Morbid Matters: Medical Assistance in Dying in Federal Corrections

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ABSTRACT

The perennial problem of federal prisons in Canada continues to be deaths in custody. While the issues of prison suicides (i.e., dying by unnatural causes) and aging in prison (i.e., dying by natural causes) remain significant concerns, the legalization and introduction of medical assistance in dying (MAiD) raises policy and operational challenges for federally sentenced and terminally ill prisoners. Correctional Service of Canada (CSC) policy now allows for an external provider to end the life of a prisoner, contingent upon exceptional circumstances. Beyond the optics of an agency of the state enabling or facilitating inmate deaths, there are greater moral, ethical and practical considerations that must be discussed. This article explores the state and challenges of carrying out MAiD in relation to penitentiary settings. As the findings suggest, the arrival of MAiD has prompted an expansion of ideas of what constitutes fostering life or marking for death, and the relationship between the pair.

KEY WORDS: *death; dying; prison; MAiD; medical assistance in dying; corrections; Canada.*

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I. INTRODUCTION[1]

The perennial problem of federal prisons in Canada continues to be deaths in custody. While the issues of prison suicides (i.e. dying by unnatural causes) and aging in prison (i.e. dying by natural causes) remain significant concerns, the legalization and introduction of medical assistance in dying (MAiD)[2] raises policy and operational challenges for federally sentenced and terminally ill prisoners. Correctional Service of Canada (CSC) policy now allows for an external provider to end the life of a prisoner, contingent upon exceptional

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1 We respectfully acknowledge that we work and live on traditional territories of Indigenous peoples on Turtle Island. It is a place where the spirit of treaties signed between Indigenous peoples and settler colonial governments is not honoured; thus, we are committed to conversations and relationships in solidarity with Indigenous peoples for change, justice, and reconciliation. We offer our gratitude to Indigenous peoples for their care for, and teachings about, our earth and our relations. May we honour those teachings.

2 It is essential to note the two types of MAiD available in Canada: physician-assisted suicide and voluntary euthanasia. In terms of the former, physician-assisted suicide is defined as "A physician or nurse practitioner directly administers a substance that causes death, such as an injection of a drug. This is sometimes called clinician-administered medical assistance in dying." In terms of the latter, voluntary euthanasia is defined as "A physician or nurse practitioner provides or prescribes a drug that the eligible person takes themselves, in order to bring about their own death. This is sometimes called self-administered medical assistance in dying." Though both can be established as the same concept and work intersectionally, they have a notable difference regarding administration. Our article will discuss and reference differences between the two procedures, especially regarding international comparison. Doing so gives recognition to each system and who is administering it. Nurse practitioners have the authority to issue both methods in Canada. MAiD is an intersectional term that addresses the legalities according to each administration. Each technique is governed differently between provinces and territories that correspond with the organizations regulating the practice of medicine. As MAiD continues to evolve in practice, the terminology has expanded to include assisted suicide, euthanasia, aid-in-dying, and physician-assisted suicide. Only the above-defined methods will be actively discussed to keep the article cohesive when referring to MAiD. See Government of Canada, "Medical Assistance in Dying: Overview" (March 2023) at paras 3-4, online: <https://www.canada.ca/en/health-canada/services/health-services-benefits/medical-assistance-dying.html> [perma.cc/JTA7-6SNY]; Government of Canada, "Medical Assistance in Dying: Legislation in Canada" (March 2024) at para 2, online: <https://www.canada.ca/en/health-canada/services/health-services-benefits/medical-assistance-dying/legislation-canada.html> [perma.cc/N7QT-ZFLX].

circumstances. Beyond the optics of an agency of the state enabling or facilitating inmate deaths, there are greater moral, ethical and practical considerations that must be discussed. Drawing upon aspects of carceral and legal geography, and coupled with case law, this article explores the state and challenges of carrying out MAiD in relation to penitentiary settings.[3]

We structure the article as follows. Drawing upon aspects of carceral[4] and legal geography, as well as extant literature on law, death and dying in prison, we illustrate unique insight into strategies and techniques of law and space; spaces of incarceration, and the legal and policy challenges within them, carve open a unique opportunity to explore the concerns of dying in custody. Moreover, death persists as a topic of concern for law; while law can produce death, in this conversation of MAiD, it is death that produces law, and the potential to regulate legal deathscapes and carceral spaces in the process. Taken together, we then turn to a focus on assisted dying legislation internationally, as well as Canadian MAiD legislation. We also draw upon recent prison case law to situate our discussion, and establish the necessary footing to consider the moral, ethical, and practical challenges of CSC providing this service to terminally ill prisoners. In effect, this discussion provides a useful entry point for the analysis of prison health, death, and punishment by way of trying to die in a distinct way. We

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3 See generally Correctional Service of Canada, "Commissioner's Directive 800: Guidelines 800-9 Medical Assistance in Dying" (18 March 2024) online: <https://www.canada.ca/en/correctional-service/corporate/acts-regulations-policy/commissioners-directives/guidelines/800-9.html> [perma.cc/6RHP-6C6R] [CD 800-9]; Correctional Service of Canada, "Policy Bulletin 174" (18 March 2024) online: <https://www.canada.ca/en/correctional-service/corporate/acts-regulations-policy/commissioners-directives/policy-bulletins/714.html> [perma.cc/PV3Q-A4JJ] [Policy Bulletin 174].

4 When we speak of 'carceral space' we take our cues from Moran, Turner and Schliehe's interpretation of the 'carceral', meaning we recognize the detriment, intent, and spatiality which, taken together, composes and comprises spaces of incarceration, imprisonment, detention, and punishment themselves. As Gacek contends, an exploration of the carceral "is a perspective that examines what lies above, beneath, betwixt, between, and beyond carceral sites, practices, regimes, technologies, and schemes." See Dominique Moran, Jennifer Turner & Anna K Schliehe, "Conceptualizing the carceral in carceral geography" (2018) 42:5 Progress In Human Geography 666; and James Gacek, *Portable Prisons: Electronic Monitoring and the Creation of Carceral Territory* (Kingston: McGill-Queen's University Press, 2022) at 26 [Gacek 2022].

conclude with recommendations for improving law and federal correctional policy.

II. SETTING THE CONTEXT

The intricate tapestry of terminally ill prisoners and prisoners-as-patients is inextricably woven with the threads of recognition, rights, and protections. Within this intricate weave, we see the profoundly significant elements of life and death behind bars, both shaping and being shaped by the carceral experience and the laws and policies that oversee incarcerated individuals. The historical footprints of legal decisions echo through time, imprinting their influence on terminally ill prisoners seeking MAiD. How do these legal pathways intersect with ethics, morals, and the carceral realities terminally ill prisoners specifically and prisoners-as-patients generally face?

This article's subsequent endeavour is a journey to explore the corridors of case law and policy, aiming to illuminate the impact that law and policy have on our perception and social construction—and institutional construction—of how terminally ill prisoners and prisoners-as-patients exist within and alongside of the socio-legal, ethical and moral challenges of death and dying in prison. The intersection of assisted death/suicide and the carceral system constructs a discrete series of potential rights challenges for terminally ill prisoners and prisoner-as-patients; subjected to an institutional gaze, through the physical and socio-juridic confines of incarceration. A note of caution, however, in the following discussion – by exploring MAiD in federal corrections, one may question whether we are advocating for or against the legalization of MAiD. The answer is not a simple binary. Carceral physical settings construct multiple and intersecting harms, subjectively and objectively. The lived realities of prisoners-as-patients in physical carceral settings are critical to complicating the simplicity of a one-size-fits-all approach to penal reformation. As a result, we take neither position of advocating for or against MAiD in full. Rather, our aim in this is article is to remain agnostic in our approach of exploring MAiD in federal corrections, while at the same time recognizing the arguments on both sides and suggesting that a spectrum of justice exists, where internalist and externalist perspectives have strengths and weaknesses and each are recognizable by their epistemology. In other words, we recognize a need to understand this phenomenon, without throwing one's

hands up in the externalist angst of moral relativism. We are not suggesting here that we have an answer to the question of MAiD in prison, only that we strive to initiate certain conversations about MAiD in federal corrections in particular ways, and further conversation about MAiD in federal corrections in others.

Notwithstanding, amidst the intricacies indicated above, change remains possible—the potential for the law and correctional policy to better mirror the diverse spectrum of terminally ill prisoners and their carceral realities. As a starting point, this article explores the existing literature on death and dying in prison, drawing upon aspects of carceral and legal geography to place our article's focus within associate scholarship of the intersections within and between carceral and legal space. We then explore international perspectives on assisted death/suicide, before turning our attention toward on the evolution of Canadian jurisprudence, as case law unfurls around the contours of recognition, rights, and protections for terminally ill patients. The narrative then pivots to explore Canadian case law and data, before centring our focus upon the ethical, moral, and practical challenges of operating MAiD in federal corrections.

In the discussion below, we endeavour to decode the intricate socio-carceral interplay that binds case law with terminally ill incarcerated individuals in the Canadian context and beyond. As the exploration concludes, we strive to reconcile the complexities of autonomy, rights, and the law, and to shape a more inclusive and just future for those behind bars, reconsidering quality of life *and* quality of death in the process.

III. The Process, Problems, and Politics of Death and Dying in Prison

The ending of life in custody is—and should be—controversial. Deaths in prison "raise issues of accountability, legitimacy, and quality of life as well as questions about the quality of death (not only for those who die of natural causes in prison as a result of their age or sentence)."[5] Considerable policy development is under way in this field, especially as the prison population ages.[6] Simultaneously, rising numbers of aging prisoners and goals on

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5 Alison Liebling, (2017) "The Meaning of Ending Life in Prison" 23:1 Journal of Correctional Healthcare 20 at 20 [Liebling].

6 *Ibid.*

implementing equivalent health care in prison raise issues surround palliative end-of-life care for prisoners.[7] The guiding principle for health care in the correctional setting is the principle of equivalence of care, which suggests that the health care offered to prisoners should be equivalent to that received by individuals in the community.[8] Following this principle would entail making end-of-life services such as hospice, palliative care, and MAiD available to prisoners. Yet, the problem remains whether these services should be provided outside the prison or inside.

