

# Print Media Coverage on the Lana Dale Lewis Inquest Verdict: Exaggerated Claims or Accurate Reporting?

*Hina Laeeque & Heather Boon<sup>1</sup>*

## **Introduction**

In a 1998 national study, forty-six percent of Canadians said they read daily newspapers as a major source of information.<sup>2</sup> Sixty-one percent of respondents also claimed that they would like to see more reporting on health issues. In the United States, fifty-eight percent of people surveyed said they have changed their behaviour due to a health-related story covered in the media.<sup>3</sup> Therefore, newspaper reports that examine health issues might affect the perceptions and behaviours of Canadians and Americans.

From 1999 to 2004, newspapers across Canada covered the coroner's inquest into the death of Lana Dale Lewis, who suffered a fatal stroke in Toronto, Ontario on September 12, 1996. The Lewis family, convinced that the stroke was caused by a chiropractic neck adjustment, requested an inquest into the death. The Office of the Chief Coroner for Ontario, the agency responsible for administering the inquest, states that the purpose of an inquest is to determine the circumstances of a death. The purpose of this article is to examine how the print media portrayed the verdict in the Lewis inquest. Although the majority of newspaper articles accurately describe the conclusions of the Lewis inquest, some articles focus on blaming the cause of death on the chiropractic adjustment. This article argues that inaccurate media reports on the verdict undermine the purpose of the Lewis inquest and others like it. The lack of clarity in these

reports likely resulted from the vague definition of the purpose of inquests provided by the Office of the Chief Coroner for Ontario.

This article is divided into six main sections. Section 1 describes the nature of inquests in Ontario and compares this with other Canadian provinces and territories. Section 2 describes the Lewis inquest, including the reasons for calling the inquest and a description of the proceedings and findings. Section 3 explains how relevant newspaper articles about the inquest were identified. Sections 4 and 5 examine print media coverage on the verdict. Section 4 provides examples of accurate and complete coverage, whereas Section 5 provides examples of inaccurate coverage of the verdict. Section 6 discusses findings of the print media analysis. The article concludes with recommendations that may help coroners' offices improve their capacity to disseminate accurate information of an inquest verdict.

## **Section 1: Nature of Inquests in Ontario**

The Office of the Chief Coroner for Ontario (Coroner's Office), a division of the Ministry of Safety and Correctional Services, carries out inquests under authority of the provincial *Coroners Act*.<sup>4</sup> The *Coroners Act* defines the nature of inquests, including the purpose and conclusions of



an inquest. An inquest is an investigation into the death of an individual in the community, which is open to the public. The purpose of an inquest is fourfold: first, to determine the identity of the deceased and how, when, where and by what means the deceased died.<sup>5</sup> Secondly, an inquest directs public attention to a death that could have been prevented. Thirdly, an inquest allows the concerned parties to respond to the inquest findings. Fourthly, an inquest should correct misinformation disseminated to the public about a death. Thus, the main focus of an inquest is to consider the circumstances of the death in question while informing the public about the death.

In Ontario, the Coroner's jury can offer only a one- or two-word response at the conclusion of the inquest. The jury must decide that the death in question is a result of an accident, natural causes, undetermined, suicide or a homicide. Neither the Coroner's Office website<sup>6</sup> nor the *Coroners Act*<sup>7</sup> defines these terms explicitly. According to a Coroner's Office representative, an accident is "an incident or event that happens without foresight or expectation." Natural causes were defined as "death due to life course."<sup>8</sup> An undetermined death means that the death in question does not fit the definitions of the other four outcomes or that inconclusive evidence was presented at the inquest. The response options given to the jury is meant to sufficiently and conclusively describe the manner in which an individual came to his or her death.

