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Editorial – Volume 3 – nº 02- 2025

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HUMAN RIGHTS, BIOETHICS, AND SPIRITUALITY IN INTEGRAL PATIENT HEALTH CARE [1]

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Abstract

Contextualization: At the beginning of human history, there was a clear interconnection between science and religion. However, events in modern Western society created a division between them and the segmentation of patient care. **Problem:** Studies show that neglecting the patient's spiritual needs leads to dissatisfaction with received care. They also prove that support for their beliefs correlates with better health outcomes. **Objective:** To understand the correlation and benefits of integrating spirituality into patient care, assess whether there is support in Human Rights and Bioethics ensuring its practice, and examine the training of professionals. **Method:** Exploratory research based on the analysis of high-quality scientific literature on the subject. **Results:** It was observed that in environments where spirituality is relevant, there is a better quality of life, improved health, and greater longevity. The World Health Organization (WHO) recognizes spirituality as valuable for individual quality of life and supports it through Human Rights and Bioethics. Thus, Brazil has already implemented laws and health policies promoting its practice. **Conclusions:** In a society where Human Rights and Bioethics prevail, ensuring individual autonomy and aspirations is essential, making it inconceivable to offer patient care based solely on biological aspects. However, despite existing health laws and policies, the spiritual dimension remains neglected in patient care due to prejudice, misinformation, and the need for further studies demonstrating spirituality's effectiveness as a predictor of health risks. Nevertheless, the findings of this article highlight sufficient benefits supporting the importance of patient spirituality and the training of healthcare professionals in this practice.

Keywords: Human Rights, Bioethics, Spirituality, Integrality in Health, Health Policies**.**

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Introduction[4]

Since ancient times, human history has shown an interconnection between the concepts of God and nature. To understand and dominate their environment, humans sought to correlate their observations with forces and intelligences beyond their comprehension and control. However, historical events in modern Western society - such as the Inquisition, the fall of Feudalism, the Enlightenment, and the rise of Capitalism, backed by Newtonian and Cartesian philosophies - led to a separation between science and religion. This was necessary to enable scientific and technological advancements previously obscured by religious beliefs and dogmas.

In Western Europe and the United States, industrial modernization was driven by the logic of science and technical rationality, resulting in minimal comfort for most of the population, leading to secularization and distancing from religious structures in organizing subjectivity. However, in Latin America, modernization did not have the same positive effect. On the contrary, it significantly increased social inequality and subordination. Thus, the transition from a

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religious mindset to a reason and logic-centered perspective was much less pronounced. Despite economic and social changes in countries like Brazil, the population maintains a deep-rooted religious perspective and need for spirituality (VASCONCELOS, 2006, p. 1375-1425).

As science evolved, knowledge became increasingly fragmented and specialized, producing individuals more focused on their specific fields. In healthcare, this led to the segmentation of patient care. For many, religion and science remain incompatible and antagonistic. However, studies show that neglecting patients' spiritual needs leads to dissatisfaction with received care (KOENIG, 2018).

Thus, the need to understand the patient holistically, consolidating the knowledge acquired throughout history arises. To integrate the benefits of seemingly opposing practices, it is crucial to identify their commonalities, so that, through mutual respect, they can construct a reality capable of unifying actions.

This article aims to understand the impact of addressing patient spirituality on health. It also seeks to analyze how Human Rights and Bioethics foster the connection and coexistence of Science and Spirituality, enabling integrative

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patient care and the creation of laws and health policies supporting this practice.

To achieve this, we conducted exploratory research analyzing publications on Spirituality in Health, Human Rights, and Bioethics available in Google Scholar, PubMed, Scielo, high-quality scientific literature, and official documents. The text was constructed through content analysis of collected materials, creating thematic categories for a better understanding of the findings.

Human Rights, Spirituality and Healthcare

The Universal Declaration of Human Rights (UDHR) was proclaimed and adopted by the United Nations General Assembly in Paris through resolution 217 A (III) on December 10, 1948. It is a landmark in human rights history, having been developed with representatives from diverse legal and cultural backgrounds worldwide. The core committee comprised nine influential individuals, including diplomats and jurists, led by Eleanor Roosevelt, the U.S. ambassador to the United Nations (UN).

Emerging from global perplexity following World War II - marked by events like the Holocaust and atomic bombings - the UDHR aims to recognize and protect human dignity. It

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commits member states to promoting universal respect for fundamental human rights and freedoms, emphasizing that a common understanding of these rights is essential for fulfilling this commitment (UN, 1948).

The content of the Universal Declaration of Human Rights is the unification of what is expected of the best for humanity. Through it, member countries commit to promoting its content as:

> "the common ideal to be achieved by all peoples and all nations, with the aim that each individual and each organ of society (...) strives, through teaching and education, to promote respect for these rights and freedoms, and by the adoption of progressive measures of a national and international character" (UN, 1948).

At the article 18, the UDHR states that:

> "everyone has the right to freedom of thought, conscience, and religion; this right includes freedom to change religion or belief and freedom, either alone or in community with others and in public or private, to manifest one's religion or belief in teaching, practice, worship, and observance" (UN, 1948).

Thus, the UDHR establishes a direct relationship between fundamental human rights and individual beliefs, seeking to prevent violent imposition of dominant beliefs that disrespect minority religious or cultural systems (DONATO et al., 2019).

