Commentary

MEDICAL LAW INTERNATIONAL

Assisted dying for prison populations: Lessons from and for abroad

Medical Law International
2019, Vol. 19(2-3) 207–225

DOI: 10.1177/0968533219866235
journals.sagepub.com/home/mli
SAGE

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Abstract

Canadian federal legislation setting out the framework for medical assistance in dying (MAiD) in Canada came into effect in June 2016. Because of section 86(1) of the Corrections and Conditional Release Act, as soon as MAiD became available in the community, it also needed to be made available to federal prisoners. There are some good reasons to be concerned about MAiD in the Canadian corrections system based on logistical, legal, and moral considerations. Fortunately, Canada is not the first country to decriminalize assisted dying and so Canadian policies and practices can be compared to others and take some lessons from their experiences. Thus, by reviewing the legal status of assisted dying in prisons internationally, the regulation of assisted dying, demand for assisted dying from prisoners, and the process for prisoners accessing assisted dying, this article offers a comparative overview of assisted dying for prisoners around the world in an effort to inform Canadian and other jurisdictions' law, policy, and practice.

Keywords

Corrections, end-of-life in prison, medical assistance in dying, comparative corrections, CSC, prison policies

Received 14 May 2019; Revised 25 June 2019; Accepted 8 July 2019

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Introduction

In June 2016, medical assistance in dying (MAiD) became legal throughout Canada.[1] Section 86(1) of the *Corrections and Conditional Release Act* (CCRA) requires the prison service to provide 'essential health care' to incarcerated individuals, therefore as soon as MAiD became available in the community, it also needed to be made available to federal prisoners.[2] By September 2017, there had been eight requests for MAiD from people incarcerated in the federal system.[3] The number of requests will likely increase given the aging of the prison population (as more people enter prison at an older age, leave prison at older ages, or stay until they are older and die in prison) and the phenomenon of "accelerated aging" in prisons (as incarcerated individuals tend to present the health problems of people in the community who are 10–15 years older).[4] In November 2017, Correctional Service Canada (CSC) released a guideline establishing its operational directive for MAiD.[5] According to the Office of the Correctional Investigator (OCI) Annual Report 2017–2018, the first case of MAiD for a Canadian prisoner has now occurred.[6]

There are good reasons to be concerned about MAiD in the Canadian corrections system. These include, for example:

- the possibility that the first case of MAiD for a Canadian prisoner involved one physician providing both of the two required assessments of eligibility (contrary to the federal legislation) and that the MAiD provider was not sufficiently independent of CSC (contrary to the CSC Guideline)[7];

1. Bill C-14, *An Act to amend the Criminal Code and to make related amendments to other Acts (medical assistance in dying)*, 1st Sess., 42nd Parl., 2016.
2. *Corrections and Conditional Release Act*, SC 1992, c. 20, s. 86(1) (*CCRA*). The federal correctional system, run by Correctional Service of Canada, incarcerates individuals sentenced to over 2 years in prison. Individuals sentenced to 2 years or less, or who are awaiting trial in custody, are incarcerated in provincial/territorial jails run by each individual provincial/territorial government. While the provincial/territorial systems incarcerate significantly more individuals, individuals in federal penitentiaries serve much longer sentences, including life sentences. As a result, more federal prisoners are likely to meet the eligibility criteria for medical assistance in dying (MAiD). The federal system is the focus of this article. *Criminal Code of Canada*, RSC 1985 c. C-46, s. 743.1(1)–(3).
3. Correctional Service Canada, "Medical assistance in dying as of 17 September 2017." Access to Information Request, Document A-2017-00302 (2017a).
4. A. Iftene, 'The Pains of Incarceration: Aging, Rights, and Policy in Federal Penitentiaries', *Canadian Journal of Criminology and Criminal Justice* 59(1) (2017a), p. 64; F. Kouyoumdjian, A. Schuler, F.I. Matheson and S.W. Hwang, 'Health Status of Prisoners in Canada: Narrative Review', *Canadian Family Physician* 62(3) (2016), pp. 215–222.
5. Guideline 800-9, 'Medical Assistance in Dying' (Ottawa: CSC, 29 November 2017).
6. Canada, Office of the Correctional Investigator, *Annual Report of the Corrective Investigator 2017–2018* (Ottawa, OCI, 2017), Available at: www.oci-bec.gc.ca (accessed 26 July 2019).
7. Op. cit.

- the possibility that the inadequacies of the mechanisms for release or transfer into community for assessments, provision, and decision-making regarding MAiD may result in lack of access for those who are eligible under the legislation; and
- the moral complexities of implementing MAiD in a context within which voluntariness, information, and access to end of life care have not been adequately analyzed; and where access to general health care has been documented to be inadequate.[8]

Fortunately, Canada is not the first country to decriminalize assisted dying and so we can compare our policies and practices to others and take some lessons from their experiences. We can also, in turn, offer lessons based on our experiences to the increasing number of jurisdictions considering the decriminalization of assisted dying.[9]

In Part 1, we discuss the legal status of assisted dying in prisons internationally, the regulation of assisted dying, demand for assisted dying from prisoners, and the process for prisoners accessing assisted dying. In Part 2, we draw lessons from jurisdictions that permit assisted dying by reflecting on how they have grappled with the implementation of assisted dying for prisoners. In sum, in this article, we offer a comparative overview of assisted dying for prisoners around the world in an effort to inform Canadian and other jurisdictions' law, policy, and practice.

Before doing so, however, we must explain the terminology used in this article and provide a brief overview of the most recent and transformative steps on the journey to legalizing MAiD in Canada.

Different jurisdictions use distinct terms to refer to various forms of assisted dying. In Canada, we use "medical assistance in dying" (MAiD) as an umbrella term to capture both provider-administered and self-administered assistance in dying.

