Letters

Mexico and the tobacco industry

Editorial lost sight of the real enemy

Editor—In their editorial on the tobacco industry in developing countries Sebrié and Glantz did not take into account potential positive effects and disregarded important accomplishments of Mexico's health ministry in tobacco control.[1]

Over the past five years, the ministry, under the leadership of the current minister of public health, Julio Frenk, has implemented several tobacco control initiatives. A tax increase on tobacco products reversed an industry friendly trend set by previous administrations. Restrictions on radio and television advertising have been put into action, and a media campaign will be launched soon to discourage tobacco use. Furthermore, the recent development of an efficient system to monitor and evaluate national trends in tobacco use, especially among young adults, is providing epidemiological data that will be key in guiding medium and long term strategies to reduce tobacco consumption.

To develop and consolidate policies to restrict and control the tobacco industry, constructive action is needed. Governmental agencies in Mexico, as well as international lobbyists, need to provide pressure to support the health ministry along its path towards a more aggressive tobacco tax policy and breaking the barrier that impedes the use of special taxes earmarked for anti-tobacco programmes. The ministry has circumvented such barriers and used funds provided by the mentioned agreement to finance medical institutions directly involved in treating tobacco related illnesses. Activists who issue criticisms based on short term results and brush aside advances may create pressure in the wrong direction and ultimately benefit the tobacco industry by tarnishing the reputation of an administration that is making long term progress.

MARTIN PARR/MAGNUM

A more complete analysis than that of Sebrié and Glantz would recognise, as Samet et al acknowledge, that Mexico has been a leader in tobacco control.[2] Minister Frenk was an early supporter of the World Health Organization's convention and is a champion of tobacco control in Mexico. The balance of the Frenk administration has been positive, and Mexico is making advances towards tobacco control.

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1 Sebrié E, Glantz SA. The tobacco industry in developing countries. *BMJ* 2006;332: 313-4. (11 February.)
2 Samet J, Wipfli H, Perez-Padilla R, Yach D. Mexico and the tobacco industry: doing the wrong thing for the right reason. *BMJ* 2006;332:353-4. (11 February.)

Response from the Ministry of Health

Editor—Mexico was the first country in the Americas to ratify the World Health Organization's Framework Convention on Tobacco Control. Since 2001, Mexico has carried out a comprehensive tobacco control policy, which includes:

- Unprecedented increases in the taxation rates of tobacco products
- A total ban on tobacco publicity on the radio, television, and internet
- A substantial increase in the size of the warning label on cigarette packs (50% of one of the largest sides) and
- Total restriction on smoking in all federal buildings.

Two articles in the *BMJ* of 11 February that discuss a tobacco control measure implemented by Mexico's government provide incomplete information and disregard the context in which an agreement between the Ministry of Health of Mexico and the tobacco industry was implemented,[1 2] suggesting that, due to the agreement, no additional measures will be taken. This mistaken assessment stems from two major sources of misunderstanding by the authors. Firstly, the agreement was signed after all the anti-tobacco measures outlined above had already been implemented and none of them was reverted. Secondly, the agreement imposed additional obligations on tobacco companies to the ones already passed in law.

Both articles neglect to inform that the agreement has a limited duration, thus leaving the door open for legislating further tobacco control measures, including tax increases, and exhibit major flaws in the process by which they were produced.

Mexico believes in international collective action. However, we cannot yield to self appointed judges who, lacking the most fundamental respect for diversity and sensitivity to local realities, question the decisions of a group of respected public health policy makers who are successfully confronting one of the most powerful industries worldwide in search of better health for their population.

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1 Samet J, Wipfli H, Pérez-Padilla R, Yach R. Mexico and the tobacco industry: doing the wrong thing for the right reason? *BMJ* 2006;332:353-4. (11 February.)
2 Sebrié E, Glantz SA. The tobacco industry in developing countries. *BMJ* 2006;332:313-4. (11 February.)

Prisoners in general hospitals: doctors' attitudes and practice

Editor—Research into professional conduct towards prisoners being assessed and treated in general hospitals, as opposed to prison settings and psychiatric services,[1 2] is lacking. This hospital is near a large prison, and we noted that prisoners were frequently assessed while chained to prison officers. Guidelines from the BMA recommend examination and treatment without restraints, and without prison officers present, unless the risk of escape is high or the prisoner is a threat to himself or herself, the healthcare team, or others.[3] Healthcare teams and prison officers should assess together the degree of risk in each case.