However, the relationship between spirituality and human rights is far more complex and multifaceted, drawing interest

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from scholars worldwide. Beyond being a right to be guaranteed for every individual, spirituality, in its search for connection with the divine, influences how individuals perceive and advocate for basic human rights, regardless of their beliefs. The pursuit of human dignity is a fundamental principle in both spirituality and human rights, aiming to ensure that every individual is treated with respect, justice, and equality (DONATO et al., 2019).

Despite of the diversity of beliefs, different spiritual perspectives can be reconciled in defending human rights through interfaith dialogue, mutual respect, and identifying common values such as the sanctity of life, human dignity, and peace. Among the common spiritual principles that underpin human rights, we can mention love of neighbor, empathy, solidarity, nonviolence, and the recognition of the interconnectedness between all beings (DONATO et al. 2019).

The Brazilian Constitution of 1988 defines the rights and duties of Brazilian citizens and was inspired by the Universal Declaration of Human Rights. In its article 196, it establishes that:

> "health is a right of all and a duty of the State, guaranteed, through social and economic policies aimed at reducing the risk of disease and other problems, universal and equal access to actions

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> and services for its promotion, protection and recovery" (BRASIL, 1998).

With the objective of ensuring this right to the population, the following articles, from 197 to 200, aim to structure, establish responsibilities and obligations, organize financing and provide guidance on the complementarity of the Unified Health System known as SUS in Brazil (BRASIL, 1998).

On September 9th, 1990, Law nº. 8080, known as the Organic Health Law, was signed, which provides the conditions for the promotion, protection and recovery of health, the organization and functioning of the corresponding services, thus establishing the SUS (BRASIL, 1990). Health care, according to Matta and Moresini, refers to the strategic organization of the health system and practices in response to the needs of the population, and can be expressed both in policies and in health programs and services, which must be congruent with the Principles and Guidelines of the SUS (MATTA; MORISINI, 2009).

The American Hospital Association (AHA), replacing the Patients' Bill of Rights, publishes the Patient Care Partnership to inform patients about what they should expect during their hospital stay regarding their rights and responsibilities. Although the importance that spirituality has in the health/disease relationship is subjective for each individual, it

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is evident that in extreme moments, such as the need for hospitalization, the patient values more this dimension. Aware of this importance, the Understanding Your Health Care Goals and Values section of the brochure highlights to the patient that if they have health care goals and values or spiritual beliefs that are important to their well-being, they will be considered as much as possible throughout their stay in the hospital. It also advises the importance of the patient making sure that his doctor, your family and your care team know your wishes (AHA, 2003).

In 2000, Brazilian Federal Law nº 9,982/2000 on Religious Assistance in Public and Private Hospitals, and in Civil and Military Prisons regulated this practice, providing for the provision of religious assistance in public and private hospitals, as well as in civil and military prisons. In article 1, the law guarantees religious of all denominations access to public or private hospitals, as well as to civil or military prisons, to provide religious care to internees, provided that the consent of the patient or his family members is respected in the case of patients who are no longer in the enjoyment of their mental faculties (BRASIL, 2000).

Such attention is important when scientific studies show that: (1) 75 a 90% of critically ill patients report spiritual or

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religious needs during hospitalization, (2) more than 70% of these spiritual needs are met minimally or not served by the health care system (including chaplains), and (3) patient satisfaction surveys indicate that the approach of spiritual needs during hospitalization are among the lowest ranking of all clinical care indicators and greater need for improvement of quality (KOENIG, 2018).

Health care professionals, even non-religious ones, can help by briefly evaluating each patient to identify religious or spiritual beliefs that may influence medical care or interfere with recovery from illness. The physician has a unique opportunity to obtain a brief spiritual history. Notice that the non-religious health professional will only be responsible for making a brief screening assessment, leaving any other action to a trained chaplain, used to assist the problems related to spiritual needs (KOENIG, 2018).

Bioethics, Spirituality and Health Professional Training

The scientific and technological advances in health that occurred in the last century are undeniable. Among them, the discovery of the antibiotic in 1928, the fusion of atoms in 1940 and the discovery of the DNA double helix in 1953 stand out.

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The 1970s was the period in which such advances intensified and, at the same time, began to be questioned about their ethical aspect (ICUs, transplants, diagnosis of death, fertilization, prenatal diagnosis) (DE SOUZA et al., 2012)

In the face of the doubts and questions related to scientific advances, bioethics emerges, a neologism derived from ethics. The term bioethics, a legacy from Van Rensselaer Potter, through the work *Bioethics: bridge to the future*, "bio" would represent biological knowledge, and "ethics", knowledge of human principles and values in the face of the discoveries of scientific and technological society. Thus, what is studied in ethics, practiced in morals, obliged in deontology, in bioethics is problematized (DE SOUZA et al., 2012).

In the doctor-patient relationship bioethics of, there is a conflict between the emotional and the rational; the greatest wear and tear of the medical professional often isn´t due to the number of hours worked, but to the emotional intensity with which they experience all their acts, as they´re constantly dealing with life, honor and health of another person. However, usually, this conflict is unknown to both the physician and society (DE SOUZA et al., 2012). In this context, neglecting the spiritual dimension of health care can further

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compromise not only the professional but also the quality of the care offered.

In the health professionals training, particularly physicians, the teaching of bioethics has only met the requirements of the biomedical model. As Frijot Capra reports, the conceptual foundation of modern scientific medicine, based on the strict division between body and mind of Descartes' philosophy, is constituted by a mechanistic and fragmented conception of the human body, in which disease is seen as a malfunction of one of the parts of this machine, causing the need to be fixed by the doctor (CAPRA, 2012).

