CREATING A SPECIALTY BY COUNCIL RESOLUTION: OROFACIAL AESTHETIC SURGERY, LEGISLATIVE CHALLENGES AND PROFESSIONAL BOUNDARIES IN BRAZIL

CRIAÇÃO DE UMA ESPECIALIDADE POR RESOLUÇÃO DO CONSELHO: CIRURGIA ESTÉTICA OROFACIAL, DESAFIOS LEGISLATIVOS E LIMITES PROFISSIONAIS NO BRASIL

CREACIÓN DE UNA ESPECIALIDAD POR RESOLUCIÓN DEL CONSEJO: CIRUGÍA ESTÉTICA OROFACIAL, DESAFÍOS LEGISLATIVOS Y LÍMITES PROFESIONALES EN BRASIL

10.56238/sevened2026.041-037

Vinicius Henrique Alves Ferreira[1]

ABSTRACT

In 2026, the Brazilian Federal Council of Dentistry recognized Orofacial Aesthetic Surgery as a dental specialty through Resolution CFO-286/2026, authorizing dentists to perform facelifts, blepharoplasty, otoplasty and rhinoplasty, among other operations. The article asks whether this creation falls within the normative competence that federal law grants the council, and where it overlaps with activities reserved to physicians. The analysis rests on the resolution, on the federal statutes that create the dentistry councils and regulate dentistry and medicine, and on studies of professional regulation and of disputes over the medical act. The statute that created the councils gives them the supervision of professional ethics and inward-facing rule-making powers, and never mentions specialties. The dentistry statute defines the dentist's field as the acts pertinent to dentistry without naming aesthetics, the face or the stomatognathic system. The Medical Act Law reserves surgery and general anesthesia to physicians while exempting dentistry within its area of practice. The resolution fills this chain of mutual referrals with its own reading of the dentistry statute. The textual anchor is stronger for perioral procedures and weaker for operations on the ears, eyelids, eyebrows and nose. The creation of the specialty lacks an express statutory basis and rests on an interpretation that the laws allow but do not confirm, leaving the boundary to be settled by the courts or by Congress.

Keywords: Dental Specialties. Professional Regulation. Scope of Practice.

RESUMO

Em 2026, o Conselho Federal de Odontologia reconheceu a Cirurgia Estética Orofacial como especialidade odontológica, pela Resolução CFO-286/2026, e autorizou o cirurgião-dentista a realizar ritidoplastias, blefaroplastias, otoplastias e rinoplastias, entre outras operações. O artigo pergunta se essa criação cabe na competência normativa que a lei federal confere ao conselho e em que pontos ela se sobrepõe a atividades privativas do médico. A análise se apoia na resolução, nas leis federais que instituem os conselhos de odontologia e regulam a odontologia e a medicina, e em estudos sobre regulação profissional e disputas em torno do ato médico. A lei que criou os conselhos lhes atribui a supervisão da ética profissional e competências normativas de organização interna, sem mencionar especialidades. A lei da odontologia define o campo do dentista como os atos pertinentes à odontologia, sem nomear

[1] PhD Candidate in Dental Sciences. Institution: Universidade Estadual Paulista (UNESP). E-mail: viniciushaferreira1@gmail.com Lattes: http://lattes.cnpq.br/2549768117846222

a estética, a face ou o sistema estomatognático. A Lei do Ato Médico reserva ao médico a cirurgia e a anestesia geral, mas excetua a odontologia no âmbito de sua área de atuação. A resolução preenche essa cadeia de remissões recíprocas com a sua própria leitura da lei da odontologia. A ancoragem textual é mais forte nos procedimentos periorais e mais fraca nas operações em orelhas, pálpebras, sobrancelhas e nariz. A criação da especialidade não tem base legal expressa e repousa numa interpretação que as leis permitem, mas não confirmam, de modo que a fronteira deverá ser definida pelos tribunais ou pelo Congresso.

Palavras-chave: Especialidades Odontológicas. Regulação Profissional. Escopo de Prática.

RESUMEN

En 2026, el Consejo Federal de Odontología de Brasil reconoció la Cirugía Estética Orofacial como especialidad odontológica por medio de la Resolución CFO-286/2026, autorizando a los dentistas a realizar facelifts, blefaroplastia, otoplastia y rinoplastia, entre otras operaciones. El artículo cuestiona si esta creación se encuentra dentro de la competencia normativa que la ley federal otorga al consejo, y dónde se superpone con actividades reservadas a los médicos. El análisis se basa en la resolución, en los estatutos federales que crean los consejos de odontología y regulan la odontología y la medicina, y en estudios de regulación profesional y de disputas sobre el acto médico. El estatuto que creó los consejos les otorga la supervisión de la ética profesional y poderes normativos internos, y nunca menciona especialidades. El estatuto de odontología define el campo del dentista como los actos pertinentes a la odontología sin nombrar estética, cara o sistema estomatognático. La Ley del Acto Médico reserva la cirugía y la anestesia general a los médicos mientras exime la odontología dentro de su área de práctica. La resolución llena esta cadena de remisiones mutuas con su propia lectura del estatuto de odontología. El anclaje textual es más fuerte para los procedimientos periorales y más débil para las operaciones en las orejas, párpados, cejas y nariz. La creación de la especialidad carece de una base estatutaria expresa y descansa en una interpretación que las leyes permiten pero no confirman, dejando la frontera para ser resuelta por los tribunales o por el Congreso.

Palabras clave: Especialidades Odontológicas. Regulación Profesional. Alcance de la Práctica.

1 INTRODUCTION

In Brazil, removing excess skin from the upper eyelids, reshaping the nose and correcting prominent ears have traditionally been treated as acts of medical plastic surgery. Since the resolution of March 2026, these same operations appear in the list of procedures a dentist is authorized to perform under the title of specialist in Orofacial Aesthetic Surgery (Cirurgia Estética Orofacial, CEOF). The Federal Council of Dentistry (Conselho Federal de Odontologia, CFO) created this specialty through its own resolution, not through an act of Congress (Conselho Federal de Odontologia, 2026).

Resolution CFO-286, dated 20 March 2026, completes a trajectory in which Brazilian dentistry moved from the oral cavity toward the aesthetics of the whole face. Orofacial Harmonization (HOF) was recognized as a dental specialty in 2019. Its advocates presented the stomatognathic system, the set of structures involved in chewing, swallowing and speech, as the anatomical basis for the dentist's work on facial aesthetics (Custódio *et al.*, 2020). Clinical studies then described HOF combined with orthognathic surgery, the domain of the specialty of Oral and Maxillofacial Surgery and Traumatology (CTBMF), as a way to refine facial results (Lima; Lima; Oliveira, 2024; Noronha Filho *et al.*, 2022). The new resolution joins these two lines. It recognizes CEOF as a dental specialty in its art. 1, authorizes 12 groups of surgical procedures in its art. 4, and reserves the transitional route to the title for dentists already registered in both HOF and CTBMF (Conselho Federal de Odontologia, 2026).

The federal laws that frame this decision were not written with facial cosmetic surgery in mind. Law 4,324/1964 created the federal and regional councils of dentistry as an autarchy whose purpose is to supervise professional ethics (Brasil, 1964). Law 5,081/1966 lists what a dentist may do, and opens the list with all acts pertinent to dentistry that derive from knowledge acquired in regular or postgraduate courses (Brasil, 1966). Law 12,842/2013, known as the Medical Act Law, reserves to physicians the indication and execution of surgical interventions and of invasive procedures, aesthetic ones included. It also declares that this reservation does not apply to dentistry within its area of practice (Brasil, 2013). None of the three laws draws an anatomical line around that area. The resolution draws one.

