Royal Model United Nations
2026

GLOBAL BOARD OF MEDICAL ETHICS

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LETTER FROM THE SECRETARIAT

Dearest participants of ROYMUN'26,

It is the greatest honor to welcome you to the first edition of Royal Model United Nations 2026 and our GLOBAL BOARD OF MEDICAL ETHICS committee.

While shaping the ideas from the very beginning, our main goal was to ensure an extensive experience with both academic and organisational perfection.

In this prestigious committee, you will be raising impeccable ideas, debating about the current and the upcoming process, building new structures and turning the non-integrated actions and solutions to a masterpiece. Your board members will be guiding you to reach perfection in any situation.

While preparing, you will be discovering every single step about your topic and you may even find yourself in the middle of this sequence of events. It will be clear that you embrace your role in the committee.

Keep in mind that every speech you deliver, every motion you give, every question that you ask will gain a new perspective for everyone. The key point is to remain active and work confidentially while shaping the decision-making process with your colleagues.

As the Secretary-General, I am impatiently waiting to see your intelligent work and looking forward to sharing this royal experience with you.

Sincerely,
İmge Belgin
Secretary-General of ROYMUN'26

LETTER FROM THE CHAIRBOARD

Dear Delegates,

It is an honor, and a delight to welcome you to this year's inaugural edition of RoyalMUN as your under-secretary-general Emir Elhatip. We have prepared a committee for you where you are trusted with the politics that surround the most instrumental concept in the world, the allocation and preservation of life itself, and henceforth. During these three days, you will be navigating the complex-yet-compelling waters of medical ethics, and argue from positions not of legal and procedural standings, but of morality, humanity, and equity. I sincerely believe that this experience will allow you to connect deeply with the underlying themes of being an MUN delegate, and help you separate the procedure from the principle. I, personally, am looking forward to the debates, and wish you a spectacular time. Before I conclude, I would like to thank the rest of my team, Alper, Bahar, and Yağız for their remarkable contributions to the preparations, and their evident participation in said debates as board members.

All the best,

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Global public health experienced significant transformation in the early 20th century, particularly with the involvement of institutions such as the Rockefeller Foundation (RF). The RF established new frameworks that transcended narrow political and economic self interest.The RF shaped other health organizations and spearheaded the establishment of public health schools and disease campaigns. It contributed to the creation of national public health departments around the world and institutionalized international health.

In 1946, the World Health Organization (WHO) was founded to serve as a permanent international health agency. Its creation supported the professionalization of the global health field and facilitated the coordination of international health interventions. The WHO's early efforts supported the development of global health interventions through mandates focused on data collection, epidemiological surveillance, training, research, and greater resource mobilization.

Public health interventions originated with early efforts in disease surveillance, quantification of illness, and intervention implementation. These interventions further expanded to analyze the efficacy of various approaches. As urbanization and community life increased, the need for organized health protection grew.Over time, public health strategies have evolved to involve both public and private sectors, often working together to intervene in human rights issues related to health.Despite advances in healthcare access and coverage, social inequalities continue to impact equitable health. Inequality, war, and infectious diseases contribute to the need for public health interventions.Common issues that are the subject of public health interventions include obesity,drug, tobacco,and alcohol usage and the spread of infectious disease like HIV. Public health interventions are distinct from healthcare interventions in terms of their scope, methods, and objectives.

3.Sovereignty Rights Over The Individuals

3.1.Mandatory Public Health Interventions

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Screening

In medicine, screening is a strategy used to look for as-yet-unrecognised conditions or risk markers.This testing can be applied to individuals or to a whole population without symptoms or signs of the disease being screened.Although screening may lead to an earlier diagnosis, not all screening tests have been shown to benefit the person being screened- overdiagnosis, misdiagnosis, and creating a false sense of security are some potential adverse effects of screening. Additionally, some screening tests can be inappropriately overused. For these reasons, a test used in a screening program, especially for a disease with low incidence, must have good sensitivity in addition to acceptable specificity.In 1968, the World Health Organization published guidelines on the Principles and practice of screening for disease, which is often referred to as the Wilson and Jungner criteria.The principles are still broadly applicable today:

The condition should be an important health problem.
There should be a treatment for the condition.
Facilities for diagnosis and treatment should be available.
There should be a latent stage of the disease.
There should be a test or examination for the condition.
The test should be acceptable to the population.
The natural history of the disease should be adequately understood.
There should be an agreed policy on whom to treat.
The total cost of finding a case should be economically balanced in relation to medical expenditure as a whole.

Mass screening or Population-based screening: The screening of a whole population or subgroup. It is offered to all, irrespective of the risk status of the individual.

High risk or targeted screening or selective screening: High risk screening is conducted only among high-risk people.

Multiphasic screening: The application of two or more screening tests to a large population at one time, instead of carrying out separate screening tests for single diseases.

Limitations of screening programmes can include:

Screening can involve cost and use of medical resources on a majority of people who do not need treatment.

Adverse effects of screening procedure like radiation exposure and chemical exposure

Stress and anxiety caused by prolonging knowledge of an illness without any improvement in outcome.

In many countries there are population-based screening programmes. In some countries, such as the UK, policy is made nationally and programmes are delivered nationwide to uniform quality standards. Common screening programmes include:

Cancer Screening

PPD tests for screening tuberculosis

Beck Depression Inventory to screen for depression

SPAI-B, the Liebowitz Social Anxiety Scale and Social Phobia Inventory to screen for social anxiety disorder

Alpha-fetoprotein, blood tests and ultrasound scans for pregnant women to detect fetal abnormalities

Vaccination

Vaccines are a way of artificially activating the immune system to protect against infectious disease. The activation occurs through priming the immune system with an immunogen. Stimulating immune responses with an infectious agent is known as immunization. Vaccination includes various ways of administering immunogens.

While minor side effects, such as soreness or low grade fever, are relatively common, serious side effects are very rare and occur in about 1 out of every 100,000 vaccinations and typically involve allergic reactions that can cause hives or difficulty breathing.In rare cases immunizations can cause serious adverse effects, such as gelatin measles-mumps-rubella vaccine (MMR) causing anaphylaxis, a severe allergic reaction or A febrile seizure, which is a seizure associated with a high body temperature but without any serious underlying health issue.Mostly occur in children between the ages of 6 months and 5 years.A vaccine failure is when an organism contracts a disease in spite of being vaccinated against it. Primary vaccine failure occurs when an organism's immune system does not produce antibodies when first vaccinated. Vaccines can fail when several series are given and fail to produce an immune response.

Thimerosal was used as a preservative to prevent the growth of bacteria and fungi in vials that contain more than one dose of a vaccine.That reduces the risk of potential infections or serious illness that could occur from contamination of a vaccine vial. Although there was a small increase in risk of injection site redness and swelling with vaccines containing thimerosal, there was no increased risk of serious harm or autism. Even though evidence supports the safety and efficacy of thimerosal in vaccines, thimerosal was removed from childhood vaccines in the United States in 2001 as a precaution.

Anti-vaccine activism is the refusal or complete opposition to vaccination for oneself and one's child, despite having access to vaccination services. The World Health Organization listed anti-vaccination sentiment as one of the ten biggest health threats of 2019.Vaccine hesitancy could be influenced by factors such as lack of proper scientific-based knowledge,fear of needles and distrust of public authorities and a lack of confidence or complacency.