Prioritizing the biological instead of the subjective aspects involved to illness, occurred due to the growing development of specialties and subspecialties. So, the training of health professionals prioritized, mainly the diagnosis and treatment of segmented portions of the human body, focusing the healing process evolving accentuated use of medications and surgeries (BATISTA,2010). Remain neglected existential and spiritual aspects of the patient.

Bioethics and spirituality, when integrated into patient care, provide the exercise of a sensible balance between the care of organic insufficiency and the relief of suffering, generating comfort for the patient (DE SOUZA et al., 2012).

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The new Brazilian Code of Medical Ethics (CME) presents a great advance in relation to its predecessor, by admitting the finiteness of life, guiding how medical care should be in this context (CFM, 2019). Until then, the patient´s death characterized the failure of the professional in the cure and maintenance of human life. However, regarded to spirituality, the CME evolves very little, unlike the similar codes from other countries such as Canada, Australia, Mexico, Portugal and Argentina. All of them refer to the patient's right to receive religious and/or spiritual comfort. (SOUZA et al., 2012).

Similarly, the Universal Declaration on Bioethics and Human Rights, acclaimed in October 2005 at the UNESCO General Conference, presents in its introduction the importance of an integral vision of the individual, contemplating the spiritual dimension. It states that cultural diversity is necessary for humanity and, in this sense, constitutes the common heritage of humanity. It emphasizes that the identity of the person has biological, psychological, social, cultural and spiritual dimensions (UNESCO, 2005).

For the implementation of this model of care into the medical practice, it is necessary that two elements work together: the Universities and the State. The first (University) is the formative element, with the responsibility of offering

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scientifically qualified professionals to society with solid ethical and professional training. The second (State), on the other hand, must discipline and supervise the courses responsible for the training of these professionals, ensuring that the graduates are able to fully meet the needs of the population and curbing those without adequate qualification (DE SOUZA et al., 2012).

The American Association of Medical Colleges (AAMC) has endorsed the need to train medical students to incorporate spiritual, religious, and cultural beliefs and practices into the care of patients in a variety of clinical settings and recognized that the practitioner's own spirituality, belief, and cultural practices can affect the ways in which patients relate to and provide care (AAMC, 1999). Following these guidelines, a study conducted in 115 of the 122 medical schools accredited by the AAMC indicated that, in 2010, 90% of them indicated that they had "courses" or "content from an existing course" in spirituality and health in their curriculum. However, in only 7% of the institutions this was a mandatory course. (KOENIG et al., 2010).

In a survey conducted in Brazil about this the subject, of the 180 existing medical schools, only 86 (47.7%) responded. The questionary results indicated that 10.4% of Brazilian

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medical schools have dedicated courses on religiosity/spirituality (R/E) and 40.5% have courses or content on spirituality and health. Only two medical schools have R/E courses that involve practical training, and three schools have R/E courses that teach how to conduct a spiritual story. Despite of the fact that few Brazilian medical schools have courses that specifically deal with R/E, the majority of medical directors (54%) stated that they believe that the R/E relationship is important enough to be taught in their schools (LUCCHETTI et al., 2012).

However, due to lack of training, most health professionals do not feel comfortable talking to patients about the subject; they do not understand why they should dedicate precious time to collecting this information; they do not know how and when to collect a spiritual history; they are afraid of how long it will take; they do not know what to do with the information obtained and do not know how to answer the patient's questions (KOENIG, 2018).

Spirituality in Health Care

The 37th General Assembly of the World Health Organization (WHO), held in 1983, is considered by some researchers the founding event of debates on spirituality within

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the institution. During that event, representatives of 22 countries sent a draft resolution to the Assembly, requesting the consideration of the spirituality factor as a determining element for human health. The referral was not accepted without resistance. Dr. M. Savel'ev, a delegate from the Soviet Union, and elected for this debate as spokesman for countries "where the church is separated from the state", although not opposing the recognition of the importance that the spiritual dimension has on the health of people in some of the WHO member states, did not sign the resolution and also pointed out "that the director general [of the WHO] will find it difficult to consider religious aspects in the elaboration and development of primary care programs" (TONIOL, 2020).

The problem posed by the Soviet delegate gave indications of what would be the condition for the establishment of spirituality as a legitimate category in its interface with health in the WHO: to demarcate its difference in relation to religion. Thus, the relationship between religion and spirituality within the WHO can be summarized from the following contrast: while spirituality is a side of the person, religion is a doctrine that may or may not be followed. The religious collective that is formed through culture or adhesion

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contrasts with the spiritual foundation of the person, forged in human nature (TONIOL, 2020).

Considering the report of the [WHO] Directorate-General on the spiritual dimension for the *'Health for All Programme in the Year 2000'* and following the instructions of the Executive Committee on resolution EB73. R3, the assembly recognized that the spiritual dimension has an important role in motivating people in all aspects of their lives, stimulating healthy attitudes and should be considered as a factor that defines what health is. It also invites all its Member States to include this dimension in their national health policies, defining it according to the local cultural and social patterns (WHO, 1984; TONIOL, 2020)

Then, in 1999, at one of the World Health Assembly´s meetings, a proposal for a Constitutional Amendment recommended that "spirituality" should be incorporated as one of the dimensions of human health, thus suggesting that its new definition should be: "Health is a dynamic state of complete physical, mental, spiritual and not merely the absence of disease or infirmity." Although not yet approved by all UN members, this proposal had far-reaching consequences, becoming essential for spirituality that, once considered a dimension of human health, could be instituted

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as a right in other WHO documents and in national health policies (WHO, 1999).