By limiting the outcomes of an inquest to one of five terms, a jury cannot lay blame or legal responsibility of a death on an individual or organization.<sup>9</sup> On the other hand, the limitation may stifle the jury's ability to accurately depict what caused the death in certain circumstances. In addition to reaching a conclusion about the means by which the death occurred, the jury may also offer recommendations to specific agencies that may help prevent future deaths. By this means, the Coroner's Office aims to fulfill its mandate to "speak for the dead to protect the living."<sup>10</sup>

The nature of inquests in the provinces and territories of Canada varies significantly with respect to the administrator, the authorizing legislation and who offers the recommendations, if any, at the conclusion of the inquest. Inquests may be administered by agencies other than the Coroner's Office, such as the Office of the Chief Medical Examiner

(Alberta, Manitoba, and Nova Scotia) or the Department of Justice (Newfoundland). The legislation governing the manner in which a coroner or medical examiner should carry out inquests varies across the country because it is province- or territory-specific. For example, the *Coroners Act*, provides the authority to administer inquests in British Columbia,<sup>11</sup> Northwest Territories<sup>12</sup> and Ontario, whereas Manitoba<sup>13</sup> and Alberta<sup>14</sup> follow the *Fatality Inquiries Act*.

*From its inception, the Lewis inquest was entrenched in media speculation and political warfare.*

The Coroner's jury differs in size depending on the legislation of the province and is limited to the five terms specifying the manner of death described above in Saskatchewan<sup>15</sup> and British Columbia.<sup>16</sup> In other provinces (such as Manitoba

and Alberta),<sup>17</sup> no jury is summoned for the inquest. Rather, a judge witnesses the evidence presented during the investigation and may provide recommendations in a final report on how to prevent future deaths.

Although significant differences exist in how an inquest is conducted and concluded, the purpose of an inquest in the different provinces and territories is identical to that of Ontario. That is, an inquest is performed to investigate the circumstances of a death and determine how, when, where and by what means an individual came to his or her death. Furthermore, all legislation regarding the conduct of coroners/medical officers and inquests states that legal culpability cannot be assigned to an individual or organization during an inquest. Since different Canadian jurisdictions undertake inquests with a similar mandate, the Lewis Inquest can provide lessons for the administering agencies of all provinces and territories.

## **Section 2: Background on the Lana Dale Lewis Inquest**

### **I. Summons for an Inquest into the Death of Lana Dale Lewis**

From its inception, the Lewis inquest was entrenched in media speculation and political warfare. The Lewis family requested the Regional Coroner for Toronto, Dr. William Lucas, to conduct an inquest on two occasions.<sup>18</sup> The request was denied on both occasions, in December 1996 and January 2000. However, in April 2002, the Chief Coro-



ner of Ontario, Dr. James Young, overruled the original decision and announced an inquest would be held to investigate Lewis' death. Print media extensively covered this unprecedented move by Dr. Young. In the *Coroners Act* of Ontario, the Chief Coroner of the province may overrule the decision of a Regional Coroner.<sup>19</sup> Unlike the Regional Coroner, the Chief Coroner need not provide a reason for the decision. Thus, the Chief Coroner has an enormous amount of discretion to decide whether an inquest should be held. Furthermore, the decision of a Chief Coroner is final.<sup>20</sup>

Since the motive behind Dr. Young's announcement is unknown to the public, journalists and others speculated why the first two decisions were overruled. Some journalists suggested statements made by chiropractic associations in the media after the 1996 and 2000 decisions may have provoked the Chief Coroner's review. For example, Canadian chiropractors claimed that the decision not to hold an inquest to investigate the death of Lewis implied that the neck manipulation was not a factor in her death.<sup>21</sup> Other writers, including the executive directors of the Canadian Chiropractic Protection Agency (CCPA) and the Canadian Chiropractic Association (CCA), claimed that the inquest was announced as a deliberate attempt by opponents of chiropractors to prevent any affiliation of Canadian Memorial Chiropractic College (CMCC) with York University.<sup>22</sup> Some academics at York University felt that an affiliation of the two schools would damage York University's reputation as a scientific institution. Thus, the commencement of the Lewis inquest may have had little to do with investigating the circumstance of the death and more to do with politics.

