UN WOMEN

Abortion in Complex Medical Cases: Maternal Rights, Fetal Conditions, and Brain-Dead Pregnancy Cases in Global Ethical Standards

1. History of the committee

The United Nations Entity for Gender Equality and the Empowerment of Women, known as UN Women, was established in 2010 by the United Nations General Assembly. It brought together several existing offices and mechanisms focused on women's rights into a single body, with the primary aim of promoting gender equality and strengthening women's participation in all spheres of life. Its creation reflected a recognition that fragmented approaches were insufficient and that a dedicated institution was needed to advance women's rights globally, particularly in areas where cultural, social, and legal barriers had long limited progress.

UN Women was designed to ensure equal representation and consideration of women's perspectives within the broader UN system. It operates not as a legislature but as a policy-setting and coordinating body that works with member states to set global standards, provide technical expertise, and support the implementation of commitments. This structure was intended to amplify women's voices on the global stage and to serve as a stable, deliberative institution within the United Nations system.

Since its creation, UN Women has played a central role in shaping international dialogue on gender equality, from combating violence against women to promoting women's leadership and economic participation. Its influence grew rapidly, especially through its support of the Commission on the Status of Women (CSW) and through its leadership in implementing frameworks like the Beijing Declaration and Platform for Action and the Sustainable Development Goals, particularly Goal 5 on gender equality. UN Women has also supported

regional and national efforts to harmonize laws and policies with international standards on reproductive health and rights.

One development in recent decades has been the increasing recognition of reproductive rights as fundamental to women's human rights. International debates over maternal health have brought attention to difficult medical and ethical situations, such as cases involving women declared brain-dead during pregnancy or pregnancies where severe fetal anomalies are diagnosed. While approaches vary widely across regions, the global conversation has increasingly focused on balancing maternal autonomy and cultural or religious values.

Recently, UN Women has been the center of discussions about abortion in complex medical cases, where ethical and legal principles intersect with human rights protections. Cases such as that of Marlise Muñoz in Texas, or similar incidents in Ireland and Poland, have emphasized the absence of a unified global framework. This is why there is a need for international debate on whether pregnant women who are brain-dead must remain on life support, whether abortion should be permitted in cases of severe fetal anomaly, and how global norms should resolve different cultural, religious, and legal traditions.

UN Women continues to exercise deep influence on international policy, particularly when it comes to contested issues at the intersection of health, ethics, and individual freedoms. It is within this global institutional context that the current discussion on abortion in complex medical cases including maternal rights, fetal conditions, and brain-dead pregnancy cases must be addressed.

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1. Introduction

The debate surrounding abortion in complex medical cases has become one of the most

challenging issues in global reproductive rights. Situations such as pregnancies carried by women who are declared brain-dead, or pregnancies where severe fetal anomalies like Down syndrome or anencephaly are diagnosed, show the profound dilemmas at the intersection of maternal autonomy, medical ethics, and societal values. These cases force difficult questions: should life support be maintained for a woman who is legally dead in order to sustain a pregnancy? Should abortion be permitted when a fetus is diagnosed with conditions that will cause lifelong disability or make survival impossible? And who bears responsibility when families are left with financial, emotional, and legal burdens after such cases?

One tragic example is the case of Adriana Smith, a woman declared brain-dead during pregnancy whose family was compelled by hospital policy to maintain her on life support until delivery. Despite her inability to consent, medical treatment continued for months, and after the child was delivered, her family was left with heavy debts from prolonged hospitalization. Her case drew international attention to the costs, both human and financial, of laws and practices that override a woman's autonomy for the sake of fetal viability. Other cases, such as that of Marlise Muñoz in the United States and similar incidents in Ireland and Poland, have underscored the recurring global pattern: families and doctors caught between legal mandates, ethical principles, and deeply personal decisions.

