Victorian Civil and Administrative Tribunal Decisions

Morgan v Austin Health & Anor (Anti-Discrimination) [2007] VCAT 2229 (7 November 2007)

Last Updated: 26 November 2007

VICTORIAN CIVIL AND ADMINISTRATIVE TRIBUNAL

HUMAN RIGHTS DIVISION

ANTI-DISCRIMINATION LIST **VCAT REFERENCE NO. A64 /2007**

CATCHWORDS

Equal Opportunity Act 1986 – age discrimination – succession planning – attribute of age – appropriate comparator.

COMPLAINANT:	Trefor Morgan
FIRST RESPONDENT:	**Austin Health**
SECOND RESPONDENT:	Dr Gwynne Thomas
WHERE HELD:	Melbourne
BEFORE:	Her Honour Judge Harbison
HEARING TYPE:	Hearing
DATE OF HEARING:	11, 12, 13 & 25 September 2007
DATE OF ORDER:	7 November 2007
CITATION:	Morgan v **Austin Health** & Anor (Anti-Discrimination) [2007] VCAT 2229

ORDERS

1. That this proceeding be discontinued by consent as against the Second Respondent.

2. That this proceeding be dismissed as against the First Respondent.

HER HONOUR JUDGE HARBISON
VICE PRESIDENT

APPEARANCES:

For Complainant:	Ms Richards of Counsel, instructed by TressCox Lawyers.
For Respondent:	Mr D'Abaco of Counsel, instructed by DLA Phillips Fox.

REASONS FOR DECISION

BACKGROUND

1. Trefor Morgan is a Medical Specialist. He is aged 71 years. He trained as a General Physician. For many years, he held a Professorship at the University of Melbourne in Physiology. Since 1971 he has also been working as a sessional specialist at the Hypertension Clinic of the Heidelberg Repatriation General Hospital. In fact, he founded the Clinic. He has worked there as a sessional specialist for several hours each week over a continuous period from 1971 up to the present time (save for a short break between 1978 and 1980).

2. The Repatriation Hospital merged with the Austin Hospital in 1996, and since that time he has continued working as a sessional specialist (or visiting medical officer) for **Austin Health**, the amalgamated entity. For those 10 years, he has worked five sessions each fortnight. Each session is 3½ hours long. He has built up a reputation with his patients at the Clinic over the many years he has worked there. Some of his patients have been attending the Clinic for up to 30 years. The Clinic is well known throughout Australia, and Professor Morgan has an established international reputation and is widely published in the area of hypertension.

HYPERTENSION

3. Hypertension is not a recognised speciality in itself. Its subject matter spans several disciplines. Professor Morgan has a background in physiology. Cardiologists are also clearly concerned with the treatment of hypertension. So are Clinical pharmacologists – because drug administration and drug trials are a significant part of treatment of and research into hypertension. The study of nephrology and endocrinology also overlaps with hypertension. Many General Physicians are also involved in the treatment of hypertension.

4. In Professor Morgan's view, the great advantage of a specialist Hypertension Unit is that expertise can be developed in a way not possible if the primary focus is on emergency situations in a particular discipline – such as emergency cardiac surgery. Prevention by careful monitoring is better than emergency operative intervention. Emphasis on monitoring rather than acute medical intervention can save lives. In

particular, Professor Morgan explained to me that he practises the "modern management" of hypertension. He described this as following several emerging international standards of blood pressure and symptom monitoring. He emphasises the need for 24-hour blood pressure monitoring as an extremely valuable diagnostic tool. He also emphasises dietary intervention and reduction in salt intake, and monitors his patients very closely in these respects. In essence, his approach appears to consist of a rigorous application of international best practice standards to individual patients. Professor Morgan typically sees patients at regular intervals of time over a period of years. He is actively involved in detailed management of their condition.

5. Professor Morgan's view of the importance of specialist management of hypertension is unfortunately not shared by most hospital administrators. Most hospitals in Australia do not have a Hypertension Unit. At the time of the merger, there was a Hypertension Unit at both the Austin and the Repatriation Hospitals, so the amalgamated entity assumed responsibility for not one, but two specialist hypertension units.

PRIVATISATION

6. When the hospitals were amalgamated, Professor Louis was appointed the Head of the Department of Clinical Pharmacology at **Austin Health**. He was thus the person with overall responsibility for the hypertension units at both the Austin and the Repatriation Hospitals. He retired in late 2005.

7. Prior to his retirement Professor Louis had initiated the "privatisation" of the hypertension units at both hospitals. He had told Professor Morgan in 2005 that the hospital had wished to close down the Clinics completely, and that privatization was the only course open if the Clinic was to survive. Indeed, I heard evidence in this case that almost all of the outpatient Clinics attached to the Austin have now been privatised, for budgetary reasons.

8. The process of privatization was completed by Dr Louis' successor, Professor Flauman, in February of 2006.

9. Privatization has a special meaning for hospital administration. It does not mean that the Clinics are privately owned. It means that instead of accessing running costs out of the general budget of the hospital, a privatised Clinic is substantially funded by Medicare. Patients attending the Clinic are bulkbilled and the revenue received is put towards the payment of overheads and staff costs, including the cost of sessional specialists. Privatization is really just a way of allowing a State-funded hospital to access Federal Government funding for its outpatient Clinics through Medicare payments.