We used a questionnaire to assess practices towards prisoners of consultants and junior hospital doctors in adult clinical practice in this hospital. Of 76 consultants and 139 junior hospital doctors, 184 responded—60% of consultants and all jun-

Professional practices with patients. Values are numbers (percentages) of doctors

Practice	Always	Sometimes	Never
Doctor asks prison officer to leave	7 (4)	108 (66)	50 (31)
Doctor asks prison officer whether patient is safety risk	23 (14)	95 (57)	48 (29)
Doctor examines patient who is manacled	26 (16)	111 (67)	28 (17)

ior hospital doctors. In all, 181 were unaware of any guidelines in place for the treatment of prisoners in general hospitals. Almost all (180) had treated prisoners as patients at some stage in their career, and 166 had done so in the previous two years. Almost two thirds (111) felt uncomfortable while examining prisoners.

Breaches of confidentially were considered to occur commonly in the management of prisoners who were patients. Only six doctors believed that such breaches never occurred whereas 13 thought that they happened always and 162 sometimes; two were unable to give an estimate. Consistent adherence to BMA guidelines was carried out by a minority (table).

This survey shows that most hospital doctors in a hospital adjacent to a prison are likely to have clinical contact with prisoners. Hospital doctors have a low awareness of guidelines for due preservation of confidentiality and also report patterns of professional conduct which militate against confidentiality.

These findings pose several challenges. Hospitals and prison authorities need to develop procedures to allow for reasonable levels of medical confidentiality between prisoners and healthcare staff.[3]

Nationally, medical organisations need to clarify guidelines for preservation of medical confidentiality where they may be in conflict with law or custom. For example, Scottish law on restraint and prison officer attendance is at variance with BMA guidelines.[4]

Professionals who teach ethics and professional conduct to undergraduates and postgraduates need to incorporate routine training on the care of prisoners, a group with high rates of morbidity and death. This need will become more pronounced with the ageing of our society and the presence of more older prisoners, who show alarmingly high rates of illness[5] and for whom hospital based care is likely to become more common.

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We thank our colleagues who participated in the survey.

Competing interests: None declared.

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Time for food industry to adopt signposting model

Editor—The *BMJ* of 4 February contained a full page advertisement for Walkers crisps ("You are changing and so are we"), which purports to show that crisps are becoming healthier.[1] Healthier they may be; healthy they are not.

Why is Walkers making these changes now? A response to consumer demand, as the population is waking up to the fact that a diet based on snacks and fizzy drinks is a fast track to obesity? An attempt to head off threatened controls by the UK government and the European Commission as they attempt to tackle the obesity epidemic?

Why is the food industry so averse to adopting the signposting model developed by the Food Standards Agency and which has undergone rigorous testing?[2] If industry persists in using a range of indicators that have not been scrutinised by peer reviewed scientific studies then the outcome will be consumer confusion and increases in the rate of obesity. The "Our Health, Our Care, Our Say" white paper published in January showed that people want to keep themselves well and control their own health.[3] If the confused messages from the food industry persist we will see not only the 54% rise in type 2 diabetes, 28% rise in hypertension, and 18% rise in heart attacks by 2030 predicted—but a whole lot worse.[3]

The government and its agents must drive through the recommendations of the Food and Health Action Plan[4] and Choosing Health[5] and maintain the resolve to follow through as necessary with regulation at UK and EU levels if sufficient progress is not made by early 2007, to create an environment in which people are able to make healthy informed choices.

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Competing interests: None declared.

1 Advertisement. *BMJ* 2006;332:between pages 252 and 253. (4 February.)
2 Research underpins signposting proposals. www.food.gov.uk/news/newsarchive/2005/nov/trafficlightresearch (accessed 24 Feb 2006).
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Patients need not give consent in all clinical education

Editor—Lawler argues that patients taking part in assessments of clinical skills as part of postgraduate training programmes should give written informed consent.[1]

The ultimate goal of optimising competency based training and assessment in medical education is creating the best possible doctors and specialists for patients. Does explicitly asking informed consent from patients participating in clinical education really serve this goal? The willingness of most patients to take part in numerous authentic learning situations at all degrees of competence is highly appreciated and essentially inevitable. Their cooperation is the backbone of medical training.

