This article on recent events in international health law is divided into four parts: (1) informed consent standards for alternative medicine; (2) intersexuality; (3) HIV/AIDS; and (4) other recent developments.

I. An International Informed Consent Standard

In the last thirty years or so, legal doctrine has changed worldwide with respect to the concept of informed consent in medical malpractice cases. Health care is also changing. Patients are self-referring to complementary and alternative health care practitioners, and traditional health care practitioners are offering non-traditional health care services. Is there an international concept of informed consent that fits this new brand of health care?

A greater recognition of patient autonomy, arguably resulting from the human rights movement, has changed the lens through which informed consent is judged in a patient-centered approach. While this has shifted risk onto the patient, it has also generated a greater burden on health care professionals to provide more information to patients before undertaking medical procedures. Widespread use of treatments and procedures called alternative or complementary now raises the issue of the duty to disclose more of these choices.

There are various theories regarding the duty to inform, including measuring the duty from the physician’s viewpoint, or from the patient’s viewpoint. The traditional view in

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most jurisdictions is that the duty is measured by professional medical standards.\(^1\) By contrast, almost half of the jurisdictions in the United States have recently taken a more modern view that the duty to inform is measured by the patient's need for information material to his decision whether to accept or reject the proposed treatment.\(^2\) This modern view has also been adopted by several foreign countries, as will be noted in this review.

The questions this review addresses are: does an international informed consent standard exist and where do nations stand in relation to it?

A. In General

The concept of consent is customarily found in international law and conventions in the area of human rights. A review of international materials indicates that consent before treatment is a principle of customary international law. For example, the European Community Convention on Human Rights and Biomedicine discusses informed consent.\(^3\) The European Community Convention demands that no health care intervention be carried out until a person has given free and informed consent.\(^4\) The details and specifics that "inform" the person must be appropriate "as to the purpose and nature of the intervention as well as its consequences and risks."\(^5\) Although the European Community Convention lacks explicit reference to alternative medicine, it is often argued that document drafters considered and rejected a separate treatment of the subject. This reasoning is supported by the widespread use of alternative medicine throughout European Community member states.

The duty to inform and obtain consent appears in other international statements as well. Although these statements do not explicitly reference alternative medicine, they offer some guidance, as many were developed in light of experimental treatments. Consider that the World Health Organization (WHO) adopts the duty to inform,\(^6\) Principle One of the Nuremberg Code. Although only persuasive in U.S. courts,\(^7\) it requires absolute informed consent;\(^8\) the World Medical Association adopts the 1964 Declaration of Helsinki, as

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1. See, e.g., Laurent B. Frantz, Annotation, Modern Status of Views As to General Measure of Physician's Duty to Inform Patient of Risks of Proposed Treatment, 88 A.L.R. 3d 1008 (1999). This annotation collects representative modern cases bearing on the status of views as to the general measure of a physician's duty to inform his patient of the risks of a proposed treatment. It considers only pertinent cases decided in or after 1966; even as to those, it does not attempt to be exhaustive of such cases, but focuses on those that illustrate the basic dichotomy between the viewpoints relating to the customary or reasonable disclosure practices of physicians, and the viewpoints looking to the patient's need for information material to a decision whether to accept or reject the proposed treatment. Id.

2. Id. Jurisdictions that follow the patient viewpoint standard include Alabama, Alaska, California, Colorado, Connecticut, the District of Columbia, Florida, Hawaii, Illinois, Indiana, Iowa, Louisiana, Massachusetts, Mississippi, New Jersey, the 1st, 2nd, and 3rd Departments of New York, North Carolina, Ohio, Pennsylvania, Rhode Island, Texas, Vermont, Washington, and Wisconsin for a total of 24. See id.


4. Id. at ch. II, art. 5.

5. Id.

6. See Joe Collier, The Patient's Right to Know, 9/11/94 WORLD HEALTH 18, 1994, available in 1994 WL 13650795 (endorsing the principle that before a medicine is proscribed, the patient must be provided reliable and understandable information about it).