10. The relevance of this process to this case was that the Hypertension Clinic did not have an unlimited budget to employ specialist staff. All staff, except for full-time employees of the hospital, or staff funded under other arrangements, needed to be employed out of the Clinic budget. It also meant there was a necessary focus on the income generated by each sessional specialist. Up until the present time Medicare payments attributable to Professor Morgan's patients have constituted about 50% of the total fees generated.

THE RESTRUCTURE OF THE HYPERTENSION UNIT

11. As I have said, after Professor Louis' retirement, his post was taken over by Professor Flauman, who had previously held the post of Deputy Head. He was appointed initially as Acting Head of the Department of Clinical Pharmacology and Therapeutics. His appointment as Permanent Head was made in early 2006. He was also appointed Head of a newly established Clinical Trials Unit at the Hospital.

12. The appointment of Professor Flauman and the establishment of the Clinical Trials Unit presented an opportunity to reassess the future of both Hypertension Units. Professor Flauman did this in consultation with Professor Gwynne Thomas, the Medical Director of the Hospital, and thus the person with overall medical responsibility for Medical and Emergency Services at **Austin Health**.

13. Professor Thomas gave evidence that privatization had not been sufficient to protect both Clinics from closure. The Hospital Board had instructed him that it still wished to close down each of the Hypertension Clinics, as all other Hospitals in Melbourne had done. It wished to emphasise the "core business" of the Hospital, and did not see the Hypertension Unit as part of that core business. The Board wished the functions of the Clinics to be absorbed by other relevant outpatient Clinics, such as the Cardiac Clinic. Professor Thomas had fought against the closure. He said the Unit could perform a valuable research function. Its particular strength was that it comprised a group of longstanding patients – going back some 30 years. These patients would be very valuable for research. Their medical histories were known and accessible. They were conditioned to and agreeable to the carrying out of research.

14. Thomas and Flauman discussed two initiatives to make the continuation of the Hypertension Clinics more palatable to the Hospital Board and so secure the Clinics' survival. The first was the amalgamation of the two Hypertension Units into one, based at the Repatriation site. This had obvious advantages. Each site was thought to be running at less than capacity (although Morgan disputed this as far as the Repatriation Clinic was concerned). It was clear that staff could be concentrated in the unified facility, with obvious economies of scale.

15. The second proposal was to reorganise the amalgamated service completely. Instead of the current sessional arrangement, Professor Thomas wished to formalise three Clinics to correspond to the three days on which the Clinics ran; thus creating the Monday Clinic, the Tuesday Clinic and the Thursday Clinic. Each Clinic would be standalone, with one senior specialist as mentor to two junior specialists. Each Clinic would organise its own research projects, and develop its own expertise. He said this restructure would "rejuvenate" the Clinic.

16. There is no question that the first initiative, which involves the amalgamation of the two Units was seen by all, including the Complainant, to be a wise and necessary move.

17. The change of rostering of sessional staff contained in the second proposal is the reason for this complaint.

THE DISCRIMINATORY CONDUCT

18. Professor Thomas gave evidence that in all there were ten specialist sessions a fortnight funded out of the Privatised Clinic budget. Richardson and Thomas gave evidence that the budget for the Clinic was "extremely tight".

19. Professor Thomas gave evidence that it was essential that each sessional specialist in the amalgamated Clinic worked for at least two sessions a fortnight. Two units a fortnight was selected as the minimum that a specialist could work without losing professional capacity and to enable the specialist to fulfil his clerical, administrative and research duties, and also expand and refine his Clinical skills. It was also the maximum that the hospital could afford, given that the Clinic was generating approximately $100,000 in income from bulkbilling each year. Professor Thomas said that each session effectively cost the hospital $20,000 a year.

20. This equalisation of sessions presented a problem. The present arrangements provided for each specialist to work different amounts of time:-

a. Dr Sadanand Anavekar worked 1 session a fortnight.

b. Dr Adrianne Anderson worked 4 sessions a fortnight.

c. Professor Morgan worked 5 sessions a fortnight.

d. This made a total of 10 fully funded sessions a fortnight.

21. Further, Dr Nagesh Anavekar, son of Dr S Anavekar, worked two sessions a fortnight (on a temporary contract) and Dr Munir Bishara worked two sessions a fortnight (also on a temporary contract).

22. The temporary contracts for Doctors Bishara and Nagesh Anavekar were due to run out at the end of the current funding period and new funding was not available for them. Funding for these two doctors had come from some sessions allocated to the retiring Head, Dr Louis, as part of his professorship entitlements. This was a device which was to lapse as a result of a direction of the Hospital Board.

23. Doctors Flauman, O'Callaghan and Mashford also worked at the Clinic from time to time. Neither of these three was funded through the Clinic, so their salaries did not need to come out of the Clinic budget. Professor Flauman and O'Callaghan were full-time employees and Dr Mashford's salary was paid through a separate arrangement.