## II. Description of the Lewis Inquest

The parties attending the Lewis inquest included members of the Lewis family, the CMCC, the CCA, the Coroner's Office, and Dr. Philip Emanuele, the chiropractor who had performed the adjustment on Lewis.<sup>23</sup> For twenty months, the longest inquest in Ontario's history, the jury considered over 240 pieces of evidence and testimony from twenty international expert witnesses.<sup>24</sup> The evidence and testimonials centred on the association of chiropractic manipulations of the cervical spine with the risk of vertebral artery dissection. Many of the expert witnesses, including physi-

cians and chiropractors, presented conflicting opinions regarding the scientific issues concerning cervical manipulations.

## III. Findings of the Lewis Inquest

On January 16, 2004 the verdict of the Coroner's jury was death by means of an accident.<sup>25</sup> The jury offered seventeen recommendations to several agencies, including the Coroner's Office, the Ministry of Health and Long-Term Care, CMCC, the College of Chiropractic Regulatory Body and the CCA. Many of the recommendations concerned the practice of chiropractors; such as the creation of a standard consent form, accurate record-keeping of chiropractic treatments and further research into the risk of stroke and cervical manipulations. From the planning to concluding stages of the inquest, the investigation focussed on chiropractic adjustments rather than on the death in question.

## Section 3: Methods for Identifying Relevant Newspaper Reports

English-language newspaper articles on the Lana Dale Lewis Inquest were retrieved from various sources. A search for "Lana Dale Lewis" on *Factiva* identified 199 articles.<sup>26</sup> Thirty-eight newspaper articles were collected from the CMCC archived library, which contains a media tracking system for articles up to the present year. Lastly, two articles were found from a search for "Lana Dale Lewis inquest" and "Lewis inquest" on the *google.ca* website. These searches resulted in a total of 239 articles commenting on the Lewis inquest (Table 1). Since this paper focuses on the newspaper coverage of the inquest verdict, only articles printed on or after January 16, 2004 to May 4, 2004 were included in the study. Forty-four articles were analyzed for their coverage of the inquest verdict. Of these forty-four articles, twenty-seven were copies of the same article written by the Canadian Press (CP) under different headings.

The articles were coded by two independent reviewers and a third if the two reviewers did not agree. An article was coded as complete and accurate if it included all three of the fol-

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lowing: the jury's verdict, explanation that inquests in Ontario cannot assign blame to a person, and a listing of the five possible outcomes of an inquest. These three statements are necessary to inform the public about the purpose and outcome of an inquest. An article was categorized as inaccurate and/or incomplete if it: did not contain statements about the inquest verdict of accidental finding; or lay blame on the adjustment or the chiropractor; or did not mention the five possible outcomes of an inquest. Articles were also called incomplete if they did not contain all three statements necessary to be defined as accurate.

## **Section 4: Accurate Newspaper Reports on the Lewis Inquest Verdict**

Out of the forty-four articles, thirty-nine (89%) described the Lewis inquest in a complete and accurate manner (Table 2). Since twenty-seven of the articles are repeated publications from the Canadian Press (CP), seventy-two percent (13/18) of the unique articles are accurate based on the defined criteria.

### **I. Coverage on the Accidental Death Finding**

In the case of the Lewis inquest, the jury and Coroner were aware of who the deceased was, and how, when and where the deceased came to her death. The jury was expected to find *by what means* Lewis died. From the inquest proceedings, it was evident that the likely conclusion would be an accident, natural causes or undetermined death (not suicide or homicide). Accordingly, the most important aspect of media coverage on the inquest is how the media reported the jury's verdict; that is, how journalists report and interpret death by means of an "accident."

Sixty-one percent (27/44) of newspapers on the Lewis inquest were the same article written by the CP. For these twenty-seven articles, the CP explains the verdict of the inquest as: "The death of a factory worker who suffered a fatal stroke in 1996 after having her neck manipulated by a chiropractor was ruled Friday as accidental and not due to natural causes."<sup>27</sup> Although this statement says the conclusion of the inquest was an accidental death, the statement also implies that the chiropractic adjustment had some role in the death by stating that the death occurred after a neck manipulation. However, since the statement does not draw a direct link between the adjustment and the stroke, the statement is fairly accurate. Due to the limited nature of the

inquest, the manipulation cannot be stated as the cause of the death.