When performing a complex task for the first time—be it communicating bad news or doing a laparoscopy—performance below professional standards seems more likely to happen than by the time a trainee has to take a summative assessment. Obtaining consent only when a patient is asked to participate in a formal assessment does not seem rational. The greatest risks are probably afterwards, when someone starts practising independently without supervision, as is the case with newly licensed drivers.

Requesting patients to agree explicitly whenever a trainee is involved in their care would eventually ruin learning, teaching, and assessment in clinical practice. Overzealous requesting of consent is impractical, may cause avoidable anxiety, and may even seriously harm individual patients since it interferes with trustworthy patient-doctor relationships between trainees and their patients.

Although this seems paradoxical, asking informed consent with respect to clinical training may not always be in the best interests of patients. It should be reserved for selected procedures such as video recordings. Instead, we have to guarantee supervision of trainees at all times and teach them to develop adequate professional attitudes to seek supervision and help whenever they feel the need. Disseminating ample information among the public about the importance of the role of patients in clinical education and their rights seems to merit more attention than it generally gets.

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Competing interests: None declared.

1 Lawler PG. Assessment of doctors in training: should patients give consent? *BMJ* 2006;332:431. (18 February.)

Offering results to research participants

Editor—The distinction between giving a general summary of trial results to study participants and providing them with their own trial results is not made clear in the

paper by Dixon-Woods et al or the accompanying editorial.[1 2] Investigators may provide patients with a summary of the trial results, but even if they do not they should be aware that study participants may access these results elsewhere. The provision of personalised trial results, and in particular treatment allocation (unblinding), is quite a different matter and much debated.[3 4] This is the more likely of the two to result in emotional consequences for the participants.

In a large scale study of cardiovascular disease prevention in older patients conducted over five years,[5] we pledged at the outset to provide all study participants with a lay summary of the general study results on the same day that the results were to be published, which was done. Unblinding of participants was considered a completely separate and potentially more problematic exercise.[4] In designing our unblinding strategy we acknowledged the right of patients to know their treatment allocations and personal results in the study, and their equal right not to know.

At the end of the study in Scotland we sent all appropriate participants in the study (n=2067) a brief questionnaire asking if they wished to be unblinded and if so whether this should be done by telephone or a face to face visit with our study nurses. Altogether 1492 questionnaires were returned, of which 850 requested face to face unblinding, 541 requested a telephone unblinding, and the remainder asked for no unblinding. Many more subjects in our study (67%) requested details about their participation than that reported in the ORACLE study (20%).[1] This may be explained by differences in the demographics of our patient population, our longer follow-up period and important differences in the background disease being studied. Whatever the reason, we should be cautious in generalising these findings.

Any evaluations on the clinical trial methods for providing participants with trial results should acknowledge the important distinction noted above.

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Does melatonin improve sleep?

Efficacy of melatonin

Editor—Buscemi et al in their meta-analysis report that melatonin is ineffective in treating secondary sleep disorders or sleep disorders accompanying sleep restriction such as jet lag or shift work.[1] The published reports in this domain certainly show some inconsistency, and now there is inconsistency in the meta-analyses.[2] Numerous published studies, mostly with a positive result, have not been included, even the first controlled jet lag trial, published in the *BMJ*.[3]

Buscemi et al may have done a disservice to people who do benefit from melatonin and may in consequence be denied access (in the United Kingdom) to this prescription-only medication. For example, the authors do not mention the importance of melatonin in blind sleep disorder and delayed sleep phase syndrome. Some of the data have appeared previously in a report from the Agency for Healthcare Research and Quality,[3] where benefits for delayed sleep phase syndrome were identified.[4]

Successful use of melatonin to counter the effects of a change in time zones or shift work requires correct timing of treatment relative to internal circadian rhythms. Incorrect timing can lead to undesirable effects. It is difficult to time melatonin correctly in field studies. Uncontrolled exposure to natural light (which shifts internal timing), individual differences, and unscheduled sleep times all contribute to the problems. If a reliable and rapid method for assessing the timing of the human internal clock (and hence the timing of treatment) were available no doubt the efficacy of melatonin would be enhanced.

A more helpful approach to assessing the usefulness of melatonin would be to evaluate those few studies where circadian timing was either measured or accurately predicted before treatment.