Several studies have examined parts of this problem. The legislative history of the Medical Act bill shows that the other health professions feared clinical actions would be concentrated in the hands of physicians (Travassos *et al.*, 2016). A recent analysis of the law adds that a restrictive reading of its art. 4 carries criminal consequences for non-physicians who perform activities deemed exclusive (Wanderley, 2024). The normative competence of collegiate bodies has been questioned in telemedicine (Romão, 2023), in notarial services

(Dias; Menossi, 2017) and in monetary regulation (Meinberg, 2021). The Supreme Federal Court's decision in ADPF 131 has been read as opening room for non-medical professions in health care (Silva Filho; Dias, 2026). From inside dentistry, authors have argued that cosmetic facial surgery belongs to the dentist's field (Custódio *et al.*, 2020).

What these studies do not offer is a confrontation of one specific dental specialty, procedure by procedure, with the exact text of the statutes that grant the council its powers and that reserve acts to physicians. That confrontation matters. It decides who may operate on the face, under which kind of anesthesia, and with which legal exposure for professionals and patients.

The question guiding this article is: does the creation of the CEOF specialty by Resolution CFO-286/2026 fall within the normative competence that federal legislation grants to the Federal Council of Dentistry, and at which points does it overlap with activities the law reserves to physicians?

The question has practical weight as well as legal weight. Its practical side rests on an assumption that this article states rather than demonstrates: patients may read a specialist title shown on a certificate as evidence that the professional is legally authorized to perform the procedure. Doctrine on consent treats an intervention performed with a vitiated consent as a matter with civil and criminal effects (Carvalho; Lima, 2023), so the legal status of a title becomes part of what the patient needs to know. Professionals who hold a title whose legal basis is disputed face administrative, civil and criminal risk (Wanderley, 2024). The institutional design is also at stake. The French case shows how a model in which regulatory questions remain with professional bodies, mainly medical councils, has come under criticism as health regulation becomes a matter of interest to all citizens (Brissy, 2018).

The general objective is to assess whether the creation of CEOF by council resolution fits within the limits of the normative competence that federal law confers on the CFO. The specific objectives are four:

- to identify what Laws 4,324/1964 and 5,081/1966 attribute to the council and to the dentist;
- to map the procedures authorized by Resolution CFO-286/2026 against the provisions of Law 12,842/2013;
- to examine, through the precedents documented in the literature, the legislative and judicial grounds on which the creation is open to contestation;
- to weigh the arguments that support the council's reading.

The contribution is a reading of the resolution against the three statutes, procedure by procedure. This reading reveals a chain of mutual referrals: the Medical Act Law exempts dentistry within its area, the dentistry law defines that area as what is pertinent to dentistry, and no statute says who defines what is pertinent. The resolution occupies that empty space. Section 2 describes the method. Sections 3 to 6 examine, in turn, the statutory source of the council's power, the content of the resolution, the overlaps with medical acts and the grounds for contestation. Section 7 discusses what these findings mean.

2 METHODOLOGY

This is a qualitative study that combines documentary analysis with a narrative review of the literature, using content analysis as its technique. Each component answers one side of the question. The documentary analysis establishes what the norms say. The narrative review places that reading among studies on professional regulation and scope of practice. A narrative review suits a problem in which the decisive evidence lies in legal texts and in a small body of studies from law, dentistry and public health.

The documentary corpus has two parts. The first is Resolution CFO-286, of 20 March 2026, issued by the Federal Council of Dentistry. It recognizes Orofacial Aesthetic Surgery as a dental specialty and defines its area of practice, procedures, settings, training parameters and transition rules. Its text was read at the official address that reproduces its publication (Conselho Federal de Odontologia, 2026).

The second part is the federal legislation:

- Law 4,324/1964, which created the dentistry councils;
- Law 5,081/1966, which regulates the practice of dentistry;
- Law 12,842/2013, which regulates the practice of medicine.

The three laws were identified by type, number and year in the open data of the Federal Senate. Their compiled texts, which include later amendments, were read at normas.leg.br (Brasil, 1964; 1966; 2013).

The legislative and judicial dimension enters through precedents documented in the literature:

- the bills that led to the Medical Act Law (Travassos *et al.*, 2016);
- the judicial application of that law to aesthetic procedures (Wanderley, 2024);
- the regulation of telemedicine by the medical council (Romão, 2023);

• the Supreme Federal Court's decision in ADPF 131 (Silva Filho; Dias, 2026).

The corpus did not include bills or court decisions addressed specifically to Resolution CFO-286/2026. The analysis of challenges therefore rests on the statutory grounds and on these precedents, not on the record of a particular lawsuit or bill.

The material was analyzed through five categories, applied to every relevant provision:

1. the source of normative competence, that is, which statute authorizes the council to act and in what terms;
2. the material scope, meaning the anatomical region and the nature of the act;
3. the technical means, namely anesthesia, sedation and the physical setting;
4. the qualification and titling of the professional;
5. the overlap with acts reserved to physicians or protected for other professions.

Each of the 12 items in art. 4 of the resolution was coded against the provisions of the three laws. Because the compiled statutes were read in full, their silences could be measured. For each statute, the analysis recorded whether the terms specialty, aesthetic, surgery, face, head, neck and stomatognathic occur, how many times, and in which provision.

The documents were then compared with the studies in three blocks:

• studies on the regulation and normative competence of councils and agencies;
• studies on the medical act and professional boundaries;
• studies on aesthetic and surgical practice in dentistry, complemented by studies on interprofessional work and on dental specialties in the public health system.

Where a study supported the council's reading, it was treated as a counterargument and examined on its own terms.

The bibliographic survey was conducted in November 2026 in four databases: Crossref; Oasisbr and the Brazilian Digital Library of Theses and Dissertations (BDTD), both maintained by the Brazilian Institute of Information in Science and Technology (IBICT); and the Directory of Open Access Journals (DOAJ). It covered publications from 2016 to 16 October 2026. That date is the cut-off for the whole collection, and no act, data or study published afterwards was used. Because the question involves the council's legal powers, the boundary with medicine and the clinical practice the specialty organizes, the search was designed to reach all three dimensions. Forty studies were selected by pertinence: works with

identified authorship and an abstract that deal with the regulation of dental or medical practice, with the normative competence of professional councils and regulatory bodies, or with the aesthetic and surgical practice of dentists, in Brazil or in comparable settings. The studies that bear directly on the question are discussed in the text.

The method reads norms and arguments, not practice. It does not measure how many dentists hold the title or perform the procedures. Its interpretation of the statutes is a reasoned reading and does not anticipate the one a court will adopt.

3 THE STATUTORY SOURCE OF THE COUNCIL'S NORMATIVE POWER

The federal statutes examined give the CFO an ethical and administrative mandate. They do not give it an express power to define the dentist's field or to create specialties. This section shows how that conclusion follows from each law and from a comparison with the medical statute.

3.1 AN ETHICS AUTHORITY WITH INWARD-FACING RULE-MAKING POWERS

Law 4,324/1964 defines the councils by their purpose. Its art. 2 establishes the federal and regional councils, taken together, as an autarchy: each has legal personality under public law and administrative and financial autonomy. Their purpose is to supervise professional ethics throughout the country and to protect the ethical performance of dentistry and the standing of the profession (Brasil, 1964).