Death and dying are not purely medical issues; they involve many more facets because of their finality.[9] This complexity raises additional and even metaphysical questions regarding the limits of punishment and law, such as whether death in prison is justified by the goals of imprisonment and, if yes, under what conditions.[10] In this article, death refers to the process of dying and thus incorporates "the period in which there is an awareness of what will end a particular person's life[.]"[11] For example, one can contemplate the criteria for a "good death" and "death with dignity" such as relieving pain and suffering, readiness, control, and autonomy using Allmark's concept of "death without indignities."[12] This concept is useful as it identifies two important factors that allow an ethical analysis: measures that

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7 Dumsday warns against the conflation of 'medical assistance in dying' with standard palliative care; while the latter can form the basis of the former, it is not necessary to do so, as many people choose palliative care for a diverse set of reasons and do not want MAiD. See generally Travis Dumsday, *Assisted Suicide in Canada: Moral, Legal, and Policy Considerations* (Kingston: McGill-Queen's University Press, 2021). See generally Violet Handtke & Tenzin Wangmo (2014) 11:3 Bioethical Inquiry 373 [Handtke & Wangmo].

8 See generally United Nations, "Basic Principles for the Treatment of Prisoners" (14 December 1990) online: <https://www.ohchr.org/sites/default/files/basicprinciples.pdf> [perma.cc/D62Q-XB92]; and World Health Organization, "The WHO/Europe Health in Prison Programme (HIPP)" (no date) online: <https://www.who.int/europe/teams/alcohol-illicit-drugs-prison-health/the-who-europe-health-in-prisons-programme-(hipp)> [perma.cc/7YQM-QM2L].

9 See generally Ira Byock, "Dying Well in Corrections: Why Should We Care?" (2002) 9:2 Journal of Correctional Health Care 107.

10 Handtke & Wangmo, *supra* note 7.

11 Peter Allmark "Death with Dignity" (2002) 28:4 Journal of Medical Ethics 255 at 255 [Allmark].

12 *Ibid* at 257.

would reinforce autonomy and removal of barriers to dignity (as we discuss below). In Liebling's assessment of deaths in custody, the author indicates they have long supported the principle of euthanasia, under certain circumstances, and on the grounds of dignity and freedom; in other words, of being the author of one's own life. As Liebling contends, autonomy and self-determination are central to dignity. But in prison, this is a double-edged dilemma (like religion and meditation, which bring comfort but counsel acceptance and adjustment).[13] As we will see, there are also questions of capability, resources, and environmental effects that the Canadian federal system has yet to meaningfully consider and make clear for those who wish to pursue MAiD in prison.

When we consider the general natural and unnatural causes of death in custody, dying in prison shares many of the qualities of the worst kind of death: realistically no one shares in it, few are prepared for it, there is no progressive disentangling from commitments and activities, "bringing to closure or completeness of one's affairs"[14], no saying of goodbyes, and no "affirmation of the whole person" characteristic of the "good death".[15] These are undignified deaths, marking a kind of completeness of the exclusion so often experienced by prisoners. We may even constitute these deaths a form of "disenfranchised dying"[16], insofar as illness rarely precedes the death, and more rarely still can the deceased make choices about the dying experience or the funeral to follow. In the aftermath, shared experiences of loss and mourning are also often inaccessible.

To focus on death and dying in prison means we must also consider how the detriment and intent of spaces of incarceration are perceived and experienced; this is where aspects of carceral and legal geography come into

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13 Liebling, *supra* note 5.

14 Geoffrey Scarre, "Dying and Philosophy" in Allan Kellehear ed, *The Study of Dying: From Autonomy to Transformation* (Cambridge, England: Cambridge University Press, 2009) 147 at 149.

15 Michael Ashby, "The Dying Human: A Perspective from Palliative Medicine" in Allan Kellehear ed, *The Study of Dying: From Autonomy to Transformation* (Cambridge, England: Cambridge University Press, 2009) 76 at 82.

16 Allan Kellehear, "What the Social and Behavioural Studies Say About Dying" in Allan Kellehear ed, *The Study of Dying: From Autonomy to Transformation* (Cambridge, England: Cambridge University Press, 2009 1 at 14; and R Lane, *Disenfranchised and Imprisoned Grief and Loss Within the Prison Context* (PhD Thesis, University of Chester, 2015) [unpublished].

view. For example, carceral geography and its subsequent scholarship have taken seriously regimes of imprisonment, detention, temporary holding, and captivity. A major contribution of carceral geography is that definitions of "carceral" should encompass more than the spaces people are enclosed within.[17] Prison spaces, as carceral, typically maintain "a selective and imperfect degree of separation" between what lies beyond and what exists inside the "carceral".[18] Carceral geography "is well-suited to focusing on a range of carceral spaces and places, from institutional, political, and structural contexts at the macro-level to the minute experiences, practices, and agency of everyday life".[19] The discipline is ripe for discussions about death and dying; while some prisoners do die in custody, and others feel a sort of 'social death' in custody[20] their position is not akin to that of deceased.[21] As indicated above, deaths of prisoners occurring in custody usually are due to causes such as suicide, violence, accidents, and illnesses. Suicides are especially frequent in prison, and can be prevented in most cases.[22] Natural deaths, however, necessitate different care and interventions might become more frequent in the future due to the rising number of prisoners living to very old ages[23], a trend visible in the United

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17 Dominique Moran, "Carceral Geography and the Spatialities of Prison Visiting: Visitation, Recidivism and Hyperincarceration" (2013) 31:1 Environment and Planning D: Society and Space 174 at 176.

18 Dominique Moran, *Carceral Geography: Spaces and Practices of Incarceration* (Farnham, England: Ashgate, 2015) at 90.

19 Gacek 2022, *supra* note 4 at 26.

20 See generally Joshua M Price, *Prison and Social Death* (New Brunswick, NJ: Rutgers University Press, 2015).

21 See generally Avril Maddrell, "A Place for Grief and Belief: The Witness Cairn, Isle of Whithorn, Galloway, Scotland" (2009) 10:6 Social and Cultural Geography 675; Avril Maddrell, "Living With the Deceased: Absence, Presence, and Absence Presence" (2013) Cultural Geographies 20501; and Avril Maddrell & James D Sidaway, "Introduction: Bringing a Spatial Lens to Death, Dying, Mourning and Remembrance" in Avril Maddrell & James D Sidaway, eds, *Deathscapes: Spaces for Death, Dying, Mourning and Remembrance* (Farnham, England: Ashgate, 2010).

22 See generally Norbert Konrad et al, "Preventing Suicide in Prisons, Part I: Recommendations from the International Association for Suicide Prevention Task Force on Suicide in Prisons (2007) 28:3 Crisis 113 and Seena Fazel et al, "Suicide in Prisoners: A Systematic Review of Risk Factors" (2008) 69:11 Journal of Clinical Psychiatry 1721.

23 See generally Mary Turner, Sheila Payne & Zephyrine Barbarachild, "Care or Custody? An

States[24] and in Canada.[25] The rise in the number of elderly prisoners is attributed to demographic changes in society, trends towards longer as well as harsher sentences, and more older adults entering the prison system.[26] Moreover, the ways in which the spaces of the prison are thus experienced resonates with geographical work on the 'hauntological'. As Moran and Disney contend, "[t]he negation of presence is experienced almost as a haunting", insofar as the deceased can live on through space and law, manifesting themselves in a sort of pseudo-presence; the deceased reappears not in flesh and blood, but through spectral hauntings, keepsakes, or memories for some, and through law, legislation, and policy for others.[27] How and why people die in custody (or are saved from death)[28] remains a conversation for carceral and legal geography and cognate disciplines to continue to have in greater detail.

Since pre-confederation, prisons in Canada, like in other Western countries, exist as a multifaceted reflection of the building of settler colonial infrastructures; they remain the result of political development while embracing the changing approaches of penal philosophy. Yet, federal prison conditions remain invariably poor for correctional officers (COs) and

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Evaluation of Palliative Care in Prisons in Northwest England" (2011) 25:4 Palliative Medicine 370.

24 See generally FD Glamser & DA Cabana, "Dying in a Total Institution" in Clifton D Bryant, ed, *Handbook of Death and Dying* (Thousand Oaks, CA: SAGE Publications, 2003) 495 [Glamser & Cabana].

25 See generally Adeline Iftene, *Punished for Aging: Vulnerability, Rights, and Access to Justice in Canadian Penitentiaries* (Toronto: University of Toronto Press, 2019) [Iftene 2019] and Adeline Iftene, "We Must Decarcerate Across the Country, Then Fix the Prison System" (20 April 2020) Policy Options available online: <https://policyoptions.irpp.org/magazines/april-2020/we-must-decarcerate-across-the-country-then-fix-the-prison-system/> [perma.cc/M73C-WZNF].

26 Glamser & Cabana, *supra* note 24 ; Iftene 2019 *supra,* note 25.

27 Dominique Moran & Tom Disney, "'It's a horrible, horrible feeling': Ghosting and the Layered Geographies of Absent-Presence in the Prison Visiting Room" (2020) 20:5 Social and Cultural Geography 692 at 695.

28 See generally Rosemary Ricciardelli, Maia Idzikowski & Keltie Pratt, "Lives Saved: Correctional Officers' Experiences in the Prevention of Prison Death by Suicide" (2020) 1:2 Incarceration 1 [Ricciardelli et al 2020].

prisoners[29] alike.[30] The physical conditions of a correctional facility can also have a significant impact on relations among prisoners and prisoners and COs.[31] Besides poor hygiene practices and increased rates of communicable diseases, outdated building infrastructure, poor ventilation and plumbing systems all factor into the health of a prison itself and to those who work and are incarcerated inside of it.[32] Overcrowded prisons, in part due to double-bunking and lack of physical distancing opportunities, represent a risk of contagion in environments that are confined; the COVID-19 pandemic is evidence of this risk. Recent calls to reconsider the traditional architectures and landscapes of prisons in light of health, well-being, quality of life, and ontological security similarly concern prison infrastructure health, staff and prisoner health as well.[33]

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[29] Literature differs on whether to use terms like 'prisoners' versus 'inmates' versus 'offenders'. Rather than engage in a discussion of semantics, we respectively recognize how some literature may interchange the terms while others have distinctive reasons to use one term instead of others. Our use of terms will vary by context.

[30] Iftene 2019, *supra* note 25; See generally Katie Doke Sawatsky & Krista Baliko, "Healthcare Reform Needed in Correctional Institutions" (30 March 2021) Discourse, available online at <https://www.discoursemagazine.ca/healthcare-reform-needed-in-correctional-institutions/2021/03/29/> [**perma.cc/389U-SL6S**] ; James Gacek, "Ethical Considerations for Pandemic Prison Research" (2021) 10 Annual Review of Interdisciplinary Justice Research 172 [Gacek 2021a]; and James Gacek, "Opinion: All Workers and Inmates in Saskatchewan Jails Need to Be Vaccinated Now", *Regina Leader-Post* (29 April 2021), <https://leaderpost.com/opinion/columnists/opinion-all-workers-and-inmates-in-saskatchewan-jails-need-to-be-vaccinated-now> [perma.cc/RP2L-2GDE] [Gacek 2021b].