The World Health Organization (WHO) defines Quality of Life as an individual's perception of their position in life, in the context of the culture and value system in which they live, and in relation to their goals, expectations, standards, and concerns. In the 1980s, the WHO began the process of developing the WHOQOL (World Health Organization Quality of Life), an instrument to measure multidimensional aspects of quality of life in different cultures and contexts, going beyond traditional measures of health. WHOQOL has been widely used in academic research, health policy evaluations, and studies of interventions to improve the quality of life, providing a globally comparable database (WHO, 1995).

The WHOQOL-100 instrument consists of one hundred questions referring to six domains: physical, psychological, level of independence, social relationships, environment and spirituality/religiosity/personal beliefs (FLECK, 2000). The inclusion of spirituality as a dimension recognizes its significant importance in the human experience and in the individual perception of quality of life, regardless of cultural contexts or specific religious ones.

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As with ethics and morals, spirituality and religiosity are not synonymous. The definition, understanding and distinction of both are essential for the feasibility of studies and research. The etymology of the word religion comes from the Latin – *religare*, whose meaning is "to re-unite" or "to re-connect" man to his "divine essence", which is established as an organized system of beliefs, ritual practices and symbols designed to facilitate proximity to the sacred and the transcendent (CASTILHO; CARDOSO, 2015). One of the greatest researchers on the subject today, MD. Harold Koenig defines religiosity as the belief and ritualistic practice of a religion, whether in participation in a religious environment or in the act of praying or praying (KOENIG, 2012).

Religion establishes its own dogmas, doctrine, and rituals, involving moral and ethical precepts, thus creating a specific system focused on and linked to the Being or Force Supreme. It is usually associated with a community that shares beliefs and behaviors, offers the individual support and meaning of life beyond earthly and material reality. Although institutionalized, it can foster and enrich the spirituality (DE SOUZA et al., 2012).

The word spirituality derived from the latin *spiritus*, meaning the essential part of the person, which controls the

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mind and body; the etymology of the word spirituality means breath of life and the term is related to the meaning of life and the reason for living (CASTILHO; CARDOSO, 2015). Thus, spirituality consists in personal relationship with the transcendent object (God or Higher Power), the metaphysical, in which the person seeks fundamental meanings and purposes of life and which may or may not involve religion (KOENIG, 2012). It is a feeling that something transcends us and therefore gives us a meaning to what we do and who we are. It is an implicit way of treating deep dimensions of subjectivity without necessarily including religiosity (DE SOUZA et al., 2012).

In his book *Spirituality for Skeptics*, the American philosopher Robert Solomon points out that he noticed that he was confusing spirituality and religion, and with the worst of religion, which led him to group the two by fears and prejudices that he had carried since childhood. He reports that, out of moralistic hypocrisy and aversion, he wrongly rejected what he now perceives to be an essential dimension of life. He argues that "spirituality can be separated from both vicious sectarianism and unreflective banalities." He then understands spirituality as the well-thought-out love of life (SOLOMON, 2003)

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In the early days of human civilization, religiosity/spirituality (R/E) has always been a mechanism for healing and promoting health. With scientific advances, it has become necessary to abandon some of the mystical knowledge associated with healing, without, however, completely excluding spirituality from the essence of the individual (BORGES et al., 2017).

However, such advances end up distancing science from spirituality, placing it in the position of taboo. In the search for a better understanding and investigation of the human mind and its processes, aiming to offer individual instruments for the maintenance of mental health, many scholars argued that belief and religion had no scientific basis, and could be compared to a brain failure (BORGES et al., 2017).

For Sigmund Freud, for example, religion consisted of a neurosis, justifying all transcendent behaviors as defense mechanisms or something similar (BORGES et al., 2017). However, despite maintaining relationships with great scholars in the area, Viktor Frankl, by systematizing Logotherapy and Existential Analysis, shows himself contrary to the current vision of man in search of pleasure and power. Born in Vienna in 1905, since he was a child, he was concerned with questions about existence, life and of death.

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He studied Medicine, choosing Neurology and Psychiatry as areas of expertise. He was a prisoner in the concentration camps of World War II, experiencing suffering and the imminence of death. Based on his experiences and observations, he created Logotherapy, arguing that, although he did not seek to invalidate serious and legitimate discoveries of pioneers such as Freud, Adler, Pavlov, Watson or Skinner, defended that "man cannot be considered as just a creature whose fundamental interest is to satisfy the impulses to gratify instincts or (...) to reconcile the id, ego and superego". Nor did he believe that human presence could be understood as the result of conditioning or conditioned reflections. On the contrary, he argued that man was a being in search of meaning (FRANKL, 1991).

So, Logotherapy integrates and includes what, in the face of scientific advances, has been excluded, the spiritual dimension and search for meaning, presenting a new interactive existential anthropological paradigm. The search for meaning consists of the primary motivation, and it is specific to each person in each situation, according to experienced values (SOUZA et al., 2021).

Currently, the instantaneity of information and the means of communication weakens interpersonal relationships and

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the richness of reflection, generating an individualism lacking in sharing and commitment to the other. The most valued things are: science – technique – industry – profit (DE SOUZA et al., 2012).

As the philosopher Zygmunt Bauman argues, we live in a modern liquid society, in which "the conditions under which its members act change in a shorter time than necessary for the consolidation in habits and routines, of the ways of acting" (BAUMAN, 2021), thus amplifying human concerns and anxieties.