MAiD means:

a. the administering by a medical practitioner or nurse practitioner of a substance to a person, at their request, that causes their death; or

8. Op. cit; Canada, Office of the Correctional Investigator, *Annual Report of the Correctional Investigator 2015–2016* (Ottawa, OCI, 2016). Available at: www.oci-bec.gc.ca.; A. Miller, 'Prison Health Care Inequality', *Canadian Medical Association Journal* 185(6) (2013), pp. E249–E250; Iftene, 'The Pains of Incarceration'; Kouyoumdjian, Schuler, Matheson and Hwang, 'Health Status of Prisoners in Canada'.
9. In this article, we focus on the Canadian lessons learned re: MAiD and prisoners. Lessons learned from the Canadian experience with legalizing MAiD in general can be found in, for example, J. Downie, 'Medical Assistance in Dying: Lessons for Australia from Canada', *Queensland University of Technology Law Review* 17(1) (2017), p. 127. Lessons can also be drawn from critiques of and reflections on the new law. See, for example, T. McMorrow, 'MAID in Canada? Debating the Constitutionality of Canada's New Medical Assistance in Dying Law', *Queen's Law Journal* 44(1) (2018), p. 69; R.M. Carter, B. Rodgerson and M. Grace, 'Medical Assistance in Dying: Canadian Registry Recommendations', *Alberta Law Review* 56(1) (2018), p. 55; J. Bond, 'A Minor Issue? The Shortcomings of the Eligibility Requirements for Medically Assisted Death in Canada', *APPEAL: Review of Current Law and Law Reform* 23 (2018), p. 41.

b. the prescribing or providing by a medical practitioner or nurse practitioner of a substance to a person, at their request, so that they may self-administer the substance and in doing so cause their own death.[10]

Other jurisdictions use a range of other terms including *suicidio asistido* and *eutanasia* (Colombia), *levensbeeindiging op verzoek* (ending of life on request) and *hulp bij zelfdoding* (assisted suicide) (the Netherlands), voluntary assisted dying (Victoria, Australia), and aid in dying (many US states). Conceptually, these all map onto either self-administered or provider-administered assisted dying. In this article, we use MAiD to refer to assisted dying specifically in Canada, "assisted dying" to refer to both self- and provider-administered assistance in dying in other jurisdictions that allow both kinds of assisted dying (including Canada when not referring solely to Canada), and "provider-administered assistance in dying" and "self-administered assistance in dying" when referring to only one of the two kinds of assisted dying.

In February 2015, the Supreme Court of Canada in *Carter v. Canada (Attorney General)*[11] ruled that the *Criminal Code of Canada* prohibitions on MAiD violated the *Canadian Charter of Rights and Freedoms.*[12] In response to this decision, the federal government passed amendments to the *Criminal Code* to establish the legal framework for MAiD in Canada.[13] A competent adult can access MAiD if they have made a voluntary request and have a "grievous and irremediable medical condition"[14] (which does not require a terminal illness or a finding of temporal proximity to death). Physicians and nurse practitioners can provide MAiD, and MAiD can be provider- or self-administered. It should also be flagged that Quebec is unique in Canada insofar as there is provincial legislation governing MAiD which came into force before the federal legislation and is narrower in scope (e.g. it allows only physician provision and only provider- and not self-administered MAiD and it requires that the person be at the "end of life" in order to be eligible).[15]

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10. *Criminal Code*, s. 241.1.
11. 2015 SCC 5.
12. They breach s. 7 ("7. Everyone has the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice") and cannot be saved under s. 1 ("The *Canadian Charter of Rights and Freedoms* guarantees the rights and freedoms set out in it subject only to such reasonable limits prescribed by law as can be demonstrably justified in a free and democratic society").
13. Bill C-14, 2016.
14. "Grievous and irremediable condition" is defined as requiring that the person have a "serious and incurable illness, disease, or disability," be in "an advanced state of irreversible decline in capability," be experiencing "enduring physical or psychological suffering that is intolerable to them and that cannot be relieved under conditions that they consider acceptable," and their "natural death" must have become "reasonably foreseeable, taking into account all of their medical circumstances, without a prognosis necessarily having been made as to the specific length of time they have remaining."
15. For the Quebec legislation. Available at: http://legisquebec.gouv.qc.ca/en/ShowDoc/cs/S-32.0001. Full details about MAiD in Canada can be found. Available at: at http://www.eol.law.dal.ca (accessed 26 July 2019).

Part I: Assisted dying in the prison context around the world

Assisted dying legislation and guidelines

Currently, 15 jurisdictions allow the practice of assisted dying. Six of these jurisdictions are countries (Belgium, Canada, Colombia, Luxembourg, the Netherlands, and Switzerland). Eight are jurisdictions within the United States (California, Colorado, the District of Columbia, Hawaii, Montana, Oregon, Vermont, and Washington) and one is a state in Australia (Victoria).[16] The prison context is not mentioned in any assisted dying law in any jurisdiction with the exception of Canada.[17] No law explicitly excludes prisoners from accessing assisted dying or describes a different legal framework for assisted dying that is specific to prisoners. We found no official guidelines specifically regulating assisted dying in prisons in any permissive jurisdiction, with the exception of Canada.[18]

The legal requirement to make assisted dying available to prisoners in a permissive regime

Once assisted dying has been decriminalized, in many jurisdictions, it must be made available to a country's prison population because of the principle of equivalence of care. This principle establishes that a country's prisoner population must be provided with health care that is equivalent to what members of that country's general population receive.[19] This principle has received international recognition and is included in the Standard Minimum Rules for the Protection of Prisoners (known as the Mandela Rules), one of the main United Nations guidelines for the protection of prisoners.[20]

In Canada, section 86 of the CCRA requires that essential health care (including mental health care) be provided to the prison population, and that the prison population have reasonable access to nonessential health services.[21] The *Act* also stipulates that the