24. Thus Professor Thomas explained that in order to be able to offer one extra session a fortnight to Dr Sadanand Anavekar, and to be able to permanently appoint Doctors Nagesh Anavekar and Dr Bishara at two sessions a fortnight each, a further five fully funded sessions a fortnight were required. Being unable to fund these sessions in any other way, Thomas and Flauman said it was necessary to reduce Dr Anderson's sessions by two a fortnight and Professor Morgan's sessions by three a fortnight.

25. Professor Morgan says that the proposal to reduce his sessions and the corresponding increase in the allocation of sessions to younger specialists constitutes discrimination against him on the grounds of his age.

THE LAW

26. In order to make his claim under the *Equal Opportunity Act* 1995, Professor Morgan must show that he has been discriminated against because of his age.

27. He says he has been the subject of direct discrimination. Under section 8 of the Act, direct discrimination occurs when a person treats, or proposes to treat, someone with an attribute less favourably than someone without that attribute, in the same or similar circumstances.

28. The attribute Professor Morgan relies on is age.

29. Under section 8(2) of the Act, it is irrelevant whether the person who performs the discriminatory act is aware of the discrimination or considers the treatment less favourable.

30. It is also irrelevant whether or not the attribute was the only or dominant reason for the treatment, as long as it is a substantial reason.

31. Section 8(2) has a significant purpose. It will often be hard to prove that someone has been discriminated against because of an attribute. It will be rare indeed for the perpetrator to openly acknowledge that he or she is knowingly discriminating in an illegal manner. Further, the section acknowledges human behaviour. Perpetrators will often seek to justify discrimination on other grounds to protect themselves, or out of a mistaken belief that they are doing the right thing. This legislation is remedial. It is designed to signal to the community that outdated prejudices will not be tolerated and to facilitate the success of valid claims.

32. Not all forms of discrimination in our community are illegal. One of the prohibited forms of discrimination is discrimination in employment. Professor Morgan relies on this prohibition which is found in section 14 of the Act. His complaint under section 13 was not pursued in this hearing.

33. Most of the subsections of section 8 of the *Equal Opportunity Act* are not applicable to the Complainant. He does not say he has been discriminated against in the denial of access to any training program or opportunities for promotion, or by being dismissed. Rather he relies on section 14 sub-section (d), which provides that an employer must not discriminate against an employee by subjecting the employee to "any other detriment". He says the detriment to which he has been subjected is the reduction of his sessions in the manner proposed.

34. If Professor Morgan can prove that he has been treated less favourably than someone of a different age would have been treated in the same or similar circumstances, by the reduction of his sessions in the manner proposed, and that a substantial reason (not the only or even the dominant reason), for that less favourable treatment was his age, then he has proved his claim. This applies to whether or not the Hospital authorities consider the treatment less favourable, and irrespective of whether they recognise what they have done as discriminatory.

35. Counsel for the Complainant referred me to dictionary definitions of the word "substantial" cited with approval in the Equal Opportunity Board decision of *OyeKanmi v National Forge* (1996) EOC 92-797 at page 895. "Substantial" was there defined as *"existing and not illusory", "considerable",* and *"solid".* The Board expressed the view in *OyeKanmi* that "substantial", in the context of the Victorian *Equal Opportunity Act*, meant *"of substance or weight as opposed to of little moment, insignificant or negligible"*.

THE BURDEN AND STANDARD OF PROOF

36. Dr Morgan brings this proceeding. The onus is therefore on him to prove each of the facts on which he relies to establish his claim. The standard of proof applicable is proof on the balance of probabilities. Thus, I am required to evaluate whether it is more probable than not that the facts alleged by Professor Morgan are true.

37. Counsel for the Respondent has suggested to me that the allegations made against Professor Thomas and Professor Flauman are so grave, amounting to an allegation of laying a false trail to cover up a clear case of age discrimination, that I should be guided by the test in *Briginshaw v Briginshaw* (1938) 60 CLR 337, which requires a strenuous examination of the allegations in the light of the gravity of the matters alleged, and rejection of those allegations unless there is clear and cogent evidence to support them.

38. Counsel for the Complainant has argued that *Briginshaw* should not be applied in this case, it not being one which involves criminal conduct, fraud or moral turpitude and, in that respect, has referred me to the Federal Court decision of *Victoria v Macedonian Teachers Association of Victoria Inc* [1999] FCA 1287; (1999) 91 FCR 47 at page 50. In that case the Court declined to apply the *Briginshaw* principle, noting that the case did not involve the making of serious allegations against the Respondent.

39. In contrast, in *Department of Health v Aramugam* [1988] VicRp 42; (1988) VR 319, Fullager J made the following observation on the allegations made in that case and the consequent need for caution in drawing inferences from the evidence:-

"It is, of course, a serious allegation that two prominent and highly qualified medical men, in government positions of trust and responsibility, and engaged in the task of selecting the best man for a very important job which involved the highly skilled care and management of sick people, deliberately rejected the best man and appointed a person known to them to be a far less suitable man .... Of course, it may nevertheless happen, and, if it happens in the case of intelligent trained minds, one might expect some skilled attempt at concealment as well. But it is not lightly to be inferred."

