BUTLER v FOURTH MEDICAL SERVICES REVIEW TRIBUNAL and ANOTHER

FEDERAL COURT OF AUSTRALIA — GENERAL DIVISION

NORTH J

16, 19, 20 May, 15 August 1997 — Melbourne

Health — Health professionals — Medical practitioners — Excessive services — Appeal from Medical Services Review Tribunal — Whether it was necessary to find that the medical practitioner knew or was recklessly unconcerned whether the services were reasonably necessary — Whether onus of proof applied to tribunal proceedings — Whether minister estopped from making determination — (CTH) Health Insurance Act 1973 ss 79(1B), 105, 106AA, 106AB, 124A, 129.

On 10 June 1993 a delegate of the second respondent, the minister, made a reference to a Medical Services Committee of Inquiry (the committee) under s 82 of the Health Insurance Act 1973 (Cth) (the Act) with respect to services provided by the applicant a general practitioner, between 1 April 1992 and 31 March 1993. On 21 March 1994 the committee reported to the minister that it was satisfied that the applicant had rendered excessive services to five patients, and disallowed 255 services entirely and reduced Medicare allowances in respect of 82 services. The committee recommended that the applicant repay a total of $11,005.05 to the Commonwealth, and that he be counselled. On 21 June 1994 the minister made a determination under s 106 of the Act in accordance with that recommendation. On 11 July 1994 the applicant requested the minister to refer the determination to a Medical Services Review Tribunal (the tribunal) for review. The first respondent heard submissions and gave its decision on 25 June 1996, varying the determination by reducing the amount repayable from $11,005.05 to $10,701.80 but otherwise affirming the determination. The applicant appealed to the court under s 124A of the Act. The only issue before the tribunal was whether the services rendered to the five patients were reasonably necessary for the adequate medical care of those patients. The issues of law raised on the appeal were whether it was necessary for the tribunal to find that the applicant knew the services he rendered were not reasonably necessary, or was recklessly unconcerned whether the services rendered were reasonably necessary or not, before the tribunal could find that the applicant had rendered excessive services; whether the minister had to prove that the services rendered were not reasonably necessary for the adequate medical care of the five patients; and whether the minister was estopped from making a determination that the applicant had rendered excessive services as a consequence of a meeting in May 1989 between the applicant and a medical adviser to the health commission.

Held:

(i) The question whether a practitioner had rendered excessive services was an objective question. A practitioner could be found to have rendered excessive services even if the practitioner believed that the services were reasonably necessary, and the statutory provisions did not require that the practitioner intended to render excessive services. Where the practitioner dealt directly with the patient the practitioner had knowledge to determine whether a service was reasonably necessary.

> *Tiong v Minister for Community Services and Health* (1990) 20 ALD 544; 93 ALR 308; *Minister for Health v Peverill* (1991) 29 FCR 262; 100 ALR 73; *Peverill v Backstrom* (1994) 54 FCR 410; 38 ALD 14, applied.

(ii) The legislative provisions dealing with excessive services had a dual function. They were concerned with ensuring that the public purse funded no more than a reasonable level of medical services, and they were also concerned with disciplining medical practitioners who rendered excessive services. The provisions which had a disciplinary function supported the function of ensuring that public moneys were spent on a level of services assessed by medical peers to be

reasonable. The objective standard and the nature of the processes established by the Act indicated a clear intention on the part of parliament that a practitioner would render excessive services if the services, on an objective assessment, were not reasonably necessary, even if the practitioner believed that those services were reasonably necessary.

R v O'Connor (1980) 146 CLR 64; *Coco v R* (1994) 179 CLR 427; 120 ALR 415, referred to.

(iii) The weight of authority was against describing the process before administrative tribunals in terms of onus of proof, and the term did not apply readily where there was no adversarial contents. In the proceedings before the committee or tribunal the statute defined the issue to be determined and the committee or tribunal might determine the issue when it achieved a state of positive satisfaction on the issue. The tribunal had required that it be positively persuaded that the services rendered were not reasonably necessary and that was the proper approach.

Minister for Health v Thomson (1985) 8 FCR 213; 60 ALR 701, considered.

McDonald v Director-General of Social Security (1984) 1 FCR 354; 6 ALD 6, applied.

(iv) In the present case there was no difference in outcome if that approach was used or if the traditional onus of proof approach was used.

Taylor v Minister for Health (1989) 23 FCR 53; 90 ALR 166, applied.

(v) Nothing in the tribunal's decision indicated that it failed to have regard to the serious consequences of a determination against the applicant, and its careful and extensive review of the evidence demonstrated attention to the detail of the allegations made against the applicant concerning each patient.

(vi) In the relevant period between 1 April 1991 and 31 March 1993 the applicant was on notice that the health commission was not acting on any previous view expressed in the 1989 meeting. Apart from the lack of a factual basis for the alleged estoppel the argument failed in law, since the alleged estoppel would, if accepted, prevent the minister from exercising the discretion to make a determination under s 106 of the Act.

Minister for Immigration v Polat (1995) 57 FCR 98; 37 ALD 394, applied.

(vii) Appeal dismissed with costs.

J Selimi instructed by *Jack Cohen Serry & Co* for the applicant.

R Downing instructed by the *Australian Government Solicitor* for the respondent.

North J. This is an appeal from a decision of the first respondent, Fourth Medical Services Review Tribunal (the tribunal), which, save in a small degree, affirmed a determination of the Minister for Human Services and Health, the then title of the second respondent, (the minister), that the applicant, Dr Butler, a general practitioner, rendered excessive services to five patients.

Section 82 of the Health Insurance Act 1973 (Cth) (the Act) requires a Medical Services Committee of Inquiry (the committee) to inquire into and report on a matter referred to it by the minister. On 10 June 1993, a delegate of the minister made a reference in the following terms:

> As Delegate of the Minister of State for Health and pursuant to s 82 of the Health Insurance Act 1973, I, John Peter Nearhos, General Manager, Professional Review Division, Health Insurance Commission, *hereby refer* to the Medical Services Committee of Inquiry for the State of Victoria for inquiry into and submission of a report and recommendations to the Minister of State for Health on matters relevant to the operation or administration of the said Act and which arise out of the rendering of professional services in the State of Victoria after 15 April 1977,

namely, whether any professional service rendered to a patient by Bernard Stewart Butler, medical practitioner, particulars of which are set out in Annexure marked "B", patients numbered 1 to 16, being a service for which Medicare benefit has been paid, was an excessive service within the meaning of s 79(1B), of the said Act.

Section 79(1B) defined "excessive services" as:

. . . services in respect of which medicare benefit has become or may become payable and which were not reasonably necessary for the adequate medical or dental care of the patient concerned.