The powers listed in art. 4 follow that purpose. They include:

- organizing the council's internal rules and approving those of the regional councils;
- voting on and amending the Code of Dental Deontology, after hearing the regional councils;
- issuing instructions for the functioning of the regional councils;
- settling doubts the regional councils raise;
- deciding appeals on admissions and penalties;
- approving budgets and accounts (Brasil, 1964, art. 4, a to n).

Two features of this list matter for the question. First, the rule-making powers face inward, toward the councils' own organization and the ethical code, rather than outward, toward defining what the profession may do. Second, the law contains a measurable silence. In the compiled text of Law 4,324/1964, the words specialty and specialist occur zero times,

and so do aesthetic, face, head and neck. The word surgery appears only inside the professional title cirurgião-dentista.

The only provision that touches the extent of professional practice is art. 11, g. It assigns to the regional councils the task of settling doubts about the competence and scope of professional activities, with a suspensive appeal to the federal council (Brasil, 1964). This is as close as the law comes to a power over scope, and the power is adjudicative in form. It settles doubts that arise under the law; it does not open new fields of practice.

The law also anticipates a regulation issued outside the councils. Art. 4, f, allows the federal council to propose to the federal government amendments to the regulation of the law. Art. 30 assigns to the council the drafting of a regulatory project, to be submitted through the Ministry of Health to the head of the executive branch (Brasil, 1964). The design is telling: when the law contemplated norms beyond the councils' internal life, it routed them through the executive.

3.2 THE DENTIST'S FIELD IN LAW 5,081/1966

Law 5,081/1966 defines the dentist's competence through an open clause followed by specific powers. Art. 6, I, states that the dentist is competent to “praticar todos os atos pertinentes a Odontologia, decorrentes de conhecimentos adquiridos em curso regular ou em cursos de pós-graduação”, that is, to perform all acts pertinent to dentistry that derive from knowledge acquired in regular or postgraduate courses (Brasil, 1966).

The remaining items authorize the dentist to:

- prescribe and apply pharmaceutical products indicated in dentistry;
- issue certificates within the professional field;
- perform forensic dental examinations;
- apply local and truncular anesthesia;
- use analgesia and hypnosis when demonstrably qualified;
- keep laboratory and X-ray equipment;
- give emergency medication;
- as a forensic dental expert in necropsies, use the access routes of the neck and head (Brasil, 1966, art. 6, II to IX).

The open clause is the hinge of the whole debate. Because it ties competence to knowledge acquired in courses, including postgraduate courses, it supports the argument

that the scope of dentistry was not frozen in 1966. Yet the same clause limits these acts to those pertinent to dentistry, and the law never defines pertinence.

The silence here can also be measured. In the compiled text of Law 5,081/1966, the terms aesthetic, face, facial and stomatognathic occur zero times. The word surgery appears only inside the title cirurgião-dentista. Head and neck occur once each, both in art. 6, IX, and only for necropsy in forensic work (Brasil, 1966). The law does not mention the Federal Council of Dentistry at all. It describes the registration that allows practice in terms of the education authorities and of the National Service for the Inspection of Dentistry (Brasil, 1966, art. 2).

The word specialty does appear, and in a restrictive sense. Art. 6, VII, refers to the cases of the dentist's specialty when it allows laboratory equipment. Art. 7, c, prohibits the dentist from exercising more than two specialties (Brasil, 1966). This prohibition remains in the compiled text and returns in section 4.3, when the routes to the CEOF title are examined. Art. 12 provided for a regulatory decree from the executive within ninety days (Brasil, 1966), the same routing through the executive already seen in Law 4,324/1964.

3.3 HOW FEDERAL LAW GRANTS NORMATIVE POWER WHEN IT CHOOSES TO

The Medical Act Law shows what an express grant of normative power looks like. Its art. 7 includes among the competences of the Federal Council of Medicine the power to issue norms defining the experimental character of procedures in medicine, authorizing or prohibiting their practice by physicians. Its sole paragraph assigns the inspection of compliance to the regional councils (Brasil, 2013). This grant is express, narrow and directed at the council's own professionals. The two dentistry statutes contain nothing equivalent for the definition of new areas of practice. Table 1 sets the three statutes side by side on the dimensions that matter for creating a surgical specialty.

Table 1

Treatment of the dimensions relevant to the creation of a surgical specialty in the federal statutes examined

Dimension	Law 4,324/1964 (dentistry councils)	Law 5,081/1966 (practice of dentistry)	Law 12,842/2013 (practice of medicine)
Purpose or object	Supervision of professional ethics by an autarchy (art. 2)	Regulates the practice of dentistry (art. 1)	Regulates the practice of medicine (art. 1)
Normative power of the council	Internal rules, Code of Deontology, instructions to regional councils (art. 4, a, d, g)	Council not mentioned	Federal council defines the experimental character of medical procedures (art. 7)
Definition of scope	Regional councils settle doubts on competence and scope, with appeal to the federal council (art. 11, g)	All acts pertinent to dentistry deriving from regular or postgraduate courses (art. 6, I)	List of activities reserved to physicians (art. 4); dentistry excepted within its area (art. 4, § 6)
Specialties	Term absent	Exercise of more than two prohibited (art. 7, c)	Term absent
Surgery	Term absent, except in the professional title	Term absent, except in the professional title	Indication and execution of surgical intervention reserved (art. 4, II)
Anesthesia and sedation	Terms absent	Local and truncular anesthesia; analgesia and hypnosis if qualified (art. 6, V and VI)	Deep sedation, anesthetic blocks and general anesthesia reserved (art. 4, VI)
Aesthetics	Term absent	Term absent	Invasive procedures, aesthetic ones included, reserved (art. 4, III)
Head and neck	Terms absent	Access routes of the neck and head only in forensic necropsy (art. 6, IX)	Terms absent

Source: prepared by the author based on Brasil (1964), Brasil (1966) and Brasil (2013).

The table shows a pattern: absences on the dental side and explicit reservations on the medical side. The dentistry statutes say who may practice and how the councils govern themselves. They are silent on surgery, aesthetics and anatomical region. The medical statute names surgery, aesthetic procedures and general anesthesia, and then hands the boundary back to dentistry through its § 6.

Comparable disputes in other sectors help qualify this pattern. In telemedicine, the medical council's power to introduce a new practice by resolution was contested from the start. A 2018 resolution was revoked after a negative reaction, and the legislature eventually intervened through a statute enacted during the pandemic (Romão, 2023). The limits of normative competence have also been examined for the National Council of Justice. That body repeatedly issued rules for notaries and registrars, including rules for the public selection of the private agents who receive the delegation (Dias; Menossi, 2017). Across these sectors the recurring question is how far a collegiate body may go beyond the text that

created it. The dental case gives that question a particular edge, because here the statute does not name the field the council has chosen to regulate.

4 WHAT RESOLUTION CFO-286/2026 ESTABLISHES

The resolution builds a complete specialty, with its own list of surgical procedures, settings and training. It anchors this structure in a reading of Law 5,081/1966 that goes beyond the words of that law.

4.1 RECOGNITION, COMPETENCE CLAUSE AND THE LIST OF PROCEDURES

The core of the act is short. Art. 1 provides that “Fica reconhecida a Cirurgia Estética Orofacial (CEOF) como especialidade odontológica”, that is, CEOF is recognized as a dental specialty. Art. 2 assigns to the specialist the diagnosis, planning and execution of orofacial aesthetic surgical procedures within the specialist's area of practice. The legal anchor lies in the preamble. One of its recitals invokes Law 5,081/1966 as conferring on the dentist competences for “procedimentos no sistema estomatognático e estruturas anexas, contíguas e afins, em região de cabeça e pescoço para procedimentos odontológicos” (Conselho Federal de Odontologia, 2026), meaning procedures on the stomatognathic system and annexed, contiguous and related structures in the head and neck region.

