Cadernos Ibero-Americanos de Direito Sanitário
Cuadernos Iberoamericanos de Derecho Sanitario
ISSN: 2358-1824

Article

Labor analgesia and the right of pregnant patients: an analysis of the guarantee against being subjected to torture or to inhuman or degrading treatment

Analgesia de parto e o direito da paciente gestante: uma análise da garantia de não ser submetida à tortura, a tratamento desumano ou degradante

Analgesia de parto y el derecho de la paciente gestante: un análisis de la garantía de no ser sometida a tortura, tratamiento inhumano o degradante

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Submitted on: 04/07/25
Revision on: 07/16/25
Approved on: 08/12/25

Abstract

Objective: to analyze the treatment of pain in pregnant women in labor from the perspective of the human right not to be subjected to torture or to cruel, inhuman or degrading treatment or punishment. **Methodology:** this is a theoretical documentary research. The following authors are adopted as theoretical frameworks: Aline Albuquerque, Juan Méndez, Manfred Nowak, Joachim Boldt, and Jonathan Herring. The theoretical-normative reference of Patients' Human Rights is also used, as a prescriptive component of Healthcare Bioethics, in addition to drawing on bibliographic references on Human Rights, international Human Rights treaties ratified by Brazil, the jurisprudence of the Inter-American Court of Human Rights, and General Comments and Reports prepared by the United Nations Organization. **Results:** the treatment of labor pain is neglected in Brazil, with discrepancies between the public and private systems. The parturient is in a situation of increased vulnerability, and the denial or omission of labor pain treatment can be characterized as a violation of her right not to be subjected to torture or to cruel, inhuman or degrading treatment or punishment. **Conclusion:** labor analgesia is a right of the pregnant patient, correlated to her human right not to be subjected to torture or to cruel,

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inhuman or degrading treatment or punishment. There is a State obligation, increased by the patient's particular vulnerability, to provide access to labor analgesia.
Keywords: Human Rights; Bioethics; Labor Pain; Pregnant People; Analgesia.

Resumo

Objetivo: analisar o tratamento da dor da gestante em trabalho de parto sob a perspectiva do direito humano de não ser submetida a tortura, a penas ou a tratamentos cruéis, desumanos ou degradantes. **Metodologia:** trata-se de pesquisa teórica documental. Adotam-se como marcos teóricos os seguintes autores: Aline Albuquerque, Juán Mendéz, Manfred Nowak, Joachim Boldt e Jonathan Herring. Utiliza-se também o referencial teórico-normativo dos Direitos Humanos dos Pacientes, enquanto componente prescritivo da Bioética do Cuidado em Saúde, além de embasar-se em referências bibliográficas sobre os Direitos Humanos, nos tratados internacionais de Direitos Humanos ratificados pelo Brasil, na jurisprudência da Corte Interamericana de Direitos Humanos, e nos Comentários Gerais e Relatórios elaborados pela Organização das Nações Unidas. **Resultados:** o tratamento da dor do trabalho de parto é negligenciado no Brasil, havendo discrepâncias entre os sistemas público e privado. A parturiente encontra-se em situação de vulnerabilidade acrescida e negação ou omissão do tratamento da dor do trabalho de parto pode ser caracterizada como violação do seu direito de não ser submetida a tortura, a penas ou a tratamentos cruéis, desumanos ou degradantes. **Conclusão:** a analgesia de parto é um direito da paciente gestante, correlato do seu direito humano de não ser submetida a tortura, a penas ou a tratamentos cruéis, desumanos ou degradantes. Há obrigação estatal, majorada pela situação de vulnerabilidade acrescida da paciente, de promover medidas para disponibilizar acesso à analgesia de parto.
Palavras-chave: Direitos Humanos; Bioética; Dor do Parto; Gestante; Analgesia.

