A review of the regulatory and functional aspects of prison health care and nursing staff

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ABSTRACT

The aim of this study of prison health care staff in Prison Health Care and Nursing Units is twofold. The first one is to consider those aspects of the legal system applicable to them as government employees of the General State Administration at the service of Prisons, highlighting the peculiarities of the legal regulations that can be applied as a result of providing said service. The second, based on the general regulations on prison health contained in Organic Law 1/1979, of 26 September, General Penitentiary Law and the implementing regulations thereof, approved by Royal Decree 190/1966, of 9 February, sets out to provide a critical analysis of the obligatory and functional framework for health care and nursing staff established in the old Penitentiary Regulations of 1981, to determine from a legal perspective if it is possible to impede or brake so that the Prison Administration may develop or carry out the functions for which it is responsible in terms of planning, organization and management of activities geared towards maintaining and improving hygiene and health in the prison environment.

Keywords: Prisons; Legislation, Medical, Legislation, Nursing; Organization and Administration; Efficiency; Spain; Work; Employee Discipline.

Text received: 05/18/2015

Text accepted: 08/19/2015

INTRODUCTION

It is evident from the title that this paper does not intend to approach prison health care —an objective which, to be honest, would be mostly pretentious and not within a jurist's reach— but to write a few lines, not too through either, on the public employees who provide such prison health care day after day, who make it real through their work in correctional facilities. That being said and warned we would like to start this introduction by reflecting on health care in prisons.

A brief revision of prison history, as described by GARRIDO GUZMAN¹, points up how for a long time, almost until the beginning of the 20th Century, the provision of health care remained one of the darkest, gloomiest and most deficient aspects of prison systems in all countries. In the first prisons the complete abandonment of health and hygiene standards was the order of the day, with a complete lack of medical services. Repeated epidemics swept across

periodically causing hundreds of casualties among inmates. John Howard describes how in his day so called “jail fever” and the plague caused great devastation among not only prisoners but inhabitants from nearby communities. He himself passed away as a consequence of typhoid fever acquired in a visit to the prison of Kherson in Crimea.

Interestingly, GARRIDO GUZMAN explains how in the English town of Taunton in 1730 prisoners who were being judged infected the court, the lawyer, the judge and even a few hundred people who died from jail fever¹. In Spain in 1804, the great *Rafael Salillas* describes how from a group of around seventy prisoners who were being transferred, before 24 hours half of them were admitted to the infirmary, and eleven passed away a few days later and so how “any transfer of prisoners entails that around 40% are admitted to the infirmary or to hospital before the third week after their arrival”².

The deep change that has been witnessed in prison systems in general and in healthcare services in

particular, in just over a century, from the aforementioned scenario to the current provision of health care in Spanish prisons, allows for reflection.

As to focus on the content of this paper, we will say that in the lines that are to follow we will be interested in two main aspects. In the first place, to clarify the legal status of prison healthcare staff because, under certain circumstances, it seems to be diluted and not too clear. And even more if we take into account that it can be susceptible to certain regulations which are only applicable to healthcare staff from other public administrations and civil/non-civil collectives. In the second place, we will consider the operating environment of prison healthcare staff regarding Prison Health Care and Nursing Units and how we consider from a legal-normative point of view that it should be now reinterpreted in the first third of the 21st Century.

THE LEGAL STATUS OF PRISON HEALTH CARE STAFF

Prison health care employees are grouped in two different bodies: Prison Health Care and Nursing Units.

Both of them depend of the Ministry of Interior and so their corresponding staff depends directly of the National State Administration (NSA) and therefore, although this may seem redundant, they do not belong to the autonomic, local or corporative administration. Therefore, their legal status is that applicable to all staff of the NSA and not to the rules and regulations applicable to other staff such as, for example, statutory staff from health care services.

Common standards for all National State Administration civil staff: The principle of normative hierarchy.

Rules, regulatory provisions, have a certain range, that is, a level, grade or category. In a very plain and simple way this means that a provision of lower rank can never contradict the stipulations of a higher rank provision. Now, what is the actual status of normative provisions? This status will depend on several factors, but it is necessary to mention mainly two: its method of production, that is, the procedures followed and the individual or body in charge of doing so. Obviously, the normative status of a law is higher than that of a Royal Decree³. We can then find, in a lower level, decisions, orders and instructions from other administrative bodies, such as, for example, a decision by the SGIIPP (General Secretariat of Penitentiary Institutions).