Clinical trials to ensure their safety and efficacy before approval by authorities
Prior to human testing,researchers study vaccines in animals, including mice, rabbits, guinea pigs, and monkeys.Vaccines that pass each of these stages of testing are then approved by the public health safety authority to start a three-phase series of human testing, advancing to higher phases only if they are deemed safe and effective at the previous phase. The people in these trials participate voluntarily and are required to prove they understand the purpose of the study and the potential risks.During phase I trials, a vaccine is tested in a group of about 20 people with the primary goal of assessing the vaccine's safety. Phase II trials expand the testing to include 50 to several hundred people. During this stage, the vaccine's safety continues to be evaluated and researchers also gather data on the effectiveness and the ideal dose of the vaccine.Vaccines determined to be safe and efficacious then advance to phase III trials, which focuses on the efficacy of the vaccine in hundreds to thousands of volunteers. This phase can take several years to complete and researchers use this opportunity to compare the vaccinated volunteers to those who have not been vaccinated to highlight any true reactions to the vaccine that occur.

Supplementation&Behavioural

A health supplement is a product that is used to supplement a diet and to support or maintain, enhance and improve the healthy functions of the human body.
health supplement must also contain one or more, or a combination of the following ingredients:

Vitamins, minerals, amino acid, fatty acids, enzymes, probiotics and other bioactive substances;

Substances derived from natural sources, including animal, mineral and botanical materials in the forms of extracts, isolates, concentrates.

A health supplement must be administered in small unit doses in dosage forms such as the following:
Capsules
Softgels
Tablets
Liquids
Syrups

Products used on animals, as well as products presented in the form of food and beverages, such as biscuits, cookies, coffee, and juice are not health supplements.Substances not allowed and restricted ingredients,Health supplements that are imported or sold must not contain the following:
Ingredients controlled and prohibited under the Poisons Act (Chapter 234) and Poisons Rules, Misuse of Drugs Act (Chapter 185) and its Regulations, and the ASEAN Guiding Principles for Inclusion into or Exclusion from the Negative List of Substances for Health Supplements Ingredients that contain agents that can lead to animal-transmissible diseases such as Transmissible Spongiform Encephalopathy (TSE). Ingredients regulated under the Endangered Species (Import & Export) Act, unless permitted. Convention on International Trade in Endangered Species of Wild Fauna and Flora (CITES) import permit is needed from NParks.
Active substances that are not stated on the label.
Active ingredients are documented to have inherent pharmacological properties that could lead to the use of the substance for a medicinal purpose to treat or prevent any disease or disorder.
Some substances have the potential to cause adverse health effects or safety concerns when used in health supplements and traditional medicines, and hence should be used with specific restrictions or conditions such as maximum daily dose limits or labelling specifications.

Behavioral Change

Health behavior change refers to the motivational, volitional, and action based processes of abandoning such health-compromising behaviors in favor of adopting and maintaining health-enhancing behaviors.Health conditions and infections are associated with risky behaviors such as; Tobacco use, alcoholism, multiple sex partners, substance use, reckless driving, obesity, or unprotected sexual intercours.

Behavior modification is a treatment approach that uses respondent and operant conditioning to change behavior. Based on methodological behaviorism,overt behavior is modified with (antecedent) stimulus control and consequences, including positive and negative reinforcement contingencies to increase desirable behavior, as well as positive and negative punishment, and extinction to reduce problematic behavior.Health behavior change refers to the motivational, volitional, and action based processes of abandoning such health-compromising behaviors in favor of adopting and maintaining health-enhancing behaviors.

Behavior change communication, or BCC, is an approach to behavior change focused on communication. It is also known as social and behavior change communication, or SBCC. The assumption is that through communication of some kind, individuals and communities can somehow be persuaded to behave in ways that will make their lives safer and healthier. BCC was first employed in HIV and TB prevention projects.More recently, its ambit has grown to encompass any communication activity whose goal is to help individuals and communities select and practice behavior that will positively impact their health, such as immunization, cervical cancer check up, employing single-use syringes.SBCC has several levels at which it can be implemented. Each level includes several theories. Each level (and each theory) employs specific communication channels.

Individual level

Health belief model

Theory of reasoned action and planned behavior

Transtheoretical model/Stages of change

Social learning theory

Community level

Diffusion of innovations theory

Community mobilization

Change in organizations

Public policy Level

Distinct stages of initiation, action, implementation, evaluation and re-formulation

3.2.Reproductive Rights

Reproductive rights includes; right to abortion, freedom from coerced sterilization and contraception,The right to access good-quality reproductive healthcare; the right to give birth where and with whom someone chooses; and the right to family planning in order to make free and informed reproductive choices.Sexual and reproductive health refers to a broad range of services that cover access to contraception, fertility and infertility care, maternal and perinatal health, prevention and treatment of sexually transmitted infections (STIs), protection from sexual and gender-based violence, and education on safe and healthy relationships.

Experiencing sexual and reproductive health means that a person has complete physical, mental and social well-being in all matters relating to their reproductive system and its functions. In everyday life, this means that people are able to have satisfying and safe sex lives, to have healthy pregnancies and births, and decide if, when and how often to have children. Access to sexual and reproductive health services is a human right and should be available to all people throughout their lives, as part of ensuring universal health coverage. This not only contributes to improved health outcomes, but also to gender equality and wider development

Reproductive rights began to appear as a subset of human rights in the 1968 Proclamation of Tehran, which states: "Parents have a basic human right to determine freely and responsibly the number and the spacing of their children".This right was affirmed by the UN General Assembly in the 1969 which states "The family as a basic unit of society and the natural environment for the growth and well-being of all its members, particularly children and youth, should be assisted and protected so that it may fully assume its responsibilities within the community. Parents have the exclusive right to determine freely and responsibly the number and spacing of their children."

Cairo Programme of Action 1994

The twenty-year "Cairo Programme of Action" was adopted in 1994 at the International Conference on Population and Development (ICPD) in Cairo. The non-binding Programme of Action asserted that governments have a responsibility to meet individuals' reproductive needs, rather than demographic targets. It recommended that family planning services be provided in the context of other reproductive health services, including services for healthy and safe childbirth, care for sexually transmitted infections, and post-abortion care. The ICPD also addressed issues such as violence against women, sex trafficking, and adolescent health. The Cairo Program is the first international policy document to define reproductive health.

The Cairo Programme of Action was adopted by 184 UN member states. Nevertheless, many Latin American and Islamic states made formal reservations to the programme, in particular, to its concept of reproductive rights and sexual freedom, to its treatment of abortion, and to its potential incompatibility with Islamic law.

Beijing Platform

The 1995 Fourth World Conference on Women in Beijing, in its non-binding Declaration and Platform for Action, supported the Cairo Programme's definition of reproductive health, but established a broader context of reproductive rights.The Beijing Platform demarcated twelve interrelated critical areas of the human rights of women that require advocacy. The Platform framed women's reproductive rights as "indivisible, universal and inalienable human rights." The platform for the 1995 Fourth World Conference on Women included a section that denounced gender-based violence and included forced sterilization as a human rights violation.