16. As the practice has expanded around the globe and jurisdictions have explored decriminalization of assisted dying, comprehensive summaries of assisted dying laws, policies, and regulations have been compiled and will not be duplicated here. See Australia, Parliament of Victoria, *Legal and Social Issues Committee, 2016 Inquiry into End of Life Choices* (Parliament of Victoria, Victoria, 2016). Available at: www.parliament.vic.gov.au (accessed 26 July 2019).
17. Even then, there are no special provisions re: eligibility and so on. Rather, the provision simply amends the CCRA to make it clear that MAiD deaths are not to be subject to s. 19 investigations. *CCRA*.
18. Guideline 800-9, 2017.
19. A. Charles and H. Draper, 'Equivalence of Care in Prison Medicine: Is Equivalence of Process the Right Measure of Equity?', *Journal of Medical Ethics* 38(4) (2012), p. 215.
20. *The United Nations Standard for Minimum Rules for the Treatment of Prisoners (the Nelson Mandela Rules)*, GA 70/175, UNODC 2015 Rules 24–35.
21. *CCRA*, s. 86.

provision of these services must conform with professionally accepted standards.[22] In addition, there is a common-law duty of care, which includes the duty to provide health care.[23]

It is important to note here that MAiD in Canada is treated as a form of health care—it is delivered by medical and nurse practitioners[24] and is funded by the provincial/territorial health systems in the same way other health services are funded.[25]

Internationally, besides the Mandela Rules, there are various regional and national guidelines describing the principle of equivalence, and its role as the benchmark for the minimum standard of care that should be met in prison medicine. The Council of Europe, of which Belgium, Luxembourg, and the Netherlands are members, has set standards for prison medicine.[26] These standards make explicit reference to equivalence of care. The principle shares a similar position in the American prison system, although it has only been recognized in case law exploring prisoners' rights to medical care.[27] Again, it is important to note that, as in Canada, assisted dying is treated as a form of health care in these jurisdictions. That is, in these jurisdictions, assisted dying is provided by physicians within the physician–patient relationship and is covered by the health insurance system.

It therefore appears that Canada, Belgium, Luxembourg, the Netherlands, and the United States must ensure that prisoners can access assisted dying.

The demand for assisted dying from prisoners

Given that assisted dying is now legal and must be made available to individuals in prisons in some jurisdictions, the next question to ask is whether there is any demand for it within the prison context.

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22. *CCRA*, s. 86(2).
23. See, for example A. Iftene, L. Hanson and A. Manson, 'Tort Claims and Canadian Prisoners', *Queen's Law Journal* 39(2) (2014), p. 655 at 663–664; *Lavoie v. Canada*, [2008] OJ No 4564 (QL) at para 13 (Sup Ct); *Sutherland v. Canada*, 2003 FC 1516 at para 67, [2003] 243 FTR 297; *Levasseur v. Canada*, 2004 FC 976 (available on WL Can); *Steele v. Ontario*, 1993 CarswellOnt 2686 (WL Can) at para 3 (Ct J (Gen Div)); *Swayze v. Dafoe*, [2002] OTC 699, 116 ACWS (3d) 781 (Sup Ct); *Lipcsei v. Central Saanich* (District), [1995]7 WWR 582, 8 BCLR (3d) 325 (SC).
24. *Criminal Code*, s. 241(2).
25. See, for example, Ontario, Ministry of Health and Long-Term Care, 'Medical Assistance in Dying' (Toronto, Queen's Printer for Ontario, 14 December 2018). Available at: health.gov.on.ca/en/pro/programs/maid/#funding (accessed 26 July 2019).
26. European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT), *CPT Standards* (Strasbourg, France: Council of Europe, 2011).
27. In *Newman v. Alabama,* 349 F. Supp. 278 (MD Ala. 1972), the Alabama state correctional system was held to have violated the Eight Amendment rights; In *Plata v. Schwarzenegger*, 560 F Supp. (3d) 976 (ND Cal. 2009), a federal class action lawsuit was brought against the California Department of Corrections and Rehabilitation alleging violation of the Eight Amendment.

Demand in Canada. Complete and reliable information about MAiD in Canadian prisons is not readily available. Information that CSC disclosed on July 7, 2018, in response to a freedom of information request indicated that, as of September 17, 2017, only one prisoner had met the eligibility criteria for MAiD, but they passed away before the procedure could be provided.[28] CSC did not disclose the number of requests made (despite this information having been requested). In March 2018, CBC News reported that eight Canadian prisoners had requested MAiD, three had been deemed eligible for MAiD, and two of these eligible persons had not yet received the procedure, but were living in the community.[29] No information is available on the reasons for prisoners having been deemed ineligible or about the underlying medical conditions of the one deemed eligible. The 2017–2018 Annual Report of the OCI reported that one prisoner had received MAiD.[30]

While complete and reliable data regarding actual demand for MAiD in prisons is not yet available, given the demographics of the Canadian prison population, it is reasonable to assume that there will be demand. The number of Canadian prisoners aged 50 years and older is growing,[31] and, in 2016, this group made up about one-quarter of the federal prison population.[32] The latest data available indicates that the average age at death was 60,[33] which is significantly lower than the average life expectancy outside prison at 82.[34] The leading causes of prisoners' deaths were cancer, cardiovascular illness, respiratory diseases, liver issues, and infections.[35]

In Canada, 3714 MAiD deaths were reported among members of the general population between December 2015 and December 2017.[36] On average, recipients