One article reported the verdict as "a Toronto woman's fatal stroke was accidental, thus suggesting the upper neck adjustment she received was to blame for her death."<sup>28</sup> This statement says that the death was a result of an accident and that the chiropractic adjustment is linked to the death. The interpretation is valid, given the recommendations provided by the jury. This report is accurate because the author distinguishes the jury's verdict from his own interpretation of the results by using the word "suggesting" in the statement.

### **II. The Reason that Laying Blame is Not Permitted in a Coroner's Inquest**

Since the *Coroners Act* clearly states that an inquest does not place legal blame on a person<sup>29</sup> nor is any individual on trial, a distinguishing factor between accurate and inaccurate articles is whether the chiropractor is held responsible for the death. For example, one article states: "jurors in such cases are never asked to find blame."<sup>30</sup> The jury was reminded on the last day of the inquest, prior to determining their verdict, of their role and responsibilities. Hence, journalists who attended the last day of the inquest were aware that the jury could not conclude, under any circumstances, that the chiropractor was responsible for the death of Lewis.

In addition to the assertion that the inquest findings cannot lay blame on an individual, some reports also indicate that the chiropractic treatment cannot be blamed as the precipitating cause of the stroke suffered by Lewis. One article states that "inquest juries cannot assign blame and this one could not say directly that her treatment was responsible."<sup>31</sup> The author of this article is accurate in noting that the conclusions of the inquest could not find fault with the chiropractic treatment. Given that an inquest limits the determination of a death to specific outcomes and that the purpose of the inquest is to uncover the circumstances of the death, the chiropractic treatment is not under investigation in the inquest.

### **III. List the Five Possible Outcomes of an Inquest**

In order to adequately inform, educate and explain the inquest to the public, authors should mention the five possible outcomes of an inquest. The five terms are necessary because the findings of an inquest are significantly different from that of a legal trial. An individual or organization is not found guilty nor is fault attributed to the therapeutic treatment at the conclusion of a trial. At the same time, journal-



ists are unable to explain the meanings of the five terms because the Coroner's Office has not provided standard definitions for them. Thus, at best, journalists can state that a jury must decide whether the cause of death is accidental, homicide, suicide, undetermined or natural causes.<sup>32</sup> A phrase to this effect is included in seventy-two percent (13/18) of the reviewed unique articles.

## **Section 5: Examples of Incomplete and Inaccurate Coverage on the Lewis Inquest**

Excluding the CP articles, twenty-eight percent (5/18) of the reviewed articles meet the criteria of inaccurate and incomplete articles. The articles in this category make causal claims and portray the inquest as a battle among the involved parties, as described below.

### **I. Causal Statements in the Print Media Coverage of the Lewis Inquest Verdict**

A causal statement associating the death from a stroke and the chiropractic adjustment characterizes inaccurate articles. Twenty-eight percent (5/18) of articles included a causal statement (Table 2). For example, journalists for *The Hamilton Spectator* wrote that "a coroner's jury ruled that a 45-year old woman named Lana Dale Lewis died in 1996 as a result of a chiropractic upper-neck manipulation."<sup>33</sup> This was not the jury's conclusion, nor was it empowered to make such a finding. Similar statements of causation were written in three other national publications: *The Globe and Mail*,<sup>34</sup> *National Post*,<sup>35</sup> and *Canwest Global*.<sup>36</sup> Causal statements in these news providers are particularly disconcerting due to their vast readership across Canada.

### **II. Overall Tone of the Article**

Four newspapers depict the findings of the inquest as a victory for the Lewis family over chiropractors, rather than as investigative findings into a death. Authors Paul Benedetti and Wayne MacPhail say that chiropractors "lost" because the verdict found that the death was "accidental."<sup>37</sup> They also suggest that the inquest turned into a fight by the profes-

sion to maintain its legitimacy, rather than an inquiry into a death. In a *Canwest Global* article, the husband of Lana Lewis was reported to say: "This is the little guy fighting for all of the little guys and we're happy. We won."<sup>38</sup> The overall tone of these articles suggests the inquest was a battle between the Lewis family and chiropractors, more than an inquiry into a death.

