

Morbid Matters: Medical Assistance in Dying in Federal Corrections

JAMES GACEK*, RICHARD
JOCHELSON**, BRANDON TRASK***,
LAUREN CORCORAN & MARISA
RANIERI****

ABSTRACT

An ongoing problem of federal prisons in Canada continues to be deaths in custody. While prison suicides (i.e., dying by unnatural causes) and aging in prison (i.e., dying by natural causes) remain significant challenges, the legalization and introduction of medical assistance in dying (MAiD) raises policy and operational challenges for federally sentenced and/or 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 enabling or facilitating inmate deaths via state agency, 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.*

* Associate Professor, Department of Justice Studies, University of Regina.

** Dean, Faculty of Law, University of Manitoba.

*** Assistant Professor, Faculty of Law, University of Manitoba.

**** Master of Human Rights, University of Manitoba. Currently working for Manitoba Justice. Note: All views expressed by Ms. Corcoran and Ms. Ranieri are strictly their own.

I. INTRODUCTION¹

An ongoing problem of federal prisons in Canada continues to be deaths in custody. Certainly, when one considers the quality of life in federal prisons, one must also consider the nature, cause, and kind of death that may follow the prisoner. Prison suicides (i.e. dying by unnatural causes) and aging in prison (i.e. dying by natural causes) remain significant challenges behind these walls; yet, the legalization and introduction of medical assistance in dying (MAiD)² raises policy and operational challenges for federally sentenced and/or 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

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, they have a notable difference regarding their respective administration. Our article will discuss and reference differences between the pair, especially regarding international comparison. Doing so gives recognition to each system as well as who is administering the procedure. In Canada, nurse practitioners have the authority to issue both methods. We acknowledge here how MAiD is an intersectional term addressing the legalities according to each specific administration process. Each technique is governed differently between provinces and territories and that correspond and connect with the organizations regulating medical practice. As MAiD continues to evolve in practice, the terminology has expanded to include terms like ‘assisted suicide,’ ‘euthanasia,’ ‘aid-in-dying,’ and ‘physician-assisted suicide.’ We note that 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 enabling or facilitating inmate deaths via state agency, there are greater moral, ethical and practical considerations that must be discussed. Indeed, the introduction of MAiD in federal corrections must now have us consider the quality of life alongside the socio-legal ethics and quality of death behind bars. 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 carceral⁴ 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 remains a significant topic of concern, for society at large but also specifically for law. While law can, at times and in particular circumstances, produce death, in this conversation of MAiD, it is death itself that produces law, which means both making and regulating meaning from outside and within 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

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 draw upon Moran, Turner and Schliehe’s interpretation of the ‘carceral’, insofar as we acknowledge how the carceral conditions of incarceration –meaning the ways in which detriment, intention, and spatiality—are brought together to compose and comprise spaces of incarceration, imprisonment, detention, and punishment writ large. 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 specifically and prisoners-as-patients generally is inextricably woven with the socio-legal threads of recognition, rights, and protections. Within this intricate weave, we see the profoundly significant elements of both life and death behind bars, as both shape and are shaped by the carceral experience, along with and the laws and policies that oversee incarcerated individuals. The historical footprints of legal decisions reverberate through time, echoing if not imprinting their influence on prisoners, especially those terminally ill and/or seeking MAiD. How then 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 law and policy can have on our perception and social construction—and perhaps institutional construction—of how federal terminally ill prisoners (constituted as both prisoners and patients, in our view) 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 prisoners; 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. We believe the answer is not a simple binary (in other words, reducing a position to 'yes, we are in favour of' or 'no, we are against' is easier said than accomplished). Carceral physical settings, as we demonstrate below, continue to construct multiple and intersecting harms, both subjectively and objectively. The lived realities of prisoners-as-patients in physical carceral settings are then critical to complicating the simplicity of penal reform through any one-size-fits-all approach applied. We therefore take neither position of advocating for or against MAiD in full. Instead, our aim in this article is to remain agnostic in our approach of exploring MAiD in federal corrections, while simultaneously recognizing the arguments on both sides and suggesting that a spectrum of justice exists, where internalist and externalist perspectives have both strengths and pitfalls, each certainly recognizable by their own epistemology and implementation. In other

words, we recognize a need to understand this phenomenon, to discuss this topic without nihilistically throwing our hands up in exhaustion or angst of moral relativism. We are not suggesting here that we have solved 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 centering 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 a provocative topic, and rightly remains a controversial one to discuss. 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 already under way in this field, especially when one considers the aging prison population at present.⁶ Simultaneously, the increase in aging prisoners come into contact with the moving goal posts of implementing

