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NEW TECHNOLOGIES AND THE INVESTIGATION OF LATE PATERNITY: LEGAL CHALLENGES AND IMPLICATIONS FOR CHILDREN'S MENTAL HEALTH [1]

Ariane dos Santos Barreto da Silva [2]

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New technologies and the investigation of late paternity: legal challenges and implications for children's mental health

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Abstract

This study analyzes the challenges and legal and emotional repercussions of late paternity investigation, in light of technological advances, such as DNA testing and artificial intelligence. These advances have transformed the process of recognizing paternity, bringing greater accuracy and speed to investigations, but also raising questions about privacy and accessibility. The objective of this work is to explore the impact of these new technologies in the legal field, discuss the ethical and legal challenges, and evaluate the emotional consequences of late paternity on children's mental health, in addition to proposing regulatory improvements. Methodology used was based on a detailed literature review, analysis of relevant case law and comparative study of legal norms. The research also involved the psychological effects of late paternity disclosure and the analysis of guidelines on the use of genetic data. Data collection included analysis of court documents, academic and scientific articles on the emotional impact of late paternity disclosure. Results indicate that DNA testing is widely accepted in courts, but affordability remains an obstacle for low-income families. In addition, late disclosure of paternity can have negative impacts on children's mental health, such as anxiety, identity confusion, and rejection. The research highlights the importance of psychotherapeutic support and points to the need for strict regulation of the use of genetic data and artificial intelligence in paternity investigations. Inconclusion, the study suggests that while technologies advance, legislation needs to evolve to ensure equitable accessibility and protect children's rights. Psychosocial support is crucial to minimize emotional harm, and judicial decisions should consider not only biological evidence, but also the psychological well-being of minors.

Keywords: Children's mental health, paternity investigation, DNA testing, Psychological impact, artificial intelligence.

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1. Introduction[3]

The question of paternity has always been intrinsically linked to biological aspects[4], emotional and legal. However, with the advancement of new technologies, especially in the field of genetics, paternity investigation has become significantly more accurate and accessible. This evolution, in turn, has generated profound transformations in Family Law, particularly in cases of late paternity, when legal recognition of the paternal bond occurs years after the child or adolescent's life.

The incorporation of DNA testing and, more recently, the use of artificial intelligence (AI) and data science in the field of genetics have facilitated the process of identifying biological kinship. However, this technological advance also brings ethical, legal and emotional challenges. On the legal level, there is a growing demand for regulation regarding the use of genetic data and the protection of the privacy rights of the parties involved. On the emotional level, the late disclosure of paternity can significantly affect the psychological well-being of the child, who often finds himself faced with a new family reality, altering

[3] The original version of this article was published in Portuguese at the CIDS - International Congress of Health Law, 2024.
[4] According to Diniz (2011), filiation is a very personal and imprescriptible right, fundamental for the dignity and integral development of the child.

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pre-existing dynamics and potentially generating emotional conflicts.

Even though technological evolution[5]has enabled greater democratization in access to these tests, allowing families from different social classes to seek paternal recognition, the cost of such technologies is still a limiting factor. In addition, the use of algorithms to cross-reference large genetic databases in order to identify kinships raises questions about privacy and the ethical use of this information.

Therefore, this research seeks to analyze the legal repercussions of late paternity investigation in light of these new technologies, with a special focus on the implications for children's mental health. Interface between Law and health, in this context, cannot be neglected, since the judicial decision that recognizes paternity can both promote the emotional integrity of the child and potentially generate new psychological challenges. Thus, in addition to considering technological advances, it is necessary to pay close attention to the social and emotional aspects involved.

[5] According to Gonçalves (2013), technological advances, such as the use of DNA testing, have brought greater precision to paternity recognition, but also raise ethical challenges.

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2. Objectives

The main objective of this article is to analyze, in depth, the legal and psychological repercussions resulting from late paternity investigations, especially in light of the technological advances that have revolutionized this field. In particular, it seeks to examine how new technologies, such as DNA testing, artificial intelligence (AI) and data science, have transformed the paternity recognition process, providing greater precision and speed to investigations. In this context, it intends to discuss the legal implications arising from the use of these technologies in late paternity processes, considering the regulatory challenges, the need to protect genetic data, as well as the ethical issues related to their use.

The principle of human dignity is supported by the Federal Constitution, in its article 1, section III, which states that it is the duty of the family, society and the state to safeguard the minimum rights so that human beings have their value and dignity preserved in the face of what is provided by public authorities.

The Supreme Federal Court states:

> (...) the postulate of human dignity, which represents - considering the centrality of this essential principle (CF, art. 1, III) - a significant interpretative vector, a true source value that shapes and inspires the entire constitutional order

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> in force in our country and which expressively translates one of the foundations on which the republican and democratic order enshrined by the positive constitutional law system is based among us (...).[6](HC 95464, Rapporteur: Min. CELSO DE MELLO, Second Chamber, tried on 02/03/2009, DJe-048 DISCLOSED 03-12-2009 PUBLISHED 03-13-2009 EMENT VOL-02352-03 PP-00466)

Therefore, human dignity is a fundamental right of constitutional order for the individual who may at any time be exposed to social vulnerability, and this is no different in the aforementioned issue of filiation. The state guarantees everyone the right to a name and surname in order to guarantee this right as well as to protect those who do not have their paternity registered in their birth certificate the right to seek this institute through the appropriate action.

Another fundamental aspect addressed in this study is the analysis of the emotional impacts that late paternity disclosure can have on the children and adolescents involved, considering the emotional vulnerability that permeates these processes. The article aims to explore how this disclosure, facilitated by the use of advanced technologies, can interfere in family dynamics

[6] HC 95464, Rapporteur: Min. CELSO DE MELLO, Second Chamber, decided on 02/03/2009, DJe-048 DISCLOSED 03-12-2009 PUBLISHED 03-13-2009 EMENT VOL-02352-03 PP-00466 disponible in: http://www.stf.jus.br/portal/jurisprudencia/visualizarEmenta.asp?s1=000083730&base=baseMonocraticas

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and affect the psychological development of minors, making it essential to reflect on the need for psychotherapeutic support in such cases.

"The right to recognition of paternity is linked to the preservation of the child's identity, and it is essential to guarantee accessibility to these resources" (CAHALI; HIRONAKA, 2014)

In addition, there will be a discussion on accessibility and price regulation of genetic tests, taking into account that, although technological advances have popularized these tests, there are still economic barriers that hinder access for low-income families. The research therefore seeks to propose regulatory measures that ensure both the ethical and safe use of these technologies and the democratization of access to them, in order to guarantee that all individuals, regardless of their financial status, can enjoy the benefits provided by scientific advances. In this way, the aim is to contribute to the debate on the modernization of Health Law and Family Law, expanding the understanding of the role of new technologies in the legal field and in children's mental health.

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3. Methodology

The methodology adopted for the development of this study was based on an interdisciplinary approach, combining bibliographic review and documentary analysis. (DIDIER JR; ZANETI JR., 2014) In order to provide a broad and integrated view of the impacts of new technologies in the legal field and their implications for children's mental health. The first step consisted of conducting a literature review, involving the collection and analysis of scientific articles and specialized books that discuss the use of advanced technologies, such as DNA testing, artificial intelligence and data science, in paternity recognition processes. This bibliographic survey aimed to structure technological advances in the field of genetics and their applications in Family Law, in addition to identifying the ethical and legal discussions associated with the use of these technologies.

To verify the status of filiation, it must be analyzed through technical evidence, where a DNA test will be used, which can be carried out judicially, or extrajudicially if the parties so prefer, and which will have the same value in the scope of evidence. With this understanding,Fredie Didier Jr, Rafael Alexandria de Oliveira and Paula Sarno Braga, discuss:

> “Although there is no legal provision, it is still possible to consider the so-called extrajudicial or

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> amicable expert assessments, which would be those that the parties promote outside the proceedings to clarify doubts and questions that have arisen or may arise about facts that interest them. They would always be carried out consensually, by agreement of both parties. Produced in an extrajudicial adversarial process, with the consent of both parties to the material legal relationship, this expert assessment will produce a report that may be used as evidence in court, with a status very similar to that of pre-constituted evidence."[7]

In parallel, an analysis of relevant case law was carried out,involving the use of genetic testing to investigate late paternity. These cases were selected based on their representativeness in relation to the topics addressed, especially with regard to the legal and emotional consequences of recognizing paternity after childhood. The analysis of the cases was instrumental in identifying how the courts have dealt with the use of these new technologies and how judicial decisions have considered the emotional aspects of the children involved, in order to guarantee the best interests of the child.

In addition, a normative and regulatory research was carried out, focused on the analysis of current legislation, technical guidelines and ethical protocols that regulate the use

[7] Civil Procedural Law Course, vol. II, 2015, 10th edition. Fredie Didier Jr, Rafael Alexandria de Oliveira and Paula Sarno Braga, p. 263

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of genetic technologies and the processing of sensitive data in the context of paternity investigation. This effort included the review of national standards, such as the Statute of Children and Adolescents (ECA), and international standards, with a view to comparing different legal approaches on the subject and identifying gaps in the regulation of these technologies, especially with regard torefers to the protection of privacy and equal access to it.

"The literature review is essential to map the state of the art on the use of genetic technologies in paternity recognition processes." (GONÇALVES, 2006)

Finally, theoretical reflections were made on the challenges of accessibility and issues related to the regulation of DNA testing prices, in order to include a critical analysis of the democratization of access to new technologies. The combination of these different sources of information allowed a comprehensive and critical analysis of the legal and psychological repercussions of late paternity investigation, offering support for the formulation of more robust and inclusive regulatory proposals in the areas of Health Law and Family Law.

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4. Results

The results obtained from this research reveal a series of complex legal and emotional implications that arise with the advancement of new technologies in the field of late paternity investigation.(MADALENO, 2009), bringing to light several challenges and opportunities for Health Law and Family Law. First, the detailed analysis of the case law and the reviewed literature demonstrates that the use of DNA tests, now widely accepted as irrefutable evidence in legal proceedings, has transformed the recognition of paternity, especially in situations where this recognition occurs late, years after the birth of the child. What could previously be a difficult dispute to resolve in the legal sphere can now be resolved with scientific precision, thanks to genetic advances. However, this widespread acceptance of DNA tests also highlights the urgent need for more robust and detailed regulation, especially with regard to the collection, storage and use of genetic data.

Another relevant point that emerged from this research was the finding that, although DNA tests are widely accessible in many contexts, financial accessibility remains a significant barrier for a portion of the population. The high cost of many of these tests still prevents low-income families from using this technology to resolve paternity disputes, even in late

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processes. This inequality in access highlights the need for public policies that promote the democratization of new technologies, ensuring that the right to paternal recognition is guaranteed in an equitable manner, regardless of the socioeconomic status of those involved. In this sense, the results indicate that one of the biggest gaps is in the regulation of genetic test prices and the lack of government subsidies for families in vulnerable situations, pointing to the urgency of a legal reform that ensures universal access to these technological innovations.

From an emotional perspective, the research results highlight the significant impacts on the mental health of children and adolescents involved in late paternity proceedings. Disclosure of paternity, often facilitated by technological advances, can generate a series of adverse emotional reactions, including feelings of rejection, identity confusion, and even the destabilization of previously established family dynamics. This emotional aspect, although already recognized by some courts, still needs to be addressed in greater depth in judicial decisions. The research points to the need for greater involvement of mental health professionals in judicial proceedings, with the inclusion of psychological opinions that can help judges make decisions that consider not only the legal

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aspects, but also the best emotional interests of the child. Psychotherapeutic monitoring is, therefore, essential to mitigate the negative effects that late disclosure of paternity can have on the psychological development of the child.

On the other hand, the results also highlight the ethical and privacy challenges that accompany the use of new technologies, especially with the advancement of artificial intelligence (AI) and data science in the field of genetics. The use of large genetic databases to cross-reference information and the application of AI to identify kinships present considerable risks in terms of privacy. Individuals are often not fully aware of how their genetic data will be used or stored, which can lead to violations of fundamental rights. Thus, the results suggest that the use of these technologies must be accompanied by strict regulations that protect individuals' sensitive data, ensuring that scientific advances do not override privacy rights and human dignity.

Furthermore, the research highlighted the relevance of the ethical issues involved in investigating late paternity. Although technology has offered new avenues for resolving disputes, the disclosure of paternity can destabilize families and challenge pre-existing social and emotional relationships. The use of advanced technologies must therefore be balanced with an

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empathetic understanding of the human and emotional implications. Judicial decisions, in this sense, must be guided not only by the biological certainty offered by DNA testing, but also by the social and emotional considerations of each case.

In summary, the results of this research highlight the profound transformation that new technologies are bringing about in the field of late paternity recognition, while also highlighting the need for an interdisciplinary approach that combines scientific advances, legal protection and emotional support. Although technological innovations have facilitated and accelerated paternity investigation processes, it is essential that the legal system and society are prepared to deal with the emotional, ethical and social impacts that arise as a direct consequence of these innovations. The future of Family Law and Health Law, therefore, depends on the harmonization between the benefits of new technologies and the protection of the rights and well-being of the children involved.

5. Discussion

Late paternity investigation involves a series of legal and emotional challenges, both for children and for parents and their families. The right to recognition of paternity, as established in the Statute of Children and Adolescents (ECA) and the Civil

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Code, is a highly personal, imprescriptible and unavailable right. This means that, regardless of the time that has passed, the child or adult who seeks recognition of his or her filiation can do so without temporal restrictions, which highlights the importance of this right in the Brazilian legal system (DINIZ, 2011).

However, the issue of late paternity goes beyond legal rights. It touches on fundamental aspects of human dignity and the need for children and adults to know their true biological origin. The recognition of paternity is not just a question of property or food rights; it is also about the construction of the individual's personal and psychological identity. As highlighted by Dias (2011), “filiation constitutes a fundamental right of personality, linked to the recognition of human dignity”, and, therefore, must be absolutely protected by the State.

The introduction of new technologies, such as DNA testing, has revolutionized the way these processes are conducted. With the introduction of Law No. 12,004/2009, which regulates paternity investigations and authorizes the presumption of paternity when the alleged father refuses to take a DNA test, the right to biological truth has gained more judicial support. However, the question that arises is whether the mere refusal to take the test can be sufficient to determine paternity, or

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whether a set of evidence is necessary to corroborate this conclusion (GONÇALVES, 2013).

Brazilian case law, when interpreting Summary 301 of the STJ, has consolidated the understanding that refusal to undergo a DNA test may generate a presumption juris tantum of paternity. However, this presumption is relative and can be disproved by other evidence in the records, guaranteeing the right to adversarial proceedings and full defense of the person under investigation (MADALENO, 2009). In this sense, the balance between the search for biological truth and the protection of the procedural rights of the person under investigation becomes a delicate balance. It is imperative that, when dealing with these cases, the Judiciary be attentive to both the rights of the child and the procedural guarantees of the parties involved.

In the emotional field, the late disclosure of paternity can generate a series of psychological impacts. For many children and adults, the process of recognizing paternity is not only about obtaining legal rights, such as inheritance or alimony, but also about filling a gap in their identities. Lôbo (apud DINIZ, 2011) argues that “the state of filiation that results from the stability of emotional bonds constitutes an essential basis for the attribution of paternity”. The absence of a recognized father

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can generate feelings of rejection and low self-esteem, directly impacting the individual's psychological development.

Furthermore, advances in genetic technologies, especially DNA testing, have brought new ethical issues to the debate. On the one hand, these tests allow for an almost absolute determination of paternity, but on the other hand, they raise questions of privacy and the appropriate use of genetic data. With the advent of the General Data Protection Law (LGPD), the collection and use of genetic data need to be regulated to protect the privacy of those involved. The use of large genetic databases for the identification of kinships, as pointed out by Didier Jr. (2015), raises concerns about the security and confidentiality of these data, especially when they can be used for purposes other than strictly related to the recognition of paternity.

From a legal perspective, legislative developments have been significant in ensuring that paternity is recognized fairly. The Civil Code and Law No. 8,560/1992 clearly regulate the rights of children and parents, establishing that paternity can be recognized either voluntarily or through legal proceedings. However, there are still practical challenges, especially for low-income families who face difficulties in paying for DNA tests and other expert procedures. The lack of accessibility to these tests

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is an issue that needs to be addressed with public policies that democratize access to biological truth.

The analysis of the case law on paternity investigation also reveals that, in many cases, the late discovery of paternity is linked to patrimonial issues, such as the right to inheritance. The cumulation of the paternity investigation with the inheritance petition is a common practice in Brazil, and STF Summary 149 establishes that, although the paternity investigation action is imprescriptible, the inheritance petition action is subject to a 20-year statute of limitations. This distinction shows that the right to filiation must be considered independently, even when it involves patrimonial aspects (STF, Summary 149).

Therefore, the Brazilian Institute of Family Law – IBDFAM, published a publication on the subject:

> By outlining a historical and social profile of the evolution of the family as a whole and of the Brazilian family specifically, until the evolution resulting from the 1988 Constitution, it is demonstrated that filiation is a right of the personality, as it is part of its identity and psychological integrity, and must be ensured by the State. It is linked to paternity, given its relevance in the physical, moral and psychological formation of each natural person. And, based on the national legal system and the aforementioned foreign legislation, it determines three ways of establishing the status of paternal filiation: presumed paternity by law, biological paternity, and socio-affective

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> paternity. According to the theory of the best interests of the child, all children have the right to a father who meets their desires, their services, their life, their dreams, their loves and everything else that favors them. Given so many possibilities, it is concluded that only one of these types is not capable of ensuring the establishment of the status of paternal filiation in a way that is adequate and satisfactory to their interests.
>
> A new filiation is born where it will be necessary to combine two or more types of paternity, in order to guarantee the subject the right to "true" paternity. (MAIA, 2011)

Finally, it is necessary to discuss the implications of res judicata in paternity investigation actions. When DNA testing was not performed in old cases, the recognition of paternity may be reviewed in light of new evidence, as provided for in recent case law. This demonstrates the importance of making res judicata more flexible in matters of marital status, ensuring that biological truth can prevail over a decision based on insufficient evidence.

After defining the filiation bond, the legal subject must seek to recognize the legal bond of paternity, through the paternity investigation action which aims to verify the alleged allegations, on this, the lesson of Paulo Lôbo:

> “The status of filiation, which arises from the stability of the emotional bonds built in the daily life of father and son, constitutes an essential basis for the attribution of paternity or maternity. It has nothing to do with the right of each person to recognition of

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> their genetic origin. These are two distinct situations, the first having the nature of a personality right. The governing rules and the legal effects are not confused or interpenetrated.
> To guarantee the protection of the right to personality, there is no need to investigate paternity. The purpose of protecting the right to knowledge of genetic origin is to ensure the right to personality, in the form of the right to life, since current scientific data indicate the need to attribute paternity to someone in order to have the right to paternity to know, for example, the biological paternal ancestors of someone who was generated by an anonymous sperm donor, or of someone who was adopted, or of someone who was conceived by heterologous artificial insemination.
> (...)
> Every person has a fundamental right, in the form of personality rights, to claim his or her biological origin so that, by identifying his or her genetic ancestors, he or she can adopt preventive measures to preserve his or her health and, a fortiori, his or her life. This right is individual and highly personal, and does not depend on being part of a family relationship in order to be protected or supervised. It is one thing to claim genetic origin, and another to investigate paternity. Paternity derives from the state of filiation, regardless of origin (biological or otherwise)."

Given all these points, it is clear that paternity investigation involves issues that go beyond the legal right to recognition of filiation. It involves the right to identity, dignity and privacy, as well as the need for emotional support for those involved, especially when paternity is discovered late. It is essential that the Judiciary and legislators continue to advance to ensure that

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these rights are protected and that the use of new technologies occurs in an ethical and accessible manner.

6. Conclusion

This research has unequivocally revealed that technological advances in the field of genetics, especially with the use of DNA testing, artificial intelligence and data science, have had a significant impact on the process of recognizing late paternity, transforming the legal scenario and introducing new dimensions to be considered in both Health Law and Family Law. New technologies (DINIZ, 2011) have brought undeniable benefits, especially with regard to scientific precision and the speed in obtaining evidence to establish the paternal bond. However, these same advances raise crucial questions that go beyond the merely biological aspect and touch on sensitive points of the legal system, ethics and children's mental health.

The study demonstrated that, despite the popularization of DNA testing and its widespread acceptance as evidence in court, accessibility to these resources is still unequal, creating economic barriers for many families. In this sense, the lack of public policies that ensure equitable access to new technologies becomes an obstacle to the full exercise of the right to recognition of paternity, especially in cases of late

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paternity, when the child or adolescent has already gone through critical stages of development without the presence or recognition of a biological father. It is imperative that the State and legislators intervene to regulate the price of genetic testing, subsidizing it when necessary, in order to ensure that all families, regardless of their financial situation, have the possibility of using these resources in the context of legal proceedings.

In addition to the financial challenges, the results of this research point to the urgency of more robust and specific regulation regarding the use of genetic data and the protection of individuals' privacy. With the increasing use of artificial intelligence and large genetic databases, considerable ethical concerns arise, especially regarding the storage, use and sharing of sensitive data. The absence of clear regulation may open the way for the violation of fundamental rights, such as privacy and informational self-determination. Therefore, it is essential that legislation keeps pace with technological advances, imposing ethical and legal limits that ensure the protection of genetic data and the dignity of those involved in paternity investigation processes.

Another critical aspect identified in this research was the emotional impact that late paternity investigations can have on

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children and adolescents. Although DNA tests offer a quick and accurate solution for biological identification, late disclosure of a father can destabilize family dynamics, generating feelings of rejection, identity confusion and, in some cases, triggering serious psychological problems. This emotional factor, often overlooked in legal proceedings, needs to be considered more carefully, especially since the primary objective of Family Law is to protect the best interests of the child. Therefore, it is essential that, in cases of late paternity, judicial decisions are supported not only by biological evidence, but also by psychological opinions that take into account the emotional and social impacts on the child.

The research also highlighted the importance of psychotherapeutic support as a crucial tool to help children and adolescents deal with the emotional consequences of late discovery of paternity. Monitoring by mental health professionals should be considered both in the family and judicial spheres, to ensure that minors receive the necessary support throughout the process of adapting to the new family reality.

In conclusion, although new technologies have revolutionized the field of paternity investigation, facilitating access to biological truth, it is essential that society and the

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legal system are prepared to deal with the social, emotional and ethical repercussions that emerge from this transformation. The future of paternity recognition, especially in the context of late paternity, will depend on the ability of legal professionals, legislators and health professionals to harmonize technological advances with the fundamental principles of protecting the rights of children and adolescents. Only through an interdisciplinary approach, which integrates legal, ethical and psychological aspects, will it be possible to ensure that the benefits of these new technologies are widely enjoyed, while protecting the dignity and well-being of the families involved.

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PUBLIC POLICIES ON DRUGS IN BRAZIL: A CRITICAL LOOK AT THE IMPACTS OF THE DRUG LAW AND THE CHALLENGES OF THE PUBLIC SECURITY SYSTEM IN BRAZIL[1]

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Public Policies on Drugs in Brazil: A Critical Look at the Impacts of the Drug Law and the Challenges of the Public Security System in Brazil
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Abstract

The study analyzes the impacts of the 2006 Drug Law (Law No. 11.343/2006) on the public security and criminal justice system in Brazil, highlighting the challenges and consequences of the prohibitionist approach. The STF's decision on the constitutionality of article 28, which deals with the possession of marijuana for personal consumption, is discussed in contrast to common sense about the criminalization of use. The research points out that the repressive posture resulted in an increase in incarceration, mainly affecting small traffickers and perpetuating social and racial inequalities. The lack of objective criteria to distinguish users from traffickers and the inefficiency in cooperation between security forces and the judiciary have aggravated the problem, favoring the rise of criminal factions. Using literature review and qualitative analysis, the study consulted scientific articles, books, and statistical data through platforms such as Google Scholar. Documentary compilation and syntopical reading techniques were applied to identify convergences and divergences in the arguments. The work rescues the trajectory of drugs, the first regulations influenced by international guidelines and the debate of organized civil society. In summary, it questions the effectiveness of the current policy and exposes the need for alternatives focused on public health and social justice, recognizing the limits of the current model without proposing a new policy. The reflection seeks to stimulate a critical debate on the direction of drug policies in Brazil.

Palavras-chave: Racial inequality, Drug Law, Public policies, Prohibitionism, Criminal justice system.

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1. Introduction

The Drug Law of 2006 replaced the old legislation of 1976, bringing significant changes in the approach to the use, trafficking and production of narcotics in Brazil. The new legislation introduced the National System of Public Policies on Drugs (SISNAD), focusing on both prevention and repression. Although the law promised improvements, the practical results highlighted serious flaws, such as increased incarceration and persistent racial inequalities in the application of justice.

In the midst of numerous sensationalist news items placing the use and abuse of illicit drugs at the center of the most perverse criminal practices, the STF issues a decision on the constitutionality and applicability of article 28 of Law 11.343/06 dealing with the possession and possession of illicit drugs for personal consumption, specifically 'marijuana', contrary to what was already instilled in the popular common sense of prohibition because it is a crime.

This article explores the effects of the 2006 Drug Law (Law No. 11,343/2006) on the public security and criminal justice system in Brazil. The main challenges faced by the institutions involved are discussed, including the overlapping of functions, the increase in incarceration for trafficking, especially of small traffickers, racial bias, that is, the perpetuation of social and

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racial inequalities in law enforcement, and the growing influence of criminal factions. The study addresses how the lack of cooperation between security forces and the Judiciary negatively influences the efficiency of the justice system, the adoption of the prohibitionist model as the main approach to dealing with drug-related issues in Brazil.

The study seeks to analyze the national public policy on drugs with a view to highlighting the directions taken by it and its eventual effectiveness, in addition to bringing alternatives presented by social segment. Seeking to understand the impacts of the 2006 Drug Law and the challenges faced by the Brazilian public security system, the research brought to light the trajectory of drugs, their first regulations, the adoption of a repressive posture influenced by international guidelines and the debate promoted by organized civil society.

The central analysis of the work addresses the impacts of the 2006 Drug Law (Law No. 11.343/2006) in Brazil and discusses the ineffectiveness of the Brazilian prohibitionist model, the negative effects of the Drug Law on the vulnerable population and the public security system, in addition to bringing reflections on the need for alternative policies that consider public health and social justice. The study did not have the power to concisely propose a new public policy on drugs, but

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rather to bring a reflection on how the theme is being treated and, in this context, answer key evaluative questions regarding the effectiveness of the adopted model.

Currently, in common sense and in the media discourse, the use and trafficking of illicit drugs are often associated with violent crime, being pointed out as factors that feed practices such as robberies and homicides. These actions often occur in disputes over territories of action or in confrontations with the forces of repression. In addition, drug trafficking is responsible for the movement of billionaire figures, as evidenced by official data.

