

## Bioethical issues on aging

María Casado

### Abstract

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The article discusses aging by taking Alzheimer's genetic diagnosis as example for analysis. By considering advanced age as a bioethical problem, it makes considerations on the autonomy of elderly patients as well as about the purpose of medicine and the concept of health, such as welfare, formulated by World Health Organization currently adopted throughout the world. It discusses social decisions necessary to establish public policies to provide care to this population group as well as the individual predictions related to their needs. It concludes by considering that human rights provide already legal-ethical bases for an approach to the problem at the countries' legal level, while seeking dignified and non-discriminatory care to the elderly.

**Key words:** Aging. Personal autonomy. Human Rights. Public policies. Bioethics.



#### María Casado

Full professor of Philosophy and Law, Moral and Politics, director of the Bioethics Chair at Bioethics and Law Observatory, and Master's program in Bioethics and Law at the University of Barcelona (UB), member of the Bioethics Committee of Spain and Catalonia's Bioethics Commission, Spain

### Alzheimer's genetic diagnosis, an example for analysis

The previous mere knowledge that a particular number of citizens will have a specific disease requires measures that raise ethical and legal problems – both individual and collective – regarding decision-making in which individuals and societies' values and fundamental rights are involved. Concepts such as autonomy, privacy, confidentiality, non-discrimination, dignity, in short, will influence in determining the measures to be adopted and which, necessarily give rise to conflicts of interest that may affect the essential rights of people. In addition, this new knowledge will increase the possibilities of choice and decision and double responsibility, both for individuals and for the State, which should provide related social and health policies.

Analysis of the consequences in genetic disease detection presents different peculiarities depending on whether one deals with cases such as Alzheimer's<sup>1</sup>, where most of the known genes indicate susceptibility or a greater predisposition for the disease or other inherited autosomal dominant disorders. Detection of susceptibility genes does not determine whether someone is going to suffer a disease but if certain interactions occur – with other genes and with the environment – they are more likely to develop. Naturally, the consequences are different when individual decisions are taken to establish related public policies.

Genetic analysis provides information on people's health, which may be interesting for themselves as well as for third parties. In the case of Alzheimer's, what usually happens is that the genetic data suggest a mere predisposition which will actually develop only under certain circumstances, i.e., they indicate the existence of a probability, which is a statistical concept, and certainly not for a real case. However simple might the procedure be for obtaining samples for analysis – hair, saliva, tissues, fluids ... – we must not forget that the results of the tests are unsafe and it should be noted that the data are particularly sensitive variables. This is not like working with data such as purchases made at a supermarket (although this also provides valuable information about

consumers' habits and lifestyles) but this is diagnostic data and there is need to fulfill at the very least the same guarantees as any other diagnostic medical test: information, consent, confidentiality, genetic counseling...<sup>2</sup>

From the viewpoint of safeguarding people's rights, it is necessary to insert such genetic tests within the physician-patient relationship. This should give them a better guarantee against possible fraudulent uses by interested parties if granted access to this data, which, as all data relating to health, are sensitive and have special protection<sup>3</sup>. Thus, confidentiality, which is essential to the health professions, the informed consent of the person and the medical advice that necessarily requires a genetic diagnosis for a possible disease are requirements that should be met by carrying out genetic tests within the framework and the context of a health care relationship, so as to protect and insure them. This applies to the use of this information by insurers, by employers in labor contracts and their uses by the state, which in the case of conflict of laws should weigh all the factors involved in the conflict and will always be legally required to justify any decision.

In this sense, the recommendations of the Ministry Committee of the European Council on genetic screening for sanitary and medical data protection<sup>4</sup>, established that it should not be lawful to require genetic evidence to carry out insurance or

labor contracts and, in general, all Europeans countries hold this view. In the Spanish legal system, the general framework sets forth the provisions of the European Council's *Convention on Human Rights and Biomedicine*, whose Article 12 only allows the use of genetic information for medical purposes or for medical research, as well as the Personal Data Protection Law, which aims to protect the privacy and it adds importance to the so-called computer self-determination, as noted by Sanchez Urrutia <sup>5,6</sup>.

The core of the problem is that this kind of knowledge allows for *discrimination*. Although the word discrimination can have a positive sense – to consider special circumstances for the benefit of disadvantaged people – here the dilemma is that the information can be used against those with a lesser genetic endowment, although there is awareness that there is no perfect genome or 'superior' ones, and that, normality, is a cultural construction. That is precisely the circumstance in which individuals and society feel concerned about the possibility of using genetic testing for purposes other than those for obtaining data within the health context. We must bear in mind that the political-legal system is held responsible for preventing discrimination and, therefore, there can be only equal access to the benefits of genetics if there is the will to do.

