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List of Abbreviations

CC	Civil Code
CEDCMP	Ethics and Deontological Code
CMP	Peruvian Medical College
CNA	Children en Adolescents Code
CONADIS	National Committee for the Integration of Disabled People
Const.	The Constitution
COPUID	Ministry of Education
CP	Penal Code
EPS	Health Providing Entities
ESSALUD	Social Health Insurance
FMP	Peruvian Medical Federation
INABIF	Ministry of the Presidency
INEI	National Institude for Statitistics and Informatics
INMETRA	National Institude of Tradional Medicine
INMETRO	Tropical Medicine Institute
INPE	National Penitentiary Institute
JIFE	International Committee for Narcotics Control
JNE	National Election Jury
LGS	General Health Law
LTM	Medical Work Law
ONPE	National Bureau of Electoral Processes
RENIEC	National Register of Identification and Civil State
SERUMS	Marginal Urban and Rural Health Service
SIDEME	Iberoamerican Society of Medical Law
SODEME	Peruvian Society of Medical Law
UDES	Departmental Health Units

List of Abbreviations

General Introduction

Chapter 1. General Background of the Country

§1. Geography

1. Peru is situated in the mid-region of South America. Its neighbours to the north are Ecuador and Colombia, to the east Colombia, Brazil and Bolivia, to the south Bolivia and Chile and to the west it borders on the Pacific Ocean. The total surface is 1,285,216 square kilometres (496,093 square miles) and it has an extremely varied configuration resulting in three differentiated geomorphic and climatic units (natural regions) named coast, sierra and mountains or Amazonia, where a fourth region could be named formed by the Peruvian sea (with an extension of 200 sea miles), one of the world's richest areas regarding biological species. Rivers, lakes and lagoons abound in Peru.

2. The main regional characteristics are as follows,[1] the coastal region is a flat surface situated between the sea line and the Andes. Its width varies from 75 to 100 kilometres. Geographically it should have a tropical climate with abundant rainfall, but it has influences from the Andean Chain, the Peruvian cold sea stream and the South Pacific anticyclone, and is therefore a dry area with little rain (except for the northern zone of the country when the El Niño phenomenon occurs). This desert region has a general declination towards the sea and 53 rivers of a temporary or irregular sort, their flows being related to the rain season that occurs in the Andean region when the austral summer crosses it.

The sierra is the region with abrupt physiography caused by the Andean Chain. Due to its altitude and its irregular topography, it has a huge diversity of climates varying from temperate to hot. Rains occur during the summer and have a fundamentally orographic origin.

The jungle is an almost flat region with exuberant vegetation. The rains falling in this area are related to its tropical climate. This region includes the Amazon River, that is, due to its flow, the largest river in the world. Being the greatest navigating fluvial system of the planet, it is associated with intense commercial activity and is therefore of considerable importance.

1. SENAMHI (National meteorological and hydrological centre), *Clasificación climática del Perú*, Lima: 1980.

3. One of the characteristics of the Peruvian territory is the variety of climates,

ranging from tropical temperatures in the jungle, a semi-dry temperate zone in some of the coastal areas to the Polar cold of the Andean Chain.[1] Moreover, climatological investigations have shown that so-called microclimates exist in certain areas of the country, as temperature and humidity can be totally different within a relatively short distance.[2]

1. Peruvian Geographical Institute: Map of Peruvian climatic classification.
2. Quezada, J., *Estudio del confort climático en Lima Metropolitana y Callao*, Lima Thesis (Engineer Degree in Meteorology), Universidad Nacional Agraria – La Molina, Facultad de Ciencias, Departamento de física y meteorología, 1987.

4. Peru has 22,639,443 inhabitants and a population density of seventeen inhabitants per square kilometre according to the National Census of 1993.[1] The population distribution is unequal, around 52 per cent of the population lives in the coastal region, 35 per cent in the sierra region and only 13 per cent lives in the mountainous areas. Lima is the capital city.

1. The National Institute for Statistics and Informatics (INEI), *Censos nacionales*, Lima: INEI, Tomo I, 1993, p. 39. However, the estimated population in 1997 was 24,371,000 inhabitants (INEI, in: 'Estimaciones y proyecciones de la población por años calendarios y edades simples, 1970–2025', in: Webb, R. y Fernández Baca, G., *Perú en números 1997*, Lima: Cuanto S.A., 1997, p. 202).

§2. Cultural Composition

5. Peru has such multiplicity of customs, languages, races and religions that it has become a multicultural country.[1]

1. Ossio, J.: *Los indios del Perú*, Lima: Ed. Mapfre, 1992, p. 243.

6. Forty-five per cent of Peru's inhabitants are of indigenous origin, some are descendants of the Incas. Thirty-seven per cent of the population consists of mestizos (half-castes), a mixture of white (mainly Spanish) and Indian, and around fifteen per cent are white, descending from European peoples. There is also a black and mulatto population, with African origins, and some people are descendants of Asian races. All of them preserve their own customs. Almost 72 per cent of the Peruvian population lives in urban areas.

7. Seventy per cent of the population speaks Spanish, which was the only official language until the 1979 Constitution made the use of the Quechua and Aymara languages official. At present, the 1993 Constitution (Art. 48) has included all aboriginal languages, almost 50, as being official apart from the languages mentioned. More than 90 per cent of the Peruvians are Catholics, but there are certain groups who practise different creeds.

§3. Political System

8. Thirty years ago the constitutional focus of the Peruvian State was on the normative structures of the valid political system of the moment, that is the three government organs: Legislative, Executive and Judicial. Due to the *de facto* governments of that time, the 1933 Constitution was hardly implemented. The citizens were referred to as the 'people' before being considered a 'civil society', as a consequence of an oligarchic state. The 1970s brought changes in social and political areas and towards the end of the decade the 1979 political Constitution was enacted.[1]

1. Olivari, W. y Valeriano, C.: 'Sociedad civil, democracia y ciudadanía en el Perú', en: *Revista del Foro*, Lima: Colegio de abogados de Lima, Nr.1, (Año LXXXVI, enero – mayo de 1998), p. 24.

9. On 31 October 1993, the Peruvian people had to vote in a referendum about the Constitution project formulated by the Democratic Constituent Congress, which had been restored to end the forthright dictatorship that started with the military coup on 5 April 1992, during which President Alberto Fujimori Fujimori, supported by the Armed and Police Forces, abolished the Congress, the Judicial power, the Tribunal for Constitutional Guarantees and other institutions of the country due to the existing institutional crisis.[1]

1. Mayor referencia, *see* García Belaunde, D.: 'La nueva Constitución del Perú', en: Landa, C. y J. Faúndez, *Desafíos constitucionales contemporáneos*, Lima: Pontificia Universidad Católica del Perú, Fondo Editorial, 1996, pp. 35 and 39.

10. According to the 1993 political Constitution (Art. 43), the Peru Republic is a democracy because election of its authorities and their actions originate from popular will; it is social because solidarity and fraternity are the main criterions and mankind in itself is the finality; it is independent and sovereign because it is built on the principle of liberty. There is one state and it is indivisible. It has a unified government, in that it holds an internal sovereignty and therefore can formulate rules of a national character on any issue, and those rules must be obeyed; it is representative, in that the government is elected by the people and it represents the people; it is decentralized because the regional organs have the capacity to solve all issues related to their territorial area even though they are hierarchically subordinated to the central government.

11. Its organization is based on the principle of separated and equilibrated powers, and has the following structure.

12. The Executive Power is formed by the Republic's President, who is Head of the Peruvian State and personifies the nation, and by the Council of Ministers. To be elected President of the Republic one must be Peruvian by birth, be older than 35 at the postulation moment and hold the suffrage right. It is possible to have an immediate presidential re-election.

13. Management and direction of the public services is conferred to the Council

of Ministers (Art. 119, Const.). The Ministries constituting the Executive Power are: Ministry of Agriculture; of Defence; of Economy and Finance; of Education; of Energy and Mines; of Industry, Tourism, Integration and International Commercial Relations; of Justice; of the Presidency; of Fishing; of Foreign Affairs; of Health; of Work and Social Promotion; of Transport, Communication, Housing and Construction; of Internal Affairs; and of Promotion of Women and Human Development.

14. The Legislative Power (Art. 90 *et seq.* of the Const.), is held by the Congress, which has only one chamber of 120 congress members and is elected for a period of five years.

To be a member of the Congress one must be a Peruvian by birth, be older than 25 and hold the suffrage right. The Congress has the following powers: dictation of laws, as well as interpretation, modification or derogation of the existing laws; vigilance with regard to respect for the Constitution; approval of the Republic's budget; authorization of debentures; execution of the right to amnesty; approval of the territorial demarcation proposed by the Executive Power; provision to the Republic's President of authorization to go abroad; financial control of the government's acts; formal questioning and censoring of ministers and formation of investigation commissions regarding issues of public interest, among other attributes. If it loses the trust of either of the two cabinets or the Council of Ministers, the chamber can be dissolved by the Executive Power.

15. The Judicial Power is in charge of administrating justice, which comes from the people, through its hierarchic channels. Jurisdictional organs, of government and administration, integrate it.

16. According to the Constitution the structure of the state also includes other state organs that enjoy the autonomy to realize the functions allotted to them. These organs are below.

17. The National Council of Magistracy, which is in charge of selecting and appointing judges and prosecutors, except when they have been appointed by popular election.

18. The Public Ministry has the following tasks: promotion in every way possible of any judicial action aimed at defending legality and the public interests subject to the law; vigilance with regard to the independence of jurisdictional organs; representation of society in judgements; conducting crime investigations; exercise of penal action in every way possible; in the cases stated by the law, issuing of a report before the judicial resolutions; initiation of the forming of laws and notification to the Congress or the Republic's President of voids or defects in the legislation.

19. The Ombudsman is in charge of defending the constitutional and fundamental rights of the individual and the community. He or she supervises the fulfilling of

the state administration's duties and the provision of public services to the citizens. He/she is responsible for all tasks allotted to the Ombudsman.

20. The objective of the electoral system is to make sure that the electoral processes are carried out in a transparent way and to assure that the voting result is an exact and adequate reflection of the electors' will, expressed in the ballot box by direct vote. The electoral system consists of the National Elections Jury (JNE), the National Bureau of Electoral Processes (ONPE) and the National Register of Identification and Civil State (RENIEC).

21. There are two kinds of governments, regional and local (municipalities), because the territory of the Republic is divided into regions, departments, provinces and districts, and in the mentioned circumscriptions the unitary government is decentralized and non-concentric.

22. The Constitutional Tribunal is the Constitution's control organ. Its tasks are: to know, as the only instance, the unconstitutional action; to know, as last and definitive instance, the resolutions rejecting the *habeas corpus*, shelter action, *habeas data* and complying action; to know the competence or attribution actions assigned by the Constitution and according to what the law establishes.

23. In reality, the nation presents itself as a country with a highly politicized level but with little political culture, due to the lack of solid democratic values. In spite of four electoral processes of electing a President and Congress members with no fundamental alteration, a consolidation of political culture has not yet occurred.[1]

1. Olivari, W. and Valeriano, C., 'Sociedad civil, democracia y ciudadanía en el Perú', in: *op. cit.*, p. 28.

24. These last years, Peru has gone through an evident pacification process (eliminating terrorism to a great extent), and has experimented with a reduction of hyperinflation, the promotion of foreign investment and the privatization of companies and public services, all of which has enabled the development of a sustained economical and social development.

§4. Population and Vital Statistics

25. In 1990, the global fertility index (average number of children per woman between fifteen and 49 years old) was four children. In 1997, it was 3.3 children, which shows a declining tendency (in 1996 it was 3.5 children). In 1999, the index dropped to 2.8 children. The fertility index has been progressively declining, a fact that is associated with the access of women to family planning, the improvement of their education levels and the higher rate of employment of women. Fertility changes and tendencies vary depending on the women's residence area. In 1997, the fertility index of women living in urban areas was 2.6 children, while women living in rural areas had on average 5.5 children, a difference of 2.9 children per woman.

26. The child death rate (annual number of deaths of children under one year for every 1,000 live births) decreased by five per cent between 1996 and 1997. This reduction may be due to the vaccination campaigns, prenatal and delivery health services, and improved housing through basic services.

27. Chronic malnutrition in children under five years has also decreased. In 1996, retarded growth was seen in 26 per cent of the children. In 1997, this percentage had decreased to 24 per cent. This reduction may be related to the increasing maternal lactation, to the increase of knowledge of the treatment of infectious diseases and to the higher awareness of mothers with regard to nutrition.

28. As regards contraceptive methods, their use amongst women between fifteen and 49 years of age, either married or living together with their partner, increased from 64.2 per cent in 1996 to 65.3 per cent in 1997. A major increase has been registered in the rural areas of the country, where the user percentage increased from 41 per cent in 1991 to 53 per cent in 1997. In the urban areas, an increase from 66 per cent to 70.8 per cent was seen in the same period.

29. In 2000, life expectancy was 68.3 years, for both sexes.

Chapter 2. General Description of the Health Care System

§1. General Review of the Health Care System

30. The state assumed its responsibilities for the health services in the 1960s, when health was institutionalized as a social service. The traditional binomial health-illness (rehabilitation) was left aside and the combination health-service (assistance, prevention and rehabilitation) started to be used. Peru has never known a benefactor state in the health area, this being caused by the lack of financial resources. The fiscal crisis seriously affected the resources in this sector, as shown by the fact that between 1985 and 1990 the Ministry of Health expenses *per capita* decreased by 50 per cent. From 1990 on, the state hospitals began to produce more resources through special prices, which eventually became 65 per cent of their income. However, this has not generated any qualitative changes. On the contrary, it has had a negative effect on customers of the lowest income sector. Despite this, statistics show an increased demand for public hospitals.

31. These last years, human resources have increased in the health sector. In 1980 there were 7.2 physicians and 5.8 nurses per 10,000 inhabitants, while in 1991 the number had increased to 10.5 physicians and 7.5 nurses. The First and Second Census on Sanitary Infrastructure and Health Sector Resources were performed in 1992 and 1996 respectively,[1] which provided the possibility to confirm that the increase was ongoing. In 1992, there were 16,433 physicians and 11,101 nurses. In 1996, there were 24,708 physicians and 16,139 nurses. Moreover, the total number of obstetricians and odontologists in 1992 was 2,306 and 1,385 respectively, while in 1996 there were 5,105 and 2,622 respectively. However, stratification of the health professionals is inadequate and this is confirmed by the fact that in 1996 in the Madre de Dios department there were 73 physicians for a population of 76,597 inhabitants while in Cajamarca there were 331 physicians for 1,337,813 inhabitants and in Lima 13,141 physicians for a population of 6,738,285 inhabitants.

1. This Census is the most important source of statistical information related to physical and human resources in the national health sector, and it offers the possibility to keep an updated inventory, equipment and maintenance of the health establishments that provide their services to the population.

32. According to the Second Census of Sanitary Infrastructure and Health Sector Resources, this sector had 7,306 establishments, i.e. 472 hospitals, 1,849 health centres and 4,868 health posts. Until 1992, hospitals and health centres tended to expansion, but this process was reverted by the 'Programa de salud básica para todos' (Basic Health for Everyone Programme) and the 'Programa de administración compartida del Ministerio de Salud' (Ministry of Health Shared Administration Programme), promoted by the government. At the same time, the public sub-sector had 6,373 health establishments: 5,933 from the Ministry of Health, 282 from the IPSS (now ESSALUD) and the Sanity System of the Armed

and Police Forces had 158 health establishments. The non-public or private sub-sector had 689 health establishments.

33. The Ministry of Health is in charge of the sanitary care in the majority of the provinces and districts of the country, while the social security (ESSALUD) and the private health care services are restricted to the larger cities located in the departmental capitals. The private network focuses 80 per cent of its services in Lima and in Callao. The other 20 per cent is divided amongst the rest of the departmental capitals.

34. In 1980, the health sector had 166 beds for 100,000 inhabitants (one bed for every 602 inhabitants), and in 1996 this number had increased to 179 beds for 100,000 inhabitants (one bed for every 558 inhabitants). In 1992 there was a total of 26,392 beds, 81.4 per cent of which were in the public sub-sector. Even though the national average bed/inhabitant rate is one bed per 835 people, there are sectors of the population that only have one bed per 1,852 inhabitants. In Lima, there is one bed per 666 inhabitants, while inland there is one bed per 1,250 inhabitants. The Second Census of Sanitary Infrastructure and Health Sector Resources determined that this sector has at present 42,864 beds for an approximate population of 23,946,779 inhabitants.

I. Mental Health

35. This is an important issue and it is the state's responsibility to carry out the monitoring, prevention and care regarding the mental health problems of the population (Art. V, LGS). In this regard, alcoholism, drug addiction, psychiatric problems and family violence are considered to be mental health problems (Art. 11, LGS).

36. The LGS (Art. 5) establishes the health authority's obligation to promote healthy life styles, and therefore every person has the right to be well and timely informed by the health authority with regard to hygienic measures and practices, proper diet, mental health, reproductive health, contagious diseases, degenerative chronic diseases, precautious illness diagnosis, among other issues. Furthermore, every person has the right to receive information regarding the risks of tobacco addiction, alcoholism, drug addiction, family violence and accidents.

37. The National Mental Health Institute 'Honorio Delgado-Hideyo Noguchi', under the Ministry of Health, has the objective of formulating and executing the plans to carry out investigation, teaching and care activities in the mental health field, contributing to achieve the bio psychosocial well-being of the population. The hospitals 'Víctor Larco Herrera' and 'Hermilio Valdizán' fall under its jurisdiction, as does the rehabilitation centre 'Kenny Tejada' and the 'Centro juvenil de rehabilitación de Ñaña'. Amongst its tasks we can mention the following: provision of mental health care; provision of optimal care to people with mental and emotional disorders; provision of specialized training in collaboration with universities and

other organizations that train human resources in mental health care; promotion and execution of investigations and provision of the clinical setting for the development of psychiatric and mental health investigation.[1]

1. RM. 028-90, (DOEP, 12 June 1990), Institute's regulations.

II. Health of the Young[1]

38. In Peru, around four and a half million people are between fifteen and twenty-four years of age and 38 per cent of the population is younger than fifteen years. According to epidemiological investigations, the risk of drug addiction is highest between these ages, and this problem is aggravated by the lack of programmes to organize the leisure time of the young.

1. National plan for prevention and control of drugs. DS.82-94-PCM (DOEP, 3 October 1994).

39. The consumption of social drugs (tobacco, alcohol) has been increasing during the last twenty years. There is no legal or institutional framework or real information regarding the nature and characteristics of the problem. From 1984 on, with the interest and support showed by the UN and the USA government, some changes were planned in the area of prevention, cure and rehabilitation. Agreements like the DPU/87/26 (UN, UNFDAC, CEIS) allowed the training of physicians, psychiatrists and sociologists in therapeutic community techniques and family parallel therapy, in order to apply them through state services.

40. Prevention, treatment and rehabilitation are inadequately managed, and this has impeded the application of integrated plans and objectives. Furthermore, the lack of teams and resources prevents the exchange of statistical and case information, of care requirements, etc. The state's role in this issue is limited to the services of the 'Instituto nacional de salud mental Honorio Delgado – Hideyo Noguchi', on which the Departamento de fármacodependencia (ambulatory), the 'Hospital Víctor Larco Herrera', the 'Hospital Hermilio Valdizán' and the 'Centro juvenil de rehabilitación de Ñaña' are dependent.

41. The National Plan for Drugs Prevention and Control is ongoing, and its policy is to establish a treatment programme to unify, coordinate, integrate and strengthen the public, common and private efforts in order to fight the problem integrally and from various angles. Amongst the institutions participating in the planning we find the Ministry of Health – National Institute for Mental Health; the Ministry of the Presidency – INABIF; the Ministry of Education – COPUID; local governments and other institutions such as the church, non-profit organizations, clinics, etc.

42. A policy of protection against publicity of products the consumption of which is associated with the health and integrity of children and adolescents is also applicable. In this way, TV and/or radio commercials for cigarettes are aired only between midnight and six o'clock in the morning. Moreover, alcoholic drinks and

cigarette commercials must always be directed to an adult audience and must not give the impression that consumption of those products is healthy or necessary or convenient to achieve personal success or social acceptance.[1] Regarding tobacco addiction, it is specifically established that advertisements for cigarettes and other tobacco products will include, expressively and clearly, the sentence 'Smoking is dangerous for your health' and according to the law, Ley Nr. 25357, smoking is not allowed in public places.[2]

1. Art. 9, DLeg.691, Publicity regulations in defence of the consumer (DOEP, 11 May 1991), modified by the DLeg. 807 (DOEP, 18 April 1996).
2. L.25357 (DOEP, 27 November 1991) and its regulation DS. 83-93/PCM (DOEP, 26 November 1993), DS.95-93/PCM (DOEP, 22 December 1993) and its modifying law L.26849 (DOEP, 30 July 1997). The legislative background can be found in Art. 12, DLeg.691, modified by the DLeg.807 (DOEP, 18 April 1996) and the RM. 451/1991SA/DM (DOEP, 1 June 1991).

III. Maternity and Infancy

43. The sub-programme Materno-perinatal Health[1] is a technical normative unit that plans, coordinates, supervises and monitors the promotion, prevention and rehabilitation activities regarding the health of the mother and the new born in the Peruvian health regions and sub-regions. Amongst its objectives we can mention: achievement of a reduction of materno-perinatal morbidity and mortality (maternal mortality reduction of 50 per cent for the year 2000); expansion of the covering areas and improvement of the quality of pregnancy, delivery, puerperium and new born care, etc.

It must be taken into account that given the lack of infrastructure and the latent idiosyncrasy in the internal part of the country, 85 per cent of deliveries do not receive proper attention and therefore maternal mortality in rural areas is three times higher than in the cities. Only fifteen per cent of the deliveries that take place in the rural areas are handled in health establishments. In 1996 the maternal mortality rate was 265 per 100,000 live births. The most common reasons behind the low use of medical services are deficiency of the quality of those services, difficulty in geographic accessibility, lack of information and lack of cultural adaptation.

An important step towards protection of the pregnant woman and the woman in labour[2] is the establishment of the right of every woman in labour to receive the necessary medical care in any health establishment, with no exceptions. Being health establishments, they should feel obliged to offer this care at any time when a life-threatening risk for the mother or the baby still plays a role. In addition to this regulation, the right of the establishment to receive payment, after the delivery, of the fees will obviously be recognized, and this will be realized according to the evaluation of each case which will be carried out by the social service involved. On the other hand, indigent people who are officially recognized as such are exempt of any payment.

1. DS. 002-92-SA, Ministry of Health organization and functions regulation, (DOEP, 20 August 1992).
2. L. 27604 (DOEP, 22 December 2001), Art. 2. Medical attention in health establishments during delivery.

44. Immunization activities are directed at diminishing mortality caused by illnesses, mainly in the infant population, which can be prevented by vaccination and they are under supervision of the sub-programme of immunizations of the 'Ministry of Health general management of people's health office'. The General Health Law says (Art. 80) that only medical or biological reasons can lead to recognition of exceptions to obligatory vaccination and re-vaccination as established by the national health authority.

IV. Medical Care at School

45. The Ministry of Health is responsible for the provision of integral care that covers all health needs of children from the age of five and of adolescents (who represent approximately one-third of the total population). There are two main objectives of the sub-programme school and adolescent health: 1) reduction of the mortality and morbidity rates by promotion of healthy customs and habits, modification of risky behaviour and provision of proper care to detected cases and, 2) promotion of self-care behaviour and prevention of risky practices; the programme provides integral health care services to children of school age and adolescents and it establishes support networks to assure integral health care services for these children and adolescents.

§2. Regulation of the Health Care System

I. Legislation Regarding Health Issues

46. Health care, individual as well as collective, is a fundamental issue in Peru as its protection implies human development and social well-being. Health legislation is broad but disperse at the same time.

A. National Regulations

1. Constitution

47. The Constitution establishes that the defence of human beings and respect for dignity are supreme objectives of society and the state (Art. 1). Moreover, it officially establishes the principle of health protection and defence, in that health protection is a personal right and duty (Art. 7) but it is also a responsibility of the state, which will design the national health policy and will implement it in a plural and decentralized way in order to facilitate equal access to health care services for all members of the population (Art. 9), for which free access to health services and pensions, through public, private or combined entities, is recognized (Art. 11).

2. Civil Code

48. Even though the Civil Code does not explicitly refer to the right to health protection,[1] it does mention the actions carried out by a person where the right to life, to integrity and to freedom are involved such as the acts of free disposal of the human body (organ transplantation, surgery, etc.), to submission to medical examination (Art. 11) and to the agreements regarding the human body (Art. 12) as well as civil liability in general (Arts. 1314 *et seq.*, and 1969 *et seq.*), in which the physician's liability is subsumed.

1. The special committee in charge of elaborating the draft bill to reform the Civil Code has taken into consideration the addition of this new right Art. 4, saying: 'The right to life, to identity, to psychosomatic integrity, to freedom, to health, to respect and all other rights inherent to being a human are undeniable and may not be object to cession or voluntary limitation...'. *See* Varsi, E., 'Derecho civil I', in: Material de lectura, Lima, Universidad de Lima, 1998, separata N° 285, tomo II, p. 1344.
http://www.congreso.gob.pe/congreso//199798/codigo/CODIGOS1htm

3. General Health Law[1]

49. The General Health Law indicates that 'Public health is the primary responsibility of the State. Responsibility regarding individual health is shared by the individual, society and the State' (Art. IV, LGS). This special law regulates issues related to the 'right to health protection'[2] and takes into consideration all legislative precedents, either national or foreign, and the subject categories of the International Index on Basic Health Legislation published by the WHO.

1. The L.26842 (DOEP, 20 July 1997) derogated from the Sanitary Code, Dley 17505 (DOEP, 18 March 1969).
2. The recognition of the 'right to health protection' instead of the 'right to health' is based on the fact that health is not an asset that can be guaranteed in itself by any juridical regulation or by the state, given that health depends on a combination of personal and social factors. Health protection includes: 1) individual sanitary care, such as illness prevention and cure and, 2) public health conditions linked to the general conditions that affect public health.

50. This law is divided into seven clauses: Preliminary Clause: establishes the general principles and precepts as well as the roles of the people, the state and its relationships in the area of health.

51. The First Clause 'On the rights, duties and responsibilities regarding individual health' deals with the defence of rights and establishes the obligations and responsibilities regarding issues of individual health. It reaffirms a person's freedom and recognizes the right to dignity, privacy and integrity.

52. The Second Clause 'On the rights, restrictions and responsibilities taking third parties' health into consideration' deals with freedom of work, enterprise, commerce and industry, as established in the Constitution, freedom of organization and development of activities in a way judged convenient by all parties within the legal framework in order to avoid possibly dangerous actions and health detriment

or damage, be it caused by medical profession practices, by dealing with products, services or procedures related to health (for example medical care, extraction of organs and tissues, blood donation), by personal behaviour in health care (illness transmission) or by production of assets and services that affect the environment (dangerous substances and products, working environments).

53. The Third Clause 'On the end of a person's life': death is a legal concept that modifies the titularity of individual rights. In this, it is established (Art. 108) that death ends a person's existence. It is considered that the end of life occurs with the definitive stop of brain functions, regardless of the functioning of some organs and tissues or the fact that they can be used for transplantation. In cases when it is not possible to establish such a diagnosis, an irreversible cardio-respiratory stop confirms the death. This has been so established taking into account that there are some areas in the country where the instruments for brain death confirmation are not available.

54. The Fourth Clause 'On health information and its divulgence': this clause regulates information from the following perspectives: as a source of data for the health authorities; as a social communication resource to fight epidemics; as advertising or publicity for health products and services; as publicly known information, except the mentioned exceptions (related to the person's right to privacy and views); as an official warning regarding risks and damages with regard to which the population must be informed by the health authorities. As a principle it is established that the health authorities determine the kind of information that must be given by people and organizations that provide health care services. Divulgence of information by the state is vital to achieve public health (promotion, participation, mobilization, prevention and health education).

55. The Fifth Clause 'On the health authority': the Ministry of Health is the national health authority given the fact that it is the specialized organ of the Executive Power that is in charge of the direction and management of national health policy. The basic perception here is that this authority is unitary and independent.

56. The Sixth Clause 'On security measures, offences and sanctions': practices contrary to health can cause personal damage and in this sense the regulation of the security measures is based on the need to protect the rights of the possibly affected people from the possibility of greater damage, by trying to avoid or minimize deterioration of the well-being of the people, which would happen if the damaging event would occur. Security measures are, amongst others, isolation, quarantine, observation and vaccination, whether with regard to people or to animals, insect destruction, confiscation or destruction of animals that cause a danger, closure of establishments, suspension or cancellation of the sanitary register, etc.

57. The final seventh clause of the General Health Law states that the Ministry of Health will present for approval the regulations for a correct and total application of the regulated institutions mentioned.[1]

1. The following regulations have been enacted to date:
   - 'Regulation for register, control and sanitary monitoring of pharmaceutical products and the like', DS.010-97-SA (DOEP, 24 December 1997). It dictates the general rules for the registration, control and sanitary monitoring of pharmaceutical products, galenic products, therapeutic natural resources, cosmetic products, sanitary products, personal and domestic hygiene products, medical instruments and equipment either for medical surgery or for odontology. This regulation has been complemented by the 'Directive for investigation of pharmaceutical products and the like', RM. 437-98-SA-DM (DOEP, 11 November 1998), which is in charge of establishing control over pharmaceutical products that are commercialized in the country through the aforementioned investigations, which consist of analyzing product samples taken by the sanitary authority in the pharmacist's, the chemist's, production laboratories, drugstores, import and distribution centres, hospital pharmacies and all other health services in order to verify the product quality and consistency with the technical specifications by which the product was authorized. It has been modified by the decrees DS. 04-2000-SA (DOEP. 22 October 2000) and DS.020-2000-SA (DOEP, 16 July 2001).
   - 'Regulation over monitoring and sanitary control of food and drink', DS.007-98-SA (DOEP, 25 September 1998). This regulates the hygienic and sanitary conditions, requisites and procedures that apply to the production, transport, manufacturing, storage, division, elaboration and expenditure of food products and drinks for human consumption, as well as the regulations regarding the sanitary register and sanitary certification of alimentary products for export, and it regulates the sanitary monitoring of food and drink.
   - Regulation for pharmaceutical establishments, DS.021-2001-SA (DOEP, 16 July 2001). This has been precised by:
     - RM.431-2001-SA/PCM (27 July 2001) where the requisites and minimal sanitary conditions that all pharmacists and chemists must comply with are established.
     - RM.433-2001-SA/DM (27 July 2001) where regulations regarding control and monitoring of pharmaceutical products and the like are formulated.
     - RM.434-2001-SA/DM (27 July 2001) where there is a disposition regarding the information about adverse reactions to medicines stated in Art. 22 of the regulation.

4. Penal Code

58. The Penal Code establishes offences against life, the body and health, public health offences, usurpation of authority, titles and honours, amongst others (for more information *see* Part I, Chapter 3).

5. Penal Execution Code Regulation[1]

59. The Penal Execution Code Regulation presents a detailed report on the right to health of the interned convict (secluded or imprisoned) stating that: 'The interned convict has the right to: 1. Maintain or recuperate physical or mental well-being. 2. Have access to an integral health care service ...' (Art. 7). Moreover, it points out that penitentiary sanitary care must be oriented to prevention, cure and rehabilitation of the convict, to the extent that the physician and/or the health staff will visit the penitentiary centre on a weekly basis in order to supervise the environmental and food hygiene conditions. It also indicates that any medical-sanitary treatment will always take place under the informed consent of the convict, or otherwise the consent of any direct relative and, in his/her absence, by the director of the penitentiary centre (Arts. 119 to 132, Chapter IV: Health, Clause V: Penitentiary Treatment and Services). As a consequence, the convict has better protection, which will

provide him/her with genuine and progressive rehabilitation and re-entrance in society.

1. DS. 023-2001-JUS (DOEP, 21 July 2001). Complementing the dispositions of the Penal Execution Code approved by the D. Leg. 654 (DOEP, 2 August 1991), Chapter IV: Health, Arts. 76 to 82. Also Arts. 3 and 6, which refer to the physical and mental state of the convict as well as to his/her integral treatment.

6. National Policy on Population Law[1]

60. The National Policy on Population Law contains norms whose objective is to plan and execute activities related to the volume, structure, dynamics and distribution of the population in the national territory. It has the following objectives: promotion of a balanced and harmonic relationship between the growth, the structure and the territorial distribution of the population and economic and social development; promotion of and assurance of the free, informed and responsible will of the people and couples regarding the amount and timing of births in order to contribute to family stability and solidarity and in so doing improve the quality of life; achievement of a reduction of morbidity and mortality; achieve a better distribution of the population within the territory according to correct use of resources, regional development and national security.

1. DLeg. 346, (DOEP, 5 July 1985).

7. Law for the Prevention of Risks Resulting from Use of Biotechnology[1]

61. The objective of this law is to regulate the security of biotechnology according to the Constitution and to the Agreement on Biological Diversity adopted in Rio de Janeiro.[2]

Its objective is to protect human health, the environment and biological diversity; to promote security in investigation and development of biotechnology in its applications in production and service provision; to regulate, administrate and control the risks derived from confined use and liberation of voluntarily modified organisms (OVM);[3] and to regulate OVM exchange and commercialization, in the country and with the rest of the world by making international technological transfer easier and according to the international agreements that are or will be subscribed by the country.

1. L. 27104, (DOEP, 12 May 1999).
2. RLeg. 26181, (DOEP, 12 May 1993).
3. According to the Complementary Disposition of the same law, an OVM is: a living organism that contains a new genetic material combination that has been obtained through application of modern biotechnology. Human genome is explicitly excepted.

B. International Regulations

1. International Pact on Economic, Social and Cultural Rights[1]

62. This Pact establishes that the undersigning countries recognize the right of every person to social security. They also recognize the right of every person to enjoy the highest possible level of physical and mental health.

1. United Nations, 16 December 1966.

2. Universal Declaration on Human Genome and Human Rights[1]

63. Its regulation is based on the following principles: human dignity and the human genome; rights of the people concerned; investigations into human genome; conditions for the practice of scientific activities; international solidarity and cooperation; and promotion of the declaration's principles.

1. UNESCO, 11 November 1997.

II. Health Care System

64. The institutions related to the health care system that belong to the public sector are listed below.

A. Ministry of Health

65. The Ministry of Health[1] is an Executive Power organ. It is the ruling entity within the health sector that regulates and promotes the intervention of the National Health Care System in order to achieve development of human beings by promoting, protecting, recuperating and rehabilitating their health and through development of a healthy environment, with respect for fundamental human rights, from conception to birth.