Resumen

Objetivo: analizar el tratamiento del dolor de la gestante en trabajo de parto desde la perspectiva del derecho humano de no ser sometida a tortura, penas o tratamientos crueles, inhumanos o degradantes. **Metodología:** se trata de una investigación teórica documental. Se adoptan como marcos teóricos los siguientes autores: Aline Albuquerque, Juan Méndez, Manfred Nowak, Joachim Boldt y Jonathan Herring. Se utiliza también el referencial teórico-normativo de los Derechos Humanos de los Pacientes, como componente prescriptivo de la Bioética del Cuidado en Salud, además de basarse en referencias bibliográficas sobre los Derechos Humanos, en los tratados internacionales de Derechos Humanos ratificados por Brasil, en la jurisprudencia de la Corte Interamericana de Derechos Humanos, y en los Comentarios Generales y Relatorios elaborados por la Organización de las Naciones Unidas. **Resultados:** el tratamiento del dolor del trabajo de parto es negligenciado en Brasil, habiendo discrepancias entre los sistemas público y privado. La parturienta se encuentra en situación de vulnerabilidad aumentada y la negación u omisión del tratamiento del dolor del trabajo de parto puede ser caracterizada como violación de su derecho de no ser sometida a tortura, penas o tratamientos crueles, inhumanos o degradantes. **Conclusión:** la analgesia de parto es un derecho de la paciente gestante, correlato de su derecho humano de no ser sometida a tortura, penas o tratamientos crueles, inhumanos o degradantes. Hay obligación estatal, mayorada por la situación de vulnerabilidad aumentada de la paciente, de promover medidas para disponibilizar acceso a la analgesia de parto.
Palabras clave: Derechos Humanos; Bioética; Dolor de Parto; Personas Embarazadas; Analgesia.

Introduction

The experience of labor is a particular phenomenon for each woman and can be a time of intense pain and significant suffering[1,2,3]. In Brazil, the management of labor pain remains unsatisfactory, as can be seen from the reports of puerperal women in national surveys who describe the pain of labor as "terrible"[4], "unbearable" and "the worst thing in life".

In this context, inadequate pain management reflects the underuse of analgesic resources available to parturients, which can be classified as non-pharmacological and pharmacological. The former consist of water immersion, massage, hypnosis, aromatherapy, music therapy, heat therapy, Swiss ball, acupuncture and acupressure, as well as encouraging movement and adopting the pregnant woman's preferred position[5,6,7]. Although these methods have the potential to relieve pain, they may be insufficient to provide a level of analgesia considered satisfactory by the parturient woman, and in this situation it is necessary to resort to pharmacological methods[7].

Pharmacological methods for managing labor pain can be subdivided into two categories: systemic and regional analgesia. Systemic analgesia, in its most common form, consists of the intravenous infusion of opioids. Regional analgesia, on the other hand, consists of injecting drugs into the neuraxial space, i.e. into the spinal canal, using spinal or epidural techniques[8,9,10].

There is a low prevalence of the use of pharmacological analgesia for labor pain management in the country, as corroborated by two of the largest national studies on the subject - the "Nascer no Brasil"[11] survey and the "Avaliação da Rede Cegonha"[12] survey. According to an analysis of these two studies by Leal *et al.*[13] in 2011/2012, only 7.4% of women undergoing vaginal delivery received pharmacological analgesia, while in 2016/2017 the proportion rose to 20%. Despite the positive growth in this period, the prevalence seems to have stabilized[14]. For comparison with the Brazilian reality, the population study by Butwick *et al.*[15] reports that, in 2015, 73.1% of normal deliveries in the United States were performed with neuraxial analgesia. It should also be noted that there is a great disparity between the public and private systems in Brazil[16,17].

One of the biggest fears women have about normal childbirth is suffering the pain of labor[16,18] and this is one of the factors that may explain the high incidence of surgical deliveries in the country[18,19]. Lack of knowledge of pain management methods or their unavailability increases the number of patients who request a caesarean section during labor to relieve pain, even if they did not previously want the pregnancy to be resolved surgically[20]. Similarly, other pregnant women decide in advance to have a caesarean section as their first choice of delivery route for fear of having their pain neglected during labor[19].

From this perspective, this article aims to analyze the pain management of pregnant women in labor from the perspective of the human right not to be subjected to inhuman or degrading treatment. More specifically, it aims to characterize the denial or omission of pain management during labor as a violation of this right.

Methodology

This is a theoretical documentary research, which aims to develop theoretical contributions concerning a field of knowledge, in order to consolidate it and allow its practical application[21,22]. The theoretical framework used in this research is based on the following authors: Aline Albuquerque, Juán Mendéz, Manfred Nowak, Joachim Boldt and Jonathan Herring.

The choice of the theoretical framework is justified because Albuquerque was a pioneer in the formulation of the Human Rights of Patients framework; the reports by Juán Mendez and Manfred Nowak, as Special Rapporteurs of the United Nations, substantiate that the denial of pain treatment to parturients can be considered inhuman or degrading; Albuquerque, Boldt and Herring's studies on vulnerability support the increased risk of parturient women suffering harm when they are in a health unit and support the ethical duty of professionals to promote the autonomy of this patient.