The issue of drugs is presented in an intricate way, since the absence of a clear and objective definition of the term, which varies according to the context in which it is used. One can attribute to the concept meanings related to the use of medicine, recreational, festive, religious, legal or marginal. Historically, the consumption of psychoactive substances has accompanied humanity for centuries, but the history of drug repression is relatively recent, 2 based on different arguments, the main one being the protection of the user's individual health and public health.

Under the justification of health protection and influenced by the American stance, from the middle of the twentieth

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century, the tendency to adopt repressive measures against both drug trafficking and drug use spread globally. This approach resulted in the categorization of different substances as licit or illicit, according to specific criteria.

Public policies based on the North American model, under the argument of protecting public health – including those implemented in Brazil – are widely classified as repressive, also known as prohibitionist, currently predominating in most countries.

It should be noted that this study did not have the power to encourage, defend or foster the use or trafficking of illicit or licit drugs, nor to affirm that the use of these substances is safe or that it does not affect the user's health.

The purpose of this study was to examine the foundations that sustain drug policy in Brazil, evaluating whether the criminal anti-drug policy model has been effective in fulfilling its objectives of protecting public health. In addition, it sought to analyze the impacts of this legislation on the public security system, as well as to discuss the challenges faced by criminal justice, including the overcrowding of the prison system, the perception of impunity, and the strengthening of criminal factions.

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To carry out the study, a qualitative approach was adopted through bibliographic research as the main source of analysis. Initially, the compilation of materials that presented correlation with the pertinent themes was carried out, based on a textual reading and synthesis for content selection and exclusion. Then, the syntopic reading technique was applied, culminating in a narrative review of the literature.

The research was based on the analysis of journalistic articles, government statistical data and specific scientific works. To collect the materials, open access search platforms such as *Google and Google* Scholar were used . Keywords such as "public policies on drugs", "drug prohibitionism", "health of drug users", "annual report on drugs", "efficiency of drug policies", "criminal factions", "criminal justice system", "flagrant", "perception of impunity", "military police", "racial inequality", "drug trafficking" were used.

The selection of texts was based on the titles and abstracts that were most aligned with the proposed theme, followed by a detailed reading to abstract the central ideas, later reorganized and interpreted according to the objectives of the study.

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2. Brief History of Drugs and Early Regulations

As mentioned, the term "drugs" lacks an objective and clear definition, and its meaning is highly dependent on the social context in which it is used and the prism of the area of knowledge addressed. For this study, we restrict our analysis to the perspective of the social and legal sciences, focusing on the socio-historical processes that contributed to the prohibition of the use, production, and commercialization of various substances in different countries around the world.

The World Health Organization (WHO) recognizes that the harmful use and dependence of drugs, whether licit or illicit, constitute a public health problem of international scope, worrying governments and societies around the world. This problem profoundly affects cultural, social, economic and political values. The WHO defines drugs as: 'any natural or synthetic substance, which, introduced into the living organism, modifies one or more of its functions, regardless of whether it is licit or illicit' or 'any substance not produced by the organism that has the property of acting on one or more of its systems causing changes in its functioning'. (WHO, 1993)

However, these conceptualizations are broad and generic, which can lead to limited or imprecise interpretations on the subject. In this sense, several substances that do not pose

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significant health risks could be classified as drugs under this definition. On the other hand, from more specific perspectives, drugs can be conceptualized and classified based on different criteria, such as their chemical composition, active ingredients and characteristic effects, or even according to their legality or legislative regulation in certain contexts.

At the national level, **Law No. 11,343/2006**, in the sole paragraph of article 1, defines drugs as: "For the purposes of this Law, substances or products capable of causing dependence, as specified by law or listed in lists periodically updated by the Executive Branch of the Union, are considered to be drugs". (Brazil, 2006)

The use of psychoactive substances dates back to the dawn of humanity, ranging from alcohol consumption to opium use. There are historical records that indicate that civilizations such as the ancient Egyptians, Greeks and Romans used these substances for both religious and recreational purposes. In addition, Roman, Arab, and English physicians employed the tincture of opium in the treatment of dysentery and other diarrheal syndromes, highlighting the therapeutic use of these substances in historical contexts. (Duarte, 2005)

Until the middle of the fourteenth century, both the production, commercialization and consumption of various

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substances now classified as drugs, such as cocaine, opium and their derivatives, were widely disseminated.

How did substances that were widely consumed, culturally accepted and recognized for their medicinal benefits come to be seen as a problem? Berridge and Edwards (1981) point out that it is not about the potentiality of each substance in its pharmacological property, which remains the same over time, but rather the social and economic context and the purposes of specific use without forgetting the frequency, which were sometimes associated with inappropriate use with deaths derived from it, causing doctors to question free consumption.

Still when dealing with substances that alter the state of consciousness, senses and perceptions, it is essential to mention alcohol and marijuana. The latter, considered one of the exotic spices that aroused great interest from Europeans, occupies a prominent place in this context.

Shecaira (2014) teaches us that, in the United States, traditional sectors with a strong religious inclination, organized in the so-called "temperance movement", intensified, at the end of the nineteenth century, the campaign for the prohibition of the consumption of alcoholic beverages. This effort culminated in the implementation of control policies, culminating in the so-called Dry Law, between 1919 and 1933. Although the

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Prohibition Law has been overcome, the prohibitionist spirit has remained rooted in the popular imagination, now focused on what is conventionally called "drugs". In this context, the next target of prohibitionism was marijuana, which became the target of restrictive legislation and repression campaigns.

In Brazil, still in the slavery period, there are reports, according to studies carried out by Carneiro (1958), regarding the use of the herb, which had other names, such as 'liamba' or 'pito de panga', or 'diamba', was consumed among the enslaved, especially in moments of sadness or longing for Africa.

Curiously, and even before the end of slavery, Brazil was a pioneer in prohibiting the use and sale of marijuana, establishing a specific norm as early as 1830, in Rio de Janeiro, through the Code of Municipal Postures. The text of the rule mentioned that "The sale and use of pito de pango, as well as its conservation in public houses, is prohibited. The offenders will be fined, namely: the seller in 20$000, and the slaves and other people, who use him, in three days of jail". (Mott, 1986, p. 131).

This regulatory framework reflects the first initiatives to control psychoactive substances in the country, highlighting a

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context in which cultural, social, and racial aspects profoundly influenced public policies at the time.

It is evident that the norm of the time not only sought to regulate the use of marijuana, but also functioned as a form of social control of the black population, since consumption was culturally associated with marginalized groups. In addition to being a pioneer in the prohibition of marijuana, Brazil has played an active role in the spread of prohibitionism at the international level. A striking example was his contribution during the II Pan-American Scientific Congress, held in December 1915. On the occasion, José Rodrigues Dória, professor of Law and Medicine from Bahia, presented the work entitled *"Marijuana smokers: effects and evils of addiction",* reinforcing the criminalization of the substance and helping to consolidate the prohibitionist discourse in international forums.

People usually interpret the world, starting from what is familiar to them, creating a belief of uncontested truth, whose interpretations promote a kind of wisdom of social navigation, which in literature is known as common sense. This, common sense, according to Anthony Giddens (2012) is everything that the subject shares in his culture, habit and social practice, when inserted in a certain social reality, forming consensus. In this context, common sense adopts a simplistic and naturalizing

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logic, often devoid of scientific foundation and strongly impregnated with prejudices. With regard to the topic of drugs, the massification of the idea that "drugs kill and do harm" has consolidated itself as an indisputable truth in the popular imagination, creating a real terror around the subject.

According to Line Beauchesne (2015), this generalized perception is far from protecting individuals and the community from the real damage that these substances can eventually cause.

On the contrary, common sense consolidates a strong belief in the exclusively harmful character of drugs, even when this understanding lacks complete scientific support. This simplistic view, by disregarding the nuances and complexities involved, perpetuates myths and prejudices, making debates less balanced and making it difficult to find effective solutions to problems related to the use of psychoactive substances.

3. International Prohibitionist Trend

Negotiations for the prohibition of the production, commercialization and consumption of various substances, such as cocaine and morphine, began in 1912, in The Hague, led by England and the United States. However, this process was only consolidated in 1919, with the Treaty of Versailles,

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marking the beginning of the modern system of international control of substances considered drugs, under the strong influence of US policy. (Scheerer, 1993).

According to Rodrigues (2012), technological advances and the development of means of transport in the post-World War II period significantly facilitated the movement of people and goods, contributing to the expansion of drug trafficking. This phenomenon, driven by the high profits generated, gave rise to a transnational narcotics market, which reinforced the thoughts and efforts aimed at strengthening prohibition policies.

This movement, centered on the so-called "drug problem", resulted in increasingly restrictive measures, consolidated internationally through a triad of conventions that established the prohibitionist paradigm. Under the leadership of the United Nations (UN), these conventions have come to guide the formulation of drug laws in more than 170 signatory countries, reinforcing a global approach to control and repression.

The aforementioned conventions began in 1961, with the Single Convention on Narcotic Drugs, considered by Karam (2015) as the most important of the century. This convention established that the signatory states should criminalize the cultivation, production, commercialization and consumption of

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certain substances classified as narcotics, consolidating the bases of the prohibitionist paradigm at the international level:

> "... cultivation and the production, manufacture, extraction, preparation, possession, offers in general, offers for sale, distribution, purchase, sale, delivery of any kind, brokerage, shipping, shipment in transit, transportation, import and export of narcotics."

This convention also defined the substances that would be submitted to control, establishing a classification based on the degree of danger and the potential to cause dependence, with the creation of four distinct control groups. In addition, it established a body responsible for overseeing the implementation of these measures, the International Narcotics Control Board (INCB). According to Alarcon (2012), this was a fundamental initiative to structure the international drug control system. The first convention was hosted and financed by the United States, a country that led the global consolidation of the prohibitionist paradigm (Fiore, 2012).

The second convention took place in 1971, called the Convention on Psychotropic Substances, and in general repeated the guidelines of the 1961 Convention, however, it gave more specificity in the classification of substances according to the potential to provoke dependence and therapeutic value of each one of them. That same year, U.S.

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President Richard Nixon gave a speech on the issue of substances considered illicit and inaugurated what became known as the 'war on drugs', advocating that drug policy should be centered on the repression of use and trafficking, supported by international police and military interventions (Araújo, 2017)

Seventeen years after Nixon's speech, his rhetoric directly influenced the third international convention, held in 1988 and entitled the Convention Against the Illicit Traffic in Narcotic Drugs and Psychotropic Substances. The main objective of this convention was to strengthen international cooperation in the fight against drug trafficking, expanding joint efforts among signatory countries to address the problem on a global scale.

These premises sedimented in the triad of Conventions influenced the elaboration of public policies and legal statutory in most countries, including, obviously, Latin America.

Sociologist Campos (2019) listed five consequential points that resulted from the paradigm of the international conventions mentioned, the first being a model of uniform control of prohibited substances with restricted therapeutic use, followed by the defense of the criminalization of drug use and trade as the main option for imprisonment, and third, he mentions that there was no prioritization of treatment or prevention of the use of illicit drugs, Continuing with pointing out the rejection of penal

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alternatives as harm reduction measures and in the end, he points out that the rights of indigenous communities and peoples regarding the use of traditional products were not recognized, opting for the goal of eradicating plantations and traditional culture.

It is important to highlight that the internationalization of the repressive and austere fight against drugs has had direct impacts on the social, economic and political spheres of Latin American countries. This approach promoted the idealization of a world divided into blocs: on the one hand, the producing countries, often stigmatized as third world nations and blamed as the main culprits of the drug problem; on the other, the consumer countries, mostly developed, which have positioned themselves as victims of the expansion of the use of narcotics. This division reinforced inequalities and stereotypes, further aggravating tensions between these regions.

4. National Drug Policy in Brazil

As mentioned earlier, the first regulation on drugs in Brazil occurred in 1830, when the City of Rio de Janeiro established specific rules in the Municipal Code of Postures, Brazil was one of the precursor countries in the prohibition of marijuana called

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'pito de pango', as well as also making the plant definitively illegal in 1932, even preceding the United States itself.

It is important to note that Brazil is a signatory to the three Conventions mentioned, in addition to all international agreements under the aegis of the UN regarding drugs, therefore, the international prohibitionist model is what has been governing drug policies in Brazilian lands. Even before them, and inspired by the resolutions approved by the International Opium Conference (1911) and the International Opium Convention (1915), Brazil issued two decrees, one in 1914 and the other in 1915 with measures to prevent the circulation of opium and its derivatives.

Through Decree 20.930 of January 11, 1932, there was a criminalization for the trade and possession of drugs such as '*cannabis indica*' and cocaine, however, there was a differentiation of penalty and bailability between user and dealer (Brasil, 1932).

Eight years later, the Penal Code came into force, which began to provide in its article 281 (Brasil, 1940) the conduct of trafficking, maintaining the differentiation of treatment to the considered user, however, this article received a new wording in the middle of the military dictatorship, through Decree-Law 385 of December 26, 1968, when the user was equated to the

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trafficker, with the provision of the same sentence for both (Brasil, 1968).

In the 1960s, *Cannabis*, already commonly known as 'marijuana', aroused the interest of a social layer composed of intellectuals, university students, artists and the middle class, culminating in an increase in drug criminalization investigations, reaching middle-class youth in convictions (Batista, 2003)

According to Silva (2014), although the State had consolidated a mobilization throughout society on strategies for control, repression and prevention of drugs, involving the family, media and school, there was in the seventies, an intensification of drug use by middle-class young people, increasing the discussion about medicalization, bringing the psychiatric discourse closer to the criminological one, originating the change in the legislation that came with Law 6.368/76, operating the differentiation in the criminal treatment given to users and traffickers.

The equivalence of custodial sentences provided for the trafficker and the user was applicable until the entry into force of the legendary Law 6.368 of October 21, 1976 (Brasil, 1976), when the user's conduct began to be provided for in article 16 and although still punished with deprivation of liberty, its

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quantum was much lower than the provision made in article 12 for behaviors classified as trafficking, Let's see:

> Article 12. Importing or exporting, shipping, preparing, producing, manufacturing, acquiring, selling, exposing for sale or offering, supplying, even if free of charge, having in storage, transporting, bringing along, keeping, prescribing, administering or delivering, in any way, for consumption a narcotic substance or that determines physical or mental dependence, without authorization or in disagreement with legal or regulatory determination;
> Penalty – Imprisonment, from 3 (three) to 15 (fifteen) years, and payment of 50 (fifty) to 360 (three hundred and sixty) days-fine.
> ...
> Article 16. Acquire, store or bring with you, for your own use, a narcotic substance or one that determines physical or mental dependence, without authorization or in disagreement with legal or regulatory determination:
> Penalty – Detention, from 6 (six) months to 2 (two) years, and payment of (twenty) to 50 (fifty) days-fine. (Brazil, 1976)

During the government of Fernando Henrique Cardoso, in an apparent gesture of rapprochement with pro-legalization activists, **Law 10.409/2002** was enacted. However, the law suffered so many vetoes that it ended up becoming a true legislative "Frankenstein". This occurred because criminal offenses related to drugs continued to be governed by **Law 6.368/76**, without any significant modification. The new legislation dealt only with procedural procedures related to

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crimes involving drugs, without bringing substantial changes to the existing criminal framework.

In the historical sequence, in the midst of the political process of reelection of the then President Luís Inácio Lula da Silva, Law 11.343 of August 23, 2006 was sanctioned, which ended the provision of deprivation of liberty for users of illicit drugs, but on the other hand, maintained the repressive paradigm and the fight against substances. while there was a substantial increase in the penalty for those considered to be perpetrators of trafficking (Brasil, 2006)

This is the current Law in force in the country on the confrontation of issues related to illicit drugs, basically dealing with four aspects, instituting the National System of Public Policies on Drugs (SISNAS), prescribing measures for the prevention of misuse, care and social reintegration of drug users and dependents, establishing rules for the repression of unauthorized production and illicit drug trafficking and defining crimes related to illicit drugs with their respective procedural framework.

Marcelo Campos (2019) describes that during the processing of the bill that culminated in the current Law 11.343/06, there was an attempt to detach the figure of the user from the criminal scenario to the need for health treatment,

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which was partially achieved, by only abstracting the deprivation of liberty from his responsibility. He also states that to the behaviors dedicated to trafficking, there was an approximation of the labeling 'organized criminals'.

A recurring criticism of **Law 11.343/06** is the alleged absence of objective criteria to differentiate the conducts of drug use and trafficking, which has generated distortions in its application. As pointed out by Criminal Law researcher Luciana Boiteux (2009), this lack of clarity allows subjective interpretations, often resulting in inconsistent judicial decisions and possible injustices, especially against individuals in situations of social vulnerability.

It should be noted that the legal object of drug-related crimes is formally identified as **"Public Health".** However, in this author's view — in a process of continuous construction by experience and cognition over time — and based on the analysis of debates and materials on the evolution of the theme, it is perceived that the effective protection of **"Public Health"** is the least discussed or prioritized aspect in each historical phase. At most, the focus falls on the individual health of the user, relegating the broader concept of collective health to the background.

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The National Drug Policy (PNAD) is based on the annex approved by Decree 9,761 of April 11, 2019 (Brasil, 2019). In the same year, two months later, Law 13,840 of June 5 was enacted, which amended, among other norms, Law 11,343/06 itself, to deal with the National System of Public Policies on Drugs, as well as care for users and dependents (Brasil, 2019).

Due to the changes promoted and mentioned above, in 2021, the National Council on Drug Policies (CONAD) approved the National Plan on Drug Policies (PLANAD), with projections valid between 2022 and 2027. According to the initial presentation in PLANAD itself, the participation of society, representatives of public agencies and institutions is mentioned there, *in verbis*:

> The proposal for the National Plan on Drug Policies (PLANAD) was approved by the National Council on Drug Policies (CONAD), on August 3, 2021 and submitted to public consultation, held from September 3, 2021 to December 12, 2021 (100 days), exclusively through an electronic tool, through which contributions from 127 participants of the Society were received, the federal public agencies that make up CONAD and the Institutional Representatives of Drug Policies. Likewise, Planad was submitted to the Public Hearing held on 11/29/2021, in order to promote broad social participation. On this occasion, anyone (including members of public policy councils, civil society organizations and other agents of the states, the Federal District and municipalities) could present proposals and contributions about the plan. In view of the above, the National Plan on Drug Policies

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> (PLANAD) is the result of the integration and convergence of efforts of various agencies and entities (public and private), and had broad participation of civil society in its elaboration, which we submit to your appreciation, with the hope that the National Plan on Drug Policies (PLANAD), is an important tool in the coordination of government efforts to confront the issue of drugs in the country and promotes the changes desired by society in this area. (Brazil, 2022)

It can be inferred from the aforementioned legislative edicts that the Brazilian National Drug Policy is expressly based on the three international conventions within the United Nations and already mentioned here as a triad, constituting the international legal framework on drug control.

The PLANAD is seen as an instrument of a State policy and not of the government, it lists seven central problems related to the issue of drugs to be faced, namely, the consumption of illicit drugs and abusive or harmful consumption of alcohol, the trafficking and unauthorized production of drugs, smoking, the prolonged use of benzodiazepines, the fragility of governance and integration of drug policy, the insufficiency of management of assets seized from drug trafficking, the low availability of statistics and assessments. (Brazil, 2022)

Based on these identified problems and in line with the PNAD, the strategic objectives were defined, organized into five axes, namely:

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i. Prevention: involves preventive education actions focused on the individual and his or her sociocultural context, seeking to discourage the initial use of drugs, promote abstinence, and raise awareness and encourage the reduction of risks associated with the use, misuse, and dependence on licit and illicit drugs;
ii. Treatment, Care and Social Reintegration: covers actions of attention, care, support, mutual help, recovery, treatment, protection, promotion, and social reintegration of users and dependents of alcohol and other drugs;
iii. Supply Reduction: consists of actions to repress unauthorized production and illicit drug trafficking, in addition to the regulation of controlled substances and sustainable development actions;
iv. Research and Evaluation: encompasses actions to expand scientific knowledge, development of indicators, statistics and evaluation of policies, programs and projects;
v. Governance, Management and Integration: includes coordination and integration actions, in addition to promoting transparency and accountability of drug policy to society. (Brazil, 2022. p. 25)

In an apparent contradiction to the objectives and assumptions recommended by **the PNAD** (National Drug Policy) and PLANAD, on June 25, 2024, the Federal Supreme Court (STF) concluded the judgment of Extraordinary Appeal (RE) 635,659, establishing that the possession of small amounts of marijuana for personal use does not constitute a

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crime, but constitutes an administrative infraction. This decision implies that while possession of marijuana for personal use remains prohibited, it does not result in criminal sanctions, such as a criminal record. The applicable penalties include warning about the effects of the drug and participation in educational programs or courses, according to items I and III of article 28 of the Drug Law. (STF News).

The Supreme Court also defined objective criteria to differentiate users from traffickers, assuming that the possession of up to 40 grams of marijuana or the cultivation of up to six female plants characterizes personal use. However, this presumption is relative and can be challenged if there is evidence of trafficking intent, such as the presence of scales, packaging, or sales records. (Federal Supreme Court)

This decision represents a milestone in drug policy in Brazil, aligning with approaches that prioritize public health and education to the detriment of the criminalization of the user. However, the consumption of marijuana remains illegal, and administrative measures aim to discourage its use, promoting awareness of the possible associated harms.

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4.1 Brazilian Drug Policy Platform – An Organized Social Movement

Composed of Civil Society Organizations and academic associations, the Brazilian Platform on Drug Policies (PBPD) is a national network with the aim of producing political and technical advocacy in favor of drug policy reform in Brazil, proclaiming the reduction of inequalities and the guarantee of human rights to people and communities harmed by the 'war on drugs'.

Contrary to the current drug policy, the PBPD presented in 2022 an emergency agenda for the end of the war on drugs in Brazil and in this year 2024 the Brazilian Agenda for Drug Policy was prepared, with propositions arising from listening and collective dialogues with people who use psychotropic drugs, with activists, researchers and members of Civil Society Organizations related to drugs, human rights, health and safety. They emphasize that their proposals are in line with the democratic rule of law, advocating the broad participation of civil society for national consultations and conferences.

They set the objective of stimulating policies that will guarantee the dignity and citizenship of drug users, who should have the effective right to health and treatment in freedom, guaranteeing their autonomy.

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In this regard, they present as argumentative, guiding and grounding principles, the failure of the repression policy, which would not have achieved the objective of reducing the consumption and trade of drugs in the name of protecting the health of the population, and therefore defend: i) the change of focus from the substance to the user, prioritizing actions aimed at harm reduction; ii) broad social participation in the formulation, implementation and evaluation of policies and programs, promoting a qualified debate based on scientific evidence; iii) respect for freedom and the individual with guidance on what is a human right, prioritizing the promotion of public health, social and economic development, education and reduction of all types of violence (Platform website, 2024).

5. The Public Security System, Criminal Justice in Brazil

The public security system in Brazil is made up of a wide range of institutions, each with different responsibilities. The law that established the Unified Public Security System (SUSP) in 2018 reorganized the functions of the police and the Ministry of Justice and Public Security (MJSP). The SUSP is composed of the Federal Police, Federal Highway Police, Military and Civil Police, in addition to the Criminal Police and Municipal Guards.

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These institutions, however, face major challenges of coordination and cooperation. A clear example of this is the division between the Military Police, which acts in a preventive and ostensive manner, and the Civil Police, responsible for investigations. The lack of integration between these institutions often results in overlapping efforts, waste of resources and, in many cases, conflicts of competence.

One of the main structural problems of the Brazilian public security system is the lack of effective communication between police institutions and the judiciary. This results in a widespread public perception of impunity. Expressions such as "the police arrest, the justice system releases" reflect this sentiment, which is fueled by cases of violent crimes where those responsible are rarely punished.

Despite the increase in incarceration, especially for drug trafficking, many violent crimes remain unpunished due to the difficulty of investigation. Crimes caught, such as drug trafficking, are more likely to result in conviction, while crimes that require in-depth investigations, such as homicides, often go unsolved. This dynamic strengthens the sense that the criminal justice system is ineffective.

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6. Impacts Of Licit and Illicit Drugs: Individual, Social and Public Health Costs

The individual harmful effects resulting from drug use cannot be attributed only to illicit drugs, since personal health is affected by both licit and illicit substances, causing physical, mental and psychological damage to the user. Add to this the social damage related to drug use, such as physical aggression, car accidents, unemployment, cost and overload on the health network. In this vein, Nutt (2010 *apud* Baldini, 2023) concludes that alcohol, a legal drug, is the most harmful.

Another licit drug, but no less harmful is tobacco, which according to the Pan American Health Organization (PAHO) in a report on the control of the substance in the region of the Americas (2022), represents a risk factor for four of the most prevalent diseases in the world, in addition to transmissible ones, namely, cardiovascular diseases, diabetes, cancer, and chronic respiratory diseases.

Ronaldo Laranjeira (2010) states that dependence, seen as a disease, results from the initial voluntary use and culminates in the compulsion that destroys the quality of the person himself and corrodes his family relationships and with society. It argues that the affectation in brain mechanisms modifies mood, memory, perceptual cognition and emotional states, however, it

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rejects the stigmatization of the user as a defenseless victim without responsibility, on the contrary, because it understands that dependence is the result of a voluntary onset, the addict has great responsibility for his behavior and for his own recovery.

Analyzing the data recorded in the II Brazilian Report on Drugs (2021), it is possible to see the evidence of several pathologies and mortality associated with the use of licit and illicit drugs with a correlation of costs to public health. As a single example, in 2015, the number of deaths associated with the use of illicit drugs, adding all types of substances, represented only five percent of the total, where the other ninety-five percent were associated with the use of alcohol and tobacco.

7. The Role of Drug Law in Increasing Incarceration And The Impact of Impunity

The Drug Law of 2006 aimed to reduce the incarceration of users, by decriminalizing the possession of drugs for personal use. However, the practical effect was the opposite: incarceration increased significantly, especially among small-time traffickers. The distinction between "user" and "trafficker"

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is often subjective and depends on the interpretation of the police officers involved.

Elements such as the amount of drugs, the type of drug, the form of packaging, the presence of money and the place of the flagrante are used by the authorities to classify whether a person is a user or a trafficker. In many cases, this classification does not take into account individual circumstances, resulting in a disproportionate application of the law, which hits young black people from the peripheries hardest.

The research by Maria Gorete Marques de Jesus (2018) highlights how military police officers are often the main witnesses in trafficking cases, since there are no direct victims as in other types of crimes. In this way, the reports of the police officers are decisive for the conviction.

Impunity in violent crimes in Brazil is one of the most critical problems facing the criminal justice system. Studies show that crimes such as homicides and violent assaults have low resolution rates, which is due, in part, to the complexity of investigative processes. These crimes require detailed investigations, robust evidence, and long investigation periods, which makes it difficult to conclude the judicial process until conviction.

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On the other hand, crimes caught, such as drug trafficking, follow a simpler procedural flow, with high conviction rates. In these cases, the main evidence is the flagrante delicto itself, in which the police officers who make the arrest become the main witnesses in the trial. This results in a differential treatment between violent crimes and caught crimes, which contributes to the disparity in resolution rates.