1. Ministry of Health Law, L. 27657 (DOEP, 29 January 2002) derogated the D.Leg. 584 Ministry of Health Organization and Tasks Law (DOEP, 18 May 1990) and its Regulations DS. 002-92-SA (DOEP, 20 August 1992).

B. Social Health Insurance (ESSALUD)

66. Social Health Insurance is a constitutional principle (Art. 10, Const.) that the state must recognize the universal and progressive right of each person to social security in order to offer protection against problems and to achieve improvement of the quality of life. In this sense, there is a public organ called ESSALUD in charge of fulfilling this assisting task within the health care services offered by the state (*see infra* Part III, Chapter 4, §2, II).

67. All institutions related to the health care system that belong to the non-public sector must be authorized by the Ministry of Health.[1] This task is carried out in a decentralized way through departmental health units called UDES. The health establishments that form the non-public sub-sector will be stated further on in the text (*see. Infra* Part III, Chapter 1, §2).

1. DS.023-87-SA, General regulation for health establishments of the non-public sub-sector (DOEP, 26 May 1987).

68. There are also other institutions that offer health care services, *see below*.

C. Municipalities

69. Regarding population, health and environmental drainage, the municipalities' tasks[1] are: regulation and control of all activities related to environmental drainage; distribution of environmental education programmes; regulation and control of cleanliness, hygiene and health conditions in commercial establishments, houses, schools and other public places; promotion of foresting and re-foresting campaigns; installation and maintenance of hygienic public toilets and baths; promotion and organization of activities related to preventive medicine and first aid; construction and equipment of medical posts, first aid sets and first aid establishments; conducting of sanitary education programmes; conducting of rural drainage campaigns and control epidemics; conducting of public cleaning service, location of the areas where garbage is collected and/or realization of provisions for industrial exploitation of waste and control of the health conditions of the animal population.

1. Art. 66 of the L.23853, Organic Law of Municipalities (DOEP, 9 June 1984).

D. Private Administrations of Pension Funds (AFP)

70. The private system of pension funds administrations (SPP)[1] is formed by private administrations of pension funds. The benefits in favour of the employees who have joined the private pension system are exclusively: retirement, invalidity, survival and burying costs. Health and accident risks at work are not included.

1. Article 38, of the Dl.25897 (DOEP, 6 December 1992).

E. Health Providing Entities (EPS)

71. The health providing entities[1] are companies and public or private organizations other than the Social Health Insurance (ESSALUD) whose only objective is to offer health care services, with their own and third parties' infrastructure. In that way, the inscribed employee can access the different associated hospitals, clinics and medical centres without having to pay a monthly fee for the service.

The services offered by the EPS are not charged to the affiliated person but to the

employer end they are part of the nine per cent fee that is paid monthly to the ESSALUD. Thanks to this system, the affiliated person has access to a basic health care programme (emergencies, ambulatory consultation, deliveries); serious illnesses are attended by the ESSALUD.

Supervision of the health providing entities[2] has the objective of authorization, regulation and supervision of the functioning of the health providing entities and control of correct exploitation of the funds administrated by those entities.

1. Art. 13 de la L. 26790, Ley de modernización de la seguridad social (DOEP, 17 May 1997).
2. DS.006-1997/SA, Approval of the Regulation for the supervision of health providing entities, (DOEP, 17 May 1998) and DS.005-1998/SA, Approval of the Regulations for the organization and tasks of the supervision of health providing entities, (DOEP, 26 June 1997)

F. National Coordinated and Decentralized Health System

72. This system dates from 2002[1] and will link the services provided by the Ministry of Health, the social insurance, the municipalities, the Armed and Police Forces' health services as well as the private services. It states the gradual and progressive transfer of the public services to the regional and local governments, including all economic, technical, material and human resources in order to assure continuity and efficiency.

1. L. 27813 (DOEP, 13 August 2002).

§3. Financing of the Health Care System

73. In terms of economy, the health sector is a wide-ranging subject. Investment is focused on improving health conditions and on repairing the damages caused. These 'social costs' are paid by the public and private health services. Moreover, there are indirect costs booked as part of the additional costs that occur in the case of illness.

74. In 1995, the health related costs amounted to approximately USA $2,096 million. That expense had experienced a constant increase during the period 1992-1995. The average yearly growing rate was ten per cent in 1995 constant soles (or its equivalent, 1.48 per cent in American dollars). In terms of internal gross product, the expenditure has represented a relatively stable post during that period, showing figures between 3.8 per cent and 3.6 per cent of the internal gross product. In 1995 the costs for health represented approximately 3.6 per cent of the internal gross product, with 1.2 per cent of them being for private services and 2.4 per cent for public services and social security. The expenditure on health has a worldwide average of 8 per cent of the internal gross product, which demonstrates that health expenditure in Peru is relatively low. However, a recuperation of public expenditure as opposed to private has taken place, which shows better conditions to improve life standards.

75. The financing of health care quantifies the amount of resources involved and

analyzes their dynamics within the sector, their suitability and efficiency. In addition, it tries to support mobilization and re-assignation of resources inside the system. The objective of the sanitary policy is to assure that the impact of costs on health is minimal. These expectations suggest the necessity of adequate resources' acquisition, aiming at progress in their contribution to the system. Re-assignation of resources will be carried out depending on the priorities, by taking institutional capacities into consideration and by focussing the actions towards cost-effective interventions.

76. For the institutions within the public sector, the specific concepts of each revenue and cost component are predefined in the classifier existing in the country, which has its origin, at the same time, in the country's budget. The Public Sector Budgeting Law of 1998[1] establishes that the costs in that year will amount to 29,523,775,426 new soles (860,751,470 American dollars). These costs have their origin in the central government and the decentralized institutions and are a combination of regular costs, capital costs and internal as well as external debt payments.

1. L. 26894 (DOEP, 11 December 1997).

77. During the period 1992-1995, the resources for financing of the health sector came from the following sources: private households provided for an average of 43.5 per cent of the total resources of the sector; companies gave 29.7 per cent; the State gave 25.8 per cent and external sources added the remaining one per cent. The main resource fund is that of social security. The second is the fund destined for institutions that provide services to the population with no insurance.

78. Regarding the health care providing institutions, an adjustment can be observed during the period at hand, given that the private services, which in 1992 were the most important resource beneficiaries receiving 39.6 per cent of the total, reduced their relative participation to 34 per cent in 1995. On the other hand, social security, which in 1992 was the second most important fund acquisition institution with 35.4 per cent of the total, became number one in 1995 with 35.6 per cent of the total. However, the non-insured institutions offering health services have also increased their participation in resource acquisition.

79. Analysis of the geographical assignment of the health costs, reveals that approximately 60 per cent of the country's total expenditure is concentrated in Lima and only 40 per cent is distributed among the other departments. At the same time, these figures imply that the expenses for health per inhabitant registered in Lima and Callao in 1995 was of approximately 380 new soles (111.00 US dollars), while the same figure in the rest of the country was 130 new soles (20.00 US dollars). These numbers show the inadequacy of the health costs distribution in the country and have a profound impact in terms of efficiency, effectiveness, accessibility and quality of the health services offered in the interior part of the country. In order to fight this economical disproportion the Fondo Intangible Solidario de Salud has been created[1] to make sure the population with no access to quality health care services would eventually obtain such access.

1. L.27656 (DOEP, 27 January 2002).

80. The resources assigned by the government to health costs have their origin in: tributary income (general sales tax, selective consumption tax, and others), loans and donations. The state not only pays these resources directly to the different funds, it could eventually generate incentives to redirect the resource flow.

81. There is a consumption subsidy in the public services of the Ministry of Health and the health regions, and that is because of the contribution in concept of sale of assets and services, which represents approximately twelve per cent of the total costs made by the aforementioned institutions. However, there is a risk that these subsidies may in some cases be used by population groups with a higher economical level and not necessarily be received by the population groups with the greatest need.

82. The Ministry of Health has its funds assignment to implement the different budget programmes according to the costs calendar. At the same time, the ministry transfers the funds to the different health sub-regions for them to implement the national programmes under their institutional responsibility. The Ministry of Health's resources are the following: the amounts assigned in the Republic's budget during each fiscal year; its own income; contributions and transfers made by public institutions and organs; income originating from projects that have been requested by national and international entities; income from the health emergency and solidarity funds.

83. Resources of the social health insurance are: the insured people's contributions, their reserves and investments, the income from investing their resources. According to the Constitution (Art. 12) 'The funds and reserves of the social security are intangible. Resources are applied in the form and under the responsibilities established by the law'. No authority can establish cautious or implementation measures on those funds. They can only be used for purposes regarding administration, production, infrastructure provision, services allowance, technical reserves or investment and allocations that are necessary for their correct rentability.

Chapter 3. Sources of Medical Law

§1. Definition

84. 'Medical Law is the autonomous branch of Law that regulates the physician's activities, in his professional exercise, in the physician-patient relationship and its derived consequences'.[1] As such, it is a special branch of law that offers the human being juridical protection in the area of medical practice and techniques by establishing the basic principles of the right to health protection.

1. Giglio, C., *El Derecho médico en el Perú*. Lima: Thesis (Lawyer's Degree), Universidad de Lima, Facultad de Derecho y Ciencias Políticas, 1999, p. 61.

§2. Characteristics

85. Medical Law has a set of characteristics that distinguish it from the other law branches. We mention the following:

- It is mixed because it has public and private law forms, as well as substantive and adjective norms.
- It is dynamic because the regulations that rule medical professional exercise must always be able to adapt to the necessary new diagnostic, therapeutic and investigation procedures.
- It is objective in that the law is its consistence.
- It is imperative because the juridical norms that regulate it, in spite of having an ethical, moral and fundamentalist character, cannot be put aside by particular agreements, especially when public order and health are in some way involved.

§3. Sources of Medical Law

86. Medical Law in Peru consists of juridical norms as well as ethical and moral principles that 'protect and guarantee the rights of individual patients, and at the same time controls everything related to Public Health, and establishes general control and rules not only in the private exercise of the profession but also by regulating and organizing all public care services that depend on the State'.[1]

1. Giglio, C., *op. cit.*, p. 62.

87. The sources of Medical Law, as well as of other law branches, are normal sources and are contained in the juridical norms that are the content of the normative bodies.

88. If society and its needs change, in the same way that the scientific criterion does, we must modify and modernize the existing juridical norm, but essentially the

sources of medical law must as a rule be naturally based on the legislated formal source.

89. Consciousness, moral, internal thoughts, ethics, rules for behaviour within the medical professional practice are also specific main sources in that there is a regulation corps called Medical Ethics and Deontology Code that states valuating rules for behaviour, also regarding respect for human rights, patient rights, euthanasia, medical secrecy, etc. It also contains pure substantive law rules regarding certificates and the offence of false certificates that has a penal two-year sanction, medical poaching, etc.

I. National Sources

90. The main source of medical law, at a national level, is the law. That is because it is through the law that medical activity and health care are regulated. These norms are made by a set of specifically medical laws and other laws that, not being related to medical matters or health issues, are used as a basis for their structuring and application.

91. We can classify the different laws as follows:

- Specific: which directly regulate medical matters.
- Of a specific main character: the LGS (General Health Law) and the CEDCMP (Peruvian Medical College's Ethics and Deontological Code). They are the fundamental substance of medical law, in which substantive and adjective norms regulating the professional activity of the physician are established, as well as norms regulating the physician-patient relationship, the rights and duties of each participant in this relationship and its juridical consequences.
- Of a specific accessory character: for example, the Law for Reform of Social Health Security, the Law that Creates the Health Social Insurance and the Law for Transplantation of Organs and Tissues.
- General: in this law group we find the Civil Code, the Penal code, the Civil Trial Code, the Criminal Trial Code, etc.

II. International Sources

92. The most important international source of Medical Law in Peru is the Universal Declaration of Human Rights (UN 10 December 1948). We can also mention the UN International Pact on Civil and Political Rights (19 December 1966) and the American Convention on Human Rights (22 November 1969).

93. We must also consider all international declarations that may not have a legislative nature but do have moral authority as an international source of medical law. These declarations may be made by non-governmental international organizations such as the WHO, the Pan-American Health Organization or the World Medical Association, for example.

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Part I. The Medical Profession

Chapter 1. Access to the Medical Profession

§1. Training of Physicians

I. Undergraduate Medical Education

94. Undergraduate medical studies can be followed in the different medicine faculties at various universities in the country. The limited number of entry vacancies is caused by the existing excessive demand.[1] The different modalities of access examination are extraordinary examination (excellence prize), ordinary examination, direct access through the pre-academic medical school or transfer from an external medical institution.

1. The L.27154 (DOEP, 11 July 1999) institutionalizes the authorization of faculties or medical schools in order to guarantee the suitability of the academic professional education of surgeons and adequate attention to the health of the community, for which an authorizing Committee has been created, which is able to authorize all faculties or medical schools for human health (CAFME), and which comes under the Ministry of Health, whose functions are to elaborate the minimal standards required for the integral functioning of medical faculties or schools. The law covers the authorization for functioning of new faculties or schools at the new universities and requires the Committee's previous approval in existing universities. Previous legislative records of this can be found in the 4391/98-CR bill, presented by the President of the Health Committee at the Republic's Congress, proposing to create a committee for the authorization of medical faculties, in order to elaborate on the minimal exigencies and standards required for the functioning of these faculties. On the other hand, the national medical academy, in a communiqué dated 18 April 1999 (published in the newspaper *El Comercio*, Lima, Section A, p. 20) gave its opinion on the present situation of medical education in Peru, stating that part of the problem lies in the fact that at a national level medical faculties (there are 24 in total) accommodated an average of 1,254 graduated students per year between 1994 and 1999, while having a total of 14,771 inscribed students during this period, a situation which is aggravated by the deficient infrastructure, the deficiency of academic facilities necessary for the technical learning process, and the unemployment crisis. Therefore, it was necessary to evaluate the quality of medical education.

95. Medical education is combined with a service system. This requires a combination of both processes by integrating educational-service strategies that comprise each application in order to improve the quality in health services and the quality of the teaching-educational process. By introducing teachers and students to the service strategy, by active participation in health programmes involving the population, bases are created for acquisition of significant knowledge in the profes-

sional and ethical fields. Academic education is integrated with (the results of) investigation and *vice versa*, resulting in effective social development. General education of the medical student is based on acquisition of theoretical knowledge and the application of this knowledge for the benefit of humankind. Special attention is given to the study of the health-illness phenomenon as a biological process, to technical training and education, and to internships for pre-professional practice, i.e. the supervised practice and exercise of medicine in real hospitals as well as in non-hospital medical institutions.

96. The normal period of a medical study at a university is on average seven years, varying per university, and is complemented with the internship and followed by a period of practical work and in a marginal urban and rural health service (called SERUMS, Servicio rural y urbano marginal de salud).

97. After education at the medical faculties in the country, the doctor is able to function at the level of a general practitioner (medical surgeon), his tasks are: prevention and cure of illness, health promotion by education of the population, scientific investigation, health administration and legal medicine.

A. Internship

98. This is the stage of practical study of clinical medicine. It comprises four areas: general medicine, surgery, paediatrics, and gynaecology/obstetrics. This practical study is done in the last year of curriculum of undergraduate medical studies, a period in which the student integrates the acquired theoretical knowledge putting it into supervised practice in hospital units, external consultancy institutions, emergency services, surgical centres and other peripheral services.

B. Medical Academic Title

99. Universities are responsible for granting the academic titles of bachelor, master and doctor, as well as the professional diplomas, in the name of the nation, of licentiate and of the second professional specialist training. Once the university studies have been satisfactorily completed, there is automatic access to bachelor's degree studies. A professional diploma can be obtained: a) by presentation and approval of a thesis; b) after graduating and having carried out professional services, in activities related to the specialist training, during a period of three consecutive years and presenting a paper or; c) by complying with any other specifications established by the university for its convenience.[1] Medical faculties are in charge of determining which procedure the graduate must follow to be eligible for the professional title. In the case of the professional degree of medical surgeon, option b) is not applicable because it would imply the crime of illegal professional practice.

1. University Law. Art. 22 of the L.23733 (DOEP, 9 December 1983) law, modified by the DLeg.739 (DOEP, 11 December 1991) decree.

C. Marginal Urban and Rural Health Service (SERUMS)

100. The SERUMS[1] is a community service programme carried out by qualified health professionals such as: surgeons, dentists, nurses, obstetricians, pharmacists, nutrition specialists, medical technicians, social workers, biologists, psychologists, veterinarians and sanitary engineers. Their objective is to collaborate with and secure the health service for the benefit of the low income population in the less developed marginal urban and rural areas. They can also choose to work in non-governmental institutions as long as they provide social health service. The period lasts for one year at most, and is obligatory for work in the public sector and/or to be allowed to follow secondary specialist training programmes at a national level, as well as to receive state grants or similar forms of financial support. The Ministry of Health is the entity in charge of determining every year, depending on its budgetary possibilities, the number of available SERUMS vacancies.

1. L.23330 (DOEP, 10 December 1981) law and its DS. 005-97-SA (DOEP, 22 June 1997) by-law.

II. Postgraduate Medical Education

A. Professional Postgraduate

101. This type of education focuses mainly on practical work.

1. Specialist Training

102. Postgraduate medical education is realized through the national medical residence system.[1] This system has a different institutional context than a normal postgraduate, in that it is realized within a framework in which practical work is the common denominator.

1. RS.009-88-SA, (DOEP, 28 February 1988) bylaw.

103. The resident physician is a professional doing his/her secondary specialist training in medical studies,[1] which either has the 'teaching in service' modality or is contracted out to the health institutions. The physician who wants to specialize in any medical branch will apply for one of the vacancies offered by the medical faculties. The residents' selection is a yearly procedure, realized according to the procedure established by the National Committee for Medical Residency.

1. According to the regulations of the national system for medical residency (Art. 1) the applicants must comply with the following requirements: a) be a collegiate physician, b) having worked as a medical professional in peripheral health services for at least three years and, c) be physically and emotionally healthy, being thus accredited by a medical certificate.

104. The resident physician undertakes an intense intra hospital activity, which gives him the chance to learn how to act as an upright health professional, allowing

him to make human relationships (physician-patient) the final and main objective of the medical practice. The behaviour of a resident physician is not only based on the knowledge acquired in the medical faculty, but is also formed by complex social factors, obtained in the *praxis* of the residency.

2. Sub-Specialist Training

105. In Peru, sub-specialist training can be followed at the Universidad Nacional Mayor de San Marcos university or at the Universidad Peruana Cayetano Heredia university, which are the only universities offering this kind of advanced medical study. The sub-specialist training lasts for two years.

B. Academic Postgraduate

106. This type of education is mainly theoretical and focuses on those physicians who want to teach. According to the Ley universitaria law[1] (Art. 24) the academic degrees given by the Peruvian university are bachelor, master and doctor.

1. L.23733, (DOEP, 27 December 1983) law.

1. Master Degree

107. To obtain a master degree, one must follow special studies that last a minimum of four semesters, one needs support from public funds, approval of an original and critical investigation essay as well as the ability to speak a foreign language.

2. Doctor Degree

108. To become a doctor one must follow special studies that last a minimum of four semesters, one needs support from public funds, approval of an original and critical investigation essay as well as the ability to speak two foreign languages.

§2. Manpower Planning

109. Medical professionals represent the basic and most direct manpower for protection of health and sanitary service. They fulfil a very important role in promoting and realizing the modernization processes and changes in the health sector.

110. In April 2000, the CMP counted 36,187 inscribed physicians, from which 28,308 effectively perform professional practice, which implies that there is on average one physician per 861 inhabitants. This percentage does not apply to all

areas, for example in the Pasco department, there is one physician per 10,638 inhabitants and in some other departments, for example in Cajamarca, one physician per 6,183 inhabitants.

111. Confronted with this problematic situation, the Ministry of Health, in its proposal 'Health Policy Lineaments 1995–2000', referring to the analysis of human resources in the sector, concludes that there are enough physicians and that the main concern regarding the issue is their distribution, given that 66 per cent is located in the Lima department. With regard to the quality of the service there are many differences between those practising their profession in certain areas and those working mainly in the sierra and jungle areas. A better distribution has been realized by the 'Basic Health for Everyone' programme, which has provided health centres and institutions in districts and provinces that did not have those professionals before or the opportunity to contract medical professionals. The SERUMS has also made its contribution to this change.

I. Freedom of Establishment

112. The CEDCMP (Art. 12) allows the physician to establish himself freely wherever he wants in order to carry out his profession, unless this right is limited by his contract with the employing entity or because he has already voluntarily decided to work in a specific place.

§3. Licensing of Physicians

I. General Aspects

113. The LGS law (Art. 22) states that the practice of professional activities related to general medicine, odontology, pharmacy or any other activity related to health service requires the possession of a professional title and compliance with the requirements of possession of a legal diploma, having followed a specialist training, possessing a licence and compliance with all other legal exigencies.

114. Legal medical practice must comply with the following requirements: possession of the professional title of medical surgeon, possession of a legal diploma and in the case of medical specialists, inscription in the CMP's specialists national register.

II. Legal Diploma

115. The CMP is in charge of the registration of all medical surgeons that are legally allowed to practise the profession, and possession of a legal diploma is an essential requirement to practise the medical profession.[1]

In order to possess a legal diploma, one is required to present the professional

title obtained at one of the medical faculties of the country. In case of a professional title obtained in a foreign country, this must be revalidated by one of the national universities. In some cases, the professional is exempt of revalidating the title if there is an international agreement and after the reciprocity of the title has been proven.[2]

1 The L. 15173, (DOEP, 16 October 1964) law, creates the CMP.
2. The L. 17239, (DOEP, 29 November 1968) law, modifies law L.15173.

116. Medical practice may be considered the practice of professional activities related to medicine in the following areas: assistance, public health, administration, teaching, investigation and legal medicine, among others.[1] This is the reason why the matriculation of the CPM members has an official character and is continuously updated and why all legal practitioners must supply all required data and relevant information. The corresponding regional council provides certified matriculation, valid for the professional practice, to legal practitioners.

1. According to the DS 00102-69-SA (DOEP, 1 July 1969) bylaw, in the CMP regulations.

117. The LGS and special laws (*see* para. 115) require possesion of the legal diploma for the practice of any professional activity in the areas of assistance, public health, administration, teaching, investigation, and all other areas that require possesion of the title of medical surgeon.

III. Medical Acts

118. The following acts are part of professional medical practice (Art. 24, LGS law), and are therefore subject to control by the corresponding professional colleges: prescription expenditure, expenditure of certificates and reports directly related to patient attention, performance of surgical operations, prescription of and research with drugs, medicines and any other product, substance or agent used for diagnosis, prevention or treatment of disease.

IV. Physician

119. The medical surgeon or physician relies on his basic knowledge to help the individual in an upright way but also to solve the health problems of the community. He is prepared to act scientifically and technologically in the diagnosis process and in treatment of illness. He is a 'complete' physician and is able to perform a number of tasks: assistance (support, and stimulation of recovery and rehabilitation), administration, investigation, legal medical tasks (provision of birth, death, health and illness certificates, performance of medical legal necropsies and production of medical specialist reports). He treats common and basic cases, and therefore he can currently practise his professional activities only in rural and urban marginal zones.

V. Specialist

120. Although the title of medical surgeon allows unlimited exercise of activities, in practice special training is required due to the necessary vast amount of knowledge in every area, the complex techniques and the use of devices that require special knowledge.[1] A specialist is a physician dedicated to the study and practice of one of the specific areas of medical science. The special training will be accredited according to the conditions stated in the regulations and statutes of the CMP.[2] The specialist must be inscribed both in the regional council and in the national council of the CMP. For application for inscription in the CMP's national specialists register, a filled form, accompanied by the title of medical surgeon and a document stating financial ability (proof of being up to date in the periodical payments to the CMP) are required.

1. Yungano, A., *op. cit.*, p. 55.
2. The medical education and professional specialist training committee is part of the permanent counselling committees in the CMP's national council (DS.101-69-SA, DOEP CMP Statute) and its function is to know, inform and act regarding all issues related to the medical education in general and to specialist studies in particular

Chapter 2. Practice of Medicine

§1. General Aspects

121. 'Medicine is a service profession and those exercising it assume the obligation to behave according to its rules. Respect for life and human beings are the spiritual essence of these rules and they keep their legitimate validity, in our daily activities and as a true tribute from our art and science to culture and civilisation'.[1] In that sense, the medical practice is defined as a service activity focused on complying with necessities for social health. In this definition it is implicitly assumed that the medical practice has a specific objective, safeguarding health; it has an agent, the physician; there is a direct beneficiary, mankind, and an indirect one, society. The conceptual essence is that '... for Medicine, a person, as an individual and as a member of society, will always be its finality and objective, reason of its being, and of its having a persistent human and social content.[2]

This objective is a precedent in medical faculties and remains the finality of the professional practice, and therefore this essence must always be recreated and enriched in continuous medical education programmes. The practice of medicine is performed by a professional collegiate practitioner who complies with all intellectual and legal exigencies posed by this activity. The physician is the human element indispensable for a healthy community.

1. CEDCMP Declaration of Principles.
2. Peruvian Medical College. Compilation of activities and work-related documents dated 10, 11 and 12 August 1995, p. 19.

§2. The Practice of Medicine

122. The practice of medicine 'is the totality of acts, operations or proper tasks, carried out by physicians and other sanitary professionals, normally on a human body and tending, directly or indirectly, to preservation, improvement and, in general, promotion of human health, either individual or collective, in all its phases, be they physical, mental or social.'[1]

1. Ataz López, J., *Los médicos y la responsabilidad civil*, Madrid: Editorial Montecorvo, 1985, p. 29.

123. The practice of medicine has a great social interest because it focuses on preserving health and because it is a benefit for the whole population. It is because of this social interest that a 'medical monopoly' is established in order to restrict medical practice to entitled professionals. Those practising medicine but lacking the legally established requisites to do so, will be guilty of professional misconduct.

124. The outside task of the physician is a counterweight for the medical monopoly sustained by the 'duty' to act, in that medicine is a service of public

necessity. A physician's absence can result in damage to the life, health or integrity of a person; therefore the duty to act is necessary for the benefit of society in order to guard the population's health.

125. Medical surgeon, oral surgeon, pharmaceutical chemist, obstetrician, nurse, veterinarian, biologist, psychologist, nutritionist, sanitary engineer and social worker, all these are recognized as health professionals whose work, career and assisting services can be carried out in the public as well as in the private sector.[1]

1. Law regulated by the L. 23535, stating general rules regulating the work and career of health professionals (DOEP, 24 December 1982), DS. 019-83-PCM (25 March 1983) and their modification DS. 024-83-PCM (8 April 1983).

I. Medical Activities

126. The LTM[1] is in charge of setting the norms for the collegiate medical surgeon's[2] general labour, in the public as well as in the private sector, taking into account the fact that a medical surgeon's professional practice, due to its complexity and special responsibility towards defending life and towards the process of attending to a person's health, is essential for economic and social development and for national productivity (Art. 2).

1. DLeg. 559 decree, medical work law (DOEP, 30 March 1990).
2. There is a law project (Project number 1015, 13 February 1996) proposing the extension of this norm to odontologists, pharmacists and obstetricians, based on the principle of equality of treatment for all professional activities included in the group of activities with high professional specialty carried out by medical services.

127. According to the LTM, the different modalities of medical practice are: assisting, teaching, administration, and investigation, production and other activities related to the medical act (Art. 8). The daily assisting shift of a medical surgeon is six uninterrupted hours or either its weekly equivalent of 36 hours or its monthly equivalent of 150 hours (Art. 9). An ambulant consultation period must never be longer than four uninterrupted hours a day, possibly completing the daily work shift with sanitary activities according to the local situation (Art. 10).

128. The LTM establishes that working on duty includes a variety of activities that differ from routine tasks: its duration must not exceed twelve uninterrupted hours. Exceptionally, and strictly under service requirement, it may be extended to 24 hours (Art. 11). This work on duty is obligatory and subject to service requirements; professionals older than 50 years as well as those suffering from disabling illnesses are exonerated of complying with the obligation, nevertheless keeping their rights to receive the related bonus (Art. 12). The reserve duty is scheduled according to the specialty requisites and the service's necessity. During the reserve duty, the medical surgeon must be available and can be called to offer proper and effective service within the locality (Art. 13). When the medical work is carried out in its teaching-assisting modality, assisting work on a part-time basis is allowed (Art. 14).

II. Medical Professionals in the Armed Forces and in the Police Force

129. According to the regulation for Police Health Services,[1] officials belonging to the health service of the National Police are all practitioners of medical professions (surgeons, odontologists, pharmacists) as well as psychologists, biologists, nurses, clinical laboratory workers, etc. (Art. 21). The assimilation for service officials will be the rank of captain for surgeons, odontologists, pharmacists, psychologists, biologists and others. The inscription will be done on that condition during a period of two years, after which they will obtain the rank effectively if they comply with the regulated requisites. Nurses and clinical laboratory workers, after completion of their studies at the National Police Health Services' Centre for Professional Formation, will have the rank of lieutenant (Art. 22). Service officials of medical professions (surgeons, odontologists and pharmacists) can be promoted to the rank of general; the rest of the professionals (psychologists, biologists, nurses and clinic laboratory workers) can be promoted to the rank of colonel (Art. 23).

1. DS.012-87-IN (DOEP, 25 April 1987) modified by the DS.19-90-IN (DOEP, 12 July 1990).

130. One of the obligations of the Armed Forces and Police Force medical professionals is to become a criminal pathologist in places where there are no such professionals.[1]

1. Tenth Complementary Disposition, Organization and function regulation from the Peruvian Legal Medicine Institute 'Leónidas Avendaño Ureta' (DS. 004-86-JUS, DOEP, 4 May 1986).

§3. *Lex Artis Ad Hoc*

I. General Aspects

131. The *lex artis*, the rule regarding technical acts in a profession, applies to the value assigned to the task of a professional in order to determine the ability to perform the task or the lack of such ability. It is used for professional activities and refers to two important aspects: the diligence shown by the author and the results achieved. It is applicable to those professions in which it is necessary to act by using a technique through which results will be obtained, i.e. for those experimental or scientific activities where the obtained results can be appreciated materially. In that sense it has been said that 'the *lex* is applicable when measuring/correcting the work or result done/obtained by a professional practitioner'.[1] When referring to medical activities, we realize that the application of the *lex artis* depends on different factors in such a way that technique can vary depending on each specific case. We cannot speak of one general *lex artis*, but, regarding medicine as a science and as an art (the art of healing), of a *lex artis ad hoc*.

1. Martínez-Calcerrada, L., *Derecho Médico*, Madrid: Editorial Tecnos, 1986. p. 187.

II. Legal Aspects

132. The LGS establishes that expenditure of prescriptions, certificates and reports, performance of surgeries, prescription of or research with drugs, medicines or any other product, substance or agent designed for diagnosis, prevention or treatment of illness, are considered acts in the professional practice of medicine and are therefore subject to control by the corresponding professional colleges (Art. 24). It also states that those involved in professional activities, technical or auxiliary, related to human health, will be limited to carry out these activities in the area determined by the legally expedited title, certificate or authorization (Art. 35). Finally, it states that professionals, technical and auxiliary, are responsible for damages caused to patients due to negligent, ill-judged or unskilled activities (Art. 36).

133. Referring to the medical act the LTM indicates that it is the medical surgeon who has the highest moral and legal responsibility derived from it (Art. 4), being governed by the CEDCMP and by international dispositions (Art. 5).

134. The fact that the object of this medical professional practice is a human being implies that all technical capacity application acts must be subordinate to the highest ethical sense.

§4. Medical Acts

135. A medical act is every action or disposition carried out by a physician in the practice of his profession, be it in his function as director, authority, civil servant, teacher, assistant, therapist, investigator, consultant, author or any other (CEDCMP, Art. 3).

Its characteristics are: professionalism, regular or common execution and legality. As stated by the CEDCMP (Art. 3), the medical act is the result of the physician's scientific knowledge, experience and ability, and that determines that the physician can decide correctly and at the right moment based in the superior interest of the patient.

136. Medical acts present themselves in the following forms. Corporeal medical acts: (1) Direct acts: prevention or prophylaxis, diagnose, prescription, treatment, rehabilitation. (2) Indirect acts: organ transplantation, blood transfusion, necropsies and investigation or experimentation on living human beings as well as on corpses. Extracorporeal medical acts: these all concern medical investigation or research.

137. The LGS indicates that all information related to a medical act is confidential (Art. 25) and '... must be based on a true and complete clinical report containing all practices and procedures applied to the patient in order to solve the diagnosed health problem' (Art. 29). On the other hand, it establishes (Art. 42) that 'Any medical act performed in any health institution or any medical support service is liable to be submitted to external audits in which the different procedures applied

to the patient can be verified by the application thereof to prevent, diagnose, cure, rehabilitate or carry out investigatory actions'.

§5. Traditional Medicine

I. The Healing Science in Ancient Peru

A. Historical Background

138. The origins of Peruvian medicine are as unclear as those of medicine in all primitive communities.[1] It has not been decided whether the divinity gave Peruvians the first medicine notions[2] or if the very founder of the Inca Emporium (Manco Capac) was the one responsible for it.[3] That is the reason why it is said that there is no written history of ancient Peruvian medicine, and everything known about it is thanks to the chronicle writers of the sixteenth century who translated anything they saw or heard as well as to the studies of tombs and ancient quacks' healing practices.

1. Valdizan, H., *Historia de la medicina peruana*, Lima: Ed. Hora del hombre, 1944, p. 145.
2. Urteaga, H., and Romero, C., 'Relación de fábulas y ritos de los Incas', in: *Colección de libros y documentos referentes a la historia del Perú*, Vol. I, Lima: 1916, p. 10.
3. De La Vega, G., *Comentarios reales, Lima*: 1918, Vol. I, pp. 49 and 50.

B. Medicine, Magic and Religion

139. In ancient Peru, the practice of medicine was in close relation with magic and religion;[1] what is more, healing practices and religious rites had so much in common that in order to understand the professional practice of Inca medicine it is necessary to study their religion, their worshipping and divination systems, taking into account their chaotic polytheist system.[2] This singularity of their practice of medicine has led us to believe that pre columbine Peruvian medicine actually was a cultural phenomenon.

1. Kauffmann, F., *Historia general de los peruanos (El Perú antiguo)*, Vol. I, Lima: Ed. Peisa, 1986, p. 645.
2. Cabieses, F., *Dioses y enfermedades (La medicina en el antiguo Perú)*, Lima: Ed. Artegraf, 1974, p. 175.