In the context of an increasingly aging population, Alzheimer's confronts us with problems of great interest which require

multifaceted analyses that demand the establishment of distinctions, to be flexible; to be able to respond to these issues not through simplistic attitudes, but to join the discussion with a subtle and complex attitude. At the same time, this disease (not just its genetic detection) confronts us with evidence that curative medicine has limits; that there are pathological processes that can occur but not be cured and must be integrated into the health system and social and health policies to provide comprehensive care to those affected as recommended by the health system, in order to attain the highest quality of life possible for them.

But it is clear that neither the people or health officials – technical staff or policy makers - are sufficiently prepared for the change that involves the impact of technical progress in the field of health: or to predict its impact from the ethical point of view, even from an economic standpoint. However, it should be noted that at the European Union level, the Commission has been taking action – especially since 2009 – on Alzheimer's disease and other disorders <sup>7-10</sup>. There are also reports on dementia developed from the viewpoint of ethical reflection, for example, such as published by the Nuffield Council of Bioethics <sup>11</sup>.

### **Advanced age as a bioethical issue**

In this context, it would be in the Administration's interest the execution of

ethics committees, especially for geriatric care institutions – and also in primary care – as the elder’s alleged incompetence has allowed perpetuating paternalistic models in these areas that do not sufficiently take into account the values and interests of each person and their specific dignity, as generally happens in the case of the mentally ill. These committees should promote not only the discussion of specific cases, but strive to develop general protocols which would channel the ways in which the various problems are addressed according to previously established criteria, after rational and interdisciplinary discussion. They should also contribute to the formation of its members, raising the ethical culture of those centers, the overall sensitivity of the population and promoting related general reflection.

Within these committees, as interdisciplinary forum for reflection, the issues mentioned above would be debated and, more specifically those regarding informed consent in these contexts, where the limiting of mental faculties does not equal to their loss and there should be no omission whenever possible. In addition, they would serve the professionals who work together to enhance patients’ autonomous decisions - while it is still possible - for example, through documents stating their will regarding the type of assistance they would want to (or not) receive in the future.

There is a clear need now to care for the elderly as they are a part of the population

population that finds itself in a condition of vulnerability. In recent years in Spain, media has often disseminated information about the increase and severity of abuses to the elderly who are dependent both in the family context as in the institutions responsible for their care. In this some interests analyses have been done; even the Barcelona Bar Association conducted a study that has shown the elder’s terrible situation who seek for legal protection at the Association.

It should be noted that in many hospitals there are protocols for abuse and guidelines from healthcare ethics committees that encourage medical personnel to be especially diligent in abuse detection and eradication. In these protocols it is discussed who is susceptible to abuse and to which type of abuse, action plans are established and defined what is considered to be a vulnerable person. In order decrease these abuses, treatment measures must be in place to address abuses that have already occurred: breaking the silence, listening to victims by helping them get back their confidence and self-esteem, determining whether there is legal liability. Measures aimed at prevention, which affect social norms of conflict resolution and behavior models are also necessary.

The abuse may be perpetrated in the family’s home, in nursing homes and in hospitals, but the abuses occurring in diverse places are different. They can be physical, verbal, emotional, abandonment,

infantilization, of a financial kind and so on. The difficulty to detect these abuses are conditioned by the elderly person who does not dare to manifest when they occur inside the family's environment - or may have difficulty expressing it - and also because the health staff is often poorly trained to face this event.

Closely related to this issue are the so-called restrictions<sup>12</sup>, physical or chemical, that occur in health community centers or nursing homes to prevent the patient from harming himself, falls, etc. but sometimes this may show just a lack of personnel to serve them satisfactorily. Methods regarded as restricting are those which prevent physically a person's free movement, hindering activities and normal accessing, isolation, or use of medication. It should be noted that, to prevent restraint, monitoring and supervision should be increased, which in practice means an increase in staff at the centers and, for this, medical orders are required, which should be reassessed at short intervals of time. Also, as health care decision, the reasons for the decision must be explained to the patient and his family and registered in the medical records supported by sufficient motivation.

In a society focused on individual autonomy, these circumstances may seem extreme, but they are actually frequent in certain situations. They serve, therefore, to show the extreme vulnerability of elders with cognitive impairment, which is a

group of citizens needing support and monitoring to ensure that their rights are respected<sup>13</sup>.