In addition, the concentration of efforts by security forces on crimes that involve immediate flagrante delicto, such as the trafficking of small amounts of drugs, ends up neglecting more serious and violent crimes that require more complex investigations. This imbalance in the treatment between flagrantly discovered crimes and those that require investigation contributes to the perpetuation of violence in the country and to the public perception of the ineffectiveness of the justice system.

The consequences of this impunity are wide-ranging. It reinforces the population's sense of distrust in public institutions, fuels disbelief in the State's ability to control crime and, in many cases, leads to the search for extralegal solutions, such as the increase in private security mechanisms.

The rise of criminal factions in Brazil, such as the Red Command (CV) and the First Capital Command (PCC), is

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directly related to the failures of the Brazilian prison system. These criminal organizations emerged inside prisons in the 1970s and 1980s, initially as a response to inhumane conditions inside prisons, and later expanded to control drug trafficking.

The strengthening of these factions is one of the biggest challenges for public security in Brazil. Prisons have become a conducive environment for the expansion of these organizations, which use the lack of state control as an opportunity to recruit new members and organize their operations. Drug trafficking, which is one of the main sources of financing for these factions, continues to fuel high rates of violence in the country.

8. Results and Discussion

The central discussion of the work addresses the impacts of the 2006 Drug Law (Law No. 11.343/2006) in Brazil, with a critical look at the following points:

Effects of the Drug Law on the Criminal Justice System:

- Although the Law has decriminalized the use of drugs for personal consumption, in practice, it has increased incarceration, especially of small dealers.
- The lack of objective criteria to differentiate users from dealers has generated subjective interpretations on the

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part of the authorities, which has disproportionately affected black and poor young people from the peripheries.

Racial Bias and Social Inequality:

- The application of the law reflects structural racism in Brazil, where the black population is the most impacted by the criminalization of drug use and trafficking, highlighting inequalities in the criminal justice system.

Impact of Prohibitionism:

- The prohibitionist policy focused on repression failed to achieve its objectives of reducing drug consumption and trade.
- The repression has strengthened criminal factions, which use the prison system as a space for recruitment and organization.

Challenges of the Public Security System:

- The lack of integration between police institutions and the judiciary generates inefficiency in the fight against violent crimes.
- The concentration of efforts on crimes caught, such as the trafficking of small amounts of drugs, neglects more complex investigations, such as homicides, reinforcing the sense of impunity.

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Proposed Alternatives:

- Social movements, such as the Brazilian Platform on Drug Policies (PBPD), defend a model based on harm reduction, with a focus on public health, social shelter and the guarantee of human rights.
- The recent decision of the Federal Supreme Court (STF), which decriminalized the possession of small amounts of marijuana for personal use, is highlighted as a milestone in the attempt to reduce the negative effects of criminalization.

The work discusses the ineffectiveness of the Brazilian prohibitionist model, the negative effects of the Drug Law on the vulnerable population and the public security system, in addition to bringing reflections on the need for alternative policies that consider public health and social justice.

Final Considerations

This study aimed to present a comprehensive view of the issue of drugs, focusing on public policies adopted at the national and international levels, correlating them with health. A brief history of the beginning of the regulations was outlined, the current public policy was explored, the social movements

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involved were discussed and the harm associated with drug use was analyzed.

In this context, it was observed that the national drug policy is strongly influenced by the global trend of an interventionist State, with emphasis on repression and prevention, based on the prohibition of substances. At the same time, organized social movements propose alternative models, advocating differentiated approaches to treatment and a drastic change in the direction of current policies.

Furthermore, this work does not intend to determine which model is the most appropriate or correct, nor to defend any specific approach. The objective is only to present clarifications and arguments that allow a broader understanding of the different ways of facing the problem.

Elements were presented that aim to stimulate a critical reflection on the model currently recommended in the standards and written plans, confronting it with the reality of its practical application. This comparison allows us to ponder on the effectiveness of the current policy and to assess whether it is effectively achieving the objectives it proposes.

It is indisputable that issues related to drugs, whether licit or illicit, are harmful to health. As initially mentioned, this work was not intended to encourage or promote drug use, nor drug

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trafficking, but rather to foster a critical and informed discussion on the subject.

In summary, two main approaches to dealing with the drug issue were identified: one with an emphasis on criminal justice, focused on repression and control, and another focused on public health and social welcoming. The choices between these strands are profoundly influenced by moral values, public policies and criminological perspectives, especially with regard to the phenomenon of violence associated with drug trafficking.

The 2006 Drug Law, despite its initial intention to reduce prison sentences for users, resulted in a substantial increase in incarceration, particularly of small-time dealers. In addition, the law exacerbated racial inequities in the criminal justice system, with Black and poor people disproportionately affected.

The challenges faced by the Brazilian public security system are numerous: lack of coordination between institutions, perception of impunity, overcrowding of prisons, and the strengthening of criminal factions. The country needs to rethink its drug policies and seek more effective solutions to address these structural issues that compromise justice and public security.

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DECENTRALIZATION AND REGIONALIZATION OF HEALTH ACTIONS AND SERVICES AND THE CORRELATION BETWEEN SDG, IEG-M AND IGM SUS-SP[1]

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Abstract

The use of off-label medications, defined as the prescription of drugs for purposes not specified in the label approved by regulatory agencies, is a growing practice in contemporary medicine. This phenomenon is often linked to the lack of alternative therapies or the existence of favorable scientific evidence; however, it raises concerns regarding safety and efficacy. The central issue lies in the judicialization of healthcare, where patients seek access to off-label medications through legal action, burdening the healthcare system and creating complex legal precedents. This study aims to analyze the regulation, challenges, and legal implications of off-label drug use in Brazil, with a comparative analysis between Brazil, the United States, and the European Union. The methodology includes a literature review and documentary analysis of legislation, case law, and scientific studies on the topic. The results indicate that the lack of clear regulation in Brazil contributes to inconsistent and unsafe practices, in addition to intensifying judicialization. In contrast, the United States and the European Union adopt distinct but equally rigorous approaches to the regulation of off-label use. It is concluded that more robust regulation and the establishment of strict criteria for off-label prescriptions may reduce risks and mitigate the negative impacts of judicialization in Brazil, promoting greater safety for patients and healthcare professionals. The differences between the regulatory frameworks of the Brazilian Health Regulatory Agency

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(ANVISA), the United States Food and Drug Administration (FDA), and the European Medicines Agency (EMA) highlight the need for ongoing debate on the role of regulatory agencies, medical professional autonomy, and patient protection, especially in the face of increasing judicialization of healthcare.
Keywords: Health services. Public health policies. Unified health system. Right to health.

1. Introduction[4]

Initially, in a positivist and post-positivist analysis, it is understood that the right to health is essential in human life as it is related to all other fundamental rights and guarantees, and is correlated with the eradication of poverty and the reduction of social and economic inequalities (art. 1, III, art. 3, III, of the Federal Constitution). The Federal Constitution also provided for the regionalization and decentralization of health services as a measure to provide more effective and higher quality care to citizens. The Unified Health System (SUS) also brings this idea of regionalized health management (art. 198 of the Federal Constitution).

Based on this approach, and with a view to the structure of Federalism in Brazil, it is important to analyze all federated entities; however, when dealing with the right to health, the focus should be on the municipality and the public policies that

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have been implemented: the purpose is to increase awareness of the adjustments necessary for better quality in the provision of health services, in addition to intergovernmental transfers. The objectives that encourage these policies must be observed and contextualized, and the parameters for determining the real effectiveness of these objectives must be highlighted to better understand this interconnection.

It's time to understand the reasons why the indices don't show the best results in health care, even with so many investments directed to this purpose and so many public policies, in various spheres of the federation, with the same scope, and to envision possible solutions for improving services.

The purpose is to discuss the intersection between public health policies, the Sustainable Development Goals (SDGs) and municipal management effectiveness indices, especially in the Brazilian and São Paulo context. The purpose was to analyze whether public health policies must be aligned with the Federal Constitution, seeking to guarantee universal and equal access to health services. In this sense, the SDGs, established by the UN, seek to promote social, economic and environmental improvements, including health and well-being

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as one of the main objectives. However, there are challenges in effectively implementing these policies, especially at the municipal level, where the management and application of measures have a direct impact on the lives of citizens. The Court of Auditors of the State of São Paulo developed the Municipal Management Effectiveness Index (IEG-M) and the Municipal SUS Management Effectiveness Index (IEG-SUS), in addition to I-SAÚDE. They are tools to assess the effectiveness of municipal public policies, providing managers with insights on areas that need improvement.

Given this scenario of importance of the municipality, the purpose is to analyze the importance of decentralization and regionalization in health management, highlighting that municipalities play a fundamental role in this process. Regionalization seeks to reduce inequalities and adapt health policies to local needs, allowing each municipality to develop specific strategies to improve access to and quality of health services. However, there are challenges in effectively implementing these policies, including the lack of autonomy and adequate financial resources for municipalities. Therefore, in order to guarantee an effective right to health, there is a discussion on the role of the autonomy of municipalities, their expertise, the appropriate use of financial

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resources and cooperation with other federated entities, thus enabling the adaptation and continuous improvement of public health policies.

The purpose of this study is to evaluate the impacts of the federative form and the Democratic State on the fulfillment of individual rights and guarantees, especially the right to health, and how this right correlates the federative entities, determining the competence of each of them to ensure the provision of such service.

It seeks to verify the issue of public policies aimed at health actions and services and their correlation with the Sustainable Development Goals, established by the UN in 2015 and indicators relevant to the matter, such as the IEG-M and the IEG-SUS, highlighting their relevance in this context.

It also aims, in light of these indices and indicators, to determine the relationship and role of Municipalities within the Federative Republic of Brazil, as well as an analysis of the effectiveness of the right to health, in light of decentralization and regionalization measures to avoid the dysfunctionality of public health policies.

Finally, it aims, in light of these indices and indicators, to analyze the search for mitigating inequalities, with the

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regionalization of health, taking into account local issues and distributing funds for this purpose.

This research adopted a post-positivist theoretical approach and a qualitative bias, based on the inductive method. Data collection was based on a bibliographic and documentary review through the consultation of scientific sources, legislation and public data made available by the Court of Auditors of the State of São Paulo (TCE-SP), with a brief comparison between the increase in transfers and the efficiency of health indices in the municipalities of the State of São Paulo.

2. The relationship between Federalism and fundamental rights

The Federal Constitution of 1988, in its first article, provides that the Federative Republic of Brazil will be formed by the indissoluble union of the States and Municipalities and the Federal District and constitutes a Democratic Rule of Law.

The Federal State can be considered as an alliance signed between its autonomous and independent units. The Federal Constitution defines the attributions of each one, as well as the legislative competence of those who make up this Federation. This is a decentralization, with no hierarchical

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relationship between members and true autonomy, especially in relation to self-organization (Souza, 2020, p. 36). Silva highlights that if there is a division of power in the territorial space. With a multiplicity of autonomous government organizations, with regional distribution, there is a Federal State (2009, p.33).

It is worth mentioning that federalism has as its essence the idea of equality, freedom and protection of human rights. This can be seen in the wording of article 5, inserted in the title of fundamental rights and guarantees, which provides for the equality of all people before the law, without distinction of any nature, guaranteeing everyone, including foreigners residing in the country, the right to life, liberty, equality, safety and property.

In this regard, it is important to highlight the role of federalism and the way in which the characteristics of this state model influence the implementation of fundamental rights, more specifically in relation to the social right to health provided for in article 6 of the Federal Constitution.

Fundamental rights become the main objectives of a democratic state governed by the democratic rule of law. Nery Junior and Nery (2014, p. 227) emphasize that fundamental and human rights are imperative elements for the exercise of

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democracy, that is, they are founding norms of the Democratic State and their violation would disrespect the democratic regime itself.

Neme comments that the idea of democracy, in which there is an exercise of legitimate power, is intrinsically linked to the decentralization of Power and the existence of autonomous powers, of a greater approximation between citizens and their elected representatives, with greater participation and greater legitimacy in the exercise of their function (2007, p. 104).

In this way, it is possible to understand that the proportion of implementation of fundamental rights is directly linked to respect for federative principles. That is to say, if the basic elements that configure a form of State as federative are duly fulfilled, the fundamental guarantees and rights will be duly implemented, efficiently.

With this consideration, it is important to mention the characterization of the right to health as a fundamental right, considered as a right provided by the State, which must provide the health service, as it is a subjective public right in the face of the State (Lima and Pessoa, 2009, p. 38).

Consequently, health, which is considered a social right, is also considered a fundamental human right, expressly

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provided for in this way in article 2 of Law 8080 of September 19, 1990 (Organic Health Law), and the State must provide the conditions necessary for its full exercise.

Therefore, in order to be in accordance with the fundamental principles of federalism, the democratic rule of law and a balanced and fair political system, it is essential to promote fundamental rights.

3. Municipalities as entities of the Federation and executors of the fulfillment of fundamental rights, especially the right to health

After highlighting these aspects, it is important to understand how the Brazilian federal system is structured, especially with regard to municipalities. Article 18 of the Constitution reflects how the political and administrative organization of the Federative Republic of Brazil works, encompassing the Federal Government, States, Federal District and Municipalities, all of which are autonomous.

Article 29 of the Federal Constitution provides the basis for municipal autonomy, stating that the Municipality will be governed by Organic Law and Article 30 contains the powers assigned to these entities, with its item VII highlighting the provision, with the technical and financial cooperation of the

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Federal Government and the State, of health care services to the population.

It is possible to verify that the Constitution confers the status of a federated entity on the Municipality, based on the definition of the organization and by mentioning the indissoluble union of the Federal Government, States, Federal District and Municipalities.

Silva disagrees, as he understands that there is no Federation of Municipalities, highlighting that it is not because a territorial entity has constitutional political autonomy that it necessarily integrates the concept of “federative entity” (2009, p. 249).

However, despite not having their own Judiciary, the Federal Constitution endowed municipalities with autonomy (political-administrative organization, article 18) and defined their legislative and administrative powers (article 30), which inevitably provides an approach to the citizen who can participate more actively, with their representation assured, in search of the effectiveness of democratic ideals and preservation of individual freedoms.

Neme (2007, p. 116) highlights that the greater the political freedom, the greater the municipal powers, and the smaller the political freedom, the lower the degree of autonomy of this

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federated unit. Within this context, article 4 of Law 8080, of September 19, 1990, states that the set of health actions and services provided by federal, state and municipal bodies and institutions of direct and indirect Administration constitutes the Unified Health System (SUS).

Regarding the functions of each federated entity with regard to the social right to health, according to José Angelo Machado and Pedro Lucas de Moura Palotti:

> The Federal Government is responsible for coordinating, standardizing and defining national standards for government action in the health sector. The states were entrusted with the coordination and complementary regulation of their spheres, in addition to monitoring, evaluating and controlling the regionalized networks of the Unified Health System (SUS), as well as technical and financial support, while the municipalities were entrusted with "planning, organizing, controlling and evaluating health actions and services and managing and executing public health services" (article 18, item I of Law 8080/90) (2015, p. 88).

The Municipality is responsible for planning, organizing, controlling and evaluating health actions and services and managing and executing public health services. Law 8080/90, in its article 7, also establishes that such actions and services must be developed in accordance with article 198 of the Federal Constitution, in accordance with, as one of the principles, in its item IX, the political-administrative

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decentralization, with a single direction in each sphere of government: a) emphasis on the decentralization of services to the municipalities and; b) regionalization and hierarchization of the health services network.

As can be seen from this division of competences, the Municipality is responsible for the largest sphere of practical services regarding the right to health, as this is where public policy effectively takes place. The Federal Government and the States are briefly responsible for coordinating and defining national and state standards.

However, some issues must be observed, as the decentralization of public policies, the transfer of resources and the sharing of tax revenues do not in themselves generate stabilization between federated entities or greater effectiveness in relation to fundamental rights. Rammê (2015, p. 2319) explains that there is a strong imbalance between revenue generation and the responsibilities of States and Municipalities in the administrative sphere, thanks to an absurd regulatory and collection centralization, and on the other hand an excessive political-administrative decentralization.

In this area, it is important to focus on the issue of public policies to understand whether such context effectively

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generates useful results that guarantee the fundamental right to health. Likewise, it is important to observe whether regional inequalities and local peculiarities are respected in this configuration, since the Federal Government and the States define some standards and norms to be respected.

4. Public policies for health actions and services and the Sustainable Development Goals

Public policies can be considered as all acts, actions, programs and plans determined by the Government to meet a certain social demand, in compliance with the provisions of the Federal Constitution, both in relation to the objectives of the Republic, provided for in article 3, and in relation to fundamental rights and guarantees.

What is generally observed is the problem of the Public Power in establishing its goals and priorities and linking them to good public policies, as well as the evident difficulty related to establishing parameters and indicators of results, capable of demonstrating the real effectiveness of a given public policy. There is a certain deficiency in the country in relation to the measurement of these policies, and even in the case of indicators, difficulties are observed in the use of this data, to

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promote substantial improvements in well-being and disease prevention.

And, it should be noted that the Federal Constitution itself mentions that health will be guaranteed through social and economic policies, aiming at universal and equal access to actions and services for its promotion, protection and recovery (article 196) and considering the public relevance of health actions and services (article 197), with the Public Power having to regulate, monitor and control. In other words, health is a public service, which must be provided by the State.

Avanci (2021, p. 212) portrays that public policies are the way in which rights are realized and must be developed in compliance with the precepts previously conceived in the Federal Constitution, in perfect alignment with material equality and solidarity, with a focus on the eradication of poverty, a national objective provided for in item III of article 3 of the Federal Constitution.

The eradication of poverty, in fact, is listed as the first objective of the SDGs (Sustainable Development Goals), a commitment established in 2015 by several countries within the scope of the United Nations, with the commitment to implement the 2030 Agenda.

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There are 17 Sustainable Development Goals, namely: poverty eradication; zero hunger and sustainable agriculture; health and well-being; quality education; gender equality; clean water and sanitation; clean and affordable energy; decent work and economic growth; industry, innovation and infrastructure; reducing inequalities; sustainable cities and communities; responsible consumption and production; action against global climate change; life on water; life on land; peace, justice and effective institutions and; partnerships and means of implementation.

When mentioning sustainable development goals, it can be interpreted as if such premises were directed only at the environment. However, the social and economic dimension must be observed, since the three pillars of the SDGs are economic growth, social inclusion and environmental protection, which involves major issues and several fundamental rights and guarantees. The purpose is to provide people with a more sustainable world of peace and prosperity.

In view of these objectives, each country develops its plans, strategies and programs to achieve the established goals, and must monitor the development of implementation. Here, the relevance of municipalities stands out, since, as previously mentioned, it is the place where public policy

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effectively takes place and the sphere closest to the population, and is therefore the one that will generate effective results data.

The 2030 Agenda, which consists of the final compilation of all this work on the practical application of the Sustainable Development Goals, encourages a serious analysis of qualitative and quantitative indicators, with evidence-based management and with the purpose of combating poverty and social inequalities. This agenda endorses the importance of local, municipal power, enabling the establishment of democratic mechanisms in which citizens can debate and propose improvements for the community.

Among the seventeen (17) sustainable development goals, only after the eradication of poverty (SDG 1) and zero hunger and sustainable agriculture (SDG 2), there is a focus on health and well-being (SDG 3). Therefore, it is of great importance to understand the goals and objectives of this Sustainable Development Goal as set out in the 2030 Agenda available on the UN website and which are mentioned below (Brazil, 2015).

The SDG 3 goals consist of drastically reducing maternal mortality (3.1), ending preventable deaths of infants and children (3.2), and combating diseases such as acquired

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immunodeficiency syndrome (AIDS), tuberculosis, malaria, hepatitis, among other communicable diseases (3.3). It also aims to reduce premature deaths from non-communicable diseases (3.4), such as hypertension and diabetes, by one third. Since the use of alcohol, tobacco and drugs are serious public health problems, they are also targeted by this SDG (3.5). Finally, deaths in traffic situations are another concern, expressed in goal 3.6. Access to health systems and the prevention and protection system for the well-being of citizens are addressed here in this SDG (3.7), as well as new vaccine developments and research to improve health on the planet (3.b).

The specific goals to be achieved by 2030 (2030 Agenda) in SDG 3 are as follows: 3.1 by 2030, reduce the global maternal mortality ratio to less than 70 deaths per 100,000 live births; 3.2 by 2030, end preventable deaths of newborns and children under 5, with all countries aiming to reduce neonatal mortality to at least 12 per 1,000 live births and mortality of children under 5 years old to at least 25 per 1,000 live births; 3.3 by 2030, end the epidemics of AIDS, tuberculosis, malaria and other communicable diseases; 3.4 by 2030, reduce by one third premature mortality from non-communicable diseases (NCDs) through prevention and treatment, and

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promote mental health and well-being; 3.5 strengthen the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol; 3.6 by 2020, halve global deaths and injuries from road accidents; 3.7 by 2030, ensure universal access to sexual and reproductive health services, including family planning, information and education, as well as the integration of reproductive health into national strategies and programs; 3.8 achieve universal health coverage (UHC), including financial risk protection, access to quality essential health services and access to safe, effective, quality and affordable essential medicines and vaccines for all; 3.9 by 2030, substantially reduce the number of deaths and illnesses from hazardous chemicals, air and water pollution and soil contamination.

In addition: 3.a strengthen the implementation of the Framework Convention on Tobacco Control in all countries, as appropriate; 3.b support the research and development of vaccines and medicines for communicable and non-communicable diseases, which mainly affect developing countries, provide access to essential medicines and vaccines at affordable prices, in accordance with the Doha Declaration, which affirms the right of developing countries to make full use of the TRIPS provisions on flexibilities to protect public health

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and, in particular, to provide access to medicines for all; 3.c substantially increase health financing and the recruitment, development and training, and retention of health personnel in developing countries, especially in the least developed countries and; 3.d strengthen the capacity of all countries, particularly developing countries, for early warning, risk reduction and management of national and global health risks.

5. The interconnection between the SDGs, the IEG-M and the IGM-SUS-SP

The sustainable development goals are those created by the United Nations (UN) in 2015, with the purpose of improving the lives of the entire nation, including SDG 3, which deals with health and well-being, and with the purpose of achieving goals set out in the 2030 Agenda.

Municipalities are extremely relevant to the applicability and understanding of the SDGs, as local governments play an essential role in implementing and managing these policies, which have a direct impact on the lives of citizens and meet the objectives established by the UN.

Given this overview, it is still relevant to mention that in the State of São Paulo, the Court of Auditors has used the SDGs effectively, verifying their implementation by the City Halls of

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São Paulo (except the Capital) and by the Government of the State of São Paulo.

The Courts of Auditors were created by the Federal Constitution which, in article 71, provided that external control, which is the responsibility of the National Congress, would be exercised with the assistance of the Federal Court of Auditors and also, in article 75, provides that the rules established in that section apply to the organization, composition and supervision of the Courts of Auditors of the States and the Federal District, as well as the Courts and Councils of Auditors of the Municipalities.

Thus, the Court of Auditors of the State of São Paulo consists of an external control body of the Public Administration; its attributions are set out in the Constitution of the State of São Paulo (articles 31, 32 and 33), in the State Complementary Law No. 709, of January 14, 1993 (Organic Law), and in the Internal Regulations itself.

The IEG-M (Municipal Management Effectiveness Index) was also created in 2015 by the Court of Auditors of the State of São Paulo, as stated in the 2024 yearbook (2012-2022 fiscal years) as an indicator to analyze the effectiveness of public policies in São Paulo city halls. The index measures seven sectors of administration, which are health, planning,

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education, fiscal management, citizen protection (Civil Defense), environment and governance in information technology and provides an information parameter for evaluation by the Court of Auditors of the State of São Paulo, which acts as an auditor of municipal accounts and reflects possible deficiencies to managers so that they can improve some actions and planning (Brazil, 2024, p. 7/8).

Among these items that are evaluated, there is the aforementioned I-SAÚDE, which is responsible for measuring the results of the health area, through questions related to Primary Care, Family Health Teams, Municipal Health Councils, treatments and vaccination (Brazil, 2024, p. 9).

Like the SDGs, the IEG-M functions as a tool capable of helping the Public Administration to evaluate its public policies, to verify the most efficient and effective ones, and is a relevant instrument of transformation and social development. The convergence between the IEG-M and the Sustainable Development Goals of the 2030 Agenda is enormous. Of the 17 internationally defined SDGs, 9 are included in the IEG-M. In addition, another 31 items address issues directly linked to the goals set by the pact.

It turns out that, despite the existence of two such relevant instruments, as well as increased transfers from the Federal

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Government and States to Municipalities to invest in the health area, what is still observed is a low effectiveness of Municipal management, as shown in the result of the IEG-M 2023 (base year 2022) presented by the Court of Auditors of the State of São Paulo (TCESP), since of the 644 municipalities inspected, only 52 presented a grade B (Effective), another 223, a grade C+, and 369, a grade C. No municipality presented a grade A (Highly Effective) or B+ (Very Effective)[5].

In relation to I-SAÚDE, the result was 0 municipalities with grade A, 20 municipalities with grade B+, 227 grade B, 238 grade C+ and 159 grade C. In other words, the majority of municipalities are in the adequacy phase.

Given this overview, it is important to bring up issues related to the IGM-SUS-SP, which consists of an incentive to municipal management, to promote the regionalization and decentralization of health services, in compliance with the provisions of article 198 of the Federal Constitution, and with

[5] A (highly effective - IEGM with at least 90% of the maximum grade and at least 5 indices with grade A)
B+ (very effective - IEGM between 75.0% and 89.9% of the maximum grade)
B (effective - IEGM between 60.0% and 74.9% of the maximum grade)
C+ (in the process of adequacy - IEGM between 50.0% and 59.9% of the maximum grade)
C (low level of adequacy - IEGM less than or equal to 49.9%)

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the purpose of improving health services provided to citizens, with consequent improvements in the indices and items listed.

This is because each municipality has its own regional peculiarities, derived from local issues, and the health of the population is directly affected by such specificities.

The purpose of health regionalization is precisely to reduce regional inequalities, because we can see what the obstacles are and adapt from there. The IGM-SUS increases the allocation of resources to municipalities with the purpose of improving health management and the program is structured in a staggered manner, according to the vulnerability of each city. This means that transfers will be made according to the municipality's placement in six different classification bands, following six vulnerability indicators.

Some regions that, in the first cycle, hosted Regionalization Workshops were the municipalities of Bauru, Taubaté and Marilia, and in the I-Saúde of each one, respectively, the grades were C+, grade B and grade B in the I-Saúde of the Court of Auditors of the State of São Paulo. The expectation is that with the increase and targeting of these transfers, the right to health will be better assured and the rates will improve considerably.

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In view of the above, the importance of regionalization programs, capable of analyzing the vulnerability indicators of each specific location and with the primary purpose of improving the right to health, cannot be overlooked.

An intergovernmental effort is needed that involves the Federal Government, State, Federal District and Municipality, all as entities of the federation, so that greater effectiveness of the right to health can be provided.