40. I take the view that the allegations made in this case are not sufficiently grave to displace the normal civil standard of proof. It is true that if I were to find in favour of the Applicant I must necessarily reject the sworn evidence of very senior medical specialists. However, the mere rejection of a version of events without more is in my view not sufficient to attract a higher or more stringent examination. Were this so, almost every discrimination case would attract the *Briginshaw* standard. In any event, it is misleading to treat the standard of proof in a case to which *Briginshaw* applies as being some intermediate standard between the civil and criminal standards. There are not three standards of proof. What I am required to do is to evaluate the strength of the evidence, taking into account the seriousness of the allegations made, the context in which the allegations are made, and the consequences of my findings for the parties, and satisfy myself that overall it is more probable than not that the events occurred as described, and that the inferences sought to be drawn can be reasonably drawn from the facts as I find them to be.

THE COMPLAINANT'S CASE

41. As I have outlined, the restructure proposal requires that Dr Morgan will lose three sessions a fortnight. The doctors who will gain sessions will be Dr Bishara, Dr Nagesh Anavekar and Dr Sadanand Anavekar.

42. Dr Bishara is 49 years old. Dr S Anavekar is 63 years old. Dr Nagesh Anavekar is 35 years old. Thus, Professor Morgan will lose all three sessions to younger men. He says

a substantial purpose of this restructure is to ease him out of the Clinic because he is thought to be too old to occupy such a pivotal role in the Clinic. He says that the Respondents' succession planning strategy required him to be replaced with younger, less experienced specialists.

43. In his words:-

"I think it was done to get me to leave. They wanted to get rid of me and thought I would roll over easily."

44. Critical to the Complainant's case is his analysis of two meetings between himself, Professor Thomas and Professor Flauman at which the proposed reduction of his sessions took place. These meetings took place on 1st and 26th September 2006.

45. Professor Morgan says the only reason advanced to him at those meetings for the reduction of his sessions was succession planning. No mention was made of the number of sessions to be reduced. No mention was made of Dr Anderson's sessions being reduced. No mention was made of a complete restructure of the Clinics in the manner I have previously outlined.

46. The Complainant urged me to find that the other reasons advanced by the Respondent in this proceeding were not formulated until after Dr Morgan notified the hospital of his intention to complain of age discrimination during the course of the meeting on 27 September 2006. In effect I am asked to find that they were only emphasised in this proceeding to rebut this claim of age discrimination. As I understand it, Dr Morgan does not go so far as to say they were falsely manufactured as reasons, but that they were peripheral reasons, not displacing the substantial reason of age discrimination.

WHY DOES THE RESPONDENT SAY THE DECISION WAS MADE?

47. In the letter to the Complainant dated 28 September 2006, the defence filed in this proceeding, and the evidence given in this hearing, the Respondent said that the reasons for the restructure of sessions were broadly as follows; to enhance service delivery, to advance research through the Clinic, to maximise research funding opportunities, to give greater spread and depth to the skills of the Unit, and to carry out succession planning.

48. In combination with the merger of the two Clinics, the Respondents' witnesses said the restructure would allow consolidation of existing resources at the one site and improved economies of scale. It was said that there were problems inherent in any one specialist having a large complement of sessions. If he was away ill, or on conferences or on holidays, many patients could not be seen. It was not best practice to require patients to see alternative specialists. Further, there would be a significant hole in the finances of the Clinic if he was to be absent for a period, given that with five sessions a fortnight he saw a large percentage of the patients. Richardson spoke of the need for a consistent spread all year round, without interruption or delay for patients. This would improve the capacity of the Clinic to manage "peaks and troughs" which occurred where there was less patient activity when a doctor was absent.