[31] See generally David M Bierie, "Is Tougher Better? The Impact of Physical Prison Conditions on Inmate Violence" (2012) 56:3 International Journal of Offender Therapy and Comparative Criminology 338; and Rosemary Ricciardelli, *Also Serving Time: Canada's Provincial and Territorial Correctional Officers*, (Toronto: University of Toronto Press, 2019).

[32] Gacek 2021b, *supra* note 30; See generally Simonne Poirier, Gregory R Brown & Terry M Carlson, *Decades of Darkness: Moving Toward the Light, A Review of the Prison System in Newfoundland and Labrador* (St John's: Review Panel of Adult Corrections, Province of Newfoundland and Labrador, 2008) available online (pdf): <https://www.gov.nl.ca/jps/files/publications-ac-report.pdf> [perma.cc/U82D-HWJM]; and Marcella Siqueira Cassiano, Fatih Ozturk & Rosemary Ricciardelli, "Fear of Infectious Diseases and Perceived Contagion Risk Count as an Occupational Health and Safety Hazard: Accounts from Correctional Officer Recruits in Canada" (2022) 55:1 Journal of Criminology 47.

[33] See generally Yvonne Jewkes & Dominique Moran, "The Paradox of the 'Green' Prison:

In Canada, there is one federal prison system, CSC, and 13 provincial and territorial correctional systems. Although each system is largely independently governed, there are select basic underpinnings that inform how COs respond to deaths in custody. In the federal system, in accordance with section 19 of the *Corrections and Conditional Release Act*, correctional staff are required to investigate and report whenever a prisoner dies in custody[34]. In the event of a natural in-custody death, a mortality review, the purpose of which is to review the "events, overall care, quality of life, and the clinical care" the deceased received before their death, is conducted.[35] These reviews are conducted by a group referred to as a National Board of Investigation (NBOI). Often, as part of the NBOI, staff and management will also be investigated to examine if correctional policies and practices were followed.[36] Following either a mortality review or an NBOI review,

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Sustaining the Environment or Sustaining the Penal Complex?" (2015) 19:4 Theoretical Criminology 451; Yvonne Jewkes, "Just Design: Healthy Prisons and the Architecture of Hope" (2018) 51:3 Australian & New Zealand Journal of Criminology 319; Jennifer Turner & Dominique Moran, "Careful Control: The Infrastructure of Water in Carceral Space" (2019) 51:2 Area 208; Hannah Wright, *Outside Time: A Personal History of Prison Farming and Gardening,* (HMP Coldingley: Placewise Press, 2017); Yvonne Jewkes, Dominique Moran & Jennifer Turner, "Just Add Water: Prisons, Therapeutic Landscapes and Healthy Blue Space" (2020) 20:4 Criminology & Criminal Justice 381; Jennifer Turner, Rosemary Ricciardelli & James Gacek, "The 'Pains of Employment'? Connecting Air and Sound Quality to Correctional Officer Experiences of Health and Wellness in Prison Space" (2023) 103:5 The Prison Journal 1; and James Gacek, Jennifer Turner & Bastien Quirion, "Mettre en lumière la lumière: L'éclairage carcéreal, le travail correctionnel et le bien-être (2023) 56:2 *Revue Criminologie* 1.

34 CD 800-9, *supra* note 3. Note though: "After the death of an inmate through MAID, there is no requirement for CSC to convene a board of investigation or a mortality review"; See also *Corrections and Conditional Release Act* (S.C. 1992, c. 20), s 19 [*CCRA*]; and Correctional Service of Canada, "Commissioner's Directive 041: Incident Investigations" (8 September 2020) online at <https://www.canada.ca/en/correctional-service/corporate/acts-regulations-policy/commissioners-directives/041.html> [perma.cc/9NXC-YAVD] [CD 041].

35 See generally *CCRA*, *supra* note 34; and CD 041, *supra* note 34.

36 See generally Correctional Service Canada, "Death of a Person in the Care and Custody of Correctional Service of Canada: A Guide for Family and Friends" (October 2021), online: <https://www.canada.ca/en/correctional-service/corporate/library/deaths-custody/guide-family-friends.html> [perma.cc/8CP3-7DAC] [CSC 2021]; and Correctional Service Canada, "Annual Report on Deaths in Custody: 2016/2017" (2019), online: <https://publications.gc.ca/collections/collection_2020/scc-csc/PS81-

recommendations may be made to change policies and practices with the intention of preventing future deaths.[37] The occupational mandate of the federal correctional officer (CO) is to preserve life and maintain the safety and security (i.e., care, custody, and control) of prisoners, staff, the institution, and civilians or society at large.[38] Central to the CO role is maintaining the safety and wellbeing of those who are incarcerated, which includes in intervening in and preventing, if possible, nonnatural deaths.[39] In sum, Canada's federal correctional system operates with unique regulations, orders, and social functioning alongside its provincial and territorial counterparts. If we suspect that views on death and dying are imported into this system, we must question the state and implementation of MAiD in the process; this may also mean that hospice, and palliative care need to be customised to suit the purposes of federal penitentiaries (as discussed below).

Indeed, federal correctional facilities are both carceral and legal spaces. There is growing awareness among geographers and legal scholars alike that "law is constructed by geographical space[.]"[40] This is testament to decades of geographical scholarship foregrounding the co-constitution of space and law.[41] There are intimate relations between and amongst law, location, and time, not only in terms of how "a social space differentially affects the emergence or application of a law" but also how "representations of space inhere in and are produced from legal phenomena[.]"[42] The performance of law is a key mechanism of social reproduction, including social inequality.[43] Connecting to the conversation of death and dying, the law

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14-2017-eng.pdf> [perma.cc/4UXG-BVN9] [CSC 2019].

37 Ricciardelli et al, 2020, *supra* note 28.

38 See generally Correctional Service Canada, "Commissioner's Directive 001: Mission, Values and Ethics Framework of the Correctional Service of Canada" (5 April 2018), online: <https://www.canada.ca/en/correctional-service/corporate/acts-regulations-policy/commissioners-directives/001.html> [perma.cc/D23Q-HYY8].

39 CSC 2021, *supra* note 38; and CSC 2019, *supra* note 36.

40 Alex Faulkner, Bettina Lange & Christopher Lawless, "Introduction: Material Worlds: Intersections of Law, Science, Technology, and Society" (2012) 39:1 JL & Soc'y 1 at 8.

41 *Ibid.*

42 Joshua DM Shaw, "Transcarceral Lawscapes Enacted in Moments of Aboriginalistion: A Case-Study of an Indigenous Woman Released on Urban Parole" (2020) 16:4 International Journal of Law in Context 422 at 423.

43 Nick Gill, "What's Missing From Legal Geography and Materialist Studies of Law?

may indeed be everywhere, speaking to law's omnipresence but it is not experienced equally.[44] Carceral modes of social control and coercion, such as the discipline, surveillance and confinement of prisoners, increasingly extend outside the built walls of the prison as punitive modes of public administration and policing follow individuals long after they have crossed the threshold back into society.[45] Laws limit prisoners' rights and freedoms while they are incarcerated, depending on the jurisdiction.[46]

Indeed, the relationship between law and space continue to receive attention, especially when one considers end-of-life issues.[47] This is due in part to the increasing number of adults living to very advanced ages with the help of medical technologies, which inevitably lengthens the dying process. Death and dying concerns, coupled with meanings of a "good death" and a "death with dignity" have been explored in the general population. For example, end-of-life care and decision making frequently involve discourse on dignity.[48] Prior to the introduction of MAiD, a groundswell of support for death with autonomy, self-determination, freedom and, ultimately, dignity had developed over the decades.[49] This movement claims a right to "die with dignity," a concept on which palliative care and clinical decisions are based. In a parallel vein, the concept of a "good death" is central to improving the care for dying people[50] and is key to the hospice movement.[51] Though both concepts have been critiqued for

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Absence and the Assembling of Asylum Appeal Hearings in Europe" (2020) 45:4 Transactions of the Institute of British Geographers 937 at 939.

44 See generally Austin Sarat, "…'The Law is All Over': Power, Resistance and the Legal Consciousness of the Welfare Poor" (1990) 2:2 Yale Journal of Law and the Humanities 343.

45 Gacek 2020, *supra* note 4.

46 See generally Tina Maschi & Marina Richter, "Human Rights and Dignity Behind Bars: A Reflection on Death and Dying in World Prisons" (2017) 23:1 Journal of Correctional Healthcare 76.

47 Handtke & Wangmo, *supra* note 7; and Iftene 2019, *supra* note 25.

48 See generally Annette F Street & David W Kissane, "Constructions of Dignity in End-of-Life Care" (2001) 17:2 Journal of Palliative Care 93.

49 Handtke & Wangmo, *supra* note 7 .

50 See generally Ezekiel J Emanuel & Linda L Emanuel, "The Promise of a Good Death" (1998) 351 The Lancet SII21 [Emanuel & Emanuel].

51 See generally Bethne Hart, Peter Sainsbury & Stephanie Short, "Whose Dying? A Sociological Critique of the 'Good Death'" (1998) 3:1 Mortality 65.

their vagueness, the pair have led to changes in end-of-life care and the dying process, as they become key starting points to address individuals' concerns regarding a loss of dignity, decreased ability to exercise autonomy and control, and being dependent as well as a burden on others as they age.[52]

Yet, the attention and resources directed towards a good death and death with dignity in the general community may not be available to those who are incarcerated; in most cases these advances seem to halt at the threshold of the prison. The increasing older prisoner population is a challenge for various countries as death and issues surrounding end-of-life care become a pressing concern for prison health care and administration.[53] Prisons generally lack end-of-life services and the justifications for imprisonment (retribution, deterrence, rehabilitation, and incapacitation) are often in conflict with or impede the provision of quality care to prisoners.[54] For example, Iftene's study of aging prisoners in Canada indicates that of the seven federal penitentiaries she was able to visit, none of them had a palliative care unit. Where hospice is available, dying prisoners were sometimes sent there, "though the space was limited and transfers required a significant amount of paperwork".[55] While there may have been attempts to provide palliative care on an individual basis, "this venture was seriously restricted by the prisons' security policies".[56] As Iftene indicates:

> Through an *Access to Information Act Request*, I obtained a CSC guideline called *Hospice Palliative Care Guidelines for Correctional Service of Canada*. This document offers instructions to different staff members regarding how to interact with dying prisoners and emphasizes the need for a team of individuals to help with end-of-life care. [Yet] [t]he material makes it clear that palliative care is not systematic, and

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52 See generally David W Kissane, Annette Street, & Philip Nitschke, "Seven Deaths in Darwin: Case Studies Under the Rights of the Terminally Ill Act, Northern Territory, Australia" (1998) 352: 9134 The Lancet 1097; and June Mui Hing Mak & Michael Clinton, "Promoting a Good Death: An Agenda for Outcomes Research – A Review of the Literature" (1999) 6:2 Nursing Ethics 97 [Mak & Clinton].