Section 3.2 measured what the compiled text of Law 5,081/1966 contains. The expressions stomatognathic system and annexed, contiguous and related structures do not occur in it. Head and neck occur once each, and only for forensic necropsy. The recital therefore attributes to the law a content that results from interpretation, not from transcription. This does not by itself invalidate the resolution, because the open clause of art. 6, I, admits an extensive reading. It does show that the anatomical reach of the specialty rests on the council's interpretation of the statute rather than on its text. Table 2 lists what that reach includes.

Table 2

Procedures authorized for the CEOF specialist and their classification by setting

Item of art. 4	Procedure	Classification and minimum setting	Body region (author's classification)
I	Perilabial surgeries: lip lifting, corner lifting, lip reconstructions, cheiloplasty	Small; Type I under local anesthesia (art. 6)	Lips and perioral area
II	Bichectomy (buccal fat pad removal)	Small; Type I under local anesthesia (art. 6)	Cheek
III	Cervical and facial liposuction	Small; Type I under local anesthesia (art. 6)	Face and neck
IV	Cervical and facial lipectomy	Medium; Type II with sedation (art. 7)	Face and neck
V	Facial fat grafting	Medium; Type II with sedation (art. 7)	Face
VI	Platysmaplasty	Medium; Type II with sedation (art. 7)	Neck
VII	Cervicoplasty	Type III at minimum (art. 8)	Neck
VIII	Otoplasty	Medium; Type II with sedation (art. 7)	Ear
IX	Upper and lower blepharoplasty	Medium; Type II with sedation (art. 7)	Eyelids
X	Eyebrow lift	Small; Type I under local anesthesia (art. 6)	Eyebrow and forehead
XI	Rhytidectomies and rhytidoplasties (facelift)	Type III at minimum (art. 8)	Face and neck
XII, a	Rhinoplasty: alectomy	Medium; Type II with sedation (art. 7)	Nose
XII, b and c	Rhinoplasty: osteoplasties and nasal chondroplasty	Type III at minimum (art. 8)	Nose

Source: prepared by the author based on Conselho Federal de Odontologia (2026).

The distribution in the table matters for the argument that follows.

- Of the 12 items, only item I operates on the lips, a structure that borders the oral cavity dentistry has always treated. Item II operates on the cheek.
- Four items, VIII, IX, X and XII, concern the ears, eyelids, eyebrows and nose. The dentistry statutes give no textual reason to associate these structures with dentistry.
- Four items, III, IV, VI and VII, reach the neck, and item XI covers the face and neck.

Read against Law 5,081/1966, the list moves step by step away from the dental arch. The closer an item is to the ear, the eye or the nose, the more its legal basis depends on the open clause alone.

The resolution also protects what came before it. Art. 5 provides that the surgical procedures established by the norms recognizing HOF and CTBMF are not restricted by the

new act (Conselho Federal de Odontologia, 2026). CEOF is therefore added on top of the two existing specialties rather than carved out of them, which matches the transitional route that requires both, examined in section 4.3.

4.2 SETTINGS, ANESTHESIA AND SEDATION

The resolution ties each procedure to a physical setting and an anesthetic regime. The sole paragraph of art. 4 states that the procedures are performed in the settings defined in arts. 6 to 8, according to their surgical complexity, under local or general anesthesia or sedation, and in compliance with patient safety norms (Conselho Federal de Odontologia, 2026). The three settings are:

- Type I, for small procedures under local anesthesia: items I, II, III and X (art. 6);
- Type II, with sedation, for medium procedures: items IV, V, VI, VIII and IX and item XII, a (art. 7);
- Type III at minimum, for cervicoplasty, facelifts and the bony and cartilaginous rhinoplasties of item XII, b and c (art. 8).

The grading is internally consistent: the most extensive operations require the most equipped setting. It also has a notable consequence. Cervical and facial liposuction and the eyebrow lift are classified as small procedures that may be performed in a Type I setting under local anesthesia. Otoplasty and blepharoplasty fall into the medium class, performed with sedation in a Type II setting.

Art. 9 shows how far these settings are from ordinary dental care. When a procedure does not generate aerosol, the dental chair and its related equipment may be dispensed with, provided the setting has a surgical table and surgical lighting suited to the procedure, both registered with the National Health Surveillance Agency (ANVISA) (Conselho Federal de Odontologia, 2026). The provision acknowledges that the operations it covers do not need the equipment around which a dental office is organized. The setting is classified as dental, but the instruments it requires are those of an operating room.

4.3 ACCESS TO THE TITLE AND TRAINING PARAMETERS

The resolution opens three routes to the title and sets detailed training parameters for future courses. Table 3 summarizes them.

Table 3

Routes to the CEOF title and training parameters

Dimension	Requirement	Provision
Regular route	Specialization course authorized and recognized by the Ministry of Education, started after publication of the resolution, offered by an accredited higher education institution and conforming to council norms	Art. 3, I
Transitional route	Active registration in HOF and in CTBMF on the publication date; at least 3 years of registration in each; request to the regional council within 60 days	Art. 3, II
Title examination	Examination to be regulated by a supplementary resolution, open to dentists registered in HOF and CTBMF, or with requests filed in both by the publication date	Art. 3, III
Course load and duration	At least 3,000 hours over at least 36 months	Art. 11, caput
Distribution of the load	80% in the area of concentration and 10% in the connected area; within the area of concentration, at least 10% theory and 80% practice	Art. 11, §§ 1 and 2
Mandatory disciplines	Ethics and Dental Legislation, 30 hours; Scientific Methodology, 60 hours; Bioethics, 15 hours	Art. 11, § 3
Coordination	Dentist with at least a master's degree in health, registered as a CEOF specialist	Art. 12
Teaching staff	Two dentists with at least a master's degree; at least 50% CEOF specialists, including one HOF and one CTBMF specialist	Art. 15
Certification	Attendance of at least 75%, performance of at least 70% in formal assessment, and approved final paper	Art. 17
Restrictions	No course may lead to double titling; complementary courses confer no specialty	Arts. 14 and 16, § 1

Source: prepared by the author based on Conselho Federal de Odontologia (2026).

The routes reveal the professional profile the resolution has in mind.

- The regular route requires a course of at least 36 months that starts after publication. No graduate of that route can therefore complete the minimum period before 2029.
- Until then, the title is available only through the transitional route and the examination. Both presuppose registration, or a pending request, in HOF and CTBMF.
- The 3,000-hour minimum is substantial. Section 1 of art. 11 assigns 80% and 10% of that load, or 2,400 and 300 hours. The remaining 300 hours are a residue that this paragraph does not assign.
- The three mandatory disciplines add up to 105 hours, and § 2 excludes them from the theory and practice shares of the area of concentration.

The dual-registration requirement interacts with the statute in a way the resolution does not resolve. Law 5,081/1966, in the compiled text examined, prohibits the dentist from exercising more than two specialties (art. 7, c). The transitional route and the examination

presuppose two registered specialties, HOF and CTBMF, and the CEOF registration adds a third. Whether holding three registered titles amounts to exercising three specialties is a question of interpretation that the statute leaves open. It is nonetheless a point at which the resolution and the law it invokes pull in different directions.