In the face of contemporary society interested mainly in having and being visible, analyzing the human mind through Frankl's perspective allows a clearer understanding of how this posture has increasingly triggered mental disorders such as depression and anxiety. The search for a meaning in life, which we understand as spirituality, has been demonstrated with more beneficial to the health of individuals.

The growing interest of medical sciences in the relationship between health and spirituality has already been noted and reflected in some studies (HILL; PARGAMENT, 2003). As global indicators of the impact of this studying field, it is important to mention the consolidation of graduate programs on the subject in research centers in the Columbia,

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Duke, Harvard and Yale universities, in addition to the huge increase in the number of publications dedicated to the subject in scientific journals and the regular offer of courses on this subject in universities in Europe, the United States and Latin America. In this context, Brazil is recognized as occupying a prominent place, having consolidated itself as one of the countries with the highest concentration of academic publications on the subject (LUCCHETTI; LUCCHETTI, 2014).

Research shows that an environment where religiosity and spirituality are relevant aspects such as better quality of life (LEVIN et al., 1996 and SAWATZKY et al., 2005), better health (GILLUM; INGRAM, 2006 and HUMMER et al. 1999 and KING et al. 2002 and SEPHTON et al. 2001 and TARTARO et al. 2005), greater longevity (CHIDA et al., 2009; MCCULLOUGH et al., 2000; POWELL et al., 2003) and lower need for medical care (BOSCAGLIA et al., 2005 and KOENIG et al., 1998 and SMITH et al., 2003). As Harold Koenig advises us, "there is an urgent need to translate the results of this rapidly expanding research, so that they can be applied at the bedside by the most varied types of health professionals" (KOENIG, 2013).

However, many developed and developing countries, including Brazil, go through secularization, a process by which

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religion ceases to be the aggregating cultural aspect. Despite the numerous findings on the beneficial effects of spirituality on the health of the individual, it is not always easy and comfortable to talk about spirituality in health, in view of the breadth of the theme, its subjective character inherent to the popular imagination and society's demand on professionals due to the close relationship of legitimacy between health and science (SMEKE, 2011).

This has oriented medical care in a contrary direction to R/E, which is a significant characteristic of majority of the population. This secularization may be directing patients towards an increasing need for traditional biological medical care. A lower R/E is inversely correlated with alcoholism and drug abuse, delinquency, crime and teenage pregnancy, among other social problems. All this will result in an increasing expense for public health (KOENIG, 2013).

Integrality in Health Care and Public Policies

Integrality in Health seeks to break the pattern of fragmentation in patients' health care, following the recommendation of the WHO and its quality of life assessment instrument (WHOQOL) that understands the individual's health as a dynamic state of complete physical, mental,

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spiritual and social well-being, and not merely the absence of disease or infirmity.

Thus, by incorporating integrality as a guiding principle to structure the State's health policy, the objective is to guide the organization of services in this area and strengthen the purpose of creating a universal, accessible and quality health system. In this context, the insertion of integrality in the guiding principles of health practices values human subjectivity, enabling dialogue and the insertion of the various forms of action in health (CASTILHO; CARDOSO, 2015).

The understanding of the person from the way he or she relates to life can bring significant contributions to the social understanding of the demand of users of the health system, thus enhancing care for the individual and his or her needs (CASTILHO; CARDOSO, 2015).

However, an investigative study of 65 public policies presented in the Virtual Health Library (VHL), and available for research, pointed to a subtle and non-explanatory approach to spirituality in integrative care, thus demonstrating a need to broaden the discussion on the subject, since the practices of health professionals are based on the ideas proposed by public health policies (CASTILHO; CARDOSO, 2015).

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A Brazilian study, where a representative sample of the population was evaluated (3007 participants) found that only 5% of Brazilians declare that they do not have religion (MOREIRA-ALMEIDA et al., 2010). This data is like the most recent survey on the subject in the Brazilian population conducted by the IBGE in 2010, where only 15 million (8.8%) of the country's nearly 170 million inhabitants do not report ties to religious groups. No more than 616 thousand of these people (0.36%) stated that they were atheists (IBGE, 2011). Also, it was demonstrated that 83% of the interviewees considered religion very important for their lives and 37% attended some religious service at least once a week (MOREIRA-ALMEIDA et al., 2010).

A study by the World Health Organization (WHO) investigated 5,087 people in 18 countries, and among Christian countries (except the African ones), Brazil had the highest percentage of respondents that indicated they were "moderately" or "extremely" religious (WHOQOL SRPB Group, 2006). The 2022 Census accomplished in Brazil showed that there are more religious temples than schools and hospitals combined. According to the analysis, there are 580,000 places of devotion to different types of religion compared to 264,000 educational institutions and 264,000

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health units, which together total 512 establishments (IBGE, 2023).

The Brazilian Federal Constitution of 1988 points integral health care as a guideline of SUS. Since then, integrality has been placed as an important issue to government policies, intervention programs and the entire discourse of the health movement. Integrality in the context of the SUS can be seen as an objective image with several meanings that bring together three sets: (1) integrality as a trait of good medicine, (2) as a way of organizing practices and (3) as responses to specific health problems. Integrality consists in a response to the suffering of the people who seek help in the health service, taking care that they are not reduced to the biological system (CASTILHO; CARDOSO, 2015).

The great difficulty consists in training health professionals to use integrality in their practice more often. Regarding the spirituality dimension, prejudice and misinformation can make it even more difficult to attend to the patient's needs. To solve this difficulty, in his book *Spirituality in Patient Care,* Dr. Harold Koenig, in a clear and brings information and practical techniques for the implementation of spirituality to patient's care. It also discusses the limits and barriers that this practice can present, highlighting the importance of detecting whether

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spirituality is having a detrimental effect on the patient's healing process (KOENIG, 2018).