53 See generally Helene Love, "Aging Prisoners: A Brief Report of Key Legal and Policy Dilemmas" (2013) 2:1 International Journal of Criminology and Sociology 322.

54 Handtke & Wangmo, *supra* note 7 ; and Iftene 2019, *supra* note 25.

55 Iftene 2019, *supra* note 25 at 69.

56 *Ibid* at 70.

> that dying prisoners are housed in the same facilities as everyone else and, thus, subjected to the same security rules and medical regulations.[57]

Without a palliative care unit, it becomes difficult to administer the strong medication available in the outside community to terminally ill prisoners in similar situations inside these prisons. With no adjusted infrastructure and medical staff not available at all times, prisoners who are terminally ill are unable to receive the special housing and consistent support they need to live out the remaining time they have alive.[58]

If prisoners live to old ages like their counterparts in the community, then they are likely to face aging and end-of-life care earlier and probably for longer periods.[59] Therefore, "the mortality associated with an aging prison population" will often be evident within a shorter period of time.[60] Related to accelerated aging, the health of prisoners, both physical and mental, is also worse than that of the general population, with higher numbers of chronic diseases and greater indulgence in risky behaviours.[61] These health and behavioural factors, combined with possible low health literacy and living in an enclosed environment with considerably diminished autonomy, make prisoners a vulnerable group with regards to many aspects of their life and health, including end-of-life care.[62]

Literature on end-of-life care in prison and attitudes of prisoners towards death rarely use narratives of older inmates, with the exception of

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57 *Ibid.*

58 *Ibid.*

59 Handtke & Wangmo, *supra* note 7.

60 Glamser & Cabana, *supra* note 24 at 497.

61 See generally Seena Fazel et al, "Health of Elderly Male Prisoners: Worse Than the General Population, Worse than Younger Prisoners" (2001) 30:5 Age and Ageing 403; and Ronald H Aday, Aging Prisoners: Crisis in American Corrections, (Westport CT: Praeger, 2003).

62 See generally John F Linder & Frederick J Meyers, "Palliative Care for Prison Inmates: 'Don't Let Me Die in Prison'" (2007) 298:8 The Journal of the American Medical Association 894; and Carol Evans, Ronda Herzog & Tanya Tillman, "The Louisiana State Penitentiary: Angola Prison Hospice" (2002) 5:4 Journal of Palliative Medicine 553.

studies from the United States[63] and Canada.[64] Singer and colleagues point out the importance of patients' perspectives on the quality of end-of-life care as they are the "most affected".[65] Aday investigated death anxiety and attitudes towards dying in prison among 102 prisoners. Their study findings demonstrate that different factors such as age, health status, and social support influence fear of death.[66] Additionally, prisoners view death as an escape from their current condition of limited hope for the future. Deaton and colleagues examined attitudes of women offenders towards death and their findings were similar to that of Aday. Prominent themes from Deaton et al included fear of death, access to health care in cases of emergency, and the use of coping strategies such as denial and acceptance to deal with the prospect of dying in prison.[67]

In sum, the ending of life in custody continues to be controversial. As we will see below, Canada is not the only jurisdiction developing conversations with regards to the assisted dying behind bars. Aside from the extant literature on death and dying and coupled with cognate disciplines, setting up the international context for assisted dying/suicide completes our efforts to form the bedrock for the present article. We turn to international perspectives next.

IV. International Perspectives on Assisted Dying/Suicide

Before looking to Canada's perspective on MAiD, it is useful to gain an understanding of assisted dying/suicide in carceral settings internationally. Outside of Canada, only three other countries are known to have allowed MAiD/assisted suicide for incarcerated individuals; Switzerland, Belgium,

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63 See generally Ronald H. Aday, "Aging Prisoners' Concerns Toward Dying in Prison" (2006) 52:3 OMEGA: Journal of Death and Dying 199 [Aday 2006]; and Dayron Deaton, Ron H. Aday, & Azrini Wahidin, "The Effect of Health and Penal Harm on Aging Female Prisoners' Views of Dying in Prison" (2009) 60:1 OMEGA: Journal of Death and Dying 51 [Deaton et al 2009].

64 Iftene 2019, *supra* note 25 .

65 Peter A Singer, Douglas K Martin & Merrijoy Kelner, "Quality End-of-Life Care: Patients' Perspectives" (1999) 281:2 The Journal of the American Medical Association 163.

66 Aday 2006, *supra* note 63 at 207-211.

67 Deaton et al 2009, *supra* note 63 at 61-65.

and Spain. We will look at each of these countries in turn. As a note above, terminology differs internationally. For our purposes, we refer to "MAiD" or "euthanasia" interchangeably to characterize countries where a person may elect to die by another's hand (typically a medical practitioner), and "assisted suicide" to reflect states where people are permitted to end their own lives (i.e., Switzerland). The United Nations Standard Minimum Rules for the Treatment of Prisoners (a.k.a. The Nelson Mandela Rules) do not make any ruling about the ethics of allowing a prisoner to die.[68] Instead, the Mandela Rules call for administrative oversight, including the investigation and recording of any death (Rule 8), including causes, circumstances, and signs of torture, and immediately report any custodial deaths to an authority independent of the prison (Rule 71).[69]

A. Switzerland

Switzerland has gained international prominence as a hotspot for the "Right to Die" movement, a movement advocating for and facilitating a person's ability to decide how they will die.[70] Since 1942 Switzerland's penal code has stated that assisting in a person's suicide is permissible so long as the assistant has no ulterior motives, and since the 1980s Right to Die organizations have been operating to provide assisted suicide.[71] The Swiss Academy of Medical Science has firmly rejected the idea that assisted suicide is medical care,[72] setting Swiss assisted death apart from many other jurisdictions, who view it as a medical service. Instead, Assisted Suicide in Switzerland is better understood as a right, or a liberty which the government has declared non-intervention on.[73]

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68 See generally United Nations, "UNCITRAL Expedited Arbitration Rules 2021: UNCITRAL Rules on Transparency in Treaty-based Investor-State Arbitration" (United Nations, 2022) available online (pdf): <https://uncitral.un.org/sites/uncitral.un.org/files/media-documents/uncitral/en/21-07996_expedited-arbitration-e-ebook.pdf> [perma.cc/93S6-4MWP].

69 *Ibid.*

70 Yoann Della Croce, "Assisted Suicide for Prisoners: An Ethical and Legal Analysis from the Swiss context" (2022) 36:4 Bioethics 381 [Della Croce].

71 See generally Sarah Mroz et al, "Assisted Dying Around the World: a Status Quaestionis" (2021) 10:3 Annals of Palliative Med 3540.

72 Della Croce, *supra* note 70 .

73 *Ibid.*

In the same year as their assisted suicide clarification, Swiss lawmakers also clarified important principles about the function of Swiss incarceration. First, they declared that incarcerated people should never be subjected to the death penalty, and second, that the only punishment they are to be subjected to in prison is the freedom of movement.[74] Therefore, the Swiss right to die cannot, in principle, be denied to incarcerated people. This has been confirmed by The Swiss Competence Centre for the Execution of Criminal Penalties, who state that imprisoned people, in principle, have the right to assisted suicide, however the agreement of justice authorities is required in such a case.[75] Yet, despite the framework for assisted suicide for incarcerated people being in place since the 1940s, 2023 was the first year a person in prison died by assisted suicide in Switzerland.[76]

B. Belgium

Belgium legalized euthanasia in 2002 for adults with "constant and unbearable physical or mental suffering that cannot be alleviated".[77] Notably, Belgium made two landmark decisions in 2014. First, Belgium became the world's first country with MAiD available for minors, as well as adults.[78] Second, in 2014 Belgium became the world's first country to approve MAiD for an incarcerated person, Frank Van Den Bleeken.[79] According to The Guardian, Van Den Bleeken had no prospect of leaving prison, due to his inability to control his sexual urges, and did not want to live as a danger to society any longer.[80] Notably, Van Den Bleeken's own

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74 *Ibid.*

75 Swissinfo.ch "First Assisted Suicide by Swiss Prison Inmate", (9 March 2023) online <https://www.swissinfo.ch/eng/society/first-assisted-suicide-by-swiss-prison-inmate/48345652> [perma.cc/W928-MATG] [Swissinfo].

76 *Ibid.*

77 See generally The British Medical Association, "Physician Assisted-Dying Legislation Around the World" (2021) online (pdf): <https://www.bma.org.uk/media/6706/bma-where-is-pad-permitted-internationally.pdf> [perma.cc/AM3N-ZYMZ]; and Rebecca Reingold & Leticia Mora, "Child Euthanasia in Belgium" (10 February 2020), online at <https://oneill.law.georgetown.edu/child-euthanasia-in-belgium/> [perma.cc/C85X-EW4A] [Reingold & Mora].

78 Reingold & Mora, *supra* note 77.

79 Della Croce, *supra* note 70.

80 Associated Press, "Belgian convicted killer with 'incurable' psychiatric condition granted right to die", *The Guardian* (16 September 2014), online:

words on the subject paint a very different picture, when he said on Belgian television "What's the point in sitting here until the end of time and rotting away? I'd rather be euthanized."[81] Despite being the first approved euthanasia for a prisoner, Van Den Bleeken was not the first incarcerated person to die by euthanasia: his approval was withdrawn after "[doctors said] there was still hope for successful treatment at a psychiatric hospital in the Netherlands."[82] This case is archetypal of many critics' issues with allowing prisoners to receive assisted death. Van Den Bleeken was reportedly consistently denied the psychiatric care he needed prior to his application for euthanasia;[83] and based on his own words Van Den Bleeken may have viewed MAiD, at least in some ways, as a "Get Out of Jail Free" card to escape serving his sentence.

Belgium's actual first MAiD for an incarcerated person was Geneviève Lhermitte in 2023. Lhermitte has suffered from long-term suicidal ideation, including an attempt on her own life during the murder that lead to her incarceration.[84]

C. Spain

Spain, in contrast to both Belgium and Switzerland, has a much more recent history with assisted death. Spain began allowing medical assistance in dying in 2021 for adults with conditions causing unbearable suffering.[85] One year later Marin Sabu applied for MAiD while awaiting a murder trial. Sabu had opened fire on his former workplace, injuring three people before engaging in a police shootout which left him paraplegic. Critics of the decision to allow his death cited the victims' desire to see him stand trial for

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<https://www.theguardian.com/world/2014/sep/16/belgium-convict-granted-right-to-die> [perma.cc/ZEX6-YBTJ].

