of weight gain. Under Assess, we specified to conduct clinical and laboratory investigations for comorbidities and to treat comorbidities and other health risks, if present. Also, in the introduction section, we mentioned multiple reasons for obesity, but we decided to limit our discussion to the principal cause being a positive energy balance secondary to an excess intake of calories and/or with low energy expenditure. More information about other "root causes" of obesity and how they should be approached is available.[3]

Gilles Plourde MD PhD
Denis Prud'homme MD MSc
Drug Safety Unit — Director's Office (Plourde), Centre for Evaluation of Radiopharmaceuticals and Biotherapeutics, Biologic and Genetic Therapies Directorate, Health Canada, Ottawa, Ont.; the School of Human Kinetics (Prud'homme), Faculty of Health Sciences, University of Ottawa, Ottawa, Ont.; and Médicine du sport (Prud'homme), Gatineau, Que.

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Contrasting coroners

The research article by Walter and colleagues[1] highlights the work of coroners, but the results are not generalizable to Canada, or Ontario, in particular.

The authors did not attempt to analyze factors predicting coroners' decisions outside of Australia. In contrast, coroners in Australia are barristers, whereas coroners in Ontario are physicians. This is one reason why Ontario's inquest data differ significantly from those of Walter and colleagues.[1]

Ontario conducts fewer inquests than Australia per year and per capita. Ontario's system reviews all investigated deaths for potential inquest, guided by a structured review process and the Ontario Coroners Act. A discretionary inquest may be called where a coroner's jury may be able to render a verdict that could not be reached by investigation alone; where the jury could make previously unappreciated recommendations; and/or where the public interest may be served via a public hearing. However, the relative merits must be carefully considered in each case.

The Office of the Chief Coroner[2] keeps data on a number of aspects of inquests. Each year from 2000 to 2009, an average of 70 inquests were held in Ontario (59 mandatory and 11 discretionary inquests), providing an average of 493 recommendations per year (unpublished data). In contrast to Australia, Ontario conducts few inquests into pediatric deaths or those due to complications of medical care. Lay juries are challenged by complex medical issues. Hence, such matters are best dealt with by multidisciplinary expert review committees, individual case-based recommendations or regional coroner reviews.

Physician coroners allow for more efficient inquests by applying medical knowledge. Death investigation, in our view, is and ought to be based in medicine supplemented by the law.

Andrew L. McCallum MD, Albert E. Lauwers MD, Daniel E. Cass MD, Michael Blain LLB
Chief Coroner for Ontario (McCallum); Deputy Chief Coroner for Ontario (Lauwers); Regional Supervising Coroner (Cass); and Chief Counsel, Office of the Chief Coroner for Ontario (Blain), Toronto, Ont.

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The authors respond

McCallum and colleagues point out that coroners in Ontario are physicians, whereas those in Australia are lawyers.[1] Our understanding is that the physician-only model operates in some Canadian provinces (e.g., Alberta, Manitoba and Ontario) but not in others (e.g., Quebec, British Columbia and Saskatchewan). In any case, we would readily concede that specific findings from our analysis of characteristics of deaths that are disproportionately more and less likely to reach inquest in Australia[2] may not be directly generalizable to Canada.

The more important issue, however, is whether the questions about coronial practice our research poses have salience in Canada and other international settings. We believe they do. As McCallum and coauthors indicate, decisions by Ontarian coroners about which cases to take to inquest are the product of a series of subjective determinations.[1] Understanding what body of public death investigations those determinations produce, and whether and how it differs from the broader body of deaths coroners investigate, is worthwhile. Inquests are both a springboard for recommendations and an important influence on the public's understanding of untimely death. Indeed, subjecting coroners' cases to the kind of epidemiologic analysis our paper presents may be especially useful in a jurisdiction like Ontario, where inquest rates are relatively low and the vetting process is extremely selective.

Simon J. Walter LLB BSc, David M. Studdert LLB ScD
The Melbourne School of Population Health (Walter, Studdert); and Melbourne Law School (Studdert), University of Melbourne, Parkville, Australia

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Letters to the editor

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