The regular route also links the specialty to the national education system. By requiring a course authorized and recognized by the Ministry of Education, art. 3, I, connects the title to the postgraduate knowledge that art. 6, I, of Law 5,081/1966 names as the source of the dentist's acts. Section 6.3 returns to this connection, because it is the council's strongest textual argument.

5 WHERE THE SPECIALTY MEETS ACTS RESERVED TO PHYSICIANS

The overlap with medicine is concentrated in surgery and anesthesia. How it is resolved depends entirely on how far the exception in art. 4, § 6, of the Medical Act Law extends.

5.1 SURGERY AND INVASIVE PROCEDURES

Law 12,842/2013 reserves two kinds of acts that bear directly on CEOF. Art. 4, II, reserves to physicians the indication and execution of surgical interventions and the prescription of pre- and postoperative medical care. Art. 4, III, reserves the indication and execution of invasive procedures, whether diagnostic, therapeutic or aesthetic (Brasil, 2013).

The second reservation is narrower than it looks. Paragraph 4 of art. 4 defines invasive procedures for the purposes of the law, but two of its three items were vetoed. Only one criterion survives in the compiled text: “invasão dos orifícios naturais do corpo, atingindo órgãos internos”, the invasion of the body's natural orifices reaching internal organs (Brasil, 2013, art. 4, § 4, III). An operation performed through a skin incision on the eyelid, the ear or the neck does not fit that definition well. The CEOF list is therefore better framed by art. 4, II, which reserves surgical interventions without defining them. The resolution itself calls all the items in its art. 4 surgical procedures.

This brings the analysis to the exception. Art. 4, § 6, provides: “O disposto neste artigo não se aplica ao exercício da Odontologia, no âmbito de sua área de atuação” (Brasil, 2013), meaning the provisions of the article do not apply to the practice of dentistry within its area of practice. The sentence protects the dentist who extracts a tooth or operates on the jaw from the charge of performing a reserved surgical act. It does not say where the area of practice ends. For that, the reader must turn to Law 5,081/1966, which, as section 3.2 showed, refers to acts pertinent to dentistry without defining them.

The chain of referrals closes here. The medical statute points to dentistry's area, the dental statute points to what is pertinent to dentistry, and the CFO's resolution supplies the content. For the procedures in Table 2 that reach the ear, eyelids, eyebrows and nose, the reserve of art. 4, II, applies unless the exception in § 6 covers them. Whether it does depends on a reading of pertinence that only the resolution provides.

The vetoes deserve attention because they shape the field. The compiled text of Law 12,842/2013 shows ten vetoed provisions:

- three items of the caput of art. 4;
- its § 2;
- two items of § 4;
- three items of § 5;
- the first item of art. 5.

The definitions that survived are narrower than those Congress approved. This helps explain why surgical intervention, without a definition, carries the weight of the boundary. Wanderley (2024) shows what is at stake in the interpretation. A restrictive reading of the law's provisions on invasive procedures carries administrative and civil consequences, and it also exposes practitioners to the criminal offense of illegal practice of medicine when the activity is considered exclusive to physicians.

5.2 ANESTHESIA AND SEDATION

Anesthesia is the second point of contact, and it rests on a sharper textual contrast:

- Law 5,081/1966 authorizes the dentist to apply local and truncular anesthesia and to use analgesia and hypnosis when demonstrably qualified (Brasil, 1966, art. 6, V and VI).
- Law 12,842/2013 reserves to physicians deep sedation, anesthetic blocks and general anesthesia (Brasil, 2013, art. 4, VI).
- Resolution CFO-286/2026 provides that CEOF procedures are performed under local or general anesthesia or sedation, and assigns the Type II setting to procedures with sedation (Conselho Federal de Odontologia, 2026, art. 4, sole paragraph, and art. 7).

Read together, the three texts locate the boundary precisely. Local and truncular anesthesia lie within the dentist's statutory powers, and the Medical Act Law's § 6 exempts them from the reserve of anesthetic blocks within dentistry's area. General anesthesia is not

among the dentist's powers listed in Law 5,081/1966 and is reserved to physicians by Law 12,842/2013. Sedation falls in between, because the medical statute reserves deep sedation, not every form of sedation. Its classification therefore depends on depth. The resolution sets the anesthetic modalities for the procedures. Who administers general anesthesia, and at what depth sedation is performed in a Type II setting, are the variables on which the legality of each case turns.

5.3 A CROWDED FIELD: OTHER HEALTH PROFESSIONS IN FACIAL AESTHETICS

The face is not disputed by dentistry and medicine alone. Law 12,842/2013 itself acknowledges the presence of other professions. Its § 7 provides that art. 4 shall be applied so as to protect the competences of twelve professions: social workers, biologists, biomedical scientists, nurses, pharmacists, physiotherapists, speech therapists, nutritionists, physical education professionals, psychologists, occupational therapists, and radiology technicians and technologists (Brasil, 2013).

The difference in wording between the two paragraphs is significant. For these twelve professions, the law sets an interpretive rule: art. 4 must be applied so as to protect their competences. For dentistry, it sets a carve-out: art. 4 does not apply within dentistry's area. Dentistry thus received a stronger exemption than any other health profession. That strength is also what makes the extent of its area decisive.

The other professions approach facial aesthetics with their own methods. Speech therapy has developed an aesthetic practice grounded in orofacial motor function. It reconditions muscles and reprograms functions such as breathing, chewing and swallowing as a non-invasive alternative for facial aesthetic problems (Lepri, 2021). Within dentistry, the HOF literature has worked on technical standards. One review sets out the indications, contraindications and planning that procedures such as botulinum toxin application require (Santos; Paschoalotto; Tessarin, 2023). A methodological study argues for standardized photographic records as part of the patient's file in HOF (Saleme Junior *et al.*, 2021).

Moving from HOF to CEOF changes the kind of act involved. HOF operates largely through minimally invasive procedures. CEOF lists open operations such as facelifts and bony rhinoplasty, and these fall squarely within the surgical interventions that art. 4, II, of the Medical Act Law reserves. Custódio *et al.* (2020) acknowledged in their defense of HOF that it works on an anatomical region shared with several medical specialties. The new specialty takes that shared region and adds the surgical instruments that the medical statute names.

6 LEGISLATIVE AND JUDICIAL GROUNDS FOR CONTESTATION

The creation of CEOF is open to contestation in Congress and in the courts. In both arenas, the documented precedents point in more than one direction.

6.1 LESSONS FROM THE MEDICAL ACT BILL AND FROM TELEMEDICINE

The legislative history of the Medical Act Law shows that Congress decided professional boundaries in health care through prolonged conflict. A review of the bill that became Bill 25/2002 and of the bills preceding it found the same concern among all non-medical health professions: the centralization of health actions in the hands of physicians. Opponents warned of reduced autonomy, losses in teamwork and harm to the care model of the Unified Health System (SUS) (Travassos *et al.*, 2016). The law that eventually emerged in 2013, with its ten vetoed provisions and its two protective paragraphs, settled the conflict through exceptions rather than definitions. Section 5.1 showed how this leaves the extent of dentistry's area open.

Telemedicine offers a closer parallel because it involves a council regulating a practice by resolution. The medical council recognized telemedicine in 2002 amid questions about its competence. It revoked a 2018 resolution after a negative reaction. The legislature then enacted a statute during the pandemic that authorized the practice for the duration of the crisis and delegated its later regulation to the council (Romão, 2023). Romão concludes that implementation must take into account the political forces at play and the council's role in the normative process, so that the legal text yields a policy that can actually be implemented (Romão, 2023). Table 4 places these episodes alongside the other precedents examined.