### **Patients' autonomy, the aims of medicine and the concept of health**

Currently, the recognition of individuals' autonomy – a core issue in moral and legal contexts – is extended to new fields. This is the case of health, traditionally dominated by the principle of beneficence and by the idea that the physician - an expert on diseases - was the one who made the decisions.

The health relationships are experiencing important changes resulting from multiple factors, one of them is the massification and depersonalization of the large hospitals, which have contributed to the deterioration of the model of doctor-patient relationships based on trust. The new context requires the non presumption of the opinion of any of the parties involved, as the relationship develops between strangers whose hierarchy of values cannot be presumed, because the society to which they belong is not homogeneous, but plural<sup>14</sup>.

Additionally, health concept itself has changed from the absence of disease to the idea of promoting individual wellness, which is currently the definition of health promoted by the World Health Organization (WHO).

The generalization of this concept has brought important changes to the health care environment, setting emphasis not on the absence of disease but on a person's level of wellness.

If, according to WHO, we accept to consider health as a *state of complete psychosocial, psychological and social wellness*, the immediate result is that it is precisely the person, in this case it is the patient who is best placed to define their own welfare rather than an external technician (such as in a disease-centered concept of health). The scope of this change in the approach has not finished, but the first of all the consequences are to be seen yet – the most obvious and most 'revolutionary' in the realm of health has been the removal of decision-making from physician to the patient: from beneficence to autonomy.

Naturally, the movement for people's autonomy is something that transcends the realm of health: it is in the general direction of civilization and it is significant of individuals and societies' maturity. In the context of the West, it means a shift from heteronomy to autonomy. It is necessarily so in ethics, but also in law and policy making: from the allocation of status to the autonomous will; from dictatorship to democracy.

The right to vote, to choose residence, freedom of thought and expression, choice of companion, etc., the consolidation

of recognition of people's rights advanced toward wider areas regarding freedom and not surprisingly, also happens to be so in the health-related areas. Subsequently, consumer associations and patients have played a key role in the acceptance of the patients' bill of rights<sup>15</sup>, but it should be noted that the above definition of the WHO-sponsored health model has not been alien to the mentality change we are now witnessing.

On the one hand, although the movement in favor of patient's autonomy with the demand for a fair health system for all citizens provides the framework for the development of great changes in the health model, not least important is the application of biotechnology to health and the consequent rise of the biomedical sciences, which have led to a transformation so important in the health world that it has questioned the objective of traditional medicine, the demand for healthcare, research, and even the priorities of expenditures in state budgets. The considerations regarding what are the goals of medicine itself may shed light on this debate but, often the discussion is set back by the media (whether or not suitable, if provided, if enough) and in the meantime, some wonder whether medicine may have purposes other than those purposes of doctors, patients or society at large.

Traditionally, scholastics had been referring to the *finality of the thing* when evaluating the performance of institutions such as universities, hospitals or even in

a more general manner to teaching or medicine. For once, it would be more appropriate to follow its method and assess health activities based on the adequacy of the achievement according to the objectives. Thus, it would be used to decide about biomedicine's good or bad aspects - the double consideration of principles and goals by accepting human rights' principles and using medicine goals and health concept as a valuation tool from the viewpoint of finality.

It is interesting to note that often the aspects of health biotechnologies that lead to conflicts in bioethics are the same as those that question some of the commonly accepted goals of medicine<sup>16</sup>. The most notorious goal of medicine has been to save lives, but biomedicine can now extend life under circumstances that might not be considered advantageous. The lengthening of life by artificial means leads to the euthanasia debate, crucial for bioethics, but also crucial for the traditional goals of medicine that questions whether it is a benefit to prolong life at any cost

Similarly, this happens regarding the aim of promoting and maintaining health since we have already mentioned the subjective aspect of the health concept, and it is a proven fact that the demand for health does grow without limits because there is always room for improvement in healthcare. Therefore, the question is: Where does the accrual of wellness cease?

Resource allocation to one or the other viewpoint is a first order issue for bioethics and, of course, it is also important from the political point of view.

Neither the classic aim to ease pain and suffering remains intact. The current emphasis on care or treatment of mental illness and the role of medication, as it affects happiness, pose ethical as well as economic and political dilemmas and, indeed, they question the traditional conceptions on medicine's goals. These are issues that affect the principle of autonomy, but also the binomial beneficence non-maleficence, in which justice appears as a backdrop to the debate.