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1 Buscemi N, Vandermeer B, Hooton N, Pandya R, Tjosvold L, Hartling L, et al. Efficacy and safety of exogenous melatonin for secondary sleep disorders and sleep disorders accompanying sleep restriction: meta-analysis. *BMJ* 2006;332:385-93. (18 February.)
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Muddles with melatonin

Editor—Buscemi et al assert that there is no evidence base for exogenous melatonin for secondary sleep disorder.[1]

Lewy et al have shown that low doses of melatonin (0.5 mg) reset circadian rhythm but not high doses (2 mg).[2] The prolonged half life of melatonin and the sensitivity of the circadian rhythm to its presence mean that in trying to achieve phase advancement or phase delay melatonin has a limited window of opportunity. Too low a dose and no effect, too high and the chronobiological effects are lost and only the direct somnolent action is experienced.

Until very recently there have been no commercially available preparations of the correct dose, substantially hindering research. As melatonin is of most use where there is circadian rhythm dysregulation the correct dose must be used at the right time. It would be a shame if a potentially useful treatment for a limited range of disorders was discarded because of excess expectations and premature disappointment.

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1 Buscemi N, Vandermeer B, Hooton N, Pandya R, Tjosvold L, Hartling L, et al. Efficacy and safety of exogenous melatonin for secondary sleep disorders and sleep disorders accompanying sleep restriction: meta-analysis. BMJ 2006;332:385-93. (18 February.)
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Logical debate on problem based learning

Editor—Burke et al deal with an area of importance for medical education.[1] They perhaps overstated their case—that students validate problem based learning.

Students on a problem based learning course could reasonably be expected to have had explanations of its aims and hence to respond to questions about course content more in line with that information than other students. This must be a potential source of bias in their responses.

What the "traditional" curriculum represents is not clear, and, given the changes across the UK, this needs to be clear for valid comparison. The year group of students is

not mentioned, which could have an impact on their responses, especially in the earlier years of training.

The final statement seems to be unsupported by the evidence presented, following a logical approach to the argument.[2] The final statement should be along the lines of "Students from an unspecified school taking a problem based learning approach to the curriculum perceive that they spend greater time gathering and analysing information and less time memorising details than students at an unspecified school following an undefined but, for the purposes of this study 'traditional,' curriculum, which shows that problem based learning can influence students' perception of these aspects of the GMC recommendations better than a 'traditional' curriculum." Is the outcome of this that we train better doctors? As Burke et al say, the evidence base for this is still limited, and their letter cannot add as it limits itself to students' perception.

In terms of validation, the letter shows that it may be feasible to use problem based learning to achieve the specified GMC objective of discouraging memorising of detail in favour of information gathering and problem solving.[3] What other questions were asked of the students and their perceptions of how well problem based learning allowed them to develop their skills? Anecdotal information from doctors trained under problem based learning curriculums implies that how the learning is delivered can vary from the method intended. The responses of the students completing the questionnaire show that the school has succeeded in at least an important part of their aim in instituting a problem based learning curriculum. Information about how the curriculum in action has matched up with the curriculum on paper would add greater value to the information presented.

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1 Burke J, Matthew RG, Field M, Lloyd D. Students validate problem based learning. *BMJ* 2006;332:365. (11 February.)
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Chlamydia is being managed in primary care

Editor—Cassell et al described the increasing role of general practice in the diagnosis and treatment of sexually transmitted infections.[1] Chlamydia is the commonest sexually transmitted infection in the United Kingdom,[2] and we recently carried out a study investigating the management of cases of chlamydia diagnosed in primary care.

We looked at cases of *Chlamydia trachomatis* infection referred to a genitourinary medicine (GUM) clinic with a positive test from primary care. We assessed management before referral, including treatment given, contacts notified, and contacts treated. We then assessed additional benefits of referral, including additional diagnoses of sexually and non-sexually transmitted diseases, with additional contacts identified, notified, and treated.

The implications of inadequate management of chlamydia infection should not be underestimated. However, in our study most patients were treated appropriately before referral, and contact tracing had been initiated. Referral infrequently identified additional sexually transmitted diseases and led to few additional contacts being treated.

Cassell et al described the increasing engagement of general practitioners with sexual health. We have shown that, at least in our area, general practitioners are successfully managing chlamydia infection. GUM clinics are experiencing severe workload problems,[3] and in view of the implications for cost, clinics' waiting times and inconvenience to clients, routine referral of cases of chlamydia to genitourinary medicine may no longer have a place.

