



Article

Resolution No. 2.232/2019 of the Federal Council of Medicine and the decisions of the Federal Supreme Court regarding transfusion refusal: therapeutic refusal, conscientious objection and the work of the Public Defender's Office in defense of the affected group

A Resolução nº 2.232/2019 do Conselho Federal de Medicina e as decisões do Supremo Tribunal Federal sobre recusa transfusional: recusa terapêutica, objeção de consciência e a atuação da Defensoria Pública em defesa do grupo afetado

Resolución n.º 2.232/2019 del Consejo Federal de Medicina y las decisiones del Supremo Tribunal Federal sobre la negativa a la transfusión: negativa terapéutica, objeción de conciencia y la actuación de la Defensoría Pública en la defensa del grupo afectado

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Abstract

Objective: to evaluate the regulation of transfusion refusal for religious reasons, as recognized in recent decisions of the Federal Supreme Court and addressed in Resolution No. 2.232/2019 of the Federal Council of Medicine. **Methodology:** a critical expository analysis of the deontological norm, in light of current jurisprudence on the subject and its impact on the right to health. The study was conducted through normative, jurisprudential, and bibliographic research, based on the historical development within the ethical-professional field and its comparison with recent jurisprudential positions. It culminates in an exploratory assessment of how the decision affects access to health for individuals impacted by the aforementioned norms, which have prompted administrative action by the Public Defender's Office in ensuring the effective protection of this group's health. **Results:** Resolution No. 2.232/2019 was enacted with the aim of establishing "ethical standards for therapeutic refusal by patients and conscientious objection in the physician-patient relationship," following the emergence of jurisprudential debate on the issue. Its content, by simultaneously addressing multiple ethical and legal aspects, raised several issues that are currently under discussion. It was found to be relevant, including for revising previous positions of the Council that had been subject to legal challenge. However, the manner in which the norm was structured gave rise to an apparent conflict between the autonomy of the physician and that of the patient. In light of the decisions rendered in Extraordinary Appeals No. 979.742 and No. 1.212.272 by the Federal Supreme Court, which upheld the right to refuse blood transfusions, proposals were advanced concerning the regulation and practice of the issue, including normative and interpretative approaches, as well as the need to ensure the availability of alternative therapeutic options. **Conclusion:** This study highlights the need for normative and practical harmonization regarding transfusion refusal and its implications for the exercise of autonomy, including in end-of-life decisions, within the national legal framework.

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Keywords: Conscientious Objection; Blood Transfusion; Personal Autonomy; Professional autonomy; Public health.

Resumo

Objetivo: avaliar a disciplina da recusa transfusional por razões religiosas, reconhecida em recentes decisões do Supremo Tribunal Federal e objeto da Resolução nº 2.232/19 do Conselho Federal de Medicina. **Metodologia:** análise expositiva crítica da norma deontológica, em face da nova jurisprudência sobre o tema e sua repercussão no direito à saúde. O estudo foi desenvolvido mediante pesquisa normativa, jurisprudencial e bibliográfica, partindo da evolução histórica no âmbito ético-profissional e seu cotejo com o posicionamento jurisprudencial recente. Culmina em avaliação exploratória acerca de como o *decisum* repercute no acesso à saúde dos afetados pelas aludidas normas, o que provocou a atuação administrativa da Defensoria Pública quanto à proteção efetiva à saúde desse grupo. **Resultados:** a Resolução nº 2.232/19 surgiu com o escopo de estabelecer “normas éticas para a recusa terapêutica por pacientes e objeção de consciência na relação médico-paciente”, após o início da discussão jurisprudencial sobre o tema, e cujo conteúdo, ao abordar simultaneamente aspectos ético-jurídicos variados, ensejou diversas dúvidas, ora discutidas. Constatou-se que a Resolução se mostrava pertinente, inclusive para retificar posicionamentos anteriores do Conselho, que vinham sendo questionados juridicamente. Porém, o modo como é delineada a norma terminou ensejando aparente conflito entre as autonomias do médico e do paciente. Em face do julgamento dos Recursos Extraordinários nº 979.742 e nº 1.212.272 pelo STF, chancelando o direito de recusa transfusional, propuseram-se sugestões concernentes à disciplina e prática do tema, como formulações normativas e hermenêuticas, destacando-se, ainda, a necessária oferta de recursos terapêuticos alternativos. **Conclusão:** destaca-se a necessária harmonização normativa e prática acerca da recusa transfusional e sua repercussão no exercício da autonomia, inclusive em decisões de fim de vida, no ordenamento jurídico pátrio.

Palavras-chave: Objeção de Consciência; Transfusão Sanguínea; Autonomia Pessoal; Autonomia Profissional; Saúde Pública.

Resumen

Objetivo: evaluar la disciplina de la negativa transfusional por razones religiosas, reconocida en recientes decisiones del Supremo Tribunal Federal y objeto de la Resolución n.º 2.232/2019 del Consejo Federal de Medicina. **Metodología:** análisis expositivo crítico de la norma deontológica, en función de la jurisprudencia actual sobre el tema y su repercusión en el derecho a la salud. El estudio se desarrolló mediante investigación normativa, jurisprudencial y bibliográfica, partiendo de la evolución histórica en el ámbito ético-profesional y su comparación con la posición jurisprudencial reciente. Culmina en una evaluación exploratoria sobre cómo el *decisum* repercute en el acceso a la salud de los afectados por las mencionadas normas, que han motivado la actuación administrativa de la Defensoría Pública en la protección efectiva de la salud de este grupo. **Resultados:** la Resolución n.º 2.232/2019 surgió con el objetivo de establecer “normas éticas para la negativa terapéutica por parte de los pacientes y la objeción de conciencia en la relación médico-paciente”, tras el inicio de la discusión jurisprudencial sobre el tema. Su contenido, al abordar simultáneamente diversos aspectos ético-jurídicos, generó dudas que actualmente se encuentran en debate. Se constató que ello resultaba pertinente, incluso para rectificar posturas anteriores del Consejo que habían sido cuestionadas jurídicamente. Sin embargo, la forma en que se delineó la norma terminó generando un aparente conflicto entre la autonomía del médico y la del paciente. A la luz de la decisión jurisprudencial dictada en los Recursos Extraordinarios n.º 979.742 y n.º 1.212.272 por el STF, que ratificó el derecho a rechazar la transfusión, se propusieron sugerencias relacionadas con la regulación y la práctica del tema, tales como formulaciones normativas y hermenéuticas, destacándose además la necesaria oferta de recursos terapéuticos alternativos.

Conclusión: este estudio destaca la necesidad de una armonización normativa y práctica sobre la negativa transfusional y su repercusión en el ejercicio de la autonomía, incluso en decisiones de fin de vida, dentro del ordenamiento jurídico nacional.

Palabras clave: Objeción de Conciencia; Transfusión de Sangre; Autonomía Personal; Autonomía Profesional; Salud Pública.

Introduction

Recently, the decisions of the Federal Supreme Court (STF) on the possibility of refusing blood therapy for religious reasons have helped to bridge a serious gap that affected healthcare provision and the professional-patient relationship on this issue, generating multiple doubts and insecurities on both sides, as evidenced by the lawsuits mentioned below.

In this respect, the most recent parameter drawn up to settle the issue was Federal Council of Medicine (CFM) Resolution No. 2.232/19⁽¹⁾ which, in its own words, came about with the aim of establishing “ethical standards for therapeutic refusal by patients and conscientious objection in the doctor-patient relationship”. This measure proved to be pertinent, not least to rectify and update the entity’s previous and specific positions, which dated back almost four decades and had been legally questioned.

In doing so, however, it ended up addressing, in a single normative instrument with a more general claim, not only the autonomy of the patient, in their particular conscientious objection for religious reasons, but also confused the limits of this with the issue of professional autonomy, in their own conscientious objection on other issues. Finally, a third conceptual element of a legal nature was included - in other words, the mention of “abuse of rights” - in a very non-technical way, resulting in a rule that ended up giving rise to more doubts than clarifications, as will be seen.

The discussion of the current deontological rule, which could have resolved these issues and favored greater maturity and possible early revision by the Council, which had already occurred in the production of previous normative documents, was left aside, in a way, just over six months into its existence and already the subject of two judicial challenges, in the face of the urgent demands of the covid-19 pandemic. As a result, it has reached the present moment, six years later, with the structural questions that are now being analyzed.

It should be noted that the content of the Resolution also seems to clash with disciplines already established by the federal authority itself and recognized by case law, notably with regard to the limits of personal autonomy and therapeutic refusal in cases of terminality and end of life.