8. Principle One: The voluntary consent of the human subject is absolutely essential. This means that the person involved should have legal capacity to give consent; should be so situated as to be able to exercise free power of choice, without the intervention of any element of force, deceit, duress, over-reaching, or other
amended, requiring full consent; and the International Ethical Guidelines for Biomedical Research Involving Human Subjects, promulgated by the WHO and the Council for International Organizations of Medical Sciences, recognizes that though informed consent is important, it alone is insufficient to protect human subjects, particularly such vulnerable subjects as pregnant women and prisoners.

As this issue goes to press, the World Medical Association is reviewing the Helsinki Declaration, including its requirements for informed consent. The medical community has expressed concern that proposed changes will weaken the ethical principles underlying human research.

B. CANADA

The Canadian view of informed consent is consistent with the current trend in the United States that requires physicians to engage in more than a discussion about consent. The standard requires that in addition to describing the nature of the procedure, including its gravity, any material, special, or unusual risks must be discussed by the physician. For example, in *Arndt v. Smith*, the Canadian Supreme Court considered informed consent. A pregnant woman with chicken pox consulted her physician who advised her about some of the risks, but not about the less common, yet severe, ones. Her child was born with serious abnormalities related to the unmentioned, although uncommon risks. The plaintiff argued that she might have aborted her child if she had been informed of all the risks. Though the Court found no causal connection between the physician's failure to inform and the child's injuries, it reaffirmed the requirements of *Reibl v. Hughes*, an earlier decision declaring the standard.

C. FRANCE

As of 1997, France regarded the physician-patient relationship as one of contract. This is a significant departure from their previous practice. Physicians must now demonstrate

ulterior form of constraint or coercion; and should have sufficient knowledge and comprehension of the elements of the subject matter involved as to enable him to make an informed and enlightened decision. The latter requires that before the acceptance of an affirmative decision by the experimental subject there should be made known to him the nature, duration, and purpose of the experiment; the method and means by which it is to be conducted; all inconveniences and hazards reasonably to be expected; and the effects upon health or person that may possibly come from his participation in the experiment.

10. Id. at 181-84.
15. Id.
16. Id. at 66.
17. Id.
that they have effectively and validly informed the patient for all types of care, not just biomedical research. Failure to fulfill the contract may result in liability, making the format of consent more important. The concept of a contractual relationship in health care is a cutting edge approach that will reduce patient-physician litigation because of the legal principle that express agreements take precedence over common-law doctrines of negligence.

D. **England**

A review of British case law on the issue of informed consent and relevant literature reveals that Britain's medical professionals are responsible only for disclosing the amount and type of information that the responsible body of medical opinion would consider right and proper. This reasonable doctor standard significantly differs from the reasonable patient standards found in other countries such as the United States and Australia. At the core is a difference in attitude regarding the fundamental rights and responsibilities of the patient and what should take precedence in legal and medical matters. The reasonable doctor standard also disregards the premise that it is a fundamental right to determine what happens to one's body.

E. **Australia**

In 1985, Australian courts rejected the British view of informed consent, also known as the Bolam test. Instead, they adopted the reasonable patient standard enunciated in the 1957 Bolam dissent.

A study of Australian chiropractors found that informed consent for chiropractic care was usually implied. The study revealed that chiropractors seldom obtained formal verbal consent and never secured written consent. While new patients were informed about the procedures, potentially serious consequences were seldom discussed. However, the chiropractors studied actively attempted to identify at-risk patients. The study concluded that chiropractic behavior meets the moral requirements for informed consent but does not satisfy all legal requirements for such consent.