Popular Health Education is also part of integrality health care. It´s methodology is aimed at the development of a pedagogy directed to the individual inserted in their life context. It works pedagogically with the man and the groups involved in the processes of popular participation, through collective forms of learning and investigation, promoting clinical analysis of reality and strategies of struggle and coping (BATISTA, 2010).

Popular Health Education seeks better living and health conditions, being mediated by dialogue, by valuing popular knowledge, by building awareness and autonomy of the individual and the collectivity. This form of education can be perceived as an alternative model to the biomedical paradigm, which is still hegemonic today (BATISTA, 2010).

It should be noted that, currently, there is a process of institutionalization of education in the practices developed in primary care, through the Family Health strategy. Established in 2009, the National Committee for Popular Education in Health was created with objectives aimed at strengthening the struggle for the right to health and in defense of the Unified Health System (SUS), as well as aimed at building

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pedagogical bases for the transformation of health education practices developed, strengthening the autonomy of the population and the fraternal and solidary relationship between managers, professionals and users of health services (BATISTA, 2010).

In 2013, the Brazilian Ministry of Health published an ordinance that instituted the National Policy for Popular Education in Health within the scope of the Unified Health System (SUS) (BRASIL, 2013). This document contributes to deep the sense of integrality in health, based on the valorization of personal and collective projects as a fundamental part of the structuring of care (CASTILHO; CARDOSO, 2015).

Professionals and researchers on the subject, understanding the benefits of the patient's spirituality, have been working to promote the debate on the subject in the field of public health in Brazil (VASCONCELOS, 2006).

In the field of health, popular education has been used as a strategy to overcome the great cultural gap between health services and so-called scientific knowledge and the dynamics of illness and cure in the popular world (VASCONCELOS, 2009). In this sense, the relevance of the presence of spirituality in health work carried out with a focus on the

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methodology of popular health education is highlighted, since the spirituality is a force capable of helping the individual, the family and the community, to better to overcome the difficulties of life, as well as the diseases they experience, providing a better coping with everyday reality (BATISTA, 2010).

Final considerations

In a society guided by the principles of Human Rights and Bioethics, the autonomy and desires of the individual become a priority. Therefore, it is inconceivable to offer the patient care that is based only on their biological aspects. In recent decades, especially after the 1988 Brazilian Constitution, more and more health care has observed and cared for the psychological and social aspects of those who they are looking for help.

However, despite the benefits demonstrated in scientific studies on the help of spiritual support in the person´s health, this dimension is still neglected and abandoned when under the care of health professionals. Not only prejudice and misinformation contribute to this attitude, but also the absence of training and public policies that enable professionals to direct their attention to these needs, as fundamental as any other and extremely relevant, particularly in the population of

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our country. New studies are also needed to demonstrate not only its protective aspect, but also proof of its effectiveness as a predictor of risks to the individual's health. Thus, it would be possible for a new paradigm in health practice. However, the findings of the present article demonstrate that there are sufficient benefits to support the importance of attention to the patient's spirituality and training of health professionals for this practice.

References:

AAMC. (1999). Contemporary issues in medicine--medical informatics and population health: report II of the Medical School Objectives Project. *Academic Medicine : Journal of the Association of American Medical Colleges*, *74*(2), 130–141.

AHA. (2003). *The Patient Care Partnership*. https://www.aha.org/system/files/2018-01/aha-patient-care-partnership.pdf

BATISTA, P. (2010). A valorização da espiritualidade nas práticas de educação popular em saúde desenvolvidas na atenção básica. *RECIIS*, *4*(3). https://doi.org/10.3395/reciis.v4i3.389pt

BAUMAN, Z. (2021). *Vida Líquida* (2a ed.). Zahar.

BORGES, P. P., FERREIRA, R. S., & De Sousa, I. D. T. (2017). A saúde permeada pela espiritualidade. *Multitemas*, *22*(51). https://doi.org/10.20435/multi.v22i51.1309

BOSCAGLIA, N., CLARKE, D. M., JOBLING, T. W., & QUINN, M. A. (2005). The contribution of spirituality and spiritual coping to anxiety and depression in women with a recent diagnosis of gynecological cancer. *International Journal of*

DOI: https://doi.org/10.5281/zenodo.17030300

Gynecological Cancer, *15*(5), 755–761. https://doi.org/10.1111/j.1525-1438.2005.00248.x

BRASIL. (1990). LEI Nº 8.080. Available at: https://www.planalto.gov.br/ccivil_03/LEIS/L8080.htm

BRASIL. (1998). Constituição da República Federativa do Brasil. Available at:http://www.planalto.gov.br/ccivil_03/constituicao/constituicao.htm.

BRASIL. (2000). LEI Nº 9.982 - Prestação de assistência religiosa nas entidades hospitalares públicas e privadas, bem como nos estabelecimentos prisionais civis e militares. Diário Oficial da União.

BRASIL. (2013). PORTARIA Nº 2.761- Institui a Política Nacional de Educação Popular em Saúde no âmbito do Sistema Único de Saúde (PNEPS-SUS). Ministério da Saúde.

CAPRA, F. (2012). *O Ponto de Mutação: a Ciência, a Sociedade e a Cultura Emergente* (30th ed.). Cultrix.