28. CSC, *Medical assistance in dying as of 17 September 2017*; Correctional Service Canada, *Annual Report on Death in Custody 2015/2016* (Ottawa: CSC, 2017b).
29. K. Harris, "Watchdog Calls for 'Compassionate' Parole as Prison System Adopts New Assisted Death Policy', *CBC News* (2018). Available at: https://www.cbc.ca/news/politics/terminally-ill-inmates-csc-zinger-maid-1.4546773 (accessed 26 July 2019).
30. OCI, *Annual Report of the Corrective Investigator 2017–2018*.
31. Canada, Office of the Correctional Investigator, *Annual Report of the Office of the Correctional Investigator 2014–2015* (Ottawa, OCI, 2015). Available at: www.oci-bec.gc.ca (accessed 26 July 2019).
32. Public Safety Canada, *Corrections and Conditional Release Statistical Overview, 2016 Annual Report* (Ottawa: Public Safety Canada Portfolio Corrections Statistics Canada, 2017).
33. These data are the most recent, but it represents the average over only 6 years. Older data released by CSC in 2017 indicate that over 16 years (the last year considered being 2015), the average age at death was 55 (CSC, *Annual Report on Death in Custody 2015/2016*). See also OCI, *Annual Report of the Corrective Investigator 2017–2018*.
34. Statistics Canada, *2018 Archived—Life Expectancy and Other Elements of the Life Table, Canada and Provinces, Table 39-10-0007-01* (Ottawa, Government of Canada, 2018). Available at: www150.statcan.gc.ca (accessed 26 July 2019).
35. CSC, *Annual Report on Death in Custody 2015/2016*.
36. Health Canada, *Third Interim Report on Medical Assistance in Dying in Canada* (Ottawa: Health Canada, 2018), p. 5.

of MAiD were 73 years old, and roughly one half were male.[37] The most common underlying medical conditions between July 2017 and December 2017 were cancer-related (65%), circulatory/respiratory (16%), neuro-degenerative (10%), and other (9%).[38]

Given the age and burden of disease for prisoners dying behind bars and the underlying medical conditions of individuals receiving MAiD outside the prison context, it is reasonable to conclude that MAiD requests will come from the prison population and that a number of those who request MAiD will meet the eligibility criteria.

Demand in other permissive jurisdictions. Internationally, there is some information available about assisted dying requests among prisoners, primarily among Belgian (See Table 1, 2 and 3) and Swiss prisoners.

Based on the information available about assisted dying requests in Belgium, it appears that assisted dying is being viewed by prisoners (20 (91%)) as a means to end

Table 1. Requests for MAiD among Belgian prisoners (Devynck and Snacken, 2016).[39]

Request by reason	Terminal cancer	2 requests
	Constant and unbearable psychological suffering *Detention as the main source of suffering (3 of the 20)*	20 requests
Total		22 requests

Note: MAiD: medical assistance in dying.

Table 2. Characteristics of Belgian prisoners making MAiD request (Snacken Devynck, Distelmans, Gutwirth and Lemmens, 2015; Devynck and Snacken, 2016).[40]

Characteristics of prisoners making MAiD requests		
	Not criminally responsible or sentenced to at least 10 years	20 (91%)
	Has underlying psychiatric issue	19 (86%)
	Ineligible for admission to civil psychiatric hospital	20 (91%)
Total		22 prisoners

Note: MAiD: medical assistance in dying.

37. Op. cit., p. 6.
38. Op. cit.
39. Devynck and Snacken, 'Ondraaglijk Psychisch lijden en Euthanasieverzoeken'.
40. S. Snacken, C. Devynck, W. Distelmans, S. Gutwirth and C. Lemmens, 'Requests for Euthanasia in Belgian Prisons: Between Psychic Suffering, Human Dignity and the Death Penalty', *Justice and Mental Health* 48(1) (2015). Available at: drvanmol.be; Devynck and Snacken, 'Ondraaglijk Psychisch lijden en Euthanasieverzoeken'.

Table 3. Results of requests for MAiD among Belgian prisoners (Devnyck and Snacken, 2016).[41]

Request by response		
	Successful *Terminal cancer as underlying medical circumstance (2)*	2 requests
	Denied *Prisoner seeking goods and services, not death (2)*	2 requests
	Desisted *Prisoner successfully released or transferred (3)*	3 requests
	Unknown	15 requests
Total		22 requests

Note: MAiD: medical assistance in dying.

psychological suffering.[42] Notably, some prisoners who sought assisted dying (3 (15%)) attributed their psychological suffering to incarceration itself,[43] and this is not surprising given its well-documented negative impact on one's psyche.[44] However, only requests involving a physical health condition as the underlying medical circumstance (2) have been granted for Belgian prisoners.

Researchers in Switzerland have found that Swiss prisoners also report interest in exploring self-administered assisted dying as a means to end psychological suffering.[45] An unspecified number report having attempted to contact 'Exit', a self-administered assisted dying provider, but not having received a reply.[46] Interestingly, Exit's president reports never receiving any requests from a prisoner, although he sees no objection to fielding such requests.[47] It seems reasonable to conclude that there is an unmet demand for self-administered assisted dying among Swiss prisoners.

41. Devnyck and Snacken, 'Ondraaglijk Psychisch lijden en Euthanasieverzoeken'.
42. C. Devynck and S. Snacken, 'Ondraaglijk Psychisch lijden en Euthanasieverzoeken van Gedetineerden en Geinterneerden', *Fatis* 149 (2016), pp. 12–16.
43. Op. cit.
44. A. Grounds, 'Psychological Consequences of Wrongful Conviction and Imprisonment', *Canadian Journal of Criminology Criminal Justice* 46(2) (2004), pp. 165–182; L.A. Rhodes, 'Pathological Effects of the Supermaximum Prison', *American Journal of Public Health* 95(1) (2005), pp. 1692–1695; M. DeVeaux, 'The Trauma of the Incarceration Experience', *Harvard Civil Rights-Civil Liberties Law Review* 48 (2013), pp. 258–261; S. Baidawi and C. Totter, 'Psychological Distress Among Older Prisoners: A Literature Review', *Journal of Forensic Social Work* 5(1–3) (2016), pp. 234–257.
45. D. Shaw and B.S. Elger, 'Assisted Suicide for Prisoners? Stakeholder and Prisoner Perspectives', *Death Studies* 40(8) (2016), p. 480.
46. Op. cit., p. 481.
47. A.C. Menétrey-Savary, 'Mourir en Prison', *InfoPrisons* (2015). Available at: www.infoprisons.ch (accessed 26 July 2019).