140. However, the development of medicine in Ancient Peru was abruptly stopped by the Spanish Conquest which, together with the posterior trans-culturing process, prevents us from foreseeing what would have been the future of Peruvian medicine if it had continued its development autonomously.

C. Illness, Public Health and Surgeries

141. Illness was supposed to be caused by fright, by sin or by a malicious spell, and those ills were treated with magic and herbs, leading to the assumption of the Incas being great herb experts.

142. Despite these traditional healing processes, the Inca Empire had a well organized public health system. It is remarkable, however, that there was no institution that represented the equivalent of hospital assistance in the whole history of ancient Peru. An explanation for this patient assistance can be found in their belief that illness was a punishment from the gods, and that is why the first Peruvians who took good care of their hostels in order to assist those tired from physical exercise and did not attend to divinity punishments and gave no thought of establishing hospitals in order to probably avoid the wrath of those divinities responsible for punishing the person in question in the form of an illness. Moreover, it is worth considering that their healing methods did not require hospitalization because the witch doctor or bone setter did not need a hospital to exercise his beneficial action and the sick person could take the remedies or undergo the treatments and fast at his own home.[1]

1. Valdizan, H., *op. cit.*, p. 145.

143. In the Peruvian primitive villages surgeries of different levels of importance were carried out, from abscess draining and extraction of strange bodies to some other activities, simpler but better regulated, such as outer ear perforation and circumcisions. They also performed very advanced surgeries such as arm, forearm, thigh and leg amputation and others such as trepanations that cause admiration even nowadays, performed either to eliminate bone fragments in head wounds caused by accidents (hits, fractures) or in order to liberate the sick person of the spirit that had taken possession of him (mental illness). It is estimated that the development of cranial surgery in its complete evolution was practised from the year 3000 B.C. (Baracas culture) until the sixteenth century.[1] (Inca culture).

1. Rocca, *Esteban y otros, Las trepanaciones craneanas en el Perú en la época pre-hispánica*, Lima: Ed. Santa María, 1980, p. 340.

D. Healing Techniques and Folkloric Medical Practice in Ancient Peru

144. It is still a mystery whether in those times a person could dedicate himself strictly to the medical profession without being a priest or a magician at the same time. The independent medical profession is ignored or seems linked to magic spells, sorceries and religious rites.[1]

1. Cabieses, F., *op. cit.* 1974, p. 209.

145. The following different healing techniques can be discerned:

– Bone setters and inspired people, their knowledge consisted of secret and super-

natural methods, sacrifices, magical medicine. They sought cures in dreams and hallucinations.
- Another group were initiated in medicine by their own experience with a specific illness. They cured their patients in the same way they had cured themselves.
- Priests, who cured by consulting the gods or a specific deity.
- Sorcerers, who predicted their healings by sacrificing guinea pigs (the *cuy*).

146. This diversity of healing techniques must not be confused with medical professions even though chronicle writers typified each healing process with a name in order to compare it with occidental medicine. That is the case with the word used for a doctor, *Hampi-camayoc (hampi*, medicine and *camayoc*, the practitioner) and the one used for medical surgeon, *Chukri-hampi-camayoc (Chukri*, a specific sort of wound).

II. Traditional Healing Art

147. For the state, it is of preferential interest and importance to promote traditional medicine (Art. XVII, LGS).

148. The fact that bone setters and midwives are considered as part of the illegal practice of medicine does not necessarily imply the negation of our national heritage[1] (pre Incan time).

1. A bylaw presented to the Republic's Congress, rejected at the plenary session, in an attempt to legalize bone setters, herb experts, quacks, prayers and midwives' activities (Bylaw 763/95-CR, from 2 April 1996), while another was an attempt to recognize traditional medicine, and was granted a negative dictate from the Congress' Health, population and Family Committee (Bylaw 4004/98-CR, from 27 November 1998).

III. National Institute of Traditional Medicine

149. The National Institute of Traditional Medicine (INMETRA) is a decentralized public organization, with legal juridical capacity and representation for internal public rights in the health sector. Its task is formulation of traditional medicine policy at a national level, in cooperation with the regional and local governments, the filial coordinating groups, the Peruvian universities and all the entities that are part of the national health system, within the lineaments of the national health policy established by the government. The INMETRA's objectives are amongst others: promotion of investigation and teaching leading to spread, discovery, recuperation, revaluation and registration of all practical knowledge, experiences and customs from traditional medicine in the different regions of the country, as well as preservation of natural resources and products; promotion of the democratization of health in Peru; establishment of a specialized and statistical databank that will provide information services at a national and international level.

150. According to Fernando Cabieses Molina[1] the INMETRA has made a proposal for the bone setter or the midwife to inscribe in their own community in order to be officially recognized. This recognition must be taken afterwards to the nearest health centre in order to have it stamped by the Ministry of Health and for the person in question to be able to legally practise their activities within their community, never outside it. A midwife can practise her profession if she has been inscribed in the Ministry of Health under supervision of a collegiate person, an obstetrician or a physician. On the other hand, a bone setter must be inscribed in a register and have the backup of a physician to be able to practise his profession. The bone setter may even write prescriptions (sabile or rue)[2] but the physician must know to whom the signature is given because he is directly responsible for it (given his prescription authorization) or otherwise he will be sanctioned as being against the law.

1. Information obtained in an interview with physician Fernando Cabieses Molina, Director of the National Institute of Traditional Medicine of the Ministry of Health, on 19 March 1999.
2. 'Isolated acts carried out by an accused person who was not exclusively dedicated to healing but who sometimes administered medical herbs for specific illnesses, in isolated cases, are not considered to be illegal practice of medicine.' Final judgment, 5 December 1939, *Revista de los Tribunales*, 1939, p. 306. *See* Espino, J.: *Código penal*, 6ª Edición, Lima: Editorial Importadora Sevillano, 1982, p. 364.

IV. Traditional and Occidental Medicine

151. An essential point that has to be taken into account in health policy 'is the articulation of both traditional and occidental medicine, given the fact that there will always be a population sector that will temporarily be outside the reach of modern services. This is a normal gap if we take into consideration that Peru has some areas physically difficult to reach and it is unthinkable to build a hospital or health centre at each "corner" of the sierra ... it is necessary to work with the people that know and apply traditional medicine in their communities, mainly midwives. The aim is to learn from them first and capacitate them afterwards'.[1]

1. 'Peru has succeeded in improving the quality and decking of its health services', in an interview with Marie-Andrée Romish, Pan-American Health Organization representative, in: DOEP, 4 August 1999, p. 6.

152. It must be taken into account that culture is a fundamental issue for a person making decisions about his/her health; many people prefer traditional medicine, based on their ancestral beliefs or led by effect-driven publicity, which determines that in Peru health care idiosyncrasy is a very special issue.

V. Medicinal Plants

A. General Aspects

153. Medicinal plants[1] have a special juridical regulation for their protection and

their study is prioritized in order to manage, promote and realize investigation projects in traditional health practical workshops.[2]

1. Those referred to here are: Quishuara, Ratania, Sapote, Sapote goma, Sangre de grado, Tara en vaina, Totora, Thola, Ungurahui, Yareta.
2. Objectives, functions and organization by the National Health Institute, RM 0068-86-SA/DVM and the Regulations for organization and functions from the National Health Institute, RM 178-95-SA/DM, (DOEP, 31 March 1995).

154. The LGS indicates that the health authority will elaborate a list of medicinal plants that are restrictively used or banned because of their toxicity or their dangerous properties (Art. 62). Moreover, the commercialization of medicinal plants and derived products is subject to legal requisites unless it regards medicinal plants without any reference to their therapeutic, diagnostic or preventive properties, which can be freely commercialized (Art. 63).

B. Commercialization

155. Medicinal plants with no reference to their therapeutic, diagnostic or preventive properties are not subject to inclusion in the Health Register,[1] with no restriction by sanitary certificates requested by the Ministry of Agriculture for their import.[2] Likewise, the sale of natural resources for health purposes need not take place by means of a prescription unless in regard to a vegetal resource stated in the list of medicinal plants with restricted use referred to in the LGS (Art. 62) or an association of natural resources.[3]

1. Through the Health Register, the health authority monitors the hygienic and sanitary characteristics of food, drinks, cosmetic products, medical goods or tools and personal and domestic hygiene products that are to be commercialized (Arts. 88 to 92, LGS).
2. Circular on requisites for import authorization of products subject to the Sanitary Register (Circular 46-39-97-CUSTOMS-INTA, DOEP, 26 August 1997, No. 3).
3. Art. 77, Regulation on sanitary register, control and monitoring of pharmaceutical products and similar products (DS. 010-97-SA, DOEP, 24 December 1997).

VI. The Coca Leaf

A. General Aspects

156. The nutritional and therapeutic properties of the coca leaf, have been recognized by Peruvians for centuries (it is considered the divine plant of the gods); apart from satisfying hunger, thirst and fatigue, it is considered to be a magical plant[1] and has had a universal transcendence, being mentioned in various international pharmacopoeias. For more than a decade, OMS experts have included coca in medical plants' registers.

1. Kauffmann, F., *op. cit.*, p. 646.

157. On the Peruvian government's request, the OMS expressed its will (March

1992) to examine and validate all investigation results regarding the therapeutic and nutritional properties of the coca plant. Financed by the National Coca Company (ENACO) and by the Traditional Medicine Institute of the Ministry of Health there have been three investigation lines: a) effects of the traditional use of coca on mental health; b) treatment of Leishmaniasis by means of the traditional method, and; c) coca and mental fatigue. The preliminary results are positive. In its 1993 Annual Report, the International Committee for Narcotics Control (JIFE) expressed its hope that the results of scientific investigations carried out by the government will contribute to solve the existing controversy regarding the classification of the coca leaf (List 1 of the Convention in 1961).

B. The Coca Leaf. Andean Resource and Traditional Medicine

158. The National Plan for Prevention and Narcotics Control[1] includes investigation into the benefits of the use of the coca leaf, stating as a possible strategy the creation of a National Committee for the investigation and divulging of the therapeutic and nutritional properties of the coca, differentiating the mentioned agent from drugs, narcotics and psychotropic drugs. Based on the described action results and following the procedures set in the actual international normative, the objective is to take into consideration new alternative uses of coca, as an Andean resource, for the benefit of humankind.

1. DS. 82-94-PCM (DOEP, 3 October 1994).

§6. Tropical Medicine

I. Notions

159. The incidence of tropical illnesses is very high at a national level, approximately 75 per cent, and therefore it is important to study the tropical illnesses that can be transmitted in our country and those related to the rest of the world, realize *pre* and *post* graduate studies and carry out sanitary activities within the community through the external advice centres.

II. Tropical Medicine Institute

160. The history of the Tropical Medicine Institute (INMETRO)[1] begins in 1953. In 1957 an agreement was signed between the Tropical Medicine Institute in Hamburg (Germany) and the San Fernando Faculty of Medicine from the Universidad Mayor de San Marcos University in order to habilitate a place for the study of tropical medicine.

1. Information obtained in an interview with Abelardo Tejada Valencia, Professor Director of the Universidad Nacional Mayor de San Marcos university and honourable member of the Tropical Medicine Institute, on 14 September 1999.

161. In the INMETRO scientists study all contagious illnesses, from those transmitted by air, water or vectors, to all jungle illnesses (including snake or poisonous animals' bites), AIDS, sexually transmitted illnesses and other tropical ills.

III. Objectives

162. Its objectives and functions are determined based on the International Sanitary Code and on the LGS and are, basically, to offer counselling on infectivity, dermatology, parasitology, bacteriology and mycology.

163. The International Sanitary Code applies to 'illnesses requiring worldwide notification', which are some four or five (given that smallpox is non-existent and measles is also on its way to extinction). Illnesses like malaria, uta and the Peruvian wart, which are regional, are regulated by national legislation.

Chapter 3. Illegal Practice of Medicine

§1. General Aspects

164. The illegal practise of medicine is when a person practises without holding the professional title or when, holding the title, this person is not a colleague. In our country the illegal practice of medicine is very common due to various reasons: the lack of an effective health structure, accessible to all inhabitants of the community, and the ignorance of people, who allow persons without a professional degree to attend to their health, allowing widespread proliferation of false physicians.

165. The LGS determines (Art. 23) that 'Incompatibilities, limitations and prohibitions, as well as the system of sanctions that are applicable to the professionals referred to in this chapter, are ruled by the Ethical Codes and statutory norms from the corresponding professional colleges'.

§2. Sanctions on Illegal Practice of Medicine

166. The sanctions applicable to the illegal practice of medicine can be analyzed from two angles, firstly the sanctions established by the Penal Code as a result of committing a penal crime and secondly the sanctions established by the CEDCMP, i.e. products of acts contrary to professional ethics.

167. The sanction established by the Penal Code for the illegal practice of medicine is a deprivation of freedom penalty for a period not longer than two years or communal work for 20 to 52 days.

168. The CMP states the following sanctions for these cases: written notification, private caution, public caution, fine, suspension of professional exercise for a maximum of two years and expulsion from the CMP.

169. A sector of the doctrine has raised the following question, as professionalism is one of the characteristics of medical activity, a specific professional civil responsibility is configured, which is based on the exigency of a higher degree of diligence towards physicians regarding the general rules subject to the valid legal normative. They also mention the difficulty for those who, lacking the medical know-how, have to judge acts carried out by those with medical knowledge. Therefore, the existing professional civil responsibility creates the necessity of implementation of 'professional tribunals' in charge of judging acts performed by medical professionals.

I. Illegal Practice of Medicine and the Penal Code

A. General Aspects

170. To deal with the issue of the illegal practice of medical activities one must refer to the Penal Code (Section I, Contamination and Propagation, Chapter III, Offences Against Public Health, Title XII, Offences Against Public Safety) in order to determine the offensive properties.

B. Offences Through Medical Activity

1. Illegal Practice of the Sanitary Art

171. The Penal Code establishes (Art. 290) that 'The person who, lacking the official title, performs any of the following actions, will be punished with a freedom deprivation penalty for a period not longer than two years or communal work for twenty to fifty-two days: 1. Announcing, writing diagnoses, signing prescriptions, administrating or applying any measure supposedly focused on health care, even when it is free of charge. 2. Issuing legal opinions or reports meant to sustain a diagnose, prescription or administration referred to in clause 1.'

a. Bone Setter Activities

172. The penal subjects referred to in this case are those who practise an activity related to health care and do it without holding the title necessary for that specific practice. The action sanctioned in this case is announcing, writing diagnoses, signing prescriptions, administrating or applying any measure supposedly focused on health care, as well as issuing legal opinions or reports meant to sustain a diagnose, prescription or administration as mentioned above. The law seeks to avoid that people lacking the legal requisites will perform a medical activity or medical acts with the intention to cure an illness, or administrate medicines.

173. Bone setter activities[1] are very common practice in our environment. This practice is also called trespassing or witchcraft,[2] i.e. the practice of a health profession without the legal title and based on arts, rites and customs.[3]

1. 'To pronounce a convicting sentence against a sanitary professional because of illegal practice of medicine, it is necessary to establish what is the official situation of the accused, the tasks he was allowed to perform, whether he exceeded his rights in his performance and whether bone-setter activities were a regular practice.' Final judgment, 11 April 1942; *Anales judiciales*, 1942, p. 81. *See* Espino, J.,: *Código penal*, 6th Edition, Lima: Editorial importadora Sevillano, 1982, p. 364.
2. 'Those who cure without either a title or an authorisation, even when there are no physicians in the place, and let their patients undergo witchcraft practices, incur in the offence of illegal practice of medicine'. Final judgment, 11 May 1956; *Revista de jurisprudencia peruana*, 1956, p. 607. *See* Espino, J.,: *Código penal*, *op. cit.*, p. 365.
3. Polia Meconi, M., *Cuando Dios lo permite: encantos y arte curanderil*, 1st Edition, Lima: Ed. Prometeo SRL, 1994, p. 15.

174. Within the bone setter practices, fraud is committed by practising a healing activity that represents an offence towards public health. Characteristics of this fraud are: damage to the patient does not necessarily have to be involved, the offence occurs when the patient is prevented from following the treatment prescribed by a physician; profit motive is not one of the constitutive elements given that the act is sanctioned even when realized free of charge. Another of the constitutive elements is regularity, inasmuch that the bone setter must practise these activities as a regular profession, otherwise, i.e. in the case of sporadic or isolated practice, there is no offence.

175. Bone setters have a number of common characteristics: they normally have a secret device or formula, they promise quick and complete healing of almost any illness (although some are specialized), they announce their activities through testimonies of satisfied customers, some of which can be people of national or international fame. Bone setter activities are mainly found in three areas: food and nutrition, mechanical and electronic devices, and drugs and cosmetics. To make their customers believe in mistaken concepts regarding the relationship between nutrition and health and in doing so achieving their objective of selling their own products, the majority of bone setters depend on the consumer's lack of knowledge. They also use popular beliefs and punctuate their arguments with scientific terminology and false statements. As for drugs and cosmetics, people are invited to purchase a variety of potions, pomades, ointments and pills. However, there are people who visit a bone setter because some ills cannot be cured by modern medicine (cancer, arthritis and some metabolic disorders); others are well informed people who have been declared well by medical science, hypochondriacs and those suffering from psychosomatic disorders or sick people who are unsatisfied by their physician's services.

176. Cases of bone setter practices are not limited to those who lack medical studies. We can also mention other circumstances in which the active subjects have studied medicine or another health science and did not finish their university studies or have acquired their knowledge through practice. Among these cases, we find students of medicine, pharmacists who take the liberty to give medical care to sick people and to sell medicines without medical prescription (Art. 33, LGS), medical assistants, midwives and nurses who practise minor surgeries, assist during surgical operations, assist patients after a surgical procedure and apply the remedies prescribed by a medical surgeon.

177. Bone setter practices, as an illegal practice of medicine, affect patients as much as they affect clinical and union institutions, like the CMP,[1] and therefore it is established by the CEDCMP that a physician must separate scientific medicine from all forms of bone setter practices, including those pretending to be scientific (Art. 19).

1. Final judgment, 19 February 1980; DOEP, 29 March 1980; *Revista de jurisprudencia del Perú*, 1980, p. 175. *See* Espino, J.,: *Código penal, op. cit.*, p. 365.

2. Abusive Practice of Medicine

178. The Penal Code typifies (Art. 291) that 'Those holding a title who announce or promise to cure illnesses definitely or through secret or infallible means, will be punished with freedom deprivation penalty for a period not longer than two (2) years or communal work for twenty to fifty-two days'.

a. Charlatanism

179. Fraud in curing illnesses is called charlatanism. The active subject in this offence can be someone who complies with the legal requisites to practise medicine as well as someone who does not. In this case, lucrative profit need not be involved. However, charlatanism becomes a swindle offence when economic benefit is sought causing prejudice to the passive subject. The cure announcement or promise will be considered fraud when it refers to curing human beings, definitively or by secret or infallible means, because this act is contrary to professional ethics. The Penal Code aims at eliminating the motivation that may incite the professional to use procedures lacking any ethics in order to achieve a larger number of customers or a better salary. The danger to which the patient is exposed comes in second place, the fraud committed by the professional subject is the major offence.

According to the CEDCMP, a charlatan is '... the professional who achieves successes by means of personal regulations or methods that have not been previously presented to the competent medical institutions and that have not been rigorously proven by scientific methods, or those who offer secret, mysterious or magic remedies. Equally, those who flaunt unowned titles and honours'(Art. 193).

3. Other Penal Types

a. Irregular Dispensation of Medicines

180. The Penal Code typifies the sale of adulterate medicines (Art. 294) in the following way: 'Those who have authorisation for the sale of medical substances but provide a different sort, quality or quantity than that stated in the medical prescription, provide something different from what is declared or agreed, or sell products that have surpassed the period in which their good state is guaranteed, will be punished with a freedom deprivation penalty for a period not shorter than a year and not longer than three years'.

b. Ideological Falsity in Medical Certificates

181. Also called false medical certificate expedition. The Penal Code (Art. 431) states that 'The physician who purposely expedites a false certificate related to the existence or non-existence of physical or mental illnesses, present or past, will be punished with a freedom deprivation penalty for a period not longer than three

years and with one to two years suspension according to Article 36, clauses 1 and 2. When the false certification regards the admission or internment of a person in a mental institution, the punishment will be a freedom deprivation penalty for a period not shorter than three and not longer than six years and with two to four years suspension according to Article 36, clauses 1 and 2. Those making ill-intentioned use of a certificate, depending on the case at hand, will be punished with the same freedom deprivation penalties'.

182. In this penal type, the active subject can only be a physician while the passive subject is the community. It is an action offence and the aim is to sanction the expedition (emission, giving, granting) of a false medical certificate, that is 'when the content of the mentioned document does not declare the reality of the facts specifically related to the existence or non-existence of physical or mental illnesses, present or past. This means that if the concrete object falsified in the document refers to any other circumstance it will not be possible to repute the existing penal type. That could happen in case of a false medical certificate only stating the effective vaccination of a person, necessary in order to travel to a determined country that so required'.[1]

1. Bramont-Arias, Luis y GARCÍA CANTIZANO, María: *Manual de Derecho penal (parte especial)*, 2nd Edition, Lima: Editorial San Marcos, pp. 558 and 559.

II. Illegal Practice of Medicine and the Ethic and Deontological Code of the Peruvian Medical College

A. General Aspects

183. The illegal practice of medicine constitutes a major offence to the CEDCMP, and it will be punished according to the provisions of the CMP regulations and statutes, with no prejudice towards the sanctions stated in the Penal Code for the illegal practice of medicine.

B. Cases

184. In this sense, the CEDCMP (Art. 204 *et seq.*) considers the following cases to be the illegal practice of medicine: Those who hold a physician's title that has been expedited by a foreign university, not validated in Peru or not registered in the way that has been established regarding titles granted in countries with which special professional exchange treaties have been agreed; any physician holding a legitimate title but who is not inscribed in the CMP; anyone who, lacking any title, assumes medical functions or performs medical activities, either having direct contact with patients or in the capacity of civil servant; those physicians who have been suspended by judicial sentence; those physicians who have been suspended from professional practice or expelled from the CMP.

C. Administrative Sanctions

185. Anyone illegally practising medicine commits a major offence towards the professional ethical code, which leads to an administrative sanction.

186. The CEDCMP (Art. 18) indicates, referring to the union or medical association defence, that every physician has the duty to fight against medical commercialization and charlatanism in whatever form. They must oppose, by any legal means, the preparation, sale, propagation and use of so-called secret medicines that do not have scientific support, and they must denounce this at the regional medical council.

187. Professional colleges are granted certain competences that in many cases have a legal character. We mention in this sense the CMP's statute, which states amongst its specific competences the disciplinary sanctioning of any of its members who, during professional practice, offended the Ethics and Deontology Code, the statutory dispositions, the regulations or the resolutions related to the national council. 'The college can apply, depending on the gravity of the offence, the following disciplinary measures: estrangement note, private caution, public caution, fine, suspension of professional exercise for a maximum of two (2) years and expulsion from the College'.[1]

1. Arts. 103 and 110 of the DS.00101-69-SA, Peruvian Medical College Statute (DOEP, 1 July 1969).

188. As the sanction can imply expulsion from the college, and being a colleague is a must in order to exercise the medical profession, as a result the CMP could therefore impose a sanction with the same content as a punishment purposely stated in the Penal Code: suspension. This sanction can be imposed without the guarantee of a previous penal process, and the circumstance can be so extreme that the punishment is given without any offence actually having been committed.

§3. Specific Medical Activities

I. Preventive Medicine

189. There are two aspects of medical practice: preventive and curative.

190. Preventive medicine is regulated by legislation, specifically by the LGS, where guidelines for health care can be found, for example every person's right to participate, individually or collectively, in promotion and improvement programmes either for individual or collective health, as well as every person's duty to ensure the improvement, conservation and recuperation of his/her health and that of the people depending on him/her.

II. Self-care

191. Self-care may not be considered illegal practice of medicine because the law establishes that this situation arises when the medical activity is carried out by another person and not by the patient himself/herself. It would be absurd to condemn relatives or friends when the care is of an assisting nature and does not require any special knowledge.

III. Blood Sampling. Venepuncture

192. Activities such as sampling, giving, conserving, transfusing and supplying human blood, its components and its derivates are medical acts. They are regulated by the LGS (Art. 46), Law 26454,[1] its statute DS. 003-95-SA[2] (Art. 28), Law 272823 and the CEDCMP (Art. 4).[3] Given their importance, these activities are subject to supervision and inspection by the national health authorities or their delegates. Venepuncture is a medical act that may only be performed by physicians or nurses at the request of a physician.

1. Law 26454 declares obtaining, giving, conserving, transfusing and supplying human blood an issue of public order and national interest (DOEP, 25 July 1995).
2. DS. 003-95-SA, (DOEP, 30 July 1995).
3. Law 27282 (DOEP, 8 June 2000) Law promoting the donation of organs and human tissues.

A. Giving Human Blood

193. The law declares obtaining, giving, conserving, transfusing and supplying human blood, its components and its derivates an issue of public order and national interest. Likewise, it rules the functioning of blood banks, hemotherapy centres and plants of blood derivatives subject to supervision and inspection by the national health authority or its delegates.[1]

1. LGS, General Health Law, Law 26842 (DOEP, 20 July 1997).

194. Hemotherapy centres obtain, give, control, conserve, select, and apply transfusions and/or fractions and preparation of non-industrial blood derivatives. Blood banks carry out extraction of human blood for transfusions, preventive therapies and investigation, and they are in charge of ensuring its quality when obtaining, processing and storing it. It is obligatory to perform the corresponding blood and blood component tests, according to the international OMS normative, as well as the pre-transfusion compatibility tests.

195. Giving blood or any blood component is a voluntary, sympathetic, altruist, free act performed with therapeutic, diagnostic or investigational objectives. Human blood commercialization for transfusion and export is forbidden.

196. According to the CONTRASIDA (against AIDS) legislation, every blood

or blood component, cell, tissue or organ donor must be subjected to an HIV infection test, under civil, penal or administrative responsibility and depending on the health professionals involved, in order to avoid the omission of the acts mentioned or negligent, imprudent or unskilled[1] performance of these acts.

1. Art. 9, DS. 004-97-SA (DOEP, 18 June 1997).

IV. Radiographies

197. Radiology is a medical specialty that deals with the study of medical application of X-rays. The physician who can make a diagnosis based on the radiographies is called a radiologist.

198. The person making the X-rays can be the radiologist or, at the radiologist's request, a medical technician, who will not be involved in illegal practice of medicine as long as it has been at a physician's request and it is the physician who makes the diagnosis.

V. Blood Pressure Measuring and the Use of Other Simple Measuring Appliances

199. The use of a blood pressure measuring appliance or other simple appliances to measure, for instance, heartbeat and pulsation to examine the state of health of another person is considered to be an act reserved to physicians.

VI. Eye Examination and the Measuring of Eye Deviations

200. Ophthalmology is the area of pathology that deals with eye conditions, and an ophthalmologist is a physician specialized in eye conditions. According to the Regulation for Optic Centres and Technicians,[1] an optic technician is the person who elaborates and commercializes ocular refraction lenses for spectacles and contact lenses; the ophthalmologist's prescription is thereby indispensable for the processing and supplying of any corrective lens.

1. DS 004-88-SA: (DOEP, 1 February 1988).

VII. Psychoanalysis and Psychotherapy

201. Psychology is the scientific study of behaviour and experience, of how human beings and animals feel, think, learn and know how to adapt to their surroundings. According to Peruvian legislation, a psychologist is a health professional.

202. Psychoanalysis (specific method for investigating unconscious mental pro-

cesses with a focus on psychotherapy) as well as psychotherapy (treatment of mental illnesses by means of verbal and emotional communication procedures as well as other symbolic behaviour) are acts performed by psychiatrists and are therefore not considered medical acts.

VIII. Acupuncture

203. Acupuncture is originally a therapy from the Middle East (China) consisting of making punctures with thin needles at various specific points of the body to restore the balance between the positive and negative energy of the patient in order to re-establish health. No medicines or secondary effects are involved.

204. In our country there is no juridical regulation related to this subject. Therefore we can state that acupuncture is not specifically considered a medical activity.

IX. Written and Verbal Advice and Recommendations

205. Written and verbal advice and recommendations given by a physician and directly related to patient care are considered medical acts.

Chapter 4. Control over the Practice of Medicine

206. The medical profession is practised and exercised in accordance with the LGS, the CEDCMP and special laws.

§1. Professional Liability

I. Introduction

207. It is well known that civil liability discipline refers to the fundamental aspect of compensating damage caused, either as a consequence of the non-fulfilment of a voluntary obligation (contractual) or as a result of a behaviour lacking any obligation link (non-contractual). When the damage is a consequence of non-fulfilment of a voluntary obligation, in doctrinaire terms it refers to a contractual civil liability, and within the terminology of the Civil Code it refers to civil liability derived from non-performance of obligations. On the contrary, when the damage is produced without any previous juridical relationship between the subjects, or even when there is, the damage is a consequence of the non-fulfilment of the juridical general duty of not harming another person, and we find ourselves in the area of the so-called non-contractual civil liability. Civil liability, therefore, includes contractual responsibility, a consequence of the non-fulfilment of a previously agreed obligation, as well as non-contractual responsibility, derived from non-fulfilment of the duty of not harming others.

II. Physician's Liability

208. Civil liability is structured in a normative system whose aim is compensation for the damages caused, whatever the cause, given that the damage has been caused as a consequence of a behaviour that is forbidden or non-authorized by the regulations and the juridical system in general. One of the most important aspects of this general civil liability system, one that has acquired huge importance in the last years, is no doubt professional civil liability, i.e. liability of a professional who, through fraud, imprudence or negligence, has caused damage to the person or assets of the person requiring his services.

Medical liability is at the same time one of the most important typical assumptions regarding professional civil liability and it is equally subject to the civil liability general rules, as happens with penal liability, in that it is also evident that there are penal liability assumptions linked to the professional practice of medical activities. However, it is necessary to clearly distinguish a physician's civil liability from his penal liability given that they are aspects structured and regulated by different factors.

III. Medical Liability

209. Medical liability refers to the general physician's responsibility in his professional practice. Therefore it does not only refer to civil liability but also to penal liability and disciplinary liability. '... The principle of medical liability gives security to instructed, conscious and prudent physicians; it is a constant threat to physicians who are imprudent, audacious but without scruples and the imperturbably ignorant ones, and it is, at the same time, an impassable barrier against patients' fantastic claims, whims and bad moods'.[1]

1. Yungano, A., and others, *op. cit.*, 1986, p. 199.

210. The physician's professional liability, with the exception of disciplinary liability, regulated by the CEDCMP, is not regulated by special laws. This means that a physician's civil as well as penal liability for damages or lesions caused by incorrect performance of his duties are regulated by civil and penal laws that refer to civil liability as well as to penal liability. However, the LGS (Art. 36) mentions the liability of health professionals, technicians and auxiliaries who '... are liable for damages caused to a patient by practice of negligent, imprudent and unskilled activities'.

Moreover, the LGS (Art. 4) states that 'Refusing to accept medical or surgical treatment automatically exempts the treating physician from any responsibility and healing result, in that case'. In this category we can mention the cases of refusal caused by conscientious objection.

IV. Civil Liability

211. It is important to establish whether the physician's civil liability relates to contractual or non-contractual civil liability because the Civil Code states, as mentioned before, a double civil liability system: one derived from contractual non-fulfilment and the other from the non-contractual system. We must remark that as a rule a physician's civil liability, related to damages caused during the practice of his professional medical activities, is fundamentally a contractual civil liability.

212. The physician's agreed obligation towards the patient as derived from the contracting of medical services is an obligation of means, assuming the compromise to attend to the patient with care and diligence and aiming at the patient's recovery even though a positive result cannot be guaranteed. The responsibility emerging from the practice of medicine is generally of a contractual type. Only exceptionally shall it be non-contractual, when the physician assumes an anti juridical or forbidden behaviour or violates the regulatory provisions of his profession. The contractual relationship and effects apply to all assumptions of the link between patient and physician, and the non-contractual liability becomes effective in all illegal cases, where a combination of liabilities may occur: contractual non-fulfilment and non-contractual damages. The relationship between patient and physician is of a contractual sort even in situations when the patient lacks the

capacity to state his agreement; for example when someone faints and a doctor offers assistance, the physician acts according to the legal duty that lies in an *ex lege* obligation (this due to the fact that the medical activity is a public necessity service).

A. Contractual Civil Liability

213. In order to analyze a physician's contractual civil liability we must refer to the general provisions on non-fulfilment of obligations that can be found in the Civil Code (Arts. 1314 to 1332).

214. The Civil Code takes two assumptions for contractual civil liability into account: 1) non-fulfilment of obligation and, 2) partial, late or wrong fulfilment.

215. Liability for damages becomes effective when fraud or guilt (inexcusable or slight) is involved. Persons acting with ordinary diligence cannot be accused of non-fulfilment of obligations or of partial, late or wrong fulfilment. The Civil Code states a presumption, *juris tantum*, by which the debtor does not fulfil his obligation or fulfils it partially, late or wrongly due to a slight guilt. When there is no fraud or guilt the debtor is exempted from his liability, except for those cases in which the law or the type of obligation requires a fortuitous case or *force majeure*[1] in order to exonerate the liability.

The compensation includes objective damages (regarding patrimony): emerging damage and loss of profit, and subjective damages (regarding the human being): personal damages[2] and moral damages.[3]

1. According to the national system, a fortuitous case or a *force majeure* are considered to be extraordinary, unpredictable and irresistible events. Extraordinary because it is not common, unpredictable because contractors cannot predict its occurrence and irresistible because the impossibility of fulfilment is assumed.
2. Also called subjective damage is the damage that causes grievance or affects the human being, that is the essence of being and as such not subject to financial value. *See* Fernández, C., 'Hacia una nueva sistematización del daño a la persona' en: *Cuadernos de Derecho*, No. 3, 1993, Lima: Universidad de Lima, pp. 32 *et seq.*
3. It derives from the personal damage. Moral damage is one of the various psychosomatic damages that a person can suffer, and it must be considered a damage that affects the emotional life (pain, suffering) of the subject and is not present the rest of the affected person's life but it tends to disappear as time goes by. However, it is impossible to compensate economically and therefore it is considered a personal or extra-patrimonial damage. *See* Fernández, C., 'Hacia una nueva sistematización del daño a la persona' en: *op. cit.*, pp. 35 *et seq.*

216. Any provisions excluding or limiting liability due to inexcusable fraud or guilt on the part of the debtor or of those helping him are void (Art. 1986, Civil Code). Nullity is also declared in exoneration or liability limitation agreements when the debtor or those helping him violate obligations derived from public order regulations.

