

Completion of Death Certificates: A Professional Responsibility

Mimi Pattison, MD

Congressional District 6

The Medical Quality Assurance Commission has recently created guidelines for physicians and physician assistants to follow when they complete death certificates.

The Commission has received complaints that physicians and physician assistants (certifying clinicians) fail to complete death certificates in a timely manner or fail to accurately list the cause of death on the death certificate. The Commission takes this matter very seriously.

Under RCW 70.58.170, a funeral director or person having the right to control the disposition of human remains, must present the death certificate to the physician, physician assistant or nurse practitioner last in attendance upon the deceased. The certifying clinician then has two business days to certify the cause of death according to his or her best knowledge and sign or electronically approve the certificate, unless there is good cause for not doing so.

The death certificate is a public legal document that must contain precise and accurate information. The death certificate serves medical, statistical, and legal functions. The cause and manner of death is coded to national and World Health Organization standards using the International Classification of Diseases, 10th Revision. This coded data, collected by all states, is used by the Center for Disease Control (CDC), local health jurisdictions, and researchers to calculate life expectancy and mortality rates by race, age, sex, educational attainment, veteran status, and geographic area. The data is also used to determine which medical conditions receive research and development funding, to set public health goals, monitor disease outbreaks, and to measure health status at local, state, national, and international levels.

The death certificate also serves several different functions for the person's family, loved ones, and estate. It is legal proof of death and serves as a historical reference to an individual; recounting name, dates, places of birth and death, parent's names, as well as other useful demographic information. Providing accurate and timely cause and manner of death information is a final act of care for the decedent, their family, and their loved ones.

Certifying clinicians should meet the standard of care in completing all the information to the best of their ability. This must be done in a timely manner. The certifier must certify the cause and manner of death if he or she pronounced the death, were the first medical certifier to observe the decedent, were the primary care provider for the decedent and recently treated the decedent, or is covering for another physician who is unavailable.

If the certifier does not have enough information to accurately and precisely fill out the cause and manner of death, the certifier may consult with another clinician, clinician's records, or the medical examiner.

Deaths known or suspected of having been caused by injury or poisoning must be reported to the medical examiner or coroner. The medical examiner or coroner will make the decision as to who completes the cause and manner of death.

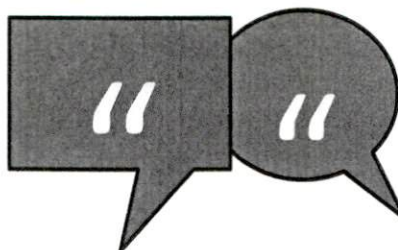
The spaces on the death certificate for the cause of death should represent the logical sequence of events that explains why the patient died. The immediate cause of death should be on the top line and should be the condition that occurred closest to the time of death. Mechanism of death, such as cardio-pulmonary arrest or asystole should not be listed. The specific disease, condition, or injury that set in motion the events leading to death should then be listed. It is acceptable to render a medical opinion on the cause of death and qualify the etiology by use of words such as 'probable' or 'presumed', or, as a last resort, state the cause of death as 'unknown'.

The best estimate of the interval between the presumed onset of each condition and death must be provided. The terms 'approximate' or 'unknown' may be used. Indicate if the time interval is unknown.

Conditions that were present at the time of death and may have contributed to death but did not result in the immediate cause of death should be listed in the box "Significant Conditions Contributing to Death."

If additional medical information or autopsy findings become available that would change the cause of death originally reported, the original death certificate should be amended by the certifying clinician by filing an Affidavit of Correction with the Department of Health.

Certifying clinicians are encouraged to review the entire guideline for additional important information.
<http://go.usa.gov/cpdGw>



What would you like to see from the Medical Commission newsletter?

Send Comments and suggestions to
jimi.bush@doh.wa.gov