Proceedings of the 4th International Conference on Educational Innovation and Philosophical Inquiries
DOI: 10.54254/2753-7048/11/20230715

The International Process of Euthanasia Legislation Based on a Comparative Law Perspective

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Abstract: The question of whether euthanasia is a means for the elimination of misfeasance has always been the focus of international attention and difficulty. Traditional studies on euthanasia have been devoted to exploring the rationality as well as the legality of euthanasia. Meanwhile, the legislative techniques of euthanasia were explored on the basis of the existing studies on euthanasia. Instead, this paper is dedicated to examining the reasons inherent in the legality of euthanasia in various countries. The current international situation with regard to euthanasia legislation was presented, and the background of countries in the world that currently have euthanasia legislation and their legal documents were described. The underlying reasons for the different attitudes towards euthanasia in countries with different development models were analyzed by comparing the attitudes towards euthanasia in developing and developed countries without euthanasia legislation, as well as the relevant drafts, proposals, and cases, and the corresponding recommendations were proposed to promote the way forward for euthanasia legislation in China. It is concluded that different factors, such as the economy, religion, and social risk-taking, have different influences on attitudes towards euthanasia in countries with different development models. For euthanasia legislation in mainland China, it is suggested that corresponding legislative proposals should be made in both substantive and procedural aspects, with China's national conditions taken into account.

Keywords: euthanasia, ground for elimination of misfeasance, developing countries, developed countries, comparative law, legislative proposals

1. Introduction

Nowadays, as material life becomes richer and richer, people are paying more and more attention to spiritual life, and the question of whether euthanasia is a good means for the elimination of misfeasance has become a hot topic of discussion. Euthanasia is a very complex issue, involving various disciplines including law, medicine, ethics, and social science. The term euthanasia first appeared in the writings of the Roman historian Suetonius, describing the quick and painless death of Emperor Augustus in his wife's arms, but it was not 'euthanasia' in the 'medical sense'. The first formal reference to euthanasia in the medical field was found in Bacon's Medicine of Euthanasia, in which he argued that it was the duty of a physician to relieve physical pain in the body. If euthanasia of unproductive 'useless' people was a saving of social resources in a society with low productivity and scarce resources, it might have been feasible in those days. However, in a society

DOI: 10.54254/2753-7048/11/20230715

where productivity is increasing at a rapid rate, the doctrine of "killing the unproductive" is undoubtedly cruel, a challenge to religion, and an act of blasphemy. Religion has had a great influence on people's thinking, and it is up to God to decide whether people live or die. During the Second World War, the Nazis carried out "genocide" in the name of "euthanasia," leaving the term "euthanasia" silent and grey for many years. But in today's society, where science and technology are improving, people are no longer just looking to 'live', but are more concerned with the "quality of life." Although medicine, science, and technology are constantly evolving, many diseases caused by congenital causes or accidents are still incurable. Patients who are in extreme pain and cannot enjoy the beauty of life, consider themselves to have lived without "dignity" and wish to make their own decisions about their lives, making the term "euthanasia" once again a difficult and focal point of discussion in society and in various disciplines.

In this paper, countries that have not legislated on euthanasia are divided into developing and developed countries according to their development model, and their attitudes towards euthanasia and the relevant draft legislation, proposals, and cases were compared with the legal documents on euthanasia in countries that have legislated on euthanasia. Depending on the national conditions, the reasons behind it were analyzed in depth. On the basis of these conclusions, corresponding legislative proposals for the legalization of euthanasia in our country were presented.

2. Evaluation of Euthanasia Legislation in Out-of-region Areas

2.1. Evaluation of Dutch Euthanasia Legislation

Since the 1970s, under the influence of the principal of compression and modesty, the complementary principle and the principle of acting according to circumstances of criminal law has become a fundamental concept in Dutch criminal justice philosophy [1]. Dutch courts have held that there is a conflict of obligation on the question of whether it is unlawful for a doctor to perform euthanasia, i.e. the doctor is obliged to comply with the requirement of assisting suicide, which is prohibited by criminal law, and at the same time, the doctor is obliged to respect the patient's wishes to alleviate his suffering and improve the quality of his life. In these circumstances, the doctor's compulsion to terminate the patient's life was excusable.