B. Non-Contractual Civil Liability

217. Modern non-contractual liability is a mechanism to economically compensate damages, which implies that there is a stronger accent on compensation of the victim than on punishment of the person responsible.[1]

1. De Trazegnies, F., *La responsabilidad extracontractual*, Lima: Pontificia Universidad Católica del Perú, Fondo Editorial, Volume IV, Book, 5th edition, 1995, p. 47.

218. Non-contractual civil liability as regulated by the Civil Code is based on two systems: the subjective system based on the notion of guilt (Art. 1969) and the objective system based on the notion of created risk (Art. 1970). Therefore, the non-contractual liability not only refers to illicit acts but also to those acts that, being illicit because of their dangerous character, make the performer objectively responsible even when there is no illegality or guilt involved in his actions.

219. According to the objective system, in cases of non-contractual civil liability it is enough to state the damage caused, its injustice, and the causality relationship, as well as the respective attribution factor, to have a legal obligation for compensation by the performer,[1] but it is necessary that the judge refrains totally from any examination of the intentionality of the author of the unjust damage. This does not mean that this intentionality factor or aspect is non-existent or not present, but it is left totally unconsidered because it is completely irrelevant for establishment of the legal compensation obligation. This is favourable for the victim's situation because in the respective judicial procedure only the damage must be accredited. Its unjust character and, fundamentally, the causality relationship, that is the presence of a causal factor and, in any case, as such impossible to prove, or the existence of a double cause in order to lessen the compensation that he will have to pay the victim,[2] is the responsibility of the offending person trying to judicially prove that the damage was not a consequence of his behaviour but a consequence of an alien cause.

1. 'The compensation refers to the consequences derived from the action or omission that causes the damage, including loss of profit, personal damages and moral damage, when there is a suitable causality relationship between the fact and the damage caused'. Exp. No. 775-95, Quinta sala Suprema. *See* Ledesma, M., *Ejecutorias*, tomo 2, Lima: Cultural Cuzco S.A., 1995, p. 148.
2. Taboada, L., 'La responsabilidad civil por aplicación defectuosa de las técnicas de reproducción humana asistida', en: *Revista jurídica del Perú*, Lima: Editora Normas Legales S.A., año XLVII, No. 13, octubre-diciembre, 1997, p. 79.

220. Likewise, regarding the subjective system based in the notion of guilt, in addition to the objective factors present in every non-contractual civil liability system, it will be necessary to accredit the subjective factor referring to the guilty character of the author of the damage because in this assumption the attribution factor is guilt, and it is not necessary to refer to the dangerous or risky character of the item or the behaviour of the author of the damage.[1]

1. Taboada, L., *op. cit.*, p. 80.

221. Medical non-contractual liability can become effective: when nullity of the contract for medical services is declared, because of a vice attributable to the physician or to the patient; when death or direct lesions are caused to the patient,[1] and this causes damages to third parties; when non-fulfilment of the medical contract means a penal offence; when the relationship between physician and patient has been imposed on the latter without his/her explicit consent due to a legal or administrative provision, such as in emergency cases,[2] and when damages are caused by fortuitous case or *force majeure.*

1. 'A physician's liability cannot be attributed regarding the results of a posterior surgery that he has not performed'. Fiscal legal opinion Nr. 060-98-2o F.S.C. – MP. Exp. 34-98, Recurso de nulidad, Sala civil, Arequipa, 31 July 1998.
2. 'Medical civil liability is non-contractual because between the person responsible for the damage and the victim there was no relationship prior to the damage apart from the emergency situation that involved the patient herein. Being proven that the medical surgeon who was required performed three surgeries regarding pathologies of a vesicular character, and that the decease of the victim was caused by a clot on the brain 90 days after he had been discharged from hospital, the causality relationship that is required by Art. 1985 of the civil code is not present.' *See* Ledesma, M., *Ejecutorias*, tomo 1, Lima: Cultural Cuzco S.A., 1995, p. 70.

C. Medical Liability and the Tools Used

222. In the practice of medicine a number of instruments, devices and medicines are used and their use or prescription can be damaging to the patient. That is the reason why their use must be based on good knowledge of their functioning, employment, as well as of the pharmacological properties. A distinction is made between damages caused 'with the items' and damages caused 'by the items'.

The first are produced because the assets mentioned are under control of the man who is manipulating them when he causes the damage (for example, lesions caused by the wrong use of an X-ray device or scalpel). The second are produced without the direct intervention of the man because the object in itself is susceptible of causing damage (for example the separating tissue or gauze forgotten in the surgical area, the use of non-corresponding blood in a transfusion or the wrong dose of a medicine).[1] The physician is responsible for the tools he uses, the fundaments of this responsibility can be found in the nature, pre-assumption and obligations generated by the contract for medical services.

1. Perez de Leal, R., *op. cit.*, p. 203.

D. Liability of Hospitals for the Acts of Their Medical Staff

223. Liability of hospitals is a consequence of a medical non-fulfilment, whether it regards public or private centres, free of charge or paid services. The liability is based on the obligation of guaranteeing the behaviour of dependants, subordinates or substitutes performing the service in substitution of the staff in charge of it. We must not forget the security obligation, accessory to the medical service contract, to give the patient the medical care that is the responsibility of the medical staff of the hospital, who will be liable for the damages the patient may suffer. This means that

the civil liability of hospitals for damages sustained by the medical staff in charge is a typical case of contractual civil liability, and the damages are caused by the action of third parties called in by the debtor in order to perform his duty, according to what is stated in the Civil Code (Art. 1325).

E. Trial Aspects of a Physician's Civil Liability

224. A trial for damages derived from medical liability is called a knowledge trial. This sort of trial is a formal trial of two instances. The conclusion of the second instance is irrefutable, except for an annulment appeal.

225. The trial considered here is a knowledge trial because of the complexity of the claim that makes it necessary to habilitate a probatory part according to the liability subject. In this trial, once the claim is presented, there is a period of 30 working days to respond to it, a ten day period to present exceptions (defence means on the side of the demanded) and five days to repeal or oppose the probatory means. Ten days after the claim has been answered, a trial indemnification and audience establishing controversial points takes place. Within the next twenty days, another audience, of a conciliatory character, will be called. Within the following 50 days, a proof audience is called and in the 50 days period a sentence in first instance is pronounced. The sentence can be appealed to the Superior Court within ten days, and after that the Court resolves it in a period not shorter than 60 days. The pronunciation of the Court is a final judgment, but in extraordinary situations a cassation repeal that aims at the just application of the law and, in that case, of the procedure is admitted. In real terms, a damage trial takes no less than twelve months in its two instances.

F. Damage Indemnification

226. The damages derived from the practice of medicine are subjective damages (personal and moral damages) and are invaluable and non-quantifiable. As a consequence, they cannot be measured precisely and exactly unless jurisprudent factors or criterions are taken into account.

227. Judges often pronounce the indemnification of medical damages according to the following parameters: the victim's records (social, cultural and financial), gravity of the lesions caused, juncture at the physician's causing of the damage, professional status of the physician and level of the health centre, amongst others.

228. Even though it is true that civil liability is not focused on the person responsible for the act but on the victim, it is also true that the average number of fraudulent or guilty acts by a famous and prestigiously recognized physician is more reduced than by a new or inexpert physician. In that same line of thought, a health centre with reasonably high standards and new technologies 'must make less mistakes' than that health centre with more general or insufficient resources.

229. For the offence of medical malpractice with possibility of posterior indeterminate damages a compensation should be established adjusted to those possibilities independently of the original damage already caused.

230. Exact pecuniary considerations aside, moral damage (understood as suffering or pain) and personal damage (affecting the psychosomatic unit and the person's free will, which determines the frustration of a life's project) are also indemnified according to the probability of ulterior damage.

231. Civil indemnification never punishes or enriches, it only compensates. Any given amount will always be discussible or arbitrary, but money will always be the common issue of everything.

232. There is a normally recurrent situation regarding medical damages: the original damage, the indemnification of which is established juridically, continues to be effective in the future, long after the trial has finished and the lesion has been repaired. It is legally possible to renew the claim if and only if it can be accredited that the new damage is caused by the original one, and obviously the prescription term of two years (starting at the moment when it is possible to present the claim) begins the moment when the victim acknowledges the new damage.

V. Criminal Liability

233. Regarding crimes committed by health professionals there is a distinction between those committed during professional practice and those committed outside professional activities.

234. 'The interest to study a physician as subject to criminal liability emerges, basically, from his own condition as a physician, his own suitability, the social transcendence of his functions, and the responsibility that the State gives him'.[1] In this sense, a physician can be responsible for homicide and lesions, as well as for other offences that are configured by virtue of his art or profession, for example the homicide by guilt, by piety or euthanasia, abortion, lesions, exposure to danger or abandonment of people in dangerous situations, false certificates, illegitimate freedom deprivation, suppression and assumption of civil state, violation of professional confidentiality, and illegal practice of medicine, amongst others.

1. Yungano, A., *Responsabilidad profesional de los médicos*, Buenos Aires: Editorial Universidad, 1986, p. 197.

235. Depending on his illicit acts, the physician can be accused of: 1) common criminality, when the physician contravenes criminal law but the exercise of his profession is not taken into account, 2) special criminality, also known as commission of the offence during the practice of the medical activity, i.e. the physician's offences.

236. The Penal Code does not regulate the cases of *iatrogenia* (from the Greek *iatro*: medicine, and *genesis*: origin), which are those cases derived, directly or indirectly, from the physician's activities that result in illness or consequences with adverse effects on the patient. The most common cases are when the physician uses an inadequate method for the cure of the illness or when the prescribed medicine causes side effects.

The concept of *iatrogenia* includes the cases of lack of responsibility or malpractice including the omissions by guilt (unskilfulness, negligence or imprudence) that cause damage and are regulated by criminal law.

VI. Indirect Liability

237. The Civil Code considers the so-called indirect or reflex liability for non-contractual civil liability (Art. 1981) as well as for contractual relationships in such a way that the fundament of the reparatory duty is also the guarantee, which means that the responsibility falling upon the debtor is purely objective[1] (objective liability without the main subject's guilt).

1. Woolcott, O., *La responsabilidad civil de los profesionales. Reflexiones y recomendaciones para su tratamiento en el ordenamiento jurídico peruano*, Lima: Tesis (Título de abogado) Universidad de Lima, Facultad de Derecho y Ciencias Políticas, 1995, p. 204.

238. Developments in science have favoured medical activity becoming specialized, and at the same time a collectivization of medical practices has taken place. As a result of these changes, medical services have improved, but one must not forget the protection that must be provided to the patient. At present, a patient is not treated by one physician but by a medical team including specialists, auxiliary employees and technical staff, all under coordination of the team leader. Physicians have two ways of participating in the patient's healing process: 1) individually, i.e. the service is given separately and it can be simultaneous or successive; or, 2) conjunctively, where the service is given collectively or in 'a team'. The treatment of the emerging civil liability depends on whether the medical participation takes one form or the other and whether it is possible to determine (or not) who is the author of the offence.[1] In principle, in cases where a medical team is involved each specialist must respond to his acts individually, to the extent to which he has professional, scientific and technical autonomy. However, when it is impossible to identify the origin of the damage, all physicians involved in healing the patient shall respond, the assumption of shared guilt falling upon them, this being based on the security duty implicit in all medical service and accessory to it.

1. Pérez de Leal, R., *Responsabilidad civil del médico*, Buenos Aires: Editorial Universidad, 1995, p. 174.

239. In cases where a medical team is involved, the professional, scientific and technical autonomy that characterizes the group is not present. In this assumption there is a predominant hierarchical order in work distribution and control, where the chief surgeon of the medical team has a pre-eminent position. The medical care

is coordinated, orientated, supervised and imposed by the team leader by delegation of tasks.[1] The surgical team leader, then, is not only responsible for his own acts but has to comply, diligently, with the chosen staff he is in charge of as well as with the control of a correct performance of the given tasks.

1. Pérez de Leal, R., *op. cit.*, p. 177.

240. In the case of a patient contracting the medical care with the clinic and not with the chief surgeon, the following must be taken into account: 1) the chief surgeon will be liable for the actions or omissions of the referred institution's staff that he is in charge of for the realization of the surgery within the limits of his having a real and true possibility of avoiding the damage, 2) on the contrary, the clinic will be liable as it is the main contractor.

241. When the head of the medical team is the person managing and coordinating other people's activities, he is indirectly liable for the facts of his auxiliary employees and collaborators lacking autonomy.

242. An agreement for medical care between the patient and the medical team can be realized as follows: 1) individually, i.e. the patient contracts each one of the members of the medical team, and in this case the chief surgeon will only be liable for the auxiliary employees and technically dependent collaborators with which the medical act was performed; and 2) contract with the head of the medical team, who is in charge of selecting the auxiliary or collaborating staff who will be involved in the medical act and therefore will be liable towards the patient. In both assumptions there is a contractual link not only between the patient and each of the professionals that form the medical team, but also between the head of the medical team and all the auxiliary and collaborating staff. That is why the head of the medical team is liable towards the patient for the acts of his dependent staff given that his guilt (in *vigilando* or *in eligendo*) is presumed to be based on the duty of security that is accessory to the assisting service.

243. It is worth mentioning that the LGS (Art. 18) establishes the liability towards third parties under the following assumption: 'Every person is liable towards third parties for the non-fulfilment of sanitary and hygienic practices aimed at preventing the appearance and propagation of contagious illnesses, as well as for the acts or facts originating environmental pollution'.

244. The physician's liability is extended to the acts of his collaborators, auxiliary and dependent employees by the indirect contractual liability system, and therefore there is a double assumption in valuating the liability: subjective, regarding the guilt of the collaborator, auxiliary or dependent employee who caused the damage, and objective, regarding the physician in charge. In this way, the physician's guilt criterion *in eligendo* or *in vigilando* is discharged in favour of the consideration that the liability mentioned is linked to the medical care contract or to a guarantee duty, and that is essential in fulfilling any contract.[1]

1. Yungano, A., and others, *op. cit.*, p. 139.

§2. Quality Assurance

245. The LGS establishes (Art. 2) that 'Every person has the right to demand that the assets used for his health care correspond to the characteristics and attributes indicated in their presentation and authorization. Moreover, he has the right to require that the services provided for his health care comply with the quality standards accepted in all institutional and professional proceedings and practices'.

246. For its part, the hospital's executive board[1] reckons supervision of the efficiency and efficacy of the care that the hospital is providing to its general tasks. Likewise, there are internal organs in the hospital that are in charge of controlling the quality of patient care.

1. DS.005-90-SA (DOEP, 25 May 1990), General hospital regulations for the health sector.

247. The internal control office is in charge of internal audition, inspection and supervision. Its general functions are to:

- Supervise, evaluate and audit the development of the services;
- Assess and suggest corrective measures in application of the health policy;
- Value, supervise, measure and confront the fulfilment of all activities related to profit/loss; and
- Investigate and evaluate the degree of technical-administrative and financial efficiency and efficacy in health care.

248. The medical corps is an organ with technical capacity to judge the acts of each one of its members in their medical activity (medical audit). The hospital's medical corps is formed by the hospital's collegiate medical professionals.

249. In every hospital, professionals of the health sciences must form an organ with a technical-ethic-deontological character that aims at clarifying and judging the quality of the care they are providing to the population.

§3. Review Boards

250. There are two aspects of the control of medical activity: administrative and ethic.

I. Administrative Aspect

251. The Ministry of Health exerts administrative control, and it is competent for the formation and training of human resources in the health sector as well as for the categorization and accreditation of health centres. The General Inspection Centre is the control organ in charge of formulating rules on medical audit for the

National Health Programme and in charge of programming and executing administrative control.

II. Ethic Aspect

252. The CMP is the entity that represents the medical profession. It exerts ethical control, according to Article 23 of the LGS, given that amongst its tasks there is that of dictation and spread of the Ethics and Deontology Code, as well as that of supervision of its fulfilment and detection, officially or by solicitation, of all acts violating the provisions of the mentioned code.

§4. Disciplinary Organizations

253. Law disposition, order and observance and organization of the medical profession is mainly carried out by the Order of Physicians, the professional codes and the Medical Ethics Committee.

I. The Order of Physicians

A. Peruvian Medical College

254. The Order of Physicians is represented by the CMP,[1] which is the autonomous entity of internal public right, representative of the medical profession in the Republic's territory in its totality. Its objectives are supervision of the ethical practice of medicine, improvement of health, contribution to the development of medical science, absolution of consultations and representation of the physicians.

1. L. 15173 law, Law for the creation of the Peruvian Medical College (DOEP, 16 October 1964).

1. Composition

255. The CMP consists of the following institutions, *see below*.

a. Managing Institutions

256. The superior organ is the National Council, located in the capital city of the Republic; and the regional councils established in the different areas of the Republic, their distribution depending on their population index, professional concentration and geographical conditions.

b. Counselling Institutions

257. The permanent counsel committees: they refer to the National Council as well as to the regional councils. The transitory counsel committees: are created by the National Council or the regional councils, according to their needs, and they have specific functions and specific terms under which the functions must be fulfilled. The local counsel committees: they originate and depend on the regional councils, the latter are in charge of establishing the quantity, location and specific functions.

B. Peruvian Medical Federation

1. Introduction

258. The Peruvian Medical Federation (FMP)[1] was created when health care was not a right but a service that the state provided in a paternalist way, and its establishment was necessary in order to determine the mechanisms of academic, scientific and training improvement and as a union entity in that it was created to defend the physician's rights.

1. Created by the RS of 27 June 1946.

259. It is a matrix institution because it originated from all existing medical institutions, such as the scientific medical associations, medical academies and even the Peruvian Medical College (CMP).

260. The difference between the CMP and the FMP lies in their origins. The first, like all professional colleges, is created by the state and all physicians must be inscribed in order to practise their profession. The second institution was created by a group of interested people and only those physicians that so wish are inscribed.

2. Functions

261. The FMP has the special function of watching over the respect for and defence of the physician's rights, requiring from the state that the right budget is provided for adequate functioning of the social security health system, supervision that the right working conditions and quality of goods and medicines are provided. All in all, its function is to make sure that health care and social security are accessible for everyone in terms of equity.

3. Objectives

262. Its objectives are to defend the physicians' working rights in cases of unjust dismissal, administrative trials or negation of their prevision rights, as well as to

assume their defence in cases of bad *praxis* (homicide or lesion by negligence). Its objectives and functions are supported by monthly economical contribution of its members.

4. Composition

263. The FMP is formed by a National Executive Board and by regional medical federations. It also has national units formed by the following groups: physicians from the Ministry of Health, retired physicians, resident physicians, physicians from the private sector, civil physicians from the Armed Forces, physicians from the Public Ministry and the physicians of the National Penitentiary Institute (INPE).

5. Achievements

264. Amongst the FMP's main achievements is promotion of the presence of lawyers in the main health centres, inclusion of the hospitals' solidarity responsibility in economic compensations by the LGS, explicit recognition of the patients' rights, the informed consent, the provision of clinic records and care free of charge in special cases, with payment after the care has been provided.

II. Professional Codes

A. *Ethics and Deontology Code (CEDCMP)*[1]

265. The CEDCMP is a set of rules with a moral character that ensure honest practice and honourable behaviour for each and every member of the medical profession. It is formed by a systematized set of permanent rules that provide orientation and direct the practice of medicine within the frame of its inherent principles. It covers all the acts of medical practice, and its acknowledgement by all physicians applying for a collegiate status is obligatory, in that they have to explicitly subject themselves to its rules. The CEDCMP, therefore, is in charge of regulating the practice of medicine through principles with an ethical character, and those acting against those rules commit an infraction that will be sanctioned as such.

1. The CEDCMP has been effective since 22 February 2000. The previous CEDCMP was approved by the Res. 8 CM-CN on 12 March 1970 and its structure was very similar to the present one.

   In 1997, a new code was approved by Res. 1223-CN-97, valid from 1 January 1998. Its validity, however, was very short, and the CEDCMP Code of 1970 was adopted again.

B. Structure and Subjects

266. The CEDCMP has nine sections:

First: general aspects. Declaration of principles and oath. Second: medical practice (professional exercise); medicine prescription; schedule; transplantation and disposition of organs, tissues, cells and genetic material; birth control, offences against humankind, patients' rights. Third: professional relations (physician-patient relationship; the relationship between the physician and the patient's relatives; physician-physician relationship; the relationship between the treating physician and the specialist physician; medical boards; specialists; physician and teaching; physician and investigation; relationship with institutions; the relationship between the physician and other health professionals). Fourth: certificates, professional confidentiality, wages. Fifth: concerns public competition. Sixth: intellectual property and publicity. Seventh: illegal practice of medicine. Eighth: elections and, Ninth: administrative issues.

III. Ethical and Deontological Supervision Committee

A. Introduction

267. There is no governmental institution *ad hoc* that regulates and focuses on medical professional behaviour regarding human beings.

B. Peruvian Medical College (CMP)

268. At private union level, however, the CMP is, through its Ethics Committee, in charge of regulating the proper application of medicine to human beings. In Lima there are two CMP ethics committees: the III Regional Council Ethical and Deontological Control Committee (controlling the Lima region) and the National Council Ethics Control Committee. These are officially in charge of controlling everything related to medical ethics in the country. Their regulations are the rules of the CMP and the CEDCMP. Their main activities have been giving opinions on subjects such as ethical medical behaviour towards the patient and towards in-patients and regulating biological and biomedical investigation.[1]

1. Information obtained in an interview with the Peruvian biotechnician Patrick Wagner Reyna-Grau, on 29 March 1999.

269. The Ethics and Deontology Control Committee is a permanent counselling institution of the National Council and of the sixteen CMP regional colleges, and therefore there are seventeen committees at a national level, one for the CMP National Council and the rest for each regional council.

Among its main functions we must mention: to know, inform and act in all ethical and deontological control issues related to the practice of medicine; to obtain information on ethical and deontological behaviour of medical professionals

coming from foreign countries; to monitor entities and people who are not collegiate but who realize activities related to medicine; to inform the National Council about claims and complaints caused by violation of the CEDCMP or by mistakes or offences against the ethical principles of medicine; to promote and co-ordinate the defence of professional prestige; to denounce those medical activities that break ethical and deontological rules or constitute illegal professional practice; to exert control to prevent professional advice from diverting from the rules that the college establishes in that regard; to report on consultations regarding ethical and deontological issues coming from either entities or individuals.

C. Project of Creation of a National Bioethics Committee[1]

1. Introduction

270. Mankind has reached an important development level in biotechnology, which has provided invaluable profit and in many cases also irreparable damage that has had negative consequences not only for human beings as subjects with individual rights, but also for humankind as a subject with collective rights. Bioethics, the science that studies the correct application of biomedicine, mainly focuses on biotechnological advances.

1. Varsi, E., 'Comité nacional de bioética', in: *Derecho@ldía*, *See http://www.rcp. net.pe/derecho* and in: *El comercio*, 1 October 1999, Section A, p. 13.

271. Compromise in bioethical issues not only focuses on some specific groups. On the contrary, it is a shared responsibility and all citizens desiring a healthy, natural and peaceful life in coexistence with bioscientific development must collaborate. There is no better way of regulating these joint efforts than by creating a National Bioethics Committee that will guide the progress of medical and biological science based on human principles, values and rights.

272. A bioethical committee will not only become a very important institution to help Peru, as a member of the UNESCO, to comply with taking the necessary measures in order to promote the principles stated in the Universal Declaration on Human Genome and Human Rights, but it also will be useful to adopt a national policy and favour the approval of internal rules that regulate biotechnological activities such as IV reproduction, experimentation on humans, embryo bioconservation and birth control, as well as administrative tasks such as, amongst others, the creation of sperm donor registers, biotechnological reproduction and genetic identification establishments and professionals in this branch of science.

2. Purpose

273. The National Bioethics Committee must be a multisector institution with the following objectives: a) to deal with ethical and juridical issues related to inves-

tigations and their application, as well as to promote the exchange of ideas and information, especially by education; b) to favour activities aimed at creating a higher level of consciousness regarding bioethical issues; c) to co-operate with organizations interested in all issues related to bioethics; d) to offer counselling in issues related to respecting the Universal Declaration on Human Genome and Human Rights and to identify all practices that might be against human dignity.

3. Objectives

274. To watch over the protection of and respect towards human beings and the dignity, freedom, identity and integrity of humankind in biomedical investigations will be the main objectives of the committee. To achieve this, it must be an independent institution with freedom and autonomy of thoughts and policies.

4. Tasks

275. It will make an ethical analysis of biotechnological progress and its consequences for life, health and environment, taking the arguments sustained by investigators and professionals as well as social exigencies into account. It will fulfil a technical counselling duty based on bioethical analysis leading to the formulation of ruling principles inspired by all rights and liberties. It will stimulate education, training and information on bioethical principles and it will promote scientific debate. Among other tasks, it will reinforce the consciousness regarding the problems that arise through biological, genetic and medical investigations and their applications.

5. Structure

276. The committee may be created by presidential or ministerial decree, or by parliamentary decision. It could also be a non-governmental organization or private institution initiative, or, on the other hand, depend on the Peruvian Medical College or be linked to an institution that does not belong to the state.

6. Composition and Functioning

277. It must have a multidisciplinary character in order to include the various criterions and arrive at concrete solutions through deep discussions on the issues at hand. This committee could be integrated by representatives of the Ministry of Foreign Affairs, Health, Justice, Education or Women's Issues and Human Development, by members of the Lima Lawyers College, Peruvian Medical College, Catholic Church, Peruvian Red Cross or University, by human sciences specialists (philosophers, anthropologists, sociologists, theologians), by a

spokesman of the cults registered in the country, a spokesman of the citizens, a spokesman of associations for the disabled and a spokesman of the biochemical, biomedical, biocosmetic and pharmaceutical industry.

7. Conclusion

278. We can conclude that the National Bioethics Committee will serve to focus (and not to stop) biotechnological development in order to achieve the maximum profit for humankind, while steering well away from those methods that have used human beings as a medium for the benefit of some biotechnological and medical interests.

Part II. The Physician-Patient Relationship

Chapter 1. General Description

§1. Introduction

279. The physician-patient relationship is based on health care. By this relationship for juridical provision of services the health professional gives attention to the person who asks for it and therefore establishes, either explicitly or not, a health care contract. The physician-patient relationship can be started by the physician's initiative, in a situation in which he/she feels called to action, or it can originate by means of a contract independently of whether it is the patient asking for it or through the physician's act of hanging a board on the practice door.[1]

1. Acosta, V., *De responsabilidad civil médica*, Santiago de Chile: Ed. Jurídica de Chile, 1990, p. 85.

§2. Duty to Care

I. Requirement of Validity

280. The mentioned contract is perfectionated by consent and must comply with the requisites of validity of a juridical act (Art. 140, CC) such as: capable agent, physically and juridically possible subject, legal objective and observance of the prescribed form under sanction of nullity.

A. Capacity

281. Regarding the capacity of the contractors, the health professional must be accredited as such (professional training) and, in case of the patient, he/she may be an adult or a minor, able or unable, the most important factor being his/her consent, that of his/her relatives or of those people entitled to give their consent in order for the patient to be given a medical or surgical treatment (Art. 4, LGS).

B. Object

282. The direct object of the physician's services is a human being (in *soma* and in *psyche*) who, by nature, is outside commerce and therefore the contract might seem to be illegal. However, that is not the case given that there are facts that, threatening integrity or health, allow for the use of a human body in order to defend its life. That is permitted by our private legal ordering in that: 1) 'The acts of disposition of one's own body are prohibited when they cause a permanent incapacity of the physical integrity or when they are in any way contrary to the public order or to good customs. However, they are valid if their exigency corresponds to a necessity state, either medical or surgical, or if they are inspired by humanitarian reasons' (Art. 6, CC) and 2) 'Stipulations by which a person obliges himself to undergo a medical examination are allowed if either preserving his mental health or his emotional or physical ability is the main reason for the contractual relationship' (Art. 11, CC).

C. Objective

283. The objective of a medical care contract is determined by the counter obligations of each of the parties. For the physician it is payment of his fees, while for the patient it is the provision of health care services directed at taking care of and defending his health.

D. Form

284. There is no legal form for a health care service contract, and therefore it is determined by mutual agreement between the parties, except when the law establishes that the patient's consent must be written (for example in case of organ transplantation, Art. 8, LGS).

II. Juridical Characters

285. The physician-patient relationship allows for different contractual figures and the contract presents itself as an atypical, special, principal, commutative, onerous and multiform one.

III. Norms

286. As previously said, the health care service contract is atypical because it lacks the legal framework that expressively regulates it. In general terms this contract is ruled by the general contractual rules of the CC (Art. 1353, integrality principle), as well as by the general rules of a provision of services contract that can be applied, either when the contract involved is a nominated one (Art. 1756, like an

order, a location of services or a construction contract) or when the contract is an unnominated but atypical contract (Art. 1757: *du ut des, do ut facios, facio ut des* and *facio ut facios*).

IV. Characteristics

287. Amongst the substantial characteristics of the medical care contract we can mention that between physician and patient the contract is essentially informal, given that it is agreed almost without a word, through gestures or attitudes from which the will to be taken care of, treated or medically intervened derives on the side of the patient, and the will to accept the duty to give medical care and receive a fee in return derives from the physician's side. It is a consensual contract because the medical care is perfectioned simply by having both parties' agreement. It is a case of an *intuito personae* contract, that is, very personal (except in cases where social security, a private insurance or an emergency is involved).

§3. Duties and Rights of Both Parties

288. As in any other subjective juridical relationship, both the physician and the patient have rights (that must be respected) and duties (that must be complied with), which fact gives them the possibility to fully develop themselves and obtain direct benefits from each other.

289. The professional activity required by the patient must be satisfied within the proper time frame and in the right way. The physician is obliged to provide his services in a diligent way (carefully, exactly and actively). This is based on the fact that the main objective of the medical profession is to assist and defend human beings against all causes that affect (or may affect) their health and threaten their life.

290. Within the frame of their obligational juridical relationship, in a contract for medical assistance only the physician and the patient intervene.

I. The Physician

A. Duties

291. The contract for medical assistance can state two types of duties on the side of the physician: a duty of means or a duty of result, depending on the objective to be achieved. The medical contract often implies a duty of means because the physician is not obliged to cure but to provide the necessary assistance, consciously and diligently, taking the level of scientific development into consideration. The exception arises when the desired result is achieved, the physician having the obligation of obtaining a specific result (for example in blood transfusions or clinical tests).

292. The physician must comply with his duty to act (as it is established *ab initio*) but his manner of acting can be determined (because it is delimited in the execution process). The duties in medical activities may consist of instant, periodical or continuing execution.

1. Duty to Care

293. The CEDCMP (Art. 44) states that to favour and/or to provide careless, superficial or incomplete medical care is not ethical. The physician must be careful to dispose of the time necessary to apply his knowledge in a proper examination of the patient. Any medical act carried out in a hurry or irresponsibly is either an abuse of the trust or product of ignorance, and constitutes a serious lack of ethics.

2. Duty of Loyalty and Courtesy

294. The CEDCMP (Art. 42), states that the physician must treat the patient with loyalty, decency, ability, dedication, courtesy, opportunity and with deep respect for the patient's dignity and privacy.

The physician must observe irreproachable behaviour towards the patient and carry out the medical examination, as well as the therapeutic indications, recommendations and suggestions within the frame of a most strict moral.

3. Duty to Keep the Dual Formula Physician-Patient

295. The basic human relationship in the practice of the medical profession is the dual relationship physician-patient. This relationship is achieved: by the voluntary and spontaneous decision of both parties; by the physician's unilateral act in emergency cases or by a third party's request, in which case the medical care must be given when: it is requested by relatives, by a competent authority or when there is an emergency; when it is requested by third parties (relatives, representatives, competent authority or people present at the place where the emergency arises). Moreover, the physician who has acquired a working compromise to provide medical care to people in charge of an administrative entity is obliged to assist anyone sent to him, and must ask of the entity that it applies the rules and provides with the physical elements necessary and proper for the patient's examination, diagnosis and treatment.

4. Duty to Refrain from Promising a Result

296. As stated, the physician's obligation is generally one of means, caution and diligence. That is why he must compromise to assist the patient according to what science and his conscience tell him, without promising any specific result. The physician has an ethical and juridical duty not to guarantee the patient's healing or

the use of infallible techniques or treatments (Art. 291, CP, abusive exercise of medicine).

5. Duty to Inform

a. About the Treatment

297. This duty is complemented by the patient's right to be informed in a simple, approximate, loyal and intelligible way about the diagnosis, prognosis, treatment and handling of the patient's health problem, as well as about the risks and consequences involved. For special treatments, risky tests or surgeries that can mentally or physically affect the patient, the physician must obtain a written informed consent beforehand (Art. 27, LGS).

b. About Medicine Prescription

298. Physicians are obliged to inform the patient about the risks, contra-indications, adverse reactions and interactions that prescribed medicines may cause and about the measures to be taken for a proper and safe use (Art. 26, LGS).

c. Informing the Authorities about Illnesses and Obligation to Declare Damages

299. In order to comply with the national health policy the LGS (Art. 32) states that health professionals, technicians and auxiliary staff must inform the health authority about the illnesses and damages they face while practising their activities.

d. Informing the Authorities about Attending Victims of Criminal Acts

300. A physician who attends to a victim of an act derived or connected, directly or indirectly, to a criminal act must inform the competent authorities about it (Art. 30, LGS). Moreover, all details regarding the injury or damage diagnosis in the above mentioned cases must be communicated to the police authority or to the public ministry at their request (Art. 25, LGS) (for more details *see* paras. 368 and 369).

6. Duty of Safety

301. Caused by the medical care contract, it is a generic, tacit, and accessory service clause in which one of the parties' safety depends on the main duties imposed on the other party in the contract. The existence of this duty depends on the more generic duty of good faith, as one of the parties stated in the contract relies on the other party to protect the first party from any damage that may be caused when carrying out what is stipulated in the contract. In addition to the physi-

cian's duty, a duty of safety may implicitly coexist, consisting of the obligation to avoid causing the patient any damage. It is based on this accessory duty that we can explain the physician's contractual liability regarding his action or his dependants.

7. Facilitating Medical Records

302. The LGS (Arts. 15, inc.i, 29 and 44, LGS) states the physician's (or the person in charge of the health establishment's) obligation to facilitate a copy of the medical record stating symptoms, signs and health problems, as well as all fundamental details that help determine the diagnosis of the problem.