This text seeks to analyze the deontological discipline of the issue and suggest possibilities for adjustment, in the light of new jurisprudential understandings, in order to improve the ethical and legal discipline of the issue in the country. The aim is to achieve a more harmonious professional-patient relationship, to guarantee the constitutional right to religious freedom and to effectively protect the health of even the most vulnerable groups, such as those assisted by the Ombudsman's Office.

To do this, we began with a historical analysis of the normative-deontological evolution of the issue, focusing on the hermeneutic and legislative engineering aspects *lato sensu*, correlating them with the jurisprudential understandings recently handed down by the country's Supreme Court, in the judgments of the following cases Extraordinary Appeals No. 979.742 and No. 1.212.272, decided on September 25, 2024⁽²⁾ and their repercussions on public health, requiring the Public Defender's Office

to act on behalf of the population dependent on the Unified Health System (SUS) and followers of Jehovah's Witnesses, in their freedom of religious exercise.

The main objective of this study was to evaluate the discipline of the possibility of refusing transfusions for religious reasons, recognized in the aforementioned STF decisions and the subject of CFM Resolution No. 2.232/19, and to discuss the doubts that the content of this rule, by simultaneously addressing various ethical and legal aspects, has given rise to. Furthermore, in addition to the hermeneutical aspects and the review considered necessary to clarify the discipline of the matter, practical issues also concern the Public Defender's Office, especially regarding the effective protection of the health of this group and the guarantee of recognized religious freedom, leading to the suggestions addressed in the text.

Methodology

This is a critical expository analysis of the deontological norm, more precisely of Resolution No. 2,232/2019 of the Federal Council of Medicine and its evolution, with regard to the discipline of the possibility of therapeutic refusal, including transfusion, in the face of current jurisprudence on the subject, and its repercussions on the right to health⁽³⁾.

The study was developed through normative, jurisprudential and bibliographical research, starting from the historical evolution of the issue in the ethical-professional sphere and its comparison with recent jurisprudential positioning.

The problem addressed consisted of questioning how to reconcile the autonomy of the patient who refuses transfusion for religious reasons with the professional autonomy of the doctor and the current ethical-legal standards (notably CFM Resolution No. 2.232/2019)⁽¹⁾ especially in light of the recent case law of the Federal Supreme Court⁽²⁾ ensuring the effectiveness of refusers' right to health.

It culminates in an exploratory assessment of how the decision affects access to health for those affected by the aforementioned rules, the object of the Public Defender's administrative action, as well as the precautions and changes that could be suggested in order to improve the protection of the rights involved.

Results and discussion

CFM Resolution No. 2.232/19 and its historical-cultural and ethical-legal context: refusal of treatment and Jehovah's Witnesses

CFM Resolution No. 2.232, published on July 17, 2019, apparently came about with the benign purpose of correcting the entity's previous interpretation, presumption and equation regarding transfusion refusal for religious reasons, which had been going on for almost four decades, even motivating the legal challenges that led to the current rulings.

It also aimed to regulate a demand that was also current and necessary, regarding the possibility of general therapeutic refusal, in order to regulate the provision admitted both hermeneutically, by the systematics of the legal system, and expressly, in art. 15 of the Civil Code of 2002, which, however, had not detailed its appropriateness, especially in situations where life and death are inexorably approaching. In this context, the document came in the wake of very enlightening resolutions by the entity (in particular Resolutions No. 1.805/2006⁽⁴⁾ and No. 1.995/2012⁽⁵⁾ the latter cited in the "recitals"

of the rule under examination), which have shaped the social vision of patient autonomy since the beginning of the 21st century in the country⁽⁶⁾.

However, by including in the same document the discipline of another ethical issue which is also challenging and not always associated with therapeutic refusal in specific cases - that is, situations in which the doctor can excuse his conscience - it ended up generating more doubts than it sought to resolve⁽⁷⁾.

On initial analysis, Resolution No. 2,232/2019 of the Federal Council of Medicine seems to have been born with the purpose of repealing CFM Resolution No. 1.021/80⁽⁸⁾, whose interpretation placed refusal of treatment at the discretion of the physician. Whose interpretation placed refusal of blood transfusion as attempted suicide, assertively concluding that: “1º - If there is no imminent danger to life, the doctor will respect the will of the patient or their guardians. 2º - If there is imminent danger to life, the doctor will perform the blood transfusion, regardless of the consent of the patient or their guardians”⁽⁸⁾. It should be noted that the text made no distinction between conduct "without consent" and that practiced "against the frank dissent" of the patient.

In view of this, the 1980 regulation was the reason for the Fundamental Precept Argument - ADPF No. 618/19⁽⁹⁾, filed by the Attorney General's Office almost half a century later. filed by the Attorney General's Office, in a similar vein to RE No.1.212.272/19, also with an opinion from the ministerial body - in the sense of the possibility of refusing blood therapy for religious reasons, as an aspect of human dignity⁽¹⁰⁾. In this ADPF, the unconstitutionality of the then current understanding was defended, which compelled the transfusion, even against the patient's will, and ruled out illegal constraint, on the grounds of the permissiveness of art. 146, § 3, I and II, of the Penal Code, the latter referring to “coercion exercised to prevent suicide”.

The administrative revocation of the deontological guideline, with no mention of this last clause in the current Resolution, was precise in that the Jehovah's Witness who refuses the transfusion does not, as a rule, wish to die - so much so that he has sought medical assistance against it. However, he refuses to submit to a certain therapy, which seems to him to be absolutely incompatible with his religious values, which are also constitutionally safeguarded, and which is more burdensome, within his moral hierarchy, than the eventual death resulting from his illness.

The question is therefore about the limits of therapeutic refusal and whether or not it is obligatory to undergo treatment when there is a risk to life, but also whether this is compatible with religious freedom as a basis for autonomy.

The refusal of non-autologous hematological therapy by followers of religion represented one of the most distressing and undefined situations, from the point of view of legal certainty, within the scope of the doctor-patient relationship in the country. This is because it involves the patient or their family refusing a therapy which is considered simple and almost commonplace, which leaves no external marks, which is capable of reversing an acute life-threatening condition and in which the refusal is for the subjective reason of a minority of the population. This was aggravated by the fact that, until then, there had been no clear specific discipline or peaceful position on the appropriate response in the country, either in the legal or judicial spheres. It was therefore a situation of conflicting fundamental rights, which had to be weighed up, often in a context of great tension in the specific case.

In this respect, the repealed Resolution was the most direct rule on the subject, interpreting a current criminal law and determining that the therapy should be administered, even in the face of the patient's refusal. It was thus based on the absolute protection of life, to the detriment of conflicting

religious freedoms. This position, in theory, despite the reservations made about its content, supported the professional, by directing the conduct and compelling the procedure, even against the express refusal of the patient or their representative.

It should be remembered, however, that the Resolution, drawn up even before the current Federal Constitution, could in fact be subject to legal-constitutional questioning, as indeed it was, on the grounds that it does not have the power to impose conduct that the law itself does not determine (Art. 5, II, CF/88: “no one shall be compelled to do or refrain from doing anything except by virtue of the law”), and there is no specific law requiring submission to non-compulsory therapy⁽¹¹⁾ which the patient considers morally unacceptable.

It is, therefore, a question of weighing up fundamental values and rights (compulsory submission to potentially life-saving treatments versus the freedom to refuse treatment deemed to be offensive to one's physical or moral integrity), in its principiological fabric⁽¹²⁾ which could not be resolved in terms of all or nothing. Furthermore, the rule ended up imposing conduct, including on non-medical patients, by means of an infralegal deontological device.

Contrary to what was said in the deontological rule, which was issued during an authoritarian regime, the systematic and teleological interpretation of the current legal system speaks in favor of the idea that blood transfusion is an invasive and optional therapy, which can be refused, even when it is intended to be curative. This is what can be seen from Law No. 8.213/1991, with the wording ratified, in particular, by Law No. 14,441/2022, as follows:

Art. 101. The insured in receipt of temporary incapacity benefit, accident benefit or permanent incapacity retirement and the invalid pensioner, whose benefits have been granted judicially or administratively, are obliged, under penalty of suspension of the benefit, to undergo:

I - a medical examination carried out by Social Security to assess the conditions that led to their being granted or maintained;

II - a professional rehabilitation process prescribed and paid for by Social Security; and

III - treatment offered free of charge, except for surgery and blood transfusions, which are optional. (emphasis added)⁽¹³⁾

A different understanding, especially in situations that involve their own risks and uncertainty of outcome, would seem to bring us closer to a historical view, today considered violent and anachronistic, such as that reported by Jean Louis Foure, in his 1929 “The Soul of the Surgeon”:

I think there is even the right to always operate, even against the patient's wishes. I think so and have done so. In these situations, the surgeon's will must prevail over the will of the patient who, through ignorance, cannot appreciate the seriousness of his refusal. It's enough to proceed in the open and in front of witnesses. Twice in hospital I have put patients to sleep against their will, forcibly held by their valid neighbors. I operated on them and saved them⁽¹⁴⁾.