Furthermore, the decentralization of the responsibilities of federated entities is a necessary measure when it comes to the right to health, characterized as centrifugal federalism, capable of mitigating inequalities and generating a more democratic society. Rammê (2015, p. 2308) defines centrifugal federalism as the tendency to preserve and strengthen local power, instead of focusing on central power, thus diluting the powers, responsibilities and competencies concentrated in the federal sphere (Federal Government) among the federated entities.

The idea of decentralization and regionalization brings the character of a regional, local focus to the municipality. In the current federal situation, municipalities are responsible for a whole range of activities related to the right to health, such as planning, organizing, controlling, executing, and these

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peculiarities are not always respected, since the Federal Government and the State define general standards and policies that, often, defend only their own interests.

Figueiredo (2012, p. 246) highlights the need for effective autonomy for the federated units, not only in relation to the ability to set the profile of their expenses, but also to pay for them.

It is possible to observe then that, given the way in which the Federative Republic of Brazil is structured, some obstacles are present in the achievement of the rights to health and improvements in people's quality of life. This is because, often, the federative entity that structures the system, coordinates and defines general standards is distant from the local and divergent realities of the country.

Khamis and Sartori (2017, p. 309) emphasize that the structuring of health federalism in Brazil (which is decentralized, centrifugal) is out of step with the national federative option (which is centralizing, centripetal). This means that the executing entity, that is, the Municipality, does not have the necessary structure to manage health services, nor does it have the flexibility to make the adaptations and adjustments – financial and regulatory – that are necessary in the day-to-day activities.

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And the actions of municipalities are beneficial to the effectiveness of public policy, and they are responsible not only for implementing it, but also for providing all the planning and monitoring the execution with a view to obtaining data on the efficacy and effectiveness of the measures that will later become part of indices such as the IEG-m of the TCE-SP.

Furthermore, the TCE-SP issued a decision regarding the 2017 municipal accounts of Palmeira D'Oeste, which received a grade of C in the IEG-M assessment, considered to be a low level of adequacy, and the Rapporteur Counselor Dr. Renato Martins Costa highlighted that public services must be "directly related to the demands of the citizens, and therefore it is urgent to carry out prior surveys and studies that support planning and the establishment of quantifiable goals, capable of continuous monitoring and control".

Therefore, it is clear that the entity implementing public health policies, namely the municipality, must have autonomy, expertise, budget availability, cooperation with other federated entities, structure and flexibility for local adaptations, if necessary, so that there is an effective and efficient right to health.

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Final considerations

In view of all of the above, it is possible to observe that all federated entities are directly and intrinsically linked to each other, with the objective of ensuring the provision of the social right to health, as well as guaranteeing the federative form of the State and the democratic rule of law. In this area, the Federal Government, member states, Federal District and Municipalities are connected by common legislation, intergovernmental transfers, public policies, and measures of national and general scope to serve the population.

Fundamental rights are met proportionally in accordance with compliance with the basic premises that constitute the Federation and the democratic rule of law and are closely related to bringing citizens closer together, thus making it possible to guarantee greater promptness and effectiveness of social rights.

The UN created the Sustainable Development Goals aiming to ensure a more just, free and egalitarian society, with several goals to achieve the purpose set out in the 2030 Agenda. The Court of Auditors of the State of São Paulo, in turn, linked to the SDGs, created the IEG-m, with the main purpose of being an indicator of the effectiveness of public policies in municipalities.

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A measure that emerged to contribute to the effectiveness of public spending was the creation of the IGM-SUS-SP, which provided an increase in transfers focused on meeting regional demands, based on assessments and workshops on health regionalization, with the creation of vulnerability indicators.

However, what we can see is that despite many efforts made towards the common good, with the intention of improving the rates of provision of health services, many difficulties still exist. The structuring of the federative state form as it is not fully competent and has an impact on the right to health. Apparently, there is a dysfunctionality in public health policies and regional inequalities need to be mitigated. It turns out that municipalities bear all the demand for health services and often depend on intergovernmental transfers to minimally address this issue.

In municipalities, public policies effectively take place, even with the lack of and dependence on external resources, but autonomy is necessary to make decisions that are adapted to local circumstances, with respect to mitigating regional inequality.

It would also be relevant to mention a greater interrelation and collaboration between the federated entities, capable of

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providing effective joint work to deliver a quality public policy, a cooperative model of federalism and not a competitive one, considering a geographical decentralization of power with a view to a more democratic society.

Finally, it would also be interesting, in this idea of democracy, for the population to have more active participation in the formulation and monitoring of public policies, with greater proximity between citizens and elected representatives, thus generating greater legitimacy in the exercise of the function.

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THE USE OF ARTIFICIAL INTELLIGENCE (AI) IN VARIOUS MEDICAL SPECIALTIES: CURRENT TRENDS, PERSPECTIVES, AND PROPOSAL FOR REGULATORY PUBLIC POLICY [1]

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The Use of Artificial Intelligence (AI) in Various Medical Specialties: Current Trends, Perspectives, and Proposal for Regulatory Public Policy
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Abstract

This paper explores the various applications of Artificial Intelligence (AI) in medicine, highlighting its growing impact and implications for medical practices. AI has become one of the most disruptive innovations in recent decades, with the ability to analyze large volumes of data, learn from them, and make autonomous or semi-autonomous decisions, which promises to transform how medical treatments are performed. The paper examines current trends in AI across different specialties, such as medical imaging, personalized medicine, and hospital management, as well as discussing the ethical and regulatory challenges associated with these technologies. It also addresses the potential benefits of AI, including improved diagnostic accuracy, optimized treatments, and reduced medical errors.

However, the use of AI in medicine faces challenges such as the lack of high-quality data, resistance from healthcare professionals, and the need for regulation to ensure patient safety and privacy. The paper proposes a regulatory public policy that addresses these issues and ensures the responsible use of AI, promoting collaboration among researchers, healthcare professionals, and legislators to shape the future of medicine with AI in an ethical and effective way. This study offers a comprehensive view of the opportunities and obstacles associated with AI implementation in the medical field, emphasizing its relevance to the future of healthcare.

Keywords: Disruptive Technology, Digital Transformation in Healthcare, AI Ethics, Precision Medicine, Medical Innovation Regulation.

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Introduction

Historically, medicine has relied on scientific evidence and more generalized approaches, with treatments applied broadly to patient groups.

Artificial Intelligence (AI) has established itself as one of the most disruptive innovations in recent decades, having a profound impact in various areas, especially in medicine. Its ability to analyze large volumes of data, learn from them, and make autonomous or semi-autonomous decisions has the potential to significantly transform medical practices (WHO, 2024).

The main goal of this paper is to explore the various applications of AI in different medical specialties, highlighting current trends, challenges, and potential for future developments. This study includes the evaluation of how AI technologies can improve diagnostic accuracy, expand treatment options, and optimize healthcare processes in specialized areas such as cardiology, ophthalmology, and medical imaging.

This study takes a qualitative approach, based on a literature review to examine the various applications of Artificial Intelligence (AI) in medicine. The review will focus on

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applications in cardiology and ophthalmology, and the study will be conducted in two main phases.

The first phase consists of a Literature Review, in which studies and scientific publications on the use of AI in medicine, particularly in the specialties of cardiology and ophthalmology, will be analyzed. The research will include sources such as specialized journals, conferences, and clinical case studies published in the past five years.

The second phase involves a Case Study Analysis, which will focus on the practical implementations of AI in clinics and hospitals. Specific cases of AI use in the early diagnosis of cardiovascular diseases, such as myocardial infarction and arrhythmias, as well as eye diseases like glaucoma and macular degeneration, will be analyzed. The qualitative analysis of publications will help identify patterns, trends, and common challenges faced in applying AI in medicine. The ethical and regulatory impacts related to the implementation of these technologies in clinical settings will also be explored.

The main objective of this study is to evaluate the current applications of Artificial Intelligence (AI) in the medical specialties of cardiology and ophthalmology, highlighting

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advancements, benefits, and challenges. Specifically, the objectives include:

- Analyzing how AI is being used in the diagnosis and treatment of cardiovascular and ophthalmological diseases, including personalized treatments and improving diagnostic accuracy.
- Identifying the key ethical and regulatory challenges related to the implementation of AI in medicine, focusing on data privacy, algorithm transparency, and bias issues.
- Assessing future perspectives for AI in medicine, considering the evolution of technologies and barriers to large-scale adoption.
- Proposing guidelines for a public policy model to regulate the implementation of AI in medicine, ensuring its ethical, safe, and effective use in clinical practice.

This study seeks to address the following questions and test the following hypotheses:

- Effectiveness of AI in Medical Diagnosis: Can AI consistently improve diagnostic accuracy compared to traditional methods, particularly in cardiology, ophthalmology, and radiology?

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- Impact of AI on Treatment Personalization: Can AI improve treatment personalization, leading to better clinical outcomes and greater efficiency?
- Ethical and Regulatory Challenges: Is the lack of clear regulations and ethical guidelines limiting the adoption of AI in medicine, especially concerning data privacy and algorithm transparency?
- Adoption of AI in Clinical Practice: What are the obstacles to AI adoption by healthcare professionals, such as resistance, lack of training, and technological barriers?

1. AI Models and Emerging Technologies

The application of Artificial Intelligence (AI) in medicine has rapidly evolved, with emerging technologies and innovative models bringing significant advances across various areas. One of the major developments is the combination of different machine learning models to improve diagnostic and treatment accuracy. The use of hybrid models that combine various machine learning approaches has proven promising, allowing for more robust and precise analysis of medical data (MAY, 2021).

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1.1 Hybrid Machine Learning Models

Hybrid machine learning models combine different learning techniques to create more powerful and accurate solutions. Instead of relying on a single type of algorithm, hybrid systems can combine deep neural networks, support vector machines (SVM), decision trees, and probabilistic models to maximize accuracy and minimize diagnostic errors (IACOM CAFÉ, 2021).

This approach is particularly useful in areas of medicine where data is complex and varied, such as cardiology, oncology, and ophthalmology, where factors like age, medical history, genetics, and imaging results must be considered.

For example, in cardiology, hybrid models can be used to analyze clinical test data, genetic data, imaging exams, and even information from wearable devices, creating a more complete picture of the patient's health status and allowing for more accurate and personalized diagnoses. Hybrid models are also advantageous in environments with large data volumes, such as hospitals and clinics, where AI needs to process information quickly and efficiently (SRINADH et al, 2023).

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1.2 Parallel Processing and GPU Use

Parallel processing is one of the most important technologies enabling AI's evolution in medicine. The use of Graphics Processing Units (GPUs) to accelerate the training and execution of deep learning algorithms has been a growing trend. GPUs are particularly effective in tasks requiring large computational power, such as analyzing large volumes of medical data and imaging exams (KRISHNASAMY et al, 2023). In medical applications, parallel processing allows for real-time analysis of imaging exams such as CT scans and MRIs, as well as enabling the training of deep neural networks with large datasets. This is essential for the early diagnosis of complex diseases such as cancer, where the speed and accuracy of the diagnosis can make a life-or-death difference (KIRIMTAT; KREJCAR, 2024).

Additionally, GPUs allow for the simultaneous analysis of multiple data sets, accelerating the detection of patterns in medical exams and enabling faster decision-making. For example, in emergency situations such as strokes (AVCs), parallel processing ensures that doctors have quick and accurate diagnoses, helping to save lives (KIRIMTAT; KREJCAR, 2024).

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1.3 Emerging Technologies and Innovations in Medicine

The field of personalized medicine is benefiting greatly from emerging technologies such as genomics and precision medicine. AI has been used to analyze large volumes of genetic data and identify patterns that can aid in developing personalized treatments. The integration of genetic data with other medical information, such as disease history and imaging results, has the potential to revolutionize the treatment of complex diseases like cancer, allowing for more targeted and effective therapies (REDE D'OR SÃO LUIZ, 2023).

Furthermore, machine learning technologies are being applied in the development of virtual medical assistants and chatbots, which can support healthcare professionals by providing evidence-based advice or conducting initial symptom screenings. These technologies not only help reduce doctors' workloads but also increase access to healthcare in remote areas where specialist availability may be limited (EXECUTIVOS DA SAÚDE, 2024).

Another significant advancement is the use of augmented reality (AR) and virtual reality (VR) in the training of healthcare professionals. These technologies allow doctors and surgeons to practice complex procedures in simulated environments,

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improving precision and confidence in performing real surgeries. The combination of AI with AR and VR can also enhance surgical planning and visualization of imaging data, such as CT scans and MRIs, before performing a surgery (VOITTO, 2023).

2. Applications of AI in Cardiology

Cardiology has been one of the medical fields that benefits the most from the application of Artificial Intelligence (AI), transforming both the diagnosis and treatment of heart diseases. From early diagnosis of conditions such as myocardial infarction, heart failure, and arrhythmias, to the personalization of treatments, AI is enabling significant advancements in personalized medicine (ABCF, 2023).

2.1 Prediction and Diagnosis of Heart Diseases

One area where AI has shown great impact is the prediction of cardiac events. Machine learning-based tools can analyze large volumes of clinical data, such as medical history, imaging test results, and wearable device data, to more accurately predict the risk of adverse events like heart attacks and arrhythmias. The use of AI algorithms to predict these events

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enables early intervention, reducing mortality and improving patients' quality of life (MARTINS et al, 2024).

Additionally, the analysis of imaging exams has been enhanced through the use of AI. Tools like artificial neural networks (ANNs) and Support Vector Machines (SVMs) are already being used for automated interpretation of images such as echocardiograms, CT scans, and MRIs. AI is capable of identifying subtle patterns in exams that may go unnoticed by human professionals, leading to faster and more accurate diagnoses (GALENO et al, 2020).

2.2 Personalization of Cardiac Treatment

Another important benefit of AI in cardiology is the personalization of treatment. By utilizing data from various sources, including laboratory tests, medical images, and clinical information about patients, AI algorithms can identify patterns and suggest therapies tailored to each individual. Personalized treatments allow for more effective management of cardiac conditions and a reduction in complications (MARTINS et al, 2024).

For example, in the case of cardiac resynchronization therapy, AI can accurately predict which patients will respond better to specific treatments, such as pacemakers and

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implantable defibrillators. The analysis of clinical and imaging data allows algorithms to tailor medical interventions to the unique needs of each patient, increasing success rates (LAHRS, 2021).

3. Applications of AI in Ophthalmology

Ophthalmology has significantly benefited from the advancement of Artificial Intelligence (AI), particularly in the diagnosis and monitoring of eye diseases. From the analysis of retinal images to the early detection of conditions such as glaucoma, macular degeneration, and diabetic retinopathy, AI has allowed for advancements in eye care, providing faster, more accurate, and more accessible diagnoses. The integration of AI into ophthalmology not only improves the accuracy of diagnoses but also contributes to the personalization of treatment and continuous monitoring of patients' eye health (GOOGLE, 2024; SHIGUEOKA; COSTA, 2024).

3.1 Diagnosis of Eye Diseases

One of the most significant impacts of AI in ophthalmology is the early detection of eye diseases. Machine learning algorithms are used to analyze high-resolution imaging exams, such as optical coherence tomography (OCT) and fundus

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photography, to detect early signs of diseases. For example, diabetic retinopathy, a common complication of diabetes, can be diagnosed at early stages before symptoms become apparent, allowing for early interventions that can prevent vision loss (GOOGLE, 2024; FERRAZ et al, 2024).

Similarly, glaucoma, which often develops silently with no visible symptoms until advanced stages, can be detected through the analysis of images of the optic nerve and intraocular pressure. AI has proven capable of identifying subtle patterns in these images that may indicate the presence of the disease, much earlier than traditional methods (LOPÉZ DE MUNAIN SAN MARTÍN, 2024).

3.2 Retina Imaging Analysis

Automated retina analysis is one of the primary areas of AI application in ophthalmology. Deep learning algorithms have been trained to identify and classify various eye conditions from retina images, with accuracy that sometimes exceeds that of ophthalmologists in certain situations. This type of analysis is particularly useful for detecting age-related macular degeneration (AMD), which affects central vision and is a leading cause of blindness in older adults (FERRAZ et al, 2024; IAPB, 2024).

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Furthermore, AI can be used to monitor the progression of these diseases over time by comparing retina images at different points and identifying subtle changes that may indicate deterioration of the eye condition. This enables faster and more precise interventions, adjusting treatments according to the evolution of the disease (GOOGLE, 2024; FERRAZ et al, 2024).

3.3 Models for Predicting the Progression of Eye Diseases

In addition to identifying the presence of diseases, AI has also been applied to predict the progression of eye conditions. For example, in cases of glaucoma, AI can analyze the rate of deterioration of the optic nerve and predict the risk of vision loss at various stages of the disease. This helps ophthalmologists personalize treatment plans for each patient, adjusting therapies as needed to slow or halt disease progression (LOPÉZ DE MUNAIN SAN MARTÍN, 2024).

In conditions like macular degeneration, AI can predict the response to treatment and identify patients at higher risk of complications, such as irreversible vision loss. This personalization of care is crucial for more effective and less invasive treatments (FERRAZ et al, 2024; IAPB, 2024).

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4 Impact of AI on Medical Imaging Interpretation

The interpretation of medical imaging has been one of the most promising areas for the application of Artificial Intelligence (AI) in medicine, primarily due to the large volume of data generated and the complexity involved in analyzing these images. AI's ability to process large amounts of data and identify subtle patterns that might be overlooked by humans has resulted in faster and more accurate diagnoses, particularly in fields such as radiology, cardiology, ophthalmology, and oncology (JUCÁ et al, 2024; NAJJAR, 2023).

4.1 Applications in Radiology and Other Medical Specialties

Radiology was one of the first areas of medicine to adopt AI for interpreting imaging exams, such as X-rays, CT scans, MRIs, and mammograms. Deep learning algorithms are capable of identifying signs of diseases such as lung cancer, brain tumors, and bone fractures with a high degree of accuracy. In some cases, AI has surpassed the accuracy of human radiologists, providing faster and more accurate initial diagnoses and reducing the risk of human error (JUCÁ et al, 2024; NAJJAR, 2023).

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In oncology, AI has proven effective in analyzing biopsy images and imaging exams of tumors. With the aid of AI, doctors can detect micro-lesions and patterns that may indicate the presence of cancer in its early stages, when treatments are more likely to succeed. AI usage can also be combined with other sources of data, such as genetic information from patients, to create more personalized and targeted treatment plans (ONG et al, 2024; CUI et al, 2023).

4.2 Diagnostic Precision and Advantages over Traditional Methods

One of the main advantages of using AI in medical imaging interpretation is diagnostic precision. AI can analyze complex patterns in images that may go unnoticed by human observers, especially when exams involve large data sets or are performed in high resolution. Additionally, AI's real-time analysis enables doctors to make quick decisions, which is crucial in emergency situations, such as diagnosing strokes, heart attacks, and trauma (JUCÁ et al, 2024; NAJJAR, 2023).

Another important advantage is the reduction of human bias. Radiologists may be affected by factors such as fatigue, time pressure, and subjectivity in interpreting images. AI, trained on large databases, can provide more objective analysis

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based on patterns learned from thousands of examples, minimizing interpretive errors (UNICLINIKA, n.d.).

5. Ethical and Practical Challenges of AI in Cardiology

Despite advancements, the implementation of AI in cardiology faces challenges. One of the major obstacles is the ethical issue of data privacy. The use of large volumes of medical and personal data requires strict security and confidentiality protocols. Additionally, health insurance discrimination based on AI predictions is a growing concern. AI could inadvertently categorize patients into higher-risk groups, leading to denials of coverage or increased costs (MURDOCH, 2021; BOUDI et al, 2024).

Algorithm transparency is also a key issue. Many AI models, especially deep learning ones, operate as “black boxes,” making it difficult to understand how decisions are made. This raises questions about accountability in cases of medical errors based on algorithmic interpretations (GERKE et al, 2019; BOUDI et al, 2024).

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5.1 Cognitive Computing and Medical Decision Support

Cognitive computing, a subfield of AI, aims to mimic human reasoning processes. In cardiology, technologies like IBM Watson are already being used to assist in making complex clinical decisions. Watson, for example, analyzes large volumes of medical and scientific data to provide evidence-based recommendations, helping cardiologists determine the best treatment courses for their patients. This is particularly useful in complicated cases where the doctor's experience needs to be complemented with comprehensive and up-to-date data (GERKE et al, 2019; BOUDI et al, 2024).

5.2 Infrastructure and Interdisciplinary Collaboration

For AI to succeed in cardiology, a robust infrastructure capable of storing and processing large amounts of data is crucial. This includes not only clinical and exam databases but also IT systems capable of efficiently integrating this information. Furthermore, interdisciplinary collaboration is essential for AI's success in cardiology. Physicians, software engineers, data scientists, and other professionals must work together to ensure that AI tools are applied correctly, respecting patient needs and clinical specifics (GERKE et al, 2019; BOUDI et al, 2024).

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In summary, AI in cardiology is transforming how heart diseases are diagnosed, treated, and monitored. While the benefits are clear, such as personalized treatments and improved diagnostic precision, ethical and practical challenges still need to be addressed to ensure this technology is used in an ethical and effective manner.

6. Ethical and Technological Challenges of AI in Ophthalmology

Although AI offers significant advantages for diagnosing and treating ocular diseases, there are also ethical and technological challenges. Data privacy is a central concern, as ophthalmic exams often involve the collection of personal and sensitive information. The implementation of AI requires patient images to be analyzed by algorithms, which raises questions about the use and sharing of these data, as well as the need to ensure their security (AAO, 2024; TOM et al, 2020).

Another challenge is the transparency of AI algorithms, which, as in cardiology, often function as "black boxes." This means that while AI can provide accurate diagnoses, it may be difficult to understand how it arrived at these conclusions. This raises concerns about responsibility in cases of diagnostic error or system failure (ABDHULLA et al, 2021).

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6.1 Impact on Health Professional Training

The implementation of AI in ophthalmology also requires adjustments in the training of health professionals. Many ophthalmologists are adapting to the use of these new technological tools, and ongoing education in AI and data analysis has become crucial to ensure doctors can correctly interpret and apply the results from AI algorithms (AAO, 2024; ABDHULLA et al, 2021).

In summary, AI in ophthalmology has shown great potential for improving diagnoses, monitoring disease progression, and personalizing treatments. However, like in other areas of medicine, it brings ethical and technological challenges that must be carefully considered to ensure its effective and responsible implementation.

7. Challenges in the Implementation of AI in Medical Image Interpretation

Despite its advantages, the implementation of AI in the interpretation of medical images faces several challenges. One of the biggest obstacles is data quality and standardization. AI requires large volumes of high-quality data to be effective, and often this data may be incomplete or of low quality, which

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compromises the performance of the algorithms (WALSH et al, 2023).

Another significant challenge is acceptance among healthcare professionals. Many doctors, especially those with more experience, may have difficulties fully trusting the results generated by AI systems. The interpretation of AI results requires doctors to understand how the algorithms work, which is not always straightforward given the complex nature of machine learning and deep learning models (WALSH et al, 2023).

Additionally, the transparency of AI algorithms remains a sensitive issue. Many AI models, such as deep neural networks, function as “black boxes,” meaning that while they provide accurate results, it is unclear how those results are achieved. This raises concerns about accountability in case of a diagnostic error. If an AI algorithm fails to identify a serious condition, such as a tumor, who is responsible? The doctor who used the AI, the software developer, or the system itself?

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7.1 The Need for Training and Interdisciplinary Collaboration

For AI to be used effectively in medical image interpretation, it is essential that doctors are properly trained. Data and artificial intelligence education should be part of healthcare professionals' curricula, enabling them to understand the capabilities and limitations of the AI systems they are using. Furthermore, interdisciplinary collaboration between doctors, software engineers, and data scientists is crucial for the success of AI in medical image interpretation. This collaboration ensures that AI systems are well-implemented and aligned with real clinical needs (PATEL et al, 2024; SZILÁGYI et al, 2024).

In summary, AI in medical image interpretation has the potential to revolutionize medicine by making diagnoses faster, more accurate, and accessible. However, there are still significant challenges to overcome, such as data quality, algorithm transparency, and acceptance by healthcare professionals. Overcoming these obstacles is critical to ensuring that AI is implemented effectively and responsibly in medical practice.

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8. Proposal for a Public Policy Model for AI Regulation in Medicine

With the growing implementation of Artificial Intelligence (AI) in medicine, there is an urgent need to establish robust regulations to ensure that this technology is used ethically, safely, and effectively. Despite its obvious benefits, AI can pose significant risks if not properly regulated, such as violations of patient data privacy, misuse of algorithms, and discrimination in medical decisions. Therefore, it is essential that the public policy for AI regulation in medicine includes clear guidelines for the responsible and efficient use of this technology (DREXEL UNIVERSITY, 2020; HARVARD UNIVERSITY, 2020; EUROPEAN PARLIAMENT, 2022; WHO, 2023).

8.1 Challenges of AI Regulation in Medicine

The regulation of AI in medicine faces several challenges (DREXEL UNIVERSITY, 2020; HARVARD UNIVERSITY, 2020; EUROPEAN PARLIAMENT, 2022; WHO, 2023), including:

1. Data Privacy and Security: AI depends on the use of large volumes of medical and personal data, raising concerns about data protection and privacy. Improper use

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of sensitive information can result in privacy violations, discrimination, and social exclusion.

2. Transparency and Accountability: Many AI algorithms operate as “black boxes,” meaning it is unclear how they arrive at their conclusions. The lack of transparency in algorithms can make accountability difficult in cases of medical errors or diagnostic failures.
3. Algorithmic Bias: AI algorithms can reflect biases present in the data they were trained on. This can lead to discrimination, particularly against minority or vulnerable groups, affecting equity in access to healthcare.
4. Professional Training and Adaptation: Healthcare professionals need to be properly trained to use AI effectively. The lack of data science and AI training among doctors and other healthcare professionals is a significant barrier.
5. Ethical Challenges: AI in medicine raises ethical issues, such as the replacement of human professionals with algorithms, automated decision-making in life-or-death situations, and the potential for misuse of technology for commercial or discriminatory purposes.

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8.2 Proposed Regulatory Framework

An effective regulatory framework for AI in medicine must be comprehensive, balancing technological innovation with patient rights protection (DREXEL UNIVERSITY, 2020; HARVARD UNIVERSITY, 2020; EUROPEAN PARLIAMENT, 2022; WHO, 2023). Below are key guidelines for creating public policies for regulating AI in the medical field:

1. Creation of Multidisciplinary Ethical and Regulatory Committees: AI regulation should involve an ethical committee comprising healthcare professionals, data scientists, ethics experts, lawyers, and government representatives. These committees should be responsible for assessing the risks and benefits of AI systems and ensuring that the technology is used fairly and responsibly. It is essential that these committees are independent and transparent, with clear rules for how AI algorithms are evaluated and monitored.
2. Certification of AI Algorithms and Platforms: The creation of standards and certification procedures for AI algorithms used in medicine is essential. Regulation should require AI systems to undergo quality testing and be regularly audited to ensure their accuracy and compliance with safety standards. These tests should

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consider algorithm transparency, ensuring that models can be understood and validated by human experts.