The reference was apparently initiated because data compiled in respect of the payment of Medicare benefits showed that Dr Butler's practice was in the 99th percentile range of average costs and services per patient for general practitioners in Victoria for the period 1 April 1992 to 31 March 1993. The average was 2.84 services per patient, costing $59.50. Dr Butler's average was 8.19 services, costing $258.10. The reference related to 16 patients. Medicare benefits totalling $41,798.55 were paid in the relevant period for services rendered by Dr Butler to those patients. The committee conducted hearings into the matter and, on 21 March 1994, reported its opinion to the minister under s 104(a) of the Act. The patients under consideration by the committee fell into two categories — patients to whom Dr Butler rendered psychotherapy services and patients to whom he rendered medical services. As to the former category, the committee was satisfied that Dr Butler had not rendered excessive services. The latter category involved five patients. The committee reported its opinion that 337 services rendered to these five patients were excessive services. It disallowed 255 services entirely, and recommended that $9,708.85 Medicare payments be repaid by Dr Butler to the Commonwealth in respect of these services. It reduced the allowance in respect of 82 services and recommended that $1296.20 Medicare payments be repaid by Dr Butler to the Commonwealth in respect of these services. It therefore recommended, under s 105(2)(f) of the Act, that Dr Butler repay a total of $11,005.05 to the Commonwealth. It also recommended, under s 105(2)(ca), that Dr Butler be counselled in accordance with the views expressed in the report concerning a certain lack of medical knowledge and the inappropriate level of servicing patients.

Section 106(1) of the Act provided that, where a committee made a recommendation under s 105(2), the minister may make a determination in writing in accordance with that recommendation. On 21 June 1994, the minister made a determination under s 106, as follows:

Now therefore, in accordance with the said committee's recommendations, I, Dr Carmen Lawrence, Minister for Human Services and Health, hereby determine that Dr Butler rendered excessive services because of the many prolonged home visits and surgery consultations rendered by Dr Butler.

(i) under paragraph 105(2)(ca) of the Act, the said Dr Bernard Stewart Butler be counselled on the use of Medicare benefits; and

(ii) under paragraph 105(2)(f) of the Act, the amount of Medicare benefits . . . of $11,005.05 in total, herein be payable by the said Dr Butler to the Commonwealth of Australia.

On 11 July 1994, Dr Butler requested the minister to refer the determination to the tribunal for review, in accordance with s 107A(1)(a). The tribunal heard submissions on 28 February 1995 and gave its decision on 25 June 1996. It varied the determination by reducing the amount repayable from $11,005.05 to $10,701.80, but otherwise affirmed the determination. Dr Butler then instituted an appeal to this court under s 124A of the Act, which allows a party to a proceeding before the tribunal to appeal on a question of law only.

The need for a guilty mind

The only issue before the tribunal was whether the services rendered by Dr Butler to the five patients were reasonably necessary for the adequate medical care of those patients. The first question of law on the appeal is whether it was necessary for the tribunal to find that Dr Butler knew that the services he rendered were not reasonably necessary, or was recklessly unconcerned whether the services rendered were reasonably necessary or not, before the tribunal could find that Dr Butler had rendered excessive services.

In considering this question, the approach taken by the tribunal can be illustrated by outlining the tribunal's reasoning in relation to one patient. The patient referred to as patient 13 was a woman aged 76 suffering from "ischaemic heart disease with a history of myocardical [sic] infarction, hypertension, congestive cardiac failure, osteoporosis, vertebro-basilar insufficiency and falls resulting in fractures, advanced osteoarthritis with right total knee replacement and involvement of the cervical spine, peptic ulcers, left deep venous thrombosis, visual acuity change". Dr Butler visited her at home, which was next door to his surgery, three times per week — a total of 138 visits in the relevant period. No clinical notes were in evidence. Dr Butler's oral evidence before the committee was that his main purpose on these visits was to mobilise the patient to prevent further vein thrombosis, pressure sores, loss of mobility and possible falls. The patient prepared her own meals and tended to her own ablutions. She used a walking frame. Her daughter and a neighbour visited regularly. The tribunal found that the patient's medical conditions required periodic assessment. It said:

> Given that during the reference period the patient's clinical status was stable and that there were no exacerbations of her multiple conditions, to which the services in question relate, periodic reviews once every two weeks would have been adequate.

On the question of the need to mobilise the patient, the tribunal said:

> In determining this issue a great deal of weight must be given to the applicant's view of the patient's needs on this aspect. He was responsible for her care and knew the situation in more intimate detail than is represented in the evidence before us. It is an important issue because it affects both the frequency and the duration of the services under review. The evidence shows that the patient would mobilise provided someone else was present and that she was otherwise active in caring for some of her own needs. In such circumstances, particularly the latter, the tribunal finds that the applicant's supervision of the patient while walking in her house was not an activity that was reasonably necessary for the patient's adequate medical care. She was not otherwise totally inactive and in any event there were other persons who could have been engaged to supervise this type of activity. In addition, given her alert intellect, her activities in capably preparing her own meals and in ensuring her personal hygiene, together with her wish to remain in her own home, the tribunal finds that the patient would more probably than not act upon medical advice and take whatever steps that were necessary, and of which she was capable, to ensure that her health did not fail. Thus the tribunal does not accept, and does not find, that the patient would remain inactive at times when the applicant was not present. Therefore this aspect of the services was not reasonably necessary for the patient's adequate medical care.

The tribunal then determined that the 24 services which were justified only required a standard duration rather than a long visit as had been charged.

Thus, the process followed by the tribunal was to review the evidence before the committee and apply the medical expertise of the two medically qualified members of the tribunal to the facts. In that process, it took account of Dr Butler's view of the patients' needs. The tribunal did not determine whether Dr Butler genuinely believed that the services rendered were reasonably necessary for the adequate care of the patients. It is implicit in the tribunal's reasoning that a finding that Dr Butler believed that the services were reasonably necessary for the adequate care of the patients would not have prevented the finding that the services rendered were not reasonably necessary within the meaning

of s 79(1B) of the Act if the members of the tribunal formed the view that the services were not reasonably necessary. Put another way, the tribunal acted on the basis that a practitioner can render excessive services without a guilty mind.

Three full court decisions have considered what is involved in the provision of excessive services by practitioners. Each case involved the provision of services by a specialist. The question was whether a specialist who acted upon the request of a referring practitioner could ever render services which were not reasonably necessary. It was contended on behalf of the specialists that, if a specialist had no knowledge of the circumstances of the patient and relied on the request of the referring practitioner, the specialist could never render services which were not reasonably necessary. However, the reasoning in these decisions must be considered for the purposes of this case, and so will be set out at some length.