In the other permissive jurisdictions, the available information either states or implies that no requests for assisted dying have been made among the prison population.[48] There are no reports of assisted dying having been accessed by prisoners in these other permissive jurisdictions.

It should be noted that some scholars have suggested that the lack of requests from prisoners in jurisdictions where assisted dying is available for non-prisoners could be due to the fact that this service, while legally permissible, is not actually available to prisoners,[49] and hence the requests are not monitored. If that is the case, the apparent lack of requests should not be taken as indicative of demand.

The process for prisoners accessing assisted dying

Having established that where assisted dying is now legal, it must also be made available to prisoners in some jurisdictions, and that some prisoners will want to access it, we turn now to exploring the process for prisoners accessing assisted dying.

Process in Canada. According to the CSC Guideline, a federal prisoner seeking MAiD must submit a request to the institution's Health Services. Within 5 days of submitting the request, they will be seen by the Chief of Health Services or the institutional physician or nurse practitioner, who will provide them with information regarding MAiD and, if requested, schedule a first eligibility assessment. This will be conducted by the prison physician or nurse practitioner. The prisoner does not have a choice of assessor and, unlike individuals outside the corrections context,

48. I. Loosman, 'A Lifelong Prisoner's Choice of Death: Ethical Issues Involved in Considering Dutch Prisoners Serving Life Sentences for Physician Assisted Death,' unpublished Master's Thesis, Utrercht University, Netherlands, 2016; Regional Euthanasia Review Committees (RERC), *Annual Report 2013* (Netherlands, Regional Euthanasia Review Committees, 2014). Available at: www.euthanasiecommissie.nl; RERC, *Annual Report 2014* (Netherlands, Regional Euthanasia Review Committees, 2015). Available at: www.euthanasiecommissie.nl; RERC, *Annual Report 2015* (Netherlands, Regional Euthanasia Review Committees, 2016). Available at: www.euthanasiecommissie.nl; RERC, *Annual Report 2016* (Netherlands, Regional Euthanasia Review Committees, 2017). Available at: www.euthanasiecommissie.nl (accessed July 29, 2019); National Commission on the Control and Evaluation of the Law of 16 March 2009 on Euthanasia and Assisted Suicide, *Third report of the Law of 16 March 2009 on Euthanasia and Assisted Suicide (years 2013 and 2014)* (City of Luxembourg: Ministry of Health, 2015). Available at: www.sante.public.lu (accessed 26 July 2019).

49. V. Handtke and W. Bretschneider, 'Will I Stay or Can I Go? Assisted Suicide in Prison', *Journal of Public Health Policy* 36(1) (2015), p. 68; Loosman, 'A Lifelong Prisoner's Choice of Death'.

cannot seek a second opinion if the first assessor believes the eligibility criteria are not met.

If the first assessor believes the criteria are met, "all release options will be considered"[50] (under the CSC Guideline, mechanisms for "release" include parole by exception, the royal prerogative of mercy, and temporary absence[51]). If the prisoner is granted parole or given a pardon, then they will be released into the community and their health care will no longer be under the authority or be the responsibility of CSC. They will need to seek access to MAiD or alternatives to MAiD in the same way as anyone else in the community. If they have been denied parole or a pardon or if they are awaiting a decision on parole or pardon and cannot delay the MAiD process until that decision comes, they will need to continue to seek access to MAiD or alternatives to MAiD through CSC.

If the first assessor believes the prisoner meets the eligibility criteria, then the prisoner will undergo a second assessment conducted by an external physician or nurse practitioner usually in the community through the "temporary absence" mechanism.[52] If both assessors are of the opinion that the eligibility criteria are met, then the prisoner will be provided with the procedure, usually in the community, again through the "temporary absence" mechanism after the required 10-day waiting period (or less if death or the loss of capacity are imminent). The Guideline assumes that most of the time the second assessment will take place in the community[53] and assumes that most of the time MAiD will be provided external to CSC, namely, in a community hospital or other location. In exceptional circumstances, at the request of the prisoner, MAiD may be provided in a prison or CSC regional hospital if:

a. an exception has been approved by the Assistant Commissioner, Health Services; and
b. the procedure includes a health professional external to CSC.[54]

Process in other permissive jurisdictions. Despite the lack of a formal guideline in other permissive jurisdictions, some Belgian and Swiss scholars have written about the procedures surrounding MAiD in prisons in practice (Table 4).

50. Guideline 800-9, 2017.
51. Guideline 800-9, 2017, s. 16; Commissioner's Directive no. 712-1, "Pre-Release Decision-Making" (Ottawa: CSC, 15 January 2018) ss. 55–60; Commissioner's Directive no. 710-3, "Temporary Absences" (Ottawa: CSC, 1 June 2016).
52. Guideline 800-9, 2017, ss. 14–17.
53. Guideline 800-9, 2017, s. 18.
54. Guideline 800-9, 2017, ss. 19–21.

Table 4. Table depicting the process of assisted death in Belgian (Van Mol, 2013)[55] and Swiss (Mentrey-Savary, 2015)[56] prisons.

	Belgium	Switzerland
In prison	Prisoner writes, dates, and signs a request for assisted dying. Prison doctor receives requests, and must verify: (a) Prisoner is competent. (b) Request meets criteria set out at law. If verifications are positive, request is reviewed by external doctor. If review is affirmative, prison doctor requests early release of prisoner and/or transfer to civil hospital.	Prisoner requests early release or a transfer. If the prisoner's request is denied, the prisoner is unable to access assisted dying services.
Outside prison	Assisted death takes place outside of prison either after early release or transfer to civil hospital.	If the prisoner's request is approved, the prisoner is released or transferred. Following release or transfer, the individual can make a request for assisted dying. Request is received, assessed, and facilitated like any request made by a member of the general public is. If the individual is deemed eligible based on criteria set out by assisted dying service providers, the assisted death takes place outside of prison.