The Yogyakarta Principles

The Yogyakarta Principles is a document about human rights in the areas of sexual orientation and gender identity that was published as the outcome of an international meeting of human rights groups in Yogyakarta, Indonesia, in November 2006. The principles were supplemented and expanded in 2017 to include new grounds of gender expression and sex characteristics and a number of new principles. The principles have never been accepted by the United Nations (UN) and the attempt to make gender identity and sexual orientation new categories of non-discrimination has been repeatedly rejected by the General Assembly, the UN Human Rights Council and other UN bodies.
Nonetheless, African, Caribbean and Islamic Countries, as well as the Russian Federation, have objected to the use of these principles as Human Rights standards.

Contraception

Birth control, also known as contraception, is the use of methods or devices to prevent pregnancy.Some cultures limit or discourage access to birth control because it is considered as morally, religiously, or politically undesirable.

The World Health Organization and United States Centers for Disease Control and Prevention provide guidance on the safety of birth control methods among women with specific medical conditions.The most effective methods of birth control are sterilization by means of vasectomy in males and tubal ligation in females, intrauterine devices (IUDs), and implantable birth control. This is followed by a number of hormone-based methods including contraceptive pills, patches, vaginal rings, and injections. Less effective methods include physical barriers such as condoms, diaphragms and fertility awareness methods.

Abortion

Abortion is the termination of a pregnancy by removal or expulsion of an embryo or fetus.Abortion occurring without intervention is known as spontaneous abortion or "miscarriage", and occurs in roughly 30–40% of all pregnancies. Common reasons for inducing an abortion are birth-timing and limiting family size.Other reasons include maternal health, an inability to afford a child, domestic violence, lack of support, feelings of being too young, wishing to complete an education or advance a career, and not being able, or willing, to raise a child conceived as a result of rape or incest.Modern methods use medication or surgery for abortions.The drug mifepristone (aka RU-486) in combination with prostaglandin appears to be as safe and effective as surgery during the first and second trimesters of pregnancy.Self-managed medication abortion is highly effective and safe throughout the first trimester.The most common surgical technique involves dilating the cervix and using a suction device. Birth control, such as contraceptive pills or intrauterine devices, can be used immediately following an abortion.

Women seeking an abortion may use unsafe methods, especially when abortion is legally restricted. They may attempt self-induced abortion or seek the help of a person without proper medical training or facilities. This can lead to severe complications, such as incomplete abortion, sepsis, hemorrhage, and damage to internal organs.Unsafe abortions are a major cause of injury and death among women worldwide. Although data are imprecise, it is estimated that approximately 20 million unsafe abortions are performed annually, with 97% taking place in developing countries

According to the Center for Reproductive Rights, a global legal advocacy organization, there are 24 countries in the world where abortion is completely prohibited. These include Andorra and Malta in Europe, El Salvador and Honduras in Central America, Senegal and Egypt in Africa, and the Philippines and Laos in Asia. Some 90 million (5%) women of reproductive age live in countries that prohibit abortion altogether.

Activists and campaigners in many of these countries continue to fight to ease abortion restrictions. The hardline laws in El Salvador, which were introduced in 1998 after campaigning from conservative sectors of the Catholic Church, have led to dozens of women being found guilty of “aggravated homicide,” even in cases of miscarriage. In March, thousands of Salvadoran women marched to demand that the ban be eased to allow abortions in cases of rape, when the fetus is not viable, or if the woman’s life is at risk.More than 50 countries and regions permit abortions only when the woman’s health is at risk. Some refer only to physical health, while others include mental health.These include Libya, Iran, Indonesia, Venezuela and Nigeria. Others have exceptions for cases of rape, incest, or fetal abnormality.

In Brazil, for example, abortion is illegal except in cases of rape, risks to the life of the mother, or when the fetus has anencephaly—missing part of the brain or skull. In these cases, the woman needs approval from a doctor and at least three other clinical experts. In August 2020, under President Bolsonaro’s far-right government, a Health Ministry regulation was introduced that requires medical professionals to collect evidence and report to the police anyone who seeks legal termination of a pregnancy after rape—which Human Rights Watch suggests is to dissuade rape survivors.

Seventy-two countries allow for abortion subject to gestational time limits—the most common being 12 weeks. Even in these countries, there are often a variety of exceptions that allow abortions to take place later. In the U.K. for example, there is a 24-week limit on abortion, but if the fetus has a disability such as Down’s Syndrome, the pregnancy can be terminated right up until birth

Roe v. Wade

Roe v. Wade, 410 U.S. 113 (1973),was a landmark decision of the U.S. Supreme Court in which the Court ruled that the Constitution of the United States protected the right of pregnant women to choose to have an abortion before the point of fetal viability. The decision struck down many state abortion laws. In 1969, a 25-year-old single woman, Norma McCorvey using the pseudonym "Jane Roe", challenged the criminal abortion laws in Texas. The state forbade abortion as unconstitutional, except in cases where the mother's life was in danger.Defending the anti-abortion law was Henry Wade - the district attorney for Dallas County - hence Roe v Wade.Ms McCorvey was pregnant with her third child when she filed the case, and claimed that she had been sexually assaulted. But the case was rejected and she was forced to give birth.

In 1973 her appeal made it to the US Supreme Court, where her case was heard alongside that of a 20-year-old Georgia woman, Sandra Bensing.They argued that abortion laws in Texas and Georgia went against the US Constitution because they infringed a woman's right to privacy.By a vote of seven to two, the court justices ruled that governments lacked the power to prohibit abortions.The case created the "trimester" system allowing:

- An absolute right to an abortion in the first three months (trimester) of pregnancy
- Some government regulation in the second trimester
- States to restrict or ban abortions in the last trimester as the foetus nears the point where it could live outside the womb

Roe v Wade also established that in the final trimester, a woman can obtain an abortion despite any legal ban only if doctors certify it is necessary to save her life or health. However,
Roe v. Wade is no longer accurate or the law of the land. The U.S. Supreme Court officially overturned the landmark 1973 decision on June 24, 2022, in the Dobbs v. Jackson Women's Health Organization ruling. This means the federal constitutional right to abortion has been eliminated. Instead of a nationwide standard, the legality and accessibility of abortion are now determined on a state-by-state basis.

HIV/AIDS

Human immunodeficiency virus (HIV) is a virus that attacks the body's immune system. Acquired immunodeficiency syndrome (AIDS) occurs at the most advanced stage of infection.HIV targets the body's white blood cells, weakening the immune system. This makes it easier to get sick with diseases like tuberculosis, infections and some cancers.HIV is spread from the body fluids of an infected person, including blood, breast milk, semen and vaginal fluids. It is not spread by kisses, hugs or sharing food. It can also spread from a mother to her baby.HIV can be prevented and treated with antiretroviral therapy (ART). Untreated HIV can progress to AIDS, often after many years.The signs and symptoms of HIV vary depending on the stage of infection.

HIV spreads more easily in the first few months after a person is infected, but many are unaware of their status until the later stages. In the first few weeks after being infected people may not experience symptoms. Others may have an influenza-like illness including:
fever
headache
rash
sore throat
The infection progressively weakens the immune system. This can cause other signs and symptoms:
swollen lymph nodes
weight loss
fever
diarrhoea
cough.
Without treatment, people living with HIV infection can also develop severe illnesses:
tuberculosis (TB)
cryptococcal meningitis
severe bacterial infections
cancers such as lymphomas and Kaposi's sarcoma.
HIV also makes a human body much more susceptible to various infections, such as hepatitis C, hepatitis B and mpox.