8. General Duties

303. There are also the so-called general duties, which are those duties sustaining the medical application and technique such as, amongst others, the duty of diligence or ability, duty to dispose of the technical means and duty to continue the patient's treatment and give a certificate.

B. Rights

1. Right to Fees or Remuneration for Services

304. Even though the medical act is intrinsically invaluable and may not be an object for commerce, the physician does have the right to receive a fee that equitably contributes to a decent living, to a continuing and progressive scientific training and to the maintenance of a household. In this way, the medical care contract is characterized by its being onerous (Arts. 26-27, CEDCMP).

2. Right to a Sabbatical Year

305. The LTM indicates that in order to apply for a specialist or academic degree for a full-time professional dedication, either in the country or abroad, a habilitating licence including enjoyment of possessions will be expedited. The law recognizes the surgeon's right to a sabbatical year (Art. 21).

3. Intellectual Property Right

306. The physician has the right to have the intellectual property of any document written during the exercise of his medical function (documents, cases, medical records).

II. The Patient

A. Duties

1. Duty to Inform and Cooperate with the Health Authorities

307. All information regarding health is of public interest.
Everyone must give the health authority any information that may be requested according to the law (Art. XIV, LGS). Every person, either natural or juridical, must give properly and appropriately the data requested by the authority for purposes such as statistics, evaluation of health resources and other special investigations that may be necessary and that contribute to a better knowledge of the health problems or the means to fight them (Art. 117, LGS).

308. Exception to this is any information that might affect the personal or family privacy, the own image, national security and external relations, as well as any information regarding issues that are protected by the regulations for industrial property according to the specific law in that area[1] (Art. 120, LGS).

1. DLeg. 823, (DOEP, 24 April 1996), General Law of Industrial Property.

B. Rights

309. It is a principle of the LGS to establish that every person has the right to have his/her health protected and this right is essential and may not be relinquished. This protection extends to conceived beings as they are considered subjects within the health law framework (Art. III, LGS). In this way, the patient is presented as the main right holder in health provisions.

310. In the LGS the patient has general rights and special rights.[1]

1. The LGS generally uses the following terms to refer to the patient: 'person', 'health services user', (Art.15, LGS).

1. Right to Dignity

311. Considered as a right, human dignity implies a human being's faculty to enjoy rights and to benefit from society's highest protection. Because of this dignity, a human being must receive special attention from the law. Therefore, the CEDCMP establishes (Art. 55) that the greatest guarantee of the physician's action towards the patient is the recognition of and respect for his right to dignity.

a. Non-Discrimination

312. According to the right to equality, nobody may be discriminated or marginalized for health reasons. Therefore it is prohibited to discriminate anybody by reason of an illness or suffering, independently of the type, gravity or consequences of the health problem involved (Art. 15, inc. e, LGS).

b. Access to Information regarding the Discharge Certificate

313. In principle, the patient has the right to be informed about his/her health condition. This right is complemented by the right to request a discharge certificate when the stay at the health establishment ends (Art. 44, LGS).

c. Right to Proper Medical Care

314. It is an essential right to request that the goods destined to contribute to the patient's health care correspond with the characteristics and attributes indicated in their presentation and with the characteristics that accredited their authorization. Furthermore, the patient has the right to request that the health care services provided comply with the quality standards accepted in the institutional and professional procedures and practices (Art. 2, LGS).

d. Right to Medical Care in Emergencies

315. Apart from the individual value of the right to health care, the law also recognizes its legitimate social value. Therefore, the medical activity must be carried out within a community and must provide services and attention to those who most need it.

316. According to this principle, every person has the right to receive, at any health establishment, and every health establishment must give, without exception, emergency medical-surgical attention whenever necessary and as long as the high risk for life or health remains. After the emergency has been attended to, payment of the costs will be arranged according to the case evaluation carried out by the relevant social service (regulation of this is pending). All accredited homeless people are exempt from any payment. The criteria for determining the liability of executive members and employees of the health establishments are without prejudice to the penal report that may be applicable to the infractors (this regulation is pending) (Arts. 3 and 39, LGS).[1]

The LGS imposes an obligatory heteronymous relationship between the patient in an emergency situation and the health establishment. That is to say, there is a forced contract by which both parties' initiative is replaced by the state's intervention. From a certain point of view it can be stated that this imposition is linked to a policy of protecting the right to health enjoyed by all subjects.[2]

1. Arts. modified by the L. 27604, Art. 1 (DOEP, 22 December 2001).
2. Barchi Velaochaga, Luciano: 'Responsabilidad civil en la atención médico-quirúrgica de emergencia', in: *Diálogo con la jurisprudencia*, year 6, No. 27 July 2000, pp. 44 and 45.

e. Right to Receive a Health Certificate

317. As part of every person's faculty to accredit his/her health condition, receiving a health certificate on request is considered a right by law (Art. 13, LGS).

2. Right to Information

a. General Notions

318. Information is of vital importance and very determining in the field of medical assistance, because a person will take the decision to accept the offered service or to look for other options to satisfy his/her health needs depending on the information given.

319. The duty to inform is the compromise to inform, clearly, properly, adequately, approximately and loyally about all details and consequences involved in the medical act. It is based on good faith and its objective is to obtain the patient's truthful and upright consent.

b. Form

320. There are two criteria related to the duty to inform:

The objective criterion, where need, urgency, danger, novelty and gravity of the information are taken into account.

The subjective criterion, where the physician must inform the patient according to his/her cultural background, age, personal, family or social situation, and taking into account other factors such as capacity, understanding, will to be informed and necessity of the treatment to appreciate the validity of the given consent.

The information given must refer to the advantages and disadvantages of the treatment. If the patient is not able to receive that information, it must be given to his/her relatives.

It must be noted that the more urgent surgery is, the less precise the information given will be. On the contrary, in case the surgery is less urgent the information given will be more detailed.

c. Area

321. The LGS (Art. 15) establishes the rights applying to all health services users, amongst which the following are stated: right to receive truthful, proper and

complete information about the service's characteristics, the financial conditions and all other terms and conditions of the service (inc. f); right to receive comprehensive information, regularly and continuously, about the process, including diagnosis, prognosis and alternative treatments as well as risks, contra-indications, precautions and advice regarding the prescribed and administered medicines (inc. g); right to be given all necessary information in order to be able to give an informed consent previous to any procedure or treatment, and also to reject it (inc. h). The same law (Art. 27, 1st paragraph), referring to the exercise of medical professions and the like, establishes that the physician as well as the dentist and the obstetrician must inform the patient about the diagnosis, prognosis, treatment and handling of his/her health problem and also about the risks and consequences involved.

322. Finally, the LGS considers the right to general information in health issues (Art. 5) by establishing that every person has the right to be informed by the health authority about hygienic measures and practices, about diets, mental and reproductive health, contagious or chronic degenerative diseases, precautionary disease diagnosis and all other actions focusing on promotion of a healthy lifestyle. Moreover, the patient has the right to receive information about the risks of smoking, alcoholism, drug addiction, violence and accidents.

d. Characteristics

323. The information must be:

Timely information. The moment and time at which the information about the treatment or medical service is given is of vital importance in order to allow for a total and correct decision by the patient in question. That is why it is established that every person has the right to be timely informed about the medical and health measures that must be taken on his/her behalf (Art. 5, LGS).

Correct information. The contents of the information about the treatment or medical service is important in order to allow for a total and correct decision by the patient in question. That is why every person has the right to receive truthful and complete information about the characteristics, financial conditions and all other terms and conditions of the service (Art. 15, inc. f, LGS).

The contents of the information must include, amongst other, the following:

- Reason for the medical act.
- Need, urgency or gravity of the medical act.
- Danger of the intervention.
- Secondary effects.
- Information about the form and means to be used.
- Objective of the treatment, detailed diagnosis and prognosis as well as existing therapeutic alternatives.
- Benefits and disadvantages of the treatment.
- Alternative treatments.
- A more exhaustive informative report in cases of new treatment methods.

The information must refer to foreseeable (typical) risks and not to exceptional or unforeseeable (atypical) risks.

Total information. The person interested in the medical services must be totally informed, that is to say that the information must be timely, proper and refer to all techniques or treatments to be used in the process in order for the person in question to give authorization. That is why it is considered a right that a person be informed about all he/she needs in order to give an informed consent prior to the application of any procedure or treatment, or to reject it (Art. 15, inc. h, LGS).

e. Information Regarding the Process

324. Every person has the right to receive clear and continuous information, in comprehensible terms, about the diagnosis, the prognosis and the alternative treatments, as well as about the risks, contra-indications, precautions and warnings regarding the prescribed and administered medicines (Art. 15, inc. g, LGS).

3. Right to Consent

325. The consent (authorization) given by a patient derives from the information (announcement) he/she has received about the medical act he/she is about to undergo.

a. Notions and General Information

326. The consent to undergo a specific surgery or receive a medical service is the decision taken by a person in order to treat a health problem. As such, the consent derives from the timely and right information that the person has received regarding the techniques or treatments to be used in the prescribed or requested process.

327. The LGS (Art. 4) states that nobody can be subject to surgical or medical treatment without his/her prior consent, or the consent of any person who might be entitled to do so in case the patient in question is unable to. Emergency interventions are exempt of this condition. With this, the patient's consent legitimates the physician's actions above the regulation regarding one's own body or *ius in se ipsum* that applies to every person. The exigency of the patient's consent seeks to protect the personal freedom given that it is not possible to act against it, not even when the intervention shall be advantageous, unless it regards an emergency case.

b. Form

328. The patient's consent can be:

Express – it can be a written consent in case of surgeries[1] or a verbal consent as in the majority of the cases.

Tacit – through unmistakable signs or acts.

1. For organ extraction and implantation *see* Art. 34 of the DS. 014-88-SA., Regulation of the law L. 24703 and Art. 8, LGS.

329. It is necessary to add that each patient, as well as each surgery that is to be carried out, needs special information in order for the consent to be proper and complete. This type of consent is known as 'informed consent *ad hoc*'[1] and it is based on the fact that informed consent protocols must be complemented by the specific details of each concrete case in order to avoid the possibility of a practice based on the patient's signing of documents by direct or non-reflexive support.

1. Galán Cortés, J., *Aspectos legales de la relación clínica*, Madrid: Jarpyo Editores S.A., 2000, p. 32.

c. Time

330. The consent is temporary and can be revoked without any formality. The patient's consent must be given before the medical act and be valid during its realization.

d. Object

331. The object of an informed consent is the medical treatment itself, and the patient must know it beforehand. Otherwise, the physician must assume the risks involved in the act.

332. The result of the surgery is not included as an object of the informed consent.

e. Limits

333. The consent applies to all aspects that the patient has been informed of.

f. Exceptions

334. The consent is ineffective when it means authorizing any act that is forbidden by the law (abortion, euthanasia).

335. On the other hand, in cases where the public order is involved – when social interests are above individual ones – the will's autonomy and therefore the individual consent is limited, such as happens in cases where measures apply to population matters (obligatory vaccination, pre-marital certificate, compulsory medical examination for military service purposes, intake of mentally ill people, access to specific areas in the country, etc.) or where the objective is to determine

the commission of civil illegal acts (obligation to undergo the alcohol test or others)[1] and in special cases such as AIDS related examinations.

1. 'All drivers must undergo any tests that the Peruvian National Police Corps in charge of traffic matters may ask in order to determine his/her level of alcohol, drugs, narcotics or other toxic substances intoxication, or to determine his/her suitability to drive at that specific moment. Refusing to undergo the tests establishes a legal presumption against him/her'. (Art. 94, DS.033-2001-MTC, DOEP, 24 July 2001, National Traffic Regulation).

336. Emergency surgeries do not require any prior consent (Art. 4, LGS).

g. Impossibility to Consent

337. In cases where the patient is unable to give authorization for the medical act (unconsciousness, coma or shock) the existence of a tacit previous will to accept the medical activity will be admitted, based on the patient's health, without any prejudice to the physician's *ex oficio* duty.

h. Experiments for Medicines

338. Nobody can be the object of experimentation for medicine or treatment application without being duly informed of the experimental condition of the acts, the risks involved and without his/her prior written consent (Art. 15, inc. d, LGS).

i. Educational Investigation

339. Even though academic investigation is the basis for medical development, a human being may not be used as a means to achieve scientific progress unless he/she gives prior consent for it.

340. No one may be subject to exploration, treatment or exhibition with educational purposes without his/her prior consent (Art. 15, inc. c, LGS).

4. Right to Privacy

341. With the exceptions established by the law, there is a special right to request the confidentiality of all the information related to the medical act and the medical record (Art. 15, inc. b, LGS) (for more information *see* para. 349 *et seq.*).

§4. Informed Consent

I. General Principle

342. Informed consent is based on the right to be informed and the right to consent.

343. The patient has the inalienable right to be informed and instructed about the effects of the medical operation he/she will undergo, in order to obtain his/her objective decision on the matter and subsequent authorization for the treatment.

II. Holder

344. The holder of the right is the patient or user of the medical care service. In cases of patient's incapacity, this right can be exercised by the patient's legal representative.

In cases where minors are involved, their opinion must be heard and considered based on the superior interest of the child and maximum respect towards his/her rights (Arts. IX, 9, CNA).

III. Legal Base

345. The LGS expressly considers the informed consent as a human being's right (Art.15, inc. h and 27, LGS).

346. In this sense, it is established that in the supposed application of special treatment, realization of risky tests or practice of surgeries that can mentally or physically affect the patient, the physician is obliged to obtain the patient's written informed consent (Art. 27, 2nd paragraph, LGS).

347. The physician may not expose his patient to unjustified risks and must ask for his/her written informed consent before applying special treatments, realize risky tests or practise any surgery that can physically affect the patient. Moreover, if the patient is not able to give authorization, the consent request must be addressed to the people responsible for the patient. If consent is not given, the physician is not authorized to act. In any case the physician will make a written statement, two witnesses being present, of the responsibility of those who refused to give authorization and will immediately communicate it to the relevant authority. Article 40, inc. d and Article 43 of the CEDCMP are additional rules regulating this right.

IV. Exceptions

348. The right to give informed consent has the same exceptions as the right to information and the right to consent.

349. In this sense, if the patient is unconscious or the situation is life threatening, the operation does not require an informed consent because in these cases the physician is acting legally, protected by the state of necessity.

§5. Privacy

I. General Principle

350. Secrecy, confidentiality and privacy are essential rights that protect the internal and spiritual life of the human being. Emotions, feelings and experiences form the interior layer of a human being that is protected by the right to privacy understood as the control and disposition of the information that we have within our thoughts, data, experiences and biological structure (informative auto determination).[1] Violation of privacy happens by interference (unlawful knowledge) or divulgence (revelation) by someone of information or confidential facts related to another person.

1 Varsi, E., *Derecho genético*, 4th edition, Lima, Ed. Grijley, 2001, p. 229.

351. Every person has the right to access any information on health matters (Art. 5, LGS) available at the national state entities, as it is of public concern, unless this information can affect the personal and family privacy, his/her own image, national security or foreign affairs, or if this information refers to matters that are protected by the regulations on industrial property[1] (Art. 120, LGS).

1. DLeg. 823, (DOEP, 24 April 1996), General Law on Industrial Property.

352. Caution and confidentiality in patients' information are essential principles in Peruvian medical law. The right to privacy is presented as an inherent faculty of the user of medical care services (Art. 15, inc. a, LGS), and therefore every patient has the right to request the confidentiality of any information related to a medical act or to a clinic record (Art. 15, inc. b, LGS).

353. According to the medical confidentiality principle (Art. 25, LGS) any information obtained through the medical act must be used with discretion and caution as it is secret. Any health professional who might give away or facilitate information related to the medical act incurs civil, penal or ethical-administrative liability.

II. Preservation of Information

354. To ask for the secrecy of the information related to the medical act and the medical record is a special right that has the exceptions established by law (Art. 15, inc. b, LGS).

355. The CONTRASIDA (anti-AIDS) legislation establishes that the results of tests related to VIH/AIDS diagnosis and the information about the certain or

possible cause of contagion have a confidential character. The mentioned results and information can only be requested by the Public Ministry or the Judicial Power, only when circumstances justify the request and only for criminal investigation purposes (Art. 5).[1]

1. L. 26626, (DOEP, 20 June 1996).

III. Exceptions

356. There are some exceptions to this principle of privacy or secrecy (Art. 25, LGS): when the patient has given written consent; when it is required by the relevant judicial authority; when the information is used for academic or scientific investigation purposes and only if the information is given an anonymous character; when the information is given to the patient's relatives in order to benefit the patient only if the patient has not forbidden it expressly; in cases of illnesses and damages that are obligatory to be declared and notified only if the information is given to the health authority; when the information is given to an insurance company or finance administration company related to the service given to the patient only if the objective is reimbursement, benefit payment, fiscalization or audit; and whenever the information is necessary to maintain the continuity of the patient's medical care.

357. In the same way, information about the diagnosis of damages or wounds caused by a weapon, a bullet, a traffic accident or any other violent act that constitutes a criminal offence, and therefore is punishable, or when there are signs of an abortion having been performed (Art. 30, LGS), must be given to the police authority or to the Public Ministry at their request.

§6. Secrecy

I. General Principle

358. In its declaration of principles, the CEDCMP establishes that respect for a person's rights, imposed by medical secrecy and according to the Hippocratic oath, contributes to ensure the continuity of human medicine. Moreover, the World Medical Association's oath[1] states the physician's duty to keep and respect the secrets that he has been given. The physician pronounces this oath at the moment of being accepted as a member of the medical profession.

1. Known as the 'Geneva Declaration', adopted by the II General Assembly of the World Medical Association (that took place in Geneva in 1948).

359. Medical secrecy not only is one of the essential duties of the profession but it is also linked to the physician-patient relationship in that the relationship starts and develops with both parties' faith in it. When secrecy is maintained, the patient's trust is preserved.

360. Medical confidentiality or secrecy '... is the duty not to reveal those facts the physician has knowledge of by means of his profession and that may affect the patient's private area.'[1]

1. Ataz López, J., *Los médicos y la responsabilidad civil*, Editorial Montecorvo: Madrid, 1985, p. 177.

361. The information comprehended in the duty regarding medical secrecy is all the information that the physician has come to know during his professional practice, the facts, confidential or not, revealed by the patient as well as the discoveries made by the physician during the diagnosis and the treatment. In that sense, the LGS establishes that all information related to the medical act has a confidential character.

II. Exceptions

362. Privacy combines perfectly with the right to health protection and that is why it is a patient's right to request the confidentiality of all the information related to the medical act and to the medical records, with the exceptions established by law (Art. 15, inc. b, LGS). The duty to secrecy is no longer applicable when the patient gives consent, in cases of legal authorization, in cases of judicial mandate or if there is a just cause that so requires.

III. Professional Secrecy

A. General Aspect

363. Professional secrecy is a physician's right, but it is also a duty not to reveal the information that he has obtained through professional contact with patients.

364. Every person has the right to keep professional secrecy (Art. 2, inc. 18, Const.), and nobody may be obliged to reveal information that was acquired under professional secrecy or when he must or may keep the secrecy by law (Art. 220, CPC.).

B. Ethical Aspect

365. The CEDCMP regulates professional secrecy (Arts. 62 *et seq.*), and it establishes that the physician is obliged, by moral and practical considerations, to keep the secrets that have been given to him or that he has come to know during the medical act and are related to it. Professional secrecy obligates the physician to keep the secret within the limits established by law, being able to reveal them only by judicial mandate. When the physician knows of a pathological condition that might cause damage to third parties he must take the decisions that protect society, taking morality, discretion and human feeling into consideration.

C. Penal Aspect

1. Revealing Secrets Obtained from Work

366. From a punishment perspective, the CP identifies revelation of secrets obtained from work as a crime in that 'The person who reveals aspects of the personal or family privacy that have come to his knowledge through the activities or services offered to the aggravated person or through the person who put his/her trust in him, will be reprimanded with a penalty of deprivation of freedom for a period not longer than a year' (Art. 156, CP). This offence is recognizable because 'the behaviour is carried out by revelation of private aspects that the active subject has come to know without having realised any activity to know them, given that the information was given in the frame of the professional activity and was given directly to him by the passive subject. That is why it is also a case of abuse of confidence'.[1]

1. Bramont-Arias, L. and García, M., *Manual de Derecho penal (parte special)*, 2nd. ed., Lima: Editorial San Marcos, 1996, p. 179.

2. Professional Secrecy

367. Regarding professional secrecy the CP establishes that 'The person who has information, because of his/her state, office, job, profession or ministry, regarding secrets whose publication can cause damage, and reveals that information without the consent of the affected person, will be reprimanded with a penalty of deprivation of freedom for a period not longer than two years or with community service for between sixty and a hundred and twenty days' (Art. 165). The protected juridical item in this offence is the protection of a 'person's privacy atmosphere, particularly the one regarding professional secrecy'.[1]

1. Bramont-Arias, L. and García, M., *op. cit.*, p. 196.

IV. Notification of Criminal Acts

368. When in an emergency a physician assists a patient who is a victim of an action derived from or connected with, directly or indirectly, a criminal act, the physician has the obligation to communicate it to the relevant authorities, stating that he has acted according to his professional duty and therefore he must be exempted from any prejudice or trouble inherent to the police or judicial investigation.

369. This regulating principle is considered in legislation in such a way that when a physician gives medical assistance to anyone with injuries caused by a weapon, a bullet, a traffic accident or any other type of violent acts that constitute a punishable offence or when the person in question shows signs of a criminal abortion, he must inform the relevant authority of the facts (Art. 30, LGS). Moreover,

the information regarding the diagnosis of the injuries or damages involved in the above mentioned cases must also be given to the police authority or the Public Ministry at their request (Art. 25, LGS).

§7. Complaints

I. Right to Complain

370. The patient's right to complain is not expressly recognized in Peruvian medical law.

II. Classification of Complaints

A. Trade Union Complaints

371. Trade union complaints are presented to the CMP either by means of a report by the aggravated person or with an official letter by the relevant authority.

1. Complaint

372. The complaint is presented to a senior member of the CMP, who will pass the application on to the corresponding regional council. The regional council sends the information to its ethics committee for evaluation and in order to determine if the facts constitute an offence according to the CEDCMP. If that is the case, the complaint is passed on to the Committee for Litigious Issues and Disciplinary Procedures, which is an Honour Tribunal and will summon all parties, request reports, request expert reports from scientific societies, will take the reported physician's declaration as well as the declaration of the aggravated party into account and will eventually pronounce a verdict with a recommended sanction.

2. Resolution

373. This recommendation will be passed on to the Executive Committee of the regional council, which will evaluate the facts, will decide if they constitute an offence and will eventually give a resolution.

3. Appeal

374. The parties will receive a copy of this resolution and those affected in their right can appeal the resolution. This appeal is presented to the National Council.

4. Resolution

375. The authority involved is the Committee for Litigious Issues and Disciplinary Procedures that, following the same procedure described above, will analyze the facts and the resolution. If they agree with the resolution of the regional council they give their opinion to the National Council, and therefore confirm or revoke the resolution. With that the ethical disciplinary process of the CMP concludes.

B. Administrative Complaints

376. The Ministry of Health has competence regarding the area in which it is active (administration, health, sanitary activity). That is why it carries out administrative procedures (not ethical procedures) that can disciplinarily be passed on to the CMP.

C. Judicial Complaints

377. One can appeal to the Judicial Power in order to request indemnification of the damages caused by the bad medical *praxis* in the civil jurisdiction (damage lawsuit) or in the penal jurisdiction in cases of homicide, damages by guilt and other criminal offences derived from the medical activity (*see* Part I, Chapter 3, §2).

III. Cases and Statistics

378. The Ethics Committee of the CMP has statistics for the period 1997–1999 regarding complaints related to medical acts. The data shows that the claims presented are divided as follows: 72 per cent are patients against physicians; fourteen per cent are physicians against physicians; eight per cent are subordinate staff (nurses and paramedics) against physicians; six per cent are patient's relatives and physician's relatives against physicians.

379. According to a journalistic report,[1] the CMP receives approximately 200 claims a year regarding offences againts professional ethics and problems in medical practice. The majority of claims are complaints of patients who declare themselves victims of bad professional practice or of medical negligence (including the cases that ended in death of the patient). The CMP has solved 20 per cent of the cases presented between 1998 and 1999, and this has led the Ethics Committee to carry out an emergency plan that focuses on speeding up the process of dealing with the claims. A statistical report, made by the Office for Juridical Advice of the CMP, determines that by 31 July 1999, at the High Court of Lima, a total of 74 claims related to the malpractice of medicine are being dealt with by the Judicial Power. There are a total of 156 physicians involved in the claims.

Of these claims, 59 try to inculpate a health professional with homicide by guilt, fourteen relate to damages by guilt and in one case the imputation is omission to attend a patient, and in so doing incurring the offence of exposition and abandonment of people in danger.

1. 'The medical college yearly receives 200 cases of professional malpractice', in: *El Comercio*, 26 March 2000, Section A, p. 2. Moreover, in a newspaper article published a few months before it was said that the CMP yearly received 150 claims related to transgressions to the CEDCMP, *See* Portugal, R., 'Patients do have rights (be informed of the sanctions for professional malpractice and medical negligence)', in: DOEP, 4 August 1999, p. 10.

§8. Medical Record

I. Definition

380. The medical record is the biography of the patient's health condition. It is a document that supports the medical act and in which there is a statement of the general information regarding the patient, his symptoms, signs and health problems as well as the fundamental element that can be used to determine the diagnosis of the health problem.

II. Characteristics

381. The medical act must be supported by a written document, a medical record, which must be objective, true, exhaustive and sufficient, and where the practices and procedures applied to the patient to solve the health problem are stated.

382. The medical record is written under the responsibility of the physician, and therefore it must state the signature and register of the person who elaborates it. Moreover, all the details of the patient's health problem that have been obtained during the intake interview and the physical examination must also be stated, and they must clearly state the patient's medical state from the first medical visit. The therapy used may not be omitted and the terminology used must not be different from that established for the case.

383. Medical records are the health establishment's property, but the physician who elaborated them holds the intellectual property right. That is why those who request the use of medical records for investigation purposes must first have the express authorization of those holding the intellectual property right.

384. Any health care service institution must have a permanent Medical Audit Committee in charge of controlling the right elaboration, use and improvement of medical records.

385. As clearly shown by comparative law results, medical records have become the central axis of many civil liability sentences and constitute a probatory element of great importance.[1]

1. Galán Cortés, J., *op. cit.*, p. 23.

III. Effects

386. The patient has the right to receive a copy of his/her medical record (Art. 29, LGS).

387. In this regard, the LGS states (Art. 15) that every user of a health service has the right to request the secrecy of all the information related to the medical act and to his/her medical record, with the exceptions established by law (inc. b), and he/she has the right to receive the discharge certificate when a stay in the health establishment has ended and, if he/she so requires, a copy of the epicrisis and of his/her medical record (Art. 15, inc. i and Art. 44, LGS).

IV. Legal Framework

388. The legal framework of the medical record in Peru is very generic[1] and needs a regulation in order to control its content given that it has been determined that in practice most of the medical records have insufficient information, state subjective details (also called sensitive details), and abbreviations that are not recognized by the health authorities are being used, which implies a process of denaturalization of the medical record.

1. Arts. 15; inc. b and inc. i; 25, inc. c; 29; 44, LGS and Arts. 73–77, CEDCMP.

V. Medical Care Register

389. The general hospital regulation of the health sector[1] mentions that the Medical and Statistical Care Register Department is the organ in charge of the elaboration, provision, handling, use and preservation of the medical care registers, as well as of the collection and processing of statistics (Art. 111), and therefore every hospital is required to have a Register Department (Art. 112). Amongst the general tasks of this Department is the continuous update of each patient's medical record. It is also established that every patient must have a complete medical record, which will be filed according to the digit terminal system, and that the content of the medical record must be confidential (Art. 114). The medical record is the establishment's property and must be codified according to international classification (Art. 115).

1. DS.005-90-SA (DOEP, 25 May 1990).

VI. Epicrisis

390. This is part of the medical record and it is added when hospitalization has ended, that is when the patient has been healed, relieved or has died. It is a medical summary of the case and reflects all that has happened during the hospitalization period. It contains sufficient information and it is very useful for later use by the patient.

391. The epicrisis states the intake and discharge date, the information regarding the specific health problem (symptoms, signs and/or main problems), the auxiliary examinations involved, the cause of the problem, the treatment, the final diagnosis,[1] the achieved results and the surgical or obstetrical treatments given during the stay. In the epicrisis the reason for intake as well as all problems that still need to be diagnosed and treated must be stated, as well as all recommendations given at the intake interview. The resident physician must sign this document.

1. According to the medical audit manual *Manual de auditoría médica* (Instituto de salud del Estado de México, 19 December 1991, p. 24) the epicrisis must be exact, and the term probable or the description symptom or syndrome cannot be used. This document is used as a guide for the audit processes that are carried out at the different hospitals.

392. The main definitive diagnosis and the secondary diagnosis must be described according to the WHO international classification of illnesses.

VII. Discharge Certificate

393. Even though the discharge certificate is not part of the medical record, it seems necessary to mention that it is an administrative document that the health establishment hands out when the patient has completed his/her hospitalization or has decided to leave.

394. In this respect, at discharge of the patient, the health establishment's responsible person must give the patient or his/her representative the discharge certificate with information including the diagnosis at the intake, the procedures followed, the discharge diagnosis, the prognosis and the recommendations regarding the problem that led to intake (Art. 44, LGS).

395. The discharge certificate is signed by the treating physician and states the patient's name, the diagnosis, the treatment, the obtained results (healed, improved, stabilized, worsened, leave, only diagnosis or dead) and the recommendations.

Chapter 2. The Physician-Patient Relationship in Specific Terms

396. For the LGS (Art. V, according to Art. 4, Const.) disabled people, children, adolescents, mothers and socially abandoned elderly people are subject to special rights in health care. In that sense the state must care for the general welfare (in terms of health) of these human beings who appear to form vulnerable groups given their physical or mental characteristics.

§1. The Minor Patient

I. General Information

397. According to our civil legislation a person who has not yet reached the age of eighteen is a minor (Art. 42, CC) and he/she enjoys the rights he/she has been given as such.

II. Legal Framework

A. Children and Adolescents Code

398. The CNA[1] states that a person is a child from the moment of conception until the age of twelve and an adolescent from the age of twelve until the age of eighteen.

1. DL. 27337, Código de los niños y adolescentes (Children and Adolescents Code) (DOEP, 7 August 2000).

399. Within this legal logic, a conceived being – conceived but not yet born-is a child and therefore enjoys the protection given by the legislation, and there is even special protection for the pregnant woman in order to guarantee the full development of the pregnancy and of the conceived being.[1]

1. 'Every woman in labour has the right to receive the necessary medical attention in any health establishment, and all health establishments without exception are obliged to provide the necessary medical attention as long as there is a life threatening risk for the mother or the child. After the delivery reimbursement of the costs will take place according to the case evaluation carried out by the relevant Social Service and payment will be made as stated in the Regulations. Accredited homeless people are totally exempt of any payment'. L. 27604 (DOEP, 22 December 2001), Art. 2. Medical attention at delivery in health establishments.

   Diagnosis or therapeutic procedures that need abdominal exposure of a pregnant (or possibly pregnant) woman must be avoided at all times unless there are strong clinical reasons to proceed, in which case all the protective measures to reduce the exposition dose given to the fetus or embryo must be taken. Reglamento de Seguridad Radiológica (Radiological Safety Regulation), Art. 39 of the DS. 009-97-EM, (DOEP, 29 May 1997).

400. Every child and every adolescent has the right to complete health care and,

in cases of illness, physical or mental disabilities, or drug addiction, he/she has the right to treatment and a rehabilitation process in order to facilitate his/her participation in the community according to his/her capacities (Art. 21).

B. General Health Law

401. The LGS, when dealing with the patient's prior consent to medical treatment, states that in cases where the legal representatives of those patients are unable or relatively unable (this is the case with patients older than sixteen but younger than eighteen, mentally retarded and those suffering from a mental damage that prevents them from expressing their free will) or refuse to give consent for medical treatment for the person they are in charge of, the physician or the health establishment will inform the judicial authority in order to make a statement of the actions that would be necessary to safeguard the patient's life and health (Art. 4).

C. Special Legislation

402. There are laws that forbid a minor's participation in medical acts such as the Regulation of the Law for Human and Corpse Organ and Tissue Transplantation,[1] which establishes that it is a requisite for performing the extraction of organs for transplantation from a living person to another that the donor is not a minor (Art. 15).

Moreover, even though the law declaring the taking, donation, conservation, transfusion and provision of human blood, an issue of public order and national interest,[2] does not expressly establish that a minor may not be involved, a supplementary application of the regulations on organ and tissue transplantation requires the consideration of not being a minor as a requisite for donation, given that blood is a tissue of the specialized conjunctive type (where cells are represented by erythrocytes, leucocytes, platelets and blood plasma). In medical practice certain limits for donation have even been laid down: a male can only give blood if he is between eighteen and 55 years old, a female if she is between eighteen and 50 years old.

1. DS. 014-88-SA, Reglamento de la ley de transplante de órganos y tejidos de cadáveres y personas, (DOEP, 31 May1988).
2. L. 26454, (DOEP, 25 May 1995).

§2. The Mental Patient

403. For the CC a mental patient can be considered totally unable (if he/she does not have mental clarity, Art. 43, inc. 2) or relatively unable (if he/she is mentally retarded or damaged to an extent that he/she is not able to express his/her free will, Art. 44, inc. 2 and 3, respectively). In these cases, the psychiatric patient's legal representatives must give their prior consent to medical or surgical treatment. If they refuse to give their consent, the physician or the health establishment must

inform the relevant judicial authority in order to make a statement of the actions that would be necessary to safeguard the patient's life and health (Art. 4, LGS).

404. The Constitution (Art. 7) states that anyone unable to take care of himself because of a physical or mental deficiency has the right to respect for his/her dignity and to legal protection, attention, readaptation and security system.

405. Following the WHO guidelines, in which the concept of mental health is wider than the concept of mental illness, the LGS states that every person has the right to recuperate, rehabilitate and promote his/her mental health, and to deal with problems such as alcoholism, drug addiction, psychiatric problems and family violence (Art. 11). Moreover, it states the state's responsibility to monitor, attend to and take care of the population's malnutrition and mental health problems, environmental health problems, as well as health problems affecting the disabled, children, adolescents, mothers and socially abandoned elderly people (Art. V of the Preliminary Title, LGS). It is also stated that any physically, mentally or emotionally disabled person has the right to treatment and rehabilitation. The state gives preferential health care attention to children and adolescents and also to people who suffer from severe incapacity and are also suffering from another illness (Art. 9).