Therefore, what is clear is that there has been a paradigm shift in healthcare relationships, since it was previously a physician's based medicine to a patient's medicine. This does not happen smoothly and in the realm of aging also presents specific problems that cannot be ignored: the different values of autonomy in situations of decreasing capabilities, the problem of resources allocation; the cost of palliative care, and modern diagnostic systems. Such questioning highlights, among other things, the need for gerontology bioethics in a society in which the aging population puts these issues on the table with a peremptory nature.

### **Social decisions**

Life expectancy in the western world has been rising increasingly, at the same time

as the population grows exponentially, the age range over 80 years old increases at an even greater proportion. Demographic studies indicate that life expectancy grows by about three months per year – with a constant difference for women – and the increasing elderly population will not be compensated by the birth of new children in the same proportion. This is one of the biggest problems faced by Western societies in the coming decades.

The aging process must be analyzed from diverse viewpoints. From the psychological point of view, taking into account that aging is a process that transforms a healthy adult subject into a fragile individual whose competence and energy reserves decrease, and become more vulnerable to most diseases. But we must emphasize that this transformation is not restricted to the last part of life, but it is the result of continuous biological mechanisms that occur at different paces. There are intrinsic factors, discussed at length by biologists and medical geneticists, but for now, we do not even know enough to identify which genes perform the functions of aging other than in very specific cases.

It is not possible, with the current knowledge, to determine the clock of longevity from DNA; there are intrinsic involved factors at play, and for the most part, extrinsic factors such as education, socioeconomic status, geography, the environment. It is generally accepted that

that the genetic diagnosis provides valuable information for individuals and evidently it is so, but we should not forget that, perhaps in this field, more things might be revealed by a zip code. Living in Barcelona or in Delhi or in La Paz represents a major change in the life expectancy of a person, even within the districts of the same city there are significant differences, which means also that the zip code is a relevant factor and also that it is a readily available data in regard to that person.

The socio-economic circumstances have considerable influence on the health of people and populations as it is well known in public health. Extrinsic factors, such as general living conditions, work, nutrition, hygiene, play a preventive role in absolute beneficial health. But establishing correlations between all these factors and health and life expectancy does not establish demonstrations and, much less, determinations.

Currently, the unsurpassable limit of prolonging human life is unknown. What is known is that the age of death can recede to the point that issues have been raised by some scientists about the need to take measures when humans become semi-immortal, when in a medium term horizon it might be possible to reach 250 years of age. While this may sound like science fiction, it is possible to achieve this through the study of the aging process and cell reprogramming. Thus, society will have to make collective decisions.



In any case, we must agree that the chronological age does not always correspond to the aging process and, even though the years of life increase, it is also found that some people reach the same age in better circumstances. But this is not an obstacle, given there is a greater number reaching more mature ages, that there will be more people with disabilities and dementia. It is the life expectancy without disability which is desirable to increase and, with this in mind, society must take measures in order to not isolating or devaluing the elderly, more so knowing that this produces more disability.

In general, increased years of life affect the increase of people with physical and psychological dependence. There are two alternatives when people get older and become unable to defend themselves: either they are cared for in the domicile or are taken to a specialized institution. Even in the case of home care, it should be emphasized that there is a lack of caregivers, and this is obviously a profession, regardless all the emotional connotations that might be conveyed.

Frequently, a very important issue regarding these caregivers is omitted, and, in most cases, we mean female caregivers. And yet, there is additional information: the daughter is the caregiver when patient is impaired by Alzheimer or other senile disorder is done at home.

On the other hand, regarding seniors, social impairment derived from retirement must be taken into account. There is, in Spanish society, worship for youth and consumerism, so the marginalization of the elderly, which generally also coincides with a loss in purchasing power, is a concern that must be taken in consideration. Although currently there is talk about the new 'senior' consumers and for them they have created and marketed some types of cultural leisure and entertainment designed for the golden age – an euphemism – it is clear that the elderly in many cases are simply driven away. This aggravates the situation, since it is known that isolation, loneliness, not being able to exercise their skills and autonomy, generates more disability and further aging.

These data are relevant for an increasingly aging society and in which there will be an increasingly smaller number of young people. The balance of society rests in all of its members and to achieve this, it is necessary to avoid the generation of exclusion processes, contrary to respect for human rights. This is why our society has the obligation to prioritize the prevention and care of the older people's quality of life, maintaining their autonomy, which is linked to the person's dignity. A worthy example of such dual protection is the established requirement to ensure equal access to benefits for seniors without handicap – age should never be a

determinant for access – and the need for specific actions in the other cases, such as prevention and increased geriatric services as well as clinical research, basic and social into these problems.

