for it. This is an important message of hope.

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[The book reviewer responds:]

Two of Joseph Beitchman's assumptions with respect to my book review, "Berries for Brains," are particularly striking: first, that I "missed the point" of berry-picking as a way of "connecting" and, second, that I do not accept the reality of mental illness in children.

Of course mental illness in children exists; it can in any one of us. And the experiences of Fish can be early signs of it, too. They can also be signs of nutritional deficiencies, a strong need for physical exercise, or an unsupportive learning environment, to name a few examples. A responsible book about mental health in children ought to question more than one of these possibilities.

Likewise, berry-picking (or fishing) can be a way for people to connect. *Catch A Falling Star*, though, clearly suggests otherwise: it "exercises brain parts?" Would we suggest this in all seriousness to a respected peer?

There are other components to Beitchman's argument that I must challenge. One is his use of the word "symptoms," which suggests anticipation of oncoming disease and denies the reality that young minds are vulnerable to what we expect. Another is the idea that children suffering from mental illness have no idea why they feel the way they do. I dare say this supposition underestimates the inner resources of children.

Beitchman states there are no simple prescriptions. Ironically, this was part of the point my review was making. We do no service to children by teaching them that healthy minds are as simple as happy trips to special doctors; to the contrary. And although I agree that messages of hope are paramount, what inspires hope is highly subjective. There'll be more than a "small group of children" reading this book, many of which may not find the idea of a "sick brain" very encouraging.

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Opt-out prenatal HIV testing in Newfoundland and Labrador

We read with interest the conclusions of a recent research letter by Ari Bitnun and coauthors[1] and the supporting commentary by Kathleen Steel O'Connor and Susan MacDonald.[2] Although we concur with the recommendation for prenatal HIV screening on an opt-out basis, both articles seem to imply that this is not being offered in Canada. In fact, Newfoundland and Labrador was the first province in the country to recommend routine prenatal HIV testing in 1992 and also to introduce it on an opt-out basis in 1997.

Based on a province-wide anonymous prenatal HIV prevalence study,[3] in 1992 the Department of Health recommended that HIV testing be considered as part of routine prenatal care. During 1993, it was estimated that nearly half of pregnant women in the province underwent HIV testing, rising subsequently to two-thirds. A second prevalence study in 1996 indicated that HIV testing done on a voluntary basis might not include all those at risk for HIV. Consequently, in 1997 HIV testing was introduced across the province on an opt-out basis (long before such a recommendation was made by the US Institute of Medicine[4]). Currently, 94% of pregnant women are being screened for HIV status (internal data).

Since 1992, our prenatal screening program has identified a few HIV-positive pregnant women, with no cases of vertically transmitted HIV infection in children born after 1994. However, our province has a low HIV prevalence; therefore, prenatal screening on an opt-out basis may be more effective and beneficial in populations with a higher prevalence.

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[The authors of the commentary respond:]

Although we thank Christa Mossman and Samuel Ratnam for their response to our commentary,[1] we feel that we did not imply that opt-out screening is not being done in Canada. In fact, we used statistics from Alberta as an example of the increased rates of screening that can be achieved if an opt-out approach is taken.

We have found policy to be a crucial determinant of screening. In the report of our 1997/98 national survey of physicians, we showed that the highest proportion of physicians reporting that they "always or almost always" screened for HIV in pregnancy were those practising in Newfoundland, the only province which then had a policy of routine screening with an opt-out option.[2] Indeed, based on the experiences of Newfoundland and Alberta, we believe that routine screening with the

option to opt out would achieve the highest rates of screening while preserving the right of the individual to refuse an HIV test.

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Disclosure in research ethics

The issue of disclosure of decisions made by research ethics boards (REBs) is worthy of extended debate.[1] The US Food and Drug Administration (FDA) is soliciting public comments concerning the issue of institutional review board (IRB) "shopping" in anticipation of formulating a rule to address this issue.[2]

Disclosure of REB decisions should be made public through mandatory registration of trials in a publicly accessible register. In the US, for example, trial registration may involve Web-accessable registers such as www.clinicaltrials.gov. This kind of register should contain a hyperlink to a page where REB decisions would be recorded.

If the decision of an REB is one of disapproval, it should provide the reasons for the decision in one or more of the following categories: social and scientific value, scientific validity, fair subject selection, favourable risk–benefit ratio, informed consent and respect for potential and enrolled participants.[3] Entries in a category may be limited to a specified number of words.

Accessible information will enable REBs to consider the decisions of other committees at the time of initial or continuing review of clinical trial protocols, and such disclosure will also serve the interests of potential trial participants and the general public. The case for trial registration has been summarized by Tonks.[4]

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[The author responds:]

Howard Mann's reply to my article[1] contributes to the discussion about IRB "shopping," and his ideas are very intriguing. His argument in favour of public access is important, but I wonder if the system should be fully publicly available.

Whatever mechanism Canada adopts in creating a centralized REB system, I believe it must be based on promotion of the public's interest, including the protection of our country's involvement in international pharmaceutical trials. Our national regulatory authority, Health Canada's Therapeutic Products Directorate, will need to determine if a trial registry with mandatory public disclosure rules, as opposed to more limited mandatory disclosures among REBs, will negatively influence decisions to proceed with trials. Issues of intellectual property will likely be raised and may reduce Canadian trial activity, thereby influencing the number and kinds of pharmaceutical drugs or devices available in the longer term.

If mandatory public disclosure would reduce Canada's involvement in trials, then we may want to concentrate our efforts on other mechanisms to protect the public interest with respect to the conduct of clinical trials.

That being said, if the FDA were to legislate the system described by Mann, smaller countries with less market share potential would find it easier to adopt a similar system; such an action by the FDA would probably influence sponsors' acceptance of that regulatory practice. Given that international pharmaceutical trials often involve both the US and Canada, sponsors would likely accept harmonized regulatory practices with respect to public disclosure.

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1. Ferris LE. Industry-sponsored pharmaceutical trials and research ethics boards: Are they cloaked in too much secrecy? *CMAJ* 2002;166 (10):1279-80.

Breast is best for more than 6 months

The trial reported by Cindy-Lee Dennis and coauthors[1] will undoubtedly help clinicians and public health professionals to choose effective interventions to prolong the duration of breast-feeding. Nevertheless, we would like to provide a clarification regarding the authors' advice, which is based on recommendations of the Canadian Paediatric Society (CPS)[2] and the American Academy of Pediatrics (AAP)[3]

In 1998, the CPS, Dietitians of Canada and Health Canada recommended that "breastfeeding may continue for up to 2 years of age and beyond."[4] The AAP[3] recommends that breast-feeding "continue for at least 12 months, and thereafter for as long as mutually desired." Nowhere in these recommendations is there a suggestion that breast-feeding should last only 6 months. *Exclusive* breast-feeding is rec-