A lower normative regulation can never lead to the infringement of a higher regulation, or in other words, a lower regulation must respect the provisions of a higher rank regulation. Therefore, a decision by the SGIIPP has to respect the provisions of a Regulation approved by Royal Decree.

Together with the principle of normative hierarchy it is worth noting that judicial rules can be further amended⁴. Now, such principle must be endorsed, obviously by the principle of normative hierarchy since a lower rank regulation, although subsequent, can not repeal a higher rank provision. A clear example is that a regulation can never repeal the provisions established by a previously existing law.

Main regulatory standards and current transitory situation

The key regulatory standards applicable to public staff belonging to the NSA, in order of importance are the following: 1978's Spanish Constitution and the Basic Statute of Public Employees (BSPE).

The Statute as an incomplete regulation: the keys to its validity

The BSPE is a framework law in need of further development in each of the public administrations where it should be applied. For that matter we can say that it is unfinished or incomplete. This is a fundamental idea that we should carefully consider since the reform of civil service that the Statute entails will not be completed until such development is carried out, something which has not yet occurred within the NSA. At a regional level, there are still few Communities which have enforced it.

But is the BSPE valid within the Public Administrations which have not yet enforced it? Of course, but in a certainly *sui generis* way since its provisions coexist with the previously existing regulations, an all according to what is established in its Sole Repeal Provision and in its Fourth Final Provision.

Yet, what do we have now? Well then, we find the construction of a transient, temporary normative regimen, which will be only entirely, established when the provisions established by the Statute itself are fully enforced.

In essence, from our point of view, the transient regimen implied by the Statute is provisionally in force as long as it does not oppose the provisions of legal regulations governing public service in each of the Public Administrations where it is susceptible to be applied, and as long as it is not replaced by new

rules approved within the development of the Statute itself.

Other legal rules and regulations

Once our considerations on the Statute as an *incomplete regulation*, the keys to its enforcement and the transient validity of the previously existing regulations regarding public service have been stated, obviously if we intend to set a regulatory framework regarding NSA official staff and hence, that belonging to Prison Health Care and Nursing Units, we must make a reference to transitory laws and regulations, which as long as they do not oppose the provisions of the BSPE, are still applicable.

Rules with the status of formal laws

- a) Act 30/1984 as of August 2nd, on the measures to reform Public Service: a regulation with the status of basic legislation which was born with a provisional vocation, *just vocation because part of its articles is still in force thirty years later*. This Act considered a very different model of public service, structured around the work itself.
- b) Act 53/1984 as of December 26th, on incompatible activities regarding staff employed in the Public Administration, particularly important for health care staff.
- c) Act 9/1987 as of June 12th, on the regulation of the representation system of public employees and their participation and collective agreement for the establishment of conditions of employment.

Other regulations

Under the rules with a status of formal law we find other regulations among which we can also establish a relationship of hierarchy. First, we find statutory rules approved by Royal Decree by the Council of Ministers, then ministerial decrees and last, resolutions, instructions and service orders from lower-rank authorities. As far as the later are concerned, as we will see later, it is important to remember that Article 21.1 (Instructions and service orders) of Act 30/1992 as of November 26th on the Legal system applicable to Public Administration and the Common Administrative Procedure establishes in the first paragraph *“administrative bodies will be able to guide the activities of hierarchically dependant bodies by means of instructions and service orders”*, and in the second paragraph *“whenever particular provisions so provide or whenever it is considered convenient on the matter of the addressees or the consequences thereby entailed,*

instructions and service orders will be published in the corresponding public journal”.

Accordingly, we face a real statutory jungle since there is a wide quantity and variety of already existing regulations.

Prison Administration specific internal regulations

With regard to prison health care staff, internally within the Prison Administration there are fundamental standards which, somewhat, complete the regulatory framework, regarding working hours and productivity bonus regarding on-call time.