In this sense, it is necessary to point overtly, although attempts have been made to quantify and rank the benefits that the system should provide, there is no factor that would indicate which part of the collective economic effort should be devoted to health expenditures, although some attempts have been made to prioritize the provision of systems according to democratic participation. Obviously, this is clearly about political choices – in its best sense – and must be preceded by a truly democratic social debate. As part of the democratization process of rights in the Spanish health sector, it is noteworthy to observe the figure of the Ombudsman as a patient advocate to ensure the rights recognized in the Catalan health and ensure compliance by the administration <sup>17</sup>.

In one of its interesting reports <sup>18</sup>, the French National Ethics Committee refers specifically to the ethical dimension of public policy options in health care since the prioritization of spending and establishing a list of offered benefits have a major impact on individuals' health and quality of life. Therefore, the establishment of procedures for resolution of dispute is recommended, once they are produced by colliding individual aspirations and collective needs. This not only between different parts

assigned for healthcare, but also between what is spent on health and what is given to other services and facilities that are also crucial for the collective welfare, such as retirement and unemployment benefits, or education.

Among us, in Catalonia, one can say that there is some consensus, at least in regard to prioritize measures to address inequalities and provide access to the most disadvantaged citizens to healthcare services. The problem is how to do this? in which level of services? Can accessibility be set according to lifestyle, age, or situations of exclusion? In the case of senile dementia, for example, prevention is important, but can we talk about a right of access to prevention in the same manner as about access to therapy care which is considered to be the core aspects of healthcare? Is there a right to health education for citizens and, in some respects, for the health professionals themselves? And we know well that increased life expectancy and better health derive mainly from treatments, but even more to hygiene, lifestyle, and food...

Among health personnel there is an important debate about changing the goals of medicine based on the impact of health biotechnology applications, and citizens from all professions and from all social sectors should participate in that debate. Because health issues concern everyone and the decision-making in this field are collective decisions and not just technical decisions.

## Individual forecasts

Deciding for yourself when it comes to health is an example of exercising one's autonomy, but in the context described above, what can citizens do to preserve their autonomy, besides encouraging and participating in such processes and, if possible, to also have an insurance plan that guarantees access to all the necessary features?

Respect for individual freedom and for the rights of the patients and users of the health system is especially relevant in the context of health care relations, an area in which personal autonomy is central and whose most evident manifestations are reflected in the need to provide information and to obtain consent, but they do not end there. One of its most interesting effects is the possibility of establishing forecasts about therapeutic actions that shall be received, or not, for the future offered to the public, as a result of recent regulatory decisions which occurred in our country. To be able to decide when you have capacity and establish provisions in advance for when time comes when you cannot, in case of this unfortunate event, is one of the most relevant legal achievements of recent times.

State law 41-2002<sup>19</sup>, on the right of information concerning health and patient's autonomy and clinical documentation governing directives in advance – (preliminary instructions) shall apply following the Convention on Human Rights and Biomedicine – in force in Spain since January 1, 2000 – Article 9 which establishes: *We take into consideration the wishes expressed previously regarding an intervention by a patient who, at the time of the intervention, may not be in conditions to state his own will*<sup>20</sup>.

The living will is a document in which a person manifests vehemently his/her wishes about treatment and actions to which he/she does not want to be subjected, thus preventing the event in which a disease would prevent him/her from expressing. It can include or not, the name of a person designated in trust and which can handle and interpret the document as necessary to ensure compliance with the will and even proceed to take the relevant decisions, substituting the person who appointed him/her<sup>21-24</sup>.

Moreover, the position on euthanasia is the true validation of the acceptance of the principle of autonomy on which we focus, not only moral decisions, but the overall life of our society. If autonomy is truly respected, it is regarding the acceptance of other individuals' decisions where this respect must be shown. In the acceptance and respect for the views and behaviors

which we approve there isn't the slightest difficulty, but the tolerance test – in the most positive and active sense of the term – is provided by the consideration that we give to behaviors whose reasons may not be shared.

In the case of euthanasia, this manifests itself clearly enough as it is an individual and autonomous decision, in which no one may invoke damage to the rights of other individuals, or the existence of innocent third parties involved. By definition, voluntary active euthanasia (which is the core of the discussion at this time) involves only two persons: one who voluntarily requests it lucidly, expressly and affirmatively and the other who agrees to practice it, which in any case may decline and even as conscientious objector, if we could consider the existence of a legal duty, which is a supposition. One might ask why even, in some sectors of society, it is so difficult to raise the issue of euthanasia.