The Netherlands, a forerunner in the debate over the legality of euthanasia, heard the Leeuwarden case in 1973. It was proposed that Dutch physicians be allowed to use an overdose of drugs to relieve a patient's suffering. The basic conditions for a patient to die include the following: the patient must be suffering from a medical condition that is considered "incurable"; the patient must be in unbearable physical and mental pain; the patient must have indicated in writing the hospital where he or she is to end his or her life; the disease must be in the "terminal phase"; and it must be carried out by a treating physician or after further consultation with a treating physician. In 1981, building on the conditions for euthanasia derived from the Leeuwarden case heard in 1973, the Dutch courts further refined and added the following conditions: the patient must voluntarily express his or her wish to end his or her life while conscious so as to relieve suffering; the patient must be informed of all his or her options and given sufficient time to consider them; the patient's death shall not increase the suffering of others; euthanasia shall only be performed by a physician; more than one person must be involved in the decision to euthanize; and the patient must be given adequate end-of-life care when the decision to euthanize is made. In the subsequent Alkmaar case, however, euthanasia was conducted on a 95-year-old woman who was not suffering from an incurable disease but was in a deteriorating state of health. The Amsterdam Court of Appeal rejected Alkmaar's "conflict of duty" excuse and ultimately found the defendant guilty but exonerated him from criminal punishment. However, Alkmaar rejected the decision of the Court of Appeal and appealed to the Dutch Supreme Court. The Supreme Court also rejected the defendant's

DOI: 10.54254/2753-7048/11/20230715

plea of not guilty, but held that the Amsterdam Court of Appeal had not considered the possibility of the defendant pleading not guilty on the basis of a "conflict of obligation". The judgment of the Court of Appeal was therefore quashed, and the case was transferred to the Court of Appeal in The Hague for a new hearing. In the course of the case before the Court of Appeal in The Hague, the Royal Netherlands Medical Association was requested to assess the possibility of a plea of not guilty by "compulsion". Ultimately, the Royal Netherlands Medical Association gave a positive assessment of the existence of a conflict of obligation in the case. The Hague Court of Appeal eventually dismissed the charges against the accused physician, and in this way, the Royal Netherlands Medical Association influenced the process of Dutch euthanasia legislation.

After much perseverance and active discussion, the Netherlands became the first country in the world to enact a statutory law on euthanasia. The full name of the law is the Review Procedures for Termination of Life on Request and Assisted Suicide Act, which came into force on April 1, 2002. However, the Netherlands did not legalize euthanasia, but rather recognized the possibility of physicians actively assisting patients to die, subject to strict compliance with the procedures and conditions laid down in the law. Besides including the requirement imposed by the Dutch courts in 1981, the requirement that "after the consultation, at least one of the consulting physicians signs a written opinion confirming whether the patient meets other conditions" was added. The Dutch Euthanasia Act is a regulation of the conduct required of physicians to actively assist in the death of a patient, establishing standards of legality for this conduct and procedures for culpability. Meanwhile, the Dutch euthanasia act adopts an after-the-fact review procedure, i.e. no prior approval is required to perform euthanasia. Euthanasia can be conducted if the doctor is satisfied that the conditions set out in the law are met. Furthermore, the post-mortem review is not performed by a judicial authority and the procedure adopted is not a judicial one, but rather an after-the-fact administrative approval procedure. The Dutch euthanasia act merely creates an exemption from the Dutch criminal law for the offences of "requesting the termination of a person's life in accordance with the law" and "assisting suicide".

2.2. Evaluation of Belgian Euthanasia Legislation

Belgium is the second country in the world to introduce euthanasia legislation. On May 16, 2002, just over a month after the Dutch euthanasia law came into force, the Belgian Chamber of Deputies passed the euthanasia act. Belgium agrees with the Dutch definition of "euthanasia," which states that euthanasia requires a decision by a conscious and competent patient. The cessation of ineffective treatment and "passive euthanasia" shall not be defined as "euthanasia." However, in contrast to the Dutch statute law on euthanasia, which had a lot of jurisprudence prior to its enactment, there were already a large number of cases of euthanasia or other unlawful assisted termination of life in Belgium before the legislation was introduced in 2002 [2]. However, few "euthanasia cases" have been retrospectively prosecuted, not to mention punished accordingly.