The Belgian approach uses prison doctors to assess MAiD eligibility. These doctors are positioned to facilitate the assisted dying process. Assisted dying appears to have been integrated into the Belgian prison health system (albeit with provision occurring outside the prisons). In contrast, the Swiss approach requires that prisoners first leave the prison environment before they are able to be assessed for or to access self-administered assisted dying.[57] There are no assessments for, or facilitation of, self-administered assisted dying by prison officials in Swiss prisons. Self-administered assisted dying can, theoretically, only be assessed/accessed once a prisoner has been released or transferred.[58]

55. Van Mol, 'De Gezondheidszorg in de Belgische Gevangenissen'.
56. Mentrey-Savary, 'Mourir en Prison'.
57. Handtke and Bretschneider, 'Will I Stay or Can I Go?'.
58. Menétrey-Savary, 'Mourir en Prison'.

Given the connection between the process for accessing assisted dying and general release or transfer mechanisms, it is necessary here to explain these processes and mechanisms in greater detail in order to illuminate some significant barriers to accessing assisted dying facing prisoners in many seemingly permissive jurisdictions[59] and some implications for the voluntariness of the decision to access MAiD.

If assisted dying is available in prisons and in the community, then the mechanisms for release or transfer into community will affect a prisoner's ability to access assisted dying in their preferred location. If assisted dying is only available in community, then access will be contingent on prisoners' ability to be released or transferred into community. Therefore, in order to assess the availability of assisted dying for prisoners, it is essential to contrast the eligibility criteria for assisted dying with the eligibility criteria for release or transfer into community.

A comparison of Tables 5 and 6 reveals that the eligibility criteria for assisted dying and the eligibility criteria for release or transfer into community are not the same, and thus, it is possible for a prisoner to be eligible for assisted dying and ineligible for release or transfer into community. For example, a prisoner could be eligible for assisted dying in Canada because of a grievous and irremediable medical condition but be ineligible for release into community because they pose a safety risk to others.

Table 5. Overview of release or transfer mechanisms in select jurisdictions for ill prisoners.

Country	Description of release or transfer mechanisms available for ill prisoners
Belgium	A prisoner is eligible for release or transfer if they are in a terminal phase of an untreatable disease or if detention is no longer compatible with their health. Release or transfer can be denied if the prisoner poses a risk of committing a serious offence, does not have an appropriate place to go upon their release, or could disturb a victim (Lucien Nouwynck, "Les modalites d'exécution des peines et mesures privatives de liberté. Le nouveau cadre légal créépar les lois du 17 mai 2006, 21 avril 2007 et 26 avril 2007 - note pratique -." (2007), online (pdf): <www.carrefourdesstagiares.com>)[60].

(continued)

59. S. Snacken, C. Devynck, W. Distelmans, S. Gutwirth and C. Lemmens, 'Requests for Euthanasia in Belgian Prisons: Between Psychic Suffering, Human Dignity and the Death Penalty', *Justice and Mental Health* 48(1) (2015) Available at: https://www.erudit.org/en/journals/crimino/2015-v48-n1-crimino01787/1029350ar/ (accessed July 29, 2019); F. Van Mol, 'De Gezondheidszorg in de Belgische Gevangenissen', (2013). Available at: drvanmol.be (accessed 29 July 2019).
60. L. Nouwynck, 'Les modalites d'exécution des peines et mesures privatives de liberté. Le nouveau cadre légal créé par leslois du 17 mai 2006, 21 avril 2007 et 26 avril 2007 - note pratique' (2007). Available at: www.carrefourdesstagiares.com.

Table 5. (continued)

Country	Description of release or transfer mechanisms available for ill prisoners
Canada	Release is accessible to prisoners who meet the criteria set out under section 121(1) of the CCRA, which states that at any time in a sentence, an incarcerated person may be granted considered for release if they are someone: (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 excessive hardship that was not reasonably foreseeable at the time the offender was sentenced; and (d) who is subject of an order of surrender under the Extradition Act and who is to be detained until surrendered (CCRA, section 121(1))[61]. However, section 121(b)–(d) does not apply to individuals: (a) serving a life sentence imposed as a minimum punishment or commuted from a sentence of death; or (b) serving, in a penitentiary, a sentence for an indeterminate period (CCRA, section 121(2))[62]. However, these criteria only grant a right to be considered for parole by exception. Applications for release are reviewed by the Parole Board of Canada, where other factors are considered in reaching a decision: seriousness of offence, attitude during incarceration, completion of correctional plans and so on (CSC, 2017a)[63]. However, many terminally ill prisoners do not make it before the Board despite their health, sometimes because, for a hearing for release on these grounds, they need the support of CSC (Iftene, 2017a; Anthony Doob, Cheryl Marie Webster and Allan Manson, "Zombie Parole: The Withering of Conditional Release in Canada," Criminal Law Quarterly 61 (2014); Ivan Zinger, "Conditional Release and Human Rights in Canada: A Commentary," Canadian Journal of Criminology and Criminal Justice 54(1) (2012); Sarah Turnbull, Parole in Canada Gender and Diversity in the Federal System (Vancouver: UBC Press, 2016))[64]. In addition, prisoners are largely unaware of the release options (Iftene, 2017a)[65].