F. **Germany**

In Germany, lack of informed consent is an element of a criminal offense. Consent effectiveness depends on whether the patient was informed of all relevant points of treat-
ment.30 The German legislature has been asked to consider a new definition for unauthorized medical treatment.30 A 1997 study from Germany argues that physicians are responsible for "therapeutic enlightenment" as part of informed consent, by giving all information about possible or necessary treatment.31

G. Israel

Israeli Patients' Rights Law explicitly establishes the requirement of informed consent and divulges the details a doctor must relate to a patient to reach agreement on treatment.32 "In order to receive informed consent, the health care provider will relate to the patient the medical information reasonably necessary to him in order to enable him to decide whether to consent to the proposed treatment."33 In this context, "medical information" includes:34 the diagnosis and prognosis of the patient's medical condition; a description of the essence, procedure, objectives, benefits, and risks of the proposed treatment; the incidental risks associated with the proposed treatment, including side-effects, pain, and discomfort; the advantages and disadvantages of alternative medical treatments; the advantages and disadvantages of abstaining from proposed alternative therapies; and the innovative nature of the proposed treatment. The Israeli health care provider must relate the above information as soon as possible and do so in a manner that enables the patient to have the greatest possible understanding of the information. Information may be withheld only if the hospital or institution's ethics committee confirms that disclosure may cause serious damage to the patient's mental or physical health.

Interpreting the Patients' Rights Law, the Israeli Supreme Court stated that the duty to inform a patient is judged by recognized criteria of negligence, as applied on a case-by-case basis.35 The Court clarified the standard of disclosure as based on the needs of the patient whose consent is requested or upon what the reasonable patient would require to make an informed decision.36 The Court recognizes "innovative treatments" and requires a full discussion of the proposed treatment, the alternatives to treatment, and the implications of no treatment at all.37 Courts in both Israel and New York38 have referred to recognized criteria of negligence and rejected a paternalistic approach to the issue of consent with regard to innovative or unconventional treatments. The Israeli Court adds a duty to fully discuss not only the proposed treatment, but also alternative treatments.

H. Conclusion

There is an international standard that a patient must be given the opportunity to consent before treatment, although different countries judge the efficacy of that consent by different

29. See id.
30. See id.
33. Id. § 13(b).
34. Id.
36. Id. at 259.
37. Id.
criteria. No one international convention provides a set of guidelines for alternative or traditional health care providers. Current guidelines are either only for use with experimental treatments, or are limited by geographic applicability or jurisdictional limitations. Guidelines for experimental treatment can arguably be applied to the use of untested alternative treatments, but this does not alter the conclusion that no standard is adequate.

This inadequacy is important as patients are increasingly physically and electronically traveling across national borders to obtain treatment otherwise unavailable at home. In addition, pharmaceutical companies often test new drugs and devices in jurisdictions with less regulation. Without any international standards for informed consent, vulnerable populations will be at risk when untested treatments are used. There is a lack of efficacy because existing standards are not sufficiently codified, nor have they been adopted by widely recognized institutions. An international standard and a new model of contract should be considered the primary goal.

II. Intersexuality

The Constitutional Court of Colombia recently issued two decisions (SU-337/99, May 12, 1999 and T-551/99, Aug. 2, 1999) that significantly restrict the ability of parents and doctors to perform surgery on children born with atypical genitals. The two specific cases concerned a two-year-old child and an eight-year-old child. In both cases, the court found that the consent given by the parents for genital surgery on the child was invalid.

The decisions dramatically limit the ability of doctors in Colombia to perform early genital surgery on intersexed infants. The court established new rules restricting parents' authority to authorize genital surgery on their intersexed children, with the goal of forcing parents to put the child's best interest ahead of their own fears and concerns about sexual ambiguity. In the past, one ground for this surgery was that it would reduce some parents' difficulty tolerating their children's sexual difference. The court held that intersexed people constitute a minority entitled to protection by the state against discrimination. The court considered parents' authority to consent to medical procedures on behalf of their children, who are too young to consent for themselves, to depend upon (1) the exigency and urgency of the procedure; (2) how invasive and risky the procedure is; and (3) the age and degree of autonomy of the child (for instance, parents may consent to a vaccination for their child, but they may not force a teenage child to undergo cosmetic surgery).

