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DISCRETION, POLICY AND SECTION 19 (1) (a) OF THE IMMIGRATION ACT

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> "When law ends, discretion begins, and the exercise of discretion may mean either beneficience or tyranny, either justice or injustice, either reasonableness or unreasonableness."[1]

This paper has as its background the conflict between the interest of administrative agencies in developing policies which streamline decision-making processes and the interest of the individual in obtaining decisions which take account of the special features of his or her claim.[2] Its focus, however, will be on a specific example of how policy can harden into rules which effectively fetter the discretion of the decision-makers. The example selected is the examination of assessment of applicants for permanent residence under the *Immigration Act*, S.C. 1976, c-52. This function is performed by the Department of National Health and Welfare's Medical Services Branch (MSB) and the medical practictioners designated by the MSB to carry out examinations and to form binding opinions regarding admissibility. It will be argued that the MSB and its delegates have been granted considerable discretion to be used in determining who is and who is not admissible under the *Immigration Act*; that this discretion is often fettered by the adoption of policies; and that this results in the achievement of consistency and efficiency at the expense of adherence to the principle that "discretion

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1. Philip Anizman, ed., "A Catalogue of Discretionary Powers in the Revised Statutes of Canada 1970," (Ottawa: Law Reform Commission of Canada, 1975). preface.

2. D.J. Galligan, "The Nature and Function of Policies within Discretionary Power" [1976] P.L. 332.

be brought to bear on every case".[3] In this connection, it will be argued that it is generally possible to accomodate both the interests of decision-makers in having policies which may determine the result of individual cases and the individual's interest in having discretion be more than just notionally available. Lastly, it will be urged that specific steps be taken to ensure that this possibility is realized in the assessment of applicants for permanent residence under the *Immigration Act*. Before any of these propositions will be considered, however, some preliminary remarks concerning the nature of administrative discretion are in order.

The concept of legal discretion has been described as one implying the power to make a choice between alternatives where there is "room for reasonable people to hold differing opinions as to which one is to be preferred".[4] The observation "where law ends, discretion begins" has led to some confusion surrounding the exercise of "absolute", "unfettered" or "untrammelled" discretion.[5] In fact, while there exists three broad classes or types of discretion which administrative agencies avail themselves of in the exercise of their delegated powers, none of them can properly be said to be "unfettered".[6] Nonetheless, it has been contended that in spite of the theoretical checks on discretion—most of which centre on notions such as the "rule of law", "natural justice" or the "duty to be fair"—its exercise in practice may be absolute and unfettered. The notion of unlimited discretion, however, has been clearly rejected,[7] and the courts have frequently asserted their right to review exercises of discretion for a wide range of abuses. Statutory delegates have been held to have been acting outside of their

3. H.W.R. Wade, *Administrative Law*, 5th ed. (Oxford: Claredon Press, 1982) at 330-331.

4. *Secretary of State for Education and Science v. Thorneside Metropolitan Borough Council* [1977] A.C. 1014, at 1064 per Lord Diplock.

5. J.M. Bublman, "The Supervisory Role of the Courts: An Historical Perspective," *The Charter of Rights and Administrative Law*, (Toronto: Law Society of Upper Canada, 1983-1984 at 31.

6. *Ibid.* at 30. See also: Jones De Villars, *Principles of Administrative Law* (Toronto, Carswell, 1985) at 118.

7. *Roncarelli v. Duplessis*, [1959] S.C.R. 122 at 140 and 167.

jurisdiction[8] where the use of power has been for an unauthorized or ulterior purpose,[9] in bad faith,[10] or was based on either irrelevant considerations[11] or inadequate material.[12] As well, the courts have looked to the effects of the exercise of discretion to determine whether an abuse has occurred. In this way, decisions which are unreasonable[13] or discriminatory have been quashed or set aside.