49. It was also suggested that there was a need to improve the booking system for patients and rationalise nurse time – there was a mismatch of hours at the Repatriation Clinic, with Dr Morgan starting at 7.30am, but staff not rostered on until 9am.
50. Professor Thomas gave evidence that he wishes the Clinic to become the focus of research and believes this to be fundamental to the success of the Hospital's strategic plan. I heard a great deal of evidence as to the publication of papers by Professor Morgan. I heard a great deal of evidence as to the capacity of other sessional specialists in the Unit to undertake high quality research. However, in the end there was very little difference between the parties as to the research history of the Clinic. The Respondent agreed that the Complainant was a highly regarded and very prominent researcher.
51. Professor Morgan thought the personnel to whom increased sessions were given would be unlikely to advance research, and that in fact the ability of the Unit to do research and thus maximise research funding opportunities would be compromised by reducing his sessions and thus his profile in the Unit. But the Complainant's counsel announced in submissions that she had been instructed that Professor Morgan wished to make it clear that in giving that evidence, he did not want to cast any doubt on the professional capacity of his fellow sessional specialists.
52. The real issue about the evidence of research is that the Complainant suggests that, given he has been the mainstay of research in the past, the new arrangement will not promote research by reducing his involvement with the Clinic. This makes it unlikely that the enhancement of research capability of the Unit is a significant reason for the restructure.
53. The market for research funding was said to be highly competitive. Funding was available from external funding bodies or from drug companies, but would only be given to Units who could demonstrate expertise and breadth of experience. Funding was relied on to enhance the reputation of the Hospital and keep quality specialists in a market where there was said to be a labour shortage of good quality specialists. Professor Morgan gave evidence of his capacity to attract research funding. The Respondents' witnesses acknowledged his contribution, but pointed out that the projects for which he had attracted major funding were not attracted in the name of the Hospital. The Respondents' witnesses gave evidence that they wished to accelerate funding opportunities in the name of the Clinic to increase the prestige of the hospital, to cement the standing of the Clinic as a leader in hypertension research, and to maximise opportunities for all professional staff, not just Professor Morgan.
54. Many of the goals I have described above were uncontroversial, although Professor Morgan disputed whether the proposed restructure would be effective to achieve their goals.
55. However, apart from the issue of succession planning, the reasons offered by the Respondent were not strongly criticized. It is true that the Complainant has criticised many of these reasons as failing to achieve their stated object. But, in her final submissions, counsel for the Complainant did not argue that these reasons were not valid. She said they were not the full explanation as to why his sessions were reduced. She submitted that a substantial reason for the restructure was succession planning, in the sense of arrangements to reduce his involvement in the Unit and encouraging younger specialists to take over his expertise. She says the other reasons offered are peripheral to this goal.

56. Thus, I will focus on succession planning at some length.

57. However, before doing so, I will indicate my findings in relation to the evidence of reduction of the sessions of Dr Anderson. The treatment of her sessions is a major obstacle to the definition of succession planning as Professor Morgan defines it.

58. Dr Anderson, as I have outlined, worked four sessions a fortnight. Under the plan proffered by the Respondent, her sessions were also to be cut to two.

59. Professor Morgan's case was that the Respondent had originally not intended to cut her sessions at all. This was consistent with the focus of the Respondent being on removing him from the Unit, not on dividing up the work of the Unit into three different Clinics with equal attendance of Specialists in each Clinic. It was also consistent with his view of the conversations which he described with Professors Thomas and Flauman which he said made it clear that his sessions were to be cut. It is inconsistent with the Respondents' position that the Complainant was just one of a number of sessional specialists whose sessional hours had to be altered to fit in with the restructure.

60. In support of his position, the Complaint tendered a letter sent from the Respondent to Dr Anderson, sent after the discussion with himself and Professor Thomas. This letter confirmed that Dr Anderson was to be re-employed on the same basis as the previous year. The Complainant says this letter is important as it shows that the Respondent did not intend to reduce the hours of anyone but himself. The restructure into equal work Units was therefore only devised at some time after he was spoken to, and had protested about, the reduction in his sessions. In further support of this proposition, the Complainant points to the description of the allocation of sessions on the Employee Impact Statement handed to him. It lists Dr Morgan as having no change of sessions.

61. The discrepancy in the Employee Impact Statement can in my view be easily understood as an oversight on the part of its author, who prepared the document directed to Dr Morgan, not Dr Anderson. Its description of her four sessions is plainly inconsistent with the statement in the body of the letter that:-

"In line with the above objectives, over the medium term, the aim is to have all VMO's in the hypertension Clinics on 2 sessions a fortnight. To this end, over the coming weeks, discussions will be held with all specialists in the unit about how these objectives can be reached in a satisfactory manner."

62. The reference in the document to Dr Anderson's four sessions a fortnight in my view simply reflects the fact that she had not yet been spoken to about reducing her sessions, or that a mistake has been made, as I have earlier suggested.

63. The letter sent to Dr Anderson on which the Complainant relies is simply a proforma letter. It does not refer to the amount of her sessions at all, simply confirming that she is to continue at her present rate. It was sent by the Hospital's administrative staff. The Respondents' Human Resources Officer, Mr Richardson, gave evidence that such letters were automatically posted to continuing sessional staff. Professor Thomas gave evidence that he was intending to raise these matters with Dr Anderson at the time. He said he had done so before the proforma letter was sent. Whether it was before or after, those discussions have now taken place and have resulted in the reduction of Dr Anderson's sessions to two a week.

64. Dr Anderson was not called as a witness by either party to this dispute. I do not know what discussions she had with the Respondent about the reduction of her hours. All that I have been told is that she has agreed to the reduction. Had there been any significance in the correspondence to her or the failure to reflect her reduced sessions in the Employee Impact Statement, I would have expected the Complainant to call her to give evidence. In my view no inference can be drawn from this correspondence that the original proposal left Dr Anderson's sessions untouched and affected only Professor Morgan.