In comparison to the Dutch Euthanasia Act, the Belgian Euthanasia Act is more detailed and contains six chapters. The first chapter of the Act reiterates that euthanasia, as defined in the Act, means "at the request of the patient, someone other than the patient deliberately terminates his or her life." In Chapter 2, the conditions for the establishment of euthanasia are defined and divided into two parts: the conditions to be fulfilled by the patient and the conditions to be fulfilled by the doctor. In the first part, the patient is required to fulfill the following conditions: (1) At the time of the decision to euthanize, the patient must be an adult of at least 18 years of age or an emancipated minor who is living independently from his parents and is conscious and competent.(2) It is stressed that the patient must have made the decision voluntarily. (3) The patient is suffering from an incurable disease, caused by illness or accident, and is in a situation of extreme physical and mental distress. In the second part, the following requirements are imposed on doctors: (1) Doctors must

DOI: 10.54254/2753-7048/11/20230715

inform patients about their condition and discuss therapeutic and palliative options with them and their families. The Act emphasizes that "the doctor must work with the patient, that there is no reasonable alternative to the patient's illness, and that the patient's request is entirely voluntary." (2) The doctor must have several conversations with the patient over a period of time. During this deferral process, the trend of the patient's condition is confirmed. (3) The treating physician is required to consult with another physician regarding the euthanasia request. (4) If the patient has contact with the nurse, the doctor shall discuss the patient's request for euthanasia with the nurse. (5) If the patient wishes, a discussion should be held with the patient's family about their request for euthanasia. (6) It is important to ensure that the patient has the opportunity to discuss the decision with someone they wish to meet. In addition to this, in Part III of this chapter, for patients who make a request for euthanasia but do not die immediately, an independent psychiatrist should be consulted and make a judgement as to whether the request is a carefully considered situation following unbearable suffering, both physical and mental. Secondly, there should be at least one month between the time the patient makes a request for euthanasia and the time of eventual death. The form of the request for euthanasia is specified at the end of this chapter. The request must be in writing and signed by the patients themselves. Meanwhile, for those patients who are unable to make a written request themselves, the Act also provides accordingly. In addition, a request for euthanasia can be withdrawn at any time. All processes and negotiations regarding the euthanasia request should be documented in the medical record.

Chapter III of the Belgian Euthanasia Act provides for an advance directive (hereinafter referred to as an AD) for euthanasia requests, i.e., the law allows adults and minors with the capacity to request euthanasia using an AD. The AD is similar to a will in that the patient can establish a written AD in advance, which is used by a person he or she trusts to make a request to a doctor for euthanasia while he or she is unconscious. The confirmation of the AD requires the presence of two or more witnesses, at least one of whom has no interest in the patient. If the patient is no longer capable of preparing an AD, he may also appoint a trusted person to prepare the AD for him while he is conscious, but the preparation and confirmation of the AD must be performed while the patient is capable of expressing his will. The notification system and the Federal Control and Evaluation Commission are regulated in Chapters IV and V of the Act. Within four working days of the euthanasia being carried out, the doctor must submit a registration form to the Federal Control and Evaluation Commission, which will be reviewed by the Commission. The registration form shall not show the name of the patient, and only decisions made in the presence of two-thirds of the commissioners shall have legal effect. If more than two thirds of the members are of the opinion that the form does not qualify for euthanasia but the patient has died, the case is referred directly to the appropriate public prosecution authority. Furthermore, the content of the form, the composition and renewal of the committee, and the audit report of the euthanasia case are all specified in detail. The final chapter of the Act establishes three special principles, namely that patients may not be forced to request euthanasia and give advance directives, that doctors may not be forced to carry out euthanasia, and that no one may be forced to assist in carrying out euthanasia [3].

The Belgian Euthanasia Act clearly defines the nature of euthanasia as an act, not as a process or a result of death. Secondly, the provisions of the Act are very detailed and also provide for many special cases in detail. Thirdly, the Belgian Euthanasia Act provides for an advance notice system for the first time [4]. The question of whether a doctor has the right to euthanize a patient who is already unconscious and whether someone else has the right to apply for euthanasia has been resolved. Finally, the core of the Belgian Euthanasia Act has always been the "voluntary principle." Not only can a patient not be forced to request euthanasia, but doctors and other people cannot be forced to perform or assist in euthanasia, which is a very commendable aspect of the Belgian

DOI: 10.54254/2753-7048/11/20230715

Euthanasia Act, and which also clarifies the bottom line requirement that euthanasia does not constitute a crime.