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1 Cassell JA, Mercer CH, Sutcliffe L, Petersen P, Islam A, Brook MG, et al. Trends in sexually transmitted infections in general practice 1990-2000: population based study using data from the UK general practice research database. *BMJ* 2006;332:332-4. (11 February.)
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Cuba: better care for stroke

Editor—Stroke is the third leading cause of death in Cuba. The age adjusted mortality in 2003 was 43% lower than in 1970. Rates fell moderately in 1970-9 (2.8% per year), slightly over the following two decades (0.15% per year), and more rapidly in 2000 (3.5% per year).[1] This pattern shows that the impact of high rates of treatment and control of high blood pressure is just now being seen.[1,2]

Hospital admission rates for stroke doubled in 1990-2003 in Cienfuegos, Cuba's showcase for control of cardiovascular disease, while case fatality rates fell by 48%. This trend probably reflects a combination of the increasing average age of the population, improvements in ascertainment and referral of cases, less severe cases being admitted, and better quality of care.

Following the lessons learnt from the approach to acute myocardial infarction that was applied in Cienfuegos,[3] we implemented the fast track treatment to stroke approach, whose 10 components all start with the word early: awareness of the warning signs, medical contact, life support, referral, treatment in the emergency department, brain imaging, admission to the stroke unit, rehabilitation, education for patients and carers, and secondary prevention. Such patients are identified with a red code in the emergency department, and almost all of them are admitted to the stroke unit. Rehabilitation starts during the acute phase of stroke and continues after discharge, in community rehabilitation, where patients are followed up by their family doctor.

Although tertiary medical facilities lack the amenities and technology found in industrialised countries, Cuba emphasises the capability of its health system to coordinate the efforts of stakeholders to provide better care for stroke—just as Jenkinson and Ford suggest.[4]

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1 Cooper RS, Ordúñez P, Iraola-Ferrer M, Bernal JL, Espinosa A. Cardiovascular disease and associated risk factors in Cuba: Prospects for prevention and control. *Am J Public Health* 2006;96:94-101.
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A mnemonic for depression

Editor—Minerva described the mnemonic SIGECAPS, which is used to diagnose depression in the USA).[1] An improved version was suggested: C GASP DIE.[2] Obviously the value and memorability of these exercises depends on the effort each person puts into it. I thought it would be simpler to create a mnemonic in which the 10 letters of the word depression represent its 10 symptoms as described in the 10th edition of the *International Classification of Diseases*[3]:

D = Depressed mood
E = Energy loss/fatigue
P = Pleasure lost
R = Retardation or excitation
E = Eating changed—appetite/weight
S = Sleep changed
S = Suicidal thoughts
I = I'm a failure (loss of confidence)
O = Only me to blame (guilt)
N = No concentration

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1 Minerva. *BMJ* 2006;332:372. (11 February.)
2 Abraham PF, Shirley ER. New mnemonic for depressive symptoms. *Am J Psychiatry* 2006;163:329-30.
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Intrapleural streptokinase for pleural infection

EDITOR—In their editorial on intrapleural streptokinase for pleural infection Bouros and Light raise several points about the results of the MIST1 trial.[1 2]

They say that a treatment effect may have been overlooked since MIST1 enrolled a representative population of patients with pleural infection, including those with late "organised" disease. The analysis in the primary publication describing our trial result shows that this is not true.[2] In the online data repository, a subgroup analysis in 208 patients with a presentation history of less than 14 days (a sample about five times larger than any previous trial) in whom late stage disease is unlikely showed there was no treatment effect.

Data showing that streptokinase is unlikely to have had a therapeutic effect in the subgroup of patients with early loculated empyema is also presented in the online data repository.[2] No evidence of any treatment benefit was found in 318 patients with unequivocally loculated pleural fluid on chest radiography.

Our patients were not unrepresentatively old. The mean age of patients in the MIST1 trial was 60, which is in the range reported previously.[3–5]

The prevalence of comorbidity in MIST1 does not imply a particularly frail population. Many of the comorbid diseases are minor (such as gastro-oesophageal reflux). A high prevalence of such symptoms is related to the care taken to describe the population accurately.