SUCCESSION PLANNING

65. Dr Morgan was given an Employee Impact Statement on 2 October 2006. This document was prepared by Professor Thomas with the assistance of Richardson. It was brought into being specifically because Morgan had complained about the proposed loss of his sessions. The Employee Impact Statement refers to the Austin having a "major succession planning problem" particularly regarding senior medical staff. It indicates that senior medical staff and Unit Heads have been asked to develop succession plans to "ensure adequate skills and experience to cover the departure of their aging medical staff".

66. Succession planning is also a feature of the Respondents' 2005-2006 strategic plan. This plan refers to succession planning in the following terms:-

"Over the coming four years **Austin Health** will address a number of key issues facing the organisation in relation to our workforce. The aging population will result in a rise in the average age of our workforce. ... An older workforce brings with it a number of considerations to ensure that they are able to work safely and these will need to be addressed over the next four years. More particularly, an aging workforce presents important issues of succession planning to ensure that we have a sufficient number of well qualified and experienced Clinicians to meet the ever increasing demand on our services. ... The average age of our Clinical staff will also increase and we will need to develop plans to assist them manage their patient load whilst ensuring we retain and transfer their experience, skills and knowledge to a new generation of Clinicians ...

Therefore a focus over the next four years will be to develop and implement an organisation wide succession planning program for key staff. Such a program will address a key risk to the organisation and ensure that all key positions in both the Clinical and administrative areas have identified and trained staff to provide backup or act as replacements."

67. Professor Thomas himself places emphasis on the need for succession planning in his witness statement. He says:-

"We were keen to follow the Austin policy of succession planning in order to expose the new VMO's to the hypertension service and Clinical trials unit."

68. The Complainant says that Flauman and Thomas have identified him as an aging member of staff who needs to be replaced, and are carrying out the principles in the

Strategic Plan, reinforced in the Employee Impact Statement, and further reinforced in discussions with him.

69. Morgan gave evidence that there had been discussion between himself and Flauman in early 2006 when he had said he was thinking of cutting back his sessions. A further "passing" conversation took place in July/August 2006 between himself and Flauman, in which Flauman asked when he would be cutting back his sessions, and Morgan replied that he might be thinking of doing so at the end of the year. He suggests that these two conversations triggered Flauman's consideration as to how best to replace him, and ultimately led to the restructure proposals which I have outlined above.

70. He says this suggestion is reinforced by the reference in the September meeting to his retrenchment entitlements and reference to his possible resignation.

71. He is adamant that no other reason was advanced to him. Although Professor Thomas denied at the later meeting that the reduction was based on age, Dr Morgan says this is the obvious reason. He was the person who was central to the functioning of the Unit and he was aged 71. He says it is clear that, by reducing his sessions, the Hospital was trying to position itself to take over his expertise by effectively forcing him to retire.

72. The Respondent accepted that, in part, the decision to restructure the Hypertension Unit was based upon principles of succession planning. The Respondent says this is a positive thing, both for the Unit and for Professor Morgan, and not a pseudonym for age discrimination.

73. The Respondent says that succession planning is essential to any large organisation and simply recognises that employees may leave, and that the organisation must take measures to protect the Hospital from departure of its key staff.

74. Professor Thomas referred in his witness statement to the fact that Dr Morgan had 36% of the sessions in hypertension. He said this would leave the Clinic *"very exposed"* if Morgan left for any reason. He noted it would not be easy to find a replacement, as the Austin is the only Hospital in Australia with a Hypertension Unit.

75. Richardson described the process of succession planning to be:-

"identifying and preparing suitable employees through mentoring, training and job rotation to replace key players who leave an organisation for a variety of reasons."

76. The Respondent asks me to find that succession planning is not equivalent with age discrimination, and is not even primarily concerned with the age of its workforce, but with the need to ensure continuity of standards and expertise in the event of the unexpected departure from its workforce of key individuals for any of a number of reasons.

THE EVIDENCE OF THE RESPONDENT

77. The evidence of Doctors Thomas and Flauman painted a very credible picture of the need for reorganisation of the Hypertension Unit.

78. The proposal dovetails with the establishment of a separate Clinical Trials Unit at the Hospital. Professor Flauman is the Department of Clinical Pharmacology. He gave evidence that the aim of the Clinical Trials Unit would be to oversee and attract funding for clinical trials, importantly in the area of drug interaction. Professor Thomas gave

evidence that he envisaged that the main purpose of the Clinic would be to run clinical trials.

79. The evidence given by both these men was consistent with their focus, being the achievement of those aims.

80. Professor Flauman gave evidence that he wished the Clinic to develop a *"greater Clinical mass with common interests, to improve interaction and Clinical care".* He wanted to create an environment where more interaction between specialists would generate better ideas.

81. He said the main reason for the restructure was to improve service and distribute the workload more evenly, so the Unit was not contingent on one person having most of the sessions.

82. Professor Thomas said that he regarded succession planning as very important. He wanted to *"upskill"* all members of the Unit so that it would not fold if the main players resigned or retired.

83. He said he regarded the patients in the Unit as the *"core"* and that the main role of the Clinic in its rejuvenated role would be to allow Clinical trials to take place on those patients.

WAS PROFESSOR MORGAN'S AGE A SUBSTANTIAL REASON FOR THE RESTRUCTURE?