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

⁶ *Ibid.*

equivalent health care in prison, all of which raises the challenge of palliative end-of-life care (or lack thereof) for prisoners.⁷ In corrections, the guiding principle for health care is the principle of equivalence of care, meaning 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 solely issues pertaining to the medical field; given the morbid matters surrounding the finality itself, death and dying are social phenomena and facts which involve greater appreciation for a variety of socio-cultural facets.⁹ The complexity of death and dying raises even metaphysical questions surrounding the limits of punishment and law: Should death in prison be justified by the goals of imprisonment? If so, then under what circumstances would the conditions be met?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 or alleviating pain and suffering, but also recognizing a dying person’s readiness, control, and autonomy using Allmark’s concept of “death without indignities.”¹² This is useful for the current discussion as it identifies two factors that allow for an ethical

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. We must acknowledge how people may not want MAiD, and may rather consider palliative care for a multitude of reasons. 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 (HIPPP)” (no date) online: <[https://www.who.int/europe/teams/alcohol-illicit-drugs-prison-health/the-who-europe-health-in-prisons-programme-\(hipp\)](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.

analysis to follow: measures that would (1) reinforce autonomy and (2) removal of barriers to dignity (we continue this discussion below). In Liebling's assessment of deaths in custody, the author indicates they support the principle of euthanasia, under specific circumstances, and particularly on the grounds of dignity and freedom; in other words, of acknowledging and ultimately being in control of one's own life up until the moment of death. 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 generally consider the natural and unnatural causes of death in custody, dying in prison, unlike dying beyond prison, shares many socio-cultural qualities one could suggest creates the worst kind of death. Frankly and realistically speaking, no one shares in the death besides the prisoner, and few remain relatively prepared for it. A death in prison leaves no room for the prisoner to progressively disentangle from commitments or activities either in prison or beyond its walls, no "bringing to closure or completeness of one's affairs"¹⁴, no saying of goodbyes, and no "affirmation of the whole person[,]" characteristics of a "good death" we uphold and some cases even treasure in Western society and culture.¹⁵ These prison deaths are, more often than not, undignified deaths, which mark a kind of completeness of the exclusion prisoners so often experience. We may even constitute these prison deaths as a form of "disenfranchised dying"¹⁶, insofar as while illness can precede the death at times, it may not at others, which makes death in prison unpredictable in certain respects, and neglects serious consideration or inquiry into prison conditions, quality of life or

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].

death even after the prisoner has passed. Furthermore, and more rarely still, the deceased prisoner is unable to make choices about the dying experience itself, nor of the funeral arrangements and grievance process to follow. In death's aftermath, too often are shared experiences of mourning and loss remain inaccessible for friends, family, and loved ones of the deceased prisoner.

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 view. For example, carceral geography and its associated scholarship take 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 then "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 then is ripe for discussions regarding death and dying; while some prisoners do die in custody, and others feel a sort of 'social death' in custody²⁰ their position is not like that of the deceased prisoner.²¹ As indicated above, deaths of prisoners occurring in custody usually are due to causes such as suicide, violence, accidents, and/or illnesses. Suicides are especially frequent in prison, and

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).

in most cases are preventable.²² Natural deaths, however, require different care and intervention mechanisms, both of which remain an increasing trend especially as prisoners continue to live to older ages²³, a notable trend in the United States²⁴ and Canada.²⁵ The rise in the number of elderly prisoners is also attributable to demographic changes in society, including but not limited to increases in harsher sentencing considerations by socio-political and juridic authorities, and more older adults entering the system at prison intake.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 via pseudo-presence; the deceased reappears, not in flesh and bone, but through potentially ghastly and/or phantasmagorical hauntings, treasured keepsakes, or cherished memories for some-and through law, prison 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.

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 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].

Of course, we recognize how prisons in Canada, like in other Western countries, continue to exist as a complex and complicated reflections of settler colonialism, both in the physical building of settler colonial infrastructures themselves but also in the modern edifices which remain today. These carceral spaces remain the result of political development, while also attempting to embrace ever-changing approaches to penal philosophy, discipline, and punishment. At the same time, however, federal prison conditions are invariably poor for correctional officers (COs) and prisoners²⁹ alike.³⁰ The physical conditions of a correctional facility can influence relations among prisoners, and between prisoners and COs.³¹ Besides increased rates of communicable diseases and inadequate hygiene practices, there exists outdated building infrastructure, substandard 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 continue to represent a risk of contagion to those confined; the COVID-19 pandemic is certainly an example and evidence of the contagion

²⁹ Literature differs on whether to use terms like ‘prisoners’ versus ‘inmates’ versus ‘offenders’. Rather than dive into a discussion of semantics, we respectively recognize how some literature uses particular terms while avoids others. Our use of terms varies 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 Bieri, “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.