Surgical modification of intersexed infants has been standard medical practice for some forty years. Currently, however, there is much controversy as to when and whether early surgery is helpful or harmful. An alternate model is that surgery should be performed only when those persons reach an age that they can give their own consent. In Colombia, the state has an interest in protecting the privacy and autonomy of the family. The state generally assumes that parents will act in the best interests of their children and that parents are in the best position to determine what is best for their particular child; therefore, the state should not be allowed to intervene unless there is a clear risk to the child.

In the case of intersexed infants, however, the court found that parents are likely to make decisions based upon their own fears and concerns rather than what is best for the child, especially if they are pressed to decide quickly. The court required that legal and medical communities establish a new category of consent, "qualified, persistent informed consent," intended to force parental decisions to take into account only the child's interest. The judges held that parents may consent to surgery only if they have been given accurate information about the risks and the existence of alternate treatment paradigms that reject early surgery.
Furthermore, the consent must be in written form and must be given on more than one occasion over an extended period of time, so the parents have time to more fully understand their child's condition and the ramifications of alternative treatment paradigms.

For children over five, parents cannot consent because the child has achieved an autonomy that must be respected and because the child has already developed a gender identity, which reduces the urgency of a decision as well as any potential benefits of surgery. In the case of the two-year-old child, the judges found the parents' consent invalid because it was not a "qualified and persistent informed consent" (Sentencia T-551/99, Bogota, Aug. 2, 1999). The consent of the parents of the eight-year-old child was likewise invalid because the child was too old for a surrogate to consent on her behalf (Sentencia SU-337/99, Bogota, May 12, 1999).

The decisions came after exhaustive consultations, more than a year long, in which the court surveyed experts both within Colombia and abroad on the medical, psychological, ethical, and legal aspects. The decisions reference a number of opinions by the European Court on Human Rights and previous opinions of the Constitutional Court of Colombia on protections for homosexuals and transsexuals. Among sources consulted domestically were the medical faculty of the University of Javeriana, the Colombian Psychological Society, the Colombian Psychiatric Society, the Colombian Society for Urology, and Dr. Bernard Ochoa (the surgeon considered Colombia's foremost scientific authority on intersexuality).

The judges found that the only point upon which proponents and critics of the surgery seemed to agree is that there are no long-term studies that would substantiate either position. Given the increasingly controversial nature of treatment by early surgery, the court held the criticism by intersexed people themselves to be of "decisive importance."

The two cases before the court grew out of what might be called Colombia's own "John/Joan" case. In 1997, media all over the world carried the story of "John/Joan." John was a boy whose penis was accidentally destroyed during circumcision in the 1960s. Although he was not intersexed, doctors decided the best way to manage a boy without a penis was to perform a sex change on him. For decades, it was incorrectly reported that the sex reassignment had been successful, and "John" had grown into a well-adjusted woman, "Joan." In 1997, the actual outcome of the "John/Joan" case was reported in a medical journal. Though doctors removed his penis and testes and administered estrogen, John never developed a female identity. Today he lives once again as a man, is married to a woman, and has adopted her children from a previous marriage. He has had surgery to make his genitals look more masculine and to remove the enlarged breasts he developed in response to the estrogen he was given when doctors were attempting to enhance his appearance as a girl.

In 1995, a young man who had been treated in a similar fashion petitioned the Colombian Constitutional Court for redress. After his penis was destroyed in a traumatic accident during infancy, doctors performed a surgical sex reassignment. But like "John/Joan," the Colombian boy never developed a female gender identity. Ultimately, he argued his case before the high court and won. In that case, the court held that parents cannot give consent on a child's behalf to surgeries intended to determine sexual identity (Sentencia T-477/95). Subsequently, it appears some surgeons specializing in intersexuality recommended surgery to parents of intersexed children but refused to perform the surgery on the basis of the 1995 decision. The parents of two children then brought suit, requesting that the court order the surgery.
Although the high court found that adequate consent had not been given in either case, surgeons operated on the two-year-old child just three days before the court began to hear the case. Although surgery had already occurred, the judges felt that the issues raised were important enough to deliberate on the case regardless.

