receives reports of all deaths in England and Wales, oversees certification in all cases, conducts investigations, and prepares reports to inform public health will not be achieved.

This means that doctors will still bear the considerable responsibility of completing certificates for death and cremation. New certification procedures may be introduced eventually, but for now doctors will have to adhere strictly to guidance on completing these forms to minimise the weaknesses of the current systems.^{6 7}

The first paragraph of the foreword to the draft bill states that investigations and inquests "will give an official finding of the facts, and can identify lessons for preventing future deaths." This will sometimes be true, and a senior coroner "who believes that action should be taken to prevent the recurrence of" similar fatalities may report the matter "to a person who may have power to take such action, and to the Chief Coroner" (section 12(2)). But in the main text of the draft bill the aim of investigations and inquests is stated simply as to find "who the deceased was, and when, where and by what means he came by his death" (section 10(1)). Senior coroners and juries will be prohibited from expressing opinions on any other matters. The absence in the draft bill of any more explicit aim to prevent death or injury, arguably the major policy basis for a modern coroner's system, is a lost opportunity for public health.

Another important lost opportunity relates to forensic pathology. A dynamic coroner system serving the community well is a partnership between law and medicine, especially the small subspecialty of forensic pathology. A coroner's bill is the obvious place to outline the structure, powers, and processes for this subspecialty, which currently has no coherent framework to sustain and nourish it. Section 26 of the draft bill authorises a senior coroner responsible for investigating a death to request "a registered medical practitioner to make a post mortem examination of the body" but does not specify that the practitioner should even be a pathologist, let alone a forensic pathologist.

The words of Sir Henry Harvey Littlejohn, professor of forensic medicine and dean at the University of

Edinburgh and chief police surgeon of Edinburgh, spoken in the first learned address to the newly formed Medico-Legal Society in London in 1902, come to mind: "It would be ludicrous if it were not such a serious matter to reflect that in this advanced age and in an enlightened and humane country the law still permits any medical practitioner to be summoned to make a post mortem examination, without any regard to his knowledge, his previous experience or his capacity to fill the duty thus imposed on him."⁸ We hope that the Lord Chancellor will remedy this through regulations or guidance (section 65).

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Analgesia in the second stage of labour

Simple interventions would be welcome, but lidocaine spray on the perineum does not reduce pain

In this week's *BMJ*, Sanders and colleagues report a randomised controlled trial of an easy non-invasive intervention in labour: using lidocaine spray on the perineum as the baby's head is delivered.¹ Labour pain has been described as one of the most extreme forms of pain.² It is caused by uterine contractions, by dilatation of the cervix, and by stretching of the pelvic floor and vagina as the fetus descends. Epidural analgesia and its variants (combined spinal-epidural) are the most effective type of analgesia during labour, according to a Cochrane review in which all but one of the 21 included trials compared epidurals with opiates.³ Hence this method

is frequently used to relieve the pain associated with labour.

In many countries and settings epidural analgesia is rarely available. Even when it is available, some women may bear the pain until the second stage of labour. Non-pharmacological interventions including continuous support,⁴ massages, bathing,⁵ moving around, and repositioning may reduce the need for epidural analgesia during the first stage of labour. Transcutaneous electrical nerve stimulation (TENS) does not reduce the need for an epidural but may "buy time."⁶ There is little evidence of effectiveness to support the use of nitrous oxide, but again this may help in the process of labour.

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But the second stage of labour can be very painful and, for those women who have not had epidural analgesia earlier or do not want invasive treatments such as pudendal block with injectable anaesthetics, what else may help to reduce their pain? A survey of midwives showed that several interventions, including lidocaine spray on the perineum, are used to relieve pain during the end of the second stage.⁷

A systematic review was unable to show a reduction of perineal pain in the 24 hours after delivery and of the need for other analgesia with topical local anaesthetics, compared with placebo.⁸ Now Sanders and colleagues report that lidocaine spray on the perineum during the second stage of labour makes no difference in the overall assessment of pain associated with the delivery.¹

The risk of perineal trauma was, however, lower in the group who had lidocaine spray than in the placebo group. This was a secondary outcome of the trial, and needs to be interpreted with caution. The reduction in second degree tears seems at first glance unlikely to be produced by lidocaine spray. In the group given lidocaine, women may have been able to better control their very last efforts at pushing, resulting in a slower delivery with less perineal damage. This hypothesis must be evaluated in future trials.

The most satisfactory pain management during labour may not always mean complete removal of pain, and women should be able to make informed choices before and throughout labour. But fear of pain and

perineal damage may be among the reasons for women to request caesarean section when there is no obstetric indication.⁹ It is important, therefore, to continue to evaluate simple and non-threatening interventions as well as more complex ones that might improve the outcomes of vaginal delivery.

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Competing interests: None declared.

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Failed asylum seekers and health care

Current regulations flout international law

Since the start of the National Health Service, British doctors have taken pride in working in a service whose core principles include health care as a basic human right and a universal service for all based on clinical need, not ability to pay.¹ Yet the reality is different: destitute failed asylum seekers are being refused hospital treatment and being hounded by debt collectors if they have received emergency treatment.² A recent report from the Refugee Council catalogues people with potentially fatal conditions, such as bowel cancer, diabetes, and renal failure, who are being refused free treatment but cannot afford to pay or have become too intimidated to seek treatment. It concludes that people will, if they have not already, die as a result. More, however, is at stake in the NHS than a 58 year tradition as the first ever national medical service based exclusively on clinical need.

Human rights

In restricting their access to free secondary health care the British government is violating the right of failed asylum seekers to the highest attainable standard of health, guaranteed by the International Covenant on Economic, Social and Cultural Rights.³ This covenant, along with the International Covenant on Civil and Political Rights and the Universal Declaration on Human Rights, forms the International Bill of Human Rights and was ratified by the United Kingdom in

1976. Although not yet justiciable (liable to court trial or legal decision) in the UK, the International Covenant on Economic, Social and Cultural Rights is no less binding on governments than international law that has been incorporated in domestic legislation, such as the Convention against Torture or the European Convention on Human Rights. The Committee on Economic, Social and Cultural Rights, which monitors states' compliance with the covenant, found no factors that might prevent full implementation of the covenant at its last review of the UK in 2002.⁴

The International Covenant on Economic, Social and Cultural Rights puts governments under a specific obligation not to limit equal access to health care for all people. This obligation arises from the combination of article 2.2, which says that parties to the covenant guarantee that its rights will be exercised without discrimination of any kind, and articles 12.2 (c) and (d), which cover "the prevention, treatment and control of epidemic, endemic, occupational and other diseases" and "the creation of conditions which would assure to all medical service and medical attention in the event of sickness."⁵

At the time of the Committee on Economic, Social and Cultural Rights' monitoring report on the UK in 2002, Doctors for Human Rights named asylum seek-