In *Tiong v Minister for Community Services & Health* (1990) 20 ALD 544; 93 ALR 308, the tribunal had found that an ear, nose and throat specialist had rendered excessive services. The ear, nose and throat specialist had ordered radiology services from a radiologist. The tribunal had found that the radiologist had rendered excessive services on the basis that the referring practitioner had ordered services which were excessive on the information available to the referring practitioner. The full court held that the radiologist had not been shown to have rendered excessive services. Davies J said, at ALD 548; ALR 315:

> However, the issue before both the committee and the review tribunal was whether professional services performed by Dr S J were excessive, that is to say, not reasonably necessary for the adequate medical care of the patient concerned. Medical services are not excessive for the purpose of the Health Insurance Act 1973 (Cth) (the Act) unless they constitute unnecessary servicing by the medical practitioner at the expense of the health system. The terms of s 105 of the Act, which refer to a reprimand, to counselling and to a decision that the practitioner repay certain fees received, necessarily imply a disciplinary proceeding. They require personal fault on the part of the practitioner. This issue must be examined having regard to the facts which were known or available to the practitioner and must take into account the practitioner's perception of the patient's condition and the care required. Regard should also be had to acceptable practice in the medical profession.
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> The words "reasonably necessary" in the definition of "excessive services" refer to services which are reasonably appropriate: see per Higgins J in *Commonwealth and Postmaster-General v Progress Advertising and Press Agency Co Pty Ltd* (1910) 10 CLR 457 at 469 and per Latham CJ, Rich, Dixon, McTiernan and Webb JJ in *Ronpibon Tin (NL) and Tongkah Compound (NL) v FCT* (1949) 78 CLR 47 at 56. Thus, if a practitioner rendered services which, in his view, were not reasonably appropriate for the adequate medical care of the patient, but did so, eg for the purpose of enhancing his own income, the services rendered would not be reasonably necessary for the care of the patient. On the other hand, if the practitioner performed a service which, in his view, was appropriate for the adequate care of the patient concerned, his belief would be relevant as to whether the service was not reasonably necessary but it would not determine the matter. The committee, the minister and the review tribunal each have the function of making up its or his own mind on the issue as to whether the service was reasonably necessary.

Spender J said, at ALD 551; ALR 318:

> Section 105(2) of the Act permits a medical services committee of inquiry, on expressing an opinion that a practitioner has rendered excessive services and after identifying those services in respect of which a Medicare benefit is payable or has been paid, to make one or more recommendations that the practitioner be reprimanded, be counselled, that the Medicare benefit payable cease to be payable or, where the Medicare benefit has been paid to the practitioner or has been paid or is payable to another person, the amount of the Medicare benefit or a specified part of that amount be payable by the practitioner to the Commonwealth. It seems to me inherent in this provision that personal fault on the part of the practitioner is necessary.

Burchett J said, at ALD 552; ALR 320–21:

> I agree with Davies J that the conclusion of the review tribunal in respect of Dr S J Tiong was vitiated by an error of law. That conclusion embraced the proposition that a radiologist, acting upon an apparently normal request for radiology services on behalf of a patient, would be guilty of providing "excessive services" within the meaning of s 79(1B) of the Act if the ear, nose and throat specialist, who requested the provision of the service to enable him to diagnose and treat the patient's condition, lacked sufficient justification for making his request. I cannot accept that the legislature intended to heap upon an entirely innocent specialist the onerous consequences of a finding of over-servicing upon any such basis.
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> The criterion contained in s 79(1B) is whether a professional service is "not reasonably necessary for the adequate medical or dental care of the patient concerned". The necessity for the provision of a service must be considered from the viewpoint of the provider of the service. The subsection is concerned with *his* actions, and it would be incongruous to evaluate them from the viewpoint of someone differently placed and possessed of different information. What is necessary to be done by a consultant, asked to perform a test or furnish an opinion on a patient currently under treatment directed by someone else, may be quite different from what would be necessary if the consultant were the first doctor seen by a previously untreated patient. For a specialist requested to carry out a test, one thing may be necessary — to carry out that test. It will be reasonably necessary to do so for the adequate medical care of the patient, so far as he is concerned, if the request comes from an appropriate practitioner and is not on its face an inappropriate request. In a profession divided into specialties, any other approach would disrupt the activities which are intended to work together to effect diagnosis and cure.

In *Minister for Health v Peverill* (1991) 29 FCR 262; 100 ALR 73, the full court (Black CJ, Wilcox and Foster JJ), after referring to the judgments in *Tiong*, said, at FCR 276–278; ALR 87–9:

> There are some differences between the various judgments in *Tiong*. But, as we read those judgments, all of their Honours would support four propositions. First, the question whether particular services are excessive, within the meaning of s 79(1B), is a matter which must be determined having regard to the information available to the practitioner whose conduct — whether initiation or rendering of services — is under examination. Second, in determining that question, the view of that practitioner, as to necessity, will be relevant but not decisive. The view of the practitioner will not be decisive because the question is an objective one and not dependent upon the personal view of the particular practitioner. Third, in the case of an allegation that an unnecessary service has been rendered, it is not a complete answer that the service was rendered at the request of another practitioner. Although a request is a very material matter, which under normal circumstances may be acted upon without further inquiry, cases may occur in which even a requested practitioner may be found to have rendered excessive services. However, and this is the final proposition, such cases will be confined to those involving some "personal fault", to use the term of Davies J and Spender J, or lack of innocence, to adopt the concept of Burchett J.
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> As it seems to us, the first major element in the *Tiong* decision was inevitable. Section 79(1B) provides the test for determining excessiveness; namely, whether the services "were not reasonably necessary for the adequate medical . . . care of the patient concerned". But a judgment as to what measures are necessary to achieve a particular end is not something which may be made in isolation from the circumstances in which the judgment is made. Logically, s 79(1B) offers two possibilities: the circumstances which existed at the time when the question of provision of services arose; or the circumstances as they later appeared, perhaps at the time of an investigation by a medical services committee of inquiry. However, when one considers the policy of the legislation, it is obvious that the former of these two alternatives must have been intended by parliament. Not only would it be grossly unfair to practitioners to evaluate necessity by reference to subsequently available information; such an interpretation might deter practitioners from giving to their patients the benefit of any doubt as to the utility of a service, and so tend to defeat the Act's evident policy of making a reasonable level of medical service generally available.

Once it be accepted that the question of necessity must be judged in the light of the circumstances as they were at the time the service was rendered, it is a small step to say that it must be evaluated in the light of the information available to the practitioner at that time. Once again, this approach accords with both fairness and the evident policy of the Act.

If the Act had remained in its original form, the second aspect of *Tiong* — the necessity for some element of personal fault before a finding of excessive service could be made — might not have been apparent. In its original form, s 105 made no reference to reprimanding or counselling a practitioner or, of course, to revocation of a s 16C undertaking — at that time, there were no such undertakings. Section 106 provided that, if the minister accepted a committee's recommendation for repayment of a medical benefit, the amount of the repayment should be recoverable as a debt. But there was no provision for publicity about such matters. The matter was likely to remain confidential to the minister, and his advisers, and the practitioner concerned. There was no disciplinary or deterrent element in the recommendation or its acceptance. These could be regarded as being related only to the protection of public funds.