This issue is significant not only because it directly affects the dignity and autonomy of women, but also because it forces societies to confront broader questions. Should laws or medical protocols compel the use of a person's body without consent, even after death? At what point should a fetus be recognized as having rights independent of the pregnant woman? Should abortion in cases of genetic conditions be considered a medical right or a form of discrimination against people with disabilities? And to what extent should religion, culture, or tradition play a role in shaping these answers?

UN Women, as the body tasked with advancing gender equality and women's rights, is uniquely positioned to foster a global debate on these questions. Unlike national legislatures, UN

Women engages with a wide range of cultural, legal, and ethical perspectives, bringing together states that recognize abortion as a fundamental right and those that prohibit it in nearly all cases. Its role is not to impose a single answer, but to create the space for international dialogue on the principles of autonomy, human dignity, and health in the most difficult reproductive situations. This guide is intended to provide delegates with the context, background, and questions to engage meaningfully with this issue, and to consider whether international standards should be set to govern abortion in complex medical cases, including brain-dead pregnancies, maternal rights, and fetal conditions.

2. *Historical context*

The debate over abortion in complex medical cases, including pregnancies carried by women who are brain-dead and pregnancies where severe fetal anomalies are detected, is deeply connected to the global struggle for women's rights, bodily autonomy, and gender equality. Since its creation in 2010, UN Women has worked alongside other UN bodies to ensure that reproductive rights are addressed not only as health issues, but as fundamental human rights central to women's dignity and equality.

Historically, abortion was criminalized in most countries throughout the 19th and early 20th centuries, reflecting cultural, religious, and political traditions that prioritized fetal life over maternal autonomy. Change began in the mid-20th century, when feminist movements, rising awareness of maternal mortality from unsafe abortions, and the growing recognition of reproductive freedom as a human right led to gradual liberalization. Countries such as the United Kingdom, Sweden, and Denmark passed laws allowing abortion under health or social grounds. Later, constitutional reforms in Canada and South Africa further expanded abortion access as part of broader commitments to equality.

Yet restrictions remain widespread. In some states, such as El Salvador, Honduras, and Malta, abortion is prohibited under all circumstances, including when the pregnant woman's life is at risk. In others, abortion is allowed only in limited situations, such as saving the woman's life or in cases of rape. At the same time, advances in prenatal testing created new ethical dilemmas:

should abortion be permitted when conditions like Down syndrome or anencephaly are detected? Some countries, such as Iceland and Denmark, allow abortion in these circumstances, while others prohibit it, raising tensions between disability rights, parental choice, and reproductive autonomy.

Cases of pregnant women in irreversible medical conditions have drawn global attention. In Ireland, Poland, and Argentina, legal mandates or hospital decisions have compelled families to maintain life support for brain-dead or incapacitated women until fetal viability, even when such measures contradicted medical advice or family wishes. The case of Adriana Smith, whose family was forced to keep her on life support during pregnancy and later left with unpayable medical debts, reflects the deep personal and financial costs that can arise from such policies.

Internationally, no binding treaty directly governs abortion in these complex scenarios. However, several frameworks guide UN Women's engagement. The Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) obliges states to eliminate discrimination in health care and ensure equal rights in reproductive decision-making. The Beijing Declaration and Platform for Action (1995), supported by UN Women, identifies reproductive rights as essential for women's empowerment. More recently, the Sustainable Development Goals, particularly Goal 5 on gender equality, reinforce the need to ensure universal access to sexual and reproductive health and rights.