81 Marina Lopes, "Spain allows man to be euthanized ahead of trial for attempted murder", *Washington Post* (25 August 2022), online: <https://www.washingtonpost.com/world/2022/08/25/spain-assisted-suicide-euthanasia-murder-trial/> [perma.cc/45D9-WD6Z] [Lopes].

82 *Ibid.*

83 Della Croce, *supra* note 70.

84 Jeremy Gahagan, "Geneviève Lhermitte: Belgian mother who killed her five children euthanized", *BBC News* (3 March 2023), online: <https://www.bbc.com/news/world-europe-64835051> [perma.cc/64ZK-CUST].

85 Lopes, *supra* note 81.

his crimes, but the judge ultimate ruled that his rights to dignity and autonomy won the "clash of fundamental rights" in this case.[86]

V. CANADIAN LAW ON ASSISTED DYING

Prior to 2015, Canada prohibited assisted dying under the *Criminal Code* sections 14 and 241(b), which stated that a person could neither consent to die, nor aid or abet someone in their suicide.[87] These provisions were at the heart of the 2015 Supreme Court case *Carter v Canada (Attorney General)*. Complainants were seeking (or had successfully sought in Switzerland, in the case of Ms. Carter) an avenue to die with medical assistance in lieu of dying at the hands of "grievous and irremediable" illnesses that they had been diagnosed with.[88] The Court found that, due to the prohibition on assisted suicide created by the provisions, complainants faced a "cruel choice" wherein those suffering could either kill themselves prematurely while they were still physically capable, or suffer until they die of natural causes.[89] The Court, in a unanimous decision, ruled that this cruel choice violated the section 7 *Charter* rights to life, liberty, and security of the person.[90]

Thus, Canada was constitutionally required to allow assistance in dying. However, in 2019, *Truchon v Procureur général du Canada* once again challenged the constitutionality of assisted dying laws in the Quebec Superior Court. Canada's MAiD laws had included a provision that one's natural death must be "reasonably foreseeable" in order to receive assistance in dying. The complainants, Mr. Truchon and Ms. Gladu, had both been denied MAiD because, despite suffering severe degenerative medical conditions, they were not imminently dying. They successfully argued that the foreseeable death provision in the *Criminal Code* violated their *Charter* rights under sections 7 and 15: life, liberty, and security of the person, and

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86 *Ibid*.

87 *Carter v Canada (Attorney General)*, [2015] SCJ No 5 at para 19. [*Carter*].

88 *Ibid*, at para 14.

89 *Ibid* at paras 1, 13.

90 *Ibid*.

equal treatment under the law.[91] It is worth noting that this decision was not appealed.

As a result of these two cases, Canada has allowed MAiD since 2016 for people who meet certain criteria. As of 2021, in order to be eligible for MAiD under the *Criminal Code* a person must be (1) an adult, who (2) is eligible for government health services, and (3) has a "grievous and irremediable medical condition[.]" If these first three conditions are met then the person may (4) make a voluntary request for MAiD that was not the result of external pressure and (5) give informed consent after being informed of all means available to relieve their suffering, including palliative care.[92] A grievous and irremediable medical condition is defined as a situation wherein

> a) they have a serious and incurable illness, disease or disability;
> b) they are in an advanced state of irreversible decline in capability; and
> c) that illness, disease or disability or that state of decline causes them enduring physical or psychological suffering that is intolerable to them and that cannot be relieved under conditions that they consider acceptable.[93]

Despite its mention of the psychological, Canada has (for the moment, until March 17, 2027) expressly forbid mental illness—on its own—as a ground for MAiD.[94] Section 241.2(2.1) states, for the purposes of MAiD, "[A] mental illness is not considered to be an illness, disease or disability."[95] Interestingly, as examined by Mary Shariff, Derek Ross, and Trudo

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91 *Truchon c Procureur général du Canada*, 2019 QCCS 3792.

92 *Criminal Code of Canada* (RSC, 1985, c C-46), s 241.2(1) [Criminal Code].

93 *Ibid*, at s 241.2(2)

94 See generally Government of Canada, "Medical Assistance in Dying: Legislation in Canada – Updates to Legislation" (5 March 2024), online: <https://www.canada.ca/en/health-canada/services/health-services-benefits/medical-assistance-dying/legislation-canada.html#a2> [perma.cc/HBN8-WHFK]; *Criminal Code*, *supra* note 92, s 241.2(2.1); and Dumsday, *supra* note 7. Of course, it remains to be seen whether further expansion of MAiD will take place in the years ahead—perhaps the expansion of eligibility to include mature minors, legally incompetent adults suffering from dementia (via an advance directive written while still competent), and/or a reversal on this decision to exclude those suffering from no physical ailments at all (i.e., the legally competent mentally ill. This is a discussion many in the public, including but not limited to Canadian politicians, ethicists, journalists, and legal scholars, will be interested in having in the years to come.

95 *Criminal Code*, s. 241.2(2.1) *Criminal Code, supra* note 92 , s 241.2(2.1).

Lemmens, "mental illness" does not have a clear, defined meaning;[96] it is often used to refer to a subset of mental health conditions, but it is unclear what the extent of this term may be, should Parliament opt to, at a later date, proceed with permitting MAiD in situations of exclusively mental health-related concerns.[97] Should Canada ultimately allow MAiD in situations of mental illness—without co-morbidities—there would obviously be significant implications for the topic of MAiD in the context of prisons.[98]

Canada has distinguished itself internationally as the only jurisdiction to have codified the issue of incarcerated people receiving MAiD. CSC has published Commissioner's Directive 800-9 stating the process and parameters for an incarcerated person to receive MAiD.[99] These guidelines include an assumption that the procedure will take place external to the CSC facilities[100], and a timeline of five days from request to action by the CSC.[101] This timeline is a double edged sword for incarcerated people's rights: it at once prevents the CSC from delaying the process of seeking MAiD for applicants, but it also rushes the process along, creating a sense of urgency around what is, arguably, the most impactful decision of an

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96 Mary J Shariff, Derek BM Ross & Trudo Lemmens, "Mental Illness, Health Care and Assisted Death: Examining Parameters for Expanding or Restricting MAID Under Canada's Charter and Federal System" (2024) 47:2 Man LJ [Forthcoming] at 4-7 [Shariff, Ross & Lemmens].

97 *Ibid*.

98 *Ibid* at 12-17; Policy Bulletin 174, *supra* note 3

99 CD 800-9, *supra* note 3.

100 *Ibid* at 2; Within five calendar days of an inmate's request for MAID, the Chief, Health Services, or institutional Physician or Nurse Practitioner will meet with the inmate. During this meeting, the Chief, Health Services, or institutional Physician or Nurse Practitioner will:

(a) determine the inmate's reasons for requesting MAID;

(b) provide the inmate a copy of the eligibility criteria and a copy of this policy;

(c) offer referral to support services provided by a mental health professional, Chaplain, Elder/Spiritual Advisor, etc. (these support services will be available to the inmate throughout the MAID process); and

(d) schedule the inmate to be seen within seven calendar days, or sooner depending on the inmate's health status, for the purpose of performing the first eligibility assessment for MAID. This assessment will be conducted by the institutional Physician or Nurse Practitioner (internal assessor) or, if necessary, by an external Physician or Nurse Practitioner.

101 *Ibid* at 9.

incarcerated individual's life. Some additional directives of note include the requirement of CSC to consider *all* potential release options for the individual[102] and to make efforts to accommodate inmate's wishes for loved ones to be present during the provision of MAiD.[103]

Potential release options, however, may be extremely limited. Release options for MAID are considered in accordance with Commissioner's Directive 712-1 "Pre-Release Decision-Making" and the *Corrections and Conditional Release Act*. Early release for incarcerated people is defined as release "up to five days before … the inmate is entitled to be released".[104] The deeply limited scope of what is defined as "early release" by the CSC betrays the short-sighted nature of these considerations.

A. Canadian Data

Recalling above, three other countries have each reported one assisted death of an incarcerated person. Canada has reportedly approved (and enacted) MAiD for nine incarcerated people as of March 2023,[105] a steep jump from the five officially reported as of March 31, 2022.[106] With a reported application number of 27, these nine approvals represent a 33 per cent approval rating of MAiD applications made by prisoners. Canada reported that as of March 31, 2022, the amount of in custody deaths caused by MAiD was 2 per cent (this accounts for five of 250 in custody deaths annually).[107]

To compare these numbers to the general population, Canada reports that MAiD is responsible for 2.5 per cent of annual deaths in the general

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102 *Ibid* at 16.

103 *Ibid* at 22.

104 *CCRA*, *supra* note 34; Correctional Service of Canada, "Commissioner's Directive 712-1: Pre-Release Decision-Making," (22 September 2022) at 5.

105 Avis Favaro, "The number of medically-assisted deaths in Canada's prisons a concern for some experts", *CTVNews* (3 May 2023), online: <https://www.ctvnews.ca/health/the-number-of-medically-assisted-deaths-in-canada-s-prisons-a-concern-for-some-experts-1.6380440> [perma.cc/G3GX-E5Z3] [Favaro].

106 Health Canada, "Final Report of the Expert Panel on MAiD and Mental Illness", (13 May 2022), online: <https://www.canada.ca/en/health-canada/corporate/about-health-canada/public-engagement/external-advisory-bodies/expert-panel-maid-mental-illness/final-report-expert-panel-maid-mental-illness.html> [perma.cc/C5QY-TKNG].

107 *Ibid*.

population.[108] As an aside, Swiss numbers are only 1.5 per cent annually, which may be the result of assisted suicide's normalization in Swiss society making it a less commodified or highly sought option.[109] These numbers show that it is in fact somewhat less likely that a death in Canadian custody will be a result of MAiD. The rates of MAiD applications, however, tell a different story. According to Statistics Canada, the average number of people in CSC custody was 13488.6. Therefore, 27 people requesting MAiD is equivalent to 0.2 per cent of all people in custody (i.e., 2 applications per 1000 people). An average population was taken in order to gain a holistic account for the prison population since MAiD and the subsequent Commissioner's Directives were enacted. This averaging is especially useful in ameliorating the atypical drop in population caused the COVID-19 pandemic.

The numbers of application among the general population of Canada were 12,286 in 2021.[110] According to population data from the census of the same year, the rate of MAiD applications for Canadians generally was 0.033 per cent (i.e., 0.03 applications per 1000 people). Note, however, that 2021 was used for the general population sample because it represented the most accurate population data, being a census year, and also because 2021 saw a nearly 30 per cent increase in MAiD applications from the year prior, and therefore provided data that was the most accurate, and the best suited to prevent hyperbole in this comparison. The contrast between incarcerated and non-incarcerated application rates indicates that incarcerated people in Canada seek MAiD at six times the rate of the general population.