There is no cure for HIV infection. It is treated with antiretroviral drugs, which stop the virus from replicating in the body. Current antiretroviral therapy (ART) does not cure HIV infection but allows a person’s immune system to get stronger. This helps them to fight other infections.Currently, ART must be taken every day for the rest of a person’s life.
ART lowers the amount of the virus in a person’s body. This stops symptoms and allows people to live full and healthy lives. People living with HIV who are taking ART and who have no evidence of virus in the blood will not spread the virus to their partners. This is called U=U, untraceable = untransmittable, in the community.

UNAIDS

The Joint United Nations Programme on HIV and AIDS. Established by ECOSOC resolution 1994/24 on 26 July 1994, UNAIDS officially launched in January 1996. The organization is guided by a Programme Coordinating Board with representatives of 22 governments from all geographic regions, the UNAIDS Cosponsors, and five representatives of non-governmental organizations (NGOs), including associations of people living with HIV/AIDS.

3.3. Euthanasia

Euthanasia is the practice of intentionally ending life to eliminate pain and suffering.
Euthanasia is categorised in different ways, which include voluntary, non-voluntary, and involuntary. Voluntary euthanasia is when a person wishes to have their life ended and is legal in a growing number of countries. Non-voluntary euthanasia occurs when a patient's consent is unavailable, like comatose or under a persistent-vegetative state and is legal in some countries under certain limited conditions, in both active and passive forms. Involuntary euthanasia, which is done without asking for consent or against the patient's will, is illegal in all countries and is usually considered as a murder.In the majority of the world, including most of Asia, Africa, and parts of Europe, both euthanasia and assisted suicide remain explicitly illegal. Performing these acts is typically prosecuted under laws governing homicide or manslaughter,punishment up to imprisonment for 14 years.

Other terminology like assisted suicide and physician-assisted suicide are not synonyms of euthanasia.Do not resuscitate (DNR) order means the attending doctor is not required to resuscitate a patient if their heart stops and is designed to prevent unnecessary suffering. Even though DNR is considered as passive euthanasia, it is practiced in most parts of the world without much legal issues. Common conditions which make patients seek euthanasia are terminally ill cancer patients, acquired immune deficiency syndrome (AIDS) and other terminally ill conditions where there is no active treatment. Factors which are responsible for decision making are classified into physical and psychological factors. Physical conditions that affect the quality of life in these patients are unbearable pain, nausea and vomiting, difficulty in swallowing, paralysis, incontinence, and breathlessness. Psychological factors include depression, feeling a burden, fearing loss of control or dignity, or dislike of being dependent. But some argues that suicidal ideation and inadequate palliative care might also be the underlying reasons for seeking euthanasia.

The first countries to legalize euthanasia were the Netherlands in 2001 and Belgium in 2002. In 1997 Oregon became the first state in the United States to decriminalize physician-assisted suicide; opponents of the controversial law, however, attempted to have it overturned. In 2009 the Supreme Court of South Korea recognized a “right to die with dignity” in its decision to approve a request by the family of a brain-dead woman that she be removed from life-support systems.The concept of death tourism or euthanasia tourism is slowly increasing in which patients who want to seek euthanasia or other assisted suicide services will travel to countries where it is legalized to avail those services. Switzerland is known for death tourism, where every year patients primarily from British, German, and French travel there to end their lives.

Religious views on euthanasia vary significantly, though many traditional faiths oppose it, viewing life as a sacred gift from God that should not be prematurely ended. Conversely, some denominations and individuals support assisted dying, emphasizing compassion and personal autonomy

4.Allocation of Life

Before the subclauses it is crucial to understand what allocation of life stands for. Allocation of life is the systematic, ethically grounded distribution system of life-saving resources for individuals or population when demand outnumber the resources. Unlike routine, surgical procedures concerning allocation of life are both challenging by ethic and moral manners since distributions of resources will affect every individual's healthcare. In this clause the most concerning conflict is the body autonomy and distribution of lack of resources.

4.1. Crisis Triage and Rationing Protocols

Crisis triage program is a pre-established set of decision frameworks which activates when medical demand exceeds the available resources during mass casualty events, health crisis' and infrastructure failures. It is one of the most evolutionary and varying protocols in medicine. Since demand and geography affects variables in this protocol, it evolves and varies accordingly. One of the latest models are Society of critical care medicine guidelines by Society of Critical Care Medicine which is published in March 2026. Unlike the casual triage protocol, crisis triage protocol enables the withdrawal of resources and needed equipment from the patients which is not improving or getting worse. There are distinct ethical approaches to crisis triage, main ones being. Utilitarian approach, this approach prioritizes individuals with highest rate of survival in a short time period for example Italy's Covid-19 protocols which is based on age-adjusted comorbidity scores. This approach get the most criticism by lack of healthcare to disabled, old people. Another approach is egalitarian approach, it is based of random selection or who come first will be first served ignoring prognosis-based prioritization, some US states use this method to the patients with equal clinical scores, however except from that this is the least popular method among the world and seems as invalid in some authorities due to ignorization for medical urgency and waste the potential life–saving cases. Our 3rd approach will be instrumental-value based approach which prioritizes individuals essential to crisis response for example medical staff and researchers, this approach has been seen in UK's NICE protocol which gives priority to staff. This approach gets the most criticism because of the classification of individuals among society. The last approach we will mention is the life cycle approach, this approach always prioritizes younger patients over old ones due to "opportunity to complete natural life span" for instance Italian protocols prioritize patients over 85 in 2019.

This approach led to criticism by ageism and violation of equal dignity. Since we mentioned approaches of crisis triage now we should discuss the controversial criterias. To start with one of the most controversial triage criteria is QALY and DALY which is quality adjusted life years, health related quality of life and Disability- adjusted life years measure years lost to disabilities. Another controversial one is the withdrawal protocols, removal of a ventilator from a patient after 120 hours without improving is permitted by policies in order to reallocate to a new patient. However this method gets criticism of devastating emotional circumstances for their family and is not aligned with body autonomy. We should mention procedural justice need as well, firstly transparency triage criteria's should be publicly accessible, secondly appeal rights all patients have the right to request triage committee review of individual allocation decision, lastly non-discriminational clauses which prohibits all biases based on race, religion, national, socioeconomic status.

4.2. Organ Transplantation

Organ transplantation is one of the main domains of allocation of life for a long time. Since the beginning of medical care organ failures are challenging for both patients and doctors, the need for invasive surgeries and the restrictiveness of organ conditions are still risky variables. Meanwhile organ scarcity, allocation criterias, ethical concerns and regulating practices of certain actions are the fields regarding Global Board of Medical Ethics in organ transplantation. To start with organ scarcity, waitlist mortality is still an unsolved problem. For instance, globally over 150 thousand patients are waiting for a kidney, sadly 17 of them die everyday in the US. The conditions even got worse in low-income countries, most of the waitlisted patients never received the organ due to problems in infrastructure. Donors vary by deceased which means brain dead or circulatory dead patients to living donors however in low-income countries these donor percentages are significantly reduced due to lack of knowledge among topics. For the allocation of deceased donor there are criteria first one is medical urgency scores: in liver MELD (model for end-stage liver disease) vary from 6-40 40 being the most prioritized one, and the categorization made by the mortality of patient it is assumed that MELD score 40 indicates that patient has maximum 90 days to live. Another score is LAS (lung allocation score) generally varies from 0-100 which is assessed on both mortality of the patient and the assumed success rate of the operation. Another criteria and tiebreaker is the time on the waitlist. Lastly 2 of the main criteria for transplantation is the geographic proximity, organs preserved only 4-36 hours at optimal conditions, as a result patients and organs locations is a criteria in allocation.