Regulations of working hours

It is well known that Article 286 from Prison Regulations, approved by Royal Decree 190/1996 as of February 9th (PR/96) determines that prison officers, in view of the nature of their tasks, will be employed under specific time conditions. On the other hand, the list of job posts from Prison Administration outreach services, show in the remarks section the key S.H (special hours).

Therefore, the Resolution as of December 28th 2012 of the Secretariat of State's Public Administration on working times of NSA staff and other aforementioned public bodies, does not directly affect prison health care staff. In fact, such resolution, in section 1.2, establishes that the regulations thereby included will not be applicable to, among others, employees from correctional facilities, who will be susceptible to the corresponding specific regulation.

That particular regulation is in fact Instruction 3/2013 as of October 25th on working times of staff from SGIIPP outreach services and the Autonomous Agency of Penitentiary employment and training activities (I3/2013) which recently became the current State Entity for public law prison employment and training for employment ⁵.

Regulatory standards on productivity bonuses

Before talking about regulatory standards on productivity bonuses regarding on-call times complementary to ordinary working times, it is worth incorporating such bonus within the remuneration structure of NSA employees.

Considering what we have previously stated on the lack of current validity of the BSPE provisions regarding the economic rights of public employees, the basic pillars, which are indeed currently in force, of the remuneration structure are included an Articles 23 and 24 of the Legal system applicable to Pub-

lic Administration and the Common Administrative Procedure and some other regulations.

Remuneration of civil employees is classified as *basic and complementary remuneration*. The later includes productivity bonuses.

The productivity program which includes health care on-call working time is regulated by Instruction 9/97 as of June 13th of the then General Directorate of Penitentiary Institutions (19/97), partially amended by others, basically as far as the amount to be paid for each on-call shift. That instruction expressly stipulates that *"productivity bonuses will only be paid to medical and nursing staff actually on call"* and hence, no bonuses will be paid in case of not fulfilling on-call shifts regardless of the reasons⁶.

FUNCTIONAL STATUS OF PRISON HEALTH CARE EMPLOYEES

First, it is of paramount importance to mention healthcare considerations included in the General Prison Organization Act (LOGP in Spanish) and the Penitentiary Regulations (RP in Spanish). Yet before, as far as the later is considered, it is also worth partially comparing its provisions with that of its predecessor, the Penitentiary Regulations approved by Royal Decree 1201/1981 as of May 8th (RP/81).

General Prison Organization Act

LOGP includes specific regulations regarding the provision of health care, specially the staff that each facility must count upon: a general physician with knowledge on Psychiatry and a nurse. It also clearly stipulates that facilities will count upon the services of a dentist and the appropriate auxiliary staff.

As far as what we could consider *outreach health care services*, LOGP establishes that inmates will be admitted to prison hospitals and care institutions and, in case of need or emergency to regular hospitals (Article 36.2). It also establishes that inmates may request, at their sole cost, medical services from outreach Prison Administration professionals, except when due to security reasons this right needs to be limited (Article 36.3).

If we consider the regulations on prison health care included in the Act —and if we remember at all times the historical moment when it was approved which therefore entails that no criticism can be made since at least it granted minimum provision of health care in our prisons— we can conclude that it did not contemplate a so called model of health care. LOGP basically provided clear regulations as far as minimum

personal and material resources that correctional facilities had to count upon as to grant the provision of health care. As far as this is considered, there are three key aspects that we must therefore remember:

- A) Prison Administration must ensure the integrity, life and health of prisoners
- B) Prison health care staff is responsible of prisoners' physical and mental health as well as of granting hygiene conditions within the facility.
- C) Medical assistance and health care will be granted by means of initial examination of prisoners and further examinations as conveniently determined.

1981's Penitentiary Regulations

RP/81 along with the developing LOGP, stipulated that medical assistance in correctional facilities was aimed at the prevention of diseases or accidents, the provision of care, healing and physical or mental rehabilitation of prisoners by means of the corresponding health care and hygiene services.

Moreover, RP/81 provided thorough (sometimes too thorough) regulations on the responsibilities of each unit within correctional facilities and of the employees performing certain tasks, such as medical and nursing staff. However we will later consider this since this functional regulation is still in force, with a lower regulatory status, yet still in force.