If the essence of discretion is as we have described it, admitting of being exercised differently in different cases, then its existence must imply the absence of a rule dictating the result in each case. As H.W. R. Wade puts it:

> "It is a fundamental rule for the exercise of discretionary power that discretion must be brought to bear on every case; each one must be considered on its own merits and decided as the public interest requires at the time."[14]

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8. *Anisminic Ltd. v. Foreign Compensation Commission*, [1969] A.C. 147 at 171 (H.L). Lord Reid makes clear that an abuse of discretion is an error which is jurisdictional in nature, even though the delegate has complied with all the mandatory requirements, is dealing with the subject matter granted to him by the legislation, and has the right to exercise the discretionary power in question.

9. *Roberts v. Hopwood*, [1925] A.C. 578 (H.L.), which involved the payment of a municipal council of higher wages than necessary in order to be a "model employer" even though council was entitled to pay "such wages as [council] may think fit."

10. *Supra*, note 7 at 140.

11. *Smith v. Rhuland v. R.; Ex rel. Andrews*, [1953] 2 S.C.R. 95, where a Labour Relations Board rejected an application for certification of a union as a bargaining unit on the basis that the secretary treasurer of the union was a communist.

12. See D.W. Elliot, "No Evidence—A Ground for Judicial Review in Canada?" (1972-73) 37 Sask. L.R. 48.

13. *Supra*, note 7 at 132, where it is noted that unreasonableness can, in some circumstances, be treated as a synonymn for the exercise of a discretion for an improper purpose, in bad faith, or on irrelevant considerations. All the same, it is possible that a delegate can act in the best faith, ignore irrelevant considerations and still produce a result which a court might characterize as being unreasonable. See also *Roberts v. Hopwood* (*supra*, note 9).

14. *Supra*, note 7 at 137.

This observation describes the principle in which the abuse of fettering of discretion is rooted. Because delegated powers are usually exercised by the persons to whom they have been granted, there needs to be a limit on the degree to which such persons can fetter that discretion by the introduction of policy or regulations which pre-determine the result in individual cases. The adoption of inflexible policies which require a delegate to exercise his or her discretion in particular ways may "illegally limit the ambit of his (or her) power".[15] The abuse of fettering of discretion is therefore a jurisdictional one and judicial review provides for the possibility, at least in principle, that an order for *mandamus* may be obtained.[16]

This is not to suggest that delegates cannot adopt general policies to guide their decision-making. On the contrary, it is understood as both inevitable and necessary that administrative bodies faced with large numbers of discretionary decisions all but have to use such guidelines. The requirement remains, however, that policies and guidelines must not fetter the discretion of decision-makers by resulting in the wholesale determination of individual cases other than on their own merits.[17]

It has been persuasively argued elsewhere that discretion entails a power in the decision-maker to make policy choices and to develop guidelines (to achieve legitimate ends) which determine particular decisions.[18] While it is often the case that this is the practical role of policy within discretion, there is still a wide distinction to be drawn

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15. Contrast "intra-jurisdictional" abuses, such as the abuse of misconstruing the law, which may be insulated from judicial review by the use of privative clauses. An example of this is found in Section 108 of the *Alberta Municipal Government Act* (R.S.A. 1980, cm—26) which reads as follows:

> "108. A by-law or resolution passed by a council in the exercise of any of the powers conferred and in accordance with this *Act*, and in good faith, is not open to question nor shall it be quashed, set aside or declared invalid, either wholly or partly, on account of the unreasonableness or supposed unreasonableness of its provisions or any of them."

16. *R. v. Port of London Authority: Ex parte Kynoch, Ltd.*, [1919] 1 K.B. 176 at 184 (C.A.) per Bankes L.J., and *Sagnata Investments v. Norwich Corporation*, [1971] 2 Q.B. 614.

17. *Sagnata, ibid.* at 625.

18. *Supra*, note 2 at 332.

between the two ways in which this can be true. As Bankes L.J. said in *R. v. Port of London Authority. ex parte Kynoch, Ltd.*:[19]

> "There are on the one had cases where a tribunal in the honest exercise of its discretion has adopted a policy, and without refusing to hear an applicant, intimates to him what its policy is, and that after hearing him it will in accordance with its policy decide against him, unless there is something exceptional in his case... (I)f the policy has been adopted for reasons which the tribunal may legitimately entertain, no objection could be taken to such a course. On the other hand, there were cases where a tribunal has passed a rule, or come to a determination, not to hear any application of a particular character by whomsoever made."