4.3.Global Wealth Disparities and Biomedical Access

In this subarticle we will mention the systematic differences in availability and affordability in life-saving treatment between high income countries (HIC) and low income countries (LMIL). Unlike the article 5.1 these problems are caused by lack of infrastructure and structural scarcity. To start with, let's define inequity in life saving treatments. The inequality in access to treatments is not a result of lack of knowledge, it is a result of unavailability and unaffordability in poor regions. Another key point is the Out of pocket health expenditure, which is payments made directly by patients without insurance. When it exceeds %40 it is termed catastrophic and that households should make a decision on wherever they will prioritize healthcare or basic needs. Additionally some families fall into the medical poverty trap which is a cycle where households sell assets or take high-interest loans in order to pay for medical bills. Since we defined inequity consequences of wealth disparity in allocation is another factor. There are many examples and fields this consequences have been seen inter alia, medical tourism for scarcity which travelling abroad to receive unavailable illegal or expensive treatments at their home countries, While it is observed that wealth-based allocation during crisis. For instance during covid-19 private hospitals in India charged four thousand per day while government facilities were exhausted. One of the challenging circumstances for LIML's is the patent-protected therapy which a 20-year legal monopoly granted to pharmaceutical corporations, allowing them to set prices way above the production cost, as a result medicines already expensive for LIML's become unavailable. To solve these kinds of problems and inequities some measures and tactics are applied by both companies and countries. Need-based allocation (COVAX model) is the distribution policy which distributes limited supply according to need ignoring the wealth. Global solidarity fund is a central pool of voluntary contributions that purchases treatments and distributes them to LIML's for a low price or give it free. Regional pooled procurement is a group of countries jointly purchasing a bulk amount in order to achieve discounts. Cross-subsidization is the one regarding companies which charge higher price to HIMs in order to give the medicine for lower prices in LIML

5. Global State Policies Towards to the Agenda Item

5.1.Western Bloc

The western bloc is about policies on the agenda and an ideological bloc rather than a geographical one sharing a liberal medical ethic concept. Many western countries in Europe and North America are a part of this perspective towards body autonomy and allocation of life, however more developed countries such as Japan and Australia also have a similar stance on medical ethics.
The main principles western medical ethics stand on are individual autonomy, fair distribution of medical resources, non-maleficence and acting based on the patients benefit.
Body autonomy and individual consent on medical decisions are one of the most valuable in this bloc while also not being absolute to ensure public health. Informed consent before producers, right to refuse and accept treatment, patient doctor confidentiality are the core principles of individual autonomy which allows patients to decide what happens to their body. These principles are more or less seen as human rights and are treated as such when they are violated by a medical professional or the government. The government cannot force or decide upon what happens to an individual's body without a credible reason. Public health safety is the most common reason for the government to interfine. Quarantines, mandatory screenings of certain infectious diseases to prevent outbreaks and vaccination requirements for school children are seen as key elements for public safety and these regulations are enforced even though they limit body autonomy to a certain degree, public health and communal benefits are favored.

Reproductive healthcare is a controversial topic not only in the bloc but also inside countries as well. Individual autonomy is still supported on decisions about reproductive healthcare with most states allowing access to contraception, fertility treatments and sterilization procedures and third party pregnancies.
The area that brings controversy is about abortion, pregnant people's conflict of interest on fetal decisions and fetal morality. Countries and political parties have differing opinions and philosophies on abortion and fetal morality. Some claim life begins at conception and abortion is the action of taking the life of a living person while others claim that the decision and well-being of the pregnant person is more important. The ECHR does not create an absolute abortion law. However it states there shall be clear guidelines and legal frameworks ensuring that no medical personal or patient in need of critical care is left with uncertainty.

Active Euthanasia is illegal in most states because of the conflict on global medical ethics principle do-no-harm. This can be considered as limitation on body autonomy however different methods are accessible such as passive euthanasia and assisted dying. Passive euthanasia, DNR (do-not-resustiate), withholding or withdrawing life sustaining treatment and sedation to unconsciousness for end-of-life care is legal for mentally competent adults. Having passive euthanisa available is a significant part of individual autonomy as it allows for a dignified passing. Assisted dying is also available in several countries varying on the guidelines. Certain countries such as some USA states, New Zealand and Australia allow assisted dying for terminally ill patients while other European and Latin countries have it available only for patients experiencing unbearable suffering. Passive euthanasia supported by the Western bloc as it can be categorized as refusal of treatment. This gives individuals body autonomy even in emergency triage moments protecting the rights of the patient to decide what happens to their body. Sedation to unconsciousness can be used for patients experiencing immense suffering and is towards the end of their lifetime allowing them to have a more peaceful and dignified death without pain. This practice eliminates the conflict of do-no-harm and euthanasia while giving the option for terminal patients at the end of their life a relief from pain and suffering creating an opportunity for a more dignified death. However since this is only applicable for patients experiencing great pain at the end of their life, it cannot be used for terminally ill patients as a form of medical assisted dying. Its purpose is to relieve pain and make the patient more comfortable. This purpose also aligns with the core medical ethic principle of acting based on the patient's benefit.
The medical community has been voicing their opinions about prolonged unnecessary suffering and the need for a dignified death which has resulted in campaigns such as “Dignity in Dying”.

Organ transplantation allocation has clear guidelines based on medical factors. Most of the countries use a national waiting list giving priority based on urgency, waiting time, transplant success and logistical factors.The AMA and Scandiatransplant area has a priority based system that allows for the individual in need of the transplant organ most and will use the transplant organ most efficiently if the organ is allocated. The western bloc also divides on organ donation with opt-in and opt-out systems. Opt-in systems give individuals complete autonomy on their body by only considering people who have already registered as an organ donor with their consent or their medical proxies explicit consent.

This system is used by the USA, Germany, Japan and some other European countries however these countries often have limited donors. Furthermore this system can be disrupted even with a high number of organ donors as family decisions of the donor can override the previous consent of the individual resulting in even less donors. The Opt-out system is used by France, Spain and other European countries. The opt-out system considers everyone an organ donor regardless if they have previously become an organ donor or not with their consent. Family members or the patient before passing can always refuse organ donation and in practice they are usually given this decision to make. This system allows for more organ transplants and more lives saved however people have voiced opinions about the limitation of bodily autonomy.