risk. Recent calls to reconsider prisons outline greater attention towards prisoner and CO health, well-being, and quality of life, as connected with prison infrastructure health.³³

In Canada, there is one federal prison system, CSC, and 13 provincial and territorial correctional systems. Although each system is respectively, independently governed, there are basic rules informing how COs respond to deaths in custody. In the federal system, and in accordance with section 19 of the *Corrections and Conditional Release Act*, staff are required to investigate and report whenever a prisoner dies in custody³⁴. Following a review, recommendations may be made to change policies and practices with the intention of preventing future deaths.³⁵ The occupational

³³ See generally Yvonne Jewkes & Dominique Moran, “The Paradox of the ‘Green’ Prison: 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 carcéral, 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 Ricciardelli et al, 2020, *supra* note 28. However, we note how the Office of the Correctional Investigator (OCI) put forward critiques of the previous National Board of Investigation (NBOI) process in their 2013 and 2019 reports, respectively; this led to the changing of the NBOI process to a ‘quality-of-care review’, which attempts, per the OCI’s 2023 report, to increase the rigour, independence, credibility, and timeliness in completing a review of death in custody. While the revised process is still in its infancy, we encourage greater attention paid toward whether the gaps in the NBOI have been meaningfully addressed in the ‘quality-of-care’ review. See generally Office of the Correctional Investigator, *Annual Report of the Office of the Correctional Investigator 2013-2014* (Ottawa: The Correctional Investigator, 2013), access online (pdf): <<https://oci-bec.gc.ca/en/content/annual-report-office-correctional-investigator-2013-2014>> [perma.cc/M8XF-WETX]; Office

mandate of the CO is to preserve life whenever possible while also maintaining the safety and security (i.e., care, custody, and control) of prisoners, staff, the institution, and civilians or society at large.³⁶ A central feature of this CO role is uphold the safety and wellbeing of those who are incarcerated, which includes the intervention if not prevention of nonnatural deaths.³⁷ 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, it is clear how 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[.]"³⁸ This is proof to decades of scholarship foregrounding the continuous co-constituted relationship between space and law.³⁹ Indeed, there are intimate relations between space and law, but also 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[.]"⁴⁰ The (re)presentation and enactment of law is a key mechanism of social (re)production, including

of the Correctional Investigator, *Aging and Dying in Prison* (Ottawa: Corrections Officer Canada, 2019), access online: <https://oci-bec.gc.ca/sites/default/files/2024-03/oth-aut20190228-corrected_eng.pdf> [perma.cc/DY65-X9RL]; Office of the Correctional Investigator, *Annual Report of the Office of the Correctional Investigator 2023-2024* (Ottawa: Corrections Investigator, 2023), access online: <<https://oci-bec.gc.ca/en/content/office-correctional-investigator-annual-report-2023-24>> [perma.cc/Q5Z6-VAL3].

³⁶ 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].

³⁷ CSC 2021, *supra* note 36; and CSC 2019, *supra* note 34.

³⁸ 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.

³⁹ *Ibid.*

⁴⁰ Joshua DM Shaw, "Transcerceral Lawscapes Enacted in Moments of Aboriginalisation: A Case-Study of an Indigenous Woman Released on Urban Parole" (2020) 16:4 International Journal of Law in Context 422 at 423.

social marginality.⁴¹ Connecting to the conversation of death and dying, the law may indeed be everywhere, speaking to law's (omni-)presence, yet not equally experienced by all.⁴² Carceral modes of social control and coercion, including the discipline, confinement and surveillance of prisoners, increasingly extend outside the built walls of the prison, especially when one considers how punitive modes of public administration and policing have become, following people post-release and long after they returned to their communities.⁴³ There is no question law limits prisoners' rights and freedoms while they are incarcerated, depending on the jurisdiction and the socio-cultural context.⁴⁴

Indeed, the relationship between law and space continue to receive attention, especially when one considers end-of-life issues.⁴⁵ This is due in part to the aid of medical technologies allowing an increasing number of adults to live longer and to far more advanced ages, ultimately lengthening both the living *and* dying process as a result. 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.⁴⁶ Prior to the introduction of MAiD, a wave of support for death with autonomy over the decades, as well as increased advocacy for self-determination, freedom and dignity.⁴⁷ This movement claims a right to "die with dignity," a concept where palliative care, end-of-life care, and clinical decisions regarding death and dying matters intersect. In a parallel vein, the concept of a "good death" is central to improving the care for dying people⁴⁸ and remains a central

⁴¹ Nick Gill, "What's Missing From Legal Geography and Materialist Studies of Law? Absence and the Assembling of Asylum Appeal Hearings in Europe" (2020) 45:4 Transactions of the Institute of British Geographers 937 at 939.