To further nuance this data, we rule out confounding variables, such as an aging prison population. In 2020-2021, over one-quarter (25.6 per cent) of incarcerated people were age 50 or above (although one report says that the rate jumps to 60 per cent for Indigenous offenders serving life

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108 *Ibid.*

109 Swissinfo, *supra* note 75.

110 Health Canada, "Third annual report on Medical Assistance in Dying in Canada 2021", (26 July 2022), online: <https://www.canada.ca/en/health-canada/services/publications/health-system-services/annual-report-medical-assistance-dying-2021.html> [perma.cc/GB5G-RWKU].

sentences)[111].[112] In contrast, nearly 40 per cent (39.5 per cent) of the general population is age 50 or over. CSC has redacted much of the information they have collected regarding MAiD in institutions,[113] so it is not currently known the exact ages of the incarcerated applicants, but this data suggests that more and younger people are applying for MAiD behind federal penitentiary walls, at a rate that is incongruent with the age makeup of CSC.

It is important to note that regardless of applications, the rejection rate of applications is much higher within the institution. Generally, 81 per cent of MAiD applications are approved, but within the prison drops to only one-third.[114] This number may be read as encouraging, a sign that there are sufficient safeguards to stem the flow of incarcerated applicants who are seeking MAiD for disingenuous reasons (i.e., a desire to leave prison). But the limited approval rate should not overshadow the application rate, which could be indicating that the conditions within Canadian prisons are intolerable, undignified, and perhaps even a fate worse than death for people who would choose MAiD over their sentence. As indicated, this ties back to a broader discussion about whether it is appropriate and/or ethical to offer MAiD when individuals have not been offered proper environments or supports—in this context, in a prison setting, where death could be seen as being intertwined with punishment.[115] (An October 2020 report from the Office of the Parliamentary Budget Officer estimated significant savings for governments should MAiD be expanded—though the document noted, "Nevertheless, this report should in no way be interpreted as suggesting that MAID be used to reduce health care costs."[116])

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111 Kathleen Martens, "Nine offenders used MAiD up to March 27, 2022", *APTN News* (20 April 2023), online: <https://www.aptnnews.ca/national-news/maid-in-prison-nine-inmates-have-used-canadas-assisted-death-program/> [perma.cc/5N5V-JW5U].

112 Public Safety Canada, "2021 Corrections and Conditional Release Statistical Overview", (27 March 2023), online: <https://www.publicsafety.gc.ca/cnt/rsrcs/pblctns/ccrso-2021/index-en.aspx#sec-c12> [perma.cc/7VHU-T76A].

113 Favaro, *supra* note 105.

114 *Ibid.*

115 Shariff, Ross & Lemmens, *supra* note 96 at 12; see also Joshua David Michael Shaw & Daniel Konikoff, "When Prisoners' 'Right to Die' Goes Online: A Case-Study of Legal and Penal Sensibilities" (2022) 37:3 CJLS 451.

116. Office of the Parliamentary Budget Officer, "Cost Estimate for Bill C-7: 'Medical Assistance in Dying'" (20 October 2020) at 3, online: <https://distribution-a617274656661637473.pbo-

B. MAiD in Prison Case Law

Given the infancy of prison legal cases concerning MAiD, we would be remiss to deny how significant legal cases can be as sources of information, in part as cases contain the necessary analysis, argument, context, history, precedent, and reasoning to grapple with the complexities of MAiD in prison. According to Berlant, "the case represents a problem-event that has animated some kind of judgement,"[117] which may speak to greater societal concerns at large. Examining specific cases, as we do below, also enables researchers to show how disparate expert knowledges can fold space and time to produce an 'event' in the present.[118] Doing this allows for analysis to include both the social processes beginning outside of the law which have become 'juridified' as well as accounting for the ways the law structures decisions that govern social outcomes.[119]

As indicated above, the brevity of existing case law involving MAiD indicates MAiD's infancy in Canada. To demonstrate this brevity, a legal database (Lexis+) was searched to locate any and all case law in which a person in custody indicated they were or wished to seek MAiD. This search was done by cross searching terms relating to MAiD ("medical assistance in dying", "MAiD", etc.) with terms relating to prisons ("prison", "incarcerated", etc.). These search terms and their variations were searched to yield very few cases. Of these, upon further examination, all but one (and a related follow-up decision) had essentially nothing to do with MAiD in the context of prison. The one notable result was that of Mr. Delorme, who was initially found not criminally responsible in 1989. While in a

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dpb.ca/241708b353e7782a9e5e713c2e281fc5ed932d3d07e9f5dd212e73604762bbc5 > [perma.cc/EZN7-WCFH]

117. Laurent Berlant, "On the Case" (2007) Critical Inquiry 33 663 at 663.

118 *Ibid.*

119 In other words, and as we have articulated elsewhere, studying the logics of the legal case itself and underpinning legal texts ripened with 'judiciomentalities' (i.e., legal expressions that imbed social constructions of history, politics, precedential strictures, constitutionalism, and personal/political judgment) allows us to reconsider legal texts themselves as representative of a type of technology that delivers and rationalizes the governmental effects of law separate and apart from the law that itself created; for examples, see James Gacek & Richard Jochelson, "Let's Talk About Sex – Time to Tap Taboo?" in Richard Jochelson & James Gacek eds, *Sexual Regulation and the Law: A Canadian Perspective* (Bradford: Demeter Press, 2020) at 7; and James Gacek & Richard Jochelson, "Animals as Something More than Mere Property: Interweaving Green Criminology and Law" (2020) 9:122 Social Sciences 1.

psychiatric facility he reoffended, and was classified as a dangerous offender and was given an indeterminate sentence in 2007. He has lived since between medium to maximum security institutions. During an assessment, the CSC notes:

> Mr. Delorme has expressed an interest in seeking Medical Assistance in Dying ("MAID") when available in March 2023. When assessed by Mission staff, Mr. Delorme denied suicidal ideation or intent to self-harm. He indicated that his interest in pursuing MAID was because he does not expect to be eligible for release to a minimum secure facility or community living in the foreseeable future. A referral was made to the Mission's Mental Health department.[120]

Mr. Delorme is not diagnosed with any medical disorders other than Antisocial Personality Disorder, Pedophilia, and Sexual Sadism, making it unclear if he possesses any psychiatric condition grievous enough to be permitted under a potential future provision of MAiD. Despite the CSC's insistence that it is not aware of anyone applying for MAiD to escape their sentence,[121] this case makes clear that it is completely plausible for a person in prison to seek MAiD as a way out of their sentence—or, perhaps more specifically, as a way of pivoting to avoid the hopelessness associated with being in a prison environment, particularly for a lengthy or indefinite period. This possibility is critical to understand the gravity of, as Canada continues leading the way in providing MAiD in the context of prisons. Interestingly, it should be noted that a 2023 decision in relation to Mr. Delorme provided an update, stating:

> In 2022, Mr. Delorme voiced an interest in medical assistance in dying (MAID); however, he has not raised this again since his last Parole Board hearing. Mr. Delorme was encouraged by the positive things the Parole Board said and this may have given him renewed hope. Mr. Delorme is a quiet inmate; he gets on with the staff and is not involved in any gang or prison subculture.[122]

VI. The Challenges of MAiD in Federal Corrections: Moral, Ethical, and Practical Considerations

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120 *Delorme (Re)*, [2022] ORBD No 907 at para 26.

121 Favaro, *supra* note 105.

122 *Delorme (Re)*, [2023] ORBD No 1415 at para 24.

The prison continues to make us question the quality of life for incarcerated individuals, as well as the quality of death that may occur while in custody. The arrival of MAiD has prompted us to expand our ideas of what constitutes fostering life or marking for death and the relationship between the pair. As witnessed above, death, dying, and end-of-life care are extremely personal, and opinions on these issues vary based on different personalities and situations of the individual concerned. Yet there remains certain moral, ethical, and practical considerations to consider, including but not limited to fostering autonomy for prisoners, and removing barriers to make necessary medical choices in the best interests of the prisoners themselves. This is not an exhaustive list of challenges, but ones we feel are necessary to discuss as we witness MAiD unfolding in Canada's federal prison system. We outline these thoughts below.

A. Fostering Prisoner Autonomy

Fostering autonomy in end-of-life care implies supporting positive attitudes towards death and dying. As Battin writes,

> For some, maybe most, patients who seek assistance in dying, pain is not the issue as much as it's control…Patients fear future pain and want to avoid future hard deaths; but for most of them, it is retaining control, remaining capable of being the architects of their own lives, that is central. Even if all the pain could be controlled—as terminal sedation will do, though in a way that proponents find unacceptable—this would not resolve the issue. Rather, the issue has to do with respecting terminally ill patients' own choices about how they want to die, rather than—as proponents would put it—forcing them to accept their physicians' or health care institutions' models of appropriate terminal care.[123]

Battin also provides a helpfully concise statement of the autonomy argument:

> Just as a person has the right to determine as much as possible the course of his or her own life [sic], a person has the right to determine as much as possible the course of his or her own dying [sic]. If a terminally ill person seeks assistance in suicide from a physician freely and rationally, the physician ought to be permitted to provide it.[124]

Certainly, the optics of an agency of the state enabling or facilitating death behind bars is questionable, especially if the option exists for prisoners to

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123 Margaret Pabst Battin, *Ending Life: Ethics and the Way We Die* (Oxford, England: Oxford University Press, 2005) at 32.

124 *Ibid* at 20.

be seeking MAiD outside of the correctional facility or to be released from prison altogether so that the prisoner post-release can access this service. Nevertheless, positive attitudes towards death and dying should be encouraged. A prisoner's right to make decisions concerning their last stage of life and maybe even develop resilience to depressive thoughts from pondering death behind bars could be supported by a positive attitude towards death, such as its acceptance. Indeed, acceptance of death may reduce or prevent feelings of fear and despair associated with it. While CSC policy already exists in terms of contacting the deceased prisoner's family or next of kin to arrange for funeral services, it is important that making arrangements for one's funeral and formulating an advance directive are steps prisoners can take in order to retain some control over their death and the dying process.[125] In deciding upon the disposal of one's body, the person extends their "influence of control and autonomy even beyond the moment of death".[126] Likewise, drafting an advance directive is an extension of a person's autonomy to a state in which they are no longer able to express their will or defend their interests. Allowing and facilitating prisoners' realization of such advance planning will further support their autonomy and give them a sense of control in an environment in which they have limited choice.