(continued)

61. CCRA, section 121(1)
62. CCRA, section 121(2)
63. CSC, Medical assistance in dying as of 17 September 2017.
64. Op. cit.; Iftene, 'The Pains of Incarceration'; A. Doob, C.M. Webster and A. Manson, 'Zombie Parole: The Withering of Conditional Release in Canada', *Criminal Law Quarterly* 61 (2014); I. Zinger, 'Conditional Release and Human Rights in Canada: A Commentary', *Canadian Journal of Criminology and Criminal Justice* 54(1) (2012); S. Turnbull, *Parole in Canada Gender and Diversity in the Federal System* (Vancouver: UBC Press, 2016).
65. Iftene, 'The Pains of Incarceration'

Table 5. (continued)

Country	Description of release or transfer mechanisms available for ill prisoners
	Only 21 terminally ill prisoners have been released through parole by exception in the 10 years (2007–2017). At the same time, during a similar period (2005–2015), the CSC recorded 350 natural deaths in custody, out of which most were expected deaths (CSC, 2017b: Table 6)[66]. Release is also accessible using the Royal Prerogative of Mercy, which gives the Governor in Council the discretionary power to grant a free or conditional pardon to a person who has been convicted of an offence (Criminal Code subsection 748, 748.1)[67]. Since 2005, at least 49 requests have been made under the Royal Prerogative of Mercy, but none have been granted (Office of the Correctional Investigator, An Investigation of the Correctional Service's Mortality Review Process (Ottawa: OCI, 2013) at 5, online: www.oci-bec.gc.ca; OCI, 2016: 12)[68]. Release is also accessible using the mechanism of temporary absence (Commissioner's Directive no. 710-3, 2016)[69]. All prisoners are eligible for *escorted* temporary absences for medical purposes no matter the length of their sentence or how much time they have served. Subject to two exceptions (cases in which indeterminate sentences are imposed for offenses that occurred prior to August 1, 1997 and cases in which life and indeterminate sentences are followed by determinate sentences (Commissioner's Directive no. 712-1, 2018))[70], prisoners are eligible for *unescorted* absences for medical purposes when they have served a sufficient portion of their sentence (See Commissioner's Directive no. 710-3, 2016: s. 8)[71]. A maximum of 30–60 days is allowed for the parole or correctional officer who receives the request for temporary absence to complete an "assessment for decision." Then, up to 10 days is allowed for the "institutional head decision," and an unspecified length of time for review and appeal. Thus, a decision on a request for a temporary absence could be made quickly or it could take up to 70 days (more if there is an appeal (see Iftene, 2017a: 936)) (Commissioner's Directive no. 710-3, 2016)[72]. The 2014–15 OCI Annual Report revealed that "nearly 60 of the natural cause deaths involved individuals who were receiving palliative care (including end of life) services. Of those palliation cases, 60% died in a CSC regional hospital, 31% died in a community hospital, and 9% succumbed in a CSC institution"

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66. CSC, Annual Report on Death in Custody 2015/2016.
67. Criminal Code subsection 748, 748.1
68. Office of the Correctional Investigator, An Investigation of the Correctional Service's Mortality Review Process (Ottawa: OCI, 2013) at 5. Available at: www.oci-bec.gc.ca; OCI, 2016: 12.
69. Commissioner's Directive no. 710-3, 2016.
70. Commissioner's Directive no. 712-1, 2018.
71. See Commissioner's Directive no. 710-3, 2016: s. 8.
72. Commissioner's Directive no. 710-3, 2016.

Table 5. (continued)

Country	Description of release or transfer mechanisms available for ill prisoners
	(OCI, 2015: 21)[73]. Given that only 4 of the 60 cases were granted parole by exception (see below), 27% must have been on temporary absence.
Switzerland	There are four release mechanisms (Stefan Berard and Nicolas Queloz, "Fin de vie dans les prisons en Suisse: aspects légaux et de politique penale,' Jusletter, 2015: 2 (November 2015))[74] that may be utilized by ill prisoners, and which are applied for in the following order: (1) Derogatory execution allows a prisoner to serve their sentence elsewhere. (2) Conditional release requires that the prisoner has completed two-thirds of their sentence or at least 3 months of detention. (3) Interruption of sentence applies to exceptional cases only and requires a "serious reason" such as health. (4) Pardon may be exercised only after all other release mechanisms have failed.

Note: CCRA: Corrections and Conditional Release Act.

In addition, in Canada, release through parole by exception or pardon is rare to nonexistent, respectively, and the application process is cumbersome, time-consuming, and restrictive. The procedure for applying for release through a temporary absence is more accessible, and temporary absences are more common than parole by exception or pardons. However, the temporary absence mechanism is vulnerable to the lack of availability of services or beds in the community and to the costs of escorts for escorted temporary absences. Thus, it is more likely to be for short durations if at all. For example, there might be sufficient availability for a bed and escort for a day for MAiD but not a bed and escort for 6 months for palliative care. Also, unlike when a person is released on parole or pardoned, when a person is released on a temporary absence for MAiD, if they change their mind, they will be returned to prison.

In sum, if assisted dying is not available within the prison setting, the practical hurdles of the release or transfer application processes and the restrictive eligibility criteria for release or transfer into community may be barriers to access to assisted dying. If assisted dying is available in prison, the coercive and oppressive environment of prisons may be a barrier to truly voluntary decision-making about assisted dying. If assisted dying is only available outside prisons through a temporary absence mechanism, assisted dying may be more accessible than palliative care and therefore the voluntariness of the choice between assisted dying and palliative care may be compromised.

73. OCI, *Annual Report of the Office of the Correctional Investigator 2014-2015*, 21.
74. S. Berard and N. Queloz, 'Fin de vie dans les prisons en Suisse: aspects légaux et de politique penale', *Jusletter*, 2015: 2 (November 2015).

Table 6. Eligibility criteria for assisted dying by jurisdictions (Parliament of Victoria, 2016; Dyer, White and Rada, 2015)[75].