The situation is shocking, especially when the manifestation is not due to error or ignorance, but to the conscious expression of capable, enlightened people who find themselves summarily unheard, their will disregarded and presumed powerless because they are in a healthcare facility.

It should also be noted that the refusal to undergo a certain treatment (be it a transfusion, surgical procedure or ICU stay) primarily evokes the availability of therapy, given real, economic, social and structural conditions. This is because, as the Public Defender's Office is well aware, there are intense battles, including legal ones, in the search for necessary and desired resources, which are not always available to those who need them. It is therefore impossible to consider treatment that is not always accessible to all those who want and need it, as can be seen in the fight for a place in an Intensive Care Unit (ICU), for example, when there are not enough available in public units.

There is also the factor that any therapy involves its own risks, which the patient may not want to take. In the case of blood transfusion, although a frequent and generally non-iatrogenic measure, it should be noted that, even from a scientific point of view, it is not entirely risk-free. For example, it can lead to contamination by blood-borne pathogens - even if all the tests are carried out correctly - due to the so-called immunological windows (periods in which the pathogens, although present, are not yet detectable)⁽¹⁵⁾.

This consideration is pertinent insofar as, despite the constitutionally recognized freedom of religion, it is a fact that in modern times, in which scientific knowledge dating back to the positivist formulation occupies a prominent place in the sphere of social recognition and appreciation, the argument of biological risk may be better accepted than that based on religious belief. Thus, it can lead to refusal even more easily considered than that based on moral aspects, however structuring they may be for the individual.

In fact, human knowledge has gone through a series of historical stages: the mythical/religious phase, the metaphysical/philosophical phase and the empirical/scientific phase, the beginning of which was marked above all by Positivism⁽¹⁶⁾. These worldviews are permeated by ideological paradigms, ideology being understood, in the words of Tércio Sampaio Ferraz Júnior⁽¹⁷⁾, as a "hierarchy of values". as a "hierarchy of values", within the social scale of each era, context and place, even though, at the height of Positivism, attempts were made to expunge axiological and moral discussion from Law.

The discussion about autonomy, which goes hand in hand with the reincorporation of principles into the epistemological space of Law, demands a position that is in line with the hierarchy of values of the patient, who is no longer seen in a passive way, but as a citizen, owner, subject and, at the very least, co-protagonist of their treatment. Medical practice, in turn, an increasingly frequent target of legal challenges, also demands legal and ethical certainty in its provision.

The current Resolution under analysis, although it seems to have been motivated by this demand, in response to the legal questioning of the constitutionality of the previous rule - which lost its object precisely with the drafting of the current rule and the revocation of the questioned normative act - was not clear on either point. It did not resolve the hermeneutical doubt about whether or not it was possible to refuse blood transfusion - or any other treatment in a non-terminal condition⁽¹⁸⁾ nor has it clarified how the doctor should act in this context, in the face of the frank dissent of an adult and capable patient to a certain therapy, under penalty of being held civilly or even criminally liable for either approach.

The rule under examination seems to oscillate between the possible paths, hindering rather than helping systematic interpretation. Although its initial articles lean in favor of autonomy (see articles 1 and 2)⁽¹⁾ only pondering the issues of legal capacity (see articles 3 and 4)⁽¹⁾ and the so-called abuse of rights (articles 5 and 6)⁽¹⁾ the subsequent provisos suggest a trend in the same direction as the previous repealed rule: pro-compulsory treatment.

In this respect, it only removed the argument of coercion to prevent suicide, referring to general protection when life is at risk, in accordance with art. 146, § 3, I (this time without item II), of the Penal Code, which “excludes the criminality of conduct in cases of medical intervention without the patient's consent, if justified by imminent danger of death”, expressly referred to in the “recitals”. The question remains as to whether “without consent” also encompasses “against outright refusal”, as well as what can motivate a valid refusal, a question that also runs through the vast discussion about types of consent^(15,19,20).

Portuguese doctrine is divided, in this regard, between authors understood as more autonomist or more paternalist, according to the weight given to the consent of the offended party⁽²¹⁾ in medical conduct and the limits of this manifestation of will in the legal system. It should be noted that, in the case in question, the very characterization of the “offence” depends on this understanding: would it be in the physical injury or even death resulting from accepting the refusal or in the moral injury resulting from acting against it? Nor was the case law unified, which gives rise to insecurity in professional conduct in the face of a patient's refusal to receive a blood transfusion for religious reasons. This is a manifestation which, within the framework of the country’s constitutional provision, has a relevant moral basis and cannot be confused with mere misinformation, insipience or random fears⁽¹⁵⁾.

Naturally, assessing the motivation for refusal is always a challenge, due to the inescapable subjectivity involved. It is a natural tendency to consider positions that coincide with the proposer's values to be more valid, reasonable and rational, making it difficult to validate empathetically or compassionately different values that lead to decisions that the evaluator himself would not make. When the basis for the refusal is faith, and therefore not empirically verifiable, the issue of tolerance becomes even more difficult.

It is also important to note that collecting consent, especially in sensitive cases such as these, involving relevant moral values within a community, requires, in addition to effective clarification, absolute respect for secrecy and confidentiality, as ethical and deontological principles, also deriving from the constitutional rights to privacy and intimacy. These are necessary precautions, in order to ensure that the decision made is in fact an expression of the individual's own conscience, and not of external pressures or contingencies in favor of refusal, a factor that cannot be disregarded and could unduly interfere with the decision expressed. This is even more worrying in the case of particularly vulnerable patients or victims of social prejudices, such as ageism or ableism⁽¹⁵⁾.

In the case of a minor patient, the situation is relatively more peaceful in court, in line with the Resolution, as it is understood that the situation there is not one of effective autonomy, but of autonomy by representation⁽²²⁾ or consent by proxy (a term considered inappropriate by the Brazilian Society of Pediatrics⁽²³⁾) and, as such, potentially surmountable by the primacy of the minor's interests⁽¹⁵⁾. This analysis is in line with what is constitutionally recognized in art. 227, which states that it is the simultaneous responsibility of “the family, society and the state to ensure the right to life, health, etc. for children, adolescents and young people, with absolute priority”.

Within the scope of the Resolution in question, a refusal that puts the survival of the incapacitated person at risk would also be in line with Article 5, which deals with the abuse of rights, since it would consist of a procedure whose refusal, although not in itself carried out, would imply a risk to a third party.

With regard to the abuse of rights, understood as that provided for in art. 187 of the Civil Code of 2002 and provided for in the Resolution as a cause for not accepting the refusal, it is a fact that there is no such thing as an absolute right. The concept of abuse has a legal basis and can be defined as:

the fact of using a power, a faculty, a right or even a thing, beyond what is reasonably permitted by law and society. The holder of a legal prerogative, a subjective right, who acts in such a way that their conduct goes against good faith, morality, good customs, the economic and social purposes of the rule, incurs an abusive act. In this situation, the act is contrary to the law and gives rise to liability⁽²⁴⁾.

In the case of the hypotheses listed in the deontological norm, items I and II of art. 5, § 1 of Resolution 2.232/2019, which refer to the risk to third parties and to the community, in effect, could characterize improper use of the right of refusal, and justify the non-renounceability of health measures. This was also recognized during the covid-19 pandemic, under the terms of Article 3 of Law No. 13.979/2020, and despite the distinction between compulsory treatments (subject to indirect coercive measures) and compulsory or forced treatments⁽¹¹⁾ under the terms of articles 23 and 31, item 2, of Legislative Decree No. 10.212, of January 2020, which internalizes the International Health Regulations.