406. The General Law for Disabled People[1] states that a disabled person is a person who suffers from evident incapacities that include the loss of his/her physical, mental or emotional functions implying the decrease or lack of the ability to carry out an activity, who are limited in their functioning and have therefore less opportunities to participate in society (Art. 2). In order to achieve the objective and the application of the law, the National Committee for the Integration of Disabled People (CONADIS) has been created. It is a public and decentralized organ of the Ministry for the Promotion of Women and Human Development. Amongst its main tasks are the following: to formulate and approve of a policy for prevention, to give attention to and assist the social integration of disabled people; to inform, promote and support the formulation and implementation of preventive, educational, rehabilitation and social integration programmes for disabled people. The disabled person has the right to have access to the health services (Arts. 5 and 10). The condition of being a disabled person and the certificate that accredits this condition are given by the Ministry of Health and the Ministry of Defence and Internal Affairs through their medical centres (Art. 11). In terms of health, the preventive measures focus on avoiding the development of physical, mental and emotional deficiencies and that existing deficiencies should lead to further negative physical, psychological or social consequences. The CONADIS, in execution of its prevention policy and in collaboration with the corresponding public institutions, carries out the necessary scientific investigations in order to detect the causes of disability in the different areas of the country (Art. 14 *et seq.*).

1. L. 27050, (DOEP, 6 January 1999).

§3. The Dying Patient

407. In Peru there is no specific legislation regarding the dying patient. Physicians follow their diagnosis and classify the patients according to the gravity of the illness as extremely ill or dying, depending on certain principles.[1]

1. Interview with Dr. Juan Carlos Meza García, Chief of the Intensive Care Unit 'cirujano mayor Santiago Tabarra' of the Peruvian Navy Medical Centre, 5 August 1999.

I. Extremely Ill Patient

408. The extremely ill patient is the person who is seriously ill but can recover and is treated in the Intensive Care Unit (ICU) of the health establishments.

409. The ICUs can be: medical, surgical, paediatric, coronary, neurosurgical, gynaecological, and so on according to the corresponding specialty. The number and specialty of the ICUs vary in each health establishment. In the ICUs there are three types of patients: extremely ill patients, patients who can recover, and dying patients who are progressively reaching their final phase.

II. Dying Patient

410. The dying patient is the patient who suffers from an illness or sickness that has developed to a point where recovery is not possible.

411. In these cases, a Medical Committee is called in to determine the dying condition. This type of patient only receives palliative measures such as painkillers to reduce the pain. That is to say, they do not receive intensive care.

Chapter 3. Specific Activities

§1. Abortion

I. Concept

412. Regarding the beginning of life it must be stated that the civil law's criterion differs from that of the penal law. In the first place, human life starts at conception (Art. 1 CC) while for the second, human life starts at the nidation of the embryo.[1]

1. Bramont-Arias, L. and García, M., *op. cit.*, pp. 38 and 75.

413. An embryo is a human life in the basic stage of its biological development. From a juridical point of view it is a conceived being, not a natural person, and therefore the aggression against its life is not considered a homicide but the criminal offence of abortion.

II. Definition

414. Abortion is the destruction of the conception product by one of two means prior to the end of the pregnancy, either by violent expulsion of the foetus or by its destruction within the expectant mother's uterus.[1]

1. Freyre, R., *Derecho penal*, 2nd edition, Volume I, Special Part, Lima: Eddili, 1986, p. 251.

415. According to the valid legal framework abortion is not considered a family planning method.[1]

1. The DLeg. 346. National Policy on Population Law, (DOEP 5 July 1985) and Programme for Family Planning Regulations, RM. 465-99-SA/DM (DOEP, 25 September 1999).

III. General Aspects

416. The protected juridical good is the new being's life during the pregnancy, even though on a secondary level we find other goods such as the mother's health or life and, on a lower level, society's demographic capital.[1]

1. Hurtado, J., *Homicidio y aborto*, Lima: Sesator, 1982, p. 185. A jurisdictional criterion from March 1980 stated that: '1) In a delict of abortion the aggravated subjects are the expectant mother, her heirs or third parties. 2) The Public Ministry intervenes because abortion is a punishable offence and in order to safeguard social interest. 3) The intervention of the Republic's Attorney General in that the State does not have the condition or aggravated subject', in: *Anales judiciales*, 1979-1980-1981, Supreme Court of the Republic, Lima, Vol. LXXI, 1988.

417. In Peru the legal concept for the punishment of abortion can be found in the

Constitution (Art. 2, inc. 1) where it is stated that 'Every person has the right to life', in the CC (Art. 1) that states 'The human being is subject to rights from his/her birth. Human life starts at the moment of conception', in the National Policy on Population Law[1] (inc. 1 of Art. IV) that mentions 'The National Policy on Population guarantees the human being's right to life. The conceived being is subject to rights from the moment of conception', similarly the LGS (Art. III of the Preliminary Title) states that 'every person has the right to have his/her health protected in the terms and conditions established by the law. The right to health protection is non-renounceable. The conceived is subject to rights in health related issues.'

1. DL.346, (DOEP, 5 July 1985).

418. The CP adopts a system of abortion incrimination but also introduces an indication system when considering in which cases there is an offence of abortion and the penalties that apply to them.

419. By ethical principles it is by all means forbidden for a physician to suggest or practise an abortion or any other form of pregnancy interruption, except in the cases allowed by law. Those physicians who break the law fall within the sanction system established by the law.

IV. Legal Framework

420. In Peru abortion has been a criminal offence since the first CP (1863) and it was in 1924, in the second CP, when increasing the penalties and adding therapeutic abortion as an illegal practice was legally considered.

421. In 1991, when the present CP was approved, abortion is considered a criminal offence under the chapter 'Criminal offences against life, body and health', punished with a penalty of deprivation of freedom or alternatively a penalty of community service.

422. The LGS indicates that a physician who attends to a person showing signs of having had an abortion must inform the relevant authority about it (Art. 30).

V. Morphology of the Offence

423. The different types of abortion considered by the CP are: self-abortion (Art. 114), consented abortion (Art. 115), non-consented abortion (Art. 116), abusive abortion (Art. 117), preterintentional abortion (Art. 118), therapeutic abortion (Art. 119) and special abortion (Art. 120).

A. Self-abortion

1. Protected Juridical Good

424. The protected juridical good is the embryo's life during the pregnancy.

2. Subjects

425. The active subject is any pregnant woman. The passive subject is the embryo during the prenatal period.

3. Constitutive Elements

426. The constitutive elements of this offence are: the pre-existence of a pregnancy, the use of means directed at provoking abortion and used by the expectant mother or by another person with the expectant mother's authorization or incitation, death of the embryo, relationship of causality and wilful intent.

4. Penalty

427. The penalty of deprivation of freedom will be no longer than two years or a community service of 52 to 104 days.

B. Consented Abortion

1. Protected Juridical Good

428. The protected juridical good is the embryo's life during the pregnancy.

2. Subjects

429. The active subjects are the expectant mother and the person that executes the abortion. The passive subject is the embryo during the prenatal period.

3. Constitutive Elements

430. The constitutive elements of this offence are: the pre-existence of a pregnancy, the use of means directed at provoking abortion with the consent of the expectant mother, execution of the abortion and wilful intent.

4. Aggravating Factors

431. The aggravating factor is the death of the pregnant woman, when the active subject could have foreseen it. Depending on the person who executes the abortion this aggravating factor can lead to an increased penalty.

5. Penalty

432. This offence is punished with a penalty of deprivation of freedom for a period not shorter than one year nor longer than four years. The aggravating factor increases the penalty to a period not shorter than two or longer than five years.

C. Non-Consented Abortion

1. Protected Juridical Good

433. The protected juridical good is the embryo's life during the pregnancy and the expectant mother's right to freedom.

2. Subjects

434. The active subject can be any person except for the expectant mother. The passive subject is the embryo during the prenatal period as well as the expectant mother.

3. Constitutive Elements

435. The constitutive elements of this offence are: the pre-existence of a pregnancy, the use of means directed at provoking abortion with the consent of the expectant mother so that a third person executes the abortion, and wilful intent.

4. Aggravating Factors

436. The aggravating factor is the death of the pregnant woman, when the active subject could have foreseen it. Depending on the person who executes the abortion this aggravating factor can lead to an increased penalty.

5. Penalty

437. This offence is punished with a penalty of deprivation of freedom for a period not shorter than three or longer than five years. The aggravating factor increases the penalty to a period not shorter than five or longer than ten years.

D. Abusive Abortion

1. Protected Juridical Good

438. The protected juridical good is the embryo's life during the pregnancy.

2. Subjects

439. The active subject is the health professional, and it must be stated that the law requires a professional degree (students or graduates not included). The passive subject is the embryo during the prenatal period.

3. Constitutive Elements

440. The constitutive elements of this offence are: the pre-existence of a pregnancy, the use of means directed at provoking abortion, science abuse on the side of the active subject, execution of the abortion and wilful intent.

4. Penalty

441. This offence is punished with a penalty of deprivation of freedom the length of which depends on whether it concerns a consented abortion (*see infra* para. 432) or a non-consented abortion (*see infra* para. 437), and depending on the motives the penalty can include disqualification for the professional involved.

E. Preterintentional Abortion

1. Subjective Nature of the Figure

442. The preterintentional abortion is a form of guilt constituted by the combination of wilful intent in the action (use of violence) and guilt in the result of the action (abortion as a result of lack of precaution).[1]

1. Freyre, R., *op. cit.*, p. 292.

2. Protected Juridical Good

443. The protected juridical good is the embryo's life during the pregnancy and the expectant mother's life, health and freedom.

3. Subjects

444. The active subject can be any person. The passive subjects are the embryo or foetus during the prenatal period and the expectant woman.

4. Constitutive Elements

445. The constitutive elements of this offence are: the pre-existence of the pregnancy, that the pregnancy is noticeable or known to the agent, that the agent uses violence, that the violence used is not directed at provoking the abortion, that the abortion, even though foreseeable, has not been foreseen by the agent, that abortion is executed.

5. Penalty

446. This offence is punished with a penalty of deprivation of freedom for a period not shorter than two years or a penalty of community service for a period of 52 to 104 days.

F. Therapeutic Abortion

1. Definition

447. Therapeutic abortion is the interruption of pregnancy that a physician performs with the expectant mother's consent in order to save her life or prevent her from suffering a serious and permanent health problem.

2. Protected Juridical Good

448. The protected juridical good is the pregnant woman's life and health.

3. Requisites

449. To carry out this abortion the following requisites must be met: the pre-existence of pregnancy, that the pregnancy puts the mother's life or health at risk, consent of the expectant mother or her representative, that the abortion is the only method to save the pregnant woman's life or health, that the abortion is performed by a physician.

4. Penalty

450. This offence is not punishable.

G. Special Abortion

451. The Peruvian CP provides for the attenuation of abortions by ethical or eugenic considerations.

1. Sentimental Abortion

452. The abortion takes place when the pregnancy is a result of a rape or non-consented insemination.

a. Protected Juridical Good

453. This penal type protects fundamentally the woman's procreation freedom.

b. Constitutive Elements

454. To carry out this abortion the following requisites must be met: the pre-existence of pregnancy, that the pregnancy is a result of rape or non-consented insemination that happened outside marriage, that the facts have been reported or publicly investigated and wilful intent.

2. Eugenic Abortion

455. This abortion is performed when the expected being has a malformation or defect, either physical or mental.

a. Protected Juridical Good

456. This penal type protects the woman's procreation freedom and her eugenic reproductive capacity.

b. Constitutive Elements

457. To carry out this abortion the following requisites must be met: the pre-existence of pregnancy, possibilities that the expected being has serious physical or mental defects, that there is a medical diagnosis.

3. Penalty

458. In both cases (sentimental and eugenic abortion) the punishment is a penalty of deprivation of freedom for a period not longer than three months. In practice, it is impossible to punish the active subject because the police investigation and penal instruction take much longer than this period.[1]

1. Bramont-Arias, L. and García, M., *op. cit.*, p. 90.

VI. Legal Void

459. The elimination of embryos[1] *ex útero* (euphemistically called discarding) is not a manipulation case but a direct attack against human life and is therefore illegal and against the law. The discussion focuses on the following question, 'Is eliminating embryos considered a criminal offence?' If that is the case, then it would be considered an abortion *ex uterum*, *in vitro* or *micro-abortion* because there is a variation in the penal type that must protect not only the interruption of the pregnancy but also the elimination or discontinuation of the embryonic development. Another criterion (extreme viewpoint) is that, not having a pregnancy but having human life the embryo is a person and therefore we are dealing with the configuration of a homicide.

1. Varsi, E., *Derecho genético*, *op. cit.*, pp. 275–277.

460. The criteria can vary but the real offence is undoubtedly juridical.

An approximation to the legal regulation on the subject in our area was provided in the project of the present CEDCMP where it was stated that 'It is a serious ethical offence to cause, directly or indirectly, the death of a human embryo or foetus, especially when the finality is to obtain genetic material, parts of cells, tissues or organs' (Art. 41). Note that the article stated the death of a human embryo or foetus generically, independently of the place where it is, be it *in* or *ex útero*, and therefore the elimination of embryos or foetuses is consequently punishable with a special penalty (serious offence) and it differs from the offence of abortion regulated by the same project of the CEDCMP in a special and independent way (Art. 48). Unfortunately, the present CEDCMP does not state any regulation on the subject.

In comparative legislation the so-called biological offences are stated, which are offences caused by genetic and gynaecologic manipulation and where the elimination of embryos is expressly sanctioned, cases that do not have a solution yet in Peru.

§2. Sterilization

I. General Aspects

461. Every person has the right to freely choose the contraception means of his/her preference and to receive, prior to the prescription or application of any con-

traceptive method, the correct information about the available methods, their risks, contra-indications, precautions, warnings and physical, physiological or psychological effects that the use or application of the method can imply. For the application of any contraceptive method the patient's prior consent is needed. In the case of definitive methods, the consent declaration must be stated in a written document (Art. 6, LGS).

II. Voluntary Surgical Contraception

462. The voluntary surgical contraception (AQV) or sterilization is a permanent contraceptive method, which consists in an elective surgical operation of intermediate complexity in women (hysterectomy or salpingectomy) and in minor surgery in men (vasectomy).

463. If the user decides to choose the AQV: he/she must be informed that it regards an elective procedure and under no circumstance can it be considered an emergency procedure. A reflexive period must be established, which extends from the moment of informed decision, after the counselling and orientation sessions, to the surgical operation, and which cannot be shorter than 72 hours. Before making an informed decision the user must be informed that he/she is free to choose between temporary and permanent methods. The AQV is a surgical procedure and it implies risks and benefits. Its effects are permanent.

464. In cases where pregnancy is diagnosed because of a failure of the AQV and the user has complied with all post-surgery indications, the Family Planning Programme will solidarily take over the costs of prenatal control, delivery service and newborn child care services in the Ministry of Health's health establishments.

A. Voluntary Surgical Contraception in the Female

465. It is definitive and must be considered irreversible. The provider must necessarily be a qualified physician. Infrastructure and equipment is necessary, hence the need exists to carry out the surgery in qualified establishments. During the operation an anaesthesiologist must be available in the establishment or a physician trained in anaesthesiology. After the surgery the patient must rest for seven days.

B. Voluntary Surgical Contraception in the Male

466. This is a permanent contraceptive method. It is an elective surgical operation, considered a minor surgical procedure, directed at tying and sectioning the vas deferens of the man. It is not necessary to comply with any essential requisites of an operating theatre, therefore it is not necessary to have a specific qualifying process. The patient must rest for five days.

III. Legal Framework

A. National Policy on Population Law

467. The National Policy on Population Law[1] (Art. VI) excludes abortion and sterilization as family planning methods.

1. DLeg. 346 (DOEP 5 July 1985). This law establishes the basic regulations of the National Policy on Population, the objective of which is to plan and execute the state actions regarding the volume, structure, dynamics and distribution of the population in the national territory.

468. However, this was modified[1] in such a way that only abortion was excluded as a family planning method and therefore this law, even though not expressly establishing it, accepts sterilization as a contraceptive method because according to the Constitution 'nobody is obliged to do what the law does not command, nor is he/she prevented from doing what the law does not forbid' (Art. 2, inc. 24, literal a).

1. L. 26530 (DOEP, 10 September 1995), modifies Art. VI of the National Policy on Population Law.

B. Sentence of the Constitutional Tribunal

469. On 6 December 1996, 30 Republic's Congress members lodged an action of unconstitutionality against the Law L. 26530 before the Constitutional Tribunal. They based their demand on the fact that the only objective of the law was to modify Article VI of the National Policy on Population Law and with it surgical sterilization was added to the authorized family planning methods.

470. The sentence of the Constitutional Tribunal (Exp. N. 014-96-I/TC, of 28 April 1997), declared that irreversible surgical sterilization is not considered a family planning method nor authorized by the contested law, and therefore the demand was declared unproceeding given that it was directed at repealing a legal precept that, according to the Tribunal, was non-existent. According to the singular vote of Magistrate Delia Revoredo de Mur, the repealed law, by eliminating the prohibition of the previous law regarding sterilization includes surgical sterilization amongst the authorized family planning methods.[1] It must be stated that the Constitutional Tribunal's ruling concerns the form and not the content, given that the lodge action attempted to repeal a legal precept that according to the Tribunal was non-existent (the consideration that irreversible surgical sterilization is a family planning method). However, we cannot deny the contraceptive nature of the sterilization and must remark that sterilization is indeed considered a contraceptive method.

1. *Jurisprudencia del Tribunal constitucional*, tomo II, periodo 96-97, Lima: Gaceta jurídica Ed., 1998, pp. 992–998.

C. Regulations of the Family Planning Programme[1]

1. Objective of the Regulations

471. The objective of these regulations is to make the broadest source of information and the services with the highest quality available to all Peruvian men and women for them to achieve their reproductive goals. The aim is to guarantee free choice of reproductive options, to promote reproductive health and guarantee indiscriminate access to reproductive health care and to family planning, and to promote widespread coverage of the reproductive rights of the population.

1. RM. 465-99-SA/DM (DOEP, 25 September 1999).

2. Rights of the Users of the Family Planning Service Centres

472. Every person has the right: to privacy, to receive complete and updated information, to know the identity of the health service providers, to be assured of the care for and protection of his/her personal safety, to be able to communicate during his/her stay in hospital, orally or in written form, with the people he/she has chosen, to make decisions regarding the treatment without any kind of pressure, not to be subject to any procedure without his/her prior informed and voluntary consent, to reject a treatment at any given moment, to be treated respectfully, with dignity and considering his/her values and beliefs, to claim and receive indemnification for any damages caused by imprudent, negligent or clumsy performance of the health staff.

3. Reproductive Rights

473. Every person has the right: to enjoy the highest possible level of physical and mental health; to access, under equal conditions for men and women, the services that include family planning and reproductive health; to be attended regarding reproductive health without any kind of coercion; to decide freely and with responsibility on the number and timing of his/her children and to be provided with the necessary information, education and means to be able to achieve this objective; to have these principles guaranteed by the health institutions at all the various stages of the care process.

4. Responsibilities of the Users of the Health Services

474. The responsibilities of the users are: to give, according to their possibilities and knowledge, all the information regarding their background and health condition that is necessary to arrive at the right diagnosis and health plan; to follow the recommendations and advice given by the health professional in order to achieve health self-care, recovery and rehabilitation.

5. Dispositions for Care Provision in Family Planning Service Centres

475. A person's free choice of and informed access to the chosen contraceptive option will be guaranteed. Under no circumstance will there be application of a method, be it temporary or definitive, without the user's prior free and informed consent.

476. After the orientation and advice period and in order to receive a contraceptive method, even a definitive one, the informed and personal decision of the user is enough. Authorization of the partner (wedded or not) is not necessary.

477. Under no circumstance will the establishment offer material goods, presents or services as a stimulating factor to convince the user to use one specific contraceptive method, be it temporary or definitive.

478. The adolescent population at risk of an unwanted pregnancy or of suffering from a sexually transmitted sickness (e.g. AIDS) will have access to contraceptive methods provided that: he/she has been properly informed, is older than sixteen years of age and sexually active.

D. General Health Law

479. The LGS states that regarding definitive contraceptive methods the patient's consent must be a written document (Art. 26).

E. Ethic Norms

480. The CEDCMP Project, in Chapter VI, referred to as family planning, established that the physician, without coercion, could prescribe diets or methods to lengthen the period between pregnancies, respecting the will and freedom of the patient at the moment of the choice (Art. 40). Using methods to avoid fertilization contrary to the person's will was considered a serious ethical offence (Art. 50), as was participating in the decision making, designing or scheduling process of campaigns aiming at eliminating the reproductive capacity of a national, ethnical, social or religious group (Art. 51).

The varied policy on family planning that is carried out in practice seems to have determined the non-consideration of these regulations in the present CEDCMP.

IV. Non-Consented Sterilizations

481. According to some newspaper articles and broadcasted documentaries (on radio and television) there have been practices of sterilization amongst the female population (tubal ligation) without the patients' consent, which have led to the death of some patients as a result of complications in their health recovery process

and long hospital stays as a consequence of the surgical operations they had undergone in different departments of the country.

482. That is why the Executive Committee of the Public Ministry has appointed a public prosecutor *ad hoc* in order to investigate the reports regarding the mentioned practices of sterilization of the female population.[1]

1. Res. 028-98-MP-CEMP, (DOEP, 14 January 1998).

§3. *In Vitro* Fertilization

I. General Aspects

483. From a juridical point of view, medically assisted reproduction techniques are methods to make up for human infertility.

484. They are classified in: artificial insemination (AI), extra-corporeal fertilization (EF) with its variations: embryo transfer (ET), intratubal gamete transfer (IGT), intratubal embryo transfer (IET), and the so-called intracytoplasmatic sperm injection (ICSI). The ways in which they are realized are: intramarital, when genetic material (ovum and/or sperm) from the spouse or partner is used; supramarital, when genetic material of a donor is involved; and mixed, when genetic components from two or more males are involved.[1]

1. Varsi, E., *Derecho Genético*, *op. cit.*, p. 258.

II. Legal Framework

A. National Reality

485. In Peru there is no uniform legislation to regulate medically assisted reproduction techniques.[1]

1. Varsi, E., *op. cit.*, p. 304.

486. The LGS only states the basic guidelines (Art. 7) in which it is considered that:

Every person has the right to procreation and can resort to assistance methods. As a rule, the reproduction techniques area means to treat infertility and achieve procreation. In this way, their improper use is avoided and they are only applied with a therapeutic objective in cases of reproductive problems.

The biological parents' prior written consent is necessary for all practices of assisted reproduction.

These considerations have led to the existence of the so-called right to assisted procreation.

The LGS has given basic guidelines that still need further development and deal with issues such as the rights of the conceived being, the consent of the couple who

has access to these techniques, the insemination of single women, the determination of the father-son relationship, amongst other issues.

B. Bases for a Juridical Regulation

487. Even though these issues have been considered in academic proposals[1] and in different draft laws[2] at a national level, it is important to rescue the 'Bases for a legislation on medically assisted reproduction techniques' enacted by the Investigation Centre of the Faculty of Law and Political Sciences of the Lima University,[3] which deals with the following:

- Regulation of the administrative and sanitary aspects as well as the authority's control over the health establishments where the reproductive techniques are carried out, and establishment of the sanctions to be applied in case the dispositions are not complied with.
- Respect for the informed consent and make sure it is a written document.
- A guarantee that the medically assisted reproduction techniques are applied only when other fertility treatments have failed.
- The sanitary authority will analyze the gametes to be used in the reproductive techniques in order to avoid transmission of genetic defects or illnesses. The use of anomalous gametes is forbidden and will be sanctioned.
- The health centres will keep the biological data of the gamete donors.
- Personal files are confidential and will only be revealed by judicial order.
- Fertilization of a married woman with donor's sperm will only be realized with the prior consent of her husband, who will not be able to claim his paternity.
- The donor's paternity may not be investigated.
- The sperm donor may not obtain information regarding the woman who has been fertilized with his biological material.
- *Post mortem* insemination is forbidden except when the sperm has been assigned to a sperm bank.
- Surrogate motherhood does not have any effect. Maternity is established by delivery.
- In cases of embryo cryopreservation, authorization of both sperm and ovule donors must be taken into account in order to proceed with the transfer to a woman other than the donor.
- All practices contrary to human dignity (cloning, chimeras, hybrids and gamete and embryo commerce) are strictly forbidden.

1. 'Anteproyecto de ley sobre técnicas de reproducción asistida', in: Varsi, E., *Derecho genético*, 4ta. edición, *op. cit.*, pp. 353 *et seq.* 'Bases para una legislación sobre técnicas de reproducción asistida', in: Mosquera, C., *Derecho y genoma humano*, Lima: Ed. San Marcos, 1997, pp. 113 *et seq.* 'Planteamientos para la regulación jurídica de las técnicas de reproducción asistida en el Perú', in: Rodríguez-Cadilla, R., *Derecho Genético. Técnicas de reproducción humana asistida, su trascendencia jurídica en el Perú*, Lima, Ed. San Marcos, 1997, pp. 221 *et seq.*
2. This project was presented to the Committee for the Reformation of the Civil Code of 1984, Democratic Constitutive Congress, in: DOEP, on 7 January 95; Special committee in charge of elaborating the draft law for the reformation of the Civil Code in:

http://www.congreso.gob.pe/congreso/199798/codigo/CODIGOS1htm.

3. 'Bases para una legislación sobre técnicas de reproducción humana asistida', in: *Cuadernos de Derecho*, Lima: Universidad de Lima, Facultad de Derecho, Centro de Investigación Jurídica, 1992, No. 1, p. 60.

III. Surrogate Motherhood

488. There is a tacit prohibition regarding extracorporeal insemination with a donor's ovule (ovum donation), regarding alien embryo donation (embryo donation) and regarding surrogate motherhood, given that the LGS (Art. 7) states that the condition of the genetic mother must match the condition of the expectant mother.

However, the LGS has not dealt with the substitute mother, a concept arising in those cases where a woman accepts to be inseminated with genetic material of another woman's husband with the purpose of handing over the child once it has been born. In these cases, as we see, genetic maternity matches gestating maternity, but it is an act that does not comply with the law nor with moral principles and it is nevertheless not considered illegal, nor a crime nor an offence and therefore highlights a normative void. The tacit prohibition stated in the LGS does not apply here.

IV. Cloning

489. Taking the essential cloning prohibition generically mentioned in the Children and Adolescents Code that '... guarantees the life of the conceived one, protecting it against experiments or genetic manipulations that are contrary to its integrity ...' (Art. 1) and the special rule stated in the General Health Law that 'forbids insemination of human ovules with purposes other than procreation, as well as cloning of human beings' (Art. 7) into account, cloning has been penalized in Peru.

As they are dealing with acts considered crimes, these cloning prohibitions are expressly sanctioned through the Penal Code[1] in that it is stated that 'Whoever uses any genetic manipulation technique in order to clone human beings will be punished with deprivation of freedom for a period not shorter than six nor longer than eight years and disqualification according to Article 36, clauses 4 and 8' (Art. 324).

However, the legal solution is not only to restrict, forbid or punish cloning but also to give way to scientific development as long as human life is respected. For example, investigation on tissues with non-embryonic mother cells that can be obtained from skin, spinal cord, liver or adipose tissue should be promoted and investigation on foetuses and embryos should be limited.

1. Modified by the law Ley 27636 (DOEP, 16 January 2002) which incorporates the Penal Code in Chapter XIV-A Crimes against Human Life, and Chapter V Genetic Manipulation.

§4. Prenatal Diagnosis

I. General Aspects

490. These techniques, aiming at determining any complaints that may be affecting the embryo during the pregnancy, are of great value for the medical profession and could represent a real maternity service. However, contrary to the fundamental principles of medical deontology, they have become some sort of techniques for foetal quality control and consequently they are used for pregnancy termination in cases where the devised conditions are not met,[1] which denaturalizes their essential objective of protecting the conceived being (embryo or foetus).

1. Rodríguez-Cadilla, R., *op. cit.*, p. 186.

491. In practice the following techniques are used: echography, determination of serum alpha-foetoprotein level (AFP-sm), amniocentesis, foetoscopy and chorionic villus sampling, amongst other techniques. Even though prenatal diagnosis is used during the embryo-foetal period, it is important to remark that it is also being used for embryonic analysis before the implantation (pre-implantation diagnosis).

II. Legal Framework

492. In Peru there is no express regulation regarding prenatal diagnosis as a method to investigate the possible genetic problems in embryo-foetal development and the application of the corresponding treatments.

493. Although the CNA forbids genetic manipulation (Art. 1), the option to make a diagnosis regarding a conceived being, or to apply a genetic therapy (be it preconceptive, pre-implantation or prenatal) exists, which is very positive because it provides the possibility to prevent an embryo or foetus which has been diagnosed as having genetic malformation from suffering that malformation when application of a preventive treatment is feasible.[1] This is according to the principle in the LGS which states that a conceived being is subject to rights in the area of health (Art. III, LGS) and therefore has the right to protection of its whole well-being, be it in a preventive or curative way.

1. Varsi, E., *Derecho genético*, 4th edition, *op. cit.*, pp. 347–348.

§5. Psycho Surgical Interventions

I. Basic Aspects

494. They are scientifically known as functional neurosurgeries[1] because they are operations on the brain functions.

1. Interview with Peruvian neurologist Dr. Humberto Hinojosa, 23 July 1999.

495. They represent a wide medical area and are generally divided in stereotaxic surgery and psychosurgery. This last type (related to cingulotomy) regards affective disorders (schizophrenia, compulsive depressive neurosis, anxiety neurosis, etc.) and has been the most controversial and has generated an ethical discussion about its applications. There is also the amygdalectomy, a surgical procedure on the amygdala (used in cases of complex partial epilepsy or temporal lobe epilepsy, when it does not respond to medical treatment, and in cases of refractory epilepsy), which is realized through a temporal lobe lobotomy.

496. Those against psychosurgery call it lobotomy, a practice that is not longer in use (except in cases of frontal lobe tumours or complete epilepsy).

II. Legal Framework

497. In Peru these operations are carried out without any kind of ethical or legal restriction. The pillar on which the legal condition of these interventions rests is the old principle saying that the brain is a temple and therefore untouchable; nowadays this is totally absurd, and if a brain operation must be carried out in order to save a life the intervention will be realized with no further ethical or legal restrictions.

§6. Organ Transplants

I. General Aspects

498. From a juridical point of view, organ transplantation is an act of free disposition of the human body (Art. 6, CC) through which a person cedes a part of his/her body, for humanitarian purposes, in order to improve the health or save the life of another person.

499. Our legislation regulates the so-called macro-transplantations, that is transplantation of visible and palpable organs (liver, heart, lung, pancreas, etc.) and major regenerating tissues (cornea, skin, bone, marrow, blood vessels, heart valves, etc.).

500. There is no juridical regulation regarding micro-transplantations. That is, transplantations of substances that are not included in the traditional concept of free disposition of the human body and that, because of their essence and the necessary technique applied, require a special legal structure. Whether it is considered from a medical, legal or social point of view, transplantation of a kidney is not the same as transplantation of a genetic element (genes, genetic molecules, DNA sequences). This calls for special attention from the law in order to create a legislation according to the bioscientific developments because this legal void is increasing with the addition of the assisted human reproduction techniques and the implementation of the Human Genome Project.[1]

1. Varsi, E., *Derecho genético*, 4th edition, *op. cit.*, p. 181.

II. Legal Framework

501. In Peru there is no concrete and special law regarding organ transplantation. The rules are diverse, and it is still necessary to have a complete and uniform text in order to regulate such an important matter.[1]

1. Varsi, E., 'Anteproyecto de ley sobre transplantes de órganos y material anatómico humano', en: *Revista jurídica del Perú*, Lima: Ed. Normas Legales, año XLVI, No. 3, 1996, pp. 103–109.

502. The legal basis for organ and tissue transplantation from corpses as well as between live beings is formed by the CC, the LGS, the legislation[1] and the CEDCMP.

1. L. 23415 y su modificatoria la L. 24703, así como su reglamento, el DS. 014-88-SA y la L.27282.

A. Civil Code

503. According to private law, organ transplantation is a valid act of free disposition of the human body as long as it is a result of a necessity state, whether of a medical or surgical order, or if it is inspired by humanitarian reasons (Art. 6, CC) and only if it is a pure, simple and unconditional act.

504. The CC[1] generally regulates the cases of disposition of human body parts under the following principles:

- Cession of non-regenerating organs or tissues must not be health damaging or reduce the life span of the donor and his/her express and written consent must be taken into account (Art. 7).
- The altruistic, humanitarian and solidary character of the transplantation determines the validity of the acts of *post mortem* disposition of the human body (Art. 8).
- The revocable character of the acts of free disposition of the human body. A revoking action will not result in any (judicial or extra-judicial) action or exercise (Art. 9).
- *Post mortem* disposition of the human body by the health authority with the prior consent of the relatives (spouse, descendants, ascendants or brothers/sisters, exclusively and in that order). In cases of unidentified or abandoned corpses the disposition can be realized directly (Art. 10).

1. El Anteproyecto de ley de reforma del CC establece lo siguiente: 'Artículo 5™.- ... Está permitida la disposición para transplantes de órganos y tejidos de embriones o fetos muertos....', en:
http//www.congreso.gob.pe/congreso/1997-98/codigo/CODIGOS1htm.

B. General Health Law

505. The LGS fundamentally establishes that (Arts. 8, 41, 45 and 110):

- It is everyone's right to receive organs or tissues from living human beings, from corpses (homotransplantations) or from animals (xenotransplantations)[1] in order to preserve his/her life or improve his/her health.
- If the transplantation, graft or transfer regards living beings it must not damage the health of the donor.
- The act will be free of charge[2] and there must be prior consent of the donor; in cases of incapacity to give consent, the donor cannot be represented by anyone.
- What is stated in the National Identity Document will be taken into account for disposal of corpse organs and tissues,[3] unless there is an indubitable posterior declaration stating otherwise, or when necropsy must be carried out by legal order, or when embalming or cremation of the corpse takes place. In these cases, ablation can be realized without the authorization given by the dead person when alive and without prior consent of his/her relatives (Art. 110).
- At a person's death, if the person, when alive, had not communicated his/her express will to cede organs or tissues for transplantation, or his/her express refusal, the nearest relatives can make any disposition.
- At the moment of a patient's admission (except in emergency cases), the health establishment will make a written statement of the patient's will to donate, in case of death, his/her organs and tissues for transplantation, graft, educational or investigation purposes or, alternatively, his/her refusal to this (Art. 41).
- Transplantations can only be realized in specialized and qualified health establishments (Art. 45).