However, since the original enactment of the Act, not only has s 105 been amended to include provision for disciplinary measures, s 106AA has been added. This section, added by the 1977 Act, requires the minister to prepare, and table before each House of Parliament, a statement setting out particulars of any decision under s 106 to accept a committee's recommendation. The section also provides that the statement may be published in the *Gazette*, if the minister thinks fit. It follows that the acceptance of even a recommendation merely to withhold, or require the repayment of, a benefit may become a matter within the public domain. It may attract publicity. As any such publicity is almost certain to be damaging to the practitioner, we cannot think that parliament intended that this should occur in cases where the practitioner was not personally at fault.

In the light of *Tiong*, it seems to us that the matter which understandably concerned Einfeld J is of little significance. The application of the principles enunciated in *Tiong* to this case would mean that no finding of excessive servicing could be made against Dr Peverill unless the medical services committee of inquiry reached the conclusion that, looking at the situation from the viewpoint of Dr Peverill and having regard to the circumstances which existed at that time, one or more of the rendered services was not reasonably necessary for the adequate medical care of the relevant patient. In considering that question the committee would be obliged to take into account Dr Peverill's knowledge as to relevant facts. This would include his knowledge that the patient's general practitioner had requested the service; but this would not necessarily be determinative of the matter. If the committee found that Dr Peverill believed that the general practitioner's request was inappropriate or that he had reason to believe that the requesting practitioner did not genuinely or reasonably consider the requested service, or all of the requested services, to be necessary, or that Dr Peverill knew that there was doubt about one of these matters but deliberately refrained from inquiry, it would be entitled to find excessive servicing and to make appropriate recommendations under s 105. Any of the assumed situations would involve "personal fault" in the rendering of the service. Of course, the existence of "personal fault" would not itself be enough; there must be a conclusion that the rendered services were not reasonably necessary for the adequate medical care of the patient.

Following the decision of the full court, the committee of inquiry resumed its deliberations into Dr Peverill. Dr Peverill operated a very large pathology service. The committee of inquiry found that he had rendered excessive services because he had distributed and promoted pathology test order forms to general practitioners, which encouraged the general practitioners to order tests in groups. While one, or even several, of the tests may have been appropriate for a particular patient, the grouping often meant that the general practitioner ordered unnecessary tests. As this was a result of the system, and the promotion of the system by Dr Peverill, the committee found him responsible for rendering excessive services. In *Peverill v Backstrom* (1994) 54 FCR 410; 38 ALD 14, the full court considered an appeal against an unsuccessful review by Dr Peverill of the decision of the committee. One argument before the full court was that Dr Peverill could not properly have been found to have rendered excessive services because he supplied the

services in response to requests by general practitioners and, consequently, did not have any "personal fault" as required by *Minister for Health v Peverill*. The full court (Lockhart, Gummow and Lee JJ) referred to the judgments in *Tiong and Minister for Health v Peverill* and, as to the four propositions referred to in the latter case, said, at FCR 432; ALD 31–2:

> Some of these reformulations of the judgments in *Tiong* may extend beyond what was held in that case. In particular, the last passage quoted, which seems to indicate a two step test, in our view, is not found in *Tiong* and is not supported by the terms of the Act. In *Tiong* the issue of "personal fault" was relevant in determining the primary question of whether a service was not reasonably necessary for the adequate medical care of the patient.
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> Such a question is to be determined in the light of the facts known to the practitioner concerned. In dealing with the issues of construction of the statute, regard should be paid to the objectives sought to be pursued by Div 3, and the possibility that a finding of excessive servicing may expose a practitioner to various penalties. If that be done, then, in answering the question of whether excessive services have been rendered, it is difficult to maintain that regard should be had to facts which were not known and ought not reasonably to have been known to the practitioner. For example, if it is subsequently revealed by further research that a particular procedure is useless, it could not be said that all practitioners who performed the treatment at a time when it was generally thought to be efficacious have performed excessive services. Likewise, it may be that a specialist is unaware, reasonably in the circumstances, of facts concerning a patient which are known to the referring practitioner.
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> It is in this context that the concept of "personal fault" in the judgments in *Tiong* is to be understood. *Tiong* acknowledges that the terms and context of the provisions of Div 3 dictate that a practitioner who could not reasonably have known certain matters is not caught by the division.

The judgments in each of these cases express the view that the question whether a practitioner has rendered excessive services is an objective question. The answer to that question is not dependent on the view of the practitioner, although the view of the practitioner will be a relevant consideration. This means a practitioner can be found to have rendered excessive services even if the practitioner believed that the services were reasonably necessary. The statutory provisions do not require that the practitioner intended to render excessive services. Although the three successive full courts have expressed this view in the context of cases involving specialists acting on requests made by other practitioners, the view was expressed to apply generally.

Mr Selimi, who appeared as counsel for Dr Butler, pointed to the requirement in the three decisions for "personal fault" on the part of the practitioner, and contended that this requirement meant that a practitioner could not be found to have rendered excessive services unless it was shown that the practitioner had a guilty mind, that is to say, that the practitioner knew, or was recklessly unconcerned whether, the services were not reasonably necessary. This submission is inconsistent with the judgments in each of the cases which held that whether a practitioner has rendered excessive services is an objective question. The notion of "personal fault" was used to explain that a specialist did not render excessive services if the specialist had no knowledge of the patient and acted reasonably on a request for a service for the patient from another practitioner. I repeat the conclusion in *Peverill v Backstrom* at FCR 432; ALD 32:

> *Tiong* acknowledges that the terms and context of the provisions of Div 3 dictate that a practitioner who *could not reasonably have known* certain matters is not caught by the division. [emphasis added]

Where the practitioner deals directly with the patient, the practitioner has the knowledge to determine whether a service is reasonably necessary. With that knowledge, the provision of services beyond what was reasonably necessary, assessed objectively, is the "personal fault" referred to in the judgments.

Mr Selimi then contended that, if the decisions did not require the practitioner to have a guilty mind, that view was not determinative of the cases in which it was expressed because they concerned the particular problem of a lack of knowledge of the circumstances of a patient on the part of a specialist acting on a referral from another practitioner. Consequently, the view was expressed by way of obiter dicta and Mr Selimi contended that it should not be applied in the circumstances of this case, which did not involve the relationship of specialist and referring practitioner. I doubt that the view was expressed in these decisions by way of obiter dicta, but it is desirable that I say something about the arguments put on behalf of Dr Butler in any event. Mr Selimi submitted that the provisions are quasi-criminal in character and that a citizen has a fundamental right not to be found to have engaged in conduct of such a nature without having a blameworthy state of mind. He relied on the following statement by Stephen J in *R v O'Connor* (1980) 146 CLR 64 at 96:

> For criminal liability to be incurred (cases of strict liability and culpable negligence always apart) civilised penal systems have, in modern times, insisted that the accused should be shown to possess a blameworthy state of mind.

