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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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-

ommended by most experts[3,5-7] for the first 6 months of life.

If we want families to make informed decisions about their infant feeding methods, it is important that physicians understand (and communicate) that breast-feeding for only 6 months is not recommended.

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[One of the authors responds:]

We are fully aware of the breast-feeding recommendations presented by the CPS and the AAP. In fact, these recommendations provided in large measure the impetus for our breast-feeding peer support trial.[1] Clearly, exclusive breast-feeding is preferred over formula feeding for the initial 6 months postpartum.

Notwithstanding our agreement on this point, the sentence referenced was intended to express the equally important point that in North America we are not even close to achieving these breast-feeding recommendations: most Canadian and American mothers do not breast-feed at 6 months postpartum, much less exclusively. Furthermore, practising physicians should understand that most mothers discontinue breast-feeding prematurely because of practical difficulties, not because they choose to do so based on recommendations for optimal breast-feeding duration.[2] We hope that by conducting a methodologically rigorous trial we have aided physicians in their ability to provide evidence-based care. We also hope they will counsel their patients about options for overcoming breast-feeding difficulties to achieve infant-feeding goals, goals which are often developed before the mother becomes pregnant and enters the formal health care system.[2]

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Apology

Canadians may well have 2 national sports: hockey and debating health care issues. In hockey, it is often better to play the body, not the puck. But, in debate, a guiding principle of our editorial processes at *CMAJ* is that discourse should be conducted fairly and impersonally. Our intention is to referee the exchange of opinion in a way that allows ideas to stand or fall on their own merit, without recourse to *ad hominem* arguments or the imputation of motive.

We recently published a commentary[1] in which a passing remark from an article published 5 years ago is cited unfairly and out of context. Until we reviewed the replays, we didn't notice that one colleague had thrown an elbow at another. Our oversight was substandard in this instance. We apologize to Dr. C. David Naylor.

John Hoey
Anne Marie Todkill
CMAJ

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From the penalty box

One of the saddest things that can occur, in science as well as sport, is to unintentionally hurt a teammate and friend through carelessness. In writing my commentary[1] I just plain and simply didn't do a good enough job to distinguish my criticism of the unnamed "experts" from my reporting of what David Naylor wrote he was telling his patients in 1997. By singling out a colleague who has himself been a proponent of a more evidence-based and cautious approach to clinical preventive medicine and who later coauthored a study identifying new side effects of hormone replacement therapy in postmenopausal women,[2] I made a dumb mistake. So let me make it clear: I hold David Naylor in the highest regard, never intended my criticism of the experts to apply to him and regret any misinterpretation to the contrary.

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