The west's clinical trials and research are more advanced compared to the rest of the world. However access to these trials and regular medical care can be limited without insurance coverage, and underfunded medical centers. A study done by the European Commision in shows that important inequalities in access to healthcare persist, both between and within countries and vulnerable populations face multiple obstacles to get the medical care they need. These obstacles can be lack of insurance resulting in high out-of-pocket costs , lack of hospital resources and medical staff due to underfunding. Several countries lacking coverage of their whole population have significant reforms and improvements planned; however these types of actions take time to show results.
In America countless data emphasizes a major contributor to the problem of health disparities is the cost and access to many Americans for obtaining the medical care they require. Clear differences exist in rates of health insurance coverage among black and Latino population groups. The consequences of being uninsured are significant and include use of fewer preventive services, poorer health outcomes, higher mortality and disability rates, lower annual earnings because of sickness and disease, and the advanced stage of illness. The uninsured tend to be disproportionately poor, young, and from racial and/or ethnic minority groups.

5.2.Central Bloc

While the western blocs fundamental principle being individual autonomy, the central bloc is a mediator, usually in support of some of the liberal medical ethic principles about organ transplantation allocation and triage decisions however these countries tend to favor public interest at the cost of individual autonomy and they share more of a traditional value which supports familial decisions resulting in less autonomy to the patient. The bloc includes nations such as Turkey, Brazil, Mexico and other developing countries with cultures that support strong family connections .Traditional values about culture and religion tend to make an individual's body a decision of a group made out of family and friends. Medical guidelines do not state that the opinions of family matters in medical decisions; however physicians often take the family into consideration. There is no legal structure formally recognizing family authority however culturally family consultation is heavily practised and expected. This idea comes from strong family relations and that an individual's decisions affect both the family and the community. The bloc is usually more open to government required medical intervention to protect public health. and limited individual autonomy caused by family or community consultation is tolerated more.

Active euthansia is illegal in central states due to similar concerns with the west about do-no-harm and also religious and cultural concerns. These concerns also play an active role about medically assisted dying not being available in these states. Campaigns like Dignity in Dying has made efforts for assisted suicide to be formally recognized more often. However communities are usually against the idea of ending someone's life with intent to do so and they usually prefer less invasive methods such as palliative sedation or withdrawal of life sustaining treatment.
Most Central Bloc countries support access to contraception and voluntary steriliztion services. Contraception is often viewed as an important public health method because it can reduce unintended pregnancies, improve maternal health, and give individuals and families more control over when and how many children they have. Voluntary sterilization is also legal in many Central Bloc countries. However, it is often more regulated than in some Western countries. Governments sometimes require counseling, waiting periods, age requirements, or other procedures before sterilization is done irreversibly.

These regulations are usually justified as a way to ensure that the individual is fully informed about the permanent decision they are making and are fully aware of the future consequences they might face. Abortion is one of the most controversial issues within the Central Bloc and there is no single cohesive ideology shared by all countries. Some countries allow abortion under broad circumstances while others only permit it in specific situations such as when the pregnancy threatens the life of the patient, results from rape, or involves severe fetal abnormalities.

Central Bloc countries face much more limitations on medical resources. This results in a system not based on protecting individual autonomy but on distributing the resources as fairly as possible. Many countries have underfunded hospitals, limited ICUs and treatment options resulting in a system that is more focused on providing care for patients in need as well as possible. The medical care facilities in the bloc are mixed between private and public. Private medical facilities provide care for individuals who are able to pay out of pocket for treatment causing a clear inequality on access to treatment. Patients with enough economic resources are able to get the car they need much faster and more effectively. Also inequalities due to logistical problems and insufficient infrastructure causes rural areas to have very limited access to medical facilities. Income gap in countries without a strong complete public medical insurance policy directly results in unequal access and delayed treatment.Several governments have made efforts to improve insurance coverage and healthcare resources.

5.3. Southern Bloc

The Southern bloc usually shares a more traditional value towards medical decisions with usually more community and family involvement. However the main problem in the southern bloc is the scarcity of resources which result in a system not for body autonomy but for trying to have an equitable distribution of resources. This limits the importance of body autonomy and usually it is a battle of survival. Inaffordability due to low-income; limited treatment options, medical care facilities and medical personnel restrict people from getting the care they need. Many Southern Bloc countries prioritize improving access to healthcare because significant portions of their populations still face obstacles to basic medical services. Limited healthcare funding, shortages of healthcare workers, insufficient infrastructure, and unequal access to medicines and medical technologies continue to be significant challenges. This results in discussions on the allocation of life often focusing on ensuring equitable access to basic healthcare and strengthening healthcare systems rather than expanding access to advanced biomedical treatments and ensuring patient autonomy.

Voluntary sterilization is a legal method in these countries however insufficient resources and public stigma can result in individuals not having these procedures done resulting in unwanted pregnancies. Furthermore, weak body autonomy and women's rights sometimes results in involuntary sterilization. Women from an ethnic minority facing discrimination with HIV diagnosis reported involuntary sterilization done by the Honduras government. This practice is validated by the government as a precaution for ensuring public health and managing STDs. Heavy government involvement in permanent or non permanent procedures done to individuals from ethnic minorities or women has been reported in several countries. The main reason for the disregard for body autonomy comes from weak legal frameworks and practices heavily influenced by culture or religion. When it comes to abortion most countries have strict abortion guidelines restricting pregnant people from getting safe abortions resulting in a high number of unsafe abortions. Even in circumstances where abortions should be legal, insufficient medical services block people from getting reproductive care. Africa has one of the highest unsafe abortion rates with nearly half of abortions done being in least safe circumstances.

Active euthanasia and medically assisted dying is rejected in African and South Asian countries with legal systems, medical and public opinion heavily influenced by culture and religion. However Latin America has been a progressive region starting with Uruguay to accept physician assisted suicide. Colombia, Cuba, Ecuador and Uruguay allow assisted dying for patients experiencing unbearable suffering. Active euthanasia is illegal in all African nations. In most countries, passive euthanasia is either not regulated or also illegal. South African regulations seem to allow for passive euthanasia. Across the African continent, passive euthanasia is widely met with cultural and religious resistance, strongly favoring the preservation of life.

6.Case Studies

For the sake of both accuracy and privacy, the following case studies have been selected from actual medical cases, however, names, dates, and some details have been carefully altered to hide identities, location, and any other possibly identifying information.

6.1 — Teresa Taraldsen: Persistent Vegetative State & Pregnancy After Assault

Teresa Taraldsen, long thought to be safely maintained in a long-term care facility after entering a persistent vegetative state, is discovered to be pregnant. The pregnancy is the result of sexual assault by an unknown perpetrator within the facility. Teresa cannot consent, cannot testify, and left no clear advance directive. Her parents, devastated but religiously opposed to abortion, want the pregnancy carried to term.
Central Question: Can a family authorize continuation of a pregnancy caused by assault when the patient has no consciousness, no consent, and no known wishes?

6.2 — Alfie & Tyrone: HIV-Positive Spousal Kidney Transplant

Alfie needs a kidney transplant. His husband Tyrone is a compatible donor, but both men are HIV-positive. The proposed transplant raises concerns about using an HIV-positive organ, viral strain compatibility, informed consent, and whether love is clouding medical judgment. Tyrone insists he understands the risks and wants to proceed.
Central Question: Is it ethical to approve an HIV-positive living donor transplant between spouses when both donor and recipient accept the risks?