In addition, the Human Rights of Patients (henceforth HRP), which is part of Healthcare Bioethics – a framework of clinical bioethics currently under development in the Graduate Program in Bioethics at the Universidade de Brasilia –, is adopted as a theoretical and normative framework. The choice of the HRP framework for this study stems from the fact that the implementation of human rights in health care is essential to ethically and legally demarcate the conduct of health professionals and the actions and public policies that should be adopted by States. As regards the Brazilian State and the subject of this article, it should be noted that in 1991 the country ratified the Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment[23]; in 1992, the International Covenant on Civil and Political Rights[24] and the American Convention on Human Rights[25]; and in 2002, the Convention on the Elimination of All Forms of Discrimination against Women[26]. Consequently, State obligations under international human rights law require the Brazilian State to adopt public policies and legislative measures aimed at protecting patients from human rights violations perpetrated by State agents or third parties.

Based on the analysis of the material, the following categories were established to discuss the findings: the human right not to be subjected to inhuman or degrading treatment; the increased vulnerability of pregnant women in labor; and the principle of promoting the personal autonomy of pregnant women.

This study is divided into three parts. In the first part of the article, the basic pathophysiological mechanisms of labor pain and the pharmacological methods of analgesia will be presented, with an emphasis on neuraxial analgesia, as it is the most widespread method in clinical practice. In the second part, the HRP framework will be introduced and it will be argued, from this perspective, that the denial or omission of treatment for labor pain can, in certain circumstances, be considered a violation of the human right not to be subjected to inhuman or degrading treatment. The third part examines the increased vulnerability of pregnant women and argues that it is imperative to promote patient autonomy as a way of mitigating this vulnerability.

Pathophysiology of labor pain

Pain is defined as “an unpleasant sensory and emotional experience associated with, or similar to, actual or potential tissue injury”[27]. Pain is always a personal experience, influenced by biological, psychological and social factors, the concept of which is learned from the person's life experiences[28].

The organs and tissues of the human body are innervated by nociceptors, which are neurons that are sensitive to mechanical, thermal or chemical stimuli that are harmful to the organism[29]. The activation of these nociceptors causes a neuronal electrical depolarization that is carried along the entire length of this fiber until it reaches the spinal cord, where it will synapse with second-order neurons, which continue in an upward direction to the brain, culminating in the experience of pain[30,31]

Labor is divided into three clinical phases[32]. The first consists of the onset of contractions and the dilation of the cervix to allow the fetus to pass through its canal. The pain in this phase is due to the depolarization of nociceptors that enter the spinal cord at the T10 to L1 levels, which have been activated by the stretching of mechanical receptors present in the uterus and cervix, and by the ischemia of these two structures due to compression by the fetus during contractions[10,33,34]. The second phase corresponds to the expulsive period, which begins with the complete dilation of the cervix (10 cm) and ends with the expulsion of the fetus[32]. During this period, pain arises from distension of the vagina and perineum, the nociceptive stimulus of which enters the spinal cord at the S2-S4 level, adding to

the pain mechanism of the first phase[10,33,34]. The third phase consists of the period from the expulsion of the fetus to the expulsion of the placenta, called dequitation[32]. In this phase the pain is less significant because the fetus has already been expelled.

Pharmacological methods for labor analgesia

The most widely used method in clinical practice and considered the gold standard for labor analgesia is neuraxial analgesia[8] which consists of injecting local anesthetics, with or without opioids, into the spinal canal. The aim of this method is to interrupt the neuronal depolarization caused by the activation of nociceptors in the uterus, cervix and vagina, thus blocking the transmission of the nociceptive stimulus to the brain, without preventing the expulsive effort[10,35,36].

Neuraxial analgesia can be performed using either spinal or epidural techniques, which differ primarily in the site where the anesthetic is delivered to block nerve transmission. In spinal analgesia, the drug is delivered in the intrathecal space, i.e. the space inside the dura mater, dispersing in the cerebrospinal fluid; in epidural analgesia, the anesthetic is delivered on the outside of the dura mater, which is why it is also called epidural[36]. Spinal analgesia has a faster onset of action, but the epidural allows the placement of a catheter through which additional doses can be administered without the need for new punctures[37]. To relieve labor pain, both techniques can be used either alone or in combination[35].

The aim of both techniques is to selectively block nociceptors, allowing the patient to maintain intact touch and muscle strength, while the pain is eliminated or at least reduced to levels satisfactory to her. Its most common adverse effects are hypotension (due to sympathetic fiber blockade), nausea and vomiting resulting mainly from untreated hypotension and pruritus due to the opioid effect[8,34,37].

Despite being considered the gold standard, there are some contraindications to neuraxial anesthesia, such as coagulation disorder, increased intracranial pressure or lumbar infection[9,10] . In the presence of these comorbidities, systemic analgesia techniques should be used, with intravenous opioid infusion being the most common alternative method[10]. Compared to neuraxial analgesia, intravenous analgesia has lower efficacy in pain control and increased incidence of nausea, vomiting and dizziness, as well as a higher risk of maternal respiratory depression[8,10] .