3. Protection of Patient Data: Protecting patient privacy should be a priority in AI regulation in medicine. Strict laws should be established regarding the use of medical data, with protocols for explicit consent, data anonymization, and restricted access to information. Healthcare professionals, AI developers, and healthcare organizations should be required to adhere to data protection guidelines established by regulations such as Brazil's LGPD (General Data Protection Law) or the EU's GDPR (General Data Protection Regulation).
4. Promotion of Professional Training and Capacity Building: To ensure that doctors and other healthcare professionals can use AI effectively, continuous training programs must be implemented. These programs should address not only the technical use of AI systems but also the ethical and legal implications of their use. Education should include topics such as interpreting AI results, monitoring algorithm effectiveness, and managing patient data.
5. Continuous Evaluation and Auditing of AI Systems: AI in medicine should be constantly monitored and

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evaluated to ensure it continues to deliver accurate and fair results. This includes regular audits of algorithms to verify that they are functioning as expected, along with feedback processes to improve performance. Regulation should establish the need for independent audits and create feedback systems that allow doctors and patients to report issues with algorithms.

8.3 International Examples and Potential Models for Implementation

Several countries are already developing or implementing regulatory models for AI in medicine. For example:

- In the United States, the FDA (Food and Drug Administration) has approved some AI systems for use in medical diagnoses, but requires developers to follow strict safety guidelines and conduct clinical testing before commercial release (PEW TRUSTS, 2021).
- In the European Union, the GDPR already provides guidelines for the protection of personal data, including medical data. Additionally, the European Commission is creating a specific regulation for AI, focused on safety, transparency, and ethics (EMA, 2024).

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- In the United Kingdom, the NHS (National Health Service) has adopted AI systems, with a focus on improving early diagnosis of diseases such as cancer and diabetes, while also developing guidelines for data governance and risk assessment (AI4Health, 2021).

Final Considerations

Artificial Intelligence (AI) represents one of the most transformative innovations in the field of medicine. With its ability to process vast amounts of data, learn from complex patterns, and provide evidence-based recommendations, AI is reshaping how diseases are diagnosed, treated, and monitored. Its application in cardiology, ophthalmology, medical imaging, and personalized medicine has already demonstrated impressive results, from early disease detection to treatment personalization, leading to better clinical outcomes and greater efficiency in patient care.

Key Observed Trends:

1. Personalization of Treatment and Diagnosis: AI is enabling an increasingly personalized approach to medicine, tailoring diagnoses and treatments to the specific needs of each patient. Machine learning algorithms are being used to predict responses to

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treatments, identify patterns in medical data, and create individualized therapeutic strategies, particularly in complex diseases such as heart disease and cancer.

2. Diagnostic Accuracy and Efficiency: AI has proven capable of analyzing medical tests, such as MRI scans, CT scans, and ophthalmological exams, with a precision that often exceeds that of human doctors. This accuracy is especially useful in critical conditions like strokes and early-stage cancers, where rapid response times are crucial.
3. Innovation in Hybrid Models and Emerging Technologies: The use of hybrid machine learning models and real-time data processing with the aid of GPUs is accelerating the development of more efficient and robust systems. These technologies not only improve diagnostic accuracy but also expand AI's capabilities in areas such as genomic analysis and surgical planning.
4. Ethical and Regulatory Challenges: While AI advancements bring undeniable benefits, they also raise ethical and technical challenges. Patient data privacy, algorithm transparency, and medical responsibility are issues that require clear and effective regulation. The protection of personal data and the prevention of

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algorithmic bias are central concerns that need to be addressed to ensure AI is used fairly and without discrimination.

Recommendations for the Future:

1. Strengthening Regulation and Governance: Regulation of AI in medicine should be a priority for governments and health authorities. Public policy models ensuring data security, algorithm transparency, and ethics in AI application need to be developed and continuously updated. The establishment of multidisciplinary ethical and regulatory committees will be essential to ensure responsible technology use.
2. Professional Training: Training healthcare professionals in AI and data analysis is critical. Continuing education programs should be implemented to ensure that doctors, engineers, and other healthcare professionals understand both the capabilities and limitations of AI systems, as well as how to effectively incorporate them into their practices.
3. Promotion of Ethical Innovations: The ethics of AI must be discussed and integrated into technological development processes. AI should be designed to minimize bias and discrimination and should be used in a

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way that respects patient rights. Additionally, mechanisms must be created to ensure algorithm transparency and ensure that decisions made by AI can be audited and understood by healthcare professionals.

4. Promoting Inclusion and Accessibility: AI innovations in medicine should be accessible not only to developed countries but also to regions with limited healthcare infrastructure. AI can be a powerful tool to expand access to medical care in remote areas where there is a shortage of healthcare professionals.

Ultimately, AI has the potential to transform medicine, making it more precise, personalized, and efficient. The future of medicine will undoubtedly be increasingly influenced by AI, but for this transformation to benefit everyone, it is essential that the technology be applied equitably and transparently, with the goal of improving patient care and clinical outcomes. However, the implementation of AI must be accompanied by stringent regulation, along with a continuous commitment to ethics and responsibility.

Thus, the regulation of AI in medicine needs to strike a balance between innovation and the protection of patient rights. To ensure that AI is used ethically and effectively, it is crucial to

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establish a solid regulatory framework, which includes ethical committees, algorithm certification, data protection, and professional training. Only through proper regulation will it be possible to maximize AI's benefits while minimizing the risks and ethical concerns associated with its use.

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ORTHOTANASIA IN THE DIMENSION OF THE FUNDAMENTAL RIGHT TO HEALTH [1]

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Abstract

The article addresses the right to orthothanasia in the context of the fundamental right to health and human dignity, as provided for in the Federal Constitution. The central issue examined is whether orthothanasia can be considered a fundamental right to die with dignity for the terminally ill patient who chooses to refuse disproportionate medical treatments. The aim of the study is to analyze the practice of orthothanasia and integrative palliative care as possible rights inherent to human dignity and health, and to examine how the legal protection of dignity relates to the right to life in these cases. The methodology used is deductive, based on the analysis of national and international legislation, doctrine, and jurisprudence. The results indicate that orthothanasia can be legitimized as a practice of respecting the autonomy of terminally ill patients by avoiding the artificial prolongation of life with futile treatments. It is concluded that, by ensuring the right to orthothanasia, human dignity is respected, providing the patient with a dignified and humane death, in accordance with constitutional and ethical principles. The study demonstrates the intersection between constitutional and infraconstitutional norms, as well as alignment with international treaties, reinforcing that orthothanasia is an extension of the right to health and dignity.
Keywords: Integrative palliative care, Terminally Ill, Right to die, Patients´ rights**.**

Introduction[4]

Orthothanasia, derived from the Greek "ortho" (correct) and "thanatos" (death), refers to the idea of allowing death to occur at the right time, without the intervention of disproportionate medical treatments that prolong the suffering of terminally ill patients. It is a practice that aims to free the human being from

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suffering, avoiding futile procedures that do not promote healing, but only extend the agony. Given this lexical context, we intend to analyze whether orthothanasia is part of the understanding of the Fundamental Right to Health and the Fundamental Right to a dignified life, constituting a true fundamental right to a good death, a dignified death through the assurance of lawful medical interventions at the end of life, with the suspension or abstention from disproportionate medical treatments.

This article analyzed the scope and dimension of orthotanasia in the context of fundamental rights to a dignified life and health, with a focus on the autonomy of the terminally ill patient. The study also addresses the legal and ethical implications related to the patient's ability to decide about their own life, especially when they are of legal age and in full possession of their mental faculties. Integrative palliative care, which seeks to ensure a dignified death by avoiding unnecessary treatments, is also discussed. The right to choose is therefore considered, either directly through the patient's voice or through a living will, with orders not to resuscitate. We sought to analyze the depth of human dignity as a potential supporter of the right to a dignified death, which can be considered a corollary of the right to choose not to undergo

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treatment. To this end, it is essential to consider whether the person is of legal age and capable, that is, whether they are in full possession of their mental faculties. In other words, if the chances of a cure are minimal, one must consider whether the protection of human dignity takes precedence over the right to life.

It is important to highlight that the dignity of the human person was the foundation of the Democratic Rule of Law, according to article 1, paragraph III, of the Federal Constitution. Therefore, just as individuals have the right to live with dignity, they also have the right to die with dignity, without suffering or unnecessarily prolonging their lives. Thus, the term "dignified death" should be understood as the possibility for a patient suffering from a terminal or irreversible illness to have their right to choose respected regarding the way they wish to die. This was supported by articles 1, item III (human dignity), and 5 (right to life) of the Federal Constitution.

From reading and understanding the constitutional norms, notably articles 5, 6 and 196 of the Federal Constitution, it was found that health protection included not only the right to treatment, but also the right to refuse interventions that do not contribute to improving the patient's quality of life. The dignity of the human person, a fundamental principle enshrined in article

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1, III, reinforced the need to consider the patient's will and their right to choose a dignified death, without the imposition of disproportionate therapeutic measures.

The article also examines the rules of the Federal Council of Medicine and international standards, such as the Pact of San José of Costa Rica and the Universal Declaration of Human Rights. Regarding the resolutions of the Federal Council of Medicine, such as Resolution No. 1.805/2006, it corroborates the legitimacy of orthotanasia by allowing doctors to suspend or limit treatments that only prolong life artificially, respecting the will of the patient or their legal representative. These standards highlighted the importance of offering palliative care that alleviated suffering and provided physical, psychological, social and spiritual comfort.

At the international level, treaties and conventions, such as the Pact of San José of Costa Rica and the Universal Declaration of Human Rights, ensured the right to life and personal integrity, reinforcing the need for dignified and humane treatment for terminally ill patients. The case study of Maria Teresa Benito Orihuela, diagnosed with Amyotrophic Lateral Sclerosis (ALS) in Peru, illustrated the relevance of the patient's right to choose a dignified death, highlighting autonomy and

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human dignity as central elements in the decision to cease invasive and futile treatments.

Philosophical and ethical reflections, based on theorists such as Norberto Bobbio and Kant, argue that the dignity of the human person must be preserved until the end of life. Patient autonomy and respect for their decisions are ethical imperatives that guide medical practice, avoiding the instrumentalization of human beings and promoting a dignified death as a corollary of a dignified life. Just as humanized childbirth was discussed, with all its contours and protection, a good death must also be discussed and humanized. This topic must be brought to light, dispelling the belief that talking about death attracts it. After all, death is an inevitable part of life.

The objectives of this study include the analysis of orthotanasia and palliative care as possible fundamental rights to human dignity and health, verifying how the legal protection of dignity relates to the right to life. The hypothesis is raised that orthotanasia is recognized as a fundamental right inherent to the dignity of the human person, allowing terminally ill patients to refuse disproportionate medical treatments in order to ensure a dignified death. It assesses whether Brazilian legislation and ethical and medical standards support this practice as an extension of the right to health and dignity.

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The method adopted is deductive, using the analysis of national and international legislation, doctrines and jurisprudence. The methodology involves documentary research, based on legal, philosophical and scientific sources, allowing the practice to be replicated by other researchers interested in the relationship between orthotanasia, dignity and the right to health. Thus, the methodology used will be deductive, with its application through consultations of bibliographies, using law, legal articles and the Federal Constitution itself as research sources.

1. Concept and philosophical, legal and medical dimensions of orthotanasia

Orthothanasia, originating from the Greek *orthos* (correct) and *thanos* (death) (Dicionário Aurélio, 2018, p. 45), can be defined as death in due time, that is, one that is not anticipated or even postponed. It can be inferred from this that, through the practice of orthotanasia, death is not being caused - euthanasia - nor is its occurrence being indefinitely postponed – dysthanasia. What is sought is that the inevitable death occurs, but preserving all basic care for the patient's health. (Villas-Boas, 2005, p. 73).

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Before continuing to understand the distinctive aspects between orthothanasia, dysthanasia and euthanasia, it is still necessary to preliminarily conceptualize "palliative care" as an essential element in understanding orthothanasia and its dimensions discussed in this work. The World Health Organization defines palliative care as a set of actions that aim to improve the quality of life not only of patients, but also of their families, when involved with issues related to life-threatening illnesses (WHO, 2010).

According to the 2nd edition of the Global Atlas on Palliative Care, published in October 2020 by the Worldwide Palliative Care Alliance (WPCA) in partnership with the World Health Organization (WHO), palliative care is defined as a multidisciplinary approach aimed at improving the quality of life of patients, whether adults or children, who face life-threatening illnesses. Furthermore, this approach also extends to supporting patients' families, aiming to prevent and alleviate suffering through early identification, correct assessment and appropriate treatment of pain and other problems, whether physical, psychosocial or spiritual in nature. The main objectives of palliative care include: providing relief from pain and distressing symptoms; affirming life and treating death as a natural process, without hastening or postponing its course;

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integrating psychological and spiritual aspects into patient care; offering support to families in dealing with illness and bereavement; use a collaborative approach, involving a multidisciplinary team to meet the needs of both patients and their families, including bereavement counseling when necessary; and improve quality of life by positively influencing the course of the disease (Dadalto, 2001, p. 3).

In palliative care, there is a move away from modern medical techniques and the obsessive search for a cure, making room for the idea of providing good care, accepting that life is a chronological sequence that begins with fecundation, goes through all the stages of life and ends with death. The main concern is with the sick person, not the disease (Pessini, 2004).

Godinho, mentioning Klaschik, teaches that medicine should prioritize not what is technically possible, but what is ethically justifiable, considering the patient's physical, spiritual and psychological problems, respecting their dignity and autonomy (Godinho, 2017).

Pessini describes five fundamental ethical principles in palliative care: truthfulness, which underpins trust between doctors and patients, requiring doctors to provide information necessary for patients to make decisions about their care;

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therapeutic proportionality, which requires the implementation of therapeutic measures that are useful for the patient, taking into account their health, alternative courses of action, prognoses of risks and benefits, and the costs involved; the principle of double effect, allowing measures that can shorten the patient's life, as long as the purpose is to relieve the pain and symptoms of the disease, and not to cause death; prevention, which requires that medical choices, even palliative ones, come with prognoses that avoid complications and advise the patient and their relatives about future actions; and non-abandonment, which imposes on the doctor the duty to care for the patient until death, even if they disagree with the patient's choices. Pessini teaches, in Godinho's view, that this principle distinguishes orthotanasia, where care is maintained until natural death, from euthanasia, where death is induced (Godinho, 2017).

In view of this, there are some considerations between palliative care and orthothanasia: what is sought with orthothanasia is not death, but the humanization of the dying process, without abuse in its prolongation or even provoking death, since it is the result of the illness the person suffers from, but on the contrary, it is accepted as the natural end of life. (Blanco, 1997, p. 31-32). The consideration refers specifically

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to orthotanasia, which seeks to humanize the process of dying by not artificially prolonging life, but also by not causing death, accepting it as a natural result of the disease. However, when dealing with palliative care, it is important to highlight that the main objective is not to accelerate or postpone death, but rather to alleviate suffering and improve quality of life. Palliative care focuses on the patient's physical, emotional, social and spiritual well-being, providing a comprehensive approach that involves both the patient and their family. They offer ongoing support during illness and after death, in the grieving process, as a way of ensuring that the end of life occurs in a dignified manner, without unnecessary suffering, respecting the patient's wishes and promoting a natural and peaceful death. Thus, palliative care and orthotanasia complement each other in promoting a dignified death: while the former care for the patient in a holistic way and alleviate suffering until the end, orthotanasia ensures that invasive and disproportionate treatments that unnecessarily prolong the dying process are not used.

The distinction between the concepts of euthanasia, dysthanasia and orthothanasia must be carefully understood, especially with regard to orthothanasia and passive euthanasia. While passive euthanasia involves the omission of proportionate treatments or care that, if administered, could

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maintain the patient's life, orthothanasia consists of avoiding futile and disproportionate treatments, which would not bring any benefit to the patient and would only prolong the process of death. In passive euthanasia, the medical conduct that interrupts essential treatments establishes a direct causal link with the death of the patient, who does not die as a result of the disease, but rather due to the withdrawal of measures that could keep the patient alive. In contrast, in orthotanasia, death is a natural result of the patient's terminal condition, without interventions that would postpone or anticipate this process, accepting death as an inevitable consequence of the progression of the disease. (Godinho, 2017, p 135-136).

Orthothanasia can be seen as a middle ground between euthanasia and dysthanasia, where euthanasia would "speed up" death, while dysthanasia would "delay" death. In this middle ground, orthotanasia would imply that the patient would have a dignified death, avoiding unnecessary suffering.

We now move on to some reflections on the philosophical-legal context of the topic. First, the most obvious assertion: death is part of life. As Matilde Zavala de Gonzalez lectures, "*la muerta própria y a la ajena son parte de la vida, en tanto la limitam, como em um camino que llega hasta determinando ponto; y esse conocimiento sobre la inexoble mortalidade*

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impregna de sentido los momentos vividos" (Gonzalez, 2010, p. 3). To illustrate the issue, Maria Helena Diniz questions how a dignified death can be guaranteed if there are no conditions for a dignified life. She suggests that human dignity requires the absence of inhumane and violent treatment, and criticizes the incoherence of a society that offers technology to help people die well, but often fails to offer adequate means to live with dignity. (Diniz, 2006, p. 481).

Jorge Miranda (2010, p. 166) states that the Brazilian Constitution is based on the dignity of the human person, giving a unity of meaning, value and practical agreement to the system of fundamental rights, based on the concept that the person is the foundation and the purpose of society and the State. Thus, it can be seen that the individual is the center of the legal system. Dignity in dying must be pursued by legal practitioners and interpreters, just as dignity is sought in birth and in life. Although there is no specific legal provision on euthanasia and assisted suicide, the Brazilian legal system allows the defense of a dignified death as a fundamental right. From this perspective, the State should not hinder the way the individual chooses to achieve this right (Dadalto, 2019, p. 8-9).

In this way, the right to life seems to bring a dimension of a dignified life, from birth to the struggle to continue living, even

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respecting dignity in the right to die. The principle of human dignity protects the human being as a legal person, that is, as the holder of legal personality. The dignity of the human person is a spiritual and moral value inherent to each individual, manifesting itself in the conscious and responsible self-determination of one's own life, and demands respect from others. This principle constitutes an invulnerable minimum that the legal system must ensure (Melo, 2017, apud Morais). Roberto Adorno complements this idea, stating that, for Kant, human dignity is above any price and cannot be reduced to a simple exchange of interests. A person's dignity is an absolute value, which cannot be measured in terms of cost-benefit. This Kantian concept requires that people should never be treated as means to achieve other people's goals, which is especially relevant in bioethical contexts. This implies that one should not subject an individual to scientific experiments without their consent, even if the results could benefit society, nor should one force people in extreme poverty to sell organs to meet basic needs. The instrumentalization of human beings, in these cases, would be a direct violation of their dignity, something unacceptable from any ethical perspective (Adorno, 2012, p. 72).

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To reiterate, death is an integral part of life. The act of dying is the final act of each human being's personal biography and cannot be seen as something distinct from it. The right to a dignified human life must not be interrupted by an undignified death. Therefore, the legal system must implement and protect the ideal of a dignified death (Mold, 2010, p. 1). Furthermore, the so-called "Human Rights of Patients", according to Aline Albuquerque's doctrine, are international human rights regulations applicable to patients (Dadalto, 2021, p. 14). According to Albuquerque, the patient's mental and physical suffering can be aggravated by the action or omission of the state and health professionals, characterizing a violation of the right not to be subjected to torture, cruel, inhuman or degrading treatment or punishment. In palliative care, the absence of specific policies and the lack of availability and access to adequate medications to relieve pain can subject the patient to avoidable suffering, resulting in treatment that is incompatible with human rights standards (Albuquerque, 2016, p. 30).

Continuing with the philosophical reflection, religious overtones inevitably arise. In 2012, the president of the National Conference of Bishops of Brazil (CNBB), Dom Raymundo Damasceno Assis, in an interview with the Federal Council of Medicine, stated that: "Death is not a disease for which we must

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find a cure. It is necessary for people to recognize and accept their own reality and their own limits." This perspective is complemented by the view of Pope John Paul II in the Encyclical Evangelium Vitae, where he differentiates euthanasia from the decision to refuse excessive treatment. For John Paul II, when death inevitably approaches, it is possible, with due awareness, to renounce treatments that would only prolong life in a painful and poor quality way, without, however, suspending the essential and normal care due to the patient. This renunciation is not equivalent to euthanasia or suicide, but rather to the acceptance of the human condition in the face of finitude. The Church's position reinforces that dignity in the dying process lies in accepting the natural course of life, without resorting to extreme measures that would only prolong suffering, while maintaining care and respect for life until its natural end (Holy See, John Paul II. Encyclical Evangelium Vitae, 1995).

Based on what has been exposed, everything seems to indicate that a dignified death through euthanasia should be widely accepted, as it is based on principles that ensure the dignity of the human person. The defense of human dignity, the protection of life, among others, affirm that the individual has the sacrosanct right to experience their own death with dignity.

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2. Normative and case-specific frameworks of orthotanasia: comparison between Brazilian and international legislation and the case of Maria Teresa Benito Orihuela (Peru)

The analysis begins with the normative frameworks that govern the issue of orthotanasia, the right to health and a dignified life, issues that are deeply rooted in the Constitution. The dignity of the human person is a central concept in this debate and, as defined by Alexandre de Morais, it is a spiritual and moral value inherent to each individual. This dignity is manifested in the capacity for conscious and responsible self-determination over one's own life, bringing with it the demand for respect from others. Morais emphasizes that this principle constitutes an inviolable core that every legal system must protect, allowing limitations on the exercise of fundamental rights only in exceptional situations, without ever compromising the necessary respect that every person deserves as a human being (Moraes, 2003, p. 16).

Tepedino and Schreiber emphasize that this is a problem of understanding, in the constitutional context, what should be considered unavailable and absolute is not life, but the dignity of the human person. Although the aforementioned authors do not recognize a normative hierarchy between constitutional

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provisions, they argue that human dignity, as the foundation of the Republic, has axiological superiority in relation to other interests protected by the Constitution. Therefore, the dignity of the human person, and not life, is the supreme guideline of constitutional legality (Tepedino, Schreiber, 2009).

Therefore, it is essential to reflect on the concept of a good death, which is deeply connected to the idea of a good life until the last moment. Quality of life and dignity throughout the dying process are issues that deserve to be studied, as they are part of the human experience itself. Norberto Bobbio highlights the importance of what we think, love and do, stating that our identity is directly linked to our memories and the actions we cultivate throughout our lives. Bobbio adds that we are what we remember, and that our memories are the true heritage we keep. He argues that life should be lived fully while our memories accompany us, allowing us to continue to reconnect with them, preserving the value of our trajectory (Bobbio, 1997, p. 30).

Apparently, based on orthotanasia, the fundamental principle of article 1, III of the Federal Constitution, the principle of human dignity, would be reaffirmed in the sense that the human being, in the most difficult moment of his life, when his existence comes to an end, must be treated with dignity. In this

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sense, it seems that the legal system should be interpreted in such a way as to guarantee that the patient is offered all the medical, emotional and psychological support, along with comfort and peace, in order to achieve a dignified death, according to their choice not to undergo medical treatment that prolongs their life unnecessarily in the face of an incurable disease. It seems that this idea is in line with article 5 of the Federal Constitution, when it exhorts the right to life as a fundamental right. And it is proposed that, with orthothanasia, the principle set out in article 5, item III of the Federal Constitution would be fully complied with, as it establishes that "no one shall be subjected to torture or inhuman or degrading treatment". In the same sense, arts. 6 and 196 of the Federal Constitution also proclaim health as a right and duty of all people.

It is worth mentioning that these guidelines are not only enshrined in the Federal Constitution. Valério Mazzuoli states that the expression human rights is associated with public international law and refers to the rights guaranteed by international standards, such as declarations or treaties concluded between States with the purpose of protecting the

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civil, political, economic, social and cultural rights of people under their jurisdiction[5] (Mazzuoli, 2018, p. 13).

The right to health has double protection: it can be classified as a fundamental right, when protected internally by the Constitution, and as a human right, when protection occurs through international treaties. With regard to international treaties related to the protection of life, in all its aspects, the Pact of San José of Costa Rica – American Convention on Human Rights – and the International Covenant on Economic, Social and Cultural Rights (ICESCR), of which Brazil is a signatory, stand out. The Pact of San José of Costa Rica, in its Article 4, states that every person has the right to have their life respected, and that this right must be protected by law, generally from the moment of conception. Article 5 guarantees the right to physical, mental and moral integrity, prohibiting torture, cruel, inhuman or degrading punishment or treatment,

[5] Mazzuoli explains that these protective standards can exist both at a global level, within the scope of the United Nations, and at a regional level, such as in the inter-American, European or African systems of human rights protection. When a rule is established by a State or nation, it is about protecting the rights of a citizen, called "fundamental rights". On the other hand, when the norm is of external origin, that is, from international society, and protects the same right on a global scale, it is a human right. These rights are essential for a dignified life and establish a level of protection that all States must respect, under penalty of international responsibility. Thus, human rights guarantee people the means to claim their rights in international protection bodies, in addition to the domestic level (Dadalto, 2021; Mazzuoli, 2018).

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and ensuring dignified treatment for all persons deprived of liberty. The ICESCR, in its Article 12, recognizes the right of everyone to enjoy the highest attainable standard of physical and mental health. To ensure the full exercise of this right, Member States shall adopt measures that include the reduction of infant and stillbirth mortality, the improvement of hygiene conditions at work and in the environment, the prevention and treatment of epidemic, endemic, occupational and other diseases, and the creation of conditions that guarantee medical care and medical services in case of illness.

In the same sense, the right to life is considered a universal right, especially after its proclamation in articles 3 and 5 of the Universal Declaration of Human Rights (UN) of 1948. Article 3 states that everyone has the right to life, liberty and personal safety, while Article 5 prohibits subjection to torture and cruel, inhuman or degrading treatment or punishment. The Universal Declaration of Human Rights is based on ethical content that guarantees the intangibility of human dignity, equality between people, the search for effective freedom, the achievement of justice and the construction of a conscience that fully preserves these principles (Nunes, 2004, p. 361).

In addition to the aforementioned guidelines, which can be interpreted as an indirect basis for the right to a dignified death

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for terminally ill patients, the 2013 Prague Charter reinforced this right, calling on governments to guarantee access to palliative care and relief from suffering. The Charter highlighted that access to palliative care is a legal obligation, recognized by United Nations conventions and defended as a human right by several international associations. It highlighted that for patients in severe pain, the lack of palliative care by governments could be considered a form of cruel, inhuman or degrading treatment. Palliative care, in addition to being effective in alleviating suffering, could be applied at a relatively low cost, preventing even more harm to the patient (United Nations, 2013, no page).