While the line that demarcates the acceptable role of policy from the unacceptable may be a conceptually clear one, in practice it is often difficult to determine whether it has been crossed. This is so for a variety of reasons, one of which is the relative ease with which "reasons" for decisions may be couched in terms which disguise the fact of busy officials simply referring to policy guidelines. In some cases, however, it is possible to show that a decision-maker is extrapolating either expressly or impliedly, from past decisions; or, worse still, is simply invoking a "rule of thumb". Yet even where the policy is expressed or implied in manuals, the difficult task remains of showing that the policy has been invoked at the expense of judicial analysis of the merits of the individual case. Before examining the way in which this may happen to an applicant for permanent residence in Canada who is found to be medically inadmissible, it is necessary to outline the process involved and to fix the location and scope of discretion in that process.

Section 11 of the *Immigration Act*[20] provides as follows:

> 11. (1) "Every immigrant and every visitor of a prescribed class shall undergo a medical examination by a medical officer.[21]

Section 19 of the *Immigration Act* states in part:

> 19. (1) "No person shall be granted admission if he is a member of any of the following classes:

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19. *Supra*, note 16 at 625.

20. S.C. 1976, C-52.

> (a) Persons who are suffering from any disease, disorder, disability or other health impairment as a result of the nature, severity or probable duration of which, in the opinion of a medical officer concurred in by at lease one other medical officer, (i) they are likely to be a danger to public health or to public safety; or(ii) their admission would cause or might reasonably be expected to cause excessive demands on health and social services;
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> (b) Persons who there are reasonable grounds to believe are or will be unable or unwilling to support themselves, those persons who are dependent on them for care and support, except those persons who have satisfied an immigration officer that adequate arrangements have been made for their care and support."

Chapter 8 of the Immigration manual[22] indicates that although the authority to conduct medical examinations and assessments is contained in sections of the *Immigration Act and Regulations*, "responsibility" for the policies, guidelines and procedures "rest *primarily* with Health and Welfare Canada."[23] The *Department of National Health and Welfare Act*[24] states in part that the duties, powers and functions of the Minister include "the inspection and medical care of immigrants." "Medical Services" is a branch of the Department of National Health and Welfare and among its numerous functions is the Immigration Medical Activity. In turn, this activity includes, but is not limited to, the medical examination of applicants under the *Immigration Act* and the determination of their admissibility under s. 19(1) of the *Act*.

Examinations and assessments of applicants—usually overseas but in some circumstances within Canada—are conducted by medical practitioners who are recognized by order of the Minister of National Health and Welfare as medical officers for the purposes of the *Immi-*

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21. "Medical Officer" is defined in s. 2(1) of the *Immigration Act* as meaning a "qualified medical practitioner authorized or recognized by order of the Minister of National Health and Welfare as a medical officer for the purposes of this *Act*."

22. Immigration Manual, Employment and Immigration Canada, IS 8, (Selection and Control)

23. *Ibid.* at c. 8.02.

24. *Department of National Health and Welfare Act*, S.C. 1976.

gration Act.[25] The legal imperative for the medical officer is to identify "inadmissible persons" according to the two principle criteria in section 19(1); namely, danger to public health or safety (19(1)(a)(i)) and actual or potential demand on health and social services (19(1)(a)(ii)). As well, in assessing admissibility, the medical officer must use three supporting criteria described in section 22 of the Regulations to the *Immigration Act.* These are: (1) the probable response to treatment of any condition that might exist; (2) the need for surveillance; and (3) the potential employability or productivity of the applicant within Canada.