84. Although counsel for Morgan downplayed the extent of disagreement between the parties in her final submissions, the Complainant's case was run on the basis that the reasons given by the Hospital in the letter of 26 September are an afterthought, and not the real reasons for the reduction of his sessions. The Respondents' witnesses were cross-examined from the premise that those reasons were advanced to disguise the real reason for the restructure – which is to effectively remove him from the Unit because of his age.

85. The Complainant appears to me to rely on four propositions:-

Firstly, he says there was no mention of any other reason than "succession planning" in his contact with the hospital when the reduction of his hours was first discussed. The other supposed reasons have assumed a later prominence that was not present at the time;

Secondly, he says that succession planning can have only one meaning in the context of the Hypertension Unit – it means planning to hand over his expertise and sessional hours to younger specialists;

Thirdly, he says there was no discussion with Dr Anderson about reducing her hours until after he had made a claim of discrimination – and in fact her current four sessions were confirmed after he had been spoken to about reducing his sessions;

And **finally,** he says that the other reasons advanced by the hospital can be examined and shown to be unlikely reasons for the restructure.

86. The Complainant points to the lack of any more positive examples of succession planning, such as arrangements for mentoring, or grooming of a successor to Dr Morgan.

Nothing is offered, save for the appointment of younger staff. Indeed the proposed arrangement will give him little contact with other sessional specialists, reducing his days at the Unit substantially. He will only be at the Unit once a week under the proposed changes. He says he was not consulted at all about the proposed change. He suggests it is unlikely that the real reason for the change would be to achieve the maximising of research, or broadening of expertise. If this had been the reason, he would have been consulted so that his vast expertise could be utilised. In the proposed system he will have very little contact with the younger doctors. Thus there will be no chance of securing the breadth and depth referred to.

87. The Complainant's counsel suggested that any other reason for the reduction of sessions simply does not add up. Professor Morgan says two sessions a fortnight is inadequate to allow him to maintain his skills, and he does not believe other members of the Unit can acquire new skills in that time, particularly without the chance of interaction with him.

88. He says that the suggestion that research will be enhanced cannot be accurate. Dr Morgan is the person in the Unit with the research credentials. I was invited to find that the other specialists were inappropriately trained for research or at too junior a level. It was suggested that it makes no sense to push aside the leading researcher in the field, except if it was done to make way for younger staff.

89. I was invited to find that the Repatriation Clinic was functioning well before the change, and there was no operational reason for the change, apart from Dr Morgan's advancing age.

90. Finally, Complainant's counsel urged me to see the merger of the Clinics as quite a separate issue from the reduction of Dr Morgan's sessions. The sensible reasons for the merger were supported by Professor Morgan. Any financial or administrative difficulties which might have required the Clinic to justify its existence to the Hospital Board could be addressed through the merger. They did not require the reduction of Professor Morgan's sessions.

91. I do not accept that only succession planning was discussed at the meeting on 1 September. I accept that Professor Thomas took accurate notes of the issues discussed at the meeting. Those notes refer to a wide-ranging discussion. I think it is likely that Professor Morgan does not recall the meeting precisely, and his recall is coloured by his attitude to later events, and his alarm at being told that his own sessions would be reduced.

92. I do not accept that the references to retrenchment or resignation, or the production of the Employee Impact Statement lead to a conclusion that the Hospital had determined, in advance, to force Dr Morgan out of the Clinic. I accept, on the contrary, that the hospital was obliged, under its industrial award, to provide these documents to sessional specialists facing the alteration or decrease of sessional entitlements.

93. Further, I do not accept that the Respondent approached the issue of succession planning with age discrimination in mind. Professor Morgan conceded that it was appropriate for the Hospital to be concerned with succession planning. His counsel submitted to me that it was the responsibility of the Respondent to devise succession planning procedures which were not discriminatory. This is of course true. But just because the Respondent was concerned about the prospect of passing on the expertise of the Complainant to other sessional specialists in the Unit, it does not follow that the

acknowledgment of that concern proves that the Respondent was actuated by impermissible age discrimination in formulating its restructure plan.

94. Notwithstanding the force of the Respondents' case as to the benefits of the restructure, the Complainant may still succeed if he were to demonstrate that it is more probable than not that, as well as being influenced by these benefits, another substantial reason for the reduction of his sessions was his age. I have emphasised previously that Professor Morgan does not have to prove that his age was the only reason, or even the dominant reason, for the reduction of his sessions. He will make out his case if he can show it is a substantial reason – a reason of weight as a opposed to something of little moment or of negligible importance.

95. I am, however, positively satisfied that in this case the proposal was put forward for the reasons advanced, and not through any desire at all to discriminate on the basis of age. In this workplace, there were many older workers. Dr Mashford is 77. Professor Thomas is 62. Dr Anderson is over 60. In my view, it is unlikely in this context for the move to have been age based. It is not as if Professor Morgan was To be replaced by very young people. Dr Bishara is 49. The only specialist who could be described as youthful is Dr Nagesh Anavekar who is 35.