Although there is still resistance in clinical practice to the use of neuraxial analgesia due to concerns about adverse effects, advances in labor analgesia, such as the use of lower concentrations of local anaesthetics, has increased safety for patients and babies. A 2018 Cochrane systematic review[38] concluded that in women who underwent epidural analgesia, compared to those who did not receive analgesia or received other types of pharmacological and non-pharmacological analgesia, there was no increase in the rate of conversion to caesarean section or low back pain, as well as no difference in neonatal outcomes and admission to NICU.

Regarding the likelihood of an instrumented vaginal delivery (i.e. one that uses forceps, vacuum extractors or other instruments to extract the fetus), the authors found no increase in incidence in studies conducted after 2005, a finding attributed to changes in clinical practice related to the use of lower concentrations of local anesthetics[39,40].

A meta-analysis published in 2017 compared the effects of epidural analgesia with low-concentration local anesthetics (bupivacaine $\leq 0.1\%$ or ropivacaine $\leq 0.17\%$), with or without opioids, against the effects of systemic analgesia and non-pharmacological analgesia on the outcomes of 1,809 deliveries[41]. The results show that there was no difference in the duration of the first or second stages

of labor, as well as in the rate of caesarean sections and operative vaginal deliveries. A meta-analysis by Halliday *et al.*[42] partially supported these findings, reporting a reduced incidence of instrumental delivery and a shorter second stage of labor in groups using lower concentrations of epidural local anesthetics (bupivacaine≤ 0.08% or ropivacaine ≤ 0.135%) compared to those using higher concentrations (bupivacaine > 0.1% or ropivacaine > 0.175%), while no difference was observed in the rate of caesarean section between groups.

One of the most important adverse effects of neuraxial analgesia is fetal bradycardia, mainly due to the infusion of opioids into the neuraxial area, the incidence of which can increase by up to 2.3 times compared to deliveries without analgesia[40]. One of the factors behind this effect is the abrupt reduction in plasma levels of adrenaline due to the rapid analgesia induced by opioids, which can induce uterine hyperactivity and fetal bradycardia due to a reduction in placental flow, since this catecholamine has an inhibitory effect on uterine contraction[39,40]. This phenomenon usually occurs in the first 15 minutes after administration of the anesthetic, and can be managed by discontinuing oxytocin, positioning in the left lateral decubitus position, administering supplementary oxygen to the pregnant woman, correcting maternal hypotension or administering drugs that suppress uterine contraction[39]. Despite being an effect that requires monitoring, it is usually transient and it is not associated with an increase in instrumental delivery or caesarean section, or with a worsening of the Apgar score at 1 and 5 minutes[40].

Human Rights of Patients

The theoretical and normative framework of HRP has been developed since 2016 within the Graduate Program in Bioethics at the University of Brasilia. This approach is ethically and legally grounded in the theoretical, normative and jurisprudential foundations of International Human Rights Law[43].

The HRP is the prescriptive component of Healthcare Bioethics, a bioethical framework dedicated to ethical issues that emerge from clinical practice, aiming to offer a bioethical alternative to principlism, as formulated by Beauchamp and Childress. The need for an alternative framework to principlism is based on the idea that: (a) health care must be patient-centered; (b) the human rights of patients are imperative ethical-legal prescriptions for health professionals, and, *prima facie,* must prevail when in conflict with bioethical principles; (c) self-determination and respect for the patient's bodily integrity are markers that place them in a different ethical position from health professionals, so the moral equivalents proposed between patients and health professionals prove inappropriate; (d) the asymmetry of power and information intrinsic to the health care relationship must be modulated by human rights of patients; (e) historically, there has been abuse and objectification of patients in health care[44]. Another point that is part of the Healthcare Bioethics and justifies the use of HRP concerns the increased vulnerability of the patient, which is related to a person's increased vulnerability due to the mere fact that they are in the role of patient[45].

The HRP framework is grounded in international human rights conventions, covenants and declarations, as well as in international case law produced by the human rights monitoring bodies of the United Nations (UN), the Inter-American Human Rights System, the European Human Rights System and the African Human Rights System. This framework, which is embedded in Healthcare Bioethics, particularizes the application of human rights that are expressed in abstract norms to the context of health care[46].