3. Evaluation of Euthanasia Practice in Developing Countries Without Euthanasia Legislation

3.1. Evaluation of Euthanasia-related Practices in Mainland China

There is no individual legal provision for euthanasia in mainland China. Euthanasia is still recognized as an act that violates the personal rights of citizens and is an objective form of conduct for the crime of intentional homicide. At the same time, there is no literature on the topic of euthanasia in China. Jurisprudential studies on euthanasia are more often in the form of journal articles or book chapters [5]. Scholars from all walks of life in China began to be concerned with issues related to euthanasia when a case in Hanzhong, Shaanxi Province, originated in 1986 [5]. A hospital in Hanzhong City, Shaanxi Province, performed active euthanasia on a woman suffering from liver cirrhosis and hepatocerebral syndrome at the request of her son, Wang Mingcheng. Afterwards, Wang Mingcheng and the doctor who carried out the euthanasia, Pu Liansheng, were prosecuted by the procuratorial authorities on charges of intentional homicide. After a six-year trial, they were eventually acquitted. However, it did not mean that the active euthanasia carried out by the two men was recognized by the law, but rather that the dormant spirit injected into the patient by Pu Liansheng only caused his coma and accelerated his death, but was not a direct cause of death, according to a forensic medical examination.[5] Article 13 of the Criminal Law provides that the "proviso" is that the circumstances are so minor and the harm so insignificant that it does not constitute a crime. Therefore, China does not recognize any form of "active euthanasia" as a basis for the elimination of misfeasance. There are two and only two circumstances in which the lawful deprivation of another person's life is provided for in Chinese law, namely: the execution of a person by a judicial officer in accordance with the law and the killing of a person in self-defense if the conditions of self-defense are met, excluding active euthanasia. The act of active euthanasia, which is performed to relieve the patient's suffering and with the request and consent of the patient and his family, can only be used as a basis for the judge to consider a lighter or lesser punishment when sentencing [6].

However, there are still many scholars and representatives in China who are trying to promote the legalization of active euthanasia within the legal framework and have submitted several versions of euthanasia legislation proposals for this purpose. In October 1998, Zhu Shine, Feng Xiuyun, and Liang Zhongtian drew on the experience of foreign euthanasia legislation and combined it with China's national conditions to write the Provisional Regulations on Euthanasia (Draft) (Draft Proposal). The draft proposal is divided into six chapters, with Chapter 1 being the general provisions, including the definition of euthanasia, basic principles, and general legal articles such as euthanasia is a basic right of citizens. In Chapter 2, the conditions for euthanasia are defined, i.e., the patient must be a deceased person in a state of distress and the request for euthanasia must be made voluntarily. In this context, the term "suffering" refers to a patient who is in great physical and mental pain and is in a state of imminent death. Chapter 3 describes the conditions for applying for euthanasia, namely that the application must be made by the person himself or herself, or in exceptional cases, by proxy in writing. The doctor is obliged to inform the patient of the situation, and the patient has the right to be informed of the condition as well as of the alternatives and the effectiveness of their treatment. In this chapter, euthanasia is divided into three types of euthanasia: A, B, and C. Type C, active euthanasia, has special provisions, i.e., there must be no objection from the competent physician, and the competent physician may recuse himself. Chapter 4 establishes the procedure for processing euthanasia applications. Again, according to the three different types of

DOI: 10.54254/2753-7048/11/20230715

euthanasia, A, B, and C, different provisions are made. The competent physician is authorized to receive, validate, and arrange for the euthanasia of patients under his or her supervision.

However, for type C euthanasia, the euthanasia units set up at the county level and above, as well as in rural hospitals where available, are authorized to receive, validate, and arrange for the execution of euthanasia. Written procedures are required for each of the three types of euthanasia and are filed with the patient's medical records. Chapter 5 provides for the administration of euthanasia. At hospitals, euthanasia practitioners are appointed at township level and above. The euthanist is specially trained to perform euthanasia and is required to do so on the written notice of the euthanasia unit. At the same time, the circumstances under which euthanasia may be suspended, stopped, or not performed are defined, including the withdrawal or suspension of euthanasia by the applicant citizen or by the applicant's treating physician. In the case of matters relating to law enforcement, the judicial authorities request that euthanasia be suspended or withheld. The four situations in which a person under judicial control who is a rehabilitated worker, a criminal suspect, or a prisoner in custody or serving a sentence may apply for euthanasia without judicial approval. In Chapter 6, legal liability for euthanasia is set out, including the establishment of a special euthanasia arbitration committee to arbitrate euthanasia disputes. Anyone who is euthanized without meeting the conditions for euthanasia, who fails to comply with the statutory euthanasia acceptance procedures, and whose agent for euthanasia applications does not comply with the relevant regulations on agency to carry out the agency's euthanasia applications will be liable. Zhu Shine's version of the draft recommendation on euthanasia, which belongs to the draft recommendations written by scholars, is relatively complete in its structure [6]. It also divides euthanasia into three types: A, B, and C. Types A and B belong to negative euthanasia, and type C belongs to active euthanasia. Application, acceptance, validation, and execution are all governed separately. For the first time, the draft recommendation establishes a euthanasia unit and euthanist, as well as a euthanasia arbitration committee, intended to receive, validate, and administer euthanasia and to deal with euthanasia disputes by specially trained personnel. strictly separate from the clinical departments, but the feasibility in practice is not yet certain. However, the authorization level is too low to ensure that every "euthanist" and "euthanasia department" staff member has received the appropriate training and professionalism. Therefore, although the Zhu Shine version of the proposal has many innovative suggestions and is more complete in structure, it is less enforceable.