Table 4

Precedents of disputes over normative competence and professional boundaries

Precedent	Body and instrument	Point in dispute	Position or outcome reported	Source
Medical Act bill	National Congress; Bill 25/2002 and the bills that preceded it	Concentration of health actions in physicians	Other health professions feared loss of autonomy and teamwork and harm to the SUS care model	Travassos et al. (2016)
Medical Act Law in court	Judiciary; decisions applying Law 12,842/2013	Invasive and aesthetic procedures by non-physicians	Recent decisions reinforced the protection of medical activity, excluding professionals who had historically performed activities later deemed illegal	Wanderley (2024)
ADPF 131	Supreme Federal Court	Practice of optometrists without their own statute, versus the exclusive medical act	Non-medical professions contribute to comprehensive care without harming the exclusive medical act; their regulation needs to advance	Silva Filho; Dias (2026)
Telemedicine	Federal Council of Medicine; resolutions of 2002 and 2018; federal statute of 2020	Council's competence to introduce a new practice	2018 resolution revoked after negative reaction; statute authorized the practice during the health crisis and delegated later regulation to the council	Romão (2023)
Notarial services	National Council of Justice; normative acts	Limits of a control body's normative competence, including rules for public selection	Legal limits of the council's normative competence analyzed through a dogmatic and hermeneutic approach	Dias; Menossi (2017)

Source: prepared by the author based on Travassos *et al.* (2016), Dias and Menossi (2017), Romão (2023), Wanderley (2024) and Silva Filho and Dias (2026).

The table shows a recurring sequence. A collegiate body regulates by resolution. Its competence is questioned. The matter is then decided either by the body's own retreat or by the legislature. The telemedicine case documents this sequence for a medical council. Applying it to CEOF is this article's reading, not a recorded event. As stated in the methodology, this article does not analyze any specific legislative proposition concerning Resolution CFO-286/2026, and the material examined bears on that question only by analogy. What it shows is that, in an analogous dispute, the legislature was the forum that settled the matter.

6.2 THE JUDICIAL ARENA: CRIMINAL EXPOSURE AND THE ADPF 131 PRECEDENT

In the decisions analyzed, the courts have shown readiness to protect the medical domain, with recent judicial decisions reinforcing the protection of medical activity (Wanderley, 2024). These decisions excluded professionals who had historically performed activities that came to be considered illegal after the Medical Act Law. The author argues that

such restrictions affect freedom of profession, barriers to entry, free enterprise, acquired rights and public health, all of them constitutionally protected (Wanderley, 2024). For CEOF, the implication is direct. A dentist who performs a blepharoplasty on the strength of the council's title relies on a reading of dentistry's area that a court is not bound to share. If the court reads the area narrowly, the exposure is criminal as well as administrative.

The Supreme Federal Court's ADPF 131 points the other way, but on a different footing. Silva Filho and Dias (2026) start from the constitutional guarantee of free exercise of a profession, subject to the qualifications established by law. They examine professions, such as optometry, that have a recognized higher education degree but no statute of their own. Their reading of the decision is that non-medical professionals contribute to comprehensive care without harming the exclusive medical act. They also conclude that the regulation of non-medical professions needs to be discussed and advanced (Silva Filho; Dias, 2026). The precedent therefore supports professional plurality in health care. At the same time, it locates the solution in regulation, which in the constitutional framework the authors describe means law.

The two judicial lines meet on one point: in both, the decisive variable is the statute. Decisions protecting the medical domain rest on the text of Law 12,842/2013. The opening for non-medical professions in ADPF 131 rests on the constitutional reference to qualifications established by law. A council resolution does not appear in either line as the instrument that settles a boundary between professions.

Patient consent adds a final dimension. Carvalho and Lima (2023) examine the legal structure of free and informed consent and the protected interests at stake when an intervention is performed without consent or with vitiated consent, in both civil and criminal law. When the legal basis of a surgical title is disputed, whether the patient knows this becomes part of the information on which valid consent depends. This is the article's reading of how the consent framework applies to CEOF. The authors do not address dental specialties.

6.3 THE CASE FOR THE COUNCIL'S READING

The strongest argument for the resolution comes from within dentistry, and it deserves a full hearing. Custódio *et al.* (2020), writing before CEOF existed, argued that HOF is a legitimate dental specialty and that the HOF specialist's work on aesthetic facial procedures is guaranteed by Law 5,081/1966 and recognized by the 2019 resolution that created HOF. They present the stomatognathic system as the central pillar of the dentist's work. Facial aging changes soft and hard tissues, and these changes cause functional and aesthetic

imbalance. In some cases minimally invasive procedures are not enough, which makes cosmetic facial surgery a valuable option for many patients (Custódio *et al.*, 2020). The argument anticipates CEOF almost exactly. It also invokes the same statute the resolution cites, so it contradicts the textual reading developed in sections 3 and 5.

The argument has real support in the texts:

- Art. 6, I, of Law 5,081/1966 ties the dentist's acts to knowledge acquired in postgraduate courses. The regular route to CEOF requires a course authorized and recognized by the Ministry of Education (Table 3). A dentist trained in such a course holds exactly the kind of knowledge the statute names.
- Art. 4, § 6, of Law 12,842/2013 gives dentistry a carve-out, not merely an interpretive protection.
- Art. 11, g, of Law 4,324/1964 places doubts about the scope of activities within the council system.

The clinical literature adds that CTBMF already operates on the bones of the face. Combining orthognathic surgery with HOF is described as improving occlusion, facial aesthetics, chewing function, phonetics and breathing (Lima; Lima; Oliveira, 2024). A multidisciplinary case report describes how orthodontics, oral and maxillofacial surgery, implant dentistry and other dental specialties, completed by HOF, restored a patient's aesthetics and function (Noronha Filho *et al.*, 2022). On this reading, CEOF formalizes a progression already under way in dental surgical practice.

The argument still meets two limits. The first is that the postgraduate clause expands the knowledge from which acts derive, but it keeps the condition that those acts be pertinent to dentistry. A course recognized by the Ministry of Education can teach otoplasty. Whether otoplasty is pertinent to dentistry remains the very question under dispute. The second limit is anatomical. The functional bond between the stomatognathic system and the lower face, which supports the perioral items and the jaw procedures of CTBMF, weakens for the ear, the eyelids and the nose (Table 2). The council's reading is therefore stronger for some items than for others. A single answer for the whole specialty fails to capture this gradient.

7 RESULTS AND DISCUSSION

The analysis answers the research question in two parts.

On competence, the federal statutes examined contain no express grant of power to the CFO to create specialties or to define the anatomical extent of dentistry. Law 4,324/1964

gives the councils a mandate to supervise professional ethics and inward-facing rule-making powers. Its only provision on scope, art. 11, g, settles doubts and does not create fields. Law 5,081/1966 never mentions the council. It refers to specialties only to limit their number. It names neither aesthetics, nor the face, nor the stomatognathic system, and it mentions head and neck only for forensic necropsy. When federal law chose to give a professional council power over the scope of procedures, as in art. 7 of the Medical Act Law, it did so expressly and narrowly. The creation of CEOF therefore rests on three supports: the open clause of art. 6, I, of Law 5,081/1966, the carve-out of art. 4, § 6, of Law 12,842/2013, and the council's own interpretation stated in the recital of the resolution. The statutes allow this reading. They do not confirm it.