In the Brazilian context, the Federal Council of Medicine, in 2006, issued Resolution No. 1.805, establishing that doctors are allowed to limit or suspend procedures that prolong the lives of patients in the terminal phase of serious and incurable illnesses, as long as the wishes of the patient or their legal representative are respected. The Resolution also requires that the physician explain the therapeutic options to the patient or their representative, record the decision in the medical record and ensure the right to a second opinion. Furthermore, it determines that the patient continues to receive all necessary care to alleviate symptoms, ensuring their physical, psychological, social and spiritual comfort, including the right to

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hospital discharge, if desired (Brazil. Federal Council of Medicine. 2006, no page).

From a simple reading of the Resolution, it can be inferred that the practice of euthanasia was not covered by the rule, not even passive euthanasia, and furthermore, that there is the possibility of suspending futile treatments, since their suppression will not shorten the patient's life. There is also clear permission for procedures that would constitute dysthanasia, that is, that useless prolongation of the life of a terminally ill patient, imposing the duty on the doctor to inform all possible alternatives or therapies. And continuing the analysis of the Resolution in plan, article 2 enshrines the philosophy of palliative care, which must be carried out aiming at the physical, psychological, social and spiritual comfort of the patient, even if it is outside the hospital environment.

Despite the existence of this Resolution, it is clear that the doctor's duty is to prevent the patient's death, when this becomes possible, but when this is not possible, the patient will have the secular duty to comfort the terminally ill patient until their death, reducing, if possible, their pain and suffering.

Orthotanasia and palliative care are also duly covered by the Code of Medical Ethics. Article 41 of the Code explicitly prohibits doctors from shortening a patient's life, even at the

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request of the patient or their legal representative, but, in its sole paragraph, establishes that, in cases of incurable and terminal illnesses, the doctor must offer all available palliative care, avoiding diagnostic or therapeutic actions that are useless or obstinate, always respecting the expressed will of the patient or, if this is not possible, the will of their legal representative. (Brazil. Federal Council of Medicine, 2019, p. 28).

This device prohibits the practice of euthanasia, but, on the other hand, recommends orthotanasia as an appropriate medical measure for terminally ill patients, prioritizing comfort and relief of suffering through palliative care, without imposing unnecessary treatments. The Code of Medical Ethics reinforces this guideline in item XXII, determining that, in irreversible and terminal clinical situations, the physician must avoid unnecessary procedures and guarantee the patient all appropriate palliative care. This reflects the ethical commitment to the dignity and well-being of the patient during the final process of their life. (Brazil. Federal Council of Medicine, 2019, p. 17).

Finally, a brief note is also in order in the context of Brazilian infra-constitutional law. The patient's right to choose medical treatment is guaranteed by both the Federal Constitution and the Civil Code. The Constitution, as already mentioned, in its

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articles 1, III and 5, caput, ensures the inviolability of the right to life, liberty and dignity of the human person, while the Civil Code (law 10.406/02), in its articles 15 and 16, provides for the informed consent of the patient for the performance of any medical procedure. In addition to this right to choose, instruments such as the living will and the do-not-resuscitate (DNR) order allow patients to express their wishes in advance regarding medical treatments, ensuring that their decisions are respected, especially in situations where they cannot express their wishes at the time of care. These instruments are fundamental to ensuring patient autonomy and respect for human dignity at critical moments in their lives.

We will now analyze the recent case concerning the life of Maria Teresa Benito Orihuela. To demonstrate the importance of the patient's right to choose a dignified death, the case of Maria Teresa Benito Orihuela, diagnosed with Amyotrophic Lateral Sclerosis (ALS), in Peru, must be brought to light (Superior Court of Justice of Lima, Third Constitutional Chamber Exp. 04988-2023-0-1801-JR-DC-11 Subject: Protection process Page 1 of 80 FILE: 004988-2023-0-1801-JR-DC-11). The patient underwent medical interventions, including a tracheostomy, and was dependent on a mechanical ventilator due to an episode of asphyxia. Initially, the patient

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administratively requested *EsSalud* to cease the invasive treatments that were keeping her alive artificially. However, the health system denied the patient's request. The patient expressed the desire to stop these treatments, arguing that they only increased her suffering without offering any prospect of cure or significant improvement, fully understanding her condition and seeking a dignified death.

EsSalud contested the request, stating that its role was to protect the life and health of patients and that ceasing treatments would be contrary to that duty, constituting a merciful killing under Article 112 of the Peruvian Penal Code. It further argued that although ALS is incurable, it is not an imminently terminal disease, allowing many patients to live for years with an acceptable quality of life. Therefore, continuity of treatments was considered a medical and ethical obligation.

In the first instance, the lawsuit was declared inadmissible, based on the interpretation that the rights to life and health took precedence and that *EsSalud's* refusal was justified by the need to protect these rights. There was an appeal to the Third Constitutional Chamber of the Superior Court of Justice of Lima, which converted the Habeas Corpus process into a Protection process, considering that the rights to dignity and personal autonomy should be protected. The Court ordered *EsSalud* to

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respect Maria's informed decision to cease medical treatments, allowing terminally ill patients to make decisions about their bodies and treatments.

The Superior Court of Justice of Lima recognized the importance of respecting and protecting human dignity, in accordance with Article 1 of the Political Constitution of Peru, and ordered the cessation of invasive medical treatments against the patient's will, considering them a violation of her basic human rights (Article 2 of the Political Constitution of Peru), including the right to life, moral, psychological and physical integrity and free development and well-being.

In its reasoning, the Court reaffirmed that the right to human dignity is inherent to all human beings and must be respected, especially in contexts of terminal illnesses and palliative care, considering the patient's conditions, such as the progression of ALS and the loss of the ability to communicate.

The decision included a recommendation that *EsSalud* provide adequate palliative care to the patient, ensuring treatment for pain relief and other symptoms, providing comfort in her final days of life. The Court highlighted the importance of palliative care as a patient-centered approach that respects dignity and quality of life until the end. It recommended that *EsSalud* and other health entities implement policies to ensure

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that patients' decisions about medical treatments are respected, as well as ongoing monitoring to ensure compliance with the decision and the protection of patients' rights.

Finally, the Court emphasized the need for cultural change within the health system, to value and respect patients' autonomy, as well as human dignity and the patient's expressed wishes, stating that continuing treatment against the patient's will would be a violation of constitutional rights. Legal precedents were cited, such as Montgomery v. Lanarkshire Health Board in the United Kingdom (2015), which reinforced the importance of patient autonomy and the right to information about the risks of medical treatments, and the Quinlan Case (United States, 1976), in which the New Jersey Supreme Court ruled in favor of the Quinlan family to remove life support from Karen Ann Quinlan, establishing an important precedent on the right to refuse medical treatments (Baylor College of Medicine Blog Network).

Final considerations

The analysis developed in this article allowed us to conclude that orthotanasia, understood as the practice of allowing death to occur in its natural time, without the imposition of disproportionate medical treatments, is aligned with

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constitutional principles and with the fundamental rights to health and human dignity. Orthotanasia, by avoiding the perpetuation of useless treatments that only prolong suffering without providing a cure, guarantees the terminally ill patient a dignified death, in accordance with the inherent dignity of the human person. In response to the hypothesis raised, it can be concluded, from reading the opinions presented, that orthotanasia was recognized as a fundamental right inherent to the dignity of the human person, allowing terminally ill patients to refuse disproportionate medical treatments in order to ensure a dignified death. Brazilian legislation and ethical and medical standards support this practice as an extension of the right to health and dignity. In short, orthotanasia represents an essential dimension of the fundamental rights to health and human dignity, ensuring that patients who are terminally ill can live their last moments with respect, autonomy and without unnecessary suffering. The intersection between constitutional, infra-constitutional, international norms and philosophical reflections justified the legitimacy of orthotanasia as a fundamental right, demonstrating that human dignity must prevail in the conduct of end-of-life care.

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EVALUACIÓN DE LAS CONSECUENCIAS DEL EMBARAZO EN LA ADOLESCENCIA: UN ESTUDIO COMPARATIVO ENTRE BRASIL Y EE.UU. [1]

Cláudio Luiz Masutti [2]

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Evaluación de las Consecuencias del Embarazo en la Adolescencia: Un Estudio Comparativo entre Brasil y EE.UU.
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Resumen

Antecedentes: Este estudio explora las consecuencias del embarazo adolescente, un problema de salud pública con implicaciones significativas para la salud reproductiva, el desarrollo social y la igualdad de género. En Brasil y Estados Unidos, las tasas de embarazo precoz han mostrado variaciones relacionadas con factores culturales, económicos y sociales. En Brasil, las disparidades regionales exacerban el problema, especialmente en las zonas con menos acceso a la anticoncepción y la educación sexual. En los Estados Unidos, a pesar de los avances en la reducción de las tasas, persisten los desafíos entre las minorías y las poblaciones de bajos ingresos. Este estudio busca analizar cómo estas diferencias se reflejan en la salud, la calidad de vida de los adolescentes y el impacto socioeconómico, destacando las estrategias y políticas públicas implementadas en ambos contextos.
La metodologia: se basó en una revisión sistemática de datos y estudios publicados entre 2014 y 2024, con énfasis en artículos científicos indexados en bases de datos como PubMed, SciELO y CDC Reports. Se seleccionaron estudios observacionales, revisiones sistemáticas y análisis comparativos que abordaron las tasas de embarazo adolescente, los factores determinantes y la efectividad de las intervenciones preventivas. Los criterios de inclusión priorizaron los estudios que analizaron las políticas públicas y los datos epidemiológicos en poblaciones adolescentes de Brasil y Estados Unidos, considerando variables socioeconómicas y culturales.
Los resultados: indican que, mientras Brasil enfrenta barreras relacionadas con las desigualdades regionales y las limitaciones en el acceso a la salud y la educación, Estados Unidos ha avanzado en la reducción de las tasas a través de programas como el "Programa de *Prevención del Embarazo Adolescente*". Medidas como la expansión de la educación sexual, el acceso a métodos anticonceptivos modernos y la integración de los adolescentes en los sistemas públicos de salud han demostrado ser eficaces en ambos países. Sin embargo, desafíos como la escasez de fondos, las barreras culturales y la falta de

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continuidad de la atención aún limitan el impacto de las políticas implementadas. El estudio concluye que los enfoques colaborativos, culturalmente adaptados y basados en la evidencia son esenciales para mitigar los efectos del embarazo temprano y promover el bienestar de los adolescentes.
Palabras clave: Embarazo adolescente, Salud reproductiva, Políticas públicas, Brasil, Estados Unidos, Educación sexual, Anticoncepción.

Abstract

Antecedentes: Este estudio explora las consecuencias del embarazo adolescente, un problema de salud pública con implicaciones significativas para la salud reproductiva, el desarrollo social y la igualdad de género. En Brasil y Estados Unidos, las tasas de embarazo precoz han mostrado variaciones relacionadas con factores culturales, económicos y sociales. En Brasil, las disparidades regionales exacerban el problema, especialmente en las zonas con menos acceso a la anticoncepción y la educación sexual. En los Estados Unidos, a pesar de los avances en la reducción de las tasas, persisten los desafíos entre las minorías y las poblaciones de bajos ingresos. Este estudio busca analizar cómo estas diferencias se reflejan en la salud, la calidad de vida de los adolescentes y el impacto socioeconómico, destacando las estrategias y políticas públicas implementadas en ambos contextos.
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Keywords: Adolescent pregnancy, Reproductive health, Public policies, Brazil, United States, Sex education, Contraception.

1. Introducción

El embarazo adolescente es un problema multidimensional que afecta de manera desproporcionada a las poblaciones vulnerables. Aunque las tasas mundiales han disminuido, la Organización Mundial de la Salud (OMS) estima que alrededor de 12 millones de niñas de entre 15 y 19 años dan a luz anualmente, muchas de ellas en condiciones socioeconómicas desfavorables.[1,2] En Brasil, las disparidades regionales agravan el escenario, ya que las regiones Norte y Nordeste registran las mayores incidencias de embarazo precoz debido al acceso limitado a métodos anticonceptivos y a programas

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educativos consistentes.[3,4] En los Estados Unidos, los avances en la educación sexual y el acceso a los anticonceptivos han resultado en una reducción significativa de las tasas en las últimas décadas. Sin embargo, las minorías raciales y las comunidades de bajos ingresos siguen enfrentándose a barreras que perpetúan el problema.[5,6] Este estudio busca profundizar en la comprensión de las causas, consecuencias y abordajes del embarazo adolescente en dos contextos distintos, proporcionando una base para recomendaciones de políticas públicas más efectivas.

2. Objetivos

2.1 Objetivo General: Analizar las implicaciones del embarazo adolescente en Brasil y Estados Unidos, destacando similitudes, diferencias y estrategias de enfrentamiento.

2.2 Objetivos específicos

1. Comparar las tasas de embarazo adolescente entre ambos países.
2. Evaluar los impactos médicos, sociales y económicos en diferentes contextos culturales.
3. Examinar las políticas públicas y los programas de prevención implementados.

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4. Proponer recomendaciones basadas en evidencia para mejorar los indicadores de salud e igualdad social.

3. Metodología

La investigación se basó en una revisión sistemática de estudios publicados entre 2014 y 2024, utilizando bases de datos como PubMed, SciELO y CDC Reports. Se incluyeron estudios observacionales, revisiones sistemáticas y análisis comparativos que abordaron las tasas de embarazo adolescente, los determinantes culturales y sociales y la efectividad de las políticas públicas.

Criterios de inclusión:

• Estudios con datos sobre Brasil y Estados Unidos.

• Publicaciones revisadas por pares que analizan las políticas públicas y los resultados sociales y de salud.

Análisis:

Los datos se organizaron en tablas y gráficos comparativos, con análisis crítico de las intervenciones.

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4. Resultados

4.1 Tabla de estudios analizados

Referencia	Objetivo del estudio	Principales resultados
SINASC (2015-2021)[3]	Evaluar las tasas de embarazo adolescente en Brasil.	Las regiones Norte y Nordeste concentran el 63% de los casos.
CDC (2024)[5]	Analizar el impacto del "Programa de Prevención del *Embarazo en Adolescentes".*	Reducción del 58% en las tasas de embarazo adolescente entre 2010 y 2020.
SciELO (2023)[4]	Estudiar las desigualdades regionales en el embarazo adolescente.	Las regiones rurales tienen una mayor incidencia debido a la falta de acceso a métodos anticonceptivos y educación sexual.
UNFPA (2022)[7]	Comparar las políticas mundiales de salud reproductiva.	Las políticas integradas aumentan la adherencia de los adolescentes a los métodos anticonceptivos modernos.
Bicalho et al. (2021)[6]	Identificar las tendencias de fecundidad en adolescentes brasileñas.	Las tasas de fecundidad entre las adolescentes de 10 a 14 años se mantuvieron estables en 3,3 nacimientos por 1.000 habitantes.
Levandowski y Piccinini (2020)[8]	Estudiar el impacto psicológico del embarazo precoz.	Las adolescentes embarazadas son más propensas a desarrollar trastornos emocionales y abandonar la escuela.

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Martin et al. (2020)[9]	Examinar la efectividad de los anticonceptivos de acción prolongada en los Estados Unidos.	Los anticonceptivos implantables contribuyeron a una reducción del 45 por ciento en las tasas de embarazo adolescente durante cinco años.
Costa et al. (2022)[10]	Explorar las vulnerabilidades sociales asociadas al embarazo precoz en Río de Janeiro.	Las desigualdades sociales y la violencia sexual son determinantes críticos del embarazo entre las niñas de 10 a 14 años.

Fuente: Elaboración propia con base en datos de SINASC (2015-2021)[3], CDC (2024)[5], SciELO (2023)[4], UNFPA (2022)[7], Bicalho et al. (2021)[6], Levandowski y Piccinini (2020)[8], Martin et al. (2020)[9] y Costa et al. (2022)[10].

Detalles de los nuevos estudios

1. **Bicalho et al. (2021):** Este estudio brasileño destacó la estabilidad de las tasas de fecundidad entre adolescentes muy jóvenes (10 a 14 años), lo que indica que los esfuerzos actuales deben dirigirse hacia cambios culturales y estructurales profundos.[6]
2. **Levandowski y Piccinini (2020):** El impacto emocional de los embarazos tempranos fue uno de los principales focos, mostrando una mayor propensión a desarrollar depresión y otros trastornos mentales entre las adolescentes embarazadas, especialmente aquellas sin el apoyo familiar adecuado.[8]

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3. **Martin et al. (2020):** Al analizar datos de los EE. UU., la investigación demostró que los anticonceptivos reversibles de acción prolongada, como los DIU y los implantes, tuvieron un impacto directo en la reducción de las tasas de embarazo adolescente.[9]
4. **Costa et al. (2022):** Con base en datos de Río de Janeiro, este estudio reveló que las niñas expuestas a la violencia sexual y las desigualdades económicas enfrentan riesgos sustancialmente mayores de embarazo temprano. Este análisis refuerza la necesidad de intervenciones preventivas y protectoras.[10]

Análisis inicial

Indicador	Brasil	Estados Unidos
Tasa de embarazo adolescente (2020)	62/1,000 adolescentes	16/1,000 adolescentes
Consultas prenatales completas	El 49,5% de las mujeres embarazadas	El 88% de las mujeres embarazadas
Tasa de deserción escolar	33%	20%
Acceso a la anticoncepción	Limitado en las zonas rurales	Amplio, con programas específicos

Fuente: Adaptado de OMS (2022)[1], UNFPA (2023)[2], SINASC (2015-2021)[3], CDC (2024)[5], SciELO (2023)[4], Ministerio de Salud (2021)[12] y HHS (2023)[13].

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La tabla y los estudios más recientes complementan el análisis inicial, destacando la importancia de los enfoques multifactoriales. En Brasil, la implementación de políticas que aborden las cuestiones culturales y socioeconómicas sigue siendo limitada. Por otro lado, Estados Unidos demuestra que los avances tecnológicos y los programas educativos

consistentes pueden reducir significativamente las tasas de embarazo adolescente, aunque no son suficientes para eliminar las desigualdades estructurales. Los datos fueron organizados en tablas y gráficos comparativos, con análisis crítico de las intervenciones.

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Tabla 1: Indicadores comparativos del embarazo adolescente

Tabla comparativa: Tasas de embarazo adolescente por región (Brasil y EE.UU.)

Región	Brasil (por cada 1.000 adolescentes)	Estados Unidos (por cada 1.000 adolescentes)
Norte	75	-
Nordeste	65	-
Sudeste	40	-
Sur	35	45
Midwest	50	-
Sur (Estados Unidos)	-	45
Noreste (EE. UU.)	-	25
Medio Oeste (EE. UU.)	-	35
Oeste (Estados Unidos)	-	30

Fuente: Elaboración propia con base en datos de SINASC (2015-2021)[3], CDC (2024)[5] y SciELO (2023)[4].

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Análisis adicional

- **Brasil:** Las regiones Norte (75/1.000) y Nordeste (65/1.000) tienen las tasas más altas de embarazo adolescente, lo que refleja las desigualdades socioeconómicas y el acceso limitado a la salud reproductiva.
- **Estados Unidos:** Las tasas son más bajas en general, pero la región Sur (45/1,000) se destaca con las tasas más altas, relacionadas con las barreras culturales y económicas.

4.2 Datos comparativos

Indicador	Brasil	Estados Unidos
Tasa de embarazo adolescente (2023)	53/1.000 adolescentes.[10.11]	15,4/1.000 adolescentes.[11]
Consultas prenatales completas	49,5% de las mujeres embarazadas.[12]	88% de las mujeres embarazadas.[12]
Deserción escolar	33%[12]	20%[13]
Acceso a la anticoncepción	Limitado, sobre todo en las zonas rurales.[11]	Amplio, con programas subsidiados.[11]
Educación sexual en las escuelas	Fragmentado, con baja cobertura nacional.[10]	Integrado en el currículo escolar.[13]
Población más vulnerable	Regiones Norte y Nordeste; jóvenes negras e indígenas.[12]	Minorías étnicas (latinos y afroamericanos)[13]

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Tasa general de natalidad (2023)	14,3 nacimientos por cada 1.000 habitantes.[12]	11,0 nacimientos por cada 1.000 habitantes11
Mortalidad materna (2019-2021)	62-190 muertes por cada 100.000 nacidos vivos, con disparidades raciales (negros: 190; indígenas: 149)[12-14]	17 muertes por cada 100.000 nacidos vivos.[11]

Fuente: Adaptado de OMS (2022)[1], UNFPA (2023)[2], SINASC (2015-2021)[3], CDC (2024)[5], SciELO (2023)[4], Ministerio de Salud (2021)[12] y HHS (2023)[13].

5. Discusión

Los datos analizados revelan un patrón de desigualdad en el abordaje y los resultados del embarazo adolescente entre Brasil y Estados Unidos. En Brasil, aunque las tasas han disminuido gradualmente en los últimos años, siguen siendo altas en las regiones menos desarrolladas, como el norte y el nordeste. Factores como la desigualdad socioeconómica, la baja educación y el acceso limitado a métodos anticonceptivos son determinantes significativos de esta realidad. Los datos muestran que el 49,5% de las adolescentes embarazadas tuvieron 7 o más visitas prenatales, mientras que el 41% tuvieron solo de 4 a 6 visitas, lo que indica disparidades regionales significativas en el acceso a la salud básica.[5.6] En los Estados Unidos, la reducción de las tasas de embarazo

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adolescente ha sido impulsada por programas educativos y un mayor acceso a métodos anticonceptivos, como el Programa de Prevención del *Embarazo en Adolescentes*. Sin embargo, persisten problemas entre las minorías étnicas y las poblaciones de bajos ingresos, que se enfrentan a barreras culturales y económicas. La tasa de embarazo entre las adolescentes latinas y afroamericanas sigue siendo desproporcionadamente alta, lo que refleja desigualdades sociales y raciales profundamente arraigadas.[7,8] Las consecuencias sociales, como la deserción escolar y la exclusión económica, afectan gravemente al desarrollo de las adolescentes. En Brasil, alrededor del 33% de las adolescentes embarazadas abandonan la escuela, lo que agrava el ciclo de la pobreza. En Estados Unidos, esta tasa es del 20%, pero los impactos se exacerban en las comunidades marginadas. Ambos países ponen de manifiesto la necesidad de políticas más inclusivas y culturalmente adaptadas para garantizar la igualdad de oportunidades y el acceso a los derechos reproductivos.

Los factores emocionales también juegan un papel central. Las adolescentes se enfrentan a juicios sociales, aislamiento y, a menudo, a la falta de apoyo familiar adecuado, lo que intensifica los desafíos psicológicos. Los programas de apoyo

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emocional son esenciales para mitigar los efectos adversos de la maternidad temprana y promover el bienestar de las mujeres jóvenes y sus hijos.[9.10]

6. Conclusión

El embarazo adolescente representa un problema multidimensional que requiere estrategias de enfrentamiento específicas y regionales. En el Brasil, los esfuerzos deben dirigirse a reducir las desigualdades regionales y ampliar el acceso a la anticoncepción y la educación sexual, especialmente en las zonas rurales y las comunidades marginadas. Programas como "Salud en la Escuela" necesitan expansión y financiamiento para lograr una mayor cobertura y efectividad. En los Estados Unidos, aunque las tasas están disminuyendo, la brecha entre los grupos socioeconómicos y raciales indica que las políticas universales no satisfacen plenamente las necesidades de las poblaciones vulnerables. El fortalecimiento de programas específicos, como el Programa de Prevención del *Embarazo en Adolescentes*, y el aumento de las iniciativas culturales y lingüísticas inclusivas son clave para continuar reduciendo las tasas de embarazo adolescente. Ambos países pueden beneficiarse del intercambio de experiencias y buenas prácticas, especialmente en lo que

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respecta a la educación sexual integral y el apoyo socioemocional a las adolescentes embarazadas. La promoción de campañas educativas y la inclusión de las adolescentes en diálogos sobre sus derechos reproductivos son pasos cruciales para transformar este escenario.

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GENDER VIOLENCE AND THE LIMITS OF THE NORMATIVE LEGAL PROTECTION SYSTEM [1]

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Abstract

Background: As a result of the violence practiced against women, a legal and regulatory framework has been created at international and national level to protect them. In Brazil, Law 11.347/06, known as the Maria da Penha Law, identifies the types of violence and establishes mechanisms to prevent and curb it. The classification of the forms of violence practiced against women described in this law has been improved, for example by establishing a correlation between psychological violence and property violence. Identifying the forms of violence allows us to understand the relationship between violence and the effects it has on women's health. **Problem**: To what extent has the protection system created by the Brazilian state to prevent and curb gender-based violence been able to achieve its purpose? **Objectives**: to reveal that the patriarchal model of society is one of the factors that contribute to the perpetration of violence against women; to establish a comparison between the legal framework for the protection of women and the Brazilian reality. **Method**: This is an exploratory, qualitative study based on an analysis of scientific articles, doctrine, documents and data compiled by research institutes**. Results:** The evolution of women's protection under both international and national legislation has stimulated the construction of public policies and measures to protect women who are victims of violence. This normative framework is important, however, it is clear that data from the Brazilian reality still reveals that there are high rates of violence against women. **Conclusions**: Gender-based violence is a consequence of patriarchy and also has negative effects on women's psychological health. Despite legislative progress, women who suffer domestic violence encounter huge obstacles in accessing the protection mechanisms created by the Brazilian state, due to the strong historical, social and cultural roots of patriarchy, which are revealed in the alarming statistics on gender violence.

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Keywords: Women's Rights, Domestic Violence, Psychological and Property Violence, Women's Health.

Introduction[5]

Society lives with violence against women, even though there are laws to curb such violence, as well as media coverage and the existence of reporting channels to guide and help women who suffer violence. (Leme at al, 2021, p.136).

The article reveals that domestic violence has historical and socio-cultural origins, as it is based on patriarchy, which places women in a position of submission, devaluation and unequal status in relation to men, which legitimizes, trivializes, promotes and silences violence.

The study briefly presents the international and domestic legal-normative system that has been built up since the 20th century with the aim of safeguarding women's rights; it analyzes aspects of the Maria da Penha Law, sets out a list of existing protective measures and presents recent data on violence against women.

The main objective of the study is: 1. to reveal that the patriarchal model of society is one of the factors that contribute to the perpetration of violence against women; 2. to establish

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a comparison between the legal framework for the protection of women and the Brazilian reality.

The research is exploratory and qualitative, based on scientific articles, doctrine, documents and data compiled by research institutes.

1. Historical aspects of domestic violence

Violence against women has a historical and socio-cultural origin, where men are seen as stronger, due to the culture of patriarchy, which is still rooted in today's society, where men dictate the rules and women obey the rules dictated by them (Leme at al, 2021, p.136).

The doctrine mentions that since patriarchy, male supremacy has prevailed in social relations, that is, the submission of women to men, with punishment for the offender, when the rules imposed by the patriarch are not complied with (Balbinotti, in Leme, 2021, p.136).

Almeida (in Leme, 2021, p.136) states that society is viriarchal, because the man, even if he is not the father, assumes the position of dominance.

The macho culture is still dominant, causing women to be devalued and unequal to men.

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Fear and respect for the husband (submission) are already ingrained as a cultural characteristic of society, based on ancient concepts and beliefs of domination, which is not questioned because it goes against religious, moral, economic, psychological and social thinking (Menezes, 2000).