During the two sessions of the 2016 National People's Congress, Li Peigen, a member of the 12th National People's Congress and an academician of the Chinese Academy of Engineering, once again suggested that "euthanasia legislation" should be considered. It is believed that, under the regulation of the law, there is no need to be concerned about the adverse legal effects of euthanasia. When Li Jie and Ma Yide, both NPC deputies, attended the tenth session of the Standing Committee of the 13th NPC to deliberate on the draft of the personality rights section of the Civil Code, they suggested that euthanasia should be included in the personality rights section of the Civil Code and that the "ultimate dignity of human beings" should be protected. The "ultimate dignity of the human being" should be protected. During the two sessions of the National People's Congress in 2022, Liu Guifang, a representative of the NPC and a national outstanding village doctor, once again called for euthanasia to be legalized in China and for euthanasia to be regulated on a legal basis. According to Liu Guifang, euthanasia is a sensible choice for those suffering from terminal illnesses, to maintain the dignity of death and have a peaceful end-of-life state. Although euthanasia-related legislation is still underway in mainland China, the results of numerous public opinion polls conducted show that all sectors of society are overwhelmingly in favor of euthanasia. The legality of euthanasia continues to be hotly debated by scholars from all walks of life, and the legislative process of euthanasia in China has been moving forward without stagnation.

DOI: 10.54254/2753-7048/11/20230715

3.2. Evaluation of Practices Related to Euthanasia in India

Euthanasia is an illegal act in India because it is a very religious country. Suicide is not a right of the people under the Indian Penal Code, 1860. Sections 305, 306, and 309 of the code make it an offence to encourage suicide in children or mentally ill people, to encourage suicide, and to attempt suicide, which is punishable by imprisonment. In the meantime, euthanasia falls under section 300 (1) of the Indian Penal Code 1860, where a doctor kills a patient. If a doctor euthanizes a patient at the request of the patient, it is not murder, but it is still culpable homicide [7]. The act of assisting suicide, i.e., active euthanasia, by a doctor is clearly defined under section 306 of the Indian Penal Code in force as abetting suicide and is punishable. The Bombay High Court, in the case of Maruti Shripati Dubal, sought to distinguish between suicide and euthanasia. The court held that suicide should be an act of killing oneself without the help of others, whereas euthanasia necessarily requires the intervention of others to be carried out. Therefore, even if the euthanasia was requested voluntarily by the patient and the doctor performed the act based on the professional ethics of respecting the patient and improving the quality of his life, it still could not be equated with suicide, as the act was still a culpable homicide and was different on both factual and legal levels. Moreover, the right to life is an important right protected by the Indian constitution and is guaranteed under Article 21 of the Indian constitution. There has been a controversy as to whether the right to life includes the right to die. The judges of the Punjab Supreme Court, after discussion, have held that the right to life under the Indian Constitution is one that includes only the right to live and not the right to die. The code of medical ethics for medical practitioners in India also explicitly classifies euthanasia as an unethical practice.

In summary, the written laws, as well as judicial decisions in India are very clear in making euthanasia an illegal act and in eliminating it as much as possible. It is cruel that people do not have the right to choose to die. But it is also justified by the Indian context. Firstly, India is a very religious country, and various religious texts reject euthanasia and even suicide. Secondly, as a developing country with a large population, India has a low level of economic power and social security, and once euthanasia is legalized, it can easily become a "business practice." Faced with the cost of treating illnesses, the elderly, the sick and the disabled may face involuntary euthanasia, and the vulnerable would be at great risk. India is therefore very adamant that euthanasia is illegal. However, with regard to its provision that the right to life does not include the right to die and that the act of suicide may also be punishable, the author believes that it is unreasonable and that every human being has human dignity.