1. Transplantation of organs or tissues from animals to human beings has been questioned. Although there are two types, regarding animals raised in sterilized places and regarding transgenic animals, this sort of transplantation can cause epidemic outbreaks.
2. *Corpore humane est res extra comercii mancipi* (Human body is not subject to commerce), LGS, Art. 45 *in fine* ... 'The health establishments can only have organs and tissues in order to realise transplantations or grafts free of charge' and Art. 116 'The commerce with corpses and human rests is forbidden.' Moreover, the regulation of the law for organ transplantation, DS.014-88-SA, states 'Art. 3.- No cession of organs or tissues for transplantations or grafts, either between living beings or from corpses, can be realised in an onerous way or under cover modalities of compensations, advantages, pecuniary or financial benefits or any similar or analogous conditions. Any act against this is null and void. The human body and, in this case, any human rest, lacks any economic-patrimonial significance from a juridical point of view. Any cession or disposition of organs or tissues carried out according to the law responds to the supreme value of human solidarity.' In this same sense, Art. 2 of law L.27282. The CEDCMP states 'The physician who, with or without profit motive, facilitates or incurs in the traffic or commerce of genetic material, cell parts, cells, tissues or organs of a human origin commits a serious offence against professional ethics without prejudice of the civil and penal liability that may be applicable' (Art. 23).
3. The law L. 26497 modified by law L. 26745 (Organic Law of the National Register for Identification and Civil State) establishes that the National Identity Document (DNI) must state, amongst other requisites, the holder's will to cede or not his/her organs and tissues for transplantation or graft after his/her death (inc. K, Art. 32).

C. Special Laws

506. The law L. 23415, modified by law L. 24703 and its regulation by decree DS. 014-88-SA regulate the use of organs and/or tissues from corpses or living beings in order to defend and take care of the life and health of other human beings.

507. Amongst the most important institutions dealt with in this legislation we find:

1. Establishment of Death

508. Death occurs with the definitive or irreversible cessation of brain activity, which has a clinical and electro-encephalographic translation. Confirmation of brain death is the responsibility of the physician who certifies it.

509. Brain death corresponds with a person's legal death (Art. 61 del CC and Art. 108 of the LGS). However, the LGS establishes an additional criterion to determine death, which is the confirmation of cardio-respiratory activity paralysis. This criterion, which together with the previous one forms the so-called 'dichotomised criterion for death confirmation', has been based on the fact that the health technological services are not sufficient nor equally spread in the national territory. That is why in places where brain death cannot be accredited the cardio-vascular paralysis will determine the death of the person.

510. It must be noted that the special legislation states that the death of a person, who is subject to the law while alive, makes him/her become an object of special rights, worthy of respect and piety. As such, the corpse lacks any financial or patrimonial value and given that it is different from any other object and it may not be included in any of the goods classifications mentioned in comparative doctrine and legislation.[1]

1. Morales, J., *Hacia una concepción jurídica unitaria de la muerte*, Lima: Fondo editorial de la PUCP, 1997, p. 51.

2. Committee for Brain Death Confirmation

511. Any health establishment that is authorized to carry out transplantations must have a Committee for Brain Death Confirmation and a Committee for Organ Transplantation, which will include the director of the health establishment where the patient or his/her representative is, the treating physician and a neurologist or neurosurgeon. The physicians included in the committee may not be members of the team that will carry out the organ extraction and transplantation.

512. Verification of brain death is based on confirmation and concurrence, during at least 30 minutes, and persistence after six hours of the onset of the coma, of the following signs:

- Total absence of brain response to external stimuli, mainly nociceptive, with complete loss of consciousness;
- Absence of spontaneous breathing;
- Absence of encephalic reflexes, of cranial pairs and mydriatic pupils or in an intermediate position, even with intense photic stimuli;
- Flat encephalogram showing bio-electrical brain inactivity.

513. The verification takes place after two silent and isoelectric registrations, each one with a duration of no less than 30 minutes and carried out with a minimum interval of three hours between each registration. It must be stated that the mentioned signs are not enough in cases of artificially induced hypothermia or in cases of administration of drugs that depress the central nervous system.

514. Verification and certification of brain death must be carried out with the unanimous agreement of the committee members. Once brain silence is confirmed, the blood circulation and breathing of the deceased can be maintained by artificial means in order to ensure optimal conditions of the organs and/or tissues for transplantation.

3. Committee for Organ Transplantation

515. This committee is formed by the director of the health establishment where the operation will take place and by the specialists. Its objective is to authorize the extraction and transplantation as well as to verify compliance with the requisites established by the law.

4. Transplantation of Corpse Organs and Tissues

516. Any corpse organ or tissue can be used for prolongation or preservation of a human life or for scientific investigation purposes. Any medical activity related to investigation, acquisition, donation, processing and provision of organs, tissues and their components and derivatives for tissue grafting, organ transplantation or any other therapeutic or scientific objective is of public interest.

517. Extraction of organs from deceased people will be realized avoiding unnecessary mutilations or dissections and the corpse must be recomposed with the highest care that its nature demands.

518. Ablation of organs or tissues for transplantation purposes is permitted in cases of an accident resulting in confirmed brain death. Based on the supreme value of solidarity, the favourable will of the deceased person towards ablation of his/her organs after his/her death with the objective of improving another person's health or saving his/her life is presumed. In these cases it is not necessary to have authorization by the relatives of the deceased unless he/she, while alive, expressly com-

municated his/her decision against it and stated this decision in the National Organ and Tissue Donor Register.

5. Consent

519. Those being treated at a health establishment who wish to cede their organs or tissues for transplantation must expressly communicate this. In the absence of such declaration, parents, children or spouse may give authorization.

6. Information

520. The patient receiving a transplantation must be informed by the head of the Committee for Organ and Tissue Transplantation of all the safety measures adopted for a successful operation. Information will also be given regarding the concluding quality of the tests done to determine the compatibility between the receptor tissues and those of the organ that is to be transplanted, as well as regarding the reactions and consequent risks.

7. Transplantation between Living Beings

521. The physician must certify that the transplantation or graft does not imply a life or health threat for the donor. It can only be realized: with multiple organs, with regenerating or restorable tissues, and when for the recipient this is the best therapeutic alternative.

522. For organ extraction it is required that:

- The donor is not underage;
- The donor is fully in control of his/her mental faculties;
- The donor has given written consent, which must be express;
- The donor is healthy;
- The organ is compatible with the donor's life and that the transplantation does not reduce his/her functional capacity or lifespan;
- Compatibility has been certified;
- The transplantation aims at improving the life conditions;
- The recipient's acceptation is free, conscious and express.

8. Centres for Ablation and Transplantation of Organs and Tissues

523. The extraction of organs must be carried out in establishments that have the proper facilities and equipment, and the medical staff must be qualified and specialized. The health establishments will include areas and facilities for preservation and conservation of organs and tissues for transplantation.

524. Psychologists and psychiatrists must be included amongst the professionals, in order to evaluate the patients before and after the operations, and their recommendations, in written form, will be taken care of by the Committee for Organ Transplantation.

9. National Organ and Tissue Donor Register

525. In this register the donor inscribes his/her will to cede (or not) organs for transplantation after his/her death. It has an obligatory and a free determination character. It is ruled and organized by the Ministry of Health.

526. The obligation is to inscribe in this register: a person's will to donate or not his/her organs or tissues to be used after his/her accidental death and the will of a person who is admitted to a health establishment to undergo a determined treatment to cede (or not) his/her organs and/or tissues for transplantation to another person after his/her death. This inscription will take place based on the copy of the form filled in by the donor at the moment of receiving a treatment at a health establishment.

10. Social Solidarity Committee

527. It is a multisectorial organ whose purpose is to inform the population of the benefits derived from the organ and tissue transplantation programmes regarding health improvement and defence of the life of patients who need a transplant.

528. To achieve its objective, this committee will promote transplantations through highlighting their humanitarian and social meaning, and will initiate campaigns of civic and health education.

529. It is integrated by representatives of the Ministry of Health, the Peruvian Episcopate, the Lima Lawyers College, the Peruvian Medical College, the Journalists College, the National Medical Academy, the National Academy of Surgery, the Peruvian Association of Medicine Faculties, the Peruvian Red Cross, the Ministry of Education, the ESSALUD, and the Sanitary Units of the Peruvian Armed Forces and Police Corps.

11. Transplantation Organ and Tissue Bank

530. This is an organ for the integration of information that centralizes the data on patients that require a transplantation and the cases of organ disposition. It makes the individualization of ideal recipient subjects for transplantation and the establishment of the consequent priorities possible.

The authorized health establishments may install and maintain, for therapeutic purposes, physical organ and tissue banks (Art. 45, LGS).

531. The CONTRASIDA (counter AIDS) legislation states that all blood or blood components, cell, tissue or organ donor must undergo an HIV infection screening, under civil, penal or administrative liability of the responsible health professionals, and it also determines the cases where the screening is realized in a negligent, reckless or unskilled way.[1]

1. Art. 9, DS. 004-97-SA (DOEP, 18 June 1997).

532. The Law for the Promotion of Human Organ and Tissue Donation (L.27282, DOEP, 8 June 2000) has recently been approved. This law promotes, protects and encourages these medical acts. It deals with issues such as donation of blood and blood components, organs, tissues and bone marrow, as well as labour certificates and licences regarding the donation acts, amongst other subjects.

D. CEDCMP

533. The CEDCMP states that the new technologies for cell, tissue and organ transplantation will be regulated by a special normative of the CMP that through regulation will become an integrating part of the CEDCMP.

§7. Experiments on Human Beings

I. General Aspects

534. Scientific investigation is the search for new knowledge and it is realized through observation or experimentation. Observation is the means to see or observe certain phenomena without interfering in their natural process. Experimentation is the opposite. It is not a passive but an active attitude and it is basically directed at manipulation of or direct intervention in components or organisms. For many years, applied sciences using scientific investigation (genre) and observation and experimentation (species), have been directly studying human beings and in so doing they have generated many benefits and eliminated innumerable prejudices.[1]

1. Varsi, E., *Derecho genético*, 4th. edition, *op. cit.*, p. 132–133.

II. Legal Framework

A. National Laws

1. Constitution

535. The Constitution regulates the right of everyone to moral, mental and physical integrity (Art. 2, inc. 1) but it also recognizes the right to free scientific enterprise (Art. 2, inc. 2). Moreover, it establishes the role of the state referring to scientific progress and development and states the state's duty to promote the

country's scientific and technologic development (Art. 14), as scientific and technologic investigation is considered one of the objectives of university education.

2. Civil Code

536. The CC[1] establishes the right to the irrevocable character of physical integrity (Art. 5) and, accordingly, it states the prohibition of all acts of disposition of one's own body except in cases of emergency, medical or surgical order, or because of humanitarian motives (Art. 6).

1. The Draft of the Law for the Reformation of the Civil Code states the following: 'Article 4.- The right to life, to identity, to psychosomatic integrity, to freedom, to health, to honour and all other rights inherent to a human being are irrevocable and may not be subject to cession or voluntary limitation, with the exceptions stated in the second paragraph of Art. 6.' 'Article 5.- Nobody may threaten the human species' integrity. The human genome may not be modified, except when the finality is to prevent, reduce or eliminate serious illnesses. Genetic manipulations, including cloning, human gene, sex, physical or racial characteristic selections are forbidden. What is prescribed in this article will be developed through a special law' 'Article 5™.- Human embryos or fetuses, their cells, tissues or organs may not be ceded, manipulated or destroyed. Disposing of dead embryos or fetuses is allowed only for organ and tissue transplantations. Fertilization of human ovula may only be realised for procreation purposes... What is prescribed in this article will be developed through a special law.' Cfr. http://www.congreso.gob.pe/congreso/199798/codigo/CODIGOS1htm.

3. Children and Adolescents Code

537. The CNA guarantees the life of the conceived being and protects it from experiments or genetic manipulations that are contrary to its integrity and physical or mental development (Art. 1).

4. General Health Law

a. General Considerations

538. The LGS is based on the principle of promotion of scientific and technological investigation in the health area by the state (Art. XV).

539. In a special tone, referring to the assisted reproduction techniques, it prohibits both the fertilization of human ovules with objectives other than procreation and the cloning of human beings (Art. 7).

b. Informed Consent

540. It is determined that every user of the health services has the right not to be the object of experimentation for medicine or treatment application without him/her

being informed beforehand about the experimental condition of the medicine or treatment, about the risks involved and without his/her prior written consent or that of the person legally entitled to give it, if that is the case or if the user is somehow unable to give his/her consent (Art. 15, inc. d).

c. Remittal to Special Norms

541. Referring to investigation and experimentation on human beings, it is established that experimental investigation on humans must comply with the special legislation on the matter and with the ethical postulates contained in the Declaration of Helsinki and any posterior declarations that may update the mentioned postulates in the future (Art. 28).

542. In Peru, however, there is no special legislation regarding experimental investigation on human beings. In these cases, the principles of the Declaration of Helsinki are applicable.

d. *Post Mortem* Research

543. The patient's will is essential in order to use, after his/her death, the corpse for educational or investigation purposes (Art. 41), and it is stated that the corpse of unidentified people or the corpses of those that, having been identified, have not been claimed within the 36 hours after their admission to the morgue, may be used for study or investigation (Art. 114).

5. Radiological Safety Regulations[1]

544. The radiological exposure of a person for investigation purposes is not justified unless it is according to the regulations stated in the Declaration of Helsinki, it matches the regulations of the Council of International Organizations of Medical Sciences and it follows the advice of an ethics committee and the applicable national regulations. In this case, the exposure must be authorized beforehand by the national authority and can only be carried out by qualified and trained people, and under the conditions specifically prescribed (Art. 38).

1. DS.009-97-EM, (DOEP, 29 May 1997).

545. Moreover, the doses of exposure for investigation purposes must be reduced so that they do not exceed the values established by the national authority in each case. The exposure doses of people voluntarily helping in the care, relief or well-being of patients or patient's visitors, who carry radionuclides for therapeutic purposes, must be reduced to the lowest possible level and they must never be higher than the indicated level (Art. 46).

B. Ethic Norms

546. It must be noted that the CEDCMP (Annex 2) states that it is the duty of a physician involved in an investigation assignment to know and comply with what is stipulated by the Declaration of Geneva (Oath of Professional Loyalty)[1] to which must be added the International Code of Medical Ethics[2] and the Declaration of Helsinki.

1. The Declaration of Geneva was adopted by the General Assembly of the World Medical Association (Geneva, September 1948) and it was amended by the 22nd World Medical Assembly (Sydney, August 1968).
2. The International Code of Medical Ethics was adopted by the 3rd General Assembly of the World Medical Association (London, October 1949) and it was amended by the 22nd World Medical Assembly (Sydney, August 1968) and the 35th World Medical Assembly (Venice, October 1983).

C. International Documents

1. The Declaration of Helsinki

a. General Aspects

547. The Declaration of Helsinki[1] establishes the recommendations to guide physicians when carrying out investigation in human beings, and it states that it is necessary to take the accepted scientific principles into account and to proceed with properly realized experiments and on the basis of theoretical knowledge.

1. Adopted by the Eighteenth World Medical Assembly celebrated in Helsinki in 1964, revised by the 29th World Medical Assembly (Tokyo, 1975) and amended by the 35th World Medical Assembly (Venice, 1983), the 41st World Medical Assembly (Hong Kong, 1989) and the 52nd World Medical Assembly (Edinburgh, Scotland, 2000). It must be noted that the first international declaration on investigation on human subjects was the Nuremberg Code in 1947, that was laid down as a consequence of the experiments on human beings carried out during the Second World War. This code states the importance of voluntary consent.

b. Research Protocol

548. The research protocol will be sent for evaluation and suggestions to a committee that must be independent from the investigator and from the entity sponsoring the investigation. This committee must comply with the legislation of the country where the experiment takes place.

c. Ideal Condition of the Medical Professional

549. The investigation must be carried out by qualified people under the supervision of a medical professional.

d. Right to Integrity and Privacy

550. The right to integrity of the human being who is the subject of the investigation must be respected and all sorts of precautions to safeguard the individual's privacy must be taken.

e. Publication of the Research Results

551. The physician is obliged to respect the exactness of the results of his investigation when he/she publishes them. Reports that do not follow the principles described in the Declaration of Helsinki must not be accepted for publication.

f. Informed Consent

552. The participant must be informed about the objectives, methods, benefits, foreseeable risks and uncomfortable situations that the experiment may imply as well as about his/her freedom not to participate in the experiment and to cancel his/her consent at any given moment. Only then may the physician ask for a voluntary, conscious and written consent.

553. When the person giving informed consent finds him/herself in a situation of dependency on the physician or gives the consent under duress, the consent will be obtained by another physician who is not involved in the investigation and who must be totally removed from the official relationship.

554. If the physician considers it essential not to obtain the informed consent, his reasons to consider this must be stated in the protocol that will be sent to the independent committee. The physician can combine medical investigation with professional medical care in order to achieve new medical knowledge, but only to the extent that the investigation is justified by its possible diagnostic or therapeutic value for the patient.

g. Non-therapeutic Medical Investigation

555. In cases of non-therapeutic biomedical investigation on human beings, the physician must protect the life and health of the individual subject to the biomedical investigation that may only pursue scientific objectives. Individuals must be volunteers and healthy or patients whose diseases are not related to any experimental design. The investigation will be interrupted if it turns out to be damaging for the individual. Scientific and social interests may not be set before the individual's well-being in any investigation process.

2. Proposal of International Norms for Biomedical Investigation on Human Beings

556. Regarding biomedical investigation on human beings[1] it is considered that:

1. International Medical Sciences Organizations Council and World Health Organization, 1982. The objective is to deal with aspects that were not dealt with by the Declaration of Helsinki as well as to fit these principles to the particular circumstances of each specific country.

a. Area of Research on Human Beings

557. Investigation on human beings is defined as any research directed at development of biomedical knowledge that is not considered an element of clinical practice or public health and that implies physical or psychological intervention or evaluation, production, storage or analysis of medical records containing biomedical information related to identifiable people.

b. Informed Consent

558. The informed consent must be accompanied by an independent ethical evaluation of the proposed investigations.

3. Universal Declaration on Human Genome and Human Rights

a. General Aspects

559. The Universal Declaration on Human Genome and Human Rights is the most important document ever dictated regarding bioethical matters (UNESCO, 11 November 1997) and although it does not have a binding character, it is the international juridical base all Member States should adopt when they are in the process of including regulations on genetic law in their legislation.

b. Objective

560. Its objective is to determine the ethic framework for all activities related to human genome in order to protect human rights and at the same time to prevent the limitation of bioscientific investigations.

561. It is the first time a text is meant to be a world framework for the implications of genetic activities on human beings. This Declaration is a Universal Bioethics Code and was triggered by the danger posed by the absence of international rules to regulate bioethical matters. The Declaration is based on respect for everyone's dignity in cases of biotechnological investigations on human genome.

c. Genome Research

562. Any genome investigation, treatment or diagnosis must only proceed after a thorough evaluation of the risks and advantages implied and according to any other exigency of the national legislation (Art. 5, clause a).

Beneficial investigation: If a person was not able to express his/her consent, an investigation on his/her genome can only be carried out if it represents a direct benefit to his/her health and with reserve of the authorizations and protection measures stated by the law (Art. 5, clause e).

Harmful investigation: An investigation that does not represent a direct foreseeable benefit for health can only be carried out exceptionally, with the utmost prudence and with the firm will not to expose the individual to anything but a minimal risk and constraint and only if the investigation is focused to result in benefit for the health of other people who belong to the same age group or who have the same genetic conditions, with reserve of that investigation being carried out according to the conditions provided by the law and being compatible with the protection of individual human rights (Art. 5, clause e).

d. Informed Consent

563. The prior consent, voluntary and informed, of the person in question may not be missing in any investigation process. If the person is unable to give it, the consent or authorization must be obtained according to what the law states, and taking the superior interest of the person in question into consideration (Art. 5, clause b). The Declaration allows, in urgent cases and strictly complying with international regulations and with human rights, a limitation of the right to informed consent (Art. 9).

e. Right to Genetic Privacy

564. Every person has the right to genetic privacy. In that sense, his/her right to decide to be informed (right to know) or not (right not to know) about the results of a genetic examination and its consequences must be respected (Art. 5, clause c).

f. Research Protocol

565. The research protocols must be submitted to a prior evaluation, according to the national and international regulations or guidelines applicable in that matter (Art. 5, clause d).

§8. Genetic Manipulation

566. Genetic manipulation is done in biological components or parts of the human body and it affects genetic integrity as well as rights.

I. Concept

567. Based on the principle of protection of life and human beings it must be said that genetic manipulation is a manoeuvre in the biological or genetic structure of a human being that damages, denies and violates rights because it is based on techniques that attempt to modify the genetic patrimony, and to divert the natural laws of human evolution and development. Whatever the final goal and utility, present or future, genetic manipulation will always affect our species' dignity.

II. Legal Framework

568. Referring to the applicable regulations regarding human experimentation, the issue of genetic manipulation presents a special legal characteristic.

A. Children and Adolescents Code

569. The CNA establishes direct protection of the right to life and integrity (Art. 1), in that every child and adolescent has the right to life from the moment of conception and he/she has been given special protection regarding genetic experiments or manipulations that are contrary to his/her integrity and physical and mental development.

570. With this article, the CNA is the first legal text in the medical area that prohibits genetic manipulation in a taxative and express way, following *in extenso* the orientation of the Declaration of Children's Rights and taking into consideration that its inspiration comes from the Proposal of the World Association of Infancy Friends for the Child Convention project.[1]

1. Valencia, J. (*Derechos Humanos del niño*, Lima: Instituto de Derechos Humanos, 1990, pp. 114–115) states that within the framework of suggestions and recommendations presented to the Convention for Children Rights project, in 1989 the World Association of Infancy Friends sent the Human Rights Committee a report stating its concern about the silence kept on the Convention project regarding the situation of the conceived being. The Association proposed that the project deal with the protection of the conceived being because the scientific developments in genetics remain contrary to human dignity.

571. From the mentioned article's analysis we note that it is very strict regarding the protection of the conceived being against experiments contrary to human integrity and physical or mental development. At the same time it does not set any limits to the performance of technical operations the objective of which is purely therapeutic. The limits can be found regarding the realization of genetic procedures that, instead of being applied for the benefit of human beings, are fundamentally used to define or promote the development of biomedical techniques without taking into consideration factors such as the violation of and attack on the psychosomatic unit that is committed against those subject to rights.

572. What is singular about this rule, according to a strict legal application criterion, is that it can only apply to the child (from conception until the age of twelve) and to the adolescent (from the age of twelve until the age of eighteen) but not to adults, given that adults are outside its legal application range.

B. General Health Law

573. The LGS (Art. 7), following the same line, states that fertilization of human ovules has the sole objective of procreation, and therefore the possibility of carrying out processes of fertilization for scientific or experimental objectives is out of the question. Following the compared legislation criterion, we have tended to specify the prohibition of two genetic manipulation practices such as fertilization of human ovules for purposes other than procreation and cloning.[1]

We can state that within this rule embryo cryopreservation is expressly forbidden given that this technique is a genetic manipulation carried out in the conceptive stage and by which the embryo development process comes to a halt without any specific benefit for the conceived being, which violates the fundamental principle stating that fertilization of ovules' only objective is procreation and not paralysis of human life.[2]

1. Varsi, E., *Derecho y manipulación genética (calificación jurídica de la clonación)*, 2nd edition, Lima: Universidad de Lima, Fondo de desarrollo editorial, 1997.
2. The CMP Committee for ethical and deontological control, through its president Dr. Patricio Wagner, has stated that 'Embryo freezing is an outrage to human dignity and an anti-ethical practice', in, *El Comercio*, Lima, 21 June 2000, pp. A-10.

C. CEDCMP

574. The CEDCMP project directly supported the protection of human life, including respecting the human genome and embryo, and considered genetic operations or experimentation that either put them at risk or do not respect their life, integrity and physical or mental development, that imply a deprivation of their freedom, or that are not expressly carried out with the objective of improving their health or their survival contrary to ethics (Art. 40).

The present Code (Art. 84) only states that experiments directed at obtaining a human being through parthenogenesis, embryonic fusion, cloning, chimeras or any other analogous procedure are contrary to ethics. This rule is very similar to the one present in the Code project (Art. 42).

Moreover, it states that new technologies such as the different forms of assisted reproduction, embryo cryopreservation, and use of human genes for experimental purposes will be regulated by special regulations in the CMP, which will also be included in the CEDCMP. (Art. 84).

§9. EUTHANASIA

I. General Aspects

575. The Constitution protects human life and integrity (Art. 2, inc. 1) and the CC states that the right to life and to physical integrity cannot be relinquished and may not be object to cession (Art. 5). In this way, the CP typifies the crimes of pious homicide (Art. 112) and of suicide instigation or help (Art. 113).

576. The ethical norms of the CMP reject euthanasia because it is opposed to the basic principles of the medical profession, which are established not only in the CEDCMP[1] but also in international ethical dispositions.[2]

1. From the Declaration of Principles we can clearly deduce that respect for life and human beings is the spiritual essence of the medical ideals and maintains their legitimate validity, in the day-to-day activities and as a tribute from art and science to culture and civilization. The main objective of the medical profession is to attend to and defend the human being against all causes that can damage his/her health or life or put them at risk (Art. 59). Among the patient's rights is the right to have his/her natural death process respected, and that excludes any abusive life shortening method (euthanasia) and any painful and unjustified life extension (dysthanasia) (Art. 41, inc. m).
2. The Hippocratic Oath establishes, as one of the physician's compromises, that he/she does not give anyone a fatal medicine, not even when he/she has been asked for it, nor will he/she initiate a suggestion in that direction. Moreover, the Declaration of Geneva of the World Medical Association (where the Professional Loyalty Oath is established) states the physician's duty to care for human life with the utmost respect from its beginning, even under threatening circumstances, and not to use his/her medical knowledge to contravene the human laws.

II. Types

A. Active Euthanasia

577. The pious homicide or homicide at request constitutes so-called active and voluntary euthanasia.

1. Protected Juridical Good

578. The good juridically protected in this offence is human life.

2. Subjects

579. The active subject can be any person. The passive subject is the dying patient.

3. Constitutive Elements

580. The constitutive elements of this offence are: pre-existence of a human life, extinction of a human life based on piety motives, that the act is expressly and consciously requested by the passive subject, that the patient has an incurable condition and wilful intent.

581. It is so that the essential elements established by penal law are the pious motive (compassion, pity) of the author, the express and conscious request of the victim and the suffering from an incurable sickness (impossibility of recuperation, not necessarily fatal).[1]

1. Bramont-Arias, L. and García, M., *op. cit.*, pp. 64–66.

4. Realization

582. This offence can be realized by commission (lethal injection) or by improper omission (not offering help or aid).

5. Penalty

583. It is an extenuated offence in which the penalty may be reduced as opposed to other types of homicide. The penalty is deprivation of freedom for a period not longer than three years.

B. Suicide Instigation or Help

584. The Peruvian penal system does not sanction suicide. The author is not penalized, the participant is. This criterion, contrary to the penal theory of participation, is valid because of the need to guarantee the right to life.[1] The Peruvian penal system states that helping to commit suicide only means 'non-executive aid'.[2]

1. Bramont-Arias, L. and García, M., *op. cit.*, p. 71.
2. Freyre, R., *op. cit.*, p. 244.

585. The Peruvian CP establishes two different behaviours, instigation (promotion) and help (collaboration) to commit suicide.

586. In this supposition euthanasia could be configured, regarding the help action, either by action or by omission to take one's life i.e. it can be active or passive euthanasia.

1. Protected Juridical Good

587. The good juridically protected in this offence is human life.

2. Subjects

588. The active subject can be any person. The passive subject is the person who willingly tries to commit or commits suicide.

3. Constitutive Elements

589. The constitutive elements of this offence are: pre-existence of human life, extinction of a human life, suicidal act attempted or accomplished, cooperation either by instigation or help, acceptation of the instigation or help on the victim's side, relationship of causality and wilful intent.

4. Aggravating Factors

590. An egotistical motive is considered an aggravating factor.

5. Penalty

591. The penalty is deprivation of freedom for a period not shorter than one or longer than four years. If the agent is moved by an egotistical motive the penalty will not be less than two nor more than five years.

§10. Sex Adaptation

I. General Aspects

592. Sex is one of the main characteristics of human identity. Sexual identity, therefore, is an important aspect of human identity given that sexuality is present in all the manifestations of the human personality.[1]

1. Fernández, C., *El derecho a la identidad personal*, Buenos Aires: Ed. Astrea, 1992, pp. 287 and 291.

II. Right to Identity

593. The right to identity is a person's faculty to be him/herself, different from the rest. As such, this right is classified as the right to personal identity and it is

related to the group of attributes that determine the individuality of a person (name, age, sex, capacity, etc.); genetic identity, through which a human being, biologically a genome, has his/her own genetic code, inherited from his/her parents (giving way to the right to paternity investigation and the right to know one's biological origin) and, finally, the right to sexual identity, which guarantees the psychosomatic integrity of the person in relation to his/her sex, in such a way that identification between physical sex and psychological sex is achieved. This right tries to find a legal reformulation in order to achieve coincidence between the different sexes (chromosomal, gonadal, anatomic, mental/emotional and registered) of the human being.[1]

1. Varsi, E., *FiliAción, Derecho y geNética. Aproximaciones a la teoría de la filiación biológica*, Lima: coedition of the Universidad de Lima, the Fondo de Desarrollo Editorial and the Fondo de cultura económica, 1999, pp. 237–241.

III. Juridical Problems

594. Essentially, the discussion about the legality of sex adaptation is about determining whether recurring to this surgical operation is a way of validly exercising the right to integrity, as a free act of human body disposition, the right to sexual identity, the right to free development of personality (inc. 1, Art. 2, Const.) or the right to health protection, always under the regulations of public order and good customs.

IV. Legal Framework

595. In Peru there is no legal disposition that expressly regulates this type of physical intervention.

A. National Reality

596. The CC states that the acts of disposition of one's own body are forbidden when they result in a permanent decrease of the physical integrity or when they are somehow contrary to public order or to good custom. They will, however, be valid when they respond to necessity, medical or surgery requests or if they are inspired by humanitarian motives (Art. 6). 'These exceptional acts have a very clear limit, the duty to preserve one's own health, that corresponds to the social interest of every person enjoying the best conditions possible in order to contribute to the common well-being. That is why Article 7 of the CC states that cession of organs or tissues that are non-regenerating may not "seriously damage health or significantly reduce the life span of the donor"'.[1]

1. Fernández, C., *Derecho de las personas*, 8th edition, Lima: Ed. Grijley, 2001, p. 67.

597. Sex adaptation is therefore a valid free act of disposition of the human body

in that it is related to a necessity state and consolidates the right to health protection and free development of personality.

598. This is an indirect legal reference because in Peru there is no legal disposition that expressly regulates this type of intervention.

B. Bases for a Juridical Legislation

599. The Juridical Investigation Centre of the Faculty of Law and Political Sciences of the Universidad de Lima elaborated on the basic principles that must be taken into account in future legislation.[1] These basic principles state the following:

- Based on freedom, identity and health, the processes of sex adaptation must be allowed in cases of transsexualism (Basic Principle VI);
- Surgical intervention attempting to eliminate the dissociation *soma-psyche* that the transsexual presents are allowed because their objective is to adapt the genital organs to the experienced sex (Basic Principle VII);
- Surgical interventions to adapt the genital organs to the dynamic sex may be adopted in cases of transsexualism where other types of therapy prove inefficient (Basic Principle VIII);
- Sex adaptation must be the result of a reserved judicial process in which the expert's report, the interview with the recurrent and the dimensions of the existential conflict experienced will be evaluated and the petitioner will have been informed of the consequences of the decision (Basic Principle IX);
- Authorization for the surgical intervention can only be given to unmarried people, and in order to modify the register inscription an expert's report must be available in which the incapacity for procreation is confirmed (Basic Principle X);
- The process of sex adaptation and the consequent modification of the pronoun must be protected by the right to secrecy (Basic Principle XI);
- The duties and rights that emerge from the family relationships of those who underwent a sex adaptation remain unaltered (Basic Principle XII).

1. 'Bases para una legislación sobre adecuación de sexo en casos de transexualidad y consiguiente modificación del nombre', In: *Cuadernos de Derecho*, No. 1, Lima: Universidad de Lima, Facultad de Derecho y Ciencias Políticas, Centro de Investigación Jurídica, No. 1, 1992, p. 61.

C. Cases

600. At a judicial level there have been non-litigious processes of rectification of the birth certificate in order to adapt the name of the applicant after having realized the medical intervention.

601. However, jurisprudence has stated that for sex adaptation purposes one must refer to '... a process of (ordinary) appraisal in which it is possible to change the civil condition referring to sex and consequently change the names, after a

medical physical and psychological expert report, not being proceeded to present the question in a process of rectification of the birth certificate',[1] which is a non-litigious process.

1. Statement of the Civil Court of Callao. Exp. 7806-92/Callao, Second Civil Court of Callao.

§11. Acquired Immunodeficiency Syndrome (AIDS)

602. Peru experiences a continuous and accelerated increase in the number of cases of Sexually Transmitted Diseases (STD) and AIDS, with estimates for 1997 stating no less than 8,000 AIDS cases and between 50,000 and 70,000 cases of people affected by the HIV virus, hence the importance of creating a special juridical framework.