⁴² 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.

⁴³ Gacek 2020, *supra* note 4.

⁴⁴ 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.

⁴⁵ Handtke & Wangmo, *supra* note 7; and Iftene 2019, *supra* note 25.

⁴⁶ See generally Annette F Street & David W Kissane, "Constructions of Dignity in End-of-Life Care" (2001) 17:2 Journal of Palliative Care 93.

⁴⁷ Handtke & Wangmo, *supra* note 7.

⁴⁸ See generally Ezekiel J Emanuel & Linda L Emanuel, "The Promise of a Good Death" (1998) 351 The Lancet SII21 [Emanuel & Emanuel].

tenet of the hospice movement.⁴⁹ Though both concepts have been critiqued on the grounds of vagueness, the pair have led to changes in how we perceive and implement end-of-life care and thinking about the dying process. These notions are key starting points to potentially redress individuals' concerns regarding a loss of dignity, as well as the challenges of decreased ability to exercise autonomy and control, along with being dependent on others as they age.⁵⁰

Yet, the attention and resources directed towards a good death and death with dignity in the general community may not be available to those incarcerated; in most cases, these advances in thinking seem to stop at the prison's threshold. The increasing older and elderly prisoner population is a challenge for various countries, especially as death, as indicated above, is not solely a social phenomena and fact, but also not one contained to any one jurisdiction (indeed, the apt phrase 'death comes for us all' by English playwright Robert Bolt is not lost on us). These issues surrounding end-of-life care become a pressing concern for varied prison health care and administration, in many countries all over the world.⁵¹ Research demonstrates how generally prisons lack end-of-life services, and the justifications for incarceration (retribution, deterrence, rehabilitation, and incapacitation) too often come into conflict and impede prisoners' access to health care and quality care at that.⁵² 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".⁵³ While there may have been attempts to provide palliative care on an individual basis, "this venture was seriously restricted by the prisons' security policies".⁵⁴ As Iftene indicates:

⁴⁹ See generally Bethne Hart, Peter Sainsbury & Stephanie Short, "Whose Dying? A Sociological Critique of the 'Good Death'" (1998) 3:1 *Mortality* 65.

⁵⁰ 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].

⁵¹ 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.

⁵² Handtke & Wangmo, *supra* note 7; and Iftene 2019, *supra* note 25.

⁵³ Iftene 2019, *supra* note 25 at 69.

⁵⁴ *Ibid* at 70.

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 that dying prisoners are housed in the same facilities as everyone else and, thus, subjected to the same security rules and medical regulations.⁵⁵

Without a palliative care unit, there are difficulties in administering the strong medication (which is available in the outside community) to terminally ill prisoners. With no renovated and/or retrofitted infrastructure, and coupled with the lack of medical staff available, prisoners who are terminally ill are unable to receive the consistent support they need to live out the remaining time they have alive.⁵⁶

Prisoners living to old ages like their counterparts in the community suggests the former are likely to face aging and end-of-life care earlier than the latter, and most likely for longer periods.⁵⁷ Therefore, “the mortality associated with an aging prison population” will often be evident within a shorter period of time.⁵⁸ Related to accelerated aging, the mental and physical health of prisoners is worse off than that of the general population, with higher numbers of chronic diseases and illness than community counterparts.⁵⁹ These health and behavioural factors make prisoners a longstanding vulnerable group with regards to many aspects of their health and life, including end-of-life care.⁶⁰

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

⁵⁵ *Ibid.*

⁵⁶ *Ibid.*

⁵⁷ Handtke & Wangmo, *supra* note 7.

⁵⁸ Glamser & Cabana, *supra* note 24 at 497.

⁵⁹ 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).

⁶⁰ 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.

exception of studies from the United States⁶¹ and Canada.⁶² Singer and colleagues point out the importance of older and elderly patients' perspectives on the quality of end-of-life care, as these people are the "most affected".⁶³ Furthermore, Aday investigated death anxiety and attitudes towards dying in prison among 102 prisoners. Their study findings demonstrate that different and intersecting factors, such as age, health status, and social support, influence in their research participants the fear of death.⁶⁴ Additionally, when recognizing the limited hope for their respective futures, prisoners can, at times, view death as a respite and an escape from their current conditions of health and/or confinement. For instance, Deaton and colleagues examined attitudes of women prisoners towards death; their findings were akin to Aday. Prominent themes from the study conducted by Deaton and colleagues include but are not limited to fear of death; access to health care (especially in cases of emergency); and the use of coping strategies, like denial and acceptance, to manage their understandings of dying in prison.⁶⁵

In sum, we see how the ending of life in custody continues is controversial, and no less complex. As we will discuss 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

⁶¹ 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].