Mr Selimi then relied on the following passage in the joint judgment of Mason CJ, Brennan, Gaudron and McHugh JJ in *Coco v R* (1994) 179 CLR 427 at 436; 120 ALR 415 at 419:

> The courts should not impute to the legislature an intention to interfere with fundamental rights. Such an intention must be clearly manifested by unmistakable and unambiguous language . . .
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> At the same time, in our view, the principle was expressed more simply by Brennan J in *Re Bolton; Ex parte Bean* (1987) 162 CLR 514 at 523 in these terms:
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> "Unless the parliament makes unmistakably clear its intention to abrogate or suspend a fundamental freedom, the courts will not construe a statute as having that operation."
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> In *Bropho v Western Australia* (1990) 171 CLR 1 at 18 Mason CJ, Deane, Dawson, Toohey, Gaudron and McHugh JJ pointed out that the rationale against [sic] the presumption against the modification or abrogation of fundamental rights is to be found in the assumption that it is:
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> ". . . in the last degree improbable that the legislature would overthrow fundamental principles, infringe rights, or depart from the general system of law, without expressing its intention with irresistible clearness; and to give any such effect to general words, simply because they have that meaning in their widest, or usual, or natural sense, would be to give them a meaning in which they were not really used: *Potter v Minahan* (1908) 7 CLR 277 at 304."

Mr Selimi contended that the statutory provisions did not manifest a clear intention to override the fundamental principle that a guilty mind is required before a person can be held responsible for criminal or quasi-criminal conduct.

I now turn to examine the statutory provisions in the light of these submissions. The reference in s 79(1B) to the concept of services which are "not reasonably necessary" is, on its face, a reference to an objective standard. The definition of excessive services is concerned with an assessment of the services by reference to common and accepted standards of medical practice. The words convey this meaning and the processes established by the Act confirm it. The committee is comprised of five medical practitioners (s 80(2)), of whom four are to be appointed after consultation with the Australian Medical Association: s 80(3). The committee may, in certain circumstances, engage as consultants persons with suitable qualifications and experience: s 93. The tribunal is constituted by a person with legal experience and two medical practitioners, one nominated by the minister after consultation with the Australian Medical Association and one employed by a Department of State (s 108(4)(a) and 108(4)(b)). The obvious purpose of constituting the committee entirely of medical practitioners and the tribunal by a majority of medical practitioners is to allow them to bring their medical expertise to the task. The committee

may inform itself in such manner as it thinks fit (s 92) and the rules of evidence do not apply to the hearing before the committee: s 97(3).

The provisions dealing with excessive services have a dual function. They are concerned with ensuring that the public purse funds no more than a reasonable level of medical services, and they are also concerned with disciplining practitioners who render excessive services. These functions are necessary to support a health insurance system in which practitioners are able to determine the level of their income by determining the number and duration of services provided to patients. The function of protecting the public purse is performed by sections such as s 105(2)(f), which empowers a committee to recommend that a practitioner repay any Medicare benefit paid for excessive services. This way, public expenditure on an unreasonable level of service is reclaimed. Under s 105(2)(ca), the committee may recommend that a practitioner be counselled. If the minister makes a determination in accordance with such a recommendation and the practitioner is counselled as a result, the chance of a repetition of overservicing is reduced and the public expenditure is thereby protected. Two other provisions have a more direct disciplinary function. Section 106AB provides that, where the minister makes a determination that a practitioner has rendered excessive services in accordance with the recommendation of a committee, the practitioner must pay a penalty to the Commonwealth of an amount equal to the Medicare benefit on the services found to have been excessive. Subsections 106AA(1) and 106AA(1A) provide that, after a determination is made, a statement prepared by the minister is laid before parliament and may be published in the *Gazette*. The statement sets out the determination, reasons for the determination and any other comment the minister wishes to make.

While these two provisions have a disciplinary function, that function is in aid of the statutory system of ensuring that public expenditure is made in respect of a reasonable level of service only. The provisions relating to excessive services are part of a special statutory scheme which regulates the payment of fees for medical services under the health insurance system. Part VII of the Act contains provisions making certain conduct criminal offences. They are dealt with separately in the Act and punish conduct which offends against general community standards of behaviour, such as bribery. Their function is not directly linked with the purpose of protecting public expenditure. Where the legislation deals with criminal conduct by creating specific criminal offences, the Act makes the mental element a specific requirement or defence. For instance, s 129(2) creates an offence in the following terms:

> A person shall not furnish, in pursuance of this Act or of the regulations, a return or information that is false or misleading in a material particular.
>
> Penalty: $10,000 or imprisonment for 5 years.

and subs (3) provides a defence in the following terms:

> In a prosecution of a person for an offence against this section, it is a defence if the person proves that he did not know, and had no reason to suspect, that the statement, document, return or information, made, issued, presented or furnished by him was false or misleading, as the case may be.

The language and features of the legislation make it evident that the provisions relating to excessive services are concerned with ensuring that public moneys are spent on a level of services assessed by medical peers to be reasonable. Provisions which have a disciplinary aspect support this function. The objective standard and the nature of the processes established by the Act indicate a clear intention on the part of parliament that a practitioner will render excessive services if the services, on an objective assessment, are not reasonably necessary, even if the practitioner believed that those services were reasonably necessary.

The tribunal did not regard Dr Butler's view as to the reasonable necessity of the provision of the services as determinative. It did, however, have regard to his view in determining whether, objectively assessed, the services were reasonably necessary. I have already set out the tribunal's approach in relation to patient 13. Another example is the patient referred to as patient six, in relation to whom the tribunal said:

> The tribunal gives considerable weight to the applicant's view of the need for frequent consultations as he was responsible for the patient's well-being and treatment during the period.

In my view, the tribunal was correct in this approach.