Paragraph 2 of Article 5 of this Resolution was the subject of ADPF No. 642/19⁽²⁵⁾ and Public Civil Action No. 5021263-50.2019.4.03.6100/SP⁽²⁶⁾ which, at first, succeeded in partially suspending the effectiveness of articles 5, § 2; 6 and 10, which limited the freedom of the pregnant woman, if an abuse of rights in the face of the fetus was characterized. In May 2021, the sentence handed down in the ACP denied the request and withdrew the preliminary injunction aimed at revoking the aforementioned articles. It was based on the understanding that the interests of the fetus should be weighed, but together with those of the mother. In January 2026, ADPF No. 642, in turn, was the subject of a request for review, following a vote by the Rapporteur, Justice Nunes Marques, to the effect of

ratifying the legal theses established in Themes 952 and 1.069 of the general repercussion system, partially granted the requests formulated in ADPF 618 and ADPF 642, to: (i) establish the partial non-reception, without reduction of text, of art. 146, § 3, I, of the Penal Code, in order to exclude the interpretation that doctors must carry out blood transfusions against the prior or current wishes of a patient of legal age who, for reasons of personal conviction, opposes the treatment; and (ii) declare the partial unconstitutionality, without reducing the text, of arts. 5º, § 2º, 6º, 10 and 11 of Resolution No 2.232/2019/CFM; 22 and 31 of Resolution No. 2.217/2018/CFM (Code of Medical Ethics); and 3 of Resolution n. 136/1999/CREMERJ, in order to exclude a hermeneutic that authorizes doctors to transfuse blood when it goes against the prior or current wishes of a patient of legal age and capacity who, for reasons of personal conviction, opposes the treatment (...)⁽²⁵⁾.

In the previous request for review, Justice Cristiano Zanin partially diverged in relation to the extent of the decision, considering that “the judgment goes beyond the debate restricted to Jehovah's Witnesses and must reach the broader definition of the right of all adult and capable patients to refuse medical interventions, regardless of the motivation”, as a consequence of the dignity of the human person, the right to privacy, physical integrity and one's own body, except in the exceptional cases of

presumed consent, when it is impossible to obtain a manifestation of will. It also considered that the CFM had overstepped its normative competence by issuing rules that restrict patients' rights⁽²⁷⁾.

In the case of therapeutic refusal involving minors, questions could still be raised about the mature minor theory⁽¹³⁾ especially for adolescents, and more notably for those over the age of fourteen, given the content of some international and internal documents², or by analogy with the criminal provision for presumed rape below this age, thus recognizing some legal validity to consent above it, even though civil emancipation can only take place from the age of sixteen.

In cases involving blood transfusion to minors, case law has tended more consistently towards pro vita conduct, as in the emblematic HC No. 268.459/SP⁽²⁸⁾ ruled in September 2014, in which the STJ held that, in a situation in which a thirteen-year-old child had died, attributed to the non-performance of a blood transfusion due to the refusal of the parents, who were then accused of murder, the parents should not be held responsible for the death, since it was up to the doctors to perform the procedure, to the detriment of the parental refusal. However, the decision did not clarify whether, if the patient was of age, the conclusion would be the same, despite the personal refusal.

Several decisions have revealed this lack of definition, especially in relation to older patients and other refusals (such as the provisional interdiction, determined in November 2017, of 22-year-old JHPCF, a chronic kidney patient from Goiás who refused hemodialysis and a transplant. The decision stated that the interdiction was limited to the issue of treatment, but paradoxically stated that there should not be "any form of physical coercion, including sedation"⁽¹⁵⁾. To illustrate the variability of understandings, there are headlines, news items and decisions such as: "Jehovah's Witness cannot receive forced blood transfusion"⁽²⁹⁾ from the Federal Regional Court of the 1st Region, and, in the opposite direction, a decision by the São Paulo courts, according to which: "Justice forces Jehovah's Witness to receive blood transfusion"⁽³⁰⁾.

It can thus be seen from the above that the deontological standard, as it has been set out and in the light of the most contemporary understandings of the fundamental rights involved, has not resolved the professional doubt in this respect - that is to say, the possibility or not of refusing procedures, in conditions other than terminality, and blood transfusion, in particular, by the adult and capable Jehovah's Witness patient.

On the other hand, the regulation has added questions by merging another aspect into the same document, notably the also controversial issue of conscientious objection by the professional (the argument for such an excuse is much more associated with the Jehovah's Witness himself, in the face of obligations imposed by the State, such as military service), as will be commented on below.

That said, in order to seek greater clarity and coherence, a suggestion for a more detailed discipline of the subject, taking as a model the Statements of the judicial adjuvant bodies, could be worded as follows:

² Ex vi, art. 12, 1, International Convention on the Rights of the Child, UN, New York, 1989: "States Parties shall ensure to the child who is capable of forming his or her own views the right to express his or her views freely on all matters relating to the child, and such views shall be considered in the light of the age and maturity of the child". Other documents, including national ones, also mention the need to hear from minors, including in the health sphere, according to their ability to understand and express themselves, such as the determination of the minor subject's consent to participate in research on human beings, provided for in item II.2 of National Health Council Resolution No. 466/2012, which replaced Resolution No. 196/96 in regulating the subject, without, however, dispensing with the manifestation of the legal guardian.

In therapeutic refusal for religious reasons, the following must be observed:

- a) capacity: in the case of a minor and/or incapacitated person, beneficence indicates the procedure, if there is a technical recommendation;
- b) risk of imminent death: if there is no personal decision to the contrary, the procedure is supported by art. 146, § 3, I, CP;
- c) current manifestation of refusal, in a private consultation with a capable patient, informed of the risks: record in medical records and provide all applicable resources, except for the therapy expressly refused;
- d) the existence of an advance directive, preferably recent (up to a year) or, in the case of urgent care, the patient's own declaration or identification card with a record of the refusal, even if issued more recently: this shows that the refusal is current and supports non-transfusion, as per item c).

This would adjust the specific ethical and legal discipline, resolve doubts and standardize approaches to the different nuances of the issue.

On technique and clarity: the mixture of themes in the normative instrument and the inadequacy of the discipline of the doctor's excuse of conscience in the same document

The work of the Federal Council of Medicine, with its resolutions, has played an important role in regulating various aspects related to the interface between law and health in the country. These include, *verbi gratia*, Resolution no. 1.805/2006⁽⁴⁾ which clarified the issue of orthothanasia, and Resolution No. 1.995/2012⁽⁵⁾ which regulated the possibility and exercise of Advance Directives of Will - as they are not prevented by legislation.

Resolution No. 2.232/2019, however, in trying to redeem itself from the previous and controversial approach of CFM Resolution No. 1.021/1980, regarding blood transfusion, which had challenged, in the same year of 2019, lawsuits against its constitutionality, ended up generating even broader doubts and criticism. On the one hand, it has tended to generalize, without actually clarifying, action against the patient's will, at a time when we are seeking a more respectful weighing of the subject's autonomy and fundamental values. These weaknesses regarding therapeutic refusal were not enough, and the Resolution in question raised another criticism by concentrating, in the same act, two issues that are not necessarily linked: the patient's therapeutic refusal and the doctor's conscientious objection, a combination that is not usually seen as a good idea in a clarifying rule, such as resolutions.

This is reminiscent of the drafting phase of CFM Resolutions No. 1.805/2006 and No. 1.826/2007⁽⁷⁾. Both rules deal with the omission and suspension of artificial support in orthothanasia (the first) and brain death (the second), pointing out the different causes that support the conduct in both situations. Initially, the approach was considered in a single document. At the time, it was thought that such a measure would lead to more confusion than clarification, by suggesting that they were necessarily related topics, rather than the distinct situations that they actually are. On that occasion, the Council concluded, very wisely, that “two in one” resolutions do not usually bear good fruit, unfolding the proposal into the two that were actually published, with great progress for the issues in the country.

It would therefore be suggested that the Resolution on therapeutic refusal be limited to this issue, in line with the rules already in place, and to the possible situations in which it would not be possible - which do not necessarily involve the personal disagreement of the professional, as if there were a hierarchical gradation between the individual values of the two subjects.

Another Resolution would then be drawn up for cases of conscientious objection by the doctor, referred to in articles 7 to 10, with the respective causes in which the objection cannot be admitted, notably the hypothesis in which there is no other professional able to provide the assistance to which the patient is entitled.

Special note should be made of the suggestion to dissociate the themes in articles 8 and 10, which ended up being particularly confusing, as they tried to merge therapeutic refusal by the patient and conscientious objection by the doctor, when both are situations of habitual omission or non-doing, which are therefore difficult to confront or justify addressing in a single rule.

In the case of art. 10, for example, when dealing with a situation that would prevent the professional from objecting (urgency or emergency), it is assumed that the patient wants the treatment, and the doctor cannot fail to offer it in the name of such an excuse. However, by adding, in the same statement, the hypothesis of inadmissibility of refusal that entails risk, it refers to the idea that the patient does not wish to be treated, generating a paradox.

