

These issues identify 3 specific classes or categories of “actors” — care providers and institutions; research funding agencies; and care governance and funding bodies — that would be required to revise their current operations for a *CMAJ*-type editorial policy to make sense.

We recognize that we are offering these observations unencumbered by any evidence on institutions’ actual views on these matters. We need data from a survey of institutional and care-provider attitudes toward revealing their identities in the context of prospective research studies that address clinical or organizational management practices. To what extent would widespread implementation of the *CMAJ* editorial position simply choke off researchers’ access to the only settings in which publicly accountable performance measures can be validated and the data collected? Perhaps this is all a “storm in a teacup,” and most institutions and providers would already be comfortable participating even with the understanding that they would be identified. But we suspect not.

We offer these thoughts as part of the debate on the important issues that your commentary raises and in the hope that some of the practical issues will be addressed soon. In the interim, neither CHSRF nor CIHR is planning to introduce a new “non-anonymity” condition on funding, at least in situations where a major part of a research project is development and validation of new measures, or the application of existing instruments in new contexts or for new purposes.

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Reference

1. Hoey J, Todkill AM, Flegel K. What’s in a name? Reporting data from public institutions [editorial]. *CMAJ* 2002;166(2):193-4.

[The editors respond:]

We still don’t understand how public health care institutions can be “transparent and accountable” and at the same time anonymous. Our editorial view is that data on publicly funded health care institutions should be available not only to researchers and regulators, but also to the public. We see no inconsistency between our claims that the public may be interested to know the track records of specific institutions and is capable of interpreting such information in a reasonable way. Rarely is the public interest served by the suppression of information, although in our commentary we allow for exceptions to our policy on disclosure where “there is a clear and demonstrable potential for net harm.”

We agree with Shoo Lee and colleagues and with Jonathan Lomas and Morris Barer that studies of the validity of measures used to compare institutions need not reveal the names of the institutions (perhaps ever). The aim of such studies is the measuring stick, not the measured. Further, as Lomas and Barer rightly state, journals must respect existing agreements and “grandfather” such papers. (As we did.)

But what about the future? If anonymity of our public institutions derives from the patronizing attitudes of some of our health care facilities and professionals, then those attitudes need to change. Lomas and Barer are right that we need some data. But we need this data not just on provider and institutional attitudes, but also on what the public wants.

Lastly, we understand the reluctance of the directors of 2 key institutions “to introduce a new ‘non-anonymity’ condition on funding”: They are near the front lines and want to encourage, not discourage research. But they should also take the lead and publicly promote more public disclosure among our institutions and funding agencies so that non-anonymity becomes the rule rather than the exception. Perhaps their letter is a start.

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Mercury in seafood

I am writing to alert physicians to a common but infrequently considered source of mercury.

I recently saw a young woman who was referred to me because of high levels of blood mercury. The patient, who was 26 years old, had been diagnosed with multiple sclerosis (by MRI) following a bout of optic neuritis and peripheral neuropathy, both of which resolved spontaneously. Yet because of her interest in a possible correlation between mercury levels and dental fillings, she had asked her family physician to measure her blood mercury level. The result, 63 nmol/L, was markedly elevated (normal 0 to 49 nmol/L). However, several case-control studies have failed to find a relationship between dental amalgams and development of multiple sclerosis.¹⁻³

On examination she appeared well and physical examination was entirely within normal limits.

Past medical history revealed a childhood exposure to mercury brought home by her father, who was a dentist, and more recently to a broken mercury-containing thermostat in her apartment. (Mercury poisoning has resulted from exposure to devices that contain mercury such as sphygmomanometers.⁴)

The patient lived with her mother and both women worked at a local hotel. There had been recent renovations to interior of their apartment including replacement of drywall. The building was 35 years old. She had no unusual hobbies that might have exposed her to mercury. Both she and her mother consumed health food supplements. Her mother’s levels of blood mercury were normal.

Further questioning revealed that both the patient and her boyfriend enjoyed sushi and other seafood, eating out at restaurants 4 to 5 times a week. Her boyfriend, aged 22, had a blood mercury level that was elevated (59 nmol/L).

It has been widely publicized that larger fish such as shark, swordfish and fresh or frozen tuna contain high levels of mercury. A recent report revealed that in 10 of 11 patients referred to an occupational health referral clinic in the US