Both large and small chest tubes were used at the doctor's discretion. Which tube size was used did not predict outcome (unpublished data). An adequately powered, randomised trial is required to assess whether image guided chest tube insertion leads to better outcomes.

Patients were referred for surgery using the same criteria as outlined in the previous small (31 patients) trial.[5]

The overall result of MIST1 showed no evidence of a benefit from intrapleural streptokinase. If there are benefits in one substantial subgroup, there must be commensurate disadvantages in other subgroups to produce the overall trial result. Thus streptokinase should not be used for empyema for any subset of patients without well executed randomised trials defining patients who will benefit.

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5 Bouros D, Schiza, Tzanakis N, Chalkiadakis G, Drositis J, Siafakas N. Intrapleural urokinase versus normal saline in the treatment of complicated parapneumonic effusions and empyema. *Am J Resp Crit Care Med* 1999;159:37-42.

Secondary care is not evil

EDITOR—Although secondary care has come to expect hospital and consultant bashing as a government pastime, it is disappointing that the *BMJ*, under the editorial by Lewis,[1] follows the party line. It is not secondary care that drives unscheduled activity but patients. Hospitals are not "sucking" funds from primary care in some grotesque saprophytic manner. The opposite is true in practice.

Secondary care trusts, through emergency care networks, have been attempting various admission avoidance strategies to reduce the excessive demands placed on emergency admissions areas and accident and emergency departments. The *NHS in England Operating Framework 2006-7* sets a differential payment by results tariff for emergency care above 2004-5 (+3.2%) rates of only 50%.[2] Not only will primary care trusts and the government get emergency care on the cheap, but the editorial implies that secondary care trusts should be being punished in this way for meeting the demands that patients and primary care place on them. Apparently, like leeches, secondary care has been looking for financial incentives to increase emergency admissions.[1]

I believe that the NHS is on the critical list and am becoming disillusioned by the lack of understanding that the Department of Health has with regard to provision of patient care and services. The privatisation of primary care and elective care will leave the expensive care for complicated patients to hospitals that have been financially starved and downsized, but by that stage they will be incapable of providing such services.

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Competing interests: None declared.

1 Lewis RQ. A new direction for NHS community services. *BMJ* 2006;332:315-6. (11 February.)
2 Department of Health. *The NHS in England: the operating framework for 2006/7*. London: DH, 2006.

No easy solutions for frequent hospital attendances

EDITOR—Hitchen writes that a partnership between the NHS's Health and Social Care Information Centre and the health research company Dr Foster will publish data on patients who repeatedly use hospital services.[1]

Professionally, I know that some community health services can help prevent admission to hospital. But, as the King's Fund report on predicting hospital admissions showed, it is not easy to predict which of these patients will be admitted again in the next 12 months.[2] As a result, although community support will be potentially beneficial, it is not a quick fix that can be targeted directly to the right patients. A substantial part of the cost of community support will go on patients who would not be back in hospital this year.

I would not begrudge them support, but we must beware of assuming that big savings can be made or lots of hospital beds freed up. If community support is targeted carefully, it will have a small effect. If it is provided more widely, it will have a greater effect at a much greater cost and a larger proportion of the costs will go on patients who would not have gone into hospital anyway. The King's Fund shows that, even on moderately optimistic estimates, community support programmes might make only a limited impact on the rising tide of acute admissions to hospital.

Personally, I know, from telephone calls late at night, of the fear of someone who is frail, chronically ill, and deteriorating rapidly. In those hours, only the ambulance services and hospitals are open to provide much needed relief, from fear as much as from illness or symptoms. Community support can reduce problems and improve self management. But unless there are also round the clock flying squads of home nurses, with personal general practitioners who have the patient's confidence also available, many chronically ill patients will continue to see hospital as a place of safety for a while, until they can cope at home again, rather than an "inappropriate" place for their care.

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Competing interests: YHEC is a contract research company providing research services to the NHS, DH, and to the pharmaceutical industry. No conflict has been identified on repeat admissions to hospital.

1 Hitchen L. Partnership publishes data on patients who repeatedly use hospital services. *BMJ* 2006;332:384. (18 February.)
2 King's Fund. Predictive risk project. News update, 1 February 2006. www.kingsfund.org.uk/health_topics/patients_at_risk/predictive_risk.html (accessed 24 Feb 2006.)