We have various documents and organizations created to protect women's rights, such as the Inter-American Commission on Women (CIM-1928), the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW-UN-1979), which came into force in 1981 and was ratified by Brazil in 1984.

Created by the UN in 1982, the Committee on the Elimination of Discrimination against Women has the task of examining progress in the implementation of the Convention, as well as access to the global protection system.

Article 5 of the Federal Constitution of 1988 grants equal rights to men and women, based on the principle of isonomy, but in the face of social culture, these rules are only formal.

Violence against women comes in many forms and affects all races, ethnicities, social classes and levels of education. It is not an isolated event, as such violence takes the form of a sequence of episodes, which usually become more severe.

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According to the UN definition (1992), violence against women is "...any act of violence based on gender difference, resulting in physical, sexual and psychological harm to women, including threats of such acts, coercion and deprivation of liberty, whether in public or private life."

In 1993, at the United Nations Conference on Human Rights, it was recognized that violence against women is an offence against human rights, and it was stated that such violence is a fact of public domain (Vienna Convention, 1994).

Domestic violence has been recognized by the World Health Organization (WHO) as a public health issue, which negatively affects the victim's physical and emotional integrity, their sense of security, a vicious circle of "comings and goings" to health services and the consequent increase in public spending (Grossi, 1996).

In Brazil, we have the Belém do Pará Convention, which states that gender-based violence can occur in the sphere of the family, the domestic unit, the community and institutions. (IACHR, 1994)

Violence against women is characterized as a pandemic, as it is prevalent at an international level, given that 30% of women in the world have suffered some type of domestic violence perpetrated by an intimate partner. In Brazil, 27.4%

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of women aged 16 or over have suffered some form of physical or psychological violence or harassment in 2018 (Leme et al, 2021, p. 138).

2. Domestic and intrafamily violence and types of violence

Violence against women stems mainly from gender inequality, occurring since childhood, and is motivated by jealousy and infidelity, which generate physical, psychological and social consequences, having a higher incidence in the domestic and family environment, due to the culture of patriarchy (Leme et al, 2021, p. 138).

Studies carried out in Brazil show that 42% of violence against women occurs in the domestic environment (IBSP and Data Folha, 2019), and can be classified as physical, sexual (the ultimate expression of gender inequality), moral, property and psychological (Article 7 of the Maria da Penha Law). It should be noted that violence has now reached the virtual environment (Leme et al, 2021, p.139).

A recent study by the Brazilian Institute of Geography and Statistics points out that domestic violence against women has increased considerably in Brazil, indicating that among 100,000 women, in 2021 and 2022, there were 230.1 and

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236.7 records of domestic violence, respectively. In the same years of 2021 and 2022, it was also found that in 11 Brazilian states there was a decrease in violence against women, but in the other states there was an increase in violence, with the states of Amazonas and Roraima showing the highest rates of increase in violence against women.

According to the Maria da Penha Institute, based on the Law of the same name, in Chapter II, Article 7, items I, II, III, IV and V, there are five types of violence against women: physical violence, psychological violence, sexual violence, property violence and moral violence.

According to the Institute, physical violence is considered to be any conduct that offends a woman's bodily integrity or health, which can be characterized by the aggressor beating her, throwing objects, shaking and squeezing her arms, strangling or suffocating her, injuries with sharp or piercing objects, injuries caused by burns or firearms and torture. Sexual violence is any conduct that forces a person to witness, maintain or participate in an unwanted sexual relationship through intimidation, threats, coercion or the use of force. Examples of these practices are rape, forcing a woman to perform sexual acts that cause discomfort or repulsion, preventing the use of contraceptive methods or forcing a

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woman to have an abortion, forcing marriage, pregnancy or prostitution through coercion, blackmail, bribery or manipulation, limiting or annulling the exercise of a woman's sexual and reproductive rights. Moral violence is considered to be any conduct that constitutes slander, defamation or insult, characterized by accusing a woman of betrayal, making moral judgments about her conduct, making untruthful criticisms, exposing her intimate life, demeaning a woman by cursing her character, devaluing the victim because of the way she dresses.

We must also mention discrimination against women, which is invisible, a practice of disrespect, through jokes, public comments, advertisements, songs, inferiorizing women, stating that women should be restricted to the kitchen, the bed or the shadows (Penha, 2012).

3. The Cycle of Violence Theory

The term Cycle of Domestic Violence was coined by American psychologist Lenore Walker to identify certain patterns of abuse in relationships of affection, as well as stating that it is very difficult for women to leave a violent affective union, which represents a vicious, repetitive pattern

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in the same relationship, as it is renewed with each aggression (Leme et al, 2021, p.140).

This cycle is divided into three phases (Soares, 2005): Phase 1 - tension in the relationship. It begins with arguments, jealousy, verbal aggression, without physical violence. The woman seeks justification for the tension and this phase is indefinite. Phase 2 - maximum tension. Physical aggression and psychological pressure begin, and this phase lasts less than phase 1. Phase 3 - begins after the actual violence, when the aggressor repents and promises not to commit any more violence, so as not to break off the relationship, and the cycle continues.

This cycle can be understood by the patriarchal - macho pattern, which comes from a historical condition of submission with more complex non-physical abuse, passed down from generation to generation within the family structure.

The aggressor's promises of change give the violence a cyclical character, which takes the form of moments of aggression and love. It is therefore important for women to be aware of the cycle in which they are involved, so that they can get out of the situation (Miller, 1999).

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The majority of women remain in relationships because of their economic and social dependence on their partner, and aggressors use strategies to maintain their relationships.

Women are unmotivated to file complaints because they fear retaliation, because it is a personal matter, because of the humiliation of exposing the fact at the police station, because of the guilt and shame of the aggression, because of the difficulty of reporting the aggressor in cases of rape, because of the aggressor's economic dependence, because of the family constitution with the aggressor and because of the children (Campos, 2012, p.39).

Several factors can also trigger domestic violence, such as the use of alcohol, psychotropic drugs and illicit drugs, as well as the presence of bladed weapons and firearms in the domestic environment.

4. Data related to violence against women

Research shows that 52% of women do not take action after suffering violence, and 22.2% who seek help report the aggressor (IBSP and Datafolha, 2018).

The São Paulo Public Prosecutor's Office, according to a survey carried out between March 2017 and March 2018, found that of the 124 cases of femicide, only 5 had a police

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report against the aggressor, demonstrating the silent attitude of the violated woman. This statistic also occurs at an international level, due to the failure of the state to guarantee the effective protection expected by women and the simple fact of not reporting it (Leme at al, 2021, p.141).

During the pandemic, there has been an increase in violence against women, with an 18% increase in March 2020 alone, verified through the hotline services (Leme at al, 2021, p.141).

In March 2023, the Network of Security Observatories recorded 2,423 cases of violence against women, showing that every four hours a woman was a victim of violence. This is revealed in the bulletin Elas Vivem: data that won't be silenced. This bulletin monitors seven states: BA, CE, PE, SP, RJ and, for the first time, MA and PI. Among the cases recorded, 495 are femicides. The methodology applied in this bulletin is that of daily monitoring of what circulates in the media and on social networks about violence and security, thus encompassing cases in which reports may or may not have been made to official bodies. The information collected is fed into a database which is then reviewed and consolidated.

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The study also points out that 75% of femicides are committed by former partners and that the main reasons for crimes against women are break-ups and fights.

The research also provides evidence of violence against women, indicating the existence of underreporting in relation to gender-motivated violence, with data that portrays a portion of daily events whose totality is even greater and more painful than the surveys carried out by public bodies.

According to the Ministry of Racial Equality, black women, noting that 'black women' includes black women and brown women, within the spectrum of colorism, are the ones who suffer most from psychological, physical or sexual violence, data from 2021.

Cases of psychological violence against women increased by 89%, while property violence increased by 34%, with 35% of victims earning up to 2 minimum wages (Datasenado, Brasília, 2023).

Underreporting is as much as 10 times higher than that registered as domestic violence, which creates a gap in the protection of women, and a correlation in the reliability of public protection systems in defense of women's rights (UFMG- 2023).

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5. Psychological violence and property violence

As defined by the Maria da Penha Institute, psychological violence is defined “as any conduct that causes emotional damage and diminished self-esteem, that harms and disturbs a woman's full development or that aims to degrade or control her actions, behaviors, beliefs and decisions.”

Psychological violence is revealed by various actions of the aggressor to control the woman in her daily life, which cause emotional damage and deteriorate her mental health. The perpetrators of psychological violence act in a similar way in order to create a modus operandi that inhibits, deceives, isolates, manipulates, belittles and humiliates the victims.

These acts can be practiced with threats, embarrassment, humiliation, manipulation, isolation (prohibiting studying and traveling or talking to friends and relatives), constant surveillance, constant persecution, insults, blackmail, exploitation, limiting the right to come and go, ridicule, taking away freedom of belief, distorting and omitting facts to leave the woman in doubt about her memory and sanity, as exemplified by the Maria da Penha Institute.

There is a recurring practice of keeping women away from their families and social circles, so that these groups don't oppose, warn or denounce the violence.

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Furthermore, aggression helps the perpetrators, who can be spouses, parents, children, siblings, stepparents, to achieve their goals, which is to put these women in a state of psychological vulnerability.

It is worth noting that trans women and transvestites are also part of the cycle of psychological violence against women, and are protected by the Maria da Penha law. It should be noted that the aggressor can be another woman, who also uses interpersonal relationships and power relations to commit violence against her partners.

Psychological violence is mainly evidenced by disrespect for others, and can happen in various relationships, such as work, family and interpersonal relationships. But it usually happens in situations where there is an emotional bond between the parties. The partner believes they can't live without the other (Serafim, 2023).

Gaslighting, a term in English that can be translated as psychological manipulation in relationships, manipulation that can take place in different ways and to different degrees, according to the Penal Code, in its article 147-b.

The gender of the aggressor does not prevent women from suffering all forms of psychological violence that are unfortunately implicit in the social correlations of gender power

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and control of women, although the vast majority of aggressors are men, demonstrating the correlation of machismo and misogyny.

The Maria da Penha Institute defines property violence as “any conduct that constitutes the retention, subtraction, partial or total destruction of objects, work instruments, personal documents, goods, values and rights or economic resources, including those intended to satisfy their needs”.

Property violence against women stems from fragility and emotional dependence, in which aggressors take advantage of personal relationships to take advantage of their victims. These relationships can be dating, marriage, stable union or just a promise of a relationship. "Violence against women always aims to control women. And one of the forms of control is to keep the partner financially dependent, so that she can't afford to leave the man," according to Judge Madgéli Frantz Machado, head of the 1st Court of Domestic and Family Violence against Women in Porto Alegre at the Rio Grande do Sul Court of Justice (TJRS).

There are cases in which the women have a profile of financial independence or a socio-economic condition capable of maintaining the luxuries and privileges of these exploiters, with elderly women being the main victims of this violence. It

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is important to note that many abuses can also be committed when the woman works for the aggressor without receiving any benefits or payments, putting aside her professional earnings in the job market to support her partner.

Victims of property violence often sell their only possessions to give to the aggressor, or the aggressor manages all their assets, and there are cases of financial control in which the woman has to give all her salary to the aggressor, who controls all her earnings and expenses (Maria da Penha Law, Art. 7, IV).

The abusive behaviors characteristic of aggressors range from financial restriction, preventing the woman from participating in decisions about her own money; destruction of personal belongings, such as valuables, or selling them; concealment of personal documents, to curb flight and the taking of property; changing bank passwords, to deprive access to financial resources; preventing work, to curb financial independence; among others (Maria da Penha Law, Art. 7, IV).

These are some of the controls that victims of property violence can suffer from their aggressors, and there is often a correlation between psychological and property damage,

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revealed by the emotional and psychological dependence between the victim and the aggressor.

Domestic violence against women has been recognized by the World Health Organization (WHO) as a public health issue, resulting negatively in the physical and emotional integrity of the victim and their safety, with “comings and goings” to health services, consequently generating an increase in public spending on health (Grossi, 1996).

Violence against women has consequences for their health, especially their mental health. Studies show that 75.3% of women who have suffered violence suffer from depression, but a more recent study (Bittar, 2017, p.451) points to various psychological symptoms resulting from domestic violence against women, such as depression, post-traumatic stress, anxiety, phobias, discouragement, irritability, panic syndrome, suicidal ideation, attempted suicide, homicide, low self-esteem, feelings of guilt, inferiority, insecurity, shame, social isolation, difficulty making decisions, extreme dependence, smoking, alcohol use, lack of concentration (Leme at al, 2021, p.143).

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6. The Maria da Penha Law

The Maria da Penha Law was created as a result of a recommendation by the Inter-American Commission on Human Rights, which found that Brazil had failed to provide judicial protection to the victim (Maria da Penha Maia Fernandes) in relation to the abuse she suffered from her husband, i.e. the various assaults and micro-aggressions inflicted by her partner, which almost took her life, leaving her paraplegic and at risk of death. (Maria da Penha Institute).

Brazil was also condemned in 2021 by the Inter-American Court of Human Rights (IACHR), in the case of the murder of Márcia Barbosa de Souza, which took place in 1988. This condemnation was handed down for the first time in an absolute manner based on the violation of gender-related human rights, with Brazil being held responsible for the difficulty in accessing justice and the lack of investigation in cases of femicide, including the discrediting of the victim in both the trial and the investigation, revealing the abusive power relations of public agents in the exercise of their functions.

In Brazil, around 4 women a day die as a result of gender crimes, a high rate that leaves Brazil in 5th place in the world for femicide, behind countries such as El Salvador, Colombia,

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Guatemala and Russia, according to the United Nations High Commissioner for Human Rights (UNHCHR). Brazil kills 48 times more women than many countries such as the United Kingdom.

The term feminicide was coined in the 1970s by South African writer and women's activist Diana Russel, who researched sexual violence committed against women and girls, studying in depth the misogynistic murders committed by men, especially their partners, and publicly defending her actions at the Crimes against Women Tribunal in Brussels (Dias et al; 2021).

Death by gender crimes against women can occur in the family, in interpersonal relationships, by illegal armed groups, at the behest of state agents or even in public spaces.

With such discrepant measures and such frightening estimates, after Brazil was condemned internationally for its failure to act in cases of domestic violence against women, what would be left for the state to do but to promote legislation that protects all women from aggression?

The Maria da Penha Law, as it is popularly known, came about with this in mind, following the international condemnations that Brazil has suffered and with repeated popular pressure. This law creates mechanisms to curb

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domestic violence against women, regardless of social class, ethnicity, sexual orientation, income, culture, educational level, age and religion, as stated in Article 3 of the law.

7. Protective measures

With the advent of Law No. 14.188/21, which defines a red light cooperation program against domestic violence, the penalty for bodily injury on the grounds of female gender and the criminal type of psychological violence against women have been altered, even amending Decree Law No. 2.484/40, known as the Penal Code.

> "Psychological violence against women. Art. 147-B. Causing emotional damage to a woman that harms her and disturbs her full development or that aims to degrade or control her actions, behaviors, beliefs and decisions, through threat, embarrassment, humiliation, manipulation, isolation, blackmail, ridicule, limitation of the right to come and go or any other means that causes damage to her psychological health and self-determination: Penalty - imprisonment, from 6 (six) months to 2 (two) years, and a fine, if the conduct does not constitute a more serious crime."

It is important to note that red light cooperation can be applied in public offices and private entities throughout the country, and that an information campaign and permanent training of professionals belonging to the program must be carried out, referring the victim to specialized care.

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Judge Alexandre Takaschima, head of the 2nd Criminal Court of the District of Lages, when commenting on the changes to the Maria da Penha Law, emphasized that "recognizing psychological violence as something that cannot be accepted as normal in relationships. I remember a woman who, in court, crying, said that the physical pain had passed, but the trauma and psychological pain she couldn't overcome."

In order to request emergency protective measures and even the criminal investigation itself, it is necessary to go to the official bodies, or through a lawyer, who will know the necessary means to file this type of protection.

The Ministry of Human Rights and Citizenship, on the federal government's website, which is available for reporting violence against women and providing nationwide assistance (call 180), makes referrals to the main agencies, including reference centers and women's shelters.

There are many protective measures against the aggressor to protect the woman from violence, some of which include seizing the aggressor's firearm or restricting him from carrying it; removing the aggressor from the home or the place where he lives with the victim; prohibiting the aggressor from going to or coming close to certain places, such as the victim's

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home or work; prohibiting the aggressor from approaching or maintaining contact with the victim, her relatives and witnesses to the aggression; restricting or suspending the aggressor's visits to his children; payment of provisional maintenance to the victim and her children or only to the latter; measures to benefit the woman; referral of the victim and her dependents to programs for the protection and care of women in situations of domestic and family violence (shelters); guaranteeing the return of the victim and her children to the home abandoned as a result of the aggression suffered, as soon as the aggressor's removal is determined; the victim's right to leave the home with her children in cases of danger or to remain there if the aggressor is removed or arrested; separation of bodies, i.e. the release of the duty to live in the same house, removing the aggressor from the home and no longer having the obligation to sleep together and have sexual relations; removal of the victim from their home, without prejudice to rights relating to property, custody of children and maintenance; return of property that the aggressor has taken from the victim; temporary prohibition on the aggressor making acts or contracts to rent or sell the property that is common to the couple; suspension of the validity of powers of attorney that the victim has given to the aggressor; payment

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of a provisional bond (guarantee) to the victim, by means of a deposit in court, for material losses due to the aggression committed; inclusion of the woman, for a certain period, in the register of assistance programs of the federal, state and municipal governments; priority access to removal, when she is a public servant of the direct or indirect administration; access to emergency contraception services, prevention of STDs and HIV/AIDS and abortion provided for by law.

Crimes of violence against women and their possible punishment will be investigated through criminal proceedings, in compliance with criminal and procedural law, in addition to the crime of non-compliance with protective measures under the law.

In cases of psychological, moral and property violence, it is difficult for victims to file a complaint, either because they are afraid of the aggressor, because of pressure from their social environment, or because it is difficult to prove the causal link, since the evidence of these types of violence is difficult to prove, which means that the protective measures provided for in the Maria da Penha Law are not requested by the victims.

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Final considerations

The study reveals that the Maria da Penha Law was a legislative breakthrough in the system of protection for women who suffer domestic violence, typifying the types of violence and establishing protective measures to safeguard the integrity of the victim against the aggressor.

However, given Brazil's patriarchal roots, domestic violence is still present and on the rise, as the recent statistics reported in the study show.

The article also points out that two types of violence against women are intertwined - psychological and property violence - and that these affect women's mental health, which can lead to depression, post-traumatic stress, anxiety, phobias, discouragement, irritability, panic syndrome, suicidal ideation, attempted suicide, homicide, low self-esteem, feelings of guilt, inferiority, insecurity, shame, social isolation, difficulty making decisions, extreme dependence, smoking, alcohol use, lack of concentration, etc.

The article also points out that there is underreporting of cases of domestic violence against women and that reporting psychological and property violence is even more difficult due to the emotional and financial dependence of the victim, as well as the construction of evidence.

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It is clear that public policies to support women who suffer violence are not implemented effectively in all cities in Brazil, especially those to welcome and offer legal and psychological advice.

In addition to building a legislative framework, it is essential to combat gender stereotypes and deconstruct patriarchal society by consolidating gender equality in order to combat, mitigate and extinguish domestic violence.

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LA PROTECCIÓN DE LOS DERECHOS HUMANOS DE LAS PERSONAS CON DISCAPACIDAD: UN PANORAMA HISTÓRICO [1]

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Resumen

Problema: La violación de los derechos humanos de las personas con discapacidad es una realidad histórica que requiere respuestas urgentes y efectivas. **Objetivos**: realizar un análisis de la evolución histórica de los derechos de las personas con discapacidad, explorando cómo el trato dado a estas personas a lo largo de los siglos influyó en el desarrollo del marco jurídico contemporáneo. **Métodos**: se trata de un análisis bibliográfico-documental. **Resultados**: se puede comprobar que los tratados internacionales de derechos humanos han sido instrumentos innovadores e imprescindibles para garantizar los derechos fundamentales de las personas con discapacidad a lo largo de la historia. **Conclusiones**: Si bien se reconocen todos los avances inherentes a la protección de los derechos de las personas con discapacidad, aún existen vacíos legislativos por superar, para promover una mayor inclusión y respeto a los derechos de estas personas en una sociedad globalizada.
Keywords: Persona con Discapacidad, Violación de los Derechos Humanos, Evolución social**.**

Introducción[4]

De conformidad con el artículo 2º de la ley brasileña nº 13.146/2015, se considera persona con discapacidad aquella que presenta una deficiencia de larga duración, de naturaleza física, psíquica, intelectual o sensorial, que puede impedir su participación plena y efectiva en la sociedad, en igualdad de condiciones con las demás personas. Esta definición, a su vez, surge de una evolución histórica del tratamiento dirigido

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a las personas con discapacidad, quienes, durante mucho tiempo, fueron mantenidas al margen de la sociedad.

Las deficiencias (físicas, psíquicas o intelectuales) de las personas con discapacidad, naturalmente, pueden provocarles dificultades para integrarse en determinados sectores de la sociedad que, por regla general, no están preparados para responder a las peculiaridades de este segmento de ciudadanos. Estos obstáculos que frecuentemente enfrentan las personas con discapacidad se denominan barreras sociales, que impiden, o hacen extremadamente difícil, la participación de las personas con discapacidad en la vida social.

A lo largo de la historia, las personas con discapacidad han sido objeto de numerosas formas de discriminación y exclusión, lo que ha resultado en una violación persistente de sus derechos fundamentales. La marginación sistemática y la falta de políticas públicas inclusivas contribuyeron a un escenario de desigualdad e invisibilidad social de estas personas, por lo que, hasta el día de hoy, la protección de los derechos humanos de las personas con discapacidad es un desafío jurídico y social.

El presente trabajo, por lo tanto, tiene como objetivo realizar una retrospectiva histórica sobre la lucha por los

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derechos de las personas con discapacidad, con el fin de demostrar cómo el trato dirigido a estos individuos, a lo largo de los siglos, influyó en la formación del marco jurídico que sustenta a las personas con discapacidad en la actualidad, especialmente a la luz de los tratados internacionales de derechos humanos.

El estudio adopta una metodología de análisis bibliográfico-documental, con el objetivo de investigar la influencia de los tratados internacionales de derechos humanos en la protección de los derechos de las personas con discapacidad, además de identificar cómo los acuerdos y convenios internacionales ratificados por Brasil se han incorporado al ordenamiento jurídico nacional y han contribuido a la promoción de una sociedad más inclusiva y justa.

Para recopilar la bibliografía adoptada para la elaboración de este artículo se utilizó la herramienta "*google academic*", empleando marcadores de búsqueda relacionados con el tema en cuestión, como, por ejemplo, "violación de derechos humanos" y "persona con discapacidad". De la investigación se dio prioridad a trabajos científicos que contuvieran abordajes jurídicos del tema y que exploraran los textos de convenciones internacionales de derechos humanos.

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Resultados y discusión

Un amplio camino ha sido recorrido, a lo largo de la historia, para que las personas con discapacidad sean reconocidas como sujetos de derechos. No se puede ignorar que gran parte de la lucha social que enfrentan las personas con discapacidad surge de la necesidad constante de desmitificar diversos estereotipos que han sido cultivados y arraigados en las sociedades, reflejando, hasta el día de hoy, la forma de pensar de las sociedades modernas, aunque en menor escala.

En las sociedades antiguas, fuertemente marcadas por los conocimientos tradicionales, había una gran tendencia a interpretar las discapacidades físicas y mentales como signos de disgusto o castigo divino. Esto se debe a que, en determinados períodos históricos, las creencias religiosas dominaban la comprensión del mundo, de modo que comúnmente se aceptaban explicaciones sobrenaturales para esclarecer cualquier acontecimiento que pareciera incomprensible. Así, una persona con discapacidad a menudo enfrentaba no sólo los desafíos inherentes a su condición, sino también el estigma social y la marginación derivados de la idea de que su situación era resultado de un castigo de los dioses.

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Sin embargo, las creencias religiosas no siempre han sido la razón principal de la marginación de las personas con discapacidad. En las ciudades griegas, como Esparta, se entendía que los hombres nacían para unirse al ejército y convertirse en soldados de guerra. Los valores sociales cultivados en Esparta estaban completamente centrados en la preparación física de los jóvenes y la exaltación de los valores militares, pues ese era invariablemente el destino de los niños insertos en ese contexto.

Así, era común que los niños nacidos con algún tipo de discapacidad, principalmente física, fácilmente identificable, fueran separados de sus familias y entregados a los mayores -ciudadanos espartanos que destacaban por su sabiduría, experiencia y virtud- quienes serían los responsables del destino de estos niños. Según Silva (1986), en aquella época se creía que los niños nacidos con determinadas discapacidades difícilmente podrían desarrollarse hasta el punto de vivir en sociedad, por lo que eran entregados, poco después de nacer, a los ancianos, para que los arrojaran al abismo:

> Si les parecía feo, deforme y frágil, como dice Plutarco, esos mismos ancianos, en nombre del Estado y del linaje de familias que representaban, se quedarían con el niño. Inmediatamente después la llevaron y la llevaron a un lugar llamado

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> Épothetai, que significa depósito. Era un abismo situado en la sierra de Tahgetos, cerca de Esparta, donde el niño fue arrojado y encontraría la muerte, pues opinaban que no era bueno para el niño ni para la república que viviera, ya que desde su nacimiento no estaba bien constituido para ser fuerte, sano y fuerte durante toda su vida. (Silva, 1986, p. 12)

En la Antigua Roma todavía estaba vigente la Ley de las Doce Tablas, que abordaba diversos aspectos de la vida en sociedad y la constitución de las familias romanas. El cuadro cuarto de la citada Ley, que trataba sobre el ejercicio de la patria potestad y las normas relativas al matrimonio, establecía que el padre tenía derecho a, legítimamente, matar a su propio hijo que naciera con algún tipo de “deformidad”, refiriéndose, evidentemente, a aquel que nacía con discapacidad física.

Estos contextos sociales ponen de relieve una realidad inhumana para las personas con discapacidad en las sociedades antiguas, donde estas personas ni siquiera eran consideradas sujetos de derecho. Además de las barreras físicas y sociales que enfrentaron durante ese período, las vidas de las personas con discapacidad también se vieron amenazadas sistemáticamente y se las mantuvo al margen de la sociedad. La falta de reconocimiento de sus necesidades específicas de salud, combinada con la

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exclusión social y la marginación, resultó en condiciones de vida precarias, acentuando su vulnerabilidad.

Durante el período de la Ilustración, que floreció en Europa entre los siglos XVII y XVIII, el surgimiento de debates filosóficos sobre la naturaleza humana y la igualdad condujo a un avance considerable en la percepción que la sociedad tenía de las personas con discapacidad. Filósofos como Voltaire, Rousseau y Montesquieu, entre otros, cuestionaron las jerarquías sociales tradicionales y defendieron ideas que ponía en duda la exclusión y discriminación de determinados grupos por sus características físicas o mentales.