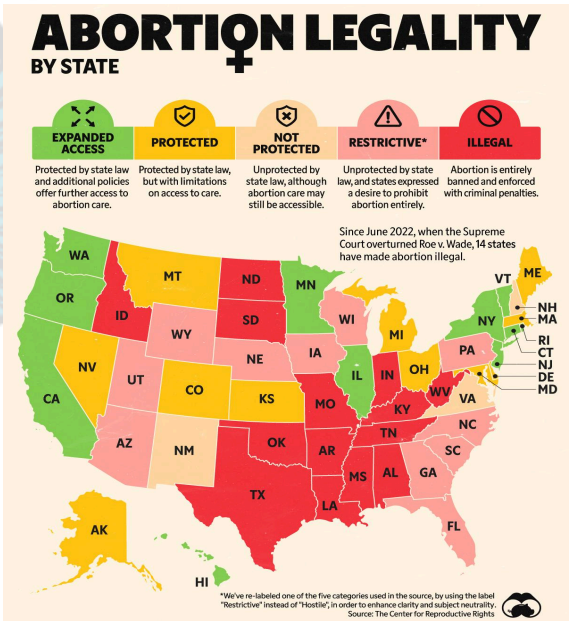
Despite these structures, the global divergence continues. Some states interpret international standards as supporting abortion access in complex medical cases, while others resist such interpretations, framing abortion as incompatible with cultural or religious values. This gap shows why UN Women plays a critical role: creating a space for dialogue, raising awareness of women's lived experiences, and pushing for global consensus that respects autonomy, dignity, and equality in even the most difficult medical circumstances.

3. Current Issue

The legal and moral environment surrounding abortion in complex medical cases has

become increasingly contested worldwide. While some countries have expanded access to reproductive health services, others have enacted restrictive policies that compel women and families into situations of profound ethical and emotional difficulty. Among the most pressing of these dilemmas are cases where pregnant individuals are declared brain-dead or otherwise incapacitated, and situations where severe fetal anomalies are detected but abortion is legally prohibited.

Across the world, laws differ sharply. In countries such as Canada, Sweden, and South Africa, reproductive rights frameworks emphasize autonomy and informed consent, ensuring that a woman's prior medical wishes or her family's decision are respected even in cases of brain death. In contrast, countries like Poland, El Salvador, and Honduras enforce restrictive laws that may prevent abortion even in circumstances where the pregnant woman is legally dead or where the fetus has no chance of survival. In some contexts, hospitals are required to maintain life support until fetal viability, regardless of medical prognosis or consent. The case of Adriana Smith, a woman declared brain-dead and kept on life support for months until delivery, left her family devastated and burdened with enormous medical debts, underscoring the heavy human and financial costs of such mandates.



The situation is equally complex when it comes to fetal anomalies. In Iceland and Denmark, abortion is commonly permitted in cases of chromosomal conditions such as Down syndrome, and termination is frequently chosen by families following prenatal testing. Supporters frame this as a matter of reproductive choice and compassion, while critics argue it risks perpetuating stigma and discrimination against people with disabilities. In contrast, many countries, particularly in Latin America and sub-Saharan Africa, prohibit abortion in these cases, forcing families to continue pregnancies even when children will be born with conditions incompatible with long-term survival.

These divergent policies have sparked growing concern among doctors, bioethicists, and

human rights advocates. Leading medical organizations, including the World Health Organization, affirm that forcing women or their families into continuing pregnancies against their will undermines the principles of autonomy, informed consent, and dignity in health care. International experts warn that such mandates not only violate medical ethics but may also constitute cruel, inhuman, or degrading treatment under international human rights law.

Still, strong opposition remains in many states and communities. Religious and pro-life advocacy groups defend restrictive laws as necessary to protect fetal life, even when it requires extraordinary medical measures. Some argue that advances in medical technology shift the threshold of fetal viability and therefore expand the obligations of health systems to preserve life.

In practice, families confronted with these situations often face drawn-out legal battles, emotional trauma, and severe financial costs. Hospitals and physicians are left in difficult positions, navigating unclear or contradictory rules that expose them to legal liability and public criticism. The lack of clear international standards leaves this as a legal and ethical gray area, one that magnifies inequalities between women across different regions.

4. Past International actions

Although no binding international treaty specifically addresses abortion in complex medical cases, including the treatment of brain-dead pregnant women, several instruments and global advocacy efforts have laid the groundwork for international standards on reproductive rights, bodily autonomy, and medical ethics. These frameworks guide the work of UN Women and the wider UN system in promoting global dialogue on gender equality and reproductive justice.

