctors work (i.e. doctors needing to know more; needing to do more; and doing more very differently).

Summary of AI benefits for doctors in the workplace

- Improved Decision Making: AI can provide data-driven insights that help doctors make more informed decisions.
- Enhanced Communication: AI-powered chatbots can streamline doctors' internal communication, reducing delays and improving efficiency.
- Skill enhancement / Personalised Training (individual or Unit level): AI can analyse individual doctor or Unit performance, identify needs gaps, then design targeted training programs to facilitate improvement.
- Increased Job Satisfaction: By removing mundane tasks from doctors' workload.

AI foreseeable risks in the workplace (potentially avoidable because of mandated employer communication with doctors in advance of AI purchase / implementation):

- introduced too fast and without appreciation for existing culture, setting and need for new training
- making inefficient other process or systems that exist and remain unchanged (poor interface design and/or integration)
- effects on work patterns where ongoing calibration, servicing and maintenance is required (managing technology down time)
- practical use of computer programs (how information is displayed and used (e.g. drop-down menus and their potential for selection or entry error)
- unnecessary capital expenditure (either not needed, resources should be re-directed to other priorities or evidence suggests better alternative)
- unclear medico/legal liabilities (between AI and the doctor and/or where the demarcation between doctors lies where technology enables multi-practitioner intervention in a single case)
- unsafe to patient use or unsafe integration procedures.

d. the effect of these techniques on the scope of managerial prerogative, labour rights, ability for workers to organise, procedural fairness, equality and discrimination, and dignity at work²

Discrimination (in AI assisted doctor recruitment)

The use of AI can result in indirect discrimination claims where someone with a protected characteristic suffers a disadvantage because of an algorithm's output. However, AI driven decision-making processes can mitigate bias in ways human judgement cannot (because often humans do not consciously know all the inputs that went into their decision). Artificial intelligence can improve the quality of the workforce, reduce recruitment process time, and cost and calibrate the diversity of its candidate pool. Artificial intelligence can be used to screen applicants and determine suitability on a very large scale including assessing poor cultural fit, soft skills, and personality traits during interview.

² The underlined is the aspect of d) relevant to the AMA's submission

Women doctors and the International Medical Graduate (IMG)³ community are particularly exposed to discrimination risk. For example, a doctor recruitment algorithm that demonstrates preference for men over women or language and tone of voice for IMGs can also be more difficult for AI to assess, increasing the risk of negative racial or nationality bias.

To minimise the risks of bias and discrimination, public hospitals should establish enforceable key performance indicators (KPIs) for those responsible for the development and use of AI. The AI provider should be able to demonstrate that the data and algorithms have been stress-tested for bias and discrimination particularly in respect of gender, race or age, and impact assessments should be conducted on a regular and ongoing basis.

To deal with potentially AI facilitated workplace discrimination the onus to demonstrate absence of discrimination in AI or human-led decisions could be reversed (i.e. employer burden). However, if the employer cannot discharge the onus, admissible secondary defences an employer could deploy could include that the employer (representing good practice in any case):

- did not create or modify the AI system
- audited the AI system for discrimination before using to make high-risk decisions
- procedural safeguards post audit operate to monitor the AI system.

It is likely to be difficult to identify professionally equipped staff to actively assess and interpret recommendations and decisions made by AI in the recruitment process before applying it to any doctor. Also, meaningful human reviews need to be carried out rather than rubber-stamping automated decisions. With this in mind, AI should be just one element of recruitment decisions and AI audits should regularly occur to ensure non-discrimination and appropriate use.

e. appropriate safeguards or regulatory interventions to guide responsible implementation in the workplace, including the digital skills and resources necessary for employers to appropriately utilise technology

Artificial intelligence needs to be human-centric and trustworthy. “High-risk” AI systems like those associated with doctor’s clinical practice must⁴:

- be developed based on high-quality of training, validation and testing data sets, in order to minimise errors and discriminatory outcomes
- before AI systems are put into service, the AI must be accompanied with technical documentation describing the AI system, its elements and process for development
- be designed and developed to ensure traceability of the system’s functioning throughout its lifecycle
- provide necessary information to enable users to interpret the system’s output and use it appropriately
- be designed in a way that they can be overseen, so that humans may prevent or minimise potential risks to fundamental rights generated by the systems

³ IMGs are not a homogeneous group but are all medically trained overseas now working in the Australian health care system. In many cases, particularly in rural and remote areas, IMGs represent a vital medical workforce supplement.

⁴ According to the [European Union AI risk framework](#)

- achieve an appropriate level of accuracy, robustness and security and perform consistently in these respects throughout their lifecycle.

Key considerations to public hospitals' response to AI induced change

- Doctors must be upskilled to integrate and use new technology for patients' and the profession's benefit.
- Doctors must be properly engaged by decision-makers about the sensible and safe AI implementation, integration, and appropriate use.
- Doctors' industrial rights and conditions need to be newly established that fairly remunerate new ways of working (and AI contributory work value increase) to ensure doctors (and ASMOF/AMA) are involved in employer-led change to protect against de-skilling, fatigue, and exploitation.

Doctor liability protection

New standards for clinical practice⁵ may be needed when health workplaces introduce AI in various craft fields. Express liability risk management frameworks⁶ that deal with the complexity of shared responsibility that arises via AI, in summary, as follows:

- doctor care for the patient
- health service that takes ultimate decision to introduce new AI systems and tools
- the manufacturer that developed the AI being implemented.

A doctor using AI should be responsible for AI decisions made in the course of treatment, especially if the doctor retains the power to make the final decision regarding treatment. However, as AI takes on more autonomous decision making, it may be argued by some doctors that they should not be responsible for that which they cannot control.

Where litigation arises from adverse or sentinel events, judgement as to whether the doctor's performance was of a "reasonable" standard tends to be assessed against competent professional practice as set by the profession itself. Where AI integrates into clinical practice, standards of care must require AI use, and therefore traditional common law measurement of liability may require change.

It seems unfair for doctors to be held responsible for an AI decision when they are unable to work out how and why a decision was made. Such assessment is outside of a doctor's scope would be best examined "product liability" legal question (i.e. AI manufacturer liability). One potential solution is to mandate a graduated, shared responsibility, model assessing diagnosis and clinical management liability between the between the health service (who directed the implementation of the AI system, the treating doctor, and the AI system.

Contact

⁵ Modified as a summary for generic craft application: *Standards of Practice for Artificial Intelligence in Clinical Radiology*, Royal Australian and New Zealand College of Radiologists (RANZCR)

⁶ In conjunction with workplace conditions reform that either clarify responsibilities or support the introduction of AI.