El movimiento de la Ilustración también promovió una apreciación renovada de la razón, la libertad individual y la búsqueda del conocimiento científico, principios que desafiaron las opiniones más antiguas que consideraban a las personas con discapacidad como menos capaces o inferiores. Al discutir la universalidad de los derechos humanos y la dignidad inherente de todos los seres humanos, los filósofos de la Ilustración como John Locke contribuyeron a una nueva comprensión de la inclusión social y la importancia de adaptar la sociedad para satisfacer las necesidades de todos los individuos.

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Según Moises y Stockmann (2020), la teoría de la tabula rasa de John Locke habría representado un gran avance en el pensamiento crítico de aquella época, pues defendía que todas las personas serían capaces de pensar racionalmente. La teoría desarrollada por John Locke indica que la mente humana sería como una pizarra en blanco (tabula rasa) en el momento del nacimiento, sin ningún conocimiento o idea preexistente. Con ello, todos los conocimientos y conceptos de un determinado individuo provendrían de sus experiencias sensoriales y de sus propios reflejos.

Según Locke, existen dos fuentes principales de conocimiento: las sensaciones, que son experiencias externas captadas por los sentidos, y la reflexión, que son experiencias internas y procesos mentales. Las sensaciones, a su vez, formarían ideas simples que, una vez combinadas o comparadas con otras, podrían crear ideas complejas. Tales pensamientos, según Moises y Stockmann (2020), habrían servido de inspiración para que Denis Diderot, en 1749, escribiera la “Carta sobre los ciegos para uso de quienes ven”, exaltando la capacidad de los ciegos de aprender a través de las sensaciones y los sentidos. Para los autores (2020), las producciones de Locke y Diderot también habrían contribuido

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a la fundación del Instituto Nacional de Jóvenes Ciegos, en París, en 1784, por Valentin Hauy.

Otros pensamientos ilustrados de John Locke, como su teoría de los derechos naturales, también contribuyeron a la deconstrucción de algunos paradigmas sociales, permitiendo que las personas con discapacidad fueran gradualmente vistas como sujetos de derechos. La teoría de los derechos naturales de John Locke, presentada en su obra “Segundo Tratado sobre el Gobierno Civil” (1689), sostiene que todos los seres humanos poseen derechos naturales inalienables que han existido desde su concepción y que están por encima de cualquier autoridad gubernamental.

Para el filósofo, cada individuo tiene el derecho fundamental a la vida, lo que significa que nadie tiene derecho a quitar la vida a otro. En este sentido, explican Gomes y Oliveira, las teorías defendidas por Locke habrían sido fundamentales para difundir la idea de que ningún ser humano tendría el poder de quitarle la vida a otro, lo que, por tanto, aportaba cierta protección a las personas con discapacidad, ya que ningún ciudadano tendría autonomía para atacar a otros:

> Para Locke, el derecho a la vida significa en última instancia la prohibición de que un individuo ataque a otro, debido principalmente a la jerarquía de los

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> hombres. Para el filósofo, Dios creó a los hombres iguales e independientes, eliminando por tanto la posibilidad de agresión mutua entre ellos. A pesar de no permitir la agresión mutua, en Locke, el derecho a la vida permite a todos tener derecho a la autodefensa, como consecuencia de la prohibición divina de la agresión contra la vida humana. El mundo es obra divina y le pertenece. (Gomes e Oliveira, 2007, p. 224)

La teoría de los derechos naturales ideada por John Locke tuvo una profunda influencia en el desarrollo del pensamiento político moderno, especialmente en la concepción de los derechos humanos y la fundación de los gobiernos democráticos. Sus principios eran fundamentales para el desarrollo de tratados de derechos humanos que promueven la igualdad y la libertad.

Otro hito importante en la historia de los derechos humanos fue la Revolución Francesa, que tuvo lugar entre 1789 y 1799. Inspirada por los ideales de la Ilustración, la revolución no sólo sacudió las estructuras políticas y sociales de Francia, sino que también tuvo un impacto duradero en la concepción y promoción de los derechos humanos a escala global.

La Revolución Francesa estuvo precedida por un período de intenso debate filosófico y político. Los pensadores de la Ilustración, como Voltaire, Rousseau y Montesquieu,

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cuestionaron los fundamentos de la autoridad monárquica y la jerarquía social, promoviendo ideas de igualdad, libertad y fraternidad. La Declaración de los Derechos del Hombre y del Ciudadano, adoptada por la Asamblea Nacional Constituyente en 1789, es un producto directo de estos debates y representa una ruptura radical con las injusticias sociales cometidas en el pasado.

La Declaración de 1789 establece, en su art. 1º, que todos "los hombres nacen y permanecen libres e iguales en derechos" (Francia, 1789) y establece, en su art. 6º, que "la ley debe ser la misma para todos, ya sea para proteger o para castigar" (Francia, 1789). Estos principios de igualdad y justicia fueron fundamentales para la posterior inclusión de derechos específicos para grupos históricamente marginados, considerando que era la primera vez que la legislación contemplaba expresamente el derecho a la igualdad de trato entre todos los hombres.

La Declaración de los Derechos del Hombre y del Ciudadano de 1789 a menudo se considera un hito en la historia de los derechos humanos. Aunque la declaración no menciona explícitamente a las personas con discapacidad, los principios de igualdad y dignidad contenidos en ella han servido de base para la evolución de los derechos de todas

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las personas, independientemente de sus capacidades físicas o mentales.

La Revolución Francesa impulsó una serie de reformas sociales y políticas que, con el tiempo, beneficiaron a las personas con discapacidad. La apreciación de la igualdad y los derechos humanos influyó en la forma en que se veía y trataba a las personas con discapacidad. Estas personas, anteriormente marginadas y a menudo excluidas de la vida social, comenzaron a ser reconocidas como ciudadanos con derechos y dignidad.

Los principios de igualdad y libertad establecidos por la Revolución Francesa continuaron resonando a lo largo del siglo XIX, impulsando movimientos abolicionistas y sufragistas que lucharon por la abolición de la esclavitud y la igualdad de género. La Ley de Abolición de la Esclavitud de 1833 en el Reino Unido y la Proclamación de Emancipación de 1863 en Estados Unidos son ejemplos de cómo se aplicaron ideales revolucionarios para corregir injusticias sistémicas. Sin embargo, la lucha por los derechos humanos no terminó con la Revolución Francesa; por el contrario, continuó evolucionando, enfrentando nuevos desafíos y culminando con la adopción de la Declaración Universal de Derechos Humanos en 1948.

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El comienzo del siglo XX trajo consigo dos devastadores conflictos globales que pusieron a prueba los límites de la humanidad y los derechos humanos. La Primera Guerra Mundial (1914-1918) provocó una pérdida masiva de vidas y una destrucción sin precedentes, lo que llevó a la creación de la Sociedad de Naciones en 1919 en un intento de promover la paz y la cooperación internacional. Sin embargo, la incapacidad de la Liga para prevenir conflictos futuros y proteger eficazmente los derechos humanos expuso sus limitaciones.

La Segunda Guerra Mundial (1939-1945) fue aún más catastrófica, marcada por genocidio, masacres y violaciones de derechos humanos en una escala inimaginable. El Holocausto, en particular, reveló la profundidad de la brutalidad humana, con millones de judíos, gitanos, personas con discapacidad y otros grupos minoritarios siendo sistemáticamente exterminados.

Las atrocidades cometidas durante la guerra generaron una fuerte reacción global y un consenso sobre la urgente necesidad de un marco internacional para la protección de los derechos humanos. Como respuesta a los acontecimientos de la Segunda Guerra Mundial, se creó, por tanto, la Organización de las Naciones Unidas (ONU), fundada en

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1945, a la que se le encomendó la tarea de crear un comité para redactar una declaración que pudiera servir como norma común para todos los pueblos y naciones.

La Declaración Universal de Derechos Humanos (DUDH) fue luego adoptada por la Asamblea General de las Naciones Unidas, el 10 de diciembre de 1948. Este documento histórico, compuesto por 30 artículos, define los derechos y libertades fundamentales que deben utilizarse como parámetro para la protección de los derechos humanos a nivel global. Esta Declaración proclama, en su art. 1º, que "todos los seres humanos nacen libres e iguales en dignidad y derechos" (DUDH, 1948). Luego, en su arte. 2.°, la declaración de que toda persona tiene todos los derechos y libertades establecidos en la declaración, sin distinción alguna de raza, color, sexo, idioma, religión, opinión política o de cualquier otra índole, origen nacional o social, posición económica, nacimiento o cualquier otra condición.

La Declaración Universal de Derechos Humanos (1948), adoptada por la Asamblea General de las Naciones Unidas, es un hito en la promoción y protección de los derechos humanos en todo el mundo. Sus principios de igualdad, dignidad y no discriminación han influido significativamente en la creación de normas y tratados internacionales, nacionales

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y regionales que tienen como objetivo proteger los derechos de todas las personas, incluidas aquellas con discapacidad.

Aunque no mencionan explícitamente a las personas con discapacidad, los principios de igualdad y no discriminación contenidos en la Declaración Universal de Derechos Humanos fueron fundamentales para la creación de estándares específicos que apuntan a proteger los derechos de estos individuos. La Convención sobre los Derechos de las Personas con Discapacidad (CDPD), adoptada por la ONU en 2006, es un claro ejemplo de cómo se han aplicado los ideales de la DUDH para promover la inclusión y la igualdad de las personas con discapacidad.

La Convención sobre los Derechos de las Personas con Discapacidad (2006) es un tratado internacional innovador que reafirma los derechos humanos de las personas con discapacidad y establece un marco legal para asegurar su plena participación en la sociedad. La convención enfatiza la dignidad inherente, la autonomía individual y la independencia de las personas con discapacidad, además de promover la igualdad de oportunidades y la accesibilidad.

Entre sus principios generales previstos por la CDPD (2006), se encuentran el respeto a la dignidad inherente a la persona humana, la autonomía individual, la no

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discriminación, la participación e inclusión plena y efectiva en la sociedad, la igualdad de oportunidades y la accesibilidad. La convención también establece la igualdad y la no discriminación, en su art. 5º, y garantiza que las personas con discapacidad puedan vivir de forma independiente y participar plenamente en todos los aspectos de la vida (art. 9º).

Un ejemplo práctico de la importancia de afirmar los derechos humanos de las personas con discapacidad a través de tratados internacionales es el caso Damião Ximenes Lopes, un hito en la historia de los derechos humanos en Brasil, especialmente en lo que respecta al tratamiento de las personas con discapacidad mental. Damião Ximenes Lopes era un hombre de 30 años con esquizofrenia, que ingresó en octubre de 1999 en la Casa de Repouso Guararapes, una institución psiquiátrica ubicada en Sobral, en el estado de Ceará.

Después de tres días de hospitalización, Damião fue encontrado muerto en condiciones inhumanas y con evidentes signos de tortura y malos tratos. Las investigaciones del caso llevaron a la conclusión de que había sufrido golpizas y negligencia durante su hospitalización, lo que generó un serio debate sobre la calidad de la atención

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brindada a los pacientes internados en instituciones psiquiátricas en Brasil.

La familia de Damião, con el apoyo de organizaciones de derechos humanos, llevó el caso ante la Comisión Interamericana de Derechos Humanos (CIDH). En 2004, la CIDH decidió remitir el caso a la Corte Interamericana de Derechos Humanos, alegando que Brasil había violado los derechos de Damião, incluidos el derecho a la vida, la integridad personal y la protección judicial, previstos en la Convención Americana sobre Derechos Humanos.

Según Palombo (2013), Brasil, en su defensa, había presentado una excepción preliminar, afirmando que no se habían explorado todos los recursos internos para resolver la disputa, sin embargo, la excepción fue considerada extemporánea por la Corte Internacional. En sus declaraciones, el Estado brasileño habría reconocido y confesado su irrespeto a la Convención Americana, aunque sostuvo que se habían adoptado las medidas necesarias para mejorar las condiciones de las instituciones psiquiátricas del país, además de ofrecer una pensión vitalicia a la madre de la víctima. La decisión de la Corte Interamericana de Derechos Humanos, sin embargo, no fue otra que reconocer que Brasil, en los hechos, había incumplido su obligación de garantizar y

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respetar los derechos humanos y, específicamente, en el caso de Damião, su integridad y la de su familia.

En uno de los peritajes adjuntos al expediente se puede comprobar que, según la conclusión del perito, no se demostró en el expediente que el paciente presentara algún tipo de peligro para sí mismo o para terceros, siendo evidentemente abusivo en el presente caso el uso de sujeciones físicas.

> En el caso del señor Ximenes Lopes no existe evidencia de que representara un peligro inminente para sí mismo o para terceros. Tampoco hay evidencia de intentos menos restrictivos de controlar un posible episodio de violencia por su parte. Por lo tanto, el uso de cualquier forma de restricción física en este caso fue ilegal. Una vez inmovilizado, con las manos atadas a la espalda, el Estado tenía el deber supremo de proteger a Damião Ximenes Lopes, debido a su condición de extrema vulnerabilidad. El uso de fuerza física y palizas constituyó una violación de su derecho al acceso humano. Existen otras alternativas que se pueden utilizar antes de utilizar la fuerza o decidir aislar a un paciente. Los programas de salud mental deben esforzarse por mantener un entorno y una cultura de atención que minimice el uso de dichos métodos. El uso injustificado y excesivo de la fuerza en este caso viola el artículo 5.2 de la Convención Americana y constituye prácticas inhumanas y tratos degradantes. (Corte Interamericana de Direitos Humanos, 2006)

El informe pericial presentado en el caso de Damião Ximenes Lopes revela una serie de violaciones de derechos

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humanos, destacando la ilegalidad del uso de coerción física sobre una persona que no representaba un peligro inminente para sí mismo o para otros. La negligencia y la violencia física perpetradas contra Damião constituyen una clara transgresión del deber del Estado de proteger a las personas en condiciones de extrema vulnerabilidad. Las golpizas y el uso innecesario de la fuerza, en lugar de medidas menos restrictivas y más humanas, demuestran una violación del derecho a la dignidad y a un trato humano no degradante, establecido en el artículo 5.2 de la Convención Americana sobre Derechos Humanos.

Así, en 2006, la Corte Interamericana de Derechos Humanos condenó a Brasil, responsabilizando al Estado brasileño por las violaciones de los derechos humanos de Damião Ximenes Lopes. La decisión sin precedentes destacó la responsabilidad del Estado de garantizar que todas las personas, especialmente las más vulnerables, reciban un trato digno y humano, e impuso a Brasil una serie de medidas de reparación, incluida una compensación económica a la familia, una investigación adecuada del caso y mejoras en el sistema de salud mental para evitar la repetición de tales abusos.

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La condena marcó un hito histórico en la lucha por el reconocimiento de los derechos humanos de las personas con discapacidad, ya que fue la primera vez que Brasil sufrió una condena por parte de la Corte Interamericana de Derechos Humanos. El caso sacó a la luz la urgente necesidad de reformar el sistema de salud mental y de una mayor vigilancia de las instituciones psiquiátricas para garantizar el respeto de los derechos humanos.

Brasil, inspirado en los principios de la Declaración Universal de Derechos Humanos (1948) y la Convención sobre los Derechos de las Personas con Discapacidad (2006), promulgó el 6 de julio de 2015 el Estatuto de las Personas con Discapacidad (Ley nº 13.146). También conocido como Ley Brasileña para la Inclusión de las Personas con Discapacidad, el estatuto es un marco jurídico que consolida y amplía los derechos de las personas con discapacidad, promoviendo su inclusión y igualdad de todos los aspectos de la sociedad. vida.

Ya en su artículo primero, el Estatuto de las Personas con Discapacidad establece la necesidad de garantizar y promover, en condiciones de igualdad, el ejercicio de los derechos y libertades fundamentales de las personas con discapacidad, encaminado a su inclusión social y ciudadanía.

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El único párrafo de este mismo artículo también reconoce que este estatuto se crea con base en la Convención sobre los Derechos de las Personas con Discapacidad de 2006, reforzando el compromiso internacional ya ratificado por Brasil en 2008.

El Estatuto define a una persona con discapacidad como aquella que tiene una deficiencia a largo plazo de naturaleza física, mental, intelectual o sensorial que, en interacción con una o más barreras, puede obstaculizar su participación plena y efectiva en la sociedad en igualdad de condiciones con las demás personas. Esta legislación representa un avance significativo en la protección de los derechos de las personas con discapacidad en Brasil, promoviendo su igualdad e inclusión social, para que puedan ejercer plena y efectivamente sus derechos fundamentales. Vale decir, por supuesto, que la implementación del estatuto requiere la colaboración entre el gobierno, el sector privado y la sociedad civil para eliminar barreras y promover la accesibilidad en todos los ámbitos de la vida.

Según la Ley 13.146/15, toda persona con discapacidad tiene derecho a la igualdad de oportunidades y no sufrirá ninguna forma de discriminación (Art. 4). Además, el estatuto garantiza el derecho al trabajo, con igualdad de oportunidades

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y remuneración equitativa, además de prohibir la discriminación por discapacidad en relación con la contratación, ascensos y condiciones de trabajo (Art. 27). También establece el derecho a la salud, garantizando el acceso a los servicios de salud en igualdad de condiciones con otras personas, incluidos los servicios de habilitación y rehabilitación (Art. 42).

Otro hito significativo en el Estatuto de las Personas con Discapacidad es el cambio en la nomenclatura asignada. Palumbo (2013) explica que la actual Constitución Federal, a pesar de contemplar derechos fundamentales, como la dignidad de la persona humana, no fue explícita al reaccionar ante un concepto que correspondía a las expectativas actuales, ya que fue redactada en un momento histórico en el que era normal utilizar palabras con connotaciones negativas para referirse a las personas con discapacidad, tales como: paralítico, mongoloide, sordomudo, manco, lisiado, retrasado, débil mental, entre otros. Así, existiría una dificultad histórica para calificar a una persona con discapacidad, clasificándose, en la mayoría de los casos, como minoría, incapaz, especial y, la más utilizada, después del texto constitucional de 1988, la persona con discapacidad.

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Según el autor (2013), la Ley 13.146/15 habría innovado al adoptar la nomenclatura "persona con discapacidad" y establecer directrices generales para asegurar, promover y proteger el pleno ejercicio en igualdad de condiciones para todos. Esta nomenclatura, además de ser más adecuada, atendería la motivación de Naciones Unidas de cambiar el término utilizado, con el objetivo de difundir la idea de que la discapacidad es todavía un concepto en evolución.

Así, Eugênia Augusta Gonzaga Fávero enseña que el término "persona con discapacidad" ya habría sido superado, y actualmente es preferible utilizar la expresión "persona con discapacidad" para asegurar que la discapacidad sea tratada como una característica de un determinado individuo:

> Junto a la impugnación del término "portador", se concluyó que el mejor término sería "con": persona con discapacidad". Cuanto más natural sea la forma de referirse a la discapacidad, como a cualquier otra característica de la persona, más legitimado será el texto. Y tampoco es necesario hablar o escribir siempre de la misma manera para que sea más fácil y no pensar que es necesario utilizar siempre el mismo término – "persona con discapacidad". (Fávero, 2007)

La Constitución de 1988, conocida como "Constitución Ciudadana", también marcó un avance significativo al establecer principios fundamentales de igualdad y no discriminación. Desde entonces, las enmiendas

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constitucionales y las revisiones legislativas han ampliado los derechos de las personas con discapacidad, culminando con la Enmienda Constitucional nº 45/2004, que incluyó la accesibilidad como un derecho fundamental.

A partir de entonces, la Constitución Federal brasileña pasó a garantizar derechos fundamentales a las personas con discapacidad, como la igualdad de derechos y la prohibición de la discriminación. La accesibilidad, prevista como un derecho fundamental, debe garantizarse en todos los espacios públicos y privados, mientras que disposiciones específicas sobre educación inclusiva y la igualdad de oportunidades en el mercado laboral promueven la inclusión social y económica.

Sin perjuicio de las disposiciones constitucionales antes mencionadas, la promulgación del Estatuto de las Personas con Discapacidad representó un avance significativo también en el ámbito de la legislación infraconstitucional. A modo de ejemplo, se podrían mencionar cambios significativos en relación con el reconocimiento de la capacidad civil de las personas con discapacidad en Brasil. Antes de la promulgación de este Estatuto, las personas con discapacidad estaban frecuentemente sujetas a regulaciones que presumían su incapacidad para ciertos actos jurídicos.

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Esta norma se basó en el estigma de que la discapacidad podía comprometer la plena capacidad para tomar decisiones, administrar bienes o contraer obligaciones legales, lo que derivó en la obligación legal de nombrar un curador que representara a las personas con discapacidad.

Con la entrada en vigor de la Ley núm. 13.146/15, hubo un cambio paradigmático al reconocer que la discapacidad no implica automáticamente incapacidad civil. El Estatuto se basa en principios como la dignidad de la persona humana, la autonomía, la capacidad jurídica y el respeto a las diferencias, mostrando que la discapacidad no necesariamente afecta la capacidad de estas personas para realizar actos de la vida civil, como casarse, administrar sus bienes, celebrar contratos, entre otros.

Uno de los principales avances que trae el Estatuto es la sustitución de la tutela por el apoyo a la toma de decisiones. Si bien la tutela tradicionalmente implicaba la representación legal plena de la persona con discapacidad, la toma de decisiones con apoyo permite a la persona contar con el apoyo de familiares, amigos o profesionales para tomar decisiones, preservando su autonomía y capacidad de autodeterminación.

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Según Pinheiro y Locateli (2017), la sustitución de la curaduría por la toma de decisiones apoyada, impulsada por el nuevo Estatuto, es el resultado de un proceso de humanización del sistema jurídico brasileño, según el cual la capacidad civil y la seguridad garantizan la autonomía sobre todo lo que concierne a su propio cuerpo, su sexualidad, su matrimonio, su privacidad, su educación, su salud, su trabajo y su voto:

> Los derechos humanos fundamentales, en este sentido, son esenciales en el proceso de humanización de las prácticas emancipadoras de las personas con discapacidad que, a partir del Estatuto de las Personas con Discapacidad, ahora ostentan un estándar muy importante para la realización de sus derechos, con la ruptura de paradigmas sobre su capacidad civil y la seguridad de garantizar la autonomía sobre todo lo que concierne a su propio cuerpo, su sexualidad, su matrimonio, su privacidad, su educación, su salud, su trabajo y su vida. votar. (Pinheiro e Locateli, 2017, p. 28)

Este cambio de paradigma no sólo reconoce la capacidad jurídica de las personas con discapacidad, sino que también promueve un enfoque más inclusivo y respetuoso de sus derechos. Además, el Estatuto establece medidas para garantizar que las personas con discapacidad tengan acceso a la información y los recursos necesarios para ejercer sus derechos de manera efectiva. Esto incluye garantizar la

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accesibilidad física, comunicacional y digital, así como promover la inclusión social y jurídica de estas personas en la sociedad.

El reconocimiento de la capacidad civil de las personas con discapacidad por el Estatuto de las Personas con Discapacidad tuvo un impacto significativo en el sistema jurídico brasileño, influyendo también en las revisiones posteriores del Código Civil brasileño. Estos cambios reflejan un compromiso creciente con la igualdad de derechos y oportunidades, destacando la importancia de políticas públicas y legislación inclusiva para garantizar que todos los ciudadanos, independientemente de sus capacidades, puedan ejercer plenamente sus derechos civiles con dignidad y autonomía.

Puede verse, por tanto, que la Declaración Universal de Derechos Humanos sirvió como faro de inspiración para la creación de normas y tratados internacionales destinados a proteger los derechos humanos de las personas con discapacidad. La Convención sobre los Derechos de las Personas con Discapacidad y el Estatuto de las Personas con Discapacidad en Brasil son ejemplos concretos de cómo se aplicaron los principios de igualdad, dignidad y no

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discriminación de la DUDH para promover la inclusión y participación plena de estas personas en la sociedad.

Estos marcos legales representan avances significativos en la lucha por una sociedad más justa e igualitaria, donde todas las personas, independientemente de sus capacidades, puedan vivir con dignidad y ejercer plenamente sus derechos.

Consideraciones finales

La trayectoria de las personas con discapacidad en su lucha por el reconocimiento como sujetos de derechos está marcada por un largo y arduo camino de superación de prejuicios, discriminación y exclusión social. Desde la antigüedad, donde la discapacidad era vista a menudo como un castigo divino o una condición de subhumanidad, hasta nuestros días, la sociedad y el sistema legal han evolucionado significativamente.

La Revolución Francesa y la posterior adopción de la Declaración de los Derechos del Hombre y del Ciudadano en 1789 marcaron un punto de inflexión en la historia de los derechos humanos, proclamando principios de igualdad y libertad. Sin embargo, no fue hasta el siglo XX, con la devastación de dos guerras mundiales y el reconocimiento global de los horrores cometidos contra los grupos

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vulnerables, que la comunidad internacional vio la urgente necesidad de crear un marco universal de derechos humanos. La Declaración Universal de Derechos Humanos, adoptada en 1948, sentó las bases para una protección más integral e igualitaria de los derechos de todos los seres humanos, incluidos aquellos con discapacidad.

Inspirada en los principios de la Declaración de Derechos Humanos y Ciudadanos, la Convención sobre los Derechos de las Personas con Discapacidad (CDPD), adoptada por la ONU en 2006, representó un avance significativo para reafirmar los derechos humanos de las personas con discapacidad y establecer un marco legal específico para su protección. En Brasil, la promulgación del Estatuto de las Personas con Discapacidad en 2015 consolidó y amplió estos derechos, promoviendo la inclusión y la igualdad de condiciones en todos los ámbitos de la vida social.

El Estatuto de las Personas con Discapacidad trajo avances significativos en la garantía de derechos fundamentales, como la accesibilidad, la educación inclusiva, la igualdad en el mercado laboral y el acceso a la salud. Estos marcos legales representan importantes victorias en la larga lucha de las personas con discapacidad por el reconocimiento de su dignidad y autonomía.

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Sin embargo, a pesar de estos avances, aún persisten muchas barreras, tanto legales como sociales. La implementación efectiva de estándares legales requiere un esfuerzo continuo y colaborativo entre el gobierno, el sector privado y la sociedad civil para eliminar barreras y promover la accesibilidad y la inclusión en todas las áreas de la vida. Socialmente, es necesario combatir el estigma y los prejuicios que aún rodean a la discapacidad, promoviendo una cultura de respeto y valoración de la diversidad humana.

Por lo tanto, la lucha por los derechos de las personas con discapacidad es un camino continuo que requiere vigilancia constante y acción decidida. Es fundamental que los logros jurídicos vayan acompañados de cambios sociales profundos, para que todos puedan disfrutar plenamente de sus derechos y vivir con dignidad, respeto e igualdad. La historia de las personas con discapacidad es una historia de resiliencia y valentía, y su reconocimiento como sujetos de derechos es un logro de toda la humanidad, que debe ser reafirmado y defendido constantemente.

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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.

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