4. Evaluation of Euthanasia Practice in Developed Countries Without Euthanasia Legislation

4.1. Evaluation of Euthanasia-related Practices in the UK

The United Kingdom, one of the earliest countries where the idea of euthanasia germinated, has not implemented euthanasia-related legislation. As early as the 17th century, Francis Bacon, a famous British philosopher and thinker, mentioned the term "painless death" several times in his writings. Bacon believed that it was the duty of the physician to let the patient die in peace [8]. The earliest practice of euthanasia in the UK can be traced back to the establishment of the "Chemical Society for the Legalization of Voluntary Euthanasia" in 1932, and the progress of legalizing euthanasia in the UK began to be organized. However, during World War II, the Nazis used "euthanasia" to commit genocide, making the word "euthanasia" silent for nearly half a century. But in 1993 and 2002, the U.K. Supreme Court ruled on two separate cases of "passive euthanasia," in which it agreed to stop the continuation of life-sustaining treatment regimens for patients. Although the two

DOI: 10.54254/2753-7048/11/20230715

cases were appealed by the parents or husbands of the euthanized patients to the UK Supreme Court for termination of treatment, and the hospital did not agree to the application of the patient's close relatives [8], as the UK is a case-law country, the decisions of the Supreme Court have had a great influence on the development of euthanasia in the UK, which illustrates the attitude of the UK towards passive euthanasia.

However, in terms of active euthanasia, the British courts hold a passive evaluation. In 2001, Mrs. Pretty petitioned the British prosecutor for immunity from prosecution after her husband helped her commit suicide, hoping for a court decision. However, members of the British House of Lords unanimously rejected her appeal, with the British judge holding that the "right to life" stipulated in the European Convention on Human Rights could not be expanded to include the "right to death". Mrs. Pretty's lawyer held that the court's consent to her husband's assisted suicide did not violate the European Convention on human rights, but it was far from enough for the British court to provide such proof. The plaintiff needed to prove that the British court's disagreement with her request violated the European Convention on Human Rights [8]. In the end, Mrs. Pretty survived the pain she had foreseen and finally went on to die. The British judge emphasized that once assisted suicide is legalized, it will not necessarily lead to the expected path of maintaining self-esteem and will be difficult to regulate, with the risk of multiple vicious homicides committed using "euthanasia" and a high risk of prohibition. Such a high-risk resolution should be decided by the House of England, and the courts are not competent to decide the legalization of active euthanasia.

In recent years, an increasing number of patients in the UK who are in extreme physical and mental pain have died under the "help" of doctors, but this help is limited to passive means such as removing their life-supporting ventilator or stopping nutrient injections. While passive euthanasia has been acquiesced in both moral and legal aspects, the legislative process for active euthanasia in the UK is still a long way off.

4.2. Evaluation of Euthanasia-related Practices in the Australia

Unlike the UK, Australia has enacted euthanasia legislation many times and the voted bills have been promulgated and implemented, but were repealed shortly after they were enacted and implemented. Since 1993, several drafts on active euthanasia have been drafted in Australia. It was not until 1996 that the Northern Territory of Australia passed the Dying Patient Bill of Rights, the first bill on active euthanasia passed in the world, even before the Dutch Euthanasia Act. But it was overthrown by the Australian federal government after only eight months of implementation and was repealed by the Australian Senate in March 1997 [9]. But in the past three decades, the Australian public has generally been in favor of the legalization of euthanasia, and the issue of "active euthanasia legalization" has always been a hot topic of concern to the Australian government and the public.

Between 1993 and 2016, a total of 51 euthanasia bills were proposed in Australia, but only the Bill of Rights for the Terminally Ill in 1996 was successfully voted and enacted, and only four people were legally euthanized under the Act within eight months of its entry into force [10]. In the following two decades, the debate on euthanasia and the drafting of related bills did not stop, and 28 legislative proposals for the legalization of euthanasia were defeated. In 2017, Victoria, Australia, passed an amendment to allow the legalization of euthanasia, and Victoria became the first state in Australia to legalize euthanasia. Although the Act did not officially come into effect until June 19, 2019, 272 people applied in its first year of implementation, and a total of 124 people were euthanized, almost all of whom were terminal cancer patients [9]. The implementation of the Act has played a great role in the advancement of euthanasia legislation in other states in Australia and around the world.

DOI: 10.54254/2753-7048/11/20230715

5. Analysis of Causes and Suggestions on Euthanasia Legislation in Mainland China

5.1. Analysis of Causes

From the second and third parts of this article, we can see that passive euthanasia is allowed in most countries in the world, both from the legal and moral aspects. However, in developing countries, most people accept passive euthanasia for economic reasons. In most developing countries, the economic level is low and the number of low-income people is relatively large. At the same time, medical technology is in its infancy, and the treatment methods and required drugs for intractable diseases are very expensive. Many patients cannot afford the high treatment costs, and even if they could, there is still no 100% chance of recovery or even recurrence after treatment. Therefore, most patients with incurable diseases choose to be treated for only a few days or not at all. In developed countries, patients have less economic pressure, but they are more interested in "living with dignity," preferring to have a quality of life rather than survival, and do not want to endure the expected pain and go to the end of life peacefully.