On overlap, the contact with acts reserved to physicians is concentrated at two points. The first is surgical intervention (art. 4, II), which covers all 12 items the resolution itself calls surgical procedures. The second is general anesthesia and deep sedation (art. 4, VI), which the resolution's anesthetic regime touches. The narrow statutory definition of invasive procedures matters less than it first appears, because surgery carries the weight of the boundary. For every item, the legality of the overlap turns on whether the procedure lies within dentistry's area. As section 4.1 showed, that question has a graded answer: closest to the dental arch for the perioral items, furthest for the ear, eyelids, eyebrows and nose.

The contrary reading developed in section 6.3 does not dissolve this result, but it limits how far the result reaches. Custódio *et al.* (2020) and the clinical literature on HOF and orthognathic surgery show that dental surgery already works on the face and that the profession has built a functional rationale for that work. The article's reading accepts this for the lower face and the perioral region, where the stomatognathic rationale is strongest. Its claim is narrower: for the items furthest from the dental arch, no statute examined offers a textual anchor beyond the general clause of pertinence. The answer to the question is therefore neither a flat yes nor a flat no. The creation of the specialty as a whole rests on an interpretation, and that interpretation is more persuasive for some items than for others.

The way dental specialties have functioned in public policy helps clarify what kind of category CEOF is. In the Specialized Dental Centers (CEO) of the SUS, monitoring targets cover primary care, endodontics, surgery and periodontics. From 2008 to 2018, Brazil as a whole showed a declining trend in meeting the primary care target, rising trends for surgery and periodontics, and the weakest performance in the North and Northeast (Andrade; Pinto; Antunes, 2020). Of 930 CEOs evaluated in a national program, 65.5% had teams qualified in stomatology, the specialty devoted to the diagnosis of oral lesions, including oral cancer (Ottoni *et al.*, 2023). In the public system, then, specialties are instruments for treating oral

disease. CEOF is defined by its own art. 2 as aesthetic surgery. It follows a different logic, one in which the specialty is defined by its aesthetic purpose rather than by a line of care. This difference is the article's reading of the material. It does not imply that aesthetic procedures lack clinical value.

Interprofessional work offers a different frame for the same problem. Law 12,842/2013 provides that the physician on a health team acts in mutual collaboration with the other professionals who compose it (Brasil, 2013, art. 3). Dental education, however, rarely prepares students for that collaboration. In the curriculum of one federal dentistry school, none of 97 disciplines cited the assumptions or principles of interprofessional education. Only eight mentioned any multiprofessional action, together accounting for 15% of the course's 4,005 hours (Camargos; Amaral; Rocha, 2021). The boundary dispute over CEOF frames the face as territory to be allocated to one profession. A team model in which complex facial surgery is performed jointly is an alternative the statutes already contemplate. This is a reading of the article, not a documented practice in CEOF.

Three consequences follow from these results.

The first is legal uncertainty for professionals and patients, which will persist until a court or Congress defines what dentistry's area of practice covers. Dentists who perform the items furthest from the dental arch on the strength of the council's title rely on the council's interpretation in a setting where, as Wanderley (2024) reports, recent decisions have reinforced the protection of medical practice against non-physicians. The exposure documented for non-physicians under the Medical Act Law includes the criminal offense of illegal practice of medicine (Wanderley, 2024). Patients face the corresponding uncertainty about the legal standing of the title on which their consent rests (Carvalho; Lima, 2023).

The second consequence concerns where boundaries between professions are decided. The resolution moves that decision from the legislature to a professional council, following the pattern documented in telemedicine (Romão, 2023). This raises the same concern expressed in the French case about leaving regulatory questions to professional bodies (Brissy, 2018). The chain of mutual referrals identified here, from the medical statute to dentistry's area and from there to pertinence, is a statutory gap. A professional council can fill it provisionally, but only Congress can close it.

The third consequence is that the safety rules in the resolution and its legality are separate questions and should be read separately. The grading of procedures into Type I, II and III settings, the 3,000-hour training load and the requirement of both HOF and CTBMF registration for the transition reflect concern with competence and patient safety. They do not answer the question of competence in the legal sense. A well-trained professional, operating

in a properly equipped room, still acts within or outside the law according to how far dentistry's area extends. Technical qualification and legal authorization are distinct questions, and an answer to the first does not settle the second.

8 CONCLUSION

The article asked whether creating the CEOF specialty by Resolution CFO-286/2026 falls within the normative competence that federal legislation grants to the Federal Council of Dentistry, and where it overlaps with activities reserved to physicians.

Read against their compiled texts, the federal statutes examined give the council an ethical and administrative mandate. They grant no express power to create specialties or to define dentistry's anatomical reach. The resolution supports its list of procedures with an interpretation of Law 5,081/1966 that the law's open clause allows but its words do not confirm. The overlap with medicine is concentrated in surgical intervention and general anesthesia. Its legality depends on the extent of the carve-out the Medical Act Law grants to dentistry, an extent that no statute defines.

The objective was met in part. The question of competence received a reasoned answer: the creation lacks express statutory support and rests on a contested interpretation, which is more persuasive for perioral procedures and less persuasive for the ear, eyelids, eyebrows and nose. The legislative and judicial grounds for contestation were examined through documented precedents. They point toward the statute, interpreted by the courts or rewritten by Congress, as the instrument that will settle the boundary. The arguments for the council's reading were weighed and found to have real textual support, limited by the condition of pertinence that the same clause imposes.

The method does not reach some things. The analysis worked with the statutes and the resolution, not with bills or court decisions addressed specifically to Resolution CFO-286/2026, so it does not report how any concrete challenge has been decided. The regulatory decrees anticipated by Laws 4,324/1964 and 5,081/1966 were not examined, and they might qualify the council's powers. Part of the studies discussed were consulted through their abstracts, and the collection closed on 16 October 2026, so later acts and decisions are not considered. Following the judicial and legislative fate of the resolution and gathering empirical data on who performs these procedures, and in which settings, would test the reading proposed here.

The article contributes a procedure-by-procedure reading of a dental specialty against the three statutes that frame it, showing that the boundary between dentistry and medicine

on the face rests on a chain of mutual statutory referrals that a council resolution has filled but that only law can settle.

REFERENCES

ANDRADE, Fabiola Bof de; PINTO, Rafaela da Silveira; ANTUNES, José Leopoldo Ferreira. Tendências nos indicadores de desempenho e monitoramento de produção dos Centros de Especialidades Odontológicas do Brasil. Reports in Public Health, v. 36, n. 9, 2020. Available at: https://cadernos.ensp.fiocruz.br/ojs/index.php/csp/article/view/7439. Accessed: 16 Oct. 2026.

BRASIL. Lei nº 4.324, de 14 de abril de 1964. Institui o Conselho Federal e os Conselhos Regionais de Odontologia, e dá outras providências. Diário Oficial da União, 15 abr. 1964, p. 3369. Available at: https://normas.leg.br/?urn=urn:lex:br:federal:lei:1964-04-14;4324. Accessed: 16 Oct. 2026.

BRASIL. Lei nº 5.081, de 24 de agosto de 1966. Regula o exercício da Odontologia. Diário Oficial da União, 26 ago. 1966, p. 9843. Available at: https://normas.leg.br/?urn=urn:lex:br:federal:lei:1966-08-24;5081. Accessed: 16 Oct. 2026.

BRASIL. Lei nº 12.842, de 10 de julho de 2013. Dispõe sobre o exercício da Medicina. Diário Oficial da União, 11 jul. 2013, p. 1. Available at: https://normas.leg.br/?urn=urn:lex:br:federal:lei:2013-07-10;12842. Accessed: 16 Oct. 2026.