1996's Penitentiary Regulations

Unlike what we have previously seen regarding LOGP and 1981's PR, current PR *does establish a model of health care*. However the social and penitentiary reality had undergone a deep change ever since 1981 and the need for some modifications was now more evident.

The text now defended the provision of *comprehensive health care*, aimed at the prevention (especially of communicable diseases) as well as at healing and rehabilitation.

Within the development of LOGP provisions regarding the provision of health care, 1996's regulations went much further than its 1981 predecessor and therefore *the so long undersigned basis for a health care model were them established*. It is worth noting a laudable awareness on prison health care services not becoming an isolated environment but promoting their relationship and coordination with the rest of healthcare Administrations. This later lead to a regulatory provision included in the Legal system applicable to Public Administration and the Common

Administrative Procedure which establishes in its Sixth Additional Provision, the integration of prison health care services within the National Health Service and its transfer to Autonomous Communities. This was how the provisions of relationship and co-ordination were materialized in nothing less than an integration mandate.

For the purpose of what we will later consider it is worth understanding that prison health care has undergone evident development regarding the amendments included in the LOGP between 1981 and 1996.

Other regulations concerning prison health care: The Sub-Directorate General on the Coordination of Prison Health

Regarding what we have previously stated on the provisions included in the Legal system applicable to Public Administration and the Common Administrative Procedure concerning the hierarchic governing of higher rank administrative bodies over lower rank entities by means of instructions and service orders (Art. 21.1) we must remember that, apart from legal and statutory rules, instructions and service orders are used by Prison Administration governing bodies to guide the activities of dependant entities and employees. We must therefore remember that such ability legally exists and is frequently used.

Therefore, the Sub-Directorate General on the Coordination of Prison Health is in charge of developing and enforcing the tasks of SGIIPP regarding *“the planning, organization and management of activities intended at the maintenance and improvement of hygiene and health conditions within correctional facilities”* as established by Article 5.11 and 5.10 of Royal Decree 400/2012 as of February 17th on the development of the basic organic structure of the Ministry of the Interior (RD 400/2012).

Functional regulation of health care staff included in 1981's Regulations

We have explained before how RP/81 thoroughly established the functions of each service unit within correctional facilities and of employees performing certain tasks, among them medical and nursing staff. RP/96 however did not attempt any similar functional regulation yet its Third Transitory Provision by RD 190/1996 as of February 9th establishes the following regarding services, units and job posts:

“The content of Articles 277 to 324; 328 to 332 and 334 to 343 of the Penitentiary Regula-

tions approved by Royal Decree 1201/1981 as of May 8th, will remain in force as resolutions by the governing bodies of the corresponding penitentiary Administration, as long as it does not oppose the provisions of the Penitentiary Regulations approved by this Royal Decree, until the corresponding governing body issues a resolution establishing the new organization of services and units within correctional facilities as well as the tasks of each job post included in such”.

Within the RP/81 articles still in force (instructions and circulars as it has been previously stated) we find those regarding the obligations, understood as tasks, of medical (Health Care Unit) and nursing (Nursing units) staff. This concerns Articles 288 to 291 and Article 324 from the RP/81⁷.

Now, if we consider that it has been over nineteen years since RD 190/96 was approved (which further approved today's RP) and such new regulation has not yet been enforced, from a statutory point of view we should consider that the functional regulations included in RP/ 81 remain in force with a *lower-ranking status*. We should now recall what we have previously stated on the principle of normative hierarchy.

Then we can now ask ourselves the following questions. The validity with a lower status of RP/81 articles regarding the tasks and other aspects of medical and nursing staff in correctional facilities, can now be conceived as an obstacle for the development of other functions or tasks? Can this functional and compulsory framework jeopardize the development of the health care model included in today's RP?

The changes of the prison system: The interpretation of rules according to contemporary social reality, non-opposition to higher rank regulations and the governing ability of higher instance administrative bodies over lower instance entities

Prison systems have quickly evolved over a short period of time (let's remember what we considered in the Introduction). Obviously we are not going to make a reference to prisons in the early 20th Century yet we have to recall the beginning of 1980s when RP/81 created the compulsory and functional framework for prison health care employees. Obviously, the reality within prisons has deeply changed, in many aspects. Moreover, the Spanish National Health System and that from different Autonomous Communities have undergone substantial modifications.