As for active euthanasia, the considerations of developing countries and developed countries that have not implemented legislation are basically the same, mainly due to religious belief, interpretation of the right to life, social risks after active euthanasia is lifted, and so on. Therefore, suicide, a self-terminating act of life, is considered blasphemous by believers of all religions, let alone an active euthanasia act in which a third person voluntarily allows assisted suicide to play a positive role. For countries such as the UK and India, where religion has an impact on politics, religious factors will undoubtedly have a great impact on the process of euthanasia legislation. Secondly, it is the interpretation of the term "right to life" [11]. All the existing human rights conventions in the world, as well as constitutional documents and related interpretations of various countries, basically put forward the protection of the "right to life". Whether the right to life includes the right to "allow others to end their own life" has always been the focus of debate between the pro and con sides. Undoubtedly, those who oppose the legalization of active euthanasia believe that the right to life includes the right to "allow others to end their own life." This is an expanded interpretation, which is inconsistent with the legislative purpose of the legislators at the time of legislation. On the contrary, those in favor believe that the right to life should include "human dignity." When the patient is in a situation of extreme physical and mental suffering and there is no other reasonable choice, continuing to live will undoubtedly increase the patient's suffering and will cause him/her to die without dignity. Survival without value and quality is not dignified and does not meet the requirements of various human rights conventions or constitutional documents to "protect the right to life". However, the interpretation of the right to life will be greatly influenced by factors such as people's values, current life situations, status, and identity, so I cannot draw a conclusion on which is right and which is wrong here. The third reason is whether the social risks of active euthanasia will increase as people might expect. In developed or developing countries, although there are differences in social security and national quality, it is undeniable that social instability can never be eliminated. Once active euthanasia is allowed, it is difficult to ensure that it is implemented within the framework of legal norms. Once it exceeds the provisions of the legal order, it will cause irreversible damage. This is something the government of any country does not want to see. If active euthanasia is to be legalized, it must carry out rigorous preparations, formulate strict and reasonable legal norms, and ensure that there is sufficient manpower and material resources to ensure the legal implementation of active euthanasia after operation. But obviously, not every country has the capacity to do so, and the country cannot guarantee that every citizen will cooperate and that there will be no malicious intent to use "euthanasia" to kill or to commercialize "euthanasia."

DOI: 10.54254/2753-7048/11/20230715

5.2. Suggestions on Euthanasia Legislation in Mainland China

In our country, passive euthanasia has been allowed and accepted by people and laws. As far as active euthanasia is concerned, religious factors have little influence on our country. Our country should focus the legislative focus of active euthanasia on reducing the social risks of active euthanasia after it is legal, which can be divided into two parts: substantive conditions and procedural conditions.

Substantive conditions mainly include the conditions that euthanasia applicants need to meet, the conditions that euthanasia practitioners need to meet, and other conditions such as the venue for euthanasia.

5.2.1. The Conditions That Euthanasia Applicants Need to Meet

If the applicant is the patient, the application must be made voluntarily when the patient is capable of expressing his or her will; if the applicant is a third person other than the patient, the application must be delegated to a third person when the patient is conscious, in the presence of two or more witnesses, at least one of whom has no stake in the euthanasia.At the same time, the entrustment shall be in writing with the date, the signature of the principal, the signature of the agent, and the signature of the witness. If, for special reasons, it is impossible to entrust in writing, the whole process can be recorded in the form of audio and video.

5.2.2. The Conditions That Euthanasia Practitioners Need to Meet

The euthanasia practitioner should be the attending physician of the person being euthanized. At the same time, a third person should be present when euthanasia is performed, and that third person should be a nurse who routinely cares for patients and a professional who is engaged in hospice care. According to the patient's wishes, the trusted person who wants to accompany him or her during euthanasia should communicate with the person he or she chooses after learning the patient's wishes, and ask him or her if he or she is willing to accompany the patient at the euthanasia scene.

5.2.3. Site Conditions for Euthanasia Implementation

The site where euthanasia is implemented must be the hospital. Any drugs used for euthanasia must not be available outside of the hospital, and a strict registration system must apply for physicians to extract drugs for euthanasia. However, hospitals qualified for active euthanasia should set up a special "comfort room" that is decorated to make patients feel warm and calm. Patients should be admitted to the dedicated room one week before euthanasia to adapt to and be familiar with the environment here. In addition to the patient's previous medical team, the patient's exclusive hospice care division should also be equipped to provide hospice care for the patient to ensure that the patient lives a dignified and relatively happy life. The specific implementation process of euthanasia must include the entire sound recording or video recording and be handed over to the judicial departments for the record.