⁶² Iftene 2019, *supra* note 25.

⁶³ 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.

⁶⁴ Aday 2006, *supra* note 61 at 207-211.

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

internationally. Outside of Canada, only three other countries are known to have allowed MAiD/assisted suicide for incarcerated individuals; Switzerland, Belgium, 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.⁶⁶ 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).⁶⁷

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.⁶⁸ 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.⁶⁹ The Swiss Academy of Medical Science has firmly rejected the idea that assisted suicide is medical care,⁷⁰ 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.⁷¹

⁶⁶ 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].

⁶⁷ *Ibid.*

⁶⁸ Yoann Della Croce, “Assisted Suicide for Prisoners: An Ethical and Legal Analysis from the Swiss context” (2022) 36:4 Bioethics 381 [Della Croce].

⁶⁹ See generally Sarah Mroz et al, “Assisted Dying Around the World: a Status Quaestionis” (2021) 10:3 Annals of Palliative Med 3540.

⁷⁰ Della Croce, *supra* note 68.

⁷¹ *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.⁷² 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.⁷³ 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.⁷⁴

B. Belgium

Belgium legalized euthanasia in 2002 for adults with “constant and unbearable physical or mental suffering that cannot be alleviated”.⁷⁵ 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.⁷⁶ Second, in 2014 Belgium became the world’s first country to approve MAiD for an incarcerated person, Frank Van Den Bleeken.⁷⁷ 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.⁷⁸ Notably, Van Den Bleeken’s own

⁷² *Ibid.*

⁷³ 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].

⁷⁴ *Ibid.*

⁷⁵ 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].

⁷⁶ Reingold & Mora, *supra* note 75.

⁷⁷ Della Croce, *supra* note 68.

⁷⁸ Associated Press, “Belgian convicted killer with ‘incurable’ psychiatric condition granted right to die”, *The Guardian* (16 September 2014), online: <<https://www.theguardian.com/world/2014/sep/16/belgium-convict-granted-right-to-die>> [perma.cc/ZEX6-YBTJ].

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.”⁷⁹ 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.”⁸⁰ 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,⁸¹ 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 led to her incarceration.⁸²

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.⁸³ 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 his crimes, but the judge ultimately ruled that his rights to dignity and autonomy won the “clash of fundamental rights” in this case.⁸⁴

⁷⁹ 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].

⁸⁰ *Ibid.*

⁸¹ Della Croce, *supra* note 68.

⁸² 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].

⁸³ Lopes, *supra* note 79.

⁸⁴ *Ibid.*

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.⁸⁵ 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.⁸⁶ 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.⁸⁷ 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.⁸⁸

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 equal treatment under the law.⁸⁹ 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

⁸⁵ *Carter v Canada (Attorney General)*, [2015] SCJ No 5 at para 19. [Carter].

⁸⁶ *Ibid*, at para 14.

⁸⁷ *Ibid* at paras 1, 13.

⁸⁸ *Ibid*.

⁸⁹ *Truchon c Procureur général du Canada*, 2019 QCCS 3792.

the result of external pressure and (5) give informed consent after being informed of all means available to relieve their suffering, including palliative care.⁹⁰ 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.⁹¹

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.⁹² Section 241.2(2.1) states, for the purposes of MAiD, “[A] mental illness is not considered to be an illness, disease or disability.”⁹³ Interestingly, as examined by Mary Shariff, Derek Ross, and Trudo Lemmens, “mental illness” does not have a clear, defined meaning;⁹⁴ 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

⁹⁰ *Criminal Code of Canada* (RSC, 1985, c C-46), s 241.2(1) [Criminal Code].

⁹¹ *Ibid*, at s 241.2(2)

⁹² 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 . 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). MAiD’s expansion to potentially include mental illness may be as early as March 2027; see generally Dying with Dignity Canada (2024). *Medical Assistance in Dying (MAiD) Assessment Guide*. Available at: <https://www.dyingwithdignity.ca/wpcontent/uploads/2023/03/DWDC_MAID_AssessmentGuide2024_ENG06ea089ef17d749db890f124d2577915276d627f1d34b3f4216b9fd79585fab.pdf> [perma.cc/3BT3-WKPN]. 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.

⁹³ *Criminal Code*, s. 241.2(2.1) *Criminal Code*, *supra* note 92, s 241.2(2.1).