The Constitutional Court has the final word on constitutional matters in Colombia, so no appeal is possible. However, the court noted that social attitudes toward intersexed persons are in flux. The court reserved the option of altering its opinion as social attitudes progress. Both decisions concluded with a quote from Dr. William Reiner of Johns Hopkins: “All of us must listen to these people, and we must learn not merely to live with them, but also to learn from them.”

The court made a point of sending its decision to medical and public health authorities including the National Academy of Medicine, the Colombian Urological Society, and the Ministry of Health. In addition, while the names of the parents and children involved in the cases will be kept private, the court found it important to enter all of the materials produced by its year-long investigation into the public record.

It is now the responsibility, the judges noted, of public authorities, the medical community, and ordinary citizens "to open a space to these people, who until now have been silenced."

Colombia’s Constitutional Court went further than merely discussing the question of early surgery on intersexed children. The court recognized that intersexed persons are a minority that enjoys the constitutional protection of the state against discrimination, and every individual has a constitutional right to define his or her own sexual identity.

III. HIV/AIDS

At the close of the twentieth century, a disease unknown to science just two decades earlier had claimed the lives of an estimated 16.3 million people: 6.5 million men, 6.2 million women, and 3.6 million children under the age of fifteen. HIV/AIDS struck every corner of the globe with devastating fury, killing the estimated 16.3 million people already mentioned and infecting another estimated 33.6 million people: 17.6 million men, 14.8 million women, and 1.2 million children under the age of fifteen. Of these infected persons, 5.6 million were estimated to have been newly infected in 1999: 2.7 million men, 2.3 million women, and 570,000 children under the age of fifteen.

The numbers are simply staggering. They also confirm that the AIDS crisis is not over, despite advances in antiretroviral therapy that decreased death rates in many industrialized


41. Id.

42. Id.

43. See also Kai Wright, Statistically Insignificant: Global AIDS Figures Don’t Tell the Whole Story, WASH. BLADE, Jan. 22, 1999, at 1, 10.

countries.45 Those advances produced false beliefs that there is a "cure" for AIDS and that it is no longer necessary to engage in "safe sex" or other preventive measures.46 The disease remains fatal, killing more people worldwide than any other infectious disease.47 Furthermore, even where nations can afford the cost of antiretroviral therapy,48 potential gains in life expectancy may be lost, as cases have documented the transmission of new viral strains that are resistant to existing antiretroviral drugs.49 A person who is HIV-positive may find, for example, that he or she has become reinfected with a new strain that is resistant to drug therapy. One study suggested that persons with low levels of HIV in their blood are less likely to transmit the virus to others,50 but other studies found that transmission is still possible even after successful therapy because the virus can hide in the brain and in other parts of the body that are not easily penetrated by the drugs.51 Hence, even a perceived lower risk of transmission does not remove the need for personal vigilance.

HIV remains a highly stigmatized disease in most of the world,52 and legal protections are inadequate to remove the stigma or to protect infected persons from acts of discrimination. In India, as in many other countries, the strong association between HIV and promiscuous sex causes some to believe that infected persons "somehow 'deserve' their fate."53 For example, UNAIDS and WHO reported that women whose husbands contract AIDS are especially stigmatized in India, even when the women themselves are not infected.54 In-laws may throw the women out of their homes and take their children.55 These women have little or no recourse through the Indian legal system.