6.3 — Jeremy & Hannah: UNOS, NICU, and Competing Infants

Jeremy and Hannah are both single parents whose newborns are critically ill in the NICU and awaiting the same type of transplant. As both babies deteriorate, their UNOS statuses shift rapidly: one rises above the other, then the other worsens and overtakes them, until the two infants sit at 1A and 1B. Both parents are desperate, exhausted, and watching the system quantify whose baby is “sicker enough” to be saved first.
Central Question: How should transplant allocation work when two infants are nearly equal in urgency, and every update feels like choosing which parent loses a child?

6.4 — Maria: Immigration, Frostbite, and the Right to Treatment

Maria is found after surviving a flight hidden inside an aircraft's motor compartment after fleeing Mexico. She has severe frostbite, hypothermia, and traumatic injuries. Her older brother José, who traveled with her, is in even worse condition. Neither is a citizen, neither has insurance, and both require expensive emergency and long-term care.
Central Question: Does immigration status matter when two undocumented patients need life-saving treatment after an act of desperate survival?

6.5 — Lauren: Pregnant Juvenile Inmate in Solitary

Lauren is a 17-year-old incarcerated patient with a violent history and severe behavioral instability. She is frequently held in solitary confinement due to danger to staff and other inmates. She is also pregnant. Physicians must treat both her and the fetus while correctional officers argue that ordinary prenatal care creates unacceptable security risks.
Central Question: What does adequate medical care require for a pregnant minor when that minor is also considered extremely dangerous?

6.6 — Tuomas: Depression Mistaken for Euthanasia Eligibility

Tuomas requests euthanasia, claiming his suffering is unbearable. However, his condition is not terminal; he is severely depressed. He presents his wish to die as rational and consistent, but his doctors worry that his request is a symptom of treatable mental illness rather than settled autonomy.
Central Question: Can a patient's request for death be considered competent when the primary illness driving that request is depression?

6.7 — Sara Ravenscroft: Schizophrenia, Noncompliance, and Unknown Identity

Sara Ravenscroft has schizophrenia and periodically stops taking her medication because she rejects the diagnosis and insists she is not "crazy." After another lapse, she arrives in the ER confused, paranoid, and without identification, a purse, or reliable history. She refuses parts of the workup, but clinicians cannot determine whether she understands her situation.
Central Question: How should doctors assess competence when a psychiatric patient's refusal of treatment may itself be caused by untreated illness?

6.8 — Richard: Gasoline Addiction and Public Danger

Richard is a commercial pilot with an addiction to drinking gasoline. He presents with alarming symptoms but insists he is fit to fly and has a long-haul flight scheduled later that day. Physicians must decide whether confidentiality still applies when hundreds of passengers may be at risk.
Central Question: When does a doctor's duty to protect the public override patient confidentiality?

6.9 — Daria: Estranged Parents vs. Fiancé as Medical Proxy

Daria is in a coma after a devastating car crash. Her fiancé knows her values, daily life, and medical preferences. However, her living birth parents, from whom she has been estranged since they abandoned her at sixteen, are legally next of kin and demand authority over her care.
Central Question: Should legal next-of-kin status outweigh the person who actually knew the patient's wishes?

6.10 — Eileen: DNR, Daughter, and Emergency Misconduct

Eileen is elderly, medically competent, and has signed a valid Do Not Resuscitate order. When she crashes, her daughter panics and demands CPR, intubation, and "everything possible." The medical team must act immediately while the daughter accuses them of killing her mother if they obey the DNR.
Central Question: Whose wishes control at the bedside: the competent patient's written directive, or the family member begging for intervention?

6.11 — Dillard Medical Centre: Highway Pileup and Triage

A catastrophic highway pileup sends dozens of critically injured patients to Dillard Medical Centre at once. The hospital lacks enough surgeons, operating rooms, ICU beds, and blood products to treat everyone immediately. Doctors must triage under pressure while families demand equal care for every victim.
Central Question: How should a hospital decide who receives scarce emergency resources when equal treatment is physically impossible?

6.12 — Anne & Freddie: Cystic Fibrosis and Forbidden Contact

Anne and Freddie, both living with cystic fibrosis, form a close bond despite medical warnings that contact between them could expose either to dangerous infections. They understand the risks but insist that isolation is destroying their lives. Their doctors must decide whether to respect their autonomy or intervene.
Central Question: Can medical professionals restrict patient relationships to prevent foreseeable harm?

6.13 — Hiromi: Radioactive Material Exposure

Hiromi is exposed to radioactive material in an industrial accident and requires urgent treatment. However, her contamination may endanger hospital staff, other patients, and the wider public. Physicians must balance their duty to treat her against containment protocols and public safety.
Central Question: How far does the duty to treat extend when the patient herself may be a hazard?

6.14 — East Mercy Hospital: Trial Integrity and a Mother's Chance

At East Mercy Hospital, a blinded clinical trial offers hope to critically ill patients. An intern secretly opens and alters one trial assignment to ensure her dying mother receives the experimental drug instead of the placebo. She is not otherwise involved in the trial and does not disclose what she did. The breach affects only one item, but it compromises trust in the study.
Central Question: Is it ethical to shut down a potentially life-saving trial because of one act of misconduct, or does preserving hope for all participants justify continuing?

6.15 — Dr. Connor Welch: Addiction and Medical Integrity

Dr. Connor Welch is a respected physician suspected of practicing while struggling with substance addiction. No catastrophic patient harm has yet been proven, but colleagues notice warning signs: missed details, erratic behavior, and possible impairment. The hospital must decide whether to protect him, report him, suspend him, or quietly monitor the situation.
Central Question: When does a doctor's private addiction become a professional danger?

7.Questions To Be Addressed

How should the independence of minors in reproductive health decisions be regulated?

Under what conditions can states interfere with individual freedoms to protect public health?

Who should have the right to decide what happens to a person's body after death?

Under what conditions should euthanasia be considered legal and ethical?

In pandemics, should individuals who refused vaccination beforehand be deprioritized for triage resources?

Does traveling abroad to receive an illegal treatment count as autonomy, if so does the home country have the right to refuse follow up treatments?

8.Bibliography

Cinaroglu, S. (2024). Trends in out-of-pocket health expenditure inequality in Turkey under comprehensive health reforms. World Development Perspectives, 34, 100583.

Center for Reproductive Rights. (n.d.). Brazil: Self-managed abortion. Center for Reproductive Rights. https://reproductiverights.org/maps/self-managed-abortion/brazil/

World Health Organization. (n.d.). Health financing. https://www.who.int/health-topics/health-financing

Kara M. A. (2007). Applicability of the principle of respect for autonomy: the perspective of Turkey. Journal of medical ethics, 33(11), 627–630.

Shaheen U, Naz N. Reevaluating Patient Privacy and Autonomy: Cross-Cultural and Legislative Perspectives. medtigo J Med. 2025;3(3):e3062335.

Dignity in Dying. (n.d.). Assisted dying around the world. https://www.dignityindying.org.uk/assisted-dying/assisted-dying-around-the-world/

Riley, W. J. (2012). Health disparities: gaps in access, quality and affordability of medical care. Transactions of the American Clinical and Climatological Association, 123, 167.