In order to give a medical opinion to Employment and Immigration officials in terms which are easily understood, a system of assessment has been developed whereby an applicannt is assigned a medical profile. This medical profile consists of a coded series of letters and numbers based on the two principle criteria and the three supporting criteria mentioned above. Under each criterion is a list of descriptive categories, numbered from one to seven or eight. Taken as a whole, the ratings assigned under each criterion form the basis for a legally binding medical opinion regarding admissibility.[24] This opinion is expressed by the symbol "M" at the end of the profile and represents the combined significance of the five criteria. The M statement indicates that in the opinion of a medical officer an applicant is either admissible, conditionally admissible or inadmissible.[26]

Three things need to be determined at this point. First, where the opinion of the medical officer is that the applicant is inadmissible, a second opinion is required by the *Immigration Act.*[27] Second, whether or not S. 19(1)(b) applies ("unwilling or unable to support themselves")

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25. *Supra*, note 20, s. 2(1).

26. Medical Officers Handbook, Immigation Medical Services (Ottawa: Health and Welfare Canada) s. III at 2. The applicant's status is shown in the profile in the following format:

    H D T S E M

    Where, briefly, H stands for risk to public health and safety, D for demand on health and social services, T for expected response to treatment, S for requirement of surveillance, E for employability and productivity, and M for medical status—the result of the other factors combined.

27. *Supra,* note 20 at s. 19(1)(a).

is decided by an immigration officer, based on his/her knowledge of civil factors as well as information provided by the medical officer. Third, by contrast, when the medical officer forms an opinion about the admissibility of an applicant purely on medical grounds using section 19(1)(a) of the *Act*, his/her medical judgment is legally binding so long as the visa officer is "satisfied", pursuant to s. 9(4) of the Act, that the applicant is a person described in s. 19(1).[28].

Thus there is a grant of broad discretion to medical officers to determine which applicants, if admitted to Canada, would cause, or might reasonably be expected to cause, excessive demands on health and social services. Nowhere in the *Immigration Act* or Regulations is the word "excessive" defined, although there is a list of factors to be considered by the medical officer in arriving at this determination.[29] Among these is whether the supply of health or social services that the person may require in Canada is so limited that the use by the applicant might prevent or delay provision of those services to Canadian citizens or permanent residents. Nevertheless, if the nature of discretion is that there is no uniquely right answer, that there is a power to make a choice between alternatives, then medical officers making determinations regarding "excessive demands on health and social services" have certainly been delegated discretion. This is especially clear when one considers that medical officers can and do find against admissibility based on the *probability* of excess demands being made in the future—thereby making use of the words "might reasonably be expected to cause" included in s. 19(1)(a)(ii).[30]

The scope of the discretion granted to medical officers is restricted to s. 22 of the *Regulations* which dictates that certain factors "shall" be taken into account. These include any other reports made by a medi-

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28. *Supra*, note 26 at 3. Where, in the opinion of the Minister of Employment and Immigration, special circumstances exist, an applicant may be admitted under a Minister's permit pursuant to s. 37 of the *Act* despite a finding by medical officers against admissibility. Also, visa or immigration officers are subject to the duty not to issue a refusal on medical grounds based on a medical notification which contains an "impropriety", *Patter v. M.E.I.*, [1987] 2 Imm. L.J. (2d) 1.

29. Regulations to the *Immigration Act*, s. 22.

30. *Ahir v. Canada (M.E.I.)*, [1984] 1. F.C. 1098, 163 N.R. 185 (F.C.A.) and *Hiramen v. Canada (M.E.I.)* (1986), 65. N.R. (F.C.A.).

cal practitioner; the communicability of the disease or disorder; any requirement of surveillance; the supply of required services for Canadians and permanent residents; the need for hospitalization; and whether the potential immigrant's employability or productivity is affected. Substance is added to these considerations in the form of the medical officer's handbook, which is distributed to medical officers by the MSB. The stated purpose of the manual is to "provide guidance" to medical officers in the medical categorization of applicants under the *Immigration Act*. The guidelines it contains, however, include what may amount to "policies" concerning the categorization of certain disabilities or diseases. Its preface states that the guidelines it contains are "confidently expected" to produce "the desired results."[31] Considering the volume of medical examinations it can be fairly assumed that among these unstated goals is that of efficient and consistant categorization of applicants.