In fact, the notion of conscientious objection or excuse by the doctor rests, in the current Code of Medical Ethics⁽³¹⁾ (CFM Resolution No. 2.217/2018), on the following articles, which show something similar to therapeutic refusal, since both situations consist of negatives based on fidelity to one's own morals. As said, however, they are situations that would hardly be in conflict, since both refute therapeutic practices, either by the patient or by the professional, because they consider them contrary to their own beliefs. These are the articles of the codex:

Chapter I - Fundamental Principles:

VII - The doctor shall exercise his profession with autonomy, and shall not be obliged to provide services that go against the dictates of his conscience or to whom he does not wish, except in situations where there is no other doctor, in cases of urgency or emergency, or when his refusal may cause harm to the patient's health.

Chapter II - Doctors' Rights:

IX - To refuse to perform medical acts which, although permitted by law, are contrary to the dictates of his conscience⁽³¹⁾.

There is therefore no justification for providing, in the same rule, the situation described here and the patient's refusal (both of which tend to be omissive), as a possible relationship of confrontation. As Albuquerque points out, the conscientious objection described above "means abstention on the part of the professional, so it is unacceptable under the argument of the objection to have positive conduct translated into forced treatment" of the patient⁽³²⁾. From this point of view, the intention of Resolution 2,232/19, in particular, seems to be less to safeguard the possibility of refusing to "perform a medical act which, although permitted, attacks the moral beliefs of the professional, in their personal and intimate sphere"⁽³¹⁾. Rather, it deals with a situation of professional disagreement with the refusal made by the patient, and therefore does not characterize the exact concept of conscientious objection. In fact, conscientious objection is not to be confused with a mere difference of opinion on the part of the professional.

On the other hand, to suppose that there would be conscientious objection on the part of a doctor who “refuses the refusal” of a patient (which, in the case of Jehovah's Witnesses, is motivated by moral opposition), because he considers it to be euthanasia or assisted suicide, contrary to the doctor's existential values, would be to fall back on the same interpretation rejected in the revoked CFM Resolution No. 1,021/80, when considering that the intention of the refuser is to cause his own death, and not to refute treatment that is personally and morally unacceptable to him.

Therefore, the only possible point in common with the original circumstance of refusing a blood transfusion would be the Jehovah's Witness doctor's objection to carrying out the transfusion on a patient with an indication for the measure and who wants it, with this objection being blocked when there is no other professional who can do it - a very different situation, therefore, from the therapeutic refusal by the patient.

Another situation of professional conscientious objection traditionally mentioned is that of a doctor who refuses to perform a legal abortion, for reasons of personal belief, in the cases allowed by the legal system, a circumstance that is also distinct from the pregnant woman's choice as to the form of delivery, which was one of the aspects legally questioned in the Resolution. Here, too, it is understood that the professional's objection cannot prevail if there is no other option in the locality to provide the patient with the treatment they deserve and want, so as not to leave the patient helpless or force them to stop doing what the law allows.

The way the current Resolution is worded, on the contrary, the doctor's objection seems to take precedence over the patient's refusal, contradicting the terms of the current Code of Medical Ethics itself and making a hierarchical distinction that the law does not make. In fact, prioritizing the doctor's personal objection over the patient's refusal or considering the professional's manifestation as a summary impediment to the refusal - and not only capable of exempting the practitioner from the conduct considered offensive to his own dictates - means assessing equally personal values in a different way, to the detriment of the main party involved in the consequences of the treatment. The doctor's spiritual peace is ensured, at the expense of fully subjecting the patient's possibility of refusing therapy to the professional's consent, regardless of differing beliefs.

The roots of the conscientious objection provision can be traced back to the 1948 Universal Declaration of Human Rights, article 18 of which states that “[e]veryone has the right to freedom of thought, conscience and religion”⁽³³⁾. In this respect, the revision of the International Code of Medical Ethics by the World Medical Assembly, approved in October 2022, should also be highlighted, which dealt with the issue *sub oculi* in its article 29, namely:

29. This Code focuses on the ethical duties of the doctor. However, in some respects, there are profound moral dilemmas that doctors and patients may seriously consider to be in conflict with their conscientious beliefs. The doctor has an ethical obligation to minimize the inconvenience of patient care. The doctor's conscientious objection to the provision of any lawful medical interventions can only be invoked if the individual patient is not harmed or discriminated against, and if the patient's health is not endangered. The doctor must immediately and respectfully inform the patient of this objection and of their right to consult another qualified doctor, as well as providing sufficient information to enable the patient to initiate such a consultation in good time ⁽³⁴⁾.

The contents of articles 9 and 10 of Resolution No. 2,232/2019, therefore, regardless of the mention of refusal in the latter - a reference made twice in the same provision and which only generates unnecessary and impertinent confusion, as we have seen - are in line with international regulations, in the sense that the objection cannot leave the patient helpless or at risk and without another professional to accompany them. The sole paragraph of art. 9, on the other hand, referring to patients seen in a doctor's office, by only providing information to the Council, does not make clear the recommendation not to abandon the patient if there is no other professional to see him or her in the locality, and also deserves better normative development.

It should be pointed out, then, that conscientious objection, in its real sense, is a doctor's right, independent of and not necessarily related to the situation of therapeutic refusal - which falls within the patient's sphere of rights - and not only in the face of it (or as an impediment to it), as articles 7 and 8 of the aforementioned Resolution seem to suggest. Nor does it necessarily prevail over the patient's right, as could be inferred from these provisions, not least because, as has been said, both behaviors tend to manifest themselves as omissive claims (refusing therapy" and "not performing an act"), making it unlikely that there will be a real clash in this case. Finally, it cannot occur if it leaves the patient unattended.

If the sacred and overriding nature of life is argued, the argument would no longer properly be about the professional's conscientious objection, returning to the discussion about the legal limits to refusal. Naturally, autonomy has limits, deriving from the social pact itself, ultimately expressed in the law, but neither does it proceed to empty the very possibility of refusal or participation in the therapeutic decision, by annulling the patient's autonomy, submitting it entirely to that of the professional, as a matter of individual values.

Thus, in the name of a better normative technique, the issue of conscientious objection deserves its own resolution, for greater clarity, protection and safety for the professional and the patient in this field, not confusing the conscientious objection of the doctor, as a moral person, with the technical disagreement of the professional to the patient's refusal of the therapy indicated by him.

Orthothanasia, therapeutic refusal and the right to the natural course of illness: the conflict between resolutions and autonomy at the end of life

When dealing with therapeutic refusal, CFM Resolution No. 2.232/19 refers to a subject that is very dear to the end-of-life discipline in current times, when most deaths occur in a hospital environment and are all the more surrounded by therapeutic or pseudo-therapeutic resources the better equipped the health unit. Progress has extended not only life expectancy, but also the process of dying, lengthened in time by resources that, without reversing the inexorable evolution of the pathological condition, slow down the process and often increase suffering.

The potential gain in time that may be obtained at the expense of artificial procedures and support should not, of course, consist of a legal obligation to submit to such resources, especially when, as mentioned above, these possibilities are not even available to everyone who wants them

or who could effectively and voluntarily benefit from them. Therefore, essential concepts have emerged for the discussion of autonomy at the end of life, such as therapeutic refusal, the omission/suspension of artificial support, therapeutic proportionality and futility, as parameters for such refusal.

The history of orthothanasia in Brazil, as death in its own time, neither anticipated nor unduly procrastinated⁽²²⁾, goes back to the evolution of the Resolutions of the Federal Council of Medicine, the first-line architect of the evolution and social discussions on the subject, at a time when there was still intense cultural resistance to the themes of death and dying. Although within their legal place as diceological norms, of professional clarification, their condition as adjuvant hermeneutical sources, within the scope of what is legally permitted, has been of relevant social utility.

Among these sparse rules, some deserve particular mention in this process, alongside the recent Codes of Medical Ethics, which have, in a way, compiled these understandings. First of all, CFM Resolution No. 1.805/2006⁽⁴⁾ which, although strangely it is not included in the “recitals” of CFM Resolution No. 2.232/19, is a substantial milestone in the discussion of orthothanasia and the discipline of autonomy at the end of life in the country, and has even had its constitutionality recognized by the courts since 2010, in Public Civil Action No. 2007.34.00.014809-3/DF⁽³⁵⁾. This Resolution recognizes the possibility of therapeutic refusal at the end of life, through the omission or withdrawal of support or therapy that proves futile, i.e. with no prospect of reversing the terminal pathological condition. It confirms the right to evolve towards death in a natural way, through the proper course of the illness, whose progression is unstoppable, following the manifestation of the patient or, alternatively, their legal representative, duly informed.