### **III. Description of Headlines for Articles Describing the Lewis Inquest**

In addition to the inaccurate statements in newspaper articles, twenty-seven percent (12/44) of the reviewed articles contained inaccurate headlines (Table 3). These titles make dramatic claims, such as "Chiropractic procedure killed woman, inquest finds"<sup>39</sup> or "Chiropractic death ruled accidental."<sup>40</sup> Interestingly, the *Canadian Press* is the source for the text of these two articles. The CP articles were categorized as accurate from the above-mentioned criteria. However, the headlines of these articles are completely false and exaggerated. Furthermore, if the CP articles are excluded from the calculation of the number of inaccurate titles, the percentage of inaccurate titles almost doubles to forty-four percent (8/18) (Table 3).

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## **Section 6: Discussion and Recommendations**

### **I. Discussion**

The significant finding of this study is that seventy-two percent of Canadian newspaper articles on the verdict of the Lewis inquest are accurately written. These articles meet the criteria of mentioning the verdict of the inquest, listing the five possible outcomes of an inquest and commenting on the meaning of an "accidental death" without finding fault with the chiropractor or the treatment. This finding indicates that journalists are sensitive to the results and interpretation of a high-profile inquest. The high quality reporting on the Lewis case is similar to the findings of a study reviewing newspaper stories on genetic research. Bubela and Caulfield found that 62.7 percent of newspaper articles made no exag-



gerated claims about the findings of scientific genetic studies.<sup>41</sup>

The high percentage of accurate print media reports is particularly noteworthy due to the vague definition of “accidental death” provided by the Coroner’s Office. During closing remarks for the inquest, the Coroner’s Counsel instructed the jury on the meanings behind a finding of accidental death, natural causes or undetermined.<sup>42</sup> Accidental death is an appropriate finding if trauma caused the formation of a clot found in the vertebral artery, which subsequently caused a stroke. A finding of natural causes means the jury came to the consensus that Lewis died from complication of a disease, such as atherosclerosis. However, the Coroner’s Office states that death by natural causes might also be a result of trauma. In essence, the definition of accident and natural causes may be the same: death due to trauma. Demarcating a death due to an accident or natural causes thus is not clearly specified by the Coroner’s Office.

A second important finding of this study is the substantial number of sensationalised headlines. Twenty-seven percent (12/44) of the reviewed articles contained inaccurate headlines. The majority of these headlines were extremely exaggerated. The percentage of inaccurate headlines increases to forty-four percent (8/18) when the CP articles are removed from the calculations (Table 3). However, twenty-seven percent is more indicative than forty-four percent for the proportion of inaccurate headlines because many of the CP articles contain accurate headlines. That is, when CP articles are removed, so are a significant number of articles with accurate titles. The percentage of inaccurate headlines is similar to the number of inaccurate articles.

Twenty-seven percent inaccurate headlines may be more troublesome than twenty-two percent inaccurate articles because sensationalised headlines may have a framing effect.<sup>43</sup> The framing effect occurs when a headline influences the reader’s interpretation of the content of an article. One study found that a reader’s interpretation of an article depends on the claim made by the headline, particularly if the article is read superficially.<sup>44</sup> Thus, readers may be per-

sued to interpret an article based on inaccurate headlines, regardless of the content of the article. On the other hand, another study on the impact of the framing effect on print media stories about genes and diabetes found that the framing effect does not hold true because readers are able to discount headlines.<sup>45</sup> Further research is necessary to determine to what degree sensationalised headlines influence a reader’s interpretation of articles on complex health issues such as inquests.

## II. Limitations of the Study Findings

The results of this study are limited because only newspaper articles were incorporated in the study. Television, radio, internet sites and advertisements were excluded from the analysis, even though these forms of media covered the Lewis inquest. The study was designed to specifically focus on how the verdict was reported in print media. Since the inquest spanned over a course of two years, substantial coverage on the purpose of the inquest is likely to be stated in these excluded reports. Lastly, the study analyzed English-language articles only.