One of the most important frameworks is the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), adopted in 1979 and often described as an international bill of rights for women. CEDAW obliges states to guarantee equal access to healthcare, including family planning and reproductive decision-making. In its General Recommendation No. 24 on women and health, the CEDAW Committee stressed that coercive

practices including forced medical interventions violate women's rights. This principle is directly relevant to cases where pregnant women, including those who are brain-dead, are subjected to life-sustaining treatment without prior consent.

The UNESCO Universal Declaration on Bioethics and Human Rights, adopted in 2005, further emphasized the centrality of individual autonomy in medical decisions. Article 5 explicitly affirms that people must be free to make responsible choices about their own health care, and that those choices must be respected even in end-of-life contexts. This principle contrasts with policies that require keeping a deceased woman on life support purely due to pregnancy.

The United Nations Human Rights Committee has also issued strong guidance in this area. In its 2018 General Comment No. 36 on the right to life, the Committee stated that restrictive abortion laws and policies forcing someone to continue a pregnancy may constitute cruel, inhuman, or degrading treatment. While the guidance focused on living women, its underlying message that reproductive autonomy is central to human dignity applies equally to cases where a woman's prior wishes are ignored after death.

International advocacy organizations, such as Amnesty International, Human Rights Watch, and the Center for Reproductive Rights, have consistently criticized laws that restrict abortion or compel women to remain pregnant against their will. They argue that such policies undermine international human rights standards and perpetuate gender inequality.

Practices vary widely among states. Countries such as El Salvador, Nicaragua, and Honduras have total abortion bans and prioritize fetal rights in almost all circumstances, but even these nations rarely require life support for brain-dead women. In most democratic countries including Canada, Japan, and those in the European Union brain death is recognized as legal death, and forcing a woman's body to sustain a pregnancy without consent is considered ethically unacceptable.

So far, there has been no coordinated international treaty or resolution that directly governs abortion in complex medical cases. However, the growing body of human rights standards, combined with UN Women's advocacy and monitoring, signals an increasing

awareness of the urgent need for global guidelines. The absence of binding norms leaves women vulnerable to inconsistent and often discriminatory policies, making it clear that the international community must take more decisive action to protect autonomy, equality, and dignity in reproductive health.

5. *Subtopics*

I. Maternal Autonomy and Consent vs. Fetal Viability

Bodily autonomy is a cornerstone of both human rights law and medical ethics. Yet in some countries, laws prioritize the continuation of pregnancy over respecting a woman's prior wishes, even when she has been declared brain-dead or is otherwise unable to consent. This section examines the tension between honoring advance directives, respecting dignity in death, and protecting potential life. It asks a fundamental question: does pregnancy alter the scope of rights an individual retains over their body, even after death or incapacity?

II. Legal Definitions of Death and Personhood Across Cultures

While brain death is recognized as legal death in most countries, exceptions in certain jurisdictions blur this standard, especially when pregnancy is involved. At the same time, definitions of when a fetus becomes a "person" vary widely: conception, viability outside the womb, or birth. This section considers how cultural, religious, and legal traditions shape these definitions, and how inconsistent standards complicate international discussions on abortion.

III. Religion, Morality, and Public Policy

Religious traditions continue to strongly influence abortion policy worldwide. In predominantly Catholic countries such as El Salvador and Poland, abortion remains severely restricted, while secular democracies such as Sweden and Canada permit it broadly. This section explores how moral and religious beliefs shape national law, how they interact with secular principles of equality, and whether international human rights standards should limit the role of religion in these decisions.

IV. Global Oversight and the Role of International Institutions

Unlike national legislatures, UN bodies cannot impose binding abortion laws, but they

can set standards and exert political and moral pressure. This section explores whether UN Women and other institutions should push for international guidelines on abortion in complex medical cases, and whether stronger commitments are needed to prevent practices that undermine women's autonomy and health.