Legal remedies have worked to protect the rights of persons with HIV in other countries, however. In Australia, for example, the Victorian Civil and Administrative Tribunal ruled that there was no justification for the Victoria Amateur Football Association to ban an HIV-

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45. See Mark E. Wojcik, Recent Developments in International Health Law, 33 INT'L LAW. 617 (1999); see also Charles C. J. Carpenter et al., Antiretroviral Therapy in Adults: Updated Recommendations of the International AIDS Society-USA Panel, 283 JAMA 381 (2000).
46. See, e.g., UNAIDS/WHO, supra note 40, at 4, 10. However, "[w]here antiretroviral therapy is widely available, it has increased the incentive for people at high risk of HIV [infection] to get tested, since the earlier they start taking the drugs the better." Id. at 8–9.
52. In an attempt to remove some of the stigma associated with AIDS in his country, South African High Court Judge Edwin Cameron announced in April that he had AIDS. See Rex Wockner, High Court Judge Says He Has AIDS, CHI. OUTLINES, May 5, 1999, at 10. He said that he had done so to ease the plight of other South Africans with HIV; just five months earlier, a woman was murdered in the township of KwaMashu after she disclosed that she had HIV. See HUMAN RIGHTS WATCH, WORLD REPORT 2000, 482–83 (1999).
53. See id.
54. See id.
55. See id. Additionally, hospitals in India are still reportedly refusing treatment to persons with HIV or serving their needs poorly, with some hospital staff believing that "treating patients with HIV was a waste of time and money because the patients would go on to die anyway." Id. See also Celia W. Dugger, Calcutta's Prostitutes Preach About Condoms, N.Y. TIMES, Jan. 4, 1999, at A1, A8.

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positive athlete and doing so violated section 65(b) of the Equal Opportunity Act. Victoria, however, also uses its general criminal law to aggressively prosecute persons living with HIV. In 1999, the Victoria County Court sentenced a bisexual doctor to more than four years imprisonment after pleading guilty to two counts. First, the doctor pled guilty to failing to tell his wife that he was HIV-positive, which was "recklessly engaging in conduct which placed a person in danger of serious injury." Second, the doctor pled guilty to submitting in February 1994 a fraudulent claim on a disability insurance policy that he had taken out the previous summer. The doctor alleged that he had become infected with HIV from a needle stick injury at work in December 1993. The court, however, found that the doctor had falsely declared to the insurance company that he had not engaged in anal sexual activity since 1980, when he was actually having anal sex regularly with other men before July 1993.

The use of criminal laws to prosecute persons with HIV continues to be criticized as counterproductive because these laws stigmatize persons with HIV, they are arbitrarily enforced, they discourage individuals from learning their HIV-status, and they focus, for example, full responsibility on the person with HIV rather than on the partner who consents to having unprotected sex. In a surprising criminal law twist in France, however, a former prime minister and two former cabinet ministers were themselves put on trial on charges of manslaughter and negligence in a scandal over their decision to allow untested blood and blood products to be used to treat hemophiliacs. The politicians were believed to have delayed testing the blood products until they could use a French HIV antibody test rather than an American test.

In the United States, the U.S. Supreme Court ruled unanimously that workers with disabilities should not automatically lose employment discrimination protection under the Americans with Disabilities Act if they apply for Social Security disability benefits. The decision was seen as a positive one for persons with HIV. However, in January 2000, the U.S. Supreme Court also refused a writ of certiorari on two other cases that were important to persons with HIV. In one case, the Seventh Circuit ruled that an insurance company could arbitrarily limit the benefits payable to persons with HIV without violating the Americans with Disabilities Act. In the second case, the Eleventh Circuit ruled that prison officials could segregate prisoners with HIV, even though medical evidence and practices

56. See Chris Ward, Making His Mark: Tribunal Rules in Favour of HIV Positive Player—When Matthew Hall Decided to Resume Playing Aussie Rules Last Year He Had No Idea He Would Make Legal History, 10 HIV/AIDS LEGAL LINK (Australia) 1, 6-7 (June/July 1999).
58. See id.
59. See id.
60. Id.
64. See, e.g., Louis Weisberg, High Court Ruling Favors People with HIV/AIDS, WINDY CITY TIMES, June 3, 1999, at 11.
in other prisons showed that such segregation was neither necessary nor warranted.\textsuperscript{66} Both decisions unfortunately upheld policies that arbitrarily discriminate against persons with HIV. The U.S. Supreme Court would have advanced the field of AIDS law by taking these cases.