Onus of proof

The second question raised by this appeal concerns the onus of proof. Mr Selimi contended that the minister had to prove that the services rendered were not reasonably necessary for the adequate medical care of the five patients. He argued that the tribunal had reversed the onus by finding that services were not reasonably necessary, on the basis that Dr Butler had not proved that the services were reasonably necessary, and by stating that there was no onus of proof in the proceeding before the tribunal. Mr Selimi relied upon the following statement by Beaumont J in the full court decision in *Minister for Health v Thomson* (1985) 8 FCR 213; 60 ALR 701, at FCR 223–224; ALR 712:

> Generally speaking, concepts of onus of proof used in adversary proceedings are inapplicable in administrative proceedings in the social security area: see *McDonald v Director-General of Social Security* (1984) 1 FCR 354; 6 ALD 6. However, where, as here, a breach of discipline, or something analogous, is alleged, the onus of proving such a breach lies upon the accuser. The general position is explained by Professor Enid Campbell in "Principles of Evidence and Administrative Tribunals", published in Campbell and Waller (ed) *Well and Truly Tried* (1982), p 53:
>
> "There may be legal burdens of proof to be discharged in administrative proceedings just as much as there are legal burdens of proof in purely judicial proceedings. Sometimes the incidence of the burden of proof is spelled out by legislation, but more often than not it is simply implied in the nature of the proceedings. If, for example, entitlement to grant of a licence or benefit depends on proof that certain qualifications have been met, the burden of proving the relevant facts going to qualifications must fall upon the applicant. Similarly, where the issue to be decided is whether circumstances have arisen which would justify cancellation or suspension of a licence, or a finding that a breach of discipline had occurred, the onus of proving that these circumstances have arisen would devolve on the accuser. This would be so, notwithstanding that the accuser was also, of necessity, the person or body having authority to adjudicate."

The other members of the court took a different approach. Fox J expressed his view, at FCR 216; ALR 704–5, as follows:

> . . . I do not think it useful, and it may be misleading, to talk in terms of onus of proof in relation to proceedings such as those with which the committee was concerned. The committee was one of inquiry, and it was inquiring into the services charged by one doctor. It was obliged to find the facts, so far as it could do so, concerning those services. There were not multiple parties to the inquiry. The process at the hearing was one in which documentary evidence was formally laid before it by its secretary and thereafter Dr Thomson gave evidence and was questioned at length by members of the committee. No other evidence was called. To talk of onus of proof, in its legal sense, is in my view inappropriate: compare *McDonald v Director-General of Social Security* (1984) 1 FCR 354; 6 ALD 6.
>
> The role of the committee was an investigative one. It would be true that the minister had referred the matter because doubts or suspicions had been raised, and it is true that in a sense Dr Thomson was there to defend himself. It is also true that no action of a punitive or disciplinary nature could be taken against him unless it was shown that he had charged for "excessive services".

Wilcox J agreed with both Fox and Beaumont JJ but added some short additional comments which included the following, at FCR 226; ALR 714–15:

> The committee was required to conduct an inquiry in relation to particular, specified, services. It was required to report its finding in relation to each service. In any case in which it was not able to reach a conclusion it was required to say so. Only if, and to the extent that, the committee positively found any particular service or services to be "not reasonably necessary" was it entitled to recommend disciplinary or recovery action under s 104.

The question of the applicability of notions of onus of proof in administrative decision-making was dealt with in *McDonald v Director-General of Social Security* (1984) 1 FCR 354; 6 ALD 6. This case involved an appeal from a decision of the Administrative Appeals Tribunal (the AAT) confirming a decision of a ministerial delegate to cancel an invalid pension which had previously been awarded to the applicant. Although the statutory provisions were different from the provisions in the present case, the approach to the question of onus is noteworthy. Woodward J said, at FCR 356–7; ALD 9–10:

> The first point to be made is that the onus (or burden) of proof is a common law concept, developed with some difficulty over many years, to provide answers to certain practical problems of litigation between parties in a court of law. One of the chief difficulties of the concept has been the necessity to distinguish between its so-called "legal" and "evidential" aspects. The concept is concerned with matters such as the order of presentation of evidence and the decision a court should give when it is left in a state of uncertainty by the evidence on a particular issue.
>
> The use outside courts of law of the legal rules governing this part of the law of evidence should be approached with great caution. This is particularly true of an administrative tribunal which, by its statute "is not bound by the rules of evidence but may inform itself on any matter in such manner as it thinks appropriate": Administrative Appeals Tribunal Act 1975 (Cth) s 33(1)(c).
>
> Such a tribunal will still have to determine practical problems such as the sequence of receiving evidence and what to do if it is unable to reach a clear conclusion on an issue, but it is more likely to find the answer to such questions in the statutes under which it is operating, or in considerations of natural justice or common sense, than in the technical rules relating to onus of proof developed by the courts. However these may be of assistance in some cases where the legislation is silent.
>
> Whether the principles adopted by such a tribunal, arising from these various considerations, are appropriately dealt with under the heading "onus of proof", becomes a matter of choosing labels. It would probably be more convenient to avoid using that expression in cases such as the present.

Northrop J said, at FCR 365–6; ALD 18–19:

> It is sufficient to say that terminology used in relation to courts may tend to cause confusion and difficulties when applied to persons exercising statutory powers of a different kind. The director-general is not a party to claims for pensions under Pt III of the Act. Under that part, persons who come within specified criteria are "qualified to receive" an age pension, an invalid pension or a wife's pension respectively; see ss 21, 24 and 31 respectively. A person makes a claim for a pension and that claim is determined by the director-general or his delegate. The director-general, or his delegate, determines a claim on all the relevant material in his possession. Parties do not appear before him. There are no adversary procedures. In one sense it is true to say that a claimant has an onus of proof, but the use of that expression obscures the true nature of the duty imposed on the director-general, or his delegate, to determine the matter. A pension is paid only so long as the pensioner is qualified to receive the pension. The rate of pension may vary depending upon what facts are known by the director-general or his delegate. If a change in circumstances occurs, it is unreal to suggest that the director-general, or his delegate, has an onus of proof, whether evidentiary or not, to be satisfied before varying a pension entitlement. The ultimate question is whether the person is qualified to receive the pension and, if so, at what rate. These questions must be decided after a consideration of all the material before the

director-general, or his delegate, when the decisions are made. The question of whether a pensioner is "permanently incapacitated for work" has to be decided in accordance with the opinions expressed above.

Similar principles apply to proceedings before the AAT. The tribunal is not bound by the rules of evidence. It has before it all the material that was before the person who made the decision under the AAT Act and which is the subject of the review before the AAT. Additional material may be placed before the AAT. As a matter of convenience, the director normally appears to assist the tribunal, but the director-general is not to be treated in the same way as a party to proceedings before a court. In *Sordini v Wilcox* (1982) 64 FLR 440, a review under the Administrative Decisions (Judicial Review) Act 1977 (Cth) (the AD(JR) Act), the administrative body whose decision was being reviewed appeared before the court. At 451 Northrop J said:

"Counsel for the respondents stated that each of the first three named respondents, being the members of the review committee, would abide by the order of the court. Counsel for the respondents, very properly, made substantive submissions on behalf of the commission. Where there are no adversary parties appearing before an administrative body, as in this case, it is important that the court receive assistance of counsel appearing for the administrative body making the decision which is being challenged under the AD(JR) Act."