There are numerous ways in which the discretion of medical officers is effectively fettered in the determination of admissibility under s. 19(1)(a)(ii), as a result of following the manual's guidelines. The first occurs when, once having made a diagnosis of a disease or disorder, the medical officer recurs to section IV of the manual where specific diseases are reviewed in relation to the criteria. There the medical officer will find explanations of how certain conditions "should be categorized" so that "logic and consistency" are maintained.[32] The danger that these guidelines may sometimes harden into rules is a very real one.

Indeed, there is considerable support in the case law to sustain the proposition that medical offices are using the manual's suggested categorizations in substitution for their own judgment on the admissibility of applicants. In *Le v Canada*,[33] for example, the Immigration Appeal Board heard an appeal from the refusal of a sponsored application for landing under s. 19(1)(a)(ii). Mediical officers had made a diagnosis of deafness, mutism and borderline intelligence. While counsel for the appellant, Barbara Jackman, attacked the reasonableness of the opin-

31. *Supra*, note 67.

32. *Supra*, note 27, Section IV at 2.

33. *Le v. Canada (M.E.I.)*, [1986] 3 Imm. L.R. (2d) at 56.

ion formed as bad in law, the case is also instructive for the obvious failure of the medical officers to really turn their minds to the questions which they were required to consider. More than anything, it appears that once the diagnosis was made, the categorization flowed not from further investigation or serious consideration of the criteria (response to treatment, future productivity, etc) but rather from the classification suggested. The medical opinion in this case was formed by an officer in Singapore and it is noteworthy that just before the medical notification was completed, the doctor in Singapore had advised the overseas medical officer in Bangkok by telex that "deaf mutism is no longer enough to warrant M7."[34] (M7 is the code for "Has a condition which *would* cause excessive demand on health or social services, and which is not likely to respond to treatment: Inadmissible as Section 19 (1)(a)(ii) applies.)"[35] The telex to Bangkok goes on to say, however, that "where deaf mutism is accompanied by borderline mental retardation" the sufferer "is to be assessed as M7."[36]

The Immigration Appeal Board has this to say about the opinion of the medical officers:

> "Their conclusion that Ngoc Thao (the dependent son of the sponsored applicant) was unemployable or unproductive was in flat contradiction (to) the material upon which they must be taken to have acted. Their conclusion that he would place an excessive demand on social services cannot be sustained... There is no evidence whatever that the government medical officers ever turned their attention to the social services Ngoc Thao might require.... We can only conclude that no evidence as to the demand on relevant social services was sought or relied upon by (the medical officer in Singapore) in arriving at his opinion."[37]

The letter of refusal received by the family began, ironically enough, with the words "we have carefully and sympathetically assessed your application under the *Immigration Act* and the Regulations..."[38] With regard to the telex, the Board's opinion was that it "unhappily shows

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34. *Supra*, note 34 at 58.

35. *Supra*, note 27, Section III at 20.

36. *Supra*, note 33 at 58.

37. *Ibid.* at 65.

38. *Ibid.* at 56.

that the originating office, Singapore, where (the medical officer) was stationed, operates in such a way as to fetter the full authority given by paragraph 19 (1)(a) of the *Act* to medical officers to form (reasonable) opinions."[39]

Again, this case was argued on the grounds of unreasonableness. There is every reason to believe that those applicants under the *Immigration Act* who have right of appeal to the board (Canadian citizens and permanent residents) will pursue remedies there or in the Federal Court of Canada along similar lines. Nevertheless, the availability of a particular remedy such as unreasonableness or acting on inadequate material (discussed above) should not obscure the fact of the larger scale abuse; the fettering of discretion by the adoption of inflexible policies. In the *Le* case there was a policy regarding deaf mutism in combination with borderline mental retardation and the discretion of the medical officers was decidedly fettered by aderence to that policy.[40] The consequences of this kind of fettering are especially severe in the case of independant applicants under the *Immigration Act*. In such cases, where there is no permanent reident or Canadian citizen sponsoring the applicatioon, no right of appeal exists, and neither is there any statutory requirement for MSB to review either the application or the medical notification. There is every reason to believe that abuses similar to those found in the *Le* case occur regularly overseas and, absent a right to review or appeal, findings of inadmissibility rooted in policy rather than on the merits will escape censure of any kind.