Moreover, respect for prisoners' autonomy means their inclusion in treatment decisions and their informed consent for the selected treatment or care plan. For example, correctional facility practices or policies which keep a dying prisoner incarcerated as long as possible and only transferring them to a hospital in the last days of their life does not abide by the principle of respecting one's autonomy.[127] Conversely, it deprives the prisoner their access to end-of-life services and takes away their right to make treatment decisions. As Young contends,

> Respect for persons demands respect for their autonomous choices, as long as those choices do not result in harm to others…In exercising autonomy, or self-determination, each of us takes responsibility for our life and, since dying is a part of life, choice about the manner of our dying, and the timing of our death, are part of what is involved in taking responsibility for our life. It is quite natural for each of us to be concerned about what the last phase of our life will be like, not merely because of fears that our dying might cause us great suffering, but also

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125 Emanuel & Emanuel, *supra* note 50.

126 Mak & Clinton, *supra* note 52 at 102.

127 Handtke & Wangmo, *supra* note 7.

> because of our desire to avoid dependency, to retain our dignity, and, more generally, to retain as much control over our life as is possible during our final phase.[128]

The 'each of us' aspect of Young's statement above is important here; in this view, we all benefit from the increased autonomy (and accompanying peace of mind) afforded by the availability of MAiD, irrespective of whether we would ever choose it for ourselves, as proponents claim. As Palmer puts it, "the prospect of being able to retain some autonomy and control over the end-of-life process is of value to more individuals than would ever choose the option of assisted death."[129] In effect, to make this decision also means respecting the individual's ability to make the choice *and* have accesses to the services to make this choice. According to international guidelines and the principle of equivalence of care, prisoners have the right to access the same end-of-life care as non-incarcerated populations.[130] Yet, this is not always the case in prison due to security and socio-political issues. Moreover, it is important to note that there are also those prisoners that may choose to die in prison, as they may have come to consider it their "home." Notwithstanding, and while wishes may vary, all should be taken into account in the prisoner's individual death and dying process.

B. Prisoners' Barriers to Access

In Handtke and Wangmo's study on specific barriers to good end-of-life care for prisoners, results suggested (1) restricted opportunities to engage in social relations; (2) reduced access to end-of-life services, including physician-assisted suicide; (3) lack of bereavement; (4) handling of prisoners' deaths by the prison administration; (5) negative experiences of death; and (6) limited choice regarding the place of death. Connecting these results to the present MAiD discussion in the article, we explore these ideas in greater detail below.[131]

In terms of the first barrier providing the opportunity for dying prisoners to re-establish or reconcile relationships gives an opportunity for

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128 Robert Young, *Medically Assisted Death* (Cambridge, England: Cambridge University Press 2007) at 21-22.

129 Stephanie Palmer, "'The Choice is Cruel': Assisted Suicide and Charter Rights in Canada" (2015) 74 191 at 194.

130 Handtke & Wangmo, *supra* note 7.

131 *Ibid* at 382.

them to resolve conflicts that might have led to estrangement and thus helps achieve a sense of completion before their death.[132] Psychiatrist Scott Peck, for instance, writes that

> [n]o work I ever did as a psychotherapist was as fulfilling to me as that with a number of dying patients. People tend to learn best when they have a deadline. (What a wonderful world!) Mind you, the majority seem to deny that they are dying right up until their final breath. But those that are not in denial, who know they have little time left, tend to speed up their development. They may choose to face issues they have been avoiding for a lifetime. It is a pleasure and a privilege to work with them at such moment. Deathbed confessionals and conversations do happen, as do forgiveness and reconciliation and leaps of learning that never seemed possible.133

Especially when intolerable pain and suffering is demonstrated by prisoners, providing the opportunity for prisoners-as-patients to feel this sense of completion with what little time they have left fosters more meaningful end-of-life care in the process.

Second, while palliative care is provided in the community through, for example, hospitals or nursing homes, prison health care services may not be adapted to ensure such care on site. Additionally, correctional physicians or medical care professionals often lack the expertise to provide necessary care; we see this especially for MAiD in federal corrections (as discussed below).[134] The lack of appropriate end-of-life services in prison necessitates planning on the part of prison health care services when a prisoner must be transferred to such an institution willing to take in the dying prisoner and provide necessary palliative care. Therefore, building strong relationships with community services could be beneficial for prison health services. Either providing palliative care in prison or ensuring that prisoners receive this care in another institution is in line with the principle of equivalence and human rights law.[135] This provision is likewise important to a prisoner's family as it helps them accept their loved one's death.[136] For correctional staff and everyone concerned with end-of-life care, role clarity and specific

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132 Mak & Clinton, *supra* note 52.

133 M Scott Peck, Denial of the Soul: Spiritual and Medical Perspectives on Euthanasia and Mortality (New York: Harmony, 1997) at 152.

134 Byock, *supra* note 9 .

135 See generally Liz Gwyther, Frank Brennan & Richard Harding, "Advancing Palliative Care as a Human Right" (2009) 38:5 Journal of Pain and Symptom Management 767.

136 Byock, *supra* note 9.

training are essential to ensure its good functioning.[137] Considering how the federal prison population is aging and getting older demographically, clearer CSC policy and guidelines on this training for MAiD would be instrumental going forward.[138]

The third barrier to liberty—lack of bereavement support—remains common in the prison context in Handtke and Wangmo's study.[139] While their study focused upon Switzerland, it is clear such support is still an essential component for good palliative care and helps those left behind in accepting the death of a loved one.[140] Connecting funeral services with counselling services for the immediate family and loved would be beneficial throughout the grieving process. Especially when we consider community hospice care, which includes services provided by a range of individuals like health care staff, social workers, chaplains, and volunteers, bereavement support would be significant to explore for those in federal corrections.[141]

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137 *Ibid.*

138 Leonard W. Sumner, Assisted Death: A Study of Ethics and Law, (Oxford, England: Oxford University Press, 2011) at 173. Our article refrains from engaging in the debate of freedom of conscience for health-care providers; however, this is a conversation we hope to enter in future research and policy work. For example, Sumner puts forward an argument for the moral requirement of all physicians to make referrals for MAiD, one focused upon the notion of care rather than autonomy:

> Some physicians will have no religious or ethical objection to providing this service for their patients, while for others it will violate the dictates of their conscience. A policy must include a 'conscience clause' that enables providers to decline to offer the service on grounds of personal conviction. However, it must also require that they not abandon patients who indicate a desire to request an assisted death; in such circumstances they must at a minimum inform their patients where they might find a provider willing to help them.

While Dumsday, *supra* note 7 at 139 questions why the requirement of non-abandonment would entail a duty to make a referral for assisted death, raising concerns about the usage of 'abandonment' vis-à-vis the duty of health-care providers to provide care, we agree that, limitations aside, that policy changes begin to establish continuous, steadfast supports and standards of care for patients and prisoners alike.

139 Handtke & Wangmo, *supra* note 7.

140 Byock, *supra* note 9.

141 See generally David Field et al, "Some Issues in the Provision of Adult Bereavement Support by UK Hospices" (2007) 64:2 Social Science and Medicine 428.

The fourth barrier—death as something unwanted and even feared in the correctional system—is important to consider as a potential threat or risk to institutional security.[142] This is emphasised by the negative image of prison that is construed in popular media when deaths occur in custody. However, this alleged 'uncertainty' surrounding MAiD in federal corrections might be remedied by creating greater transparency. Prisoners should have the possibility to bid farewell to terminally ill prisoners and pay their last respects to the deceased, emphasizing the "importance of funerals and memorials".[143] Such openness in communication could benefit not only other prisoners but also prison staff, as it provides all concerned parties the ability to discuss death freely, accept it as a natural process of life, and neither fear nor feel the need to hush when a prisoner dies.[144] Acknowledgement of death might be particularly important for long-term prisoners who might not have any contacts outside prison and whose social supports are limited to their co-prisoners and prison staff. Glamser and colleagues[145] reported that staff members who have known long-term prisoners for a significant amount of time might be affected by their death in much the same way as they would be by that of a family member. Therefore, a change towards acceptance rather than exclusion of death in prison serves the dignity of those dying in this context.

The fifth barrier—negative experiences of death—is important to consider here. Research has shown that even witnessing a "good death" can have a positive effect.[146] Accordingly, negative experiences might increase fear and mistrust prevalent towards health care services in prison.[147] Prisoners may need the opportunity to bereave the death of a fellow inmate, not to mention the loss of close family members or friends, as such losses during incarceration can have a significant impact on an inmate's life.[148]

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142 See generally Barbara L. Granse, "Why Should We Even Care? Hospice Social Work Practice in a Prison Setting" (2003) 73:3 Smith College Studies in Social Work 359.

143 Byock, *supra* note 9 at 4.

144 See generally Nancy Neveloff Dubler, "The Collision of Confinment and Care: End-of-Life Care in Prisons and Jails" (1998) 26:2 JL Med & Ethics 149 [Dubler].

145 Glamser & Cabana, *supra* note 24 .

146 See generally Jeremy Honeybun, Marie Johnston & Adrian Tookman, "The Impact of a Death on Fellow Hospice Patients" (1992) 65:1 British Journal of Medical Psychology 67.

147 Dubler, *supra* note 144.

148 See generally Ginette G Ferszt "Grief Experiences of Women in Prison Following the

The last barrier—the choice of where to die—is more complex and revolves around the question of whether dying in prison is in itself an indignity. This question extends to the issue of compassionate release, and the need to balance the autonomy of the person with the security risks of the prisoner-as-patient. Given that prisoners generally do not get to choose where they die in most cases, this choice is constrained by virtue of being one of many pains of imprisonment.[149] Yet, when we think of the modern iteration of federal corrections, the act of providing a choice to terminally ill prisoners can help us reflect upon the very purposes of carceral spaces, if any. Is it time to give new meaning to carceral space? This is something we continue to ponder as we revaluate the clinical treatments and tools available to incarcerated individuals who have little time left.

C. Reconsidering Palliative Care & Compassionate Release

We cautiously recognize how opponents to MAiD may see assisted death/suicide as a slippery slope, as if the mere legal availability of MAiD itself results in a kind of pressure on the dying, a concern raised by Bishop:

> [T]he social apparatus of palliative care will be fundamentally altered when assisted death is legally sanctioned. The patient will soon find herself in a situation in which the option of death is always at hand. Soon she will be forced to defend to herself why she continues to stay alive—one more burden, to be relieved in choosing death. In short, there are logics that are created with the auspices of our institutions and apparatuses, whether adjudicated by physicians or by judges…These procedural logics will shape our social imagination about dependency, care, and the meaning of compassion, and the meaning of life at life's end.[150]

We refrain from deploying slippery slope arguments, as what opponents of MAiD "might regard as an obvious bottoming-out point, or near bottoming-out point, of a dangerous slope the proponent of MAiD might regard as entirely unobjectionable".[151] In other words, the moral divide between certain parties to this debate has grown so radical that slippery slope arguments might no longer be worth the effort. Moreover, slippery slope

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Death of a Loved One" (2002) 10:3 Illness, Crisis and Loss 242.