European Commission. (2018). Inequalities in access to healthcare: A study of national policies. Publications Office of the European Union. https://ec.europa.eu/social/BlobServlet?docId=20339&langId=en

Atkinson, H. G., & Ottenheimer, D. (2018). Involuntary sterilization among HIV-positive Garifuna women from Honduras seeking asylum in the United States: Two case reports. Journal of Forensic and Legal Medicine, 56, 94-98.

Tesema, G. A., Okeke, S. R., Sarfo, M., Ameyaw, E. K., Oladimeji, O., & Yaya, S. (2025). Unveiling 10-Year Dynamics of Pregnancy Termination Across Sub-Saharan Africa: A Multilevel Study. Health science reports, 8(5), e70742.

World Health Organization. (n.d.). Abortion. https://www.who.int/news-room/fact-sheets/detail/abortion

Amzat, J., Kanmodi, K. K., Ismail, A., & Egbedina, E. A. (2023). Euthanasia in Africa: A scoping review of empirical evidence. Health science reports, 6(5), e1239. https://doi.org/10.1002/hsr2.1239

United Nations General Assembly, Official Records, Third Committee, Summary record of the 29th meeting held in New York, on Monday, 25 October 2010, at 3 p.m Archived 27 September 2012 at the Wayback Machine.
Aggleton, P. (April 1997). "Behavior changes communication strategies". AIDS Educ. Prev. 9 (2): 111–23.
Birn, Anne-Emanuelle (2009-01-01). "The stages of international (global) health: Histories of success or successes of history?". Global Public Health. 4 (1): 50–68.
Davidson; et al. (2003). "Evidence-based behaviour changes medicine: what is it and how do we achieve it?". Annals of Behavioral Medicine. 26 (3): 161–171.
Durbach, Nadja (2004). Bodily Matters: The Anti-Vaccination Movement in England, 1853–1907. Raleigh, North Carolina: Duke University Press.

Osbaldiston, R; Sheldon, K (2002). Schmuck, A; Schultz, W (eds.). "Social dilemmas and sustainable development: Promoting the motivation to cooperate with the future". *Psychology of Sustainability*. Boston: Kluwer: 37–57.
Ensuring Vaccine Safety Ensuring Safety Vaccine Safety CDC". U.S. Centers for Disease Control and Prevention (CDC). 12 December 2018.

Tulchinsky, Theodore H.; Varavikova, Elena A. (2014), "A History of Public Health", The New Public Health, Elsevier: 1

Wald, N J; Hackshaw, A K; Frost, C D (1999)

O'Toole, Marie T., ed. (2013). Mosby's medical dictionary (9th ed.). St. Louis, Mo.: Elsevier/Mosby. Kindle loc. 145535.

O'Sullivan, Jack W; Albasri, Ali; Nicholson, Brian D; Perera, Rafael; Aronson, Jeffrey K; Roberts, Nia; Heneghan, Carl (11 February 2018).

Moore, Brian C. J.; Lowe, David A.; Cox, Graham (January 2022). "Guidelines for Diagnosing and Quantifying Noise-Induced Hearing Loss".

Emanuel, E. J., Persad, G., Upshur, R., Thome, B., Parker, M., Glickman, A., … & Phillips, J. P. (2020). Fair allocation of scarce medical resources in the time of Covid-19. New England Journal of Medicine, 382(21), 2049-2055.

Nates, J. L., Jayaprakash, N., Carayannopoulos, K. L., Honarmand, K., Anesi, G. L., Bartlett Davis, L., Brunson, M. E., Chen, L. L., Christian, M. D., Fuentes, M., Gallagher, J. J., Harrod, C. G., Gutmann Koch, V., Miles, W. S., Mitarai, T., Narva, A. M., Sprung, C. L., Stempek, S., Zimmerman, J. L., … Sicoutris, C. (2026, March). Society of Critical Care Medicine guidelines for crisis resource allocation during critical care shortages. Critical Care Medicine. Advance online publication.

White, D. B., & Lo, B. (2020). A framework for rationing ventilators and critical care beds during the COVID-19 pandemic. JAMA, 323(18), 1773-1774.

Persad, G., Wertheimer, A., & Emanuel, E. J. (2009). Principles for allocation of scarce medical interventions. The Lancet, 373(9661), 423-431.

Schmidt, H. (2020). The way we ration ventilators is biased. Nature, 580(7802), 40-41.

Zack, N. (2020). Ethics for disaster. Rowman & Littlefield.

Hick, J. L., Hanfling, D., Wynia, M. K., & Pavia, A. T. (2020). Duty to plan: Health care crisis standards of care. National Academy of Medicine.

Organ Procurement and Transplantation Network. (2021). Pediatric allocation policy. OPTN.

Mathurin, P., & Lucey, M. R. (2022). Alcohol-related liver disease and transplantation. New England Journal of Medicine, 386(15), 1447-1457.

International Summit on Transplant Tourism. (2008). The Declaration of Istanbul. Transplantation, 86(8), 1013-1018.

Sharp, L. A. (2006). Strange harvest: Organ transplants, denatured bodies, and the transformed self. University of California Press.

Ruger, J. P. (2018). Global health justice and governance. Oxford University Press.

WHO. (2022). Global monitoring report on financial protection in health.

Shadlen, K. C. (2018). In The Oxford Handbook of Global Health Politics. OUP.

Daniels, N. (2008). Just health. Cambridge University Press.

Kanavos, P., & Wouters, O. J. (2022). The Lancet Global Health, 10(4), e466-e467

Ganatra B, Tunçalp Ö, Johnston HB, Johnson BR, Gülmezoglu AM, Temmerman M (March 2014). "From concept to measurement: operationalizing WHO's definition of unsafe abortion". Bulletin of the World Health Organization. 92 (3): 155. doi:10.2471/BLT.14.136333. PMC 3949603. PMID 24700971.

Hartmann B (1995). Reproductive Rights and Wrongs: The Global Politics of Population Control. South End Press. ISBN 978-0-89608-491-9.

Koblitz AH (2014). Sex and Herbs and Birth Control: Women and Fertility Regulation Through the Ages. Kovalevskaia Fund. ISBN 978-0-9896655-0-6.

Riddle JM (1997). Eve's Herbs: A History of Contraception and Abortion in the West. Harvard University Press.

Thomson-DeVeaux, Amelia (June 13, 2022). "How Overturning Roe Could Change The Way Americans Think About Abortion". FiveThirtyEight. Archived from the original on June 13, 2022. Retrieved June 26, 2022.

Kestler-D'Amours, Jillian (June 17, 2022). "Religious freedom: The next battleground for US abortion rights?". Al Jazeera. Retrieved June 26, 2022.

"Statements by 2 Cardinals". The New York Times. January 23, 1973. p. 20
Harris, NM. (October 2001). "The euthanasia debate". J R Army Med Corps. 147 (3): 367–70. doi:10.1136/jramc-147-03-22. PMID 11766225.

Euthanasia and assisted suicide Archived 19 July 2011 at the Wayback Machine BBC. Last reviewed June 2011. Accessed 25 July 2011. Archived from the original

Carr, Claudia (2014). Unlocking Medical Law and Ethics (2nd ed.). Routledge. p. 374. ISBN 9781317743514. Retrieved 2 February 2018.

Voluntary and involuntary euthanasia Archived 5 September 2011 at the Wayback Machine BBC Accessed 12 February 2012. Archived from the original

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