There are four guiding principles of HRP: the principle of patient-centered care; human dignity; relational autonomy; and patient responsibility[43,46]. In addition to these principles, this article proposes the inclusion of the principle of promoting personal autonomy based on the studies by Albuquerque, Boldt and Herring, which support the argument that the patient's increased vulnerability can mitigate their self-determination, implying the professional's duty to promote their autonomy so that care is patient-centered and respects their human dignity. These principles are used to guide the application of human rights in the context of healthcare, namely: the right to life; the right not to be subjected to torture or to cruel, inhuman or degrading treatment or punishment; the right to liberty and security of person; the right to respect for private life; the right to information; the right not to be discriminated against and the right to health[46].

The patient's right not to be subjected to torture or inhuman or degrading treatment

For some women, the pain of labor is a fundamental part of their process of becoming a mother[16,47]. For them, pain is an integral part of the experience of giving birth and of building themselves up; overcoming it is a source of empowerment and suppressing it reduces the totality of the experience of the moment[47]. For others, there is an ambivalent perception of pain: while the painful sensation itself is bad, it is associated with happiness and positivity because it is linked to the birth of their child[1,2,48]. For this group of women, who recognize the pain of childbirth as a positive experience, the interpretation of the omission of pain treatment as a human rights issue has implications that will not be the subject of this article. Therefore, the following analysis is limited to those women who consider the pain of labor to be a negative experience.

The prohibition against torture, cruel, inhuman or degrading treatment is laid down in Article 7 of the International Covenant on Civil and Political Rights[24] and Article 5 of the American Convention on Human Rights[25], in addition to being the scope of the Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment[23]. This last document defines torture, in its Article 1, as:

> Any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person in order to obtain from him or a third person information or a confession; to punish him for an act he or a third person has committed or is suspected of having committed; to intimidate or coerce that person or others; or for any reason based on discrimination of any kind; when such pain or suffering is inflicted by, or at the instigation of, or with the consent or acquiescence of, a public official or other person acting in a public capacity[23].

The Convention Against Torture does not define inhuman or degrading treatment, however, according to Albuquerque[43] both treatment that causes "intense physical or psychological suffering" and treatment that "fails to provide health care" - either by denying care or delaying it when feasible - can be considered inhumane. According to the same author[43], treatment can be degrading if it "causes the victim feelings of fear, anguish, humiliation or takes away the possibility of resisting morally, psychically or physically to an adverse situation".

The UN Committee against Torture, in its General Comment No. 2[49] reinforces that the prohibition against torture and ill-treatment (understood as cruel, inhuman or degrading treatment) is absolute and non-derogable, unlike most other human rights, which are subject to potential restrictions[50]. These rights can be limited when there is a conflict of rights, as long as the cases of

limitation are provided for by law, or they may be subject to temporary derogation in exceptional situations, such as states of public emergency[50,51]. However, the right not to be subjected to torture or cruel, inhuman or degrading treatment or punishment is non-derogable and cannot be limited [49.50.51]. The absolute nature of this right has been defended by UN Special Rapporteurs such as Juan Méndez[52] and Alice Edwards[53] by the United Nations General Assembly[54] as well as the jurisprudence of the Inter-American Court of Human Rights[55,56] and the European Court of Human Rights[57]. In addition, General Comment No. 2[49] states that the obligations to prevent each of the violations of that right are indivisible, interdependent and interrelated, since, in practice, the boundaries between ill-treatment and torture are unclear and the conditions that lead to the former facilitate the latter.

State indifference or inaction can be characterized as encouragement or *de facto* permission for human rights violations[49]. For this reason, the State has an obligation to protect the human rights of individuals, preventing violations from occurring by third parties[51] and suppressing practices that violate these rights[58]. The Inter-American Court of Human Rights has established that responsibility for human rights violations can be attributed to the State when it fails to respect and guarantee the effectiveness of these rights in interpersonal relations[58]. Thus, considering that in a healthcare institution patients are under the care of healthcare staff, it is up to the State to ensure that human rights are respected in the interaction between professionals and patients, as the State is ultimately responsible for protecting patients. The UN Human Rights Council's Special Rapporteur against Torture, Manfred Nowak, affirms that the State's obligation extends to acts committed in the private sphere when there is a failure to protect individuals from torture and ill-treatment within its jurisdiction[59]. This justifies that there should be no difference in the treatment of labor pain in public or private hospitals.

According to these definitions and the understanding of the UN Human Rights Council, as articulated by its Special Rapporteur Juán Méndez[52], health care that causes severe suffering for no justifiable reason can be considered inhuman or degrading. The denial of pain treatment, which is more associated with an omission than with an action, can be characterized as ill-treatment if it leads to severe pain or suffering, and there need be no action or intention, but only purely negligent conduct that leads to such an outcome. Furthermore, the Rapporteur states that the characterization of inhuman or degrading treatment will only occur when three conditions are present: the suffering caused by health care must be severe and reach "the minimum threshold of the prohibition of torture and ill-treatment"; the State is (or should be) aware of the suffering; and the State has failed to take all reasonable measures to protect the physical and mental integrity of individuals.

