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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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."[3]

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-

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ers as a vulnerable population that must be protected from discrimination and criticised the UK's continuing failure to incorporate it within national law.[5] The monitoring committee's final report criticised "de facto discrimination in relation to some marginalised and vulnerable groups" and asked the UK to ensure that its obligations under the covenant were taken into account in national legislation and policy on health and education.[4] Yet within two years the government had blocked access to free NHS hospital health care for most failed asylum seekers and expressed an intention deny them access to free NHS primary care.

Health security

A large, though difficult to quantify, proportion of failed asylum applicants are rejected by an evaluation process that the United Nations, Amnesty International, and the House of Commons Home Affairs Committee have judged inadequate.[6–8] Because failed asylum seekers are not allowed to work and earn money, denial of access to free secondary health care is, de facto, denial of access. Health security is one of the core elements of human security.[9] Given that many of these people have faced the insecurity of physical harm, are by definition denied security of residency, and as a result of government policy have no economic security, the denial of access to health care by one of the richest countries on earth is inhumane because it jeopardises their health and illegal because it violates international law.

Where do these regulations leave doctors? Conforming with legislation that denies access to health care goes against the instincts of many doctors, affronts common decency, and infringes international and domestic ethical codes. But it is in its violation of international law that the regulations offend most. The intentions of the authors of the International Covenant on Economic, Social and Cultural Rights—that no discrimination should exist in healthcare provision and that national legislation should be enacted that renders it unlawful—have been frustrated.[4] The UN General Assembly, commenting on each individual's responsibility to protect human rights, concluded that everyone has the right to the lawful exercise of his or her profession and an obligation to comply with relevant national and international standards of occupational and professional conduct or ethics.[10]

In its 2002 report the Committee on Economic, Social and Cultural Rights, the world's most authoritative body on health rights, urged the UK government to ensure that health professionals are educated in economic, social, and cultural rights and the public is informed of the requirements of the covenant,[4 11] but neither recommendation has been followed. The UK government needs to observe its obligations under the International Covenant on Economic, Social and Cultural Rights. In the meantime, health professionals who have cooperated in limiting access should understand they have unknowingly been made complicit in the abuse of a fundamental human right.[12]

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