V. Impact on Families, Healthcare Providers, and Medical Systems

The consequences of restrictive abortion laws extend far beyond the patient. Families often endure months of emotional distress, financial burdens, and legal battles when forced to sustain pregnancies against their wishes. For doctors and hospitals, unclear or conflicting laws create ethical dilemmas, professional risks, and distrust between patients and providers. This section highlights the human and systemic costs of these policies.

VI. Disability Rights and Selective Abortion

The rise of prenatal testing has led to debates about terminating pregnancies when chromosomal or structural anomalies are detected, such as Down syndrome, Edwards syndrome, or anencephaly. Some view abortion in such cases as a medical right, while others see it as discriminatory toward people with disabilities. This section considers whether international law should address the balance between reproductive freedom and disability rights.

VII. International Human Rights Standards and Gaps

Global norms, including CEDAW and the Universal Declaration on Bioethics and Human Rights, emphasize informed consent and autonomy, yet many national laws diverge from these principles. This section compares restrictive abortion laws to international human rights standards and asks whether stronger binding instruments are needed to protect women's rights in complex medical cases.

VIII. The Slippery Slope: Posthumous Use of the Human Body Without Consent

Using a deceased or incapacitated woman's body to sustain a pregnancy raises broader concerns about consent. This section explores whether such practices could open the door to other uses of human bodies without prior authorization, such as organ harvesting or experimental procedures, and what this means for global trust in medical systems.

6. *Positions*

- **United States (USA):**

  The U.S. is divided. Federally, Roe v. Wade's reversal left abortion law to the states. Some states (California, New York) support broad access, including in cases of severe fetal anomalies or maternal incapacity. Others (Texas, Alabama) enforce near-total bans, even in life-threatening cases. In international forums, the U.S. often avoids strong pro-choice commitments due to domestic politics, but aligns with Western allies like France and Sweden in defending maternal rights.

- **Canada:**

  Canada has no federal abortion law; abortion is treated as a medical decision between a patient and a doctor. It strongly supports maternal autonomy and reproductive rights globally. Canada argues that forcing brain-dead women to continue pregnancies violates human dignity and international human rights. Often partners with Nordic countries to push back against religiously restrictive policies.

- **European Union (with focus on France, Poland, and Italy):**

  Western EU members like **France, Germany, and Sweden** advocate for women's autonomy and disability-inclusive reproductive rights. By contrast, **Poland** enforces one of Europe's strictest abortion laws, allowing it only in cases of rape or threat to the mother's life — fetal anomaly exceptions were struck down in 2020. Italy sits in the middle: abortion is legal but Catholic influence keeps debate tense, with many doctors claiming conscientious objection. This internal division weakens the EU's unified voice in UN forums.

- **Latin America (Mexico, Argentina, El Salvador):**

  Latin America is a region of extremes. **Argentina** legalized abortion up to 14 weeks in 2020 and promotes progressive policies abroad. **Mexico**'s Supreme Court recently declared abortion bans unconstitutional, signaling a regional shift. But countries like **El Salvador** and **Honduras** maintain absolute bans — even prosecuting women for miscarriages. The clash reflects Catholic and evangelical influence versus rising feminist movements (the "green wave").

- **Middle East (Saudi Arabia, Iran, Turkey):**

  In **Saudi Arabia** and **Iran**, abortion is largely banned except when the mother's life is at

risk, and religious authorities dominate decision-making. Fetal anomalies or brain-dead cases are rarely accepted as grounds for termination. **Turkey**, though Muslim-majority, officially allows abortion up to 10 weeks, but in practice social and political pressure make access harder. These states tend to resist international guidelines, citing religious sovereignty.

- **Africa (South Africa, Nigeria, Ethiopia):**

  South Africa is one of the most progressive, allowing abortion on broad grounds, and often acts as a leader in African negotiations. **Nigeria**, with strong Christian and Muslim opposition, enforces severe restrictions, shaping African blocs to resist liberal UN resolutions. **Ethiopia** is somewhat more flexible, allowing abortion in cases of rape, incest, or fetal impairment. The continent's position is thus fractured between progressive health-driven states and conservative religious ones.