The medical officers' handbook contains numerous other illustrations of what may well be inflexible policies in the hands of medical officers. For example, the manual suggests that persons who suffer from Down's Syndrome "will, with rare exceptions, be categorized as M7"; that they are "expected to be unable to support themselves"; and that "the likelihood of medical and neurologic complications in addition to the mental sub-normality is also high and bears upon the matter of future demands upon health services."[41] While this is not a statement of policy that once a diagnosis of Down's Syndrome is made, inadmis-

39. *Ibid.* at 67.

40. *See also: Mohammed v. Canada (M.E.I.)*, [1987] 2 Imm. L.R. (2d) at 231.

41. *Supra*, note 27 at 40.

sibility follows, it is nevertheless precisely the sort of "guideline" which fetters the discretion of decision-makers. It does this in two ways: first, it suggests the answers to questions which the medical officer is duty-bound to entertain. For example, the question regarding expected demand on health and social services (the "D" category in the medical profile) is one in relation to "resources."[42] Even a cursory glance at the handbook makes clear that this is a complex and difficult question, and therefore one likely to be answered in a way suggested by the guidelines rather than based on any kind of committed investigation or inquiry into the facts of the individual case. In section III of the manual, (Assessing System and Method), the following passage appears after description of the considerations relevant to a "D" categorization:

> "9. It follows then that it is not possible at present to establish quantitative guidelines based on statistical analysis of Canadian Health and Social Care experience in order to differentiate the D1and D8 categories of the profile.
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> (a) They are worded, however, in such a way that the Medical Officer from his general professional experience, supplemented by such information as may be provided from time to time by Medical Services Branch, will be able to make a reasonably valid D catogorization."[43]

To arrive at a reasonable judgment as to whether or not any demand on services should be considered "excessive" is the task assigned to the medical officer. The handbook, however, prejudges this question and fetters the discretion of medical officers by suggesting the conclusion where a diagnosis of Down's Syndrome has been made: M7.

The second way in which the handbook serves to fetter the discretion of medical officers concerns the requirement that the initial medical opinion be concurred in by at least one other medical officer. Judging from many of the cases before the Immigration Appeal Board, one must seriously question whether any kind of review is done at all by the second, concurring medical officer.[44] In short, there is no reason to think that a diagnosis of Down's Syndrome, along with a notification

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42. *Supra*, note 27.

43. *Supra*, note 26.

44. *Garcha v. Canada (M.E.I)*, [1987] 6 Imm. L.R. (2d) at 92 (Editor's Note).

concluding "M7" would be reviewed with any vigor at all by the second medical officer. This process is what results in "the self-created rule of policy";[46] one which, in the case of Down's Syndrome, results in a flat refusal to consider the (admittedly difficult) questions concerning expected demand on health and social services, employability, and response to treatment.

It was suggested at the outset that it is generally possible to accomodate both the interests of decision-makers in developing policies which may determine the outcome of individual cases, and the interest of individuals in having a legitimate opportunity to have discretionary power exercised if the circumstances of their case warrant it. It was also suggested that special steps could be taken to ensure this result in the context of the Immigration Medical Activity. It is hoped that in developing proposals relating specifically to the Immigration Medical Activity, the more general proposition regarding the relationship between policy and discretion can be illustrated.

In regard to policies, the risk that has been demonstrated is that the requirement of considering each case to determine if an exception should be made can be reduced to a mere formality. What is particularly problematic in the area of medical categorizations is the absence of any meaningful participation on the part of interested parties. Such participation is essential is some consideration of the merits of each case is to be guaranteed.

At present, while the visa officer who issues a refusal on medical grounds is under a duty to provide all of the particulars and reasons for the refusal,[46] there is no duty to inform an applicant of an unfavourable diagnosis prior to the disposition of the application, and neither is there a duty to relate the refusal to the relevant criteria. In *Bal v. Canada*,[47] the Immigration Appeal Board found that the applicant had been treated unfairly because such a failure to inform (prior to disposition) denied him the opportunity to have a diagnostic liver biopsy. Such a procedure could have provided the means to rebut the grounds for inadmissibility. Yet the Board did not go further, to hold

45. J. Molot, "The Self-created Rule of Policy" 18:3 McGill L.J. at 310.

46. *Sidhu v. M.E.I.*, [1987] Imm. L.R. (2d) at 229.