Along the same lines, CFM Resolution No. 1.995/2012⁽⁵⁾ expressly referred to in the rule under examination, which regulates the possibility of refusing medical measures and interventions in advance. It applies to patients who wish to anticipate their autonomic manifestation, in case they are unconscious in the future and their illness is inexorable. This characterizes the so-called Advance Directives of Will (ADW), a genre which includes the living will (indication of the conduct to which you wish to be subjected or not, within legal limits, if you are unable to choose contemporaneously) and the lasting mandate (appointment of a person you trust to decide for you in such a circumstance), models of substitute decision making⁽³⁶⁾.

A possible criticism of this document would be the reference to care, as if it could also be suspended, without indicating its content, which is mostly associated with dignity and, therefore, distinct from treatments that can be renounced⁽²⁰⁾. The Resolution in question was also the subject of a Public Civil Action (ACP No. 0001039-86.2013.4.01.3500/GO)⁽³⁷⁾, with a ruling recognizing the validity of the possibility of prior expression of will, but with no final decision yet in 2025.

CFM Resolution No. 2.156/2016⁽³⁸⁾ establishes the criteria for admission to and discharge from an intensive care unit, emphasizing that “in cases of incurable and terminal illness, the doctor must offer all available palliative care, without undertaking useless or obstinate diagnostic or therapeutic actions, always taking into account the patient's express wishes or, if this is not possible, those of their legal representative”⁽³⁸⁾. He points out that admission to the ICU should take into account the “potential benefit to the patient from therapeutic interventions and prognosis” and that terminally ill patients, with no possibility of recovery, are generally “not appropriate for admission to the ICU (...). However, their admission may be justified on an exceptional basis, taking into account the peculiarities of the case and subject to the discretion of the intensivist doctor”⁽³⁸⁾. These patients should preferably be referred to palliative care units. For patients already in intensive care units, discharge is recommended for those for whom “the curative/restorative therapeutic arsenal has been exhausted and who can remain in the hospital environment outside the ICU in a dignified manner and, if possible, together

with their family”⁽³⁸⁾, favoring interaction and comfort in the final moments, without excessive and disproportionate interventions.

The current Code of Medical Ethics (CFM Resolution No. 2.217/18, in force from 2019, the same year as the standard under review)⁽³¹⁾ like its two predecessors, also safeguards the possibility of refusing treatments that are ineffective in reversing the underlying condition and which only prolong the process of terminality, recognizing the possibility of refusing and not recommending them.

The Resolution under review should therefore come as no surprise, given the consistency of the body's position over the previous fifteen years regarding therapeutic refusal at the end of life. However, in a way it did, giving rise to strangeness in the systematic interpretation, possibly denoting a flaw in the normative technique (contrary to the principle of the rational legislator), rather than probably a change in the basic position in relation to orthothanasia and contrary to dysthanasia. In fact, data maxima venia, Resolution 2.232/19 oscillates until its final articles (see articles 11 to 13)⁽¹⁾ converting what should be a simple and straightforward understanding into a challenging hermeneutical exercise, especially for non-lawyers, such as the public it is primarily aimed at.

In addition to the undue association between therapeutic refusal and conscientious objection, which has already been mentioned, issues involving the risk of death do not make it clear that irreversible patients can refuse. The condition of terminality is not mentioned at any time, giving the impression that it is impossible to refuse even futile or potentially inappropriate treatment - according to the distinction made in items I and II of the Annex to CREMESP Resolution No. 355, of October 2022⁽³⁹⁾ - in the case of an irreversible course towards natural death. It thus suggests an unusual obligation of therapeutic obstinacy, in order to avoid and postpone the lethal outcome at any cost, as seems to be clear from reading art. 11 of CFM Resolution No. 2.232/19, regardless of the basic condition of the patient, doing a disservice to all the value construction that has been made by the entity itself in recent decades.

Similarly, art. 3 of Resolution 2.232/19 completely empties the lasting mandate, provided for in CFM Resolution No. 1.995/12⁽⁵⁾ regarding patients who have lost the use of their mental faculties, and CFM Resolution No. 1.805/06⁽⁴⁾ regarding the will of the representative in any case.

In the hermeneutic contortionist effort to adjust the present Resolution to the previous provisions - since only CFM Resolution no. 1.021/80⁽⁸⁾ was indicated as having been revoked by it. which considered blood transfusion to be obligatory in the event of a risk of death - it can be considered that the *caput* of its article 12 admits refusal, “in writing and in front of two witnesses when the lack of the treatment refused exposes the patient to danger of death”⁽¹⁾. The question is whether this refusal will even be considered, given the other articles mentioned, and in what cases it is possible, despite the aforementioned danger - which, depending on the circumstance, is not even unexpected, but part of the natural and inevitable course of the condition and of human mortality itself.

A positive aspect of this article is the possibility of registration by any means that allows the issuer's will to be identified. This provision, contained in the sole paragraph of art. 12, is in line with the idea put forward in the aforementioned CFM Resolution No. 1.995/12⁽⁵⁾ in the sense of placing greater emphasis on the reliability of the content than on the form of end-of-life expressions of will. This provision may make it easier for them to be adopted in our culture, which is so unaccustomed to bureaucratic formalities, to thinking about death and to the scant diffusion of testaments of any kind. It is also in line with Statement No. 37 of the National Judicial Forum for Health - FONAJUS, which ratifies the issue⁽⁴⁰⁾.

Another last attempt at interpretative integration seems to be, taking the content of art. 2, caput, of CFM Resolution No. 2.232/19 under examination, to consider as “elective” any futile treatment (which strictly speaking is not even technically indicated) or potentially inappropriate - and therefore ethically waivable - for the terminally ill patient. It should be noted, however, that the article itself hinders this attempt, when it refers to the legal provision to define what elective treatment is. The Resolution, which invaded legal competence by establishing prohibitions, now assigns to the non-medical legislator precisely the analysis that undoubtedly requires technical assessment of indication, need and therapeutic response in the specific case. Also in the sole paragraph of Article 2, the opportunity was missed to expressly mention palliative care as a possibility to be indicated, in order to show that end-of-life care may be more appropriate along these lines than through strenuous attempts to artificially prolong the existence that is naturally coming to an end.

The decisions of the Federal Supreme Court, the need for therapeutic options and the work of the Ombudsman's Office in the field of public health

As we have seen, the judgments handed down by the country's Supreme Court, in Extraordinary Appeals No. 979.742 and No. 1.212.272, decided on September 25, 2024, ruled, in brief lines, on the possibility of adult and duly informed patients refusing transfusion therapy of blood or blood derivatives, due to religious reasons, even if there is a risk of death, and the Federal Government must pay for alternative procedures to replace heterologous blood.

In Extraordinary Appeal No. 979.742/AM⁽⁴¹⁾ which gave rise to General Repercussion Topic No. 952, concerning the "Conflict between religious freedom and the state's duty to ensure universal and equal health benefits", it was decided by the Full Bench that:

The Court, unanimously, considering theme 952 of the general repercussion, dismissed the extraordinary appeal and established the following thesis: "1. Jehovah's Witnesses, when of age and capable, have the right to refuse a medical procedure involving blood transfusion, based on individual autonomy and religious freedom. 2. As a consequence, in respect for the right to life and health, they are entitled to the alternative procedures available in the Unified Health System - SUS, and may, if necessary, resort to treatment outside their home." All in the terms of the vote of the Rapporteur, Minister Luís Roberto Barroso (President). Minister Dias Toffoli is absent on medical leave. Plenary, 25.9.2024⁽⁴¹⁾.

The case became final in October 2025. Extraordinary Appeal No. 1.212.272/AL⁽⁴²⁾ led to General Repercussion Topic No. 1069, which resulted in the following theses and the following decision, which became final on September 20, 2025:

Decision: The Court, unanimously, considering theme 1.069 of the general repercussion, dismissed the extraordinary appeal and established the following theses: "1. A patient, in full enjoyment of his civil capacity, is allowed to refuse to undergo health treatment for religious reasons. Refusal of health treatment for religious reasons is conditional on the patient's unequivocal, free, informed and informed decision, including when conveyed through advance directives of will. 2. It is possible to carry out a medical procedure, made available to all by the public health system, with the prohibition of blood transfusion or other exceptional measure, if there is technical-scientific feasibility of success, agreement of the medical team with its realization and unequivocal, free, informed and informed decision of the patient". All in the terms of

the Rapporteur's vote [Min. Gilmar Mendes]. Minister Dias Toffoli is absent on medical leave. Justice Luís Roberto Barroso presiding. Plenary, 25.9.2024⁽⁴²⁾.