96. This is not a workplace in which older workers appear to have been discouraged in any way. There is not one incident relied upon to show attitudes of intolerance to older workers. There has been no overt or covert suggestion to Professor Morgan that he is viewed any differently to any other employee because of his age.

97. But further, the restructure proposal did not contemplate Professor Morgan retiring. He was to head up one of the Clinics, with Professor Flauman and Dr Anderson each heading up the other two. The retention of Professor Morgan was central to the plans for reorganisation. All of the Respondent witnesses spoke highly of Professor Morgan. Professor Flauman described him as "highly regarded" and a "key participant". The fact that the Hospital rejected Professor Morgan's offer to retire over a staged period is further indication that the point of the reorganisation was not to get rid of him – it was to fundamentally restructure the Clinic.

98. The Respondent in fact offered Professor Morgan a renewal of his contract for a further five years, with the contract expiring in 2011, when he will be 76 years old. The Respondent has also extended Dr Anderson's contract for the same period.

THE COMPARATOR

99. Even if Professor Morgan can prove that the Respondent has been motivated by age discrimination in reducing his sessions, he will not prove his case unless he also is able to show that he has been treated less favourably than the Respondent would have treated someone without the attribute of age, in the same or similar circumstances.

100. So, the question is, did Professor Morgan receive less favourable treatment than a comparable employee in the same or similar circumstances to him?

101. The Complainant acknowledges that the present plan is for all specialists in the Hypertension Unit to be allocated an equal number of sessions. Dr Morgan's treatment is therefore not, on its face, less favourable than treatment of other sessional specialists in the Clinic.

102. The identification of the appropriate comparator is vitally important in this case.

103. The most recent discussion of the appropriate comparator can be found in the High Court in *Purvis v NSW* (2003) CLR at page 92. At page 161 of the report the following appears:-

"Once the circumstances of the treatment or intended treatment have been identified, a comparison must be made with the treatment that would have been given to a person without the disability in circumstances that were the same or not materially different."

104. The Complainant says that all the other specialists whose sessions were reduced had other general sessions within the Hospital, whereas he had none. Thus, the effect on him of losing three sessions per week will be more severe than the effect on anyone else. He says that the comparator should be someone in identical circumstances to the Complainant; that is, a sessional specialist in the Hypertension Unit who has been allocated five sessions a fortnight in the Hypertension Unit and who has no other sessional allocation at the Hospital, and who is younger than the Complainant. The less favourable treatment is therefore either the reduction in his sessions in the Hypertension Unit, or being allocated less sessions overall than the other specialists employed by the Respondent.

105. In my view, this is an inappropriate comparison. I am not in a position to evaluate the relative income sources of each sessional specialist employed by the Hospital in the Hypertension Unit. Each sessional specialist, of whatever discipline, simply sells a portion of his or her time to the hospital. There is no entitlement of any specialist to a minimum number of overall sessions at the Hospital, so as to guarantee him or her a minimum income. Some specialists may work in other specialities at this Hospital. Others may work in other Hospitals. Some may have private practices. Some may have teaching positions at universities. It is not appropriate for me to examine the earning characteristics of each sessional specialist to decide whether or not they have other employment opportunities or other sessions available to them in different specialities.

106. In my view, the appropriate comparator is a sessional specialist allocated five sessions a fortnight in the Hypertension Unit, of younger age, without regard to whether or not such a person has other sessions at the Hospital, or other sources of income.

CONCLUSION

107. I accept that the Hypertension Clinic was under threat of closure. The manner of dealing with that threat is a matter for the professional expertise of the doctors having overall operational responsibility for the Unit. It is not my task to decide whether or not they should have made a better decision. It may well be that the plan of splitting the Unit into three standalone treatment and research Clinics is fatally flawed. It may be that the standing of the Unit will plummet without the substantial input of Dr Morgan. It may be that none of the newer staff have the capacity to undertake research or manage the patients.

108. It is not my task to decide whether or not Professor Morgan's concerns about whether the proposed restructure will harm or advance the Clinic's reputation and service delivery are well founded. Professor Thomas does not share those concerns. But, even if the effect of the changes was to diminish standards of care for patients at the Clinic, this

would not prove discrimination. Responsibility for the maintenance of those standards rests with Professor Flauman and Professor Thomas. If they have recruited, promoted or demoted the wrong people, that is a matter for them, not for me. I am only concerned if they do so in a discriminatory manner.

109. Both Professor Thomas and Professor Flauman gave evidence that their decision to reduce Professor Morgan's sessions would have been the same whatever his age. In my view, their evidence was credible and supported by the evidence I have heard. I accept their evidence.

110. Further, I have found that the appropriate comparator is a sessional specialist having five sessions a fortnight at the Hospital of younger age. Using this comparator, no less favourable treatment to the Complainant has occurred. All specialists, regardless of age, have been allocated equal sessions.

111. Accordingly, I find that the Complainant has not made out his claim of age discrimination. The complaint is accordingly dismissed.

HER HONOUR JUDGE HARBISON
VICE PRESIDENT