Despite these limitations, the study suggests that journalists, for the most part, are accurately and completely reporting a complex issue. Furthermore, inaccurate reports may not be a result of exaggerated claims by a journalist, but an indication of the lack of clarity on the part of the Coroner’s Office. The Coroner’s Office has not clearly defined the five possible outcomes of an inquest. The Lewis inquest, in particular, was entrenched in uncertainty from the day Dr. Young made his announcement to the day the verdict was announced.

## III. Recommendations

Inaccurate reporting by the media about the inquest’s findings has implications for the Coroner’s Office. The Coroner’s Office is a neutral body whose mandate is to protect and inform the public by means of an investigation into deaths. The Lewis inquest became a forum for the chiropractic profession to gain (or lose) legitimacy in the eyes of the public. In the future, the Coroner’s Office and the Chief Coroner should clearly state the reason for calling an inquest in order to protect the neutrality of the Office.

*The significant finding of this study is that seventy-two percent of Canadian newspaper articles on the verdict of the Lewis inquest are accurately written.*



Coroner's Offices across Canada can learn from this analysis of print media reports of the Lewis inquest. First, all Coroner's Offices should ensure that they clearly define accidental death, natural causes, suicide, homicide and undetermined death or similar terms in their policy documents and website. Similarly, if a Coroner's jury is convened, it should be given clear instructions about the meanings of these types of terms. Clearer definitions will lead to less ambiguous findings, thereby reducing the amount of misinformation transmitted to the public. Secondly, Coroner's Offices should provide guidance documents for journalists and media outlets on the nature of

inquests in specific jurisdictions, including the purpose of investigations and limitations with respect to findings. By instituting such a policy, Coroner's Offices may reduce the amount of misinformation distributed to the public. Finally, Coroner's Offices across Canada must ensure that the general public has access to information pertaining to the verdict of inquests directly from the Office via websites or other means. Implementation of these recommendations is likely to increase the provision of accurate information to the public and facilitate Coroner's Offices across Canada to meet their mandates.

## Summary of Articles Assessed in the Study

Search Engine	Number of Articles Found on the Lewis Inquest	Number of Articles Specific to Verdict of the Inquest	Number of Articles Specific to Verdict of the Inquest and Excluding Repeat Articles
Factiva	199	4	4
CMCC	38	38	12
google.ca	2	2	2
Total	239	44	18

**Table 1.** A summary of where and the number of articles obtained for the study. Only articles in print newspapers written on or after January 16, 2004 were included. CMCC= Canadian Memorial Chiropractic College.

	Including Repeat Articles		Excluding Repeat Articles	
	Number	Percentage (%)	Number	Percentage (%)
Accurate Articles	39	89	13	72
Inaccurate Articles	5	11	5	28
Total	44	100	18	100

**Table 2.** The Number of Accurate and Inaccurate Articles.



	Including Repeat Articles		Excluding Repeat Articles	
	Number	Percentage (%)	Number	Percentage (%)
Accurate Headlines	32	73	10	56
Inaccurate Headlines	12	27	8	44
Total	44	100	18	100

**Table 3.** The Number of Accurate and Inaccurate Headlines

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2. Canadian Corporate News and the Angus Reid Group Inc., Report, "Canadians and the News Media" (12 March 1998), online: CCN <<http://www2.cdn-news.com/company/ccn/>>.
3. National Health Council, Report, "Americans Talk about Science and Medical News" (1997).
4. *Coroners Act*, R.S.O. 1990, c. C-37.
5. *Ibid*, s. 31(1).
6. Office of the Chief Coroner, "About the Office" *Ministry of Community Safety and Correctional Services*

(21 November 2002), online: Office of the Chief Coroner <[http://www.mpss.jus.gov.on.ca/english/pub\\_safety/office\\_coroner/coroner\\_what.html](http://www.mpss.jus.gov.on.ca/english/pub_safety/office_coroner/coroner_what.html)> ["About the Office"].