- **Russia and Eastern Europe:**

  Russia permits abortion fairly widely but under conservative rhetoric emphasizes "protecting life" and discourages what it calls "abortion on demand." It often allies with Orthodox-majority countries (Serbia, Belarus) and sometimes sides with religious states like Iran in UN negotiations, framing liberal abortion rights as "Western imposition."

- **China:**

  Historically, China promoted abortion during the one-child policy, but now with a falling birthrate it is restricting access to encourage higher fertility. While it still legally allows abortion (including for fetal anomalies), the state increasingly discourages it. At the UN, China avoids strong commitments, prioritizing sovereignty and demographic policy flexibility.

- **Holy See (Vatican):**

  Not a voting member, but an influential observer. The Vatican opposes abortion under any circumstance, including brain-dead pregnancies and fetal anomalies, arguing every life is sacred. It exerts influence over Catholic-majority countries and often lobbies within the UN system to block progressive language.

7. *Guiding questions*

- To what extent should maternal autonomy and consent prevail over fetal viability, particularly in cases where the mother is brain-dead or unable to consent?
- Should pregnancy alter the rights an individual retains over their body after death or incapacity?
- How do different legal and cultural definitions of *death* and *personhood*—such as brain death vs. cardiac death, or personhood at conception vs. birth—complicate international consensus on abortion in complex medical cases?
- Should international law protect the right to refuse medical treatment and life support even during pregnancy, or should fetal viability be treated as an overriding principle in some jurisdictions?
- How should international institutions like UN Women address the conflict between religious traditions (Catholicism, Islam, Hinduism, etc.) that restrict abortion and secular principles of equality and autonomy?
- Is it appropriate for human rights bodies to challenge the influence of religion on abortion policy?
- Should selective abortion based on severe fetal anomalies (such as anencephaly, Edwards syndrome, or Down syndrome) be treated as a medical right, or as a form of discrimination against people with disabilities?
- How can international standards (CEDAW, ICCPR, UDHR, Universal Declaration on Bioethics and Human Rights) be reconciled with national laws that criminalize abortion even in cases of maternal death, rape, or non-viable fetuses?
- Do we need a binding global instrument on reproductive rights?
- Is it ethically defensible to sustain a pregnancy in a legally deceased woman without her prior consent? Could this create dangerous precedents for other posthumous interventions (organ harvesting, experimental medicine) without consent?
- What responsibilities do healthcare providers have when national law forces them to act against medical ethics (e.g., prolonging brain-dead pregnancies, denying abortion in emergencies)? Should professional medical standards override national law in such cases?
- What impact do restrictive abortion laws have on families—emotionally, financially, and

legally—when they are forced to sustain pregnancies against their wishes? How can these burdens be addressed at the policy level?

- Could restrictive abortion laws embedded in religious or ideological beliefs violate international commitments to secular governance, pluralism, and freedom of conscience?
- Should abortion be considered a fundamental *human right* globally, or should states retain sovereignty to define it according to cultural, moral, and religious traditions?
- In societies with high rates of prenatal testing, should the availability of abortion for genetic disorders be seen as protecting maternal choice, or as contributing to systemic ableism against people with disabilities?

8. *Suggested sources*

American College of Obstetricians and Gynecologists (ACOG) – Official ethical opinions on life support, brain death, and pregnancy.
https://www.acog.org

Uniform Determination of Death Act (UDDA) – Legal framework defining brain death in all 50 U.S. states.
https://www.uniformlaws.org

National Conference of State Legislatures (NCSL) – Updated database of state laws on pregnancy, abortion, and life-sustaining treatment.
https://www.ncsl.org

Center for Reproductive Rights – Legal analysis and state-by-state maps post-*Dobbs*.
https://reproductiverights.org