Within this general social and healthcare context and the particularities of the penitentiary envi-

ronment, we can not pretend that 1981's regulations may entail an obstacle for the development of further tasks, which must be now carried out without a shift of emphasis. In short, *that operational framework is not intended to jeopardize the development of the prison health care model included in the existing RP*. Moreover, we must also consider that now in 2015 the reality is much alike that of 1996 when today's RP was approved, regardless of the years gone by and the changes undergone.

Therefore, functional and compulsory provisions of RP/81 have to be reinterpreted, yet how must this be done? First it should consider the provisions of Article 3.1 CC. This establishes that regulations will be interpreted according to the proper sense of its words, the context, historical and legal background and the *contemporary social reality*. There we have an interpretation parameter for the operating framework of RP/81.

When the Third Transitory Provision of RD 190/1996 was approved it enforced the provisions included in RP/81 as long as they did not oppose the provisions of the RP to which it belonged. Consequently, there we have another interpretation parameter: *non-opposition to the provisions of RP*.

Furthermore, since the operating framework of RP/81 is in force as a governing body resolution, it entails no obstacle for further resolutions to assign previously unexpected tasks, since they would have the same rank and they would be subsequent. This is evident, for example in I3/2011 and I5/2014 where within a particular context specific tasks and obligations are established for health care staff, which had not been previously contemplated in RP/81.

With regard to specific tasks provided in RP/81, we are going to set some examples:

- 1) Regarding nursing staff, today the obligation to "*assist the physician during consultation and examination activities*" (Art 324-a RP/81) can be considered if not contrary to, at least asynchronous with the development of the health care model established by RP/96 and the new configuration regarding the professional competence of nurses.
- 2) The tasks included in the already mentioned provisions I3/2011 and I5/2014 can not be found in the operating schedule provided by RP/81 (regardless of a great interpretation effort) and *nonetheless they should still be performed*. This is also applicable to the tasks included in further Instructions from different Health Programs.

Let alone the situation regarding the tasks implied in Instruction 10/2014 as of September 15th on the Action Program for Drug Overdose.

CONCLUSIONS

We do face a particular reality: the operational and compulsory framework of RP/81 is still in force as a governing body resolution, also known as SGIIPP. Yet this framework entails no obstacle for the development and implementation of the health care model included in today's RP, neither to the development and implementation of tasks regarding the planning, organization and governing of measures aimed at the maintenance and improvement of hygiene and health conditions within correctional facilities. The harmonization between what is established by statutory provisions and what must be done according to scientific and technical advance can be perfectly done from a legal point of view:

- 1) From an interpretation of RP/81 regulations in force according to today's social and penitentiary reality, as established by Article 3.1 CC.
- 2) By considering the opposition between such regulations and the health care model established by RP/96, which must prevail according to the Third Transitory Provision of RD 190/1996.
- 3) By assigning responsibilities and tasks to health care staff by means of internal administrative regulations, from either the higher rank governing body of Penitentiary Administration (SGIIPP) or from the governing body in charge of the development and implementation of its tasks concerning health and hygiene within correctional facilities (SGCSP).

To conclude, let me make a superficial legal consideration —not such a big deal. It highly regulated contexts, such as prisons, before different problems or situations there are always two different points of view regarding legal interpretation. On the one hand, a short, literal enslaved interpretation, and on the other hand, another which tries to reach further, to reflect on the effects and consequences of extreme interpretations, which tries to look for alternatives which will respect previously established regulations. Now, this is what we are actually talking about: we believe that the provisions of RP/81 should not be held sacred, since it implies that prison health care providers are limited by the regulations applicable to Health Care and Nursing Units almost thirty years

ago, as if things had not sufficiently changed since then. Obviously, this is still in force, and as it can not be otherwise, it has to be taken into consideration yet we are stating that *it should not entail an obstacle or jeopardize the provision of improved care, which is the main aim of prison health care and nursing staff.*

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