Research described in the introduction to this article[2,3,4,13,14,16,19,17] shows that the inadequate management of labor pain is widely recognized, especially within the Brazilian public health system (SUS), rendering any State claim of ignorance regarding the suffering caused by labor pain in parturient women unacceptable. Given the persistent reality of inadequate management of labor pain despite the State's full awareness of the situation, it can be concluded that reasonable measures have not been taken to protect pregnant patients' rights. Therefore, two of the three criteria listed by rapporteur Juán Mendez have been met. As for the first criterion, how do we determine whether the pain and suffering of the pregnant woman exceeded the "threshold of ill-treatment"?

As discussed above, pain is a subjective experience. Therefore, the practical way to determine whether the threshold of mistreatment has been crossed is by the parturient herself expressing that her pain has become too intense or that the suffering resulting from it has become unbearable. From the

moment that this pain transforms the parturient's experience, according to her own interpretation, into one of intense anguish or suffering, and she expresses the desire to alleviate her pain, the threshold of inhuman or degrading treatment has been crossed. At this point, the healthcare professionals caring for her have a duty to implement additional pain management techniques, within the therapeutic options accepted by her, to alleviate her pain to levels she considers acceptable[60,61].

The mandatory provision of pharmacological analgesia should not, however, be conditional on crossing a pain threshold that is considered unbearable. The mere glimpse, for the pregnant woman, of the imminence of crossing this threshold, when she imagines that her pain may soon reach unbearable levels for her, is already a potential cause of intense anguish, anxiety and suffering, constituting a violation of her right not to be subjected to inhuman or degrading treatment. For this reason, it is argued that, from a HRP perspective, the pregnant woman's request is sufficient indication for labor analgesia. The denial or omission to offer it when identifying a state of intense pain, or the unjustified delay in doing so, may characterize a violation of the human right not to be subjected to inhuman or degrading treatment.

This understanding is ratified by the UN Special Rapporteur, Juan Méndez, when he affirms that the State can violate the human right not to be subjected to inhuman or degrading treatment when its failure to adopt positive measures to prevent the violation of this right condemns the individual to unnecessary suffering as a result of their state of pain[52]. The same Rapporteur expressly states that the "absence of anesthesia" in the peripartum period can be considered ill-treatment and a violation of this human right[62]. The Inter-American Court of Human Rights seems to agree with this line of thought, as it directly quotes this passage from Juan Mendéz, in the case of Brítez Arce v. Argentina, when it holds that the lack of adequate medical care or the lack of access to certain procedures may violate the prohibition of torture, inhuman or degrading treatment[63]. Brennan and Lohman assert that international health institutes and associations have also recognized that the right of access to pain management derives from the human right not to be subjected to torture or inhuman or degrading treatment[64,65,66].

It should be noted that offering or providing pharmacological analgesia does not exclude non-pharmacological measures, which should be available and used according to the wishes and preferences of the pregnant woman during labor. Furthermore, considering that pharmacological analgesia, especially neuraxial analgesia, is only available in hospital settings[5], therapeutic options for pain management should be discussed during the prenatal phase so that the pregnant woman can choose her birth setting according to her preferences, taking these circumstances into account. It is therefore imperative that the Brazilian healthcare system ensures the right to information for pregnant patients, particularly with regard to pain management during labor.

Based on the assumption that childbirth analgesia should be a universally available resource so that the human rights of pregnant women are realized, we will examine the vulnerability of pregnant women from the perspective of Albuquerque, Boldt and Herring and then argue that promoting their autonomy can mitigate this vulnerability.

Increased vulnerability of pregnant women during labor

According to Herring[67] there are two dimensions to vulnerability: universal and increased. Universal vulnerability is intrinsic to all human beings, resulting from the fragility of the human body and its susceptibility to being injured; from one's physical and psychological interdependence on

others and from the very fact that one's definition of *self* is dependent on the relationship with others. This constitutes the starting point, the basic condition of human vulnerability. However, vulnerability is not uniform among individuals, as some may experience levels of vulnerability beyond this baseline, or, in other words, increased vulnerability.

Herring considers an individual to have increased vulnerability if all three of the following criteria are met: they are exposed to a risk; they lack the resources to prevent that risk from materializing; and they lack the means to respond adequately should the harm materialize [67]. In short, one has increased vulnerability if one is exposed to a risk and lacks proper means to protect oneself from it. The ability to protect oneself against risk is influenced by various factors such as educational level, financial condition, personal health situation, and the political and social context the person lives in.