47. *Bal v. Canada (M.E.I.)*, [1988] 6 Imm. L.R. (2d).

that the general duty of fairness discussed in the *Nicholson* case[48] created a specific duty to inform prior to disposition of the case. Clearly, if the merits of individual cases are to be "required reading" for medical officers, then an opportunity to rebut the medical officer's diagnosis is essential. Nonetheless, in *Stefanska v. Canada (M.E.I.)*[49] it was specifically noted that the immigration officer was not required to disclose the relevant medical information to the applicants before making her decision.[50]

This has at least two consequences relevant to the current discussion. First, and more generally, it ensures that applicants will be entirely alienated from the process to which they are being subjected. Second, and more specifically, it greatly increases the chances that abuses such as those in the *Le* and *Bal* cases will occur. Not only are the reasons for admissibility withheld until disposition—reasons which in the *Bal* case could have been rebutted—but with them also the policies which may have been invoked at the expense of the merits of the case. The conclusion that an individual's admission to Canada will cause "excessive" demands on health and social services might be patently unsustainable for reasons such as those in the *Bal* case (where no diagnosis had in fact yet been made) or because the medical officers, once having made a diagnosis, have not in fact turned their minds to the question of demand at all. Disclosure of the "reasons" prior to disposition would allow applicants an opportunity to make submissions as to why, in spite of the policy, discretion ought to be exercised in the circumstances of their particular case. For example, in the applicants diagnosed as having Down's Syndrome, an opportunity would be provided for the accumulation of evidence from teachers, doctors or employers aimed at rebutting the presumption that such applicants would probably cause excessive demands on health and social services.

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48. *Nicholson v. Haldimand—Norfold Police Commissioners Board*, [1979] 1. S.C.R. 311, 78 C.L.C.C. 14.

49. *Stefanska v. Canada* (M.E.I.), [1988] 6 Imm. L.R. (2d) at 66 (F.C.T.D.).

50. The duty of the immigration (or visa) officer is to be "satisfied", pursuant to s. 9(4) of the *Act.*, that the person concerned is in fact a member of the inadmissible class described in s. 19.

That such a requirement—mandated by the duty to be fair—would reduce abuses generally within the medical assessment sphere is plain. When one considers the number of times the Immigration Appeal Board has overturned negative medical notifications for being based on the possibility of demand being excessive, rather than on the probability[51] of excessive demand, it is clear that many such abuses could be prevented by more open administrative practice. A huge step in this direction would be taken if the policies on which medical officers act—as well as their duties—were required to be made more public and an opportunity provided to those affected to make representations in favour of an exception.

In the case of the Immigration Medical Activity, this would at the least, require the following: firstly, that the policies upon which medical officers act should be made readily accessible to interested parties; secondly, that there should be greater effort by Health and Welfare and Employment and Immigration officials to develop guidelines which explicitly recognize the fact of discretion and the need for close examination of the merits of each case in relation to the criteria; thirdly, that an interested party (made aware of the guidelines, the diagnosis, and an explanation of how the policy has been related to the particular case) should have an opportunity to make representations in favour of the discretion being used to produce an exception. In this way, the interest of the individual applicant in having discretion brought to bear on his/her case can be protected while acknowledging the inevitability that "rules of thumb" will be adopted by administrative agencies such as the Medical Services Branch.

51. *Canada (M.E.I.) v Pattar* (1988), 8 Imm. L.R. (2d) 79; *Garcho v. Canada (M.E.I.)* (1987), 6 Imm. L.R. (2d) 92; *Singh v. (M.E.I.)* (1987), 3 Imm. L.R. (2d) 240; *Longive v. Canada (M.E.I.)* (1987), 2 Imm. L.R. 174; *Esteban v. Canada (M.E.I.)* (1987), 2 Imm. L.R. (2d) 184.