I. Legal Framework

A. Constitution

603. The Constitution is the basic rule in the area of fighting AIDS given that it develops fundamental human rights.

B. Legislation for the Prevention of AIDS

604. There is a special legislation that rules in this area, the so-called CONTRASIDA (Counter AIDS) Legislation.[1]

1. L. 26626 (DOEP, 20 June 1996) and its regulation DS. 004-97-SA (DOEP, 18 June 1997).

1. National Plan Against HIV, AIDS and STD

605. The regulations contained in the National CONTRASIDA Plan present a policy to fight the diseases and determine the health policy that must be applied in the country.

a. Entity in Charge

606. The Ministry of Health is in charge of elaborating on the National Plan against the Human Immunodeficiency Virus (HIV), the Acquired Immunodeficiency Syndrome (AIDS) and the Sexually Transmitted Diseases (STD), which will be called CONTRASIDA.

b. Objectives

607. The CONTRASIDA Plan has the following objectives:

- Coordinate and facilitate implementation of the national strategies for HIV/AIDS and STD control;
- Promote national and foreign technical and financial cooperation directed at the prevention, control and assistance of HIV/AIDS and STD;
- Propose the legislative changes that will facilitate and guarantee the right development in the fight against HIV/AIDS and STD in the country.

c. Tasks

608. The entity elaborating on the CONTRASIDA Plan will also have the following tasks:

- Coordinate the prevention, control and assistance actions against HIV/AIDS and STD carried out by the public and private institutions;
- Promote and develop technical investigations and interventions directed at preventing and controlling HIV/AIDS and STD; and
- Maintain updated statistics on the HIV/AIDS and STD situation.

d. Test Characteristics

609. The tests to diagnose HIV/AIDS are voluntary and are carried out after advice has been given. Exceptional cases are those regarding blood and organ donors (Art. 4). The results of tests leading to the diagnosis HIV/AIDS and the information regarding the certain or possible cause of infection with the contagion have a confidential character.

610. Those results and information can only be requested by the Public Ministry or the Judicial Power, only when circumstances so require and only for criminal investigation purposes. Health professionals are obliged to notify the Ministry of Health regarding the diagnosed cases even when the patient is dead (Art. 5).

611. People suffering from HIV/AIDS can continue working as long as they have the capacity to fulfil their obligations. Dismissal from work based on discrimination related to carrying the HIV/AIDS virus is void (Art. 6).

2. Regulation of the CONTRASIDA (Counter AIDS) National Plan

612. This regulation of the CONTRASIDA Plan[1] contains rules that allow achievement of the objectives established in the National Plan Against the Human Immunodeficiency Virus (HIV), the Acquired Immunodeficiency Syndrome

(AIDS) and the Sexually Transmitted Diseases (STD), called CONTRASIDA. It contains dispositions of obligatory application in public and private establishments.

1. DS. 004-97-SA (DOEP, 18 June 1997).

a. Test Characteristics

613. The tests to diagnose HIV infection can only be performed after counselling and with the written consent of the person in question (Art. 11).

614. Preventive counselling on STD and HIV and AIDS infection is an obligatory requisite for those who desire a civil marriage. Counselling can be given by the respective municipality or by the nearest Health Establishment (Art. 13).

615. No medical or surgical care provision can be conditioned by a prior performance of tests to diagnose HIV infection (Art. 14).

616. The test to diagnose HIV infection may not be a requirement or condition to start or maintain an employment, educational or social relationship (Art. 15).

617. The results of the tests to diagnose an HIV/AIDS infection and the information about the certain or possible cause of contagion have a confidential character. There are some exceptions to this (Art. 16): (a) when the tests are used, exclusively in order to attend the infected person, by the health staff (b), when they are requested by the Public Ministry or the Judicial Power if they are indispensable for a fiscal report or charge or for a penal process regarding an offence against public health, at any stage of the process.

b. Report on Infection Cases

618. With the utmost respect to the right to privacy and the confidentiality of the information, the cases of HIV and AIDS infection will be reported at the moment of diagnosis, as well as the first time they are treated at a health establishment. The development of AIDS in the previously reported cases and the death of the patients will also be reported (Art. 17).

619. Liable to report the infection cases are all health professionals who request the tests to diagnose the HIV infection, those who give health care to previously diagnosed patients in the health establishments, those who diagnose the evolution to the AIDS stage and those who certify the death of a patient (Art. 18).

C. Manual of Doctrines, Norms and Procedures for the Control of Sexually Transmitted Diseases (STD) and AIDS

620. This manual[1] states the principle that every person affected by HIV/AIDS has the right to medical attention and to any provisional service required. Referring to this, the state must offer the necessary services and the Ministry of Health will be in charge of elaborating on the National Plan against the Human Immunodeficiency Virus (HIV), the Acquired Immunodeficiency Syndrome (AIDS) and the Sexually Transmitted Diseases (STD).

1. *See* Via Libre: *Manual sobre legislación peruana sobre VIH/SIDA*, Lima: 1997.

621. The general legal guidelines are: any blood or blood components, cells, tissues or organs donor must be cleared through an HIV diagnosis test; in order to perform the tests to diagnose an HIV infection it is necessary that a previous counselling session has taken place and written consent has been given; medical attention is not conditioned by the previous performance of tests to diagnose an HIV infection; the test to diagnose HIV infection may not be required as a condition to start or maintain an employment, educational or social relationship; the results of the tests are confidential; HIV/AIDS/STD prevention and control issues and biosafety issues must be included as educational subjects in the academic curriculum.

Part III. The Physician in Relation to the Health Care System

Chapter 1. Collegial Relationships

§1. Associations

I. General Aspects

622. It is any person's right (Art. 2, inc. 13, Const.) to freely take part in non-profit associations.

II. Trade Union Associations

623. Professional colleges are autonomous institutions with public legal right capacity.

624. Through the constitutional principle the abovementioned professionals can join groups in order to defend their rights and achieve their objectives.

625. The CMP and the FNM are two of the main associations. The CMP focuses on the ethical side of Medicine and the FNM on the operative side of it (work aspects, rights, obligations and payments).

A. Peruvian Medical College

626. The CMP was created by Law L. 15173.[1] It is the institution that represents the medical profession. Its main objective is to monitor medical ethics and check on the administrative conditions of the medical activities in Peru. It is formed by all licensed physicians in the country.

1. Enacted on 16 October 1964.

627. Inscription in the medical register is a requisite in order to practise the medical profession.

B. Peruvian Medical Federation

628. The foundation of the FMP occurred before that of the CMP.

Its objective is to find the best conditions for the development of medicine and physicians in the national territory. It is formed by all the physicians who want to have their rights protected. Inscribing is optional.

III. Scientific Associations

A. Medical Societies

629. Scientific medical societies are associations of physicians who, according to their specialty, perform an investigational activity (academic events, publications, etc.) whose results benefit the physician's work in the field of health care.

630. These institutions (approximately 72 inscribed in the CMP) do not carry out a direct health care service but indirectly assume a health care role through their contribution to the field of medical investigation.

B. National Medical Academy

631. The National Medical Academy is formed by the most prestigious physicians in the country, who, with their experience, practical as well as theoretical, contribute to the spreading of medical scientific developments.

632. Among the main objectives of the National Medical Academy are:

- to actively participate in the debate and orientation in the health field;
- to absolve, as a consultative corps, the issues submitted by the public powers and their dependencies, regarding health and medical matters;
- to contribute to the development of the health sciences through scientific activities as well as contribute to the development of investigation projects focused on the Peruvian medical-social reality.

§2. Health Care Centres

I. General Aspects

633. These are health centres where there is at least one physician.

634. It is estimated that there are around 6,290 health establishments in the country.

II. Types of Health Care Establishments

A. Public Health Care Establishments

635. According to the second Census of Sanitary Structure and Resources in the Health Sector of 1996 the following health establishments can be discerned.

1. Hospital

a. Concept

636. This is an establishment that has been technically planned, built, equipped and administrated for the provision of integral health services (assistance and promotion of preventive measures) by way of external consultation, emergency services and hospitalization (longer than 24 hours).

637. It has four basic services: general medicine, surgery, paediatrics and gynaecologic-obstetrician services and it has a clinic laboratory.

638. It is located in main provincial cities and the number of beds varies between 20 and 140.

b. Legal Framework

639. The General Hospital Regulations for the Health Sector[1] were approved as a consequence of the shaping of the policy in the health sector according to which a new focus in the hospital functions was given in order to direct its structure towards developing support activities.

1. DS. 005-90-SA (DOEP, 25 May 1990).

640. With this new concept, a hospital is a health establishment directed at offering integral health care, ambulatory and hospitalization services and projecting its actions towards the community.

641. The Ministry of Health, the ruling organ of the sector, states the regulations for the planning, building, equipment provision and administration of hospitals.

c. Classification

642. The General Hospital Regulations for the Health Sector classifies hospitals according to the degree of complexity, number of beds and geographical action area.

643. According to this classification, depending on the care given, a hospital can be general or specialized. Its dimensions and complexity, its facilities characteristics, the qualification of its staff as well as the quality of the equipment are also taken into account. Another criterion is the number of beds and the commodity or facilities given to intake patients as well as to ambulatory patients.

d. Functions

644. The general functions of a hospital in the public sector are the following: provision of integral health care services, education, investigation, counselling and technical-administrative support.

2. Health Care Centre

645. This is in charge of developing health promotion, protection and recovery. They provide medical consultation services (general medicine, minor surgery, obstetric services and paediatric services), odontology consultation, vaccination, environmental drainage and nurse visits at home.

646. Some health care centres have beds available for hospitalization.

647. Their action area corresponds to a jurisdiction of 2,000 or more inhabitants.

3. Health Base

648. This is the establishment in charge of developing health promotion, protection and recovery activities such as elementary medical care services, first aid, vaccinations, promotion of environmental drainage and registration of biostatistical information. They are attended by auxiliary staff that carries out activities based on manuals and instructions that guide and limit their functions. It receives regular supervision by the Health Centre.

649. These establishments are directed by infirmary technicians or health prevention employees. There are no physicians.

B. Non-Public Health Care Establishments[1]

650. This is the total of physical resources (physical plant, facilities, equipment and materials) that constitute an establishment where health care is offered.

1. Authorized by the Ministry of Health through the DS.023-87-SA, General Regulations of Health Establishments in the Private Sector DOEP, 26 May1987).

1. Establishment for Private Medical Consultation

651. One or more health science professionals are in charge of it, it is properly installed and equipped for providing attention to ambulatory patients.

2. Policlinic

652. This is a group of two or more offices that offer health care to ambulatory patients and it has a permanent infirmary service of at least twelve hours.

653. It offers the four basic services: general medicine, surgery, paediatrics and gynaecology-obstetrics. It does not include hospitalization.

3. Medical Centre

654. This offers consultation services in different specialties by a physician, and it is equipped with a clinic and radiological laboratory. It is open 24 hours a day and it also has infirmary services and a first aid kit for internal use.

4. Private Hospital or Clinic

655. This is an establishment that provides integral health care and its main function is health recovery through medical and auxiliary services for diagnosis, treatment, hospitalization and ambulatory assistance.

5. Medical Health Institute

656. This can offer ambulatory assistance as well as hospitalization in highly specialized complementary medical fields. Highly qualified staff whose activities are focused on investigation and education are in charge.

6. Medical Support Services

657. These are the so-called rehabilitation and physical therapy centres and recovery and rest centres. They deal with patients in a convalescent stage and patients requiring rehabilitation.

7. Diagnostic and Therapeutic Support Services

658. They offer clinical laboratory, pathological anatomy, X-ray diagnosis, and diagnostic imaging techniques (computerized axial tomography, hemodialysis, echography, echocardiography), among other services.

8. Patient Transport Service

659. This service has properly equipped ambulances and professional and auxiliary staff able to use the proper equipment in order to transport patients and care for their survival in all circumstances.

9. Dental Prosthesis Laboratory

660. This is an establishment specialized in making prostheses and devices for dental use. It is run by one or more technicians specialized in that field.

10. Optic Centre

661. Its function is to make and commercialize ocular refractory lenses for glasses and/or contact lenses. An optical technician specialized in glasses and contact lenses is in charge.

11. Centre for Attending to Psychoactive Substances Addicts

662. This is a residential treatment system where the patient accepts his/her responsibility in the process of changing life patterns and living without drugs or other substances that can create addiction.

12. Company for Environmental Drainage

663. This is the company that carries out fumigation, disinfection, rat plague control and atmosphere cleaning activities with proper equipment and specialized staff.

§3. Professional Duties Towards Colleagues

I. Ethic and Legal Framework

664. The Declaration of Geneva of the World Medical Association – Professional Loyalty Oath[1] states that 'At the moment of admission to the medical profession, the professionals solemnly accept to consider their colleagues as brothers.'

1. Geneva, September 1948 amended by the 22nd World Medical Association, Sydney, August 1968.

665. On the other hand, the International Medical Ethics Code[1] states that: 'The physician must behave towards his/her colleagues in the same way he/she would

want them to behave towards him/her.' 'The physician must not steal patients from his/her colleagues'. 'The physician must observe the principles of the Declaration of Geneva approved by the World Medical Association.'

1. London, October 1949, amended in Sydney, August 1968 and in Venice, October 1983.

II. Duties

666. Recognizing the duties accepted by all medical colleagues around the world, the CEDCMP states the following professional duties:

- The physician will give medical attention, free of charge, to any colleague that so requires, to his wife and children and to his parents if they are economically dependent. This service will be given according to a previously agreed moment and place, unless in emergency cases when attention must be immediate and given in the place where the emergency arises (Art. 67).
- Any physician who requests a colleague's services must always avoid causing trouble or wasting time, and will only go to the colleague's home in case of physical inability and, in case it regards a colleague who lives in a distant place he/she will pay the transport costs (Art. 86).
- When a physician, due to illness, is unable to give attention to his/her patients and his/her financial situation is difficult, it is his/her colleagues', friends' and disciples' moral duty to take over the activities with no financial interest involved and to reimburse him/her the received fees (Art. 88).
- When a physician transfers his/her patients in his/her own practice in his/her absence, the new physician in charge will receive the fees and will take over the payments regarding rent and maintenance of the practice, tributary obligations derived from the transfer, and will pay a compensation for the use of the medical equipment (Art. 89).
- Physicians must be respectful towards one another and avoid statements or criticism that might damage the moral or scientific reputation and those that eventually cause damage to the good name of the medical profession (Art. 70).

Chapter 2. Relationship with Other Health Care Providers

667. The physician must respect the other health professionals' autonomy and must treat his/her staff with justice, consideration, respect and courtesy; he/she must also promote their training.

668. The national regulation[1] states that the following health professionals can be discerned: surgeon, dental surgeon, pharmaceutical chemist, obstetrician, nurse, veterinary surgeon, biologist, psychologist, nutritionist, sanitary engineer and social worker.

1. Law L. 23536, General Regulation of Health Professionals' Work and Career (DOEP, 24 December 1982), DS. 019-83-PCM (25 March 1983) and its modifying law DS. 024-83-PCM (8 April 1983), regulate the stated regulations.

§1. Dentist

I. General Aspects

669. The dentist deals with buccal and dental problems and related problems. He/she carries out integral actions, diagnosis, prevention, promotion, treatment, recovery, rehabilitation and health administration of the stomatognathic system, individually as well as at a community level.

670. In Peru, the dentist profession has a great demand. However, 10,000 people illegally practise the dentist profession in Lima, of which 80 per cent are dental technicians (who are trained to work on plaster tooth models). According to the Peruvian Odontologists College only 6,000 accredited odontologists are active.[1]

1. 'Falsos dentistas invaden Lima', in: *El Comercio*, 7 May 2000, Section B, p. 20.

671. The professional career of stomatology, in which the dental and masticating system, tongue, gum and palate are studied, has recently been implemented.

II. Education

672. The university study of odontology has a duration of five years and one year of internship.

III. Licensing and Practice

673. In order to carry out professional odontologist activities it is required to possess the professional university degree and be inscribed in the Peruvian Odontologists College (Art. 22, LGS).[1]

1. *Cf.* Art. 2 of the L. 15251 (DOEP, 16 December 1964. Foundation of the Peruvian Odontologists College) and its regulation, the DS.280-65-SA/DGS, Art. 2.

674. Odontologists can only prescribe medicines within their professional area.

§2. Pharmaceutical Chemist

I. Denomination

675. This name, so specific and technical, identifies those health professionals whose function is to prepare, extend and commercialize medicines.

676. There is another health professional, the pharmacist, whose function, clearly technical, is to collaborate with the tasks of the pharmaceutical chemist.

II. Tasks

677. For the LGS (Art. 33) the pharmaceutical chemist is the person responsible for user provision, information and counselling regarding administration, use and dosage of the pharmaceutical product, its interaction with other medicines, its secondary effects and its storage conditions. He/she may offer the user alternative medicines equivalent in pharmaceutical form and dosage to the one prescribed.

III. Education

678. The university study of pharmacy and biochemistry has a duration of five years and one year of internship.

IV. Licensing and Practice

679. In order to practise pharmacy it is required to have the university degree of pharmaceutical chemist and be inscribed in the Peruvian Pharmaceutical Chemists College (Art. 22, LGS).[1]

1. *Cf.* Art. 2 of the L. 15266, (DOEP, 18 December 1964. Foundation of the Peruvian Pharmaceutical Chemists College) according to Art. 1.1.03 of the DS. 187-65-SA, (DOEP, 16 July 1965).

V. Prescription of Medicines

680. The LGS (Art. 26) establishes that only physicians may prescribe medicines. Dental surgeons and obstetricians may only prescribe medicines within their professional area.

681. A medicine prescription must state the 'international common name' (ICN), the make, pharmaceutical form, posology, dosage and administration period. Those who prescribe a medicine are obliged to inform the patient regarding the risks, contra-indications, secondary effects and interactions that the administration might cause and regarding the precautions that must be adopted for correct and safe use of it.

VI. Sale of Medicines

682. The pharmaceutical chemist professional working in a pharmaceutical establishment is responsible for the conditions affecting the identity, purity and good condition of the products that are elaborated, prepared, manipulated, stored or provided in the establishment (LGS, Art. 66).

683. The ambulatory sale of pharmaceutical products is forbidden, with the exception of those products that the health authority classifies as 'pharmaceutical products for sale without a medical prescription that can be commercialised in non-pharmaceutical establishments'.

684. The health authority classifies the pharmaceutical products, for expenditure purposes, in the following categories:

- For sale after presenting a special numbered prescription that can only be sold in pharmacies and chemists;
- For sale under medical prescription that can only be sold in pharmacies and chemists;
- For sale without medical prescription that can exclusively be sold in pharmacies and chemists; and
- For sale without a medical prescription that can be commercialized in non-pharmaceutical establishments.

685. Pharmaceutical products that have a sanitary register[1] and are authorized for sale without a medical prescription can be publicly publicized.

1. According to the LGS, all products comprehended in Chapter III of the LGS, 'on pharmaceutical and Galenic products and on the natural therapeutic resources', require a sanitary register in their manufacture, import, distribution or sale (Art. 5 0).

VII. Publicity of the Medicines

686. Publicity for medicines and natural therapeutic resources is regulated by the LGS, by the Regulation regarding register, control and sanitary surveillance of pharmaceutical products and similar products[1] and by the Guidelines for publicity regarding medicines and natural therapeutic resources[2] of the Committee of Repression of Disloyal Competence of the National Institute for Defence of the Competence and Protection of Intellectual Property (INDECOPI).

1. DS. 010-97-SA, DOEP, 24 December 1997.
2. Res. 026-1998-CCD/INDECOPI, (DOEP, 22 May 1998).

687. Promotion and publicity of pharmaceutical products that can only be sold with a medical prescription is restricted to those professionals who prescribe and sell them.

688. Only as an exception and attending to justified reasons can the national health authority determine the pharmaceutical products that may only be sold with medical prescription that may be the object of publicity through public means that reach the general public, and in this case publicity must encourage the consumer to read the instructions on the prospect or note that the product includes.

§3. Obstetrician

I. General Aspects

689. In the marginalized areas of Peru, a great number of people use the natural delivery system because of many reasons, e.g. because obstetricians do not reach those areas, because the care costs are not affordable for everyone or because they think the hospital will make a mistake and exchange their baby for another person's baby.

690. To provide for this void in professional care there are people with empirical knowledge (midwives) who attend to women in labour.

691. The practice of obstetrics results in lower maternal mortality and baby mortality indexes. The number of babies born dead (born dead after 20 weeks of pregnancy) and of babies who die during the first 28 days after the birth has dropped. However, not all of these deaths can be avoided given that congenital anomalies are the main cause of baby mortality.

692. The obstetrician is legally allowed to provide care to women, families and communities in the administrative, educational and investigative areas within the public, non-public and private sectors.

693. The main task of an obstetrician is to assist women according to his/her professional capacities; this allows providing care and giving information about the reproductive capacity through education and consultation during which knowledge of diagnosis and therapeutics is applied. The obstetrician decides about auxiliary examination for diagnostic purposes, prescribes the medicines that are necessary to realize an optimal pregnancy for the mother-to-be and in so doing reduces maternal and infant morbidity and mortality.

694. Obstetrics is a medical profession with preventive, diagnostic and therapeutic capacities that gives integral care in the preconceptional and conceptional stages (prenatal, intranatal, postnatal and internatal) and to the newly born.

II. Education

695. Obstetrics is a career integrated within the medical profession and studied at a university.

696. The university study of obstetrics has a duration of ten semesters.

III. Licensing and Practice

697. Given its specialty and technicality, the study has academic and professional autonomy[1] and licensing is indispensable for the professional practice.

1. RM. 198-90-SA/DM (DOEP, 20 May 1990) approves the absolute autonomy of health professionals in obstetrics who hold a university degree. Moreover, Law L. 23346 (DOEP, 18 December 1981) recognizes obstetrics as a medical profession.

§4. Nurse

I. General Aspects

698. The nurse, as a professional in the health sciences, participates in the provision of integral health services in a scientific, technologic, systemic and humanistic way, and in the processes of health promotion, prevention, recovery and rehabilitation by taking care of the patient, family and community and taking into consideration the social, cultural, financial, environmental and political context in which he/she develops in order to contribute to the improvement of the quality of life and the well-being of the population.[1]

The professional training of a nurse takes place in four functional areas: administrative, assistance, educational and investigative. It is carried out in establishments of the public or private sector that are linked with the health of the national population. Regarding the scope of the profession it is determined that it '... develops through a combination of actions directed at solving the individual, family and community's different bio-psycho-social problems, and it basically covers the following areas: Assistance, Administration, Education and Investigation'.[2]

1. *Cf.* Art. 3 de la Ley 27669 (DOEP, 16 February 2002. Law of the Nurse's Work according to Art. 2 of its Regulation, D.S. 004-2002-SA (DOEP, 22 June 2002).
2. *Cf.* Art. 3 of the Law and Art. 5 of the Regulation.

II. Education

699. The university nursing course has a duration of ten semesters. It is forbidden to use the title of nurse or similar when referring to anyone who does not have the professional university degree and/or respective licensing.

The specialty has a duration of one and a half years and deals with: intensive

care; emergency and accidents; neurology; mental health and psychiatry; oncology and paediatrics.

III. Licensing and Practice

700. The nursing degree and inscription in the Peruvian Nurses College are compulsory in order to exercise the profession (Art. 22, LGS).[1]

1. *Cf.* Arts. 2 and 3 of the DL. 22315 (DOEP, 17 October 1978. Foundation of the Peruvian Nurses College) according to Arts. 2, 3 and 7 of its Regulation DS. 007-78-SA (DOEP, 26 October 1978) and its modifying law DS. 006-90-SA (DOEP, 4 June 1990). Also Art. 7 of the Regulation of the Law of the Nurse's Work.

701. In Peru there are some 33,000 registered nurses. However, this amount does not fit the practice given that it represents one nurse for every 40 patients in the Lima hospitals, which does not comply with the international average standard of one nurse for every 15 patients.[1]

1. *See El Comercio*, 6 May 2000, Section B, p. 16.

§5. Veterinary Surgeons

I. General Aspects

702. The veterinary surgeon studies and applies scientific and technologic knowledge to preserve and project animal health, and for breeding, production, reproduction and genetic improvement of domestic animals in order to improve living standards.

II. Education

703. The university study of veterinary surgeon has a duration of five years.

III. Licensing and Practice

704. Licensing is indispensable in order to exercise the profession.

§6. Biologist

I. General Aspects

705. The biologist studies living organisms and their interrelationships, taking into consideration the morphologic, biochemical, molecular, ecological, taxonomic,

etc. aspects. He/she investigates the genetic and physiologic structure and other fundamental aspects of all life forms in laboratories and in natural conditions.

II. Education

706. The study system of the professional career is by semesters, the study plan has ten academic semesters or five years and the professional degree in biology mentions specialities: cell and genetic biology, botany, hydrobiology and fishery, microbiology and parasitology and zoology.

III. Licensing and Practice

707. Licensing is indispensable for professional exercise.

§7. Psychologist

I. General Aspects

708. A psychologist is a scientist who studies human behaviour and contributes to the development of the psychic potential of the individual in order to achieve better life conditions through harmonious interpersonal relationships.

II. Education

709. The professional degree can be obtained through a thesis, through supporting a psychological case, through accreditation of three years of service in tasks corresponding to the profession, through degree examination that can be directly accessed by bachelors with thesis.

710. The university study of psychology has a duration of five years.

III. Licensing and Practice

711. Licensing is indispensable for professional exercise.

§8. Nutritionist

I. General Aspects

712. A nutritionist is a specialist in the area of food and nutrition. His/her main objective is to contribute to solving the national alimentary problems and improve the quality of life of the population.

II. Education

713. The university study of nutrition has a duration of five years. The title given is a degree in nutrition.

III. Licensing and Practice

714. Licensing is indispensable for professional exercise.

§9. Sanitary Engineer

I. General Aspects

715. A sanitary engineer is a person in charge of applying the engineering principles to the environment in relation to water, air, soil, food, housing and work centres, for integral health protection and promotion.

II. Education

716. The study system of the professional career is in semesters, the study plan has ten academic semesters or five years and the title given is that of sanitary engineer.

III. Licensing and Practice

717. Licensing is indispensable for professional exercise.

§10. Social Worker

718. The social assistant or worker applies the principles and laws of the social sciences in order to study and treat social problems. He/she gives integral diagnosis, contributes to social and human development, gives alternative solutions to social problems, plans a group of actions directed at helping families and communities in financial, educational, social and cultural aspects.

§11. Medical Technician

I. General Aspects

719. The medical technician is the professional who applies technology in the health area by employing modern electronic equipment and adapting the resources

available at that moment. He/she develops supporting activities that assist the diagnosis, treatment and rehabilitation of illnesses and their incapacitating consequences through analysis and laboratory examination.

720. Medical technicians were included in the group of health professionals so that they realize the SERUMS.[1]

1. DS. 005-97-SA (DOEP, 22 June 1997) Regulation of the Law that establishes the Rural and Marginal Urban Health Service (Servicio rural y urbano marginal de salud, SERUMS).

II. Education

721. The university study of medical technology has a duration of five years. The title given is a degree in medical technology and it mentions one of four specialties: clinical laboratory and pathological anatomy; physical therapy and rehabilitation; radiology; and occupational therapy.

Chapter 3. Relationship with Health Technicians and Auxiliary Staff

722. The LGS (Art. 35) determines that those who realize professional, technical or auxiliary activities related to human health are limited to exercise them within the area determined by the title, certificate, and authorization that has been given according to the law.

§1. Health Technician

723. Given the great demand in the study as well as in the *praxis* of medicine, there are the so-called health technicians, whose education is realized in a higher education centre (not university) where they spend three years studying in the theoretical, technical and practical areas in order to assist and help the health professionals.

724. The health technical studies are: nursing, clinical laboratory work, physiotherapy and rehabilitation (occupational therapist, osteopath), pharmacy, obstetrician, radiology technician, dental prosthetist, among the most important ones.

I. Paramedic

A. Terminology

725. The term paramedic is used more and more often to refer to a person who has a medical education and who carries out assistance activities.

726. At present there are no restrictions as to who can be called a paramedic. However, the LGS (Art. 35) states that those who carry out professional, technical or auxiliary activities related to human health are limited to exercise them in the area determined by the legal title, certificate or authorization.

B. Functions

727. A paramedic is a person who performs technical work in the health area. He/she has been trained to solve emergency situations, participate in accident rescue actions and to diagnose, resuscitate and transport patients in a delicate health state.

728. The paramedic profession provides primary care to sick people and patients and therefore the following specialties can be stated: giving injections, first aid, pharmacy auxiliary staff, infirmary auxiliary staff, obstetrics auxiliary staff, clinic laboratory auxiliary staff and dental mechanics (dental prosthetists).[1]

1. Occupation guide. Technical level. Ministry of Work and Social Promotion, General Work Executive Committee.

C. Education

729. The academic and technical training of paramedics takes place in higher education centres (not in universities) and has a duration of approximately three years.

§2. Health Care Auxiliary Staff

730. Auxiliary staff assist health professionals. Their study takes place in higher education institutes and has a duration of one year.

731. The auxiliary staff in the health area is the following: infirmary auxiliary staff and pharmacy auxiliary staff.

Chapter 4. Relationship with Other Health Institutions

§1. Prevention Centre

732. The 'Human Health Executive Committee of the Ministry of Health' has a preventive programme that focuses on scholar and adolescent health at a national level. It has a clearly promotional and preventive orientation (for example: the preventive programme for micronutrients is in charge of realizing activities directed at improving consumption and prevention of deficiency of vitamin A, iodine, iron and fluoride).

733. Within this line of work, the programme has created the 'Preventive Centres of Integral Attention', also known as 'Centres of integral differentiated attention', at a national level. Their methodology is to offer multiple services to adolescents, such as workshops on social abilities, handcrafts workshops, recreational and cultural locations, health education, counselling and orientation, etc.

§2. Health Insurance

I. General Aspects

734. A health insurance is a way to cover or make up for the costs derived from a sickness or health problem one may suffer and it makes it possible for a person suffering from a health problem to go to a medical practice and receive treatment that will be covered by the insurance company.

II. Structure of the Health Insurance System

735. The health insurance system in Peru is structured as follows.

A. Private Insurance

1. Legal Framework

736. According to the General Law of the Finance System and the Insurance System and to the Organic Law of the Bank and Insurance Superintendence L. 26702,[1] the insurance system is conformed by the insurance and reinsurance companies and the insurance intermediaries and auxiliaries.

1. General Law of the Finance System and the Insurance System and Organic Law of the Bank and Insurance Superintendency (DOEP, 9 December 1996).

737. Insurance and reinsurance companies operate in two fields: 1) life insurance and, 2) general insurance.

738. The mentioned insurance law states (Art. 318) that the companies of the insurance system can constitute a subsidiary health providing company, according to what is established in the Law for the Modernization of Health Social Security.[1]

1. L. 26790 (DOEP, 17 May 1997).

2. Need for a General Health Insurance Law

739. It can be noted that in Peru there is no general law of health insurance. This type of law seems necessary in order to properly focus the health care services provision through a private insurance.

B. Social Health Insurance

1. Background

740. This was created based on the IPSS,[1] which was an autonomous and decentralized institution with juridical legal capacity of internal public rights, dependent on the executive power, that was in charge of social security, i.e. it offered community members protection against the various risks through organized systems that covered various problems.

1. IPSS, L.24786 (DOEP, 24 December 1987).

2. Actuality

741. As a direct integrating part of the health social security, ESSALUD[1] is a public organism, decentralized and autonomous, with juridical legal capacity of internal public right, belonging to the work and social promotion sector.

1. L.27056 (DOEP, 30 January 1999) and DS.002-99-TR (DOEP, 27 May 1999).

3. Objective

742. Its objective is to give coverage to insured people and people with derived rights, through offering them services of health prevention, promotion, recovery, rehabilitation, and financial and social provision that correspond to the contributing regime of the health social security as well as through other human risks insurances.

4. Functions

743. Its functions are, amongst others:
- Administrate the contributing regime of the social security and other human risks insurances;
- Inscribe the insured people and employing entities;

- Collect, fiscalize, determine and receive payment of the contributions and other resources;
- Determine the qualification periods for the provision of services;
- Develop occupational health and professional risk prevention programmes;
- Promote the execution of spreading programmes regarding social security and health;
- Develop special programmes for the well-being of the elderly and incapacitated people;
- Develop extended social programmes and special health plans in favour of the population with no insurance and few resources;
- Give support to the population affected by accidents and catastrophes; and
- Carry out any other task that the law states or allows.

5. Provisions

744. The main provisions are:

- Illness prevention and health promotion (health education as well as risks and vaccination evaluation and control);
- Provisions for health recovery (medical care, medicines and medical consumables, prostheses and necessary orthopaedic devices and rehabilitation services);
- Provisions for maternity (health care for the expectant mother and care at delivery, extending it to the period immediately after the delivery and to the health of the newly born);
- Provisions of well-being and social promotion (projection activities, social help and work rehabilitation activities);
- Financial provisions (temporary incapacity subsidy, maternity and parental benefit, burial subsidy);
- Programmes for social extension and health plans in favour of people with no insurance and few resources as well as all other human risks insurances within the regime of free contract.

6. Beneficiaries

745. The area of application of the ESSALUD includes:

- Workers carrying out dependent or independent activities and people with rights derived from them;
- Agricultural and marine workers and people with rights derived from them;
- Villages that have suffered catastrophes or disasters;
- Pensioners and people with rights derived from them;
- People with mental and physical incapacity; people with no income;
- People who freely affiliate; people punished with a penalty of deprivation of freedom;
- State employees working abroad;

- Foreigners visiting the country as tourists;
- People who offer unpaid voluntary services to the community, including those who participate in social organizations that give support to the less wealthy population;
- School, university and higher non-university college education students; people working exclusively in housekeeping;
- Artists and other related activities.

C. Work Insurance

746. According to the Law for the Modernization of Health Social Security,[1] the complementary insurance for risky work provides additional protection to those regular affiliates of the health social security who carry out high-risk activities.[2]

1. L. 26790 (DOEP, 17 May 1997) and its regulation by DS. 009-97-SA (DOEP, 9 September 1997).
2. According to Annex 5 of the DS. 009-97-SA, high risk productive activities are the following: fishing, production of fuel and natural gas, metallic mineral extraction, extraction of other materials, tobacco industry, textile manufacture, leather and derivatives industry, wood and cork and derivatives industry, manufacture of chemical and industrial substances, manufacture of other chemical products, oil refinery, manufacture of products from oil and coal and derivatives, manufacture of plastic products, manufacture of products of glass and derivatives, other manufacture of non-metallic mineral products, basic iron and steel industry, manufacture of metallic products and machinery construction, electricity, gas and steam, construction, air transport, medical and dental services and other sanitary services and veterinary services.

747. This type of insurance is obligatory and on the employer's account.

748. The risks covered by this insurance are the following: offering of health care services, temporary or permanent invalidity pension, survivors' pension and burial costs when the condition is the result of a work accident or when the disease has been contracted as a consequence of professional exercise.

D. Free School Insurance

749. This insurance was created in August 1997 and has provided consultation free of charge on basic common pathologies (bronchitis, fits, diarrhoea, pelvic pain, sprains, etc.) and also teenage pregnancy.

750. Since the end of 1998 the 'Pilot Project Maternal-Infant Insurance' has been active and an extension to nine regions in the country has been planned in order for the project to cover the total national territory.

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