Albuquerque[45] and Boldt[68] state that increased vulnerability can be divided into physical, emotional, and cognitive vulnerability. The patient's physical vulnerability stems from the bodily alterations and limitations imposed by the disease; from the pain that creates an experience of suffering related to the body; from the need to undergo punctures to collect tests and inject drugs; and from the adverse effects of therapies used to treat diseases[45]. Emotional vulnerability arises from the patient's increased exposure to negative emotions – such as anguish, anger or fear – related to their health condition or the risk of death, as well as discomfort and insecurity at being in a health facility that imposes certain rules and routines[68]. Patients have cognitive vulnerability when they have limited ability to seek, understand, and use information and services related to their health condition, or when their decision-making capacity is diminished[45]. This vulnerability occurs because access to technical information essential for decision-making according to the person's will and preference, such as diagnosis, prognosis, and therapeutic options is often mediated through professionals[45,68].

The patient's increased vulnerability may manifest in varying degrees, and may be greater or lesser depending on the patient's condition and the context in which they are situated[45]. Greater vulnerability of one subtype can predispose to greater vulnerability of another subtype[68].

Although pregnancy is not a disease, its consequences on women cannot be ignored, nor can the unique changes their bodies undergo during labor be underestimated, as these impose on them a potential state of increased vulnerability across physical, emotional and cognitive dimensions. Her physical vulnerability stems from her condition as a pregnant woman and the process of parturition itself, which temporarily limits her physically and potentially subjects her to a painful experience that she can neither avoid nor mitigate by her own means[69].

Regarding the emotional vulnerability of women in labor, it should be emphasized that pregnancy itself imposes an emotional burden on women, and it can a period of increased anxiety, fear and concern about changes in their bodies, in their lives and in their child's health[70]. The labor process can carry profound meaning for women[16,47] which, in itself, can influence them emotionally. However, in addition, hormonal changes, physical exhaustion and, especially, the pain triggered by the anatomical and physiological changes of labor may impose on women greater degrees of emotional vulnerability depending on the level of suffering they endure.

Women in labor are also subject to increased cognitive vulnerability. If labor pain is too severe, it may limit the patient's ability to understand, appreciate and reason about complex information[71,72], especially about analgesia options, which are often only presented for the first time in advanced stages of labor, when pain is typically severe. Another contributing factor to this type of vulnerability is the

patient's level of formal education, as it is positively correlated with the provision of pharmacological analgesia[15,73].

In healthcare settings, the care relationship itself contributes to increasing the vulnerability of patients, as the diagnosis, prognosis and treatment of their illnesses are often dependent on actions performed by professionals[74]. This vulnerability is most evident in the context of women in labor for whom non-pharmacological methods of pain control have failed. In this situation, pain treatment is dependent on the administration of intravenous or neuraxial drugs, a process that requires prescription, dispensing, preparation and administration of drugs by healthcare professionals. The increased vulnerability of women in labor under the public healthcare system may be even greater than that of women under the private system, since the former have limited access to labor analgesia and lower chances of resorting to a caesarean section to avoid labor pain[19].

The principle of promoting the personal autonomy of pregnant women in the context of childbirth

Personal autonomy refers to self-determination and self-governance of one's life, that is, the ability to make choices and be guided by them[43,75]. The perspective of relational autonomy opposes the traditional view that individuals make their decisions in isolation and according to their own best interests, apart from their personal relationships and social context[43,76].

Within a relational perspective of autonomy, the individual is considered a member of society, embedded in an economic, cultural and social context that influences their decision-making[43], since the very construction of the *self* depends on interpersonal relationships rooted in interdependence and connection between people[76]. Thus, in healthcare contexts, patients' decision-making is influenced, among other factors, by their relationships with their families, caregivers, and health professionals.

From this perspective, considering that women in labor are in a situation of increased vulnerability, mere recognition of the factors that lead to this condition and of the elements that influence patients' decision-making is insufficient. In order to mitigate the vulnerability of women in labor, it is necessary to enhance their autonomy and decision-making capacity[75]. In this context, the fundamental role of the family in promoting women's autonomy is highlighted. In addition to providing physical and emotional support, family members contribute to maintain the patient's sense of identity and foster shared decision-making by helping her understand the therapeutic options so that they can be implemented in accordance to her will and preferences[77].