The cause may lie in the enormous ideological burden this debate has ensued and which motivates certain positions that take cover in maximalist attitudes which are, in many cases, intolerant. Among the opponents of euthanasia there are often attitudes leading to a clash of absolutely opposed views – it is true that this is not the only arena in which these attitudes are assumed – while by those who advocate the right of freedom to die, it is focused as a matter of respect.

Both sides invoke the defense of human dignity but obviously interpret the content and foundation of that dignity differently: the Christian and the layman, and if discussion is not explicit, then it can turn into a sterile dialogue, it is impossible to agree if the same words denote different concepts.

Although the first key issue in this area is the invocation of autonomy and dignity, there is another approach to the problem of euthanasia which may be more fruitful: solidarity and respect are those elements that can assist in reflection from the observation of the evolution of events and the need for solidarity as a response to a real problem in our society: the derivative of the scientific and technical developments pose new challenges to human beings, in which the lengthening life by determining circumstances is not considered an advantage for everyone and in this case the subject's will has to be taken in consideration. This may be a good way to reach an agreement between different viewpoints which otherwise would be in frank opposition<sup>25</sup>.

### **As a final reflection**

Perhaps it is worthwhile clarifying that neither the government or individuals as such, are adequately prepared to embrace the changes that biotechnology is introducing in the health area with its important economic implications, and to engage actively with the necessity to create public policies that will address them in

in order to be managed for the benefit of all members of society. Given this situation, Bioethics and Law <sup>26</sup> should propose courses of action, even in the territory of uncertainty and risk.

There are already ethical and legal bases for the approach to the problem: these are supplied by the constitutional principles and human rights, which have the necessary roots in society and provide criteria to address new problems, although there is not always specific normative development in all countries. In this sense, when adopting legal decisions,

two groups of issues should be taken in consideration, in delicate balance: on the one hand, the guarantee of decent care, non-discriminatory on grounds of age or prognosis, and on the other, to take into account the fact that the sums devoted to health represent a substantial amount in all countries. And on the other hand, encourage policies that support the adoption of individual forecasts regarding them. Science puts forth its advances in a manner that is available to all, but in order to really benefit people there has to be political commitment and social demands to ensure the results.

#### **Resumo**

##### **Questões bioéticas relacionadas ao envelhecimento**

O artigo discorre sobre o envelhecimento tomando como exemplo para análise o diagnóstico genético de Alzheimer. Considerando a idade avançada como problema bioético tece considerações acerca da autonomia dos pacientes idosos bem como sobre os fins da medicina e o conceito de saúde como bem-estar, cunhado pela Organização Mundial de Saúde e atualmente adotado em todo mundo. Discute as decisões sociais necessárias para estabelecer políticas públicas destinadas a prover o cuidado com esse grupo da população bem como as previsões individuais relativas as suas necessidades. Conclui considerando que os direitos humanos já fornecem bases ético-jurídicas para uma aproximação ao problema no nível infralegal dos países buscando-se assim atenção digna e não discriminatória às pessoas idosas.

**Palavras-chave:** Envelhecimento. Autonomia pessoal. Direitos Humanos. Políticas públicas. Bioética.

#### **Resumen**

##### **Cuestiones bioéticas en torno al envejecimiento**

El artículo discurre sobre el envejecimiento tomando como ejemplo para el análisis el diagnóstico genético de Alzheimer. Considerando la edad avanzada como problema bioético haciendo consideraciones acerca de la autonomía de los pacientes mayores así como sobre los fines de la medicina y el concepto de salud como bienestar, de la Organización Mundial de la Salud que actualmente es adoptado en todo el mundo. Discute las decisiones sociales necesarias para establecer políticas públicas destinadas a proveer el cuidado con este grupo de la población así como las provisiones individuales relativas a sus necesidades. Finaliza considerando que los derechos humanos ya proporcionan bases ético-jurídicas para una aproximación al problema en el nivel legal en los países buscándose así atención digna y no discriminatoria a las personas ancianas.

**Palabras-clave:** Envejecimiento. Autonomía personal. Derechos Humanos. Políticas públicas. Bioética.

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## Contact

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Maria Casado - [mariacasado@ub.edu](mailto:mariacasado@ub.edu)

C/ Baldiri Reixac 4-8 Torre D 08028. Barcelona/CT, Spain.