The procedural conditions include the application for euthanasia, the validation and other procedural regulations, as well as the time requirements for each stage.

5.2.4. Requirements for Application Materials of Euthanasia

First of all, all application materials for euthanasia should be submitted to the department of the hospital that specializes in reviewing euthanasia. The application must be made in writing and the written application should be signed by the patient or his or her representative and his or her attending physician. In addition to the application, the entire medical record of the patient and the

DOI: 10.54254/2753-7048/11/20230715

opinion of the attending physician that euthanasia can be carried out should also be attached. In addition to the opinion of the attending physician, there should also be a psychiatrist's appraisal report that the patient is mentally competent at the time the euthanasia application was made or the application for euthanasia was commissioned. At the same time, a third physician who is in the same field as the attending physician and who can also diagnose and treat the patient's symptoms, and at the same time, who has no less experience and ability than the attending physician, but who has no stake in the patient and the attending physician, should independently identify the patient's condition and perform a submission on whether euthanasia can be implemented. This process, which includes the patients' considering period, the attending physician's inspecting period, mental state identification period, and independent appraisal period at the third doctor's appointment, should not exceed 10 days.

5.2.5. Requirements for Euthanasia Validation Procedures

After the attending physician submits the application materials to the hospital's department specifically responsible for euthanasia-related work, the reviewer shall evaluate whether the materials are complete, whether the content is true, and whether they meet the substantial conditions for active euthanasia. Then this staff shall sign it. After the review is passed, there is a review period that needs the signatures of both the reviewer and the head of this department. Hand over the euthanasia approval letter and related application materials to the local judicial department for review, and after the judicial department has reviewed and approved the euthanasia decision, sign the euthanasia decision in triplicate, one of which is kept for the record by the judicial department, and the other two will be transferred back to the hospital together with the euthanasia application materials and the validation letter. Therefore, these review pages should not exceed 10 days.

In addition to the above-mentioned substantive and procedural conditions, other principles should also be taken into account on the basis of the "voluntary principle" and the bottom line to identify the criminal act of euthanasia and provide for the corresponding legal responsibility.

6. Conclusion

This paper analyzes attitudes towards passive euthanasia and active euthanasia in countries with different development patterns. Through comparison, it can be concluded that the current attitudes towards passive euthanasia are generally consistent in all countries around the world and are basically agreeable from the perspective of morality and law. However, the difference is that patients and their families in developing countries and developed countries choose to accept passive euthanasia from different starting points. The common starting point for patients in developing countries is economic considerations, while people in developed countries are motivated by concerns about the pursuit of quality of life and their own dignity. With regard to the decriminalization or legalization of active euthanasia, developed and developing countries basically have the same starting point for their negative attitude towards it. The most important reasons are religious belief; that is, only "God" can decide life and death, and that human beings do not have the right to choose death, which is a blasphemy against "God". The second reason is that countries that have not legalized euthanasia generally believe that the "right to life" in constitutional documents or human rights conventions should not include the "right to death," which can be interpreted as not including the right to "willingly let others assist oneself in ending one's life". The third reason, which I believe is the most important reason, is that the legislative capacity of various countries varies, and not every country has the ability to formulate a "perfect" law to avoid all the social risks of opening up active euthanasia. And the social order, economic level, and national quality of each country are also different. Even if there is a perfect euthanasia law, its subsequent

DOI: 10.54254/2753-7048/11/20230715

implementation will not necessarily be effectively guaranteed, and the citizens will not fully follow the legislator's intention to implement the euthanasia law.

Combined with my country's national conditions, I believe that my country's legislation on euthanasia can be regulated on two levels: the substantive elements and the procedural elements. The substantive requirements are mainly the specification of "people," that is, what conditions should be met by the applicant, the proxy applicant, and the euthanasia executor themselves before they can apply for euthanasia or implement euthanasia. The procedural requirements are regulated by four aspects: the materials for euthanasia applications, the approval procedures, the time spent on each step, and the procedures for the specific implementation of euthanasia.

Of course, there are certain shortcomings in this paper. The classification of legislative proposals is only a simple classification based on the two aspects of substance and level. If the implementation of the proposal is enforceable, it can be further classified in more detail. Secondly, the author did not conduct sufficient public opinion research on the legislative proposals mentioned in this article, and did not fully understand the public's attitude towards them. In the next step, we can collect more opinions and attitudes from people from different classes on this proposal and make further improvements based on their opinions and attitudes, combined with our country's legislative capacity.

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