Jurisdiction	Eligibility criteria for assisted dying
Belgium	Eligibility criteria under The Belgian Act on Euthanasia of May 28, 2002 requires the following. – The patient has attained the age of majority or is an emancipated minor and is legally competent and conscious at the moment of making the request. – The request is voluntary, well-considered, and repeated and is not the result of any external pressure. – The patient is in a medically futile condition of constant and unbearable physical or mental suffering that cannot be alleviated, resulting from a serious and incurable disorder caused by illness or accident.
Canada	Individuals are eligible for MAiD if: – eligible for health services funded by government in Canada (or would be but for minimum period of residence or waiting period); – at least 18 years old; – capable of making decisions with respect to their health; – made a voluntary request; – gave informed consent to receive medical assistance in dying after having been informed of means available to relieve suffering, including palliative care; and – have a grievous and irremediable medical condition meaning: ○ they have a serious and incurable illness, disease or disability; ○ they are in an advance state of irreversible decline in capability; ○ 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; and ○ their natural death has become reasonably foreseeable, taking into account all of their medical circumstances, without a prognosis necessarily having been made as to the specific length of time that they have remaining (CSC, 2017a)[76].
Switzerland	There is no statutory framework outlining eligibility criteria. Assisted death is allowable if the person assisting does so for "unselfish reasons."

Note: MAiD: medical assistance in dying.

Part 2: Lessons learned

A number of issues have surfaced from this review of the experience to date with assisted dying in prisons in jurisdictions that permit some form of assisted dying. These are relevant for permissive jurisdictions as they seek to implement or manage assisted dying for prisoners. They are also relevant for other jurisdictions that are exploring the decriminalization of assisted dying or as they design and implement a permissive assisted dying regime.

75. Parliament of Victoria, Legal and Social Issues Committee; Dyer, White and Rada, 2015.
76. CSC, Medical assistance in dying as of 17 September 2017.

Equivalence of care

Countries that have embraced the principle of equivalence of care must wrestle with the implications of this principle for decriminalizing assisted dying. That is, if a jurisdiction has embraced the principle and decriminalizes assisted dying, they will be obliged to ensure access to assisted dying for prisoners (whether in the community or in the prison). Alternatively, they will need to include and justify an explicit exception regarding access within their legislation.

Countries appear to have failed to meet the principle of equivalence of care in the context of assisted dying. The fact that there are so few documented requests for, and provision of, MAiD given the age and burden of disease among prisoners compared to the number of requests and provision of MAiD in the general population suggests that the principle is not being met. CSC's position that a prisoner cannot seek a second assessment if the first assessor determines they are not eligible is a clear breach of this principle.

The interaction of eligibility criteria for assisted dying and for release or transfer into community

Policy-makers must be alive to the interaction of eligibility criteria for assisted dying and for release into community. This is not to suggest a particular position on the prioritization of the criteria. Rather, it is to flag that restrictive release criteria (especially non-health–related criteria) will mean that there will be more prisoners who are eligible for assisted dying seeking assisted dying within the walls of the prison (and this then links back to the issue of equivalence of care). If assisted dying is not available within the walls of the prison and if the eligibility criteria for release to community leave prisoners who are eligible for assisted dying in prison, policy-makers will be responsible for this violation of the principle of equivalence. Restrictive release criteria (again especially non-health–related ones) also make it all the more essential to wrestle with the ethical concerns about voluntariness raised by many about the provision of assisted dying inside prisons or through temporary absence/transfer rather than release (through, e.g. parole or the Royal Prerogative of Mercy).

Psychological suffering

Unbearable psychological suffering formed the basis of most prisoners' assisted dying requests internationally.[77] Some have suggested that this is an indication that prisons have failed to provide adequate mental health services to their populations[78] and have suggested that steps can and should be taken to reverse this trend.[79] At the very least, this

77. Snacken et al., 'Requests for Euthanasia in Belgian Prisons'.
78. A. Willems, 'Euthanasia of Detainee: Granting a Prisoner's Request', *Criminal Justice Matters* 102(1) (2015), pp. 47–48.
79. Op. cit.

suggests that permissive assisted dying regimes should wrestle with the role of psychological suffering as a basis for assisted dying. Specifically, what is the relevance of the fact that at least some of a prisoner's psychological suffering is likely due to the conditions of imprisonment and/or the lack of access to mental health services in prisons?

Education

As noted earlier, older Canadian prisoners report being unaware of the release options available to them.[80] Health literacy among prisoners is low[81] and can be compounded by a lack of communication between assisted dying service providers and the prison population.[82] In permissive jurisdictions, prisoners, and especially those who are aging behind bars, must be educated about assisted dying and other end of life care options as well as the release mechanisms that may be available to them. The design of education programs must, of course, be sensitive to the risk of inducing requests for MAiD.

Conclusion

Recent developments in assisted dying have raised new challenges for health and legal professionals, as well as prison administrators and staff. Attention must clearly be paid to the ramifications of the decriminalization of assisted dying practices on marginalized populations. This is especially true for prisoners given the increasing number of older individuals in prisons. This article aimed to provide a synopsis of the current state of assisted dying in prisons in permissive jurisdictions around the world in order to highlight issues that must be attended to by those who have decriminalized or are considering decriminalizing assisted dying. Lessons learned by those who have already had some experience with assisted dying in prisons are offered.

Declaration of Conflicting Interests

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding

The author(s) received no financial support for the research, authorship, and/or publication of this article.

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80. A. Iftene, 'The Case for a New Compassionate Release Statutory Provision', *Alberta Law Review* 54(4) (2017b), pp. 929–954.
81. M. Witkowski, P. Hudson, S. Batson, B. Moore and S. Mitchell, 'Systematic Review of Healthcare Use and Needs of Prisoners', in *Health Care in Belgian Prisons* (Brussels, Belgian Health Care Knowledge Centre, 2017). Available at: kce.fgov.be (accessed July 26 2019).
82. Menétrey-Savary, 'Mourir en Prison'.