⁹⁴ 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].

date, proceed with permitting MAiD in situations of exclusively mental health-related concerns.⁹⁵ 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.⁹⁶

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.⁹⁷ These guidelines include an assumption that the procedure will take place external to the CSC facilities⁹⁸, and a timeline of five days from request to action by the CSC.⁹⁹ 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 incarcerated individual's life. Some additional directives of note include the requirement of CSC to consider *all* potential release options for the individual¹⁰⁰ and to make efforts to accommodate inmate's wishes for loved ones to be present during the provision of MAiD.¹⁰¹

Potential release options, however, may be extremely limited. Release options for MAiD are considered in accordance with Commissioner's

⁹⁵ *Ibid.*

⁹⁶ *Ibid* at 12-17; Policy Bulletin 174, *supra* note 3

⁹⁷ CD 800-9, *supra* note 3.

⁹⁸ *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.

⁹⁹ *Ibid* at 9.

¹⁰⁰ *Ibid* at 16.

¹⁰¹ *Ibid* at 22.

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”.¹⁰² 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 2023,¹⁰³ a steep jump from the five officially reported as of March 31, 2022.¹⁰⁴ 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).¹⁰⁵

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 population.¹⁰⁶ 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.¹⁰⁷ 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

¹⁰² CCRA, *supra* note 34; Correctional Service of Canada, “Commissioner’s Directive 712-1: Pre-Release Decision-Making,” (22 September 2022) at 5.

¹⁰³ 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].

¹⁰⁴ 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].

¹⁰⁵ *Ibid.*

¹⁰⁶ *Ibid.*

¹⁰⁷ Swissinfo, *supra* note 73.

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 2021.¹⁰⁸ 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 sentences)¹⁰⁹.¹¹⁰ 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,¹¹¹ 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

¹⁰⁸ 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].

¹⁰⁹ 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].

¹¹⁰ 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].

¹¹¹ Favaro, *supra* note 103.

one-third.¹¹² 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.¹¹³ (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.”¹¹⁴)

B. MAiD in Prison Case Law

Given the infancy of prison legal cases concerning MAiD, we would be lax to deny how important legal cases can be as sources of historical and contemporary information. Legal cases in our view, contain the essential context, history, argument, precedent, analysis, reasoning needed 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,”¹¹⁵ which may speak to greater societal concerns at large. Examining specific cases, as we do below, also enables researchers to show how seemingly disparate expert knowledges have the ability to fold space and time together, producing a present ‘event’ in the process.¹¹⁶ Doing this allows for analysis to include both the socio-cultural processes beginning outside of the law which have then become ‘juridified’ as well as seriously

¹¹² *Ibid.*

¹¹³ Shariff, Ross & Lemmens, *supra* note 93 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.

¹¹⁴ 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-dpb.ca/241708b353e7782a9e5e713c2e281fc5ed932d3d07e9f5dd212e73604762bbc5?_perma.cc/EZN7-WCFH> [perma.cc/EZN7-WCFH].

¹¹⁵ Laurent Berlant, “On the Case” (2007) *Critical Inquiry* 33:4 663 at 663.

¹¹⁶ *Ibid.*

reconsidering how law is structured by and through judicial decisions that which ultimately govern reflected or refracted social outcomes.¹¹⁷

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 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.¹¹⁸

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,¹¹⁹ this case makes clear that it is completely plausible for a person

¹¹⁷ In other words, and as we have articulated elsewhere, studying the logics of the legal case itself along with the legal texts ripened with 'judiciomentality' (i.e., legal expressions where imbedded social constructions of history, socio-political and precedential strictures meet constitutionalism, and personal/political judgment) is necessary here, as it allows us to centre upon legal texts themselves as rationalizing the governmental effects of law separate and at times apart from the law that itself was created from; 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.

¹¹⁸ *Delorme (Re)*, [2022] ORBD No 907 at para 26.

¹¹⁹ Favaro, *supra* note 103

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.¹²⁰

VI. THE CHALLENGES OF MAiD IN FEDERAL CORRECTIONS: MORAL, ETHICAL, AND PRACTICAL CONSIDERATIONS

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 how we foster the lives of some, while mark the deaths of others. 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

¹²⁰ *Delorme (Re)*, [2023] ORBD No 1415 at para 24.

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.¹²¹

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.¹²²

Certainly, the optics of enabling or facilitating death behind bars is questionable, especially if the option exists for prisoners to be seeking MAiD outside of prison, or to be released from prison altogether so that the person 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 final stage of life (and perhaps 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 encouraging the dying person to have control and self-autonomy by making arrangements for their funeral and/or formulating an advance directive are meaningful steps to take.¹²³ In deciding upon the disposal of one's body, the person extends their "influence of control and autonomy even beyond the moment of death".¹²⁴ Likewise, drafting an advance directive is an personal extension of one's autonomy to a state where they are no longer able to express their will, nor able to 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

¹²¹ Margaret Pabst Battin, *Ending Life: Ethics and the Way We Die* (Oxford, England: Oxford University Press, 2005) at 32.