Harvard Law Review – Articles on constitutional implications of abortion restrictions post-*Dobbs*.
https://harvardlawreview.org

United Nations Human Rights Council – Reports on bodily autonomy and forced medical interventions.
https://www.ohchr.org

World Health Organization (WHO) – Guidance on end-of-life care, ethics, and pregnancy in critical care settings.
https://www.who.int

National Library of Medicine (NLM) – Research articles and clinical guidelines on brain death, pregnancy, and ethical considerations in life support cases.
https://www.ncbi.nlm.nih.gov/

Bibliography

Bohren, M. A., Vogel, J. P., Hunter, E. C., Lutsiv, O., Makh, S. K., Souza, J. P., Aguiar, C., Coneglian, F. S., Diniz, A. L. A., Tunçalp, Ö., Javadi, D., Oladapo, O. T., Khosla, R., Hindin, M. J., & Gülmezoglu, A. M. (2015). The Mistreatment of Women during Childbirth in Health Facilities Globally: A Mixed-Methods Systematic Review. *PLoS Medicine*, *12*(6), e1001847. https://doi.org/10.1371/journal.pmed.1001847

Breitwieser, L. (n.d.). *Keeping brain-dead pregnant women on life support raises ethical issues that go beyond abortion politics*. The Conversation. https://theconversation.com/keeping-brain-dead-pregnant-women-on-life-support-raises-ethical-issues-that-go-beyond-abortion-politics-258457

Center for Reproductive Rights. (2025, August 8). *Abortion laws by State - Center for Reproductive Rights*. https://reproductiverights.org/maps/abortion-laws-by-state/

Frohwirth, L., Coleman, M., & Moore, A. M. (2018). Managing religion and morality within the abortion Experience: Qualitative interviews with women obtaining abortions in the U.S. *World Medical & Health Policy*, *10*(4), 381–400. https://doi.org/10.1002/wmh3.289

Gomez, I., Diep, K., Felix, M., & Salganicoff, A. (2024, June 20). *10 things to know about abortion access since the Dobbs decision | KFF*. KFF. https://www.kff.org/policy-watch/10-things-to-know-about-abortion-access-since-the-dobbs-decision/

Goodwyn, W. (2014, January 28). The strange case of Marlise Munoz and John Peter Smith Hospital. *NPR*. https://www.npr.org/sections/health-shots/2014/01/28/267759687/the-strange-case-of-marlise-munoz-and-john-peter-smith-hospital

Historical abortion law timeline: 1850 to today. (n.d.). Planned Parenthood Action Fund. https://www.plannedparenthoodaction.org/issues/abortion/abortion-central-history-reproductive-health-care-america/historical-abortion-law-timeline-1850-today

KFF. (2025, June 17). *State and Federal Reproductive Rights and Abortion Litigation Tracker | KFF*. https://www.kff.org/womens-health-policy/report/state-and-federal-reproductive-rights-and-abortion-litigation-tracker/

Reporter, G. S. (2025a, May 15). Pregnant US woman declared brain dead is being kept alive under state abortion law. *The Guardian*. https://www.theguardian.com/us-news/2025/may/15/pregnant-georgia-woman-brain-dead-abortion-law

Senate Select Committee on Ethics: A Brief History of Its Evolution and Jurisdiction. (n.d.). CONGRESS.GOV. https://www.congress.gov/crs-product/RL30650

Shariff, M. (2012). Assisted Death and the Slippery Slope—Finding clarity amid advocacy, convergence, and complexity. *Current Oncology*, *19*(3), 143–154. https://doi.org/10.3747/co.19.1095

U.S. Senate: Origins and Foundations. (2025, February 24). https://www.senate.gov/about/origins-foundations.htm

Warren, A., Kelly, S., Karus-McElvogue, A., & Burnstein, R. (2020). Brain death in early pregnancy: A legal and ethical challenge coming to your intensive care unit? *Journal of the Intensive Care Society*, *22*(3), 214–219. https://doi.org/10.1177/1751143720918974