BRISSY, Stéphane. A regulação das profissões de saúde na França. Revista de Direito Sanitário, v. 19, n. 2, p. 156-197, 2018. DOI: 10.11606/issn.2316-9044.v19i2p156-197. Available at: https://doi.org/10.11606/issn.2316-9044.v19i2p156-197. Accessed: 16 Oct. 2026.

CAMARGOS, Débora de Oliveira; AMARAL, João Henrique Lara do; ROCHA, Najara Barbosa da. Educação interprofissional em uma Faculdade Federal de Odontologia: uma análise exploratória. Revista Sustinere, v. 9, n. 2, p. 498-513, 2021. DOI: 10.12957/sustinere.2021.53895. Available at: https://doi.org/10.12957/sustinere.2021.53895. Accessed: 16 Oct. 2026.

CARVALHO, Rayanna Silva; LIMA, Éfren Paulo Porfírio de Sá. Análise da estrutura dogmática do consentimento livre e esclarecido na pesquisa com seres humanos. Civilistica.com, v. 12, n. 1, p. 1-38, 2023. DOI: 10.5281/zenodo.18869990. Available at: https://doi.org/10.5281/zenodo.18869990. Accessed: 16 Oct. 2026.

CONSELHO FEDERAL DE ODONTOLOGIA. Resolução CFO-286, de 20 de março de 2026. Reconhece a Cirurgia Estética Orofacial (CEOF) como especialidade odontológica, define a área de atuação, as competências, os parâmetros formativos e dá outras providências. 2026. Available at: https://sintse.tse.jus.br/documentos/2026/Abr/6/saude/resolucao-no-286-de-20-de-marco-de-2026-reconhece-a-cirurgia-estetica-orofacial-ceof-como. Accessed: 16 Oct. 2026.

CUSTÓDIO, Antonio Luis Neto *et al.* Cosmetic Facial Surgery: Area of Practice of the Dental Surgeon. Aesthetic Orofacial Science, v. 1, n. 1, p. 9-19, 2020. DOI:

10.51670/ahof.v1i1.10. Available at: https://doi.org/10.51670/ahof.v1i1.10. Accessed: 16 Oct. 2026.

DIAS, Maria Tereza Fonseca; MENOSSI, Rita de Cássia. Os limites da competência normativa do Conselho Nacional de Justiça (CNJ) face aos serviços notariais e de registro. Revista de Direito Administrativo e Gestão Pública, v. 3, n. 1, p. 105-120, 2017. DOI: 10.26668/indexlawjournals/2526-0073/2017.v3i1.2167. Available at: https://doi.org/10.26668/indexlawjournals/2526-0073/2017.v3i1.2167. Accessed: 16 Oct. 2026.

LEPRI, Juliana Ribeiro. Fonoaudiologia Estética: interface entre Motricidade Orofacial e Estética da Face. Journal of Advanced Health Care, 2021. DOI: 10.36017/jahc2109-002. Available at: https://doi.org/10.36017/jahc2109-002. Accessed: 16 Oct. 2026.

LIMA, Maria Tereza Bezerra dos Santos; LIMA, Tarcya Rayanne; OLIVEIRA, Jeynife Rafaella Bezerra de. Orofacial harmonization and orthognathic surgery. Brazilian Journal of Implantology and Health Sciences, v. 6, n. 11, p. 1623-1632, 2024. DOI: 10.36557/2674-8169.2024v6n11p1623-1632. Available at: https://doi.org/10.36557/2674-8169.2024v6n11p1623-1632. Accessed: 16 Oct. 2026.

MEINBERG, Marcio Ortiz. Sobre a competência normativa do Conselho Monetário Nacional e do Banco Central do Brasil. Revista Eletrônica Direito e Política, v. 16, n. 3, p. 1097-1130, 2021. DOI: 10.14210/rdp.v16n3.p1097-1130. Available at: https://doi.org/10.14210/rdp.v16n3.p1097-1130. Accessed: 16 Oct. 2026.

NORONHA FILHO, Oriental Luiz *et al.* Harmonização orofacial para refinamento estético de pacientes submetidos a cirurgia ortognática: relato de caso clínico. Aesthetic Orofacial Science, v. 3, n. 2, p. 37-44, 2022. DOI: 10.51670/aos.v3i2.106. Available at: https://doi.org/10.51670/aos.v3i2.106. Accessed: 16 Oct. 2026.

OTTONI, Julimary Larissa Mendes *et al.* Atenção secundária em estomatologia nos centros de especialidades odontológicas do Brasil. Bionorte, v. 12, n. 2, p. 426-438, 2023. DOI: 10.47822/bn.v12i2.805. Available at: https://doi.org/10.47822/bn.v12i2.805. Accessed: 16 Oct. 2026.

ROMÃO, Ana. A competência normativa frente aos novos atores políticos: um estudo de caso da telemedicina. Saúde e Sociedade, v. 32, n. 1, 2023. DOI: 10.1590/s0104-12902022210680pt. Available at: https://doi.org/10.1590/s0104-12902022210680pt. Accessed: 16 Oct. 2026.

SALEME JUNIOR, Edson *et al.* Photographic Protocol Applied to Orofacial Harmonization. Aesthetic Orofacial Science, v. 2, n. 1, p. 72-82, 2021. DOI: 10.51670/ahof.v2i1.45. Available at: https://doi.org/10.51670/ahof.v2i1.45. Accessed: 16 Oct. 2026.

SANTOS, Ana Rebecca Santana; PASCHOALOTTO, Italo Gomes; TESSARIN, Gestter Willian Lattari. State of the art of orofacial harmonization: a review. MedNEXT Journal of Medical and Health Sciences, v. 4, 2023. DOI: 10.54448/mdnt23s403. Available at: https://doi.org/10.54448/mdnt23s403. Accessed: 16 Oct. 2026.

SILVA FILHO, José Roberto Lopes da; DIAS, Eduardo Rocha. A análise da decisão proferida pelo Supremo Tribunal Federal na ADPF nº 131 e a sua contribuição para a efetividade do direito à saúde por meio da atuação de profissionais não médicos. Direito em Debate,

v. 35, n. 65, 2026. DOI: 10.21527/2176-6622.2026.65.15939. Available at: https://doi.org/10.21527/2176-6622.2026.65.15939. Accessed: 16 Oct. 2026.

TRAVASSOS, Denise Vieira *et al.* Ato Médico: histórico e reflexão. Arquivos em Odontologia, v. 48, n. 2, 2016. DOI: 10.7308/aodontol/2012/48.11.07. Available at: https://doi.org/10.7308/aodontol/2012/48.11.07. Accessed: 16 Oct. 2026.

VELHO, Gabriel Ricardo *et al.* Biossegurança e odontologia na pandemia da COVID-19. Saberes Plurais, v. 6, n. 1 (supl.), 2022. Available at: https://seer.ufrgs.br/index.php/saberesplurais/article/view/122787. Accessed: 16 Oct. 2026.

WANDERLEY, Mayrinkellison Peres. A Lei do Ato Médico e o crime de exercício ilegal da medicina: a regulação dos procedimentos estéticos. Conpedi Law Review, v. 10, n. 1, 2024. DOI: 10.26668/2448-3931_conpedilawreview/2024.v10i1.10743. Available at: https://doi.org/10.26668/2448-3931_conpedilawreview/2024.v10i1.10743. Accessed: 16 Oct. 2026.