7. *Coroners Act* (Ontario), *supra* note 4 at s. 31.
8. A homicide was defined as "an action of a human being killing another human being, with no responsibility attached to it." A suicide was defined as "the act of killing oneself intentionally." Personal communication with anonymous representative of the Ontario Chief Coroner's Office (25 March 2004).
9. *Coroners Act* (Ontario), *supra* note 4 at s. 31(2).
10. "About the Office," *supra* note 6.
11. *Coroners Act*, R.S.B.C. 1996, c. 72, s. 27.
12. *Coroners Act*, R.S.N.W.T 1988, c. C-20.
13. *Fatality Inquiries Act*, C.C.S.M. c. F-52.
14. *Fatality Inquiries Act*, R.S.A. 2000, c. F-9.
15. Coroner's Office, "Enquiries and Inquests" *Saskatchewan Justice* (18 February 2004), online: Coroner's Office <<http://www.saskjustice.gov.sk.ca/coronersoffice/inquests.shtml>>; *Coroners Act*, S.S. 1999, c. C-38.01.
16. *Coroners Act* (B.C.), *supra* note 11; British Columbia's Coroner Service, "B.C.'s Coroners Service" Ministry of Public Safety and Solicitor General (4 June 2004), online: British Columbia's Coroner Service <<http://www.pssg.gov.bc.ca/coroners/>>.
17. In Alberta, the presiding judge writes a final report that explains the manner of death as one of the following: natural, suicide, homicide, accidental, undetermined, or unclear. Personal communication with representative from the Office of the Chief Medical Examiner of Alberta (9 June 2004).



18. Letter from Michael Ford to Dr. William Lucas (11 Jan 2000), online: Canoe.ca <[http://www.chl.ca/Health0001/24\\_chiro2.html](http://www.chl.ca/Health0001/24_chiro2.html)>.
19. *Coroners Act* (Ontario), *supra* note 4 at s. 26(2).
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23. Chiropractic Communications Working Group, Information Bulletin, "Counsel for the coroner's office summation" (11 December 2003) ["CCWG"].
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26. Dow Jones Reuters Business Interactive, "Factiva" (2004), online: <<http://global.factiva.com>> (date accessed: 23 March 2004).
27. Greg Bonnell, "Death of chiropractic patient in 1996 ruled accidental by coroner's jury" *Canadian Press* (16 January 2004) (QL).
28. Peter Small, "Jury deals blow to chiropractors; woman's strokes linked to neck manipulation" *Toronto Star* (17 January 2004) A:03.
29. *Coroners Act* (Ontario), *supra* note 9.
30. Online Staff, "Chiropractic treatment needs safety review: jury" *CBC Newsline* (16 January 2004), online: CBC Newsline <[http://www.cbc.ca/storyview/CBC/2004/01/16/chiropractic\\_inquest040116](http://www.cbc.ca/storyview/CBC/2004/01/16/chiropractic_inquest040116)>.
31. Small, *supra* note 28.
32. "About the Office," *supra* note 6.
33. Benedetti & MacPhail (*Spectator*), *supra* note 21 at F09.
34. Gay Abbate, "Chiropractic neck manipulation linked to woman's death" *The Globe and Mail* (17 January 2004), online: The Globe and Mail <<http://www.globeandmail.com/servlet/ArticleNews?TPPrint/LAC/2004117/TCHIRO17/National>>.
35. Elaine Marshall & Dawn Cuthbertson, "Chiropractic accident caused death: jury" *National Post* 2004 (17 January 2004) A20.
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37. Benedetti & MacPhail (*Spectator*), *supra* note 21 at F09.
38. "Findings by coroners jury," *supra* note 36.
39. Elaine Marshall, "Chiropractic procedure killed woman, inquest finds" *The Gazette Montreal* (17 January 2004), online: Factiva <<http://global.factiva.com>> (date accessed: 23 March 2004) [on file with the author].
40. Canadian Press "Chiropractic death ruled accidental" *Daily Miner & News* (19 January 2004), online: Factiva <<http://global.factiva.com>> (date accessed: 23 March 2004) [on file with the author].
41. Tania Bubela & Timothy Caulfield, "Does the Print Media Hype Genetic Research?: A Comparison of Newspaper Stories and Peer Reviewed Research Papers" (2004) 170 CMAJ 1399.
42. CWG, *supra* note 23.
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