The judicial positions espoused at the time therefore endorsed the autonomy of the patient who is of legal age and capable of refusing therapy, especially religiously motivated blood transfusions, even if this results in a risk of death from the underlying disease, which also resulted in the recognition of the need to provide alternative health care.

In light of the above decision, the Federal Public Defender's Office, through its National Human Rights Ombudsman and its Health Working Group, asked the Ministry of Health and the Secretariats of State of the 27 states of the Federation to question the measures that have been adopted to provide alternative routes to transfusion therapy, in order to enable the simultaneous defense of the right to life, health and religious freedom of the portion of this population dependent on the SUS. At the time, it was found that most of the Health Secretariats did not respond sufficiently to the questioning, within the timeframe set in the letter, suggesting that they were not yet sufficiently equipped to provide substitute treatment efficiently, perhaps due to the short time that had passed between the STF's decision and the consultation.

In any case, it is to be hoped that, once the jurisprudential position has been established and, consequently, the meaning of constitutional hermeneutics on the subject, both the infra-constitutional normative aspects and the administrative measures will be adjusted to the axiological content approved. The aim is to ensure that adequate and reasonable treatment is given to this section of the population, while guaranteeing them the fundamental rights of access to health and freedom, in equitable terms arising from the Federal Constitution and human rights.

Final considerations

CFM Resolution No. 2.232/2019 was produced, it seems, in response to judicial questioning of its predecessor - and revoked by it - CFM Resolution No. 1.021/80. The current rule, however, has some relevant flaws in its legislative technique, which, with all due respect, make it difficult for its primary recipients and other beneficiaries to interpret it, its hermeneutical location in the legal system and even in the normative set of the professional entity itself.

A rule with a plural and paradoxical content has emerged in some respects, when part of the function of Resolutions is precisely to clarify regulated legal provisions and facilitate their understanding, serving as a bridge between the jurist and the professional, as well as being in line with the current legal framework.

The supervening of the jurisprudential understanding on the subject of transfusion refusal, which has also been the subject of judicial controversy for a long time, given the lack of specific normative clarity, has further highlighted the fragility of the deontological norm, as a professional and social guideline.

From the above, therefore, the first suggestion to be made, for the reasons set out above, would be to split CFM Resolution No. 2.232/2019 in two, focusing on the issue of patient refusal and its limits, and separating from it what refers to the doctor's conscientious objection - to be the subject of its own regulation, since it is a distinct aspect and addressed to another subject and holder of a right. In fact, the right to conscientious objection by the professional is not necessarily associated with the

patient's refusal. On the contrary, it is unlikely that there will be a conflict between two conducts that tend to be ommissive, giving rise to relevant doubts in the way the question is posed.

A second suggestion is to harmonize the rule in question with existing provisions, including those from the Council itself, in relation to the possibility of refusal at the end of life, giving more clarity to its provisions, especially in cases of terminality, so as not to reinsert doubts that had already been resolved by previous documents, which had already been submitted and approved, including by the courts. It should be noted that this measure is in line with the trend embraced by the Federal Supreme Court, in recent decisions on the possibility of transfusion refusal by patients who are of legal age and capable, in defense of religious freedom.

This would allow doctors and patients to be better guided in the interpretation of what is already in the legal system, including in other resolutions of the entity, since these are not rules that grant rights of their own or that prohibit what the laws themselves do not prohibit, or that innovate where they are not constitutionally allowed to do so.

They are analyses and suggestions made with a constructive intent, recognizing, in the ethical-normative sphere, the relevant role that the Council has played in the evolution of bioethical discussions in the country in recent decades, as well as in homage to the constitutional protection of freedom, now endorsed.

Just as the Council has wisely revised itself on other occasions (CFM Resolutions No. 1.805/06 and No. 1.826/07, originally considered as a single standard, and, more recently, CFM Resolution No. 2.227/18, which dealt with telemedicine and was revoked after initial self-criticism, only for the discipline to be resumed, opportunely and more consensually, in CFM Resolution No. 2.314/22), it would be appropriate to review it here, in order to clarify and improve health links, favoring shared decision-making, safety, constitutional values and strengthening the relationship between professionals and patients.

Finally, the recognition of the possibility of therapeutic refusal in transfusion matters, ratified by the courts, requires practical aspects to guarantee the right to health, in the name of the principle of integrality, which is in force in public health. To this end, alternative resources to heterologous transfusion therapy must be available, in order to ensure the simultaneous rights to religious freedom and health of this group, within an expected spectrum of reasonableness, a measure that is especially necessary for the most socioeconomically vulnerable portion of the population that depends on the SUS, as well as defense assistance.

References

1. Conselho Federal de Medicina. Resolução nº 2.232, de 2019. Estabelece normas éticas para a recusa terapêutica por pacientes e objeção de consciência na relação médico-paciente [Internet]. Brasília: CFM; 2019 [cited Sep 22, 2025]. Available from: <https://sistemas.cfm.org.br/normas/visualizar/resolucoes/BR/2019/2232>
2. Brasil. Supremo Tribunal Federal. Testemunhas de Jeová têm direito de recusar procedimento que envolva transfusão de sangue, decide STF [Internet]. Brasília: STF; 2024 [cited Jun 5, 2023]. Available from: <https://noticias.stf.jus.br/postsnoticias/testemunhas-de-jeova-tem-direito-de-recusar-procedimento-que-envolva-transfusao-de-sangue-decide-stf>
3. Rampazzo L. Metodologia científica. 2 ed. São Paulo: Loyola; 2004.
4. Conselho Federal de Medicina. Resolução nº 1.805, de 2006. Dispõe sobre a limitação ou suspensão de procedimentos e tratamentos que prolonguem a vida de pacientes em fase terminal [Internet]. Brasília: CFM; 2006 [cited Sep 22, 2025]. Available from: <https://sistemas.cfm.org.br/normas/visualizar/resolucoes/BR/2006/1805>
5. Conselho Federal de Medicina. Resolução nº 1.995, de 2012. Dispõe sobre as diretivas antecipadas de vontade dos pacientes [Internet]. Brasília: CFM; 2012

[cited Sep 22, 2025]. Available from:

<https://www.legisweb.com.br/legislacao/?id=244750>

6. Villas-Bôas ME. Nota de chegada: mudanças na disciplina do final de vida no país [Internet]. Salvador; 2019 [cited Sep 22, 2025]. Available from:

<https://cvmed.com.br/2019/08/28/nota-de-chegada-mudancas-na-disciplina-do-final-de-vida-no-pais/>

7. Villas-Bôas ME. Breves sugestões para a Resolução 2.232/2019 [Internet]. Salvador; 2021 [cited Nov 12, 2023]. Available from:

<http://cvmed.com.br/2021/02/27/breves-sugestoes-para-a-resolucao-2-232-2019/>

8. Conselho Federal de Medicina. Resolução nº 1.021, de 1980 [Internet]. Brasília: CFM; 1980 [cited Sep 22, 2025]. Available from:

https://sistemas.cfm.org.br/normas/arquivos/resolucoes/BR/1980/1021_1980.pdf

9. Brasil. Supremo Tribunal Federal. Arguição de Descumprimento de Preceito Fundamental nº 618 [Internet]. Brasília: STF [cited Mar 12, 2025]. Available from:

<https://portal.stf.jus.br/processos/detalhe.asp?incidente=5769402>

10. Brasil. Supremo Tribunal Federal. Recurso Extraordinário nº 1.212.272 (Tema 1.069): recusa a transfusão de sangue por Testemunhas de Jeová [Internet]. Brasília: STF [cited Sep 22, 2025]. Available from:

https://www.stf.jus.br/arquivo/cms/noticiaNoticiaStf/ano/RE1.212.272.Testemunhadejeova769_vAO_r.pdf

11. Villas-Bôas ME. Administração pública, controle sanitário e vacinação: desafios constitucionais na pandemia de COVID-19. *Rev Defensoria Pública da União*. 2023 [cited Sep 22, 2025];20(20):217-232. Available from:

<https://doi.org/10.46901/revistadadpu.i20.p217-232>

12. Alexy R. *Teoria de los derechos fundamentales*. 3ª ed. Madrid: Centro de Estudios Políticos y Constitucionales; 2017.