It is equally important that in reviews by the AAT of decisions by administrative bodies such as the director-general, or his delegate, in which there were no adversary parties, the AAT received the assistance of persons acting on behalf of the administrative body. Likewise, in appeals of this court from the AAT on questions of law, it is important that the court receive the assistance of counsel appearing for the administrative body. This practice, however, which gives the outward appearance of an adversary system, should not be allowed to obscure the true position, and in particular to justify the introduction of concepts of onus of proof into the determination of claims under the legislation where no onus of proof in the legal sense arises.

Jenkinson J said, at FCR 36–9; ALD 21:

There may be difficulty, as Woodward J has pointed out, in adapting the curial conception to the processes of administrative determination of individual rights. Some of the purposes which the conception serves in a curial proceeding are achieved by other means in administrative proceedings. A court waits upon the parties to litigation to tender their proofs. When the parties differ as to which shall go first into evidence, their difference is resolved by determining upon which lies the burden of proof. (See W M Best, *An Exposition of the Practice Relative to the Right to Begin.*) But the administrative decision-maker will commonly inform himself of the facts by his own inquiries, as well as receiving such proofs as the individual citizen and those who may be authorised to oppose the citizen's interest choose to place before him. And he will not ordinarily be free, as a court is ordinarily free, to determine a matter against the party on whom lies the onus of proof, and who fails to offer any proof in discharge of the onus, without further inquiry. When the party to litigation on whom the onus of proof of an issue lies has concluded his evidence, the court may be called upon by the other party to determine the question of law whether that evidence can support a verdict or finding for him on whom the onus lies. Except by special legislative direction no administrative decision-maker could be so constrained. In many cases subject to administrative decision there is in any event no other party in controversy with him on whom the onus may be said to lie.

There is, however, in my opinion a dilemma in which either a court or an administrative authority determining rights or liabilities may find itself, for the resolution of which the same principles are applicable by each tribunal. Either tribunal may find itself unpersuaded either that a circumstance exists or that it does not exist. (The same may be said of a past or a future circumstance.) The court or the administrative authority will determine, by reference to the substantive law, whether it is the existence or the non-existence of the circumstance which is determinative of the question for decision. In this case the AAT would determine whether the Social Security Act 1947 (Cth), upon its proper construction, required that the applicant's pension be cancelled if she were found not to be permanently incapacitated for work, or required that the pension be cancelled unless she were found to be permanently incapacitated for work. In the former case the tribunal's lack of persuasion that permanent incapacity did not exist would preclude cancellation. In the latter case the tribunal's lack of persuasion that permanent incapacity

did exist would result in cancellation. An application of the same principles by a court in resolution of the same dilemma is to be found in *Maher-Smith v Gaw* [1969] VR 371. In a court the principles are expressed in terms of the onus or burden of proof. When those principles are applied in an administrative tribunal, there may be risk of misconception if the curial modes of expression are employed.

Thus, the weight of authority is against describing the process before administrative tribunals, such as the tribunal, in terms of the onus of proof. This concept applies to an adversarial contest in a court. The term is used to identify the obligations on the party responsible for proving a case. The concept does not apply readily where there is no adversarial contest. Thus, in the present situation, the minister does not participate in the proceedings before the committee and the committee may inform itself in such manner as it thinks fit: s 92. If there is a review, the tribunal must consider the evidence before the committee. It does not usually hear further evidence. The minister may or may not be represented at the tribunal hearing: s 117(2). In the proceedings before the committee and the tribunal, the statute defines the issue to be determined. The committee or tribunal may determine the issue when it achieves a state of positive satisfaction on the issue. In this case, the tribunal required that it be positively persuaded that the services rendered were not reasonably necessary. In my view, this was the proper approach.

In this case, there is no difference in outcome if that approach is used or if the traditional onus of proof approach is used for, as Pincus J said in *Taylor v Minister for Health* (1989) 23 FCR 53 at 59; 90 ALR 166 at 171:

> Even if the onus were on the respondent to establish excessive servicing, on orthodox principles little might be required to discharge it, if the facts were peculiarly or largely within the knowledge of the doctor concerned: see *Darling Island Stevedoring & Lighterage Co Ltd v Jacobsen* (1945) 70 CLR 635 at 642, per Starke J; *Apollo Shower Screens Pty Ltd v Building and Construction Industry Long Service Payments Corporation* (1985) 1 NSWLR 561.

I shall therefore consider Dr Butler's criticisms of the tribunal's decision on the assumption that the onus of proof was on the minister. To illustrate the criticisms made by Dr Butler, I will refer to the decision of the tribunal in relation to the patient referred to as patient six. Not only are those criticisms representative of the criticisms made generally, but they are significant because patient six accounted for the second largest amount of repayment of benefits ($3413) after patient 13 ($5234).

Dr Butler gave written and oral evidence to the committee about the medical conditions of the patients and the treatment administered by him. Patient six was in his late 50s and was a chronic alcoholic. He lived at home with his wife, who cared for him. Dr Butler visited twice a week. Dr Butler gave evidence that he routinely conducted a clinical examination to check the patient's heart, cardiovascular system, central nervous system and minor injuries from frequent falls and other incidents. Dr Butler relied on clinical examinations without objective testing, such as liver function or thyroid function tests. From this evidence, the tribunal concluded that the patient was clinically stable and cared for by his wife, so that visits beyond fortnightly intervals were not reasonably necessary for the adequate medical care of the patient. At the end of this analysis of the evidence, the tribunal said:

> Accordingly, services over and above once every two weeks were not reasonably necessary for adequate medical care and were therefore excessive. These are the 69 services noted in the MSCI report for this patient as being excessive in full. There was no evidence of any particular circumstance or symptom that gives any indication to the contrary.

Mr Selimi argued that the last sentence indicated that the tribunal placed the onus of proving that the service was not excessive on Dr Butler. I do not agree. The sentence follows a conclusion from all of the evidence that the services were not reasonably

necessary for the care of the patient. There was evidence which satisfied the tribunal that the services were excessive. The last sentence confirmed that there was no other factor which contradicted the finding on the facts discussed immediately before. Then the tribunal addressed one factor which could have justified twice weekly visits. It noted that Dr Butler had given the patient twice weekly injections of Intravite and the tribunal said that this treatment would have been justified medically if the patient was not eating well. Then followed the sentence:

> There is no evidence here that an ongoing state of nutritional deficiency existed.

Again, Mr Selimi argued that the tribunal had placed the onus of proving that the services were not excessive on Dr Butler. Again, I do not agree. The tribunal found that Dr Butler had not relied on nutritional deficiency in his treatment of the patient and it followed that there was no reason for twice weekly Intravite injections. The conclusion followed, not from the absence of evidence of excessive servicing, but from positive evidence that the service was not justified. The tribunal then addressed the duration of fortnightly visits. It said that the evidence of the treatment administered justified a standard visit of 25 minutes, not a long home visit as charged. The tribunal then said:

> ... it is appropriate to allow these services as standard home visits unless there were other circumstances that made it reasonable for them to be of longer duration. There is no evidence before the tribunal of any such circumstances.