Promoting the autonomy of women in labor starts in prenatal care. As previously mentioned, lower levels of education and giving birth in a public healthcare facility diminish the chances for women in labor to receive pharmacological analgesia[19]. Thus, one way of promoting these patients' autonomy is by discussing pharmacological techniques for labor main during prenatal consultations[43]. In addition, the fact that pharmacological analgesia is only available in hospital settings is a factor that should influence the choice of birth setting.

It should be noted that the stance adopted by certain groups in categorizing women who opt for pharmacological pain management techniques as "repressed by the medical apparatus" or as belonging to a "bad culture", in contrast to those who choose only non-pharmacological techniques as belonging to a "good culture" or as "empowered", runs directly counter to promoting the autonomy of pregnant women. All women should be able to decide, with the greatest possible autonomy, the manner of giving birth according to their will and preferences without feeling coerced to act in one way or another.

According to Albuquerque[75] universal or increased vulnerability cannot be a stigmatizing factor that automatically leads to the assumption that people in such a condition are fragile and incapable of taking charge of their own lives. Disregard for personal self-determination, when supposedly justified by the patient's increased vulnerability, can lead to paternalistic practices in which professionals make decisions on behalf of the patient, or to negligent practices stemming from a failure to recognize the patient's needs. Thus, once the patient's increased vulnerability has been established, the State's responsibility is heightened, obliging it to protect the patient's human rights[74] which must be upheld in accordance with the principle of promoting personal autonomy, a core value of HRP framework.

Implementing the model of autonomy promotion will enable pregnant patients, despite their increased vulnerability, to make their own choices and exercise their self-determination during labor, opting for pharmacological analgesia if they deem it appropriate, while protecting them against subjection to inhuman or degrading treatment. This justifies adopting decision aids for people who find themselves in vulnerable, abusive or oppressive situations[75], as may be the case with women in labor in a state of severe pain and suffering.

The right not to be subjected to torture or inhuman or degrading treatment imposes on the State not only a negative obligation to refrain from violating the right, but also a positive duty to adopt measures to prevent its violation within its jurisdiction[49,51,50]. Thus, considering the increased vulnerability of pregnant women, especially during labor, the State has a duty to guarantee conditions that ensure patients' access to pharmacological techniques of analgesia.

Final considerations

The pain of labor can be an experience of intense suffering for the parturient woman. This same pain, above a certain subjective threshold, can place the patient, regardless of other factors, in a condition of increased vulnerability. This is justified on the basis of Herring's three criteria, since all parturients are subject to the risk of intense pain due to the very physiology of labor and, in a health system in which this pain is systematically neglected, the patient has no means of avoiding its manifestation or mitigating it when non-pharmacological methods become insufficient for pain control. Thus, if analgesics are omitted or denied, the patient is unable to reverse the suffering resulting from the painful state of labor, characterizing inhuman and degrading treatment.

Therefore, it can be concluded that the denial of, or failure to provide, pain management, in this context, constitutes a violation of the absolute human right of pregnant patients not to be subjected to torture or inhuman or degrading treatment. The recognition of access to pain management as a derivative of the aforementioned right has already been accepted by the UN and international health institutes and associations; also, the Inter-American Court of Human Rights has signaled accordingly. Thus, based on the arguments developed in this article, it is proposed that the right to labor analgesia should also be recognized as a related human right.

The meta-analyses cited in this paper allow us to conclude, based on current evidence, that it is unjustified to delay or deny labor analgesia to pregnant women on the grounds that it will prolong labor, increase caesarean section rates or NICU admissions. For this reason, healthcare professionals and, ultimately, the State, must adopt measures to ensure that women in labor are protected from violations of their right not to be subjected to physical or psychological suffering, which also entails promoting their personal autonomy.

The increased vulnerability of pregnant women heightens the State's duty to protect them from inhuman or degrading treatment, as well as its obligation to take positive measures to ensure patients' access to pharmacological techniques of pain management. Guaranteeing pregnant women the right to give birth free from pain and suffering, in accordance with their will and preferences, means to acknowledge their human dignity, so that this unique moment in life to be guided by an empathetic relationship between professionals and patients in a context of respect for their human rights.

Conflict of interest
The authors declare that there is no conflict of interest.

Authors' contributions
Rocha F contributed to the conception and writing of the article. Da Rocha R contributed to writing the article, critically reviewing its content and approving the final version. Albuquerque A contributed to the critical review and approval of the final version.

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How to cite

Rocha F, da Rocha R, Albuquerque A. Labor analgesia and the right of pregnant patients: an analysis of the guarantee against being subjected to torture or to inhuman or degrading treatment. Cadernos Ibero-Americanos de Direito Sanitário. 2025 jul./set.;14(3):94-110
https://doi.org/10.17566/ciads.v14i3.1368