¹²² *Ibid* at 20.

¹²³ Emanuel & Emanuel, *supra* note 48.

¹²⁴ Mak & Clinton, *supra* note 50 at 102.

or care plan. For example, correctional facility practices or policies which keep a dying person incarcerated for as long as possible, and only then transferring said person to a hospital in the last days of their life does not uphold or respect their autonomy.¹²⁵ Moreover, it can deprive the prisoner their access to end-of-life services and serves to remove 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 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.¹²⁶

The ‘each of us’ aspect of Young’s statement above is important here; in this view, we all benefit from the increased autonomy (and associated peace of mind) afforded by the availability of MAiD, irrespective of whether we decide we wish it for ourselves at the end of our lives, 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.”¹²⁷ In effect, to make this decision also means respecting the individual’s ability to make the choice *and* respecting their ability to have access to the services to make this choice available to them. As discussed above, and 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.¹²⁸ 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 across jurisdictions, cultures, and contexts, all should be taken into account in the prisoner’s individual death and dying process.

¹²⁵ Handtke & Wangmo, *supra* note 7

¹²⁶ Robert Young, *Medically Assisted Death* (Cambridge, England: Cambridge University Press 2007) at 21-22.

¹²⁷ Stephanie Palmer, “‘The Choice is Cruel’: Assisted Suicide and Charter Rights in Canada” (2015) 74 191 at 194.

¹²⁸ Handtke & Wangmo, *supra* note 7.

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.¹²⁹

In terms of the first barrier providing the opportunity for dying prisoners to re-establish or reconcile relationships gives a pertinent opportunity for them to resolve conflicts that might have led to estrangement. This aids in achieving a sense of completion before the prisoner's death.¹³⁰ 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.¹³¹

Especially when intolerable pain and suffering is demonstrated by prisoners, providing them the opportunity 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).¹³² 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 the necessary palliative care. Therefore, building strong

¹²⁹ *Ibid* at 382.

¹³⁰ Mak & Clinton, *supra* note 50.

¹³¹ M Scott Peck, *Denial of the Soul: Spiritual and Medical Perspectives on Euthanasia and Mortality* (New York: Harmony, 1997) at 152.

¹³² Byock, *supra* note 9.

relationships with associated community services are beneficial for prison health services. Either providing palliative care in prison, or ensuring that prisoners receive this care in another institution, is aligned with the principle of equivalence and human rights law.¹³³ This provision is similarly important to a prisoner's family, supporting and helping them accept the death of their loved one.¹³⁴ For COs, prison staff, and everyone concerned with end-of-life care for prisoners, role clarity and specific training are both essential discussions to have to ensure good functioning of the prison end-of-life care process and implementation.¹³⁵ Considering the aging and elderly prison population clearer CSC policy and guidelines on this training for MAiD would be instrumental going forward.¹³⁶

The third barrier to liberty—lack of bereavement support—remains common in the prison context, as indicated in Handtke and Wangmo's study.¹³⁷ 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.¹³⁸ Connecting

¹³³ 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.

¹³⁴ Byock, *supra* note 9.

¹³⁵ *Ibid.*

¹³⁶ 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.

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 care provided by health-care providers, we agree that, limitations aside, that policy changes begin to establish continuous and stable supports and standards of care for patients and prisoners alike.

¹³⁷ Handtke & Wangmo, *supra* note 7.

¹³⁸ Byock, *supra* note 9.

funeral services with counselling and bereavement services for the immediate family and loved would be beneficial.¹³⁹

The fourth barrier—death as something unwanted and even feared in prison—is important to consider as a potential threat or risk to institutional security.¹⁴⁰ This is emphasised by the negative image of prison, conceptualized in popular media, when death occurs in custody. However, this alleged ‘uncertainty’ surrounding MAiD in federal corrections might be remedied by creating greater transparency. Prisoners should have the possibility to say goodbye to terminally ill prisoners and pay their last respects, as doing so emphasizes the “importance of funerals and memorials”.¹⁴¹ Such openness in communication could benefit not only other prisoners but also prison staff, as it provides all those concerned about the dying person the ability to discuss the topic of death freely and accept death as a natural occurrence in life.¹⁴² Acknowledgement of death would 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 colleagues¹⁴³ reported staff members who have known long-term prisoners for a longer period of time might be affected by their passing similar to that of their own family member. Therefore, a change towards acceptance, instead of avoiding discussing death in prison, serves to uphold the dignity of those dying.

The fifth barrier—negative experiences of death—is important to consider here. Research demonstrates how observing a “good death” can have a positive effect.¹⁴⁴ Accordingly, negative experiences might raise fear and/or mistrust prevalent towards health care services in prison.¹⁴⁵ Prisoners too may need the opportunity to grieve the death of a fellow prisoner, not to mention the loss of close family members or friends, as

¹³⁹ 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.