13. Brasil. Lei nº 8.213, de 24 de julho de 1991. Dispõe sobre os Planos de Benefícios da Previdência Social e dá outras providências [Internet]. Brasília: Presidência da República; 1991 [cited Sep 11, 2025]. Available from:

https://www.planalto.gov.br/ccivil_03/leis/l8213cons.htm

14. Rodrigues JV. *O consentimento informado para o acto médico no ordenamento jurídico português*. Coimbra: Coimbra Editora; 2001.

15. Minahim MA. Aspectos éticos e jurídico-penais da relação médico-paciente. São Paulo: Thomson Reuters RT; 2022.

16. Ferraz Junior TS. *Introdução ao estudo do direito: técnica, decisão, dominação*. 13ª ed. São Paulo: Atlas; 2025.

17. Ferraz Junior TS. *Teoria da norma jurídica: ensaio de pragmática da comunicação normativa*. 5ª ed. Rio de Janeiro: Forense; 2016.

18. Minahim MA, Santos GC. Interromper ou prolongar o tratamento de pacientes graves ou terminais? Uma análise sobre a omissão imprópria na conduta médica. *Revista do Programa de Pós-Graduação em Direito da UFBA*. 2022 [cited Sep 23, 2025];32:1-20. Available from: <https://doi.org/10.9771/rppgd.v32i0.49239>

19. Beauchamp TL, Childress JF. *Princípios de ética biomédica*. 3ª ed. São Paulo: Loyola; 2013.

20. Minahim MA. *Autonomia e frustração da tutela penal*. São Paulo: Saraiva; 2015.

21. Pierangeli JH. *O consentimento do ofendido na teoria do delito*. 3ª ed. São Paulo: Revista dos Tribunais; 2001.

22. Villas-Bôas ME. *Da eutanásia ao prolongamento artificial: aspectos polêmicos na disciplina jurídico-penal do final de vida*. Rio de Janeiro: Forense; 2004.

23. Sociedade Brasileira de Pediatria. *Consentimento informado em pesquisas envolvendo crianças e adolescentes*. Departamento Científico de Bioética; 2021. 11 p.

24. Venosa S. *Direito civil: responsabilidade civil*. v. 4. São Paulo: Atlas; 2016.

25. Brasil. Supremo Tribunal Federal. Arguição de Descumprimento de Preceito Fundamental nº 642 [Internet]. Brasília: STF [cited Sep, 23, 2025]. Available from: <https://portal.stf.jus.br/processos/detalhe.asp?incidente=5839268>

26. Brasil. Tribunal Regional Federal da 3ª Região. Ação civil pública nº 5021263-50.2019.4.03.6100/SP [Internet]. São Paulo: TRF3 [cited Mar 17, 2025]. Available from:

https://www.migalhas.com.br/arquivos/2019/12/3A097A4116BD54_liminar20-12-19-cfm.pdf

27. Migalhas. Moraes suspende análise de direito à recusa a tratamentos médicos no STF [Internet]. 2026 [cited Fev 13, 2025]. Available from:

<https://www.migalhas.com.br/quentes/447404/stf-moraes-suspende-analise-de-direito-a-recusa-a-tratamentos-medicos>

28. Brasil. Superior Tribunal de Justiça. Habeas corpus nº 268.459/SP [Internet]. Brasília: STJ [cited Jan 17, 2023]. Available from:

<https://www.stj.jus.br/websecstj/cgi/revista/REJ.cgi/ATC?seq=33010937&tipo=91&nreg=201301061165>

29. Brasil. Tribunal Regional Federal da 1ª Região. Testemunha de Jeová não pode receber transfusão de sangue forçada [Internet]. Brasília: TRF1 [cited Mar 17, 2023]. Available from: <https://portal.trf1.jus.br/portaltrf1/comunicacao-social/imprensa/noticias/decisao-testemunha-de-jeovao-pode-receber-transfusao-de-sangue-forcada.htm>
30. Gentile R. Justiça obriga testemunha de Jeová a receber transfusão de sangue [Internet]. UOL Notícias; 2021 [cited Jan 17, 2023]. Available from: <https://noticias.uol.com.br/colunas/rogerio-gentile/2021/10/19/justica-obriga-testemunha-de-jeovaa-receber-transfusao-de-sangue.htm>
31. Conselho Federal de Medicina. Código de ética médica: Resolução CFM nº 2.217, de 27 de setembro de 2018 [Internet]. Brasília: CFM; 2019 [cited Sep 22, 2025]. Available from: <https://portal.cfm.org.br/images/PDF/cem2019.pdf>
32. Albuquerque A. Objeção de consciência do médico e a Resolução CFM nº 2.232/19 [Internet]. 2019 [cited Jan 19, 2023]. Available from: <http://cvmed.com.br/2019/09/17/objecao-de-consciencia-do-medico-e-a-res-cfm-no-2-232-19/>
33. Organização das Nações Unidas. Declaração universal dos direitos humanos [Internet]. 1948 [cited Sep 23, 2025]. Available from: <https://www.unicef.org/brazil/declaracao-universal-dos-direitos-humanos>
34. Associação Médica Mundial. Código internacional de ética médica [Internet]. 2022 [cited Sep, 23, 2025]. Available from: <https://www.wma.net/wp-content/uploads/2022/12/Co%CC%81digo-E%CC%81tica-Me%CC%81dica-REVISADO.pdf>
35. Brasil. Tribunal Regional Federal da 1ª Região. Ação civil pública nº 2007.34.00.014809-3/DF [Internet]. Brasília: TRF1 [cited Sep, 22, 2025]. Available from: <https://www.conjur.com.br/dl/se/sentenca-resolucao-cfm-180596.pdf>
36. Aguiar M. Modelos de autonomia e sua (in)compatibilidade com o sistema de capacidade civil no ordenamento positivo brasileiro: reflexões sobre a Resolução 1995/2012 do Conselho Federal de Medicina [Internet]. Florianópolis: CONPEDI; [cited Nov 20, 2025]. Available from: <http://www.publicadireito.com.br/artigos/?cod=69c7e73fea7ad35e>
37. Brasil. Tribunal Regional Federal da 1ª Região. Ação civil pública nº 0001039-86.2013.4.01.3500/GO [Internet]. Brasília: TRF1 [cited Sep 24, 2025]. Available from: https://processual.trf1.jus.br/consultaProcessual/processo.php?trf1_captcha=st83&enviar=Pesquisar&proc=10398620134013500&secao=GO
38. Conselho Federal de Medicina. Resolução nº 2.156, de 2016: critérios de admissão e alta em unidade de terapia intensiva [Internet]. Brasília: CFM; 2016 [cited Jan 18, 2025]. Available from: <https://www.legisweb.com.br/legislacao/?id=331807>
39. Conselho Regional de Medicina do Estado de São Paulo. Resolução nº 355, de 2022 [Internet]. São Paulo: CREMESP; 2022 [cited Fev 26, 2026]. Available from: <https://www.cremesp.org.br/?siteAcao=PesquisaLegislacao&ficha=1&id=20041>. Disponível em <https://www.cremesp.org.br/?siteAcao=PesquisaLegislacao&dif=s&ficha=1&id=20041&tipo=RESOLU%C7%3O&orgao=%20Conselho%20Regional%20de%20Medicina%20do%20Estado%20de%20S%C3%A3o%20Paulo&numero=355&situacao=VIGENTE&data=23-08-2022>
40. Brasil. Conselho Nacional de Justiça. Enunciado nº 37 do Fórum Nacional do Judiciário para a Saúde – FONAJUS [Internet]. Brasília: CNJ [cited Sep 22, 2025]. Available from: <https://portal.tjce.jus.br/uploads/2023/12/FONAJUS-Enunciados-atualizados-ate-2023.pdf>
41. Brasil. Supremo Tribunal Federal. Recurso extraordinário nº 979742/AM (Tema 952 da repercussão geral) [Internet]. Brasília: STF [cited Fev 24, 2025]. Available from: <https://portal.stf.jus.br/jurisprudenciaRepercussao/verAmdamentoProcesso.asp?incidente=5006128&numeroProcesso=979742&classeProcesso=RE&numeroTema=952>
42. Brasil. Supremo Tribunal Federal. Recurso extraordinário nº 1.212.272/AL (Tema 1069 da repercussão geral) [Internet]. Brasília: STF [cited Sep 24, 2025]. Available from: <https://portal.stf.jus.br/jurisprudenciaRepercussao/verAmdamentoProcesso.asp?incidente=5703626&numeroProcesso=1212272&classeProcesso=RE&numeroTema=1069>

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