Again, Mr Selimi argued that this passage demonstrated that the tribunal placed the onus of disproving excessiveness on Dr Butler. In my view, the tribunal was merely describing the extent of the evidence and concluding that, on the material before it, the longer visits were not justified. This is quite different from saying that there was no evidence of excessive servicing but, in the absence of explanation, the tribunal will conclude that there has been such excessive servicing. Earlier in its reasons relating to patient six, the tribunal observed that Dr Butler had no medical records for this patient for the period under investigation. Mr Selimi argued that this observation again indicated that the tribunal wrongly placed the onus of disproving excessive servicing on Dr Butler. Again, I do not agree. The tribunal went on to say that Dr Butler gave oral evidence about the treatment of the patient and the tribunal proceeded to analyse that evidence to reach its conclusions. The process did not involve the tribunal determining that the services were excessive because Dr Butler had not proved that they were not, but rather determining positively on the whole of the evidence Dr Butler had given that the services were excessive.

Criticisms of other passages in the decision in relation to other patients need not be individually addressed. They all involved the same points and are all answered in the same way. The only exception is a passage in relation to patient 13, as follows:

> While there is no onus of proof in matters before the tribunal, *the tribunal must be able to make relevant findings of fact before it can determine whether a service was excessive. If no relevant findings of fact can be made the tribunal can not reach a determination that a service was excessive*. Despite the absence of clinical records concerning the consultation that occurred on each of the service dates under review, there are materials put before the MSCI, and which are properly before this tribunal, from which the following findings can be made, and upon which the following determinations can be reached. [emphasis added]

The emphasised parts of this statement reflect the proper approach for the tribunal to take. They show that the tribunal must be positively satisfied that a service was not reasonably necessary in order to make the finding and that, in the absence of such a state of satisfaction, no such finding can be made. In the context of the emphasised passage, the statement that "there is no onus of proof in matters before the tribunal" is a shorthand way

of referring to the view of the full court in *McDonald*, and to the views of Fox J and Wilcox J in *Thomson*, that the onus of proof is an inappropriate description of the process to be followed in the tribunal. It meant no more than what Fox J said in *Thomson*, namely, that it may be misleading to talk in terms of onus of proof in relation to proceedings such as this. The statement does not reveal any wrong approach.

Associated with the argument concerning the onus of proof was the argument that the tribunal failed to take account of the seriousness of the allegations made against Dr Butler and thereby failed to apply the proper standard of proof. I do not find any substance in this argument. Nothing in the decision indicates that the tribunal failed to have regard to the serious consequences of a determination against Dr Butler. On the contrary, for instance, the tribunal's careful and extensive review of the evidence demonstrates attention to the detail of the allegations made against Dr Butler concerning each patient.

Estoppel

The third question which arose in this appeal was whether the minister was estopped from making a determination that Dr Butler had rendered excessive services to the five patients. In May 1987, the health commission requested a meeting with Dr Butler to discuss the statistics of his patient treatment practices. The meeting eventually occurred in May 1989, between Dr Ralph Lewis, a medical adviser to the commission, and Dr Butler. As a result of the meeting, Dr Lewis concluded, and told Dr Butler, that Dr Butler was not rendering excessive services. Dr Butler gave evidence to the committee that, in May 1989, he was treating the same five patients at the same frequency and duration as during the relevant period between 1 April 1992 and 31 March 1993. Counsel contended that the representation made by Dr Lewis estopped the minister from making a determination that the particular level of treatment of the five patients was excessive in the relevant period. For the purpose of the following discussion, I assume that this matter raises a question of law under s 124A of the Act. In my view, the submission fails, both on the facts and in law. As to the facts, in 1991, Dr Lewis sought further discussions with Dr Butler in relation to statistics which indicated an increasing level of servicing in Dr Butler's practice. Solicitors acting for Dr Butler replied to the request by saying that Dr Lewis had told Dr Butler in 1989 that there would be no further interviews required. In response to this comment, Dr Lewis replied, by letter dated 2 May 1991, as follows:

> (1) The material for discussion related to Medicare statistics which demonstrate an increasing rendering of services per patient, with attendant costs per patient.
>
> (2) Reviews are done at intervals, with two years being a common time. It is considered that more frequent reviews or requests for discussion could be construed as harassment of practitioners, which is avoided.
>
> (3) My comment relating to no further interviews was either ill considered or misinterpreted if it is believed that following the interview in question no further interviews would be required at any point of time.

By May 1991, Dr Lewis had become aware that the statistics upon which he relied in 1989 were wrong. The accurate figures showed a higher level of servicing by Dr Butler than Dr Lewis had considered. Perhaps this caused Dr Lewis to refer in the letter to his earlier comment as "ill considered". Whatever the reason, after 2 May 1991, it was clear to Dr Butler that Dr Lewis did not intend to preclude further reviews of the level of servicing. Even if it was reasonable for Dr Butler to rely on Dr Lewis' statement in 1989, the effect of that statement was negatived in May 1991 by Dr Lewis' letter giving notice that Dr Butler's level of servicing would be scrutinised again. That was a clear signal to Dr Butler that the prior statement was to have no further effect. Thus, in the relevant period between 1 April 1992 and 31 March 1993, Dr Butler was on notice that the health commission was not acting on any previous view expressed by Dr Lewis. After

2 May 1991, Dr Butler could not have continued the level of servicing of the five patients in the belief that the level of servicing would not be investigated further.

Quite apart from the lack of a factual basis for the alleged estoppel, the argument fails in law. The alleged estoppel would, if accepted, prevent the minister from exercising the discretion to make a determination under s 106. As was said in *Minister for Immigration v Polat* (1995) 57 FCR 98; 37 ALD 394, by Davies and Branson JJ at FCR 107; ALD 401:

> Estoppel will not operate so as to contradict a statute or to extend the authority of a decision-maker beyond that given by the statute . . . Even when the power to act is a discretionary one, it has been said that, when there is a duty under statute to exercise a free and unhindered discretion, no estoppel can be raised to prevent or hinder the proper exercise of the discretion. See *Kurtovic* at 200, 210; *New South Wales Trotting Club Ltd v Municipality of Glebe* (1937) 37 SR (NSW) 288 at 307, 313; *Ansett Transport Industries (Operations) Pty Ltd v Commonwealth* (1977) 139 CLR 54 at 73–77.

A number of other arguments were put concerning the adequacy of the tribunal's reasons for decision. These arguments depended on the success of one or other of the arguments dealt with earlier in these reasons. They fail in the light of my conclusions on those arguments. An argument concerning a suggested irregularity in the handing down of the reasons for decision of the tribunal was abandoned. Thus, in the result, the appeal must be dismissed with costs.

LINDA PEARSON