149 See generally Gresham Sykes, *The Society of Captives: A Study of Maximum Security Prison*, (Princeton, NJ: Princeton University Press, 1958).

150 Jeffrey Bishop, "Arts of Dying and the Statecraft of Killing" (2016) 29 Studies in Christian Ethics 261 at 267.

151 Dumsday, *supra* note 7 at 116-117.

arguments may merely create illusory hypotheticals that do nothing more than provide a disservice to the autonomy and dignity of the individuals and communities requesting both palliative care and MAiD; rather than engage in a zero-sum game, we acknowledge the legal availability (and challenges therein) of MAiD as one tool of many to assist prisoners and patients alike in their end-of-life process.

Palliative treatment and MAiD are two clinical choices available to incarcerated individuals, provincially or federally, seeking to end their lives. As the number of individuals over 50 years old who are in custody continues to grow, the widespread presence of diseases, illnesses, and serious health conditions continues to rise in Canadian institutions.[152] According to the *Criminal Code* and the CCRA, CSC must look for alternatives to incarceration for those who are palliatively or terminally ill.[153]

As indicated by Commissioner's Directive 710-3, "temporary absences may be granted for medical reasons, administrative reasons, community services purposes, family contact purposes, parental responsibility reasons, and personal development for rehabilitative purposes. Escorted temporary absences are granted to all incarcerated individuals."[154] The cost and availability within the community for these inmates to receive the adequate standard of palliative that enhances their quality of life hinges on the feasibility of medical support within the community. The likelihood that prisoners receive a spot for medical care is improbable due to CSC's readiness to commit to medical care outside of the carceral institution.[155] The lack of support within the community for these prisoners to receive palliative care and temporary absences is likely not permitted without proper funding and resources made available to them. From a human rights perspective, one may argue that this infringes upon a prisoner's fundamental right to access adequate healthcare and continues to drive the

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[152] Adelina Iftene and Jocelyn Downie, "End-Of-Life Care for Federally Incarcerated Individuals in Canada" (2020) 14:1 McGill Journal of Law & Health at 6 [Iftene and Downie].

[153] *Ibid* at 10.

[154] Correctional Service Canada, " Commissioner's Directive No 710-3: Temporary Absences," (31 May 2016) at paras 6, 14 online: < https://www.canada.ca/en/correctional-service/corporate/acts-regulations-policy/commissioners-directives/710-3.html> [perma.cc/7CEL-ARSV].

[155] Iftene & Downie, *supra* note 152 at 12.

narrative that the federal corrections are dehumanizing.[156] Furthermore, while in principle prisoners have the opportunity to obtain specific healthcare services like palliative care and MAiD, in practice the process to do so remains highly complex in terms of execution and procedure, which demonstrates a small percentage of success within the carceral system. Requesting and administering healthcare, handling denial of permission and involuntary treatment, and handling medical crises are all covered under the healthcare guidelines established for CSC. Palliative care guidelines are ambiguous, hard to access and only accessible through an access-to-information request.[157]

Brief absence is the most typical method for getting end-of-life care in the community. Sixty per cent of the 94 deaths from natural causes involving patients receiving palliative care occurred in a CSC regional hospital, 30 per cent in a community hospital, and 9 per cent in a CSC institution.[158] Parole and brief absence are common misconceptions within the carceral system. Though they seem similar in context, they rarely correlate with each other. Brief absences are under specific circumstances, with the corresponding reasoning, and ideally shorter periods. Eligibility for parole hinders various eligibility criteria, including detailed eligibility or lack thereof, for certain types of sentences, specific time served, duration or original sentence, and behaviour. Those granted parole serve the remainder of their sentence in the community or within rehabilitation institutions or services.

Parole by Exception is commonly referred to as compassionate release. According to section 121 of the CCRA,

> Is an exceptional provision that allows an offender who has not yet reached their day and full parole eligibility dates to be considered for parole. Pursuant to section 121 of the CCRA, parole by exception may be granted to an offender:
>
> (a) who is terminally ill;
>
> (b) whose physical or mental health is likely to suffer serious damage if the offender continues to be held in confinement;

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156 See generally Marisa Ranieri, *Medical Assistance in Dying (MAiD) While Incarcerated vs Compassionate Release: A Comprehensive Analysis of "Dying with Dignity" within the Canadian Correctional System* (MHR, University of Manitoba, 2024) [unpublished] online: <https://mspace.lib.umanitoba.ca/server/api/core/bitstreams/eb51e479-50e8-4cf0-a177-f3f9dbf564e1/content> [perma.cc/4GXT-Q8KB].

157 Iftene & Downie, *supra* note 152 at 27.

158 *Ibid* at 19.

> (c) for whom continued confinement would constitute an excessive hardship that was not reasonably foreseeable at the time the offender was sentenced; or
> (d) who is the subject of an order of surrender under the *Extradition Act* and who is to be detained until surrendered. [159]

It is noteworthy that 350 persons passed away while incarcerated between 2005 and 2015 from natural causes, and 21 of 28 requests for parole by exception were granted. These requests were made for people with serious medical conditions, such as cancer, end-stage liver failure, amyotrophic lateral sclerosis, brain injury, mental health issues, and a few grave illnesses that were not explicitly mentioned.[160] Only 4 of the 14 exemption requests submitted to the Parole Board of Canada (PBC) in 36 of the 55 palliative care cases were approved. The Royal Prerogative of Mercy was not used in 49 instances, and no community-based end-of-life care was offered.[161] The Royal Prerogative of Mercy can be defined as the ancient power vested in the British monarch who had the absolute right to exercise mercy on any subject."[162] The lack of knowledge and evidence surrounding the Royal Prerogative of Mercy does not support the assertion that people are released under the Royal Prerogative of Mercy depending on their physical state.[163] Unfortunately, section 121 is minimal; there is a shortage of information regarding the possibility of petitioning for a Royal Prerogative, and a person cannot apply for parole by exception without the help of CSC.[164] Moreover, potentially meritorious requests are frequently not presented to parole boards. For a request for consideration of parole by exception or compassionate release to be granted, the prison doctor must demonstrate

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159 *CCRA*, *supra* note 34, s 121(1)(a)-(d); See generally Parole Board of Canada, "Policy 4.1.1.Decision Making Policy Manual For Board Members," (2 January 2024) online: <https://www.canada.ca/en/parole-board/corporate/publications-and-forms/decision-making-policy-manual-for-board-members/chapter-4.html#4.1.1> [perma.cc/5G4E-5WB3].

160 Iftene & Downie, *supra* note 152 at 19.

161 *Ibid* at 20.

162 Government of Canada, "What is the Exercise of Clemency (Royal Prerogative of Mercy)?" (20 March 2023), online at <https://www.canada.ca/en/parole-board/services/clemency/what-is-the-exercise-of-clemency-royal-prerogative-of-mercy.html> [perma.cc/E3FG-2VRL].

163 Iftene & Downie, *supra* note 152 152at 21.

164 *Ibid* at 22.

that the prisoner's continued incarceration would be an undue hardship or that the prisoner's health would likely suffer substantial harm.[165]

In sum, we see the necessity to reconsider palliative care and compassionate release for terminally ill prisoners, especially as prisoners are not only staying longer in prison, but living longer as well, while custodial space remains stagnant. While debates about MAiD continue to swirl around socio-political and socio-carceral circles, we believe it prudent to reenergize momentum for comprehensive and consistent palliative care for aging prisoners and prisoners who have little life left, coupled with clear palliative guidelines that are open to the public to view. A revaluation of community end-of-life care specifically for terminally ill prisoners post-release must also be included here. Moreover, we must increasingly encourage the PBC to reconsider compassionate release for this specific prisoner population, given how section 121 of the CCRA remains a significant tool in the PBC's toolkit. Given the brevity of case law, the infancy of MAiD in prison generates a unique opportunity to look for certain, swift, and effective alternatives for prisoners that are terminally ill.

D. Information Sharing and Record Keeping

Going forward, it is vital that accurate records be made and preserved to allow researchers to track the long-term prevalence of MAiD both in society and in federal corrections. Tracking this information is necessary for various reasons, including enabling governments to identify relevant patterns and trends. For example, if it is noticed that a much higher percentage of terminal pancreatic cancer prisoners in the Atlantic prison region are applying for MAiD than prisoners with the same terminal illness in the Prairie prison region, then this might enable researchers to identify shifts in the quality of palliative care services between the two regions (and their associated provinces).

Likewise important is accurate recordkeeping of the total number of requests for MAiD, even those that are denied. Fortunately, Health Canada does keep track of data on unsuccessful requests.[166] These records need to be inputted properly and made available to not only government archivists and academic researchers, but also physicians and nurse practitioners. As Dumsday contends, "[w]hen a physician or nurse practitioner receives a

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165 *Ibid* at 23.

166 Dumsday, *supra* note 7.

request for assisted death (especially if the request is from a patient with whom there is no prior professional relationship), a question needs to be asked: 'Am I the first health-care professional whom this patient has consulted about assisted death, or has the patient already sough the procedure out and been turned down?'"[167] Safeguards must be maintained to forestall this type of occurrence, as well as knowing whether that prisoner-as-patient has a prior record of requesting MAiD.

VII. Conclusion

The question of whether MAiD in prison should be avoided remains ongoing, but where unavoidable, our review of extant literature suggests it should be approached with dignity, choice, and relationships in mind. Autonomy and self-determination are central to dignity. At the same time, there are also questions of capability, resources, and environmental effects that federal corrections have yet to meaningfully work out and make clear for those who wish to pursue MAiD while incarcerated.

Death and dying are natural processes, yet the concerns surrounding quality of life *and* quality of death have not ended. As society continues to grapple with these complexities, it is imperative to critically evaluate the ongoing reforms, policy implementation, and legal interpretations to ensure the equitable treatment, safety, and dignity of terminally ill prisoners and prisoners-as-patients within the correctional milieu. The interplay between rights, risks, institutional dynamics—coupled with societal perceptions of death, dying, and MAiD—underscores the urgent need for comprehensive reforms that not only recognize the unique challenges of implementing MAiD in federal corrections, but also strive to create a correctional environment that upholds the principles of justice, equality, and respect for all individuals, regardless of their health status. While the debate surrounding MAiD in prison is currently in its infancy, debates in their infancy do not stay infant for long. Further conversations surrounding living and dying in federal corrections remain timely and warranted in equal measure.

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[167] *Ibid at* 145.