CASTILHO, C., & CARDOSO, P. (2015). ESPIRITUALIDADE, RELIGIOSIDADE E RELIGIÃO NAS POLÍTICAS PÚBLICAS DE SAÚDE: UM OLHAR PARA A INTEGRALIDADE. *REFACS*, *3*(1), 28–39.

CASTILO, C., & CARDOSO, P. (2015). ESPIRITUALIDADE, RELIGIOSIDADE E RELIGIÃO NAS POLÍTICAS PÚBLICAS DE SAÚDE: UM OLHAR PARA A INTEGRALIDADE. *Revista Família, Ciclos de Vida e Saúde No Contexto Social*, *3*(1). https://doi.org/10.18554/refacs.v3i1.1032

CFM. (2019). Código de Ética Médica: Resolução CFM nº 2.217, de 27 de setembro de 2018 , modificada pelas Resoluções CFM nº 2.222/2018 e 2.226/2019 . Conselho Federal de Medicina.

CHIDA, Y., STEPTOE, A., & POWELL, L. H. (2009). Religiosity/Spirituality and Mortality. *Psychotherapy and*

DOI: https://doi.org/10.5281/zenodo.17030300

Psychosomatics, *78*(2), 81–90. https://doi.org/10.1159/000190791

DE SOUZA, V., PESSINI, L., & HOSSNE WS. (2012). Bioética, religião, espiritualidade e a arte do cuidar na relação médico-paciente . *Rev. Bioethikos*, *6*(2), 181–190.

DONATO, N., VILARIM, F., & GOMES, E. (2019). JUSTIÇA SOCIAL, INTERCULTURALIDADE, ESPIRITUALIDADE E DIREITOS HUMANOS: APONTAMENTOS E CONTEXTOS. *Caderno Da Escola Superior de Gestão Pública, Política, Jurídica e Segurança*, *2*(2).

FLECK, M. (2000). O instrumento de avaliação de qualidade de vida da Organização Mundial da Saúde (WHOQOL-100): características e perspectivas. *Ciência & Saúde Coletiva*, *5*(1), 33–38. https://doi.org/10.1590/S1413-81232000000100004

FRANKL, V. (1991). *Em Busca de Sentido: um psicólogo no campo de concentração* (60th ed.). Editora Vozes.

GILLUM, R. F., & INGRAM, D. D. (2006). Frequency of Attendance at Religious Services, Hypertension, and Blood Pressure: The Third National Health and Nutrition Examination Survey. *Psychosomatic Medicine*, *68*(3), 382–385. https://doi.org/10.1097/01.psy.0000221253.90559.dd

HILL, P., & PARGAMENT, K. I. (2003). Advances in the conceptualization and measurement of religion and spirituality: Implications for physical and mental health research. *American Psychologist*, *58*(1), 64–74. https://doi.org/10.1037/0003-066X.58.1.64

HUMMER, R. A., ROGERS, R. G., NAM, C. B., & ELLISON, C. G. (1999). Religious involvement and U.S. adult mortality. *Demography*, *36*(2), 273–285.

IBGE. (2011). *CENSO DEMOGRÁFICO 2010 Características gerais da população, religião e pessoas com deficiência*.

DOI: https://doi.org/10.5281/zenodo.17030300

http://www.ibge.gov.br/home/estatistica/populacao/censo2010/caracteristicas_religiao_deficiencia/default_caracteristicas_religiao_deficiencia.shtm.

IBGE. (2023). *CENSO DEMOGRÁFICO 2022*.

KING, D. E., MAINOUS, A. G., & PEARSON, W. S. (2002). C-Reactive Protein, Diabetes, and Attendance at Religious Services. *Diabetes Care*, *25*(7), 1172–1176. https://doi.org/10.2337/diacare.25.7.1172

KOENIG, H. (2012). *Medicina, religião e saúde: o encontro da ciência e da espiritualidade* (I. (tradutor) ABREU, Ed.). editora L&PM.

KOENIG, H. (2018). *Espiritualidade no Cuidado como Paciente: Por Que, Como, Quando e O Quê* (3rd ed.). FE Editora.

KOENIG, H. GEORGE, LK, & PETERSON, BL (1998). Religiosity and Remission of Depression in Medically Ill Older Patients. *American Journal of Psychiatry*, *155*(4), 536–542. https://doi.org/10.1176/ajp.155.4.536

KOENIG, H. G., HOOTEN, E. G., LINDSAY-CALKINS, E., & MEADOR, K. G. (2010). Spirituality in Medical School Curricula: Findings from a National Survey. *The International Journal of Psychiatry in Medicine*, *40*(4), 391–398. https://doi.org/10.2190/PM.40.4.c

LEVIN, J. S., MARKIDES, K. S., & RAY, L. A. (1996). Religious Attendance and Psychological Well-Being in Mexican Americans: A Panel Analysis of Three-Generations Data. *The Gerontologist*, *36*(4), 454–463. https://doi.org/10.1093/geront/36.4.454

LUCCHETTI, G., LUCCHETTI, A., ESPINHA, D., DE OLIVEIRA, L., LEITE, J., & KOENIG, H. (2012). Spirituality and health in the curricula of medical schools in Brazil. *BMC*

DOI: https://doi.org/10.5281/zenodo.17030300

Medical Education, *12*, 78. https://doi.org/10.1186/1472-6920-12-78

LUCCHETTI, G., & LUCCHETTI, A. L. G. (2014). Spirituality, Religion, and Health: Over the Last 15 Years of Field Research (1999–2013). *The International Journal of Psychiatry in Medicine*, *48*(3), 199–215. https://doi.org/10.2190/PM.48.3.e

MATTA, G., & MORISINI, M. (2009). *Atenção à Saúde*. Escola Politécnica de Saúde Joaquim Venâncio/Fiocruz. Available at: <http://Www.Sites.Epsjv.Fiocruz.Br/Dicionario/Verbetes/Atesau.Html> . Accessed in Apl 25 2024.