\textbf{IV. Other Recent Developments in International Health}

\textbf{A. \textit{Female Genital Mutilation}}

The Parliament of Senegal has banned the traditional practice of female genital mutilation. Genital mutilation, called female circumcision by many Africans, involves the removal of all or part of the external female genitals to deprive women of sexual feeling. UNICEF estimates that approximately 130 million women have undergone the procedure. Several African nations have instituted similar bans.

In the largest trial of its kind in France, an African woman who performed ritual genital cuttings on forty-eight young girls was sentenced to eight years in prison. The jury also convicted twenty-seven of the victims' parents. The genital cutting tradition, practiced by members of France's African immigrant population, was ruled a violation of laws that prohibit the "mutilation" of a minor. Prosecutors described the ritual as a barbaric practice that attempts to control women by preventing sexual pleasure. Physicians testified that the practice, which may involve cutting off the clitoris and labia and sometimes sewing the vagina closed, often causes infections, painful scars, and other health complications.

\textbf{B. \textit{Genetics}}

The Parliament of Iceland sold its population's DNA or genetic information to DeCode Genetics, a biotechnology company. Iceland's geographical isolation, along with a history of population-devastating diseases, created an ideal DNA source for study. An "opt-out" system has been developed, whereby citizens have a short amount of time to refuse to donate a blood sample.

\textbf{C. \textit{Organ Donations}}

Directly related to Japan's controversial 1997 law that allows for some organ donations from brain-dead people to occur, the first legal heart and liver transplants were performed in Japan. The law does not define the absence of brain function as death but, rather, allows for organ donation by a patient whose brain has stopped functioning as long as the patient had given prior consent both to donate organs and to be diagnosed as brain-dead.

\textbf{D. \textit{Reproduction/Abortion}}

The Constitutional Court in Germany ordered Bavaria to conform to the rest of the country and allow abortion clinics. Germany's highest court ruled that the Bavarian law prohibiting abortion clinics was harmful to women's health because it forced them to travel to obtain an abortion.

\textsuperscript{66} Onishea v. Hopper, 171 F.3d 1289 (11th Cir. 1999), \textit{cert. denied sub nom.} Davis v. Hopper, 120 S. Ct. 931 (2000).
The U.K.'s 1967 Abortion Act and its 1990 amendments do not apply to Northern Ireland. Currently, in Northern Ireland, abortions are only legal when necessary to save the life of the mother. At Westminster, an all-party parliamentary committee has recommended changing the law in Northern Ireland to conform to the rest of the United Kingdom.

E. Cloning

Cloning technology continues to advance rapidly. Scientists from South Korea announced that they used the somatic cell nuclear transfer technique to create an embryo from an egg and somatic cell of an infertile woman. Scientists report that they stopped the growth of the four-cell embryo because of the legal and ethical implications of their work.

F. Forced Obstetrical Interventions

The Court of Appeal in London has issued guidelines about how to handle cases of forced obstetrical intervention. The guidelines state that competent women who refuse cesarean sections are not to be forced by hospitals or the courts to undergo the procedure.

G. Research

The Medical Research Council of Canada released an official statement titled "Ethical Conduct for Research Involving Humans," to which all persons seeking research funds from the Council must comply. The statement lists research conduct that the Council considers unethical, such as gene alteration of human germ-line cells, the use of ova or sperm obtained through commercial transactions, the creation of human embryos for research purposes, and the cloning of human beings.

H. Surrogate Motherhood

The U.K. Department of Health released its "Brazier Report" on surrogacy arrangements. The report recommended that payments to surrogate mothers should only cover pregnancy expenses, and there should be an upper and lower age limit for surrogate mothers and a limit on how often a woman can be a surrogate.