¹⁴⁰ 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.

¹⁴¹ Byock, *supra* note 9 at 4

¹⁴² See generally Nancy Neveloff Dubler, “The Collision of Confinement and Care: End-of-Life Care in Prisons and Jails” (1998) 26:2 *JL Med & Ethics* 149 [Dubler].

¹⁴³ Glamser & Cabana, *supra* note 24

¹⁴⁴ 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.

¹⁴⁵ Dubler, *supra* note 142.

such losses during incarceration can have a significant impact on the prisoners' lives.¹⁴⁶

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 balancing act of respecting the autonomy of the person while managing 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.¹⁴⁷ 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 reevaluate 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 just the mere legal availability of MAiD itself results in a kind of pressure on the dying person. This is 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.¹⁴⁸

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”.¹⁴⁹ In other words, the moral divide

¹⁴⁶ See generally Ginette G Ferszt “Grief Experiences of Women in Prison Following the Death of a Loved One” (2002) 10:3 *Illness, Crisis and Loss* 242.

¹⁴⁷ See generally Gresham Sykes, *The Society of Captives: A Study of Maximum Security Prison*, (Princeton, NJ: Princeton University Press, 1958).

¹⁴⁸ Jeffrey Bishop, “Arts of Dying and the Statecraft of Killing” (2016) 29 *Studies in Christian Ethics* 261 at 267.

¹⁴⁹ Dumsday, *supra* note 7 at 116-117.

between certain groups to the MAiD debate has grown so radical that slippery slope arguments might no longer be worth the effort. Moreover, slippery slope 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 serious health conditions continues to rise in Canadian prisons.¹⁵⁰ According to the *Criminal Code* and the CCRA, CSC must look for alternatives to incarceration for those who are palliatively or terminally ill.¹⁵¹

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."¹⁵² 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.¹⁵³ 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 health care and continues to drive the

¹⁵⁰ 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].

¹⁵¹ *Ibid* at 10.

¹⁵² 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].

¹⁵³ Iftene & Downie, *supra* note 150 at 12.

narrative that the federal corrections are dehumanizing.¹⁵⁴ 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.¹⁵⁵

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.¹⁵⁶ 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;
- (c) for whom continued confinement would constitute an excessive hardship that was not reasonably foreseeable at the time the offender was sentenced; or

¹⁵⁴ 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].

¹⁵⁵ Iftene & Downie, *supra* note 150 at 27.

¹⁵⁶ *Ibid* at 19.

- (d) who is the subject of an order of surrender under the *Extradition Act* and who is to be detained until surrendered.¹⁵⁷

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.¹⁵⁸ 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.¹⁵⁹ 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.¹⁶⁰ 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.¹⁶¹ 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.¹⁶² 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 that the prisoner's continued incarceration would be an undue hardship or that the prisoner's health would likely suffer substantial harm.¹⁶³

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

¹⁵⁷ 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].

¹⁵⁸ Iftene & Downie, *supra* note 150 at 19.

¹⁵⁹ *Ibid* at 20.

¹⁶⁰ 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].

¹⁶¹ Iftene & Downie, *supra* note 150 at 21.

¹⁶² *Ibid* at 22.

¹⁶³ *Ibid* at 23.

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 MAiD applications both in society and federal corrections. Tracking this information is necessary for various reasons, including but not limited to enabling governments to identify relevant patterns and trends. For example, if it is noticed that a much higher percentage of terminal lung 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).

Moreover, accurate recordkeeping of the total number of requests for MAiD—even those applications that are denied—is important to understand. Fortunately, Health Canada does keep track of data on unsuccessful requests.¹⁶⁴ These records, however, need to be inputted properly and consistently, 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 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 sought the procedure out and been turned down?’”¹⁶⁵ Safeguards must ultimately be maintained to envision this type of occurrence, as well as knowing whether that prisoner-as-patient has a prior record of requesting MAiD.

¹⁶⁴ Dumsday, *supra* note 7.

¹⁶⁵ *Ibid* at 145.

VII. Conclusion

The question of whether MAiD in prison should be avoided remains ongoing; notwithstanding our review of extant literature suggests that when MAiD proceeds the process should be approached with dignity, choice, and relationships in mind. Central to autonomy and self-determination is dignity of life and of death. At the same time, there are also questions of capability, resources, and environmental effects that federal corrections have neither meaningfully worked out nor make clear for those who wish to pursue MAiD while incarcerated.

Death and dying are natural processes in the human life course, yet the concerns surrounding quality of life *and* quality of death in prison 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. 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 strives 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.