MCCULLOUGH, ME, HOYT, WT, LARSON, DB, KOENIG, H, & THORESEN, C (2000). Religious involvement and mortality: A meta-analytic review. *Health Psychology*, *19*(3), 211–222. https://doi.org/10.1037/0278-6133.19.3.211

MOREIRA-ALMEIDA, A., PINSKY, I., ZALESKI, M., & LARANJEIRA, R. (2010). Envolvimento religioso e fatores sociodemográficos: resultados de um levantamento nacional no Brasil. *Archives of Clinical Psychiatry (São Paulo)*, *37*(1), 12–15. https://doi.org/10.1590/S0101-60832010000100003

WHO. (1984). A37/33. *WHO Archives*. Available at: https://iris.who.int/bitstream/handle/10665/192660/WHA37_33_fre.pdf;sequence=1

WHO. (1948). Universal Declaration of Human Rights. *Available at:* Https://Unric.Org/Pt/Wp-Content/Uploads/Sites/9/2023/10/PT-UDHR-V2023_web.Pdf?__cf_chl_rt_tk=Ou6LzwYS7VVrZjCFUg0Q1JEncgIl.NyN9aNyJ5kKt7k-1714066382-0.0.1.1-1770 - Accessed in Apl 25 2024.

POWELL, LH, SHAHABI, L & THORESEN, CE (2003). Religion and spirituality: Linkages to physical health. *American*

DOI: https://doi.org/10.5281/zenodo.17030300

Psychologist, *58*(1), 36–52. https://doi.org/10.1037/0003-066X.58.1.36

SAWATZKY, R., RATNER, P. A., & CHIU, L. (2005). A Meta-Analysis of the Relationship Between Spirituality and Quality of Life. *Social Indicators Research*, *72*(2), 153–188. https://doi.org/10.1007/s11205-004-5577-x

SEPHTON, S. E., KOOPMAN, C., SCHAAL, M., THORESEN, C., & SPIEGEL, D. (2001). Spiritual Expression and Immune Status in Women with Metastatic Breast Cancer: An Exploratory Study. *The Breast Journal*, *7*(5), 345–353. https://doi.org/10.1046/j.1524-4741.2001.20014.x

SMEKE, E. (2011). Espiritualidade e atenção primária à saúde, contribuições para a prática cotidiana. In E. Vasconcelos (Ed.), *A espiritualidade no trabalho em saúde* (pp. 341–369). Hucitec.

SMITH, T. B., MCCULLOUGH, M. E., & POLL, J. (2003). Religiousness and depression: Evidence for a main effect and the moderating influence of stressful life events. *Psychological Bulletin*, *129*(4), 614–636. https://doi.org/10.1037/0033-2909.129.4.614

SOLOMON, R. C. (2003). *Espiritualidade para céticos: paixão, verdade cósmica e racionalidade no século XXI* (1st ed.). Civilização Brasileira.

SOUZA, A. M., AITA, K. M. S. C., & CORRÊA, V. A. C. (2021). A Compreensão da pessoa Biopsicossocial e Espiritual como recurso aos Cuidados Integrais: Direitos Humanos assegurados no Planejamento e Ações em Saúde Coletiva. In *Saúde Coletiva: avanços e desafios para a integralidade do cuidado* (pp. 208–223). Editora Científica Digital. https://doi.org/10.37885/210303851

TARTARO, J., LUECKEN, L. J., & GUNN, H. E. (2005). Exploring Heart and Soul: Effects of Religiosity/Spirituality and

DOI: https://doi.org/10.5281/zenodo.17030300

Gender on Blood Pressure and Cortisol Stress Responses. *Journal of Health Psychology*, *10*(6), 753–766. https://doi.org/10.1177/1359105305057311

TONIOL, R. et al. (2020). *Espiritualidade Institucionalizada: Políticas públicas, usos clínicos e pesquisas médicas na legitimação da espiritualidade como fator de saúde*. UNICAMP - FAPESP.

UNESCO. (2005). *Declaração Universal sobre Bioética e Direitos Humanos*. Organização das Nações Unidas para a Educação, Ciência e Cultura UNESCO.

VASCONCELOS, E. (2006). *A espiritualidade no trabalho em saúde* (2nd ed.). Hucitec.

VASCONCELOS, E. (2009). Espiritualidade na educação popular em saúde. *Cadernos CEDES*, *29*(79), 323–333. https://doi.org/10.1590/S0101-32622009000300003

WHO. (1995). WHOQOL (World Health Organization Quality of Life). In *WORLD HEALTH ORGANIZATION*. https://www.who.int/tools/whoqol/whoqol-100/docs/default-source/publishing-policies/whoqol/portuguese-brazil-whoqol-100

WHO. (1999). *World Health Organization Amendments to the Constitution A52/24 [Internet].1999*. 4. https://apps.who.int/gb/archive/pdf_files/WHA52/ew24.pdf

WHOQOL SRPB Group. (2006). A cross-cultural study of spirituality, religion, and personal beliefs as components of quality of life. *Social Science & Medicine*, *62*(6), 1486–1497. https://doi.org/10.1016/j.socscimed.2005.08.001.

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