Life and death in Canadian penitentiaries

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A federal penitentiary is a prison where individuals serve long sentences, of 2 years or longer, including life sentences. Take a second to picture a person serving a sentence in such a place. Who do you see in your mind's eye?

Did you imagine a 70-year-old in an advanced stage of multiple sclerosis? Or a 72-year-old with metastatic lung cancer? Or a 55-year-old with an above-the-knee amputation and stage 1 dementia?

Probably not. And yet, these are increasingly the individuals represented in federal correctional institutions. Currently, 25% of the individuals incarcerated in federal prisons are older than 50 years of age, and this percentage is increasing at an alarming rate.[1,2] Incarcerated individuals have higher rates of mortality and morbidity for most illnesses.[3] In addition, they go through a process of accelerated aging (ie, they have the health problems of someone 10 to 15 years older than them in the community).[2] As a result, their life expectancy is around 62 years,[4] compared with the Canadian average of 82 years.[5]

The aging of the incarcerated population creates unexpected challenges. These include high rates of comorbidities, and illnesses and symptoms commonly associated with aging, such as dementia, which has now reached a rate of 5% in older prisoners.[6] Prisons were never meant to be nursing homes, and yet they are increasingly asked to perform this function. The resulting situation is inhumane, unethical, and legally problematic.

A few years ago, I interviewed 197 older adults across 7 Canadian penitentiaries, roughly 10% of all federally incarcerated individuals older than 50 years of age at that time. The purpose of my research was to investigate the self-reported needs of older adults, prison policies related to meeting these needs, and avenues of early release for those who are old, sick, and have a lower risk of reoffending owing to age and health.[1,6-9]

My research revealed that approximately 4% of incarcerated individuals older than 50 were terminally ill (ie, they have a prognosis of weeks to months to live). In Canada, sentencing someone to life imprisonment without the possibility of parole is not an option. Thus, every prisoner is eligible at some point during his or her sentence to apply to have it commuted to be served in the community under supervision. Further, the governmental agency administering the federal prisons, the Correctional Service of Canada (CSC), has an obligation to seek alternatives to incarceration when someone becomes irreversibly sick. Nonetheless, an increasing number of people are dying in prisons of expected deaths.[4] Existing release avenues are generally underused in Canada,[10] and there are no adequate medical or compassionate release systems in place. Parole by exception, the only compassionate release option in Canada, involves a bureaucratic, lengthy process and very few individuals have been released on this basis.[8]

Absence of records of end-of-life care

Between 2005 and 2015, almost 350 people died in Canadian prisons; most of them died of expected natural causes.[4,11] We can never know what kinds of lives these 350 people experienced before death. The CSC claims that it provides palliative care to all who need it.[4] But there is no record of what this care consists of, when it is offered, by whom, for how long, and what care protocol exists around it. When I attempted to answer these questions through requests made under the Access to Information Act, I received responses such as "This is private information" and "We cannot release this information, but everyone who needs it gets it."[4] In light of the prison system's record of providing inadequate health care more generally,[1-6,11] these statements do not carry much weight.

Inadequate resources

The only pain medications available in prisons are acetaminophen with codeine, and morphine, according to the CSC National Drug Formulary.[12] It is thus not surprising that half of those taking pain medication report it being ineffective[1]; anecdotes of people in pain were common among my interviewees. Perhaps none was more heartbreaking than the story of a patient with stage 4 cancer—transferred to minimum security from a medium security institution to receive better care—who was left for a week in his room, screaming and sweating, with no pain medication at all. The other prisoners collected money and bought regular acetaminophen from the canteen in an attempt to ease his pain.

Mental health care is another problematic area in corrections. Some institutions provide good mental health support. Many other correctional institutions, however, are substantially understaffed in this area and some have, for instance, only 1 psychiatrist and 1 psychologist for 600 prisoners. In such institutions, one can see a mental health specialist every few years (generally, if they state they are suicidal) and each individual is entitled to a total of 3 sessions of psychological counseling over the duration of their stay (which can be decades).[13]

A number of institutions do not have a nurse on the premises around the clock. As one prisoner put it, "You'd better not have a heart attack after 4 PM." This gap in health care has a particularly devastating effect on those who are seriously ill.[1] Escorted visits to see a community doctor are available, but their frequency depends on officer availability to take people out and on the willingness of the prison physician to make a referral. Some individuals wait for months for a doctor or other appointments (such as chemotherapy), only to be told when the day comes that no officer is available to escort them to their appointment (and thus their appointment gets canceled).[1]

No other options

Finally, in many institutions, medication is dispensed only under the direct observation of health care practitioners. That means that everyone receives their medication only once or twice daily, regardless of how effective that is for their needs. In addition, in most institutions people must pick up their medication and wait in line to do so, regardless of their ailments. At many penitentiaries, the medication line is outdoors all year round, which means that all prisoners taking medication must stand in line, rain or shine, regardless of how disabled or sick they are, for anywhere between 10 minutes and 1 hour to pick up their pills. Some choose to skip the line and do without their medication because the pain from standing to pick up their pills is greater than the relief the pills bring.[7]

Prisoners have no other option for accessing health care (even if they are willing to pay for it) and they are fully dependent on whatever the prison provides for them. It is thus unclear how end-of-life care can be provided to all who need it at acceptable levels of the profession as required by law[14] when there are systemic gaps in the prison system's ability to provide pain management, psychological care, medical staffing 24 hours a day and 7 days a week, or specialized care, just to name a few.

Care of a vulnerable population

This track record of care, coupled with the increasing number of people getting sick and dying in prison, the lack of records on end-of-life care, and the lack of effective release mechanisms for the old and the ill, raises substantial concerns about how incarcerated people are treated during their final weeks and months of life.

The overcrowded prison environment where highly vulnerable individuals live, in combination with inadequate health care, has proven to be a disastrous combination during the coronavirus disease 2019 (COVID-19) pandemic. Despite the many calls to depopulate the prisons during the pandemic, the federal government has refused to follow the model of other countries and some provinces and, with a couple of exceptions, has not released the numerous sick individuals deemed to be a low public safety risk. As a result, it was very difficult to successfully implement preventive measures to reduce transmission of the virus within prisons.[15] During the first wave, the rate of infection in federal prisons was 13 times higher than in the community, while the rate of incarcerated women who became infected was 77 times higher than that of nonincarcerated women (T. Doob, J.B. Sprott, unpublished memorandum, April 22, 2020; and T. Doob, unpublished memorandum, April 23, 2020). Two incarcerated people have died of COVID-19.[16]

I am not a medical doctor and hence I can only speak to the illegality and unconstitutionality of these practices.[1,9] I wonder how doctors feel about the mockery the state makes of their profession by calling this kind of treatment "health care"? Do doctors even know this is happening? Would a doctor in the community find this kind of care acceptable for their patients? Think of the 72-year-old with metastatic cancer. If what I described here is different from the treatment and care you would recommend for this person, consider doing something. This might mean getting more familiar with health care in prisons, writing a letter to your Member of Parliament, or volunteering your expertise to improve the lives of criminalized individuals. Prison issues are community issues and prison health is public health. If anything is to change, we all need to push toward that. As physicians, your expertise and training enable you to provide informed, evidence-based opinions to enact real change for some of society's more vulnerable members.

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Competing interests
None declared

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