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DATA FOR HEALTH INITIATIVE

IMPROVING CAUSE OF DEATH INFORMATION

Supporting physicians to perform a routine duty: medical certification of cause of death

CRVS Roadmaps for Action

August 2017

Introduction

The most effective way of generating high quality cause of death (COD) statistics is to have the COD medically certified by a physician according to World Health Organization (WHO) standards and to have the COD appropriately coded to statistical categories in accordance with the International Classification of Diseases (ICD).

Information included in medical certificates of cause of death is the most timely and complete source of statistics on *which* people are dying and *where, and what* they are dying from. *Real time and high quality* COD statistics are essential for mortality surveillance and underpin the evidence-base for policy making and planning to deliver better population health outcomes.

Quality COD information informs country health policy, planning and resource prioritisation aimed at decreasing the burden of disease and associated risk factors and targeting priority interventions to maximise health. Quality COD statistics can also be used to inform multisectoral policy and planning decisions, for example in relation to housing, social protection, education, gender, and environmental and occupational health. The disaggregation of COD information by stratifiers such as place of residence, age, sex, and socioeconomic status enables the identification of most vulnerable population groups and the development of strategies to reduce inequities.

Common roadblocks

Despite the crucial importance of accurate COD reporting for producing population health data, complex factors can arise that impede the ability or willingness of physicians to accurately record the underlying COD on the medical certificate. These challenging factors to be discussed, are often subtle and nuanced and so not always amenable to redress.

Moving forward

This *CRVS Roadmap for Action* describes potential barriers to accurate medical certification of cause of death (MCCOD) that arise worldwide. These barriers are usually not overt and frequently overlap with each other. Influencing factors include: geography, local belief systems, overarching laws and policies, the surrounding socio-economic landscape, workplace culture, and the political environment.

This *CRVS Roadmap for Action* offers suggestions for countries and their partners on how they can at both the systemic and individual levels optimally support physicians to perform a key duty in the ambit of their professional roles both as caretakers and as persons responsible for the generation of information on the occurrence and reasons for death.

When death is associated with a stigmatised disease or condition

Depending on country-setting and context, certain types of death attract community stigma.[1] Examples include where the death is a result of HIV/AIDS, tuberculosis, suicide, gender-based violence, or domestic violence. Physicians may face moral and ethical dilemmas or may fear adverse reactions in the community when recording such deaths in the medical certificate of cause of death. This is especially likely to occur when the physician is obliged by the law or regulations to share the details of the medical causes of death with the family.

Suggestions:

- Countries should ensure that legal and policy safeguards are in place – and that physicians are aware of them – to support accurate MCCOD.
- Countries and their partners should engage in research and community-awareness raising to address stigmatised or sensitive deaths.

1 Link, BG and Phelan, JC. Stigma and its public health implications. *The Lancet.*: 2006;367(9509):528-529.

Pressure is placed on the physician by the deceased's family not to disclose a stigmatised death on the death certificate

This usually comes about because the family of the decedent fears stigmatisation if the COD becomes public knowledge. In addition, they may want to avoid the memory of their loved-one to be associated with a sensitive or stigmatising illness or condition.

Suggestions:

- The regulations can require that in cases where the physician is required to provide family members or others with a copy of the medical certificate of death, the certificate should include information only on the fact of death – decedent's name, date, place, age, sex – without information on the underlying COD. The latter can be contained in a separate section destined only for the public health authorities and the national statistical agency.

Potential denial of death insurance payments to the surviving family

Some physicians fear that indicating the accurate COD may jeopardise the ability of surviving family members to access insurance pay-outs.[2] This is particularly morally and ethically challenging for physicians working in community settings.

Suggestions:

- The regulations can require that in cases where the physician is required to provide family members or others with a copy of the medical certificate of death, the certificate should include information only on the fact of death – decedent's name, date, place, age, sex – without information on the underlying COD. The latter can be contained in a separate section destined only for the public health authorities and the national statistical agency.
- Government agencies, and ideally the National CRVS Committee (or a specially appointed sub-committee), can engage and work with the national health insurance sector to support death benefit payments not being contingent on the COD.

Fear of physician/patient confidentiality breach if cause of death is stated on the death certificate

Suggestions:

- Legal and policy safeguards should be in place to support accurate MCCOD – and physicians should be made aware of these safeguards.
- Where the physician is required to provide a family member or other party with a death certificate, the death certificate handed to family members by the doctor should provide information on the fact of death, not COD.

Fear of legal or other consequence

Some physicians fear that if they enter an incorrect COD, or a correct cause associated with stigma they are vulnerable to accusations of malpractice and litigation. On the other hand, in extreme circumstances where the political or military environment is highly unstable and/or low-intensity conflict exists at the local level, physicians can fear personal or family retribution where homicide or extrajudicial killing might be inferred by the content they have entered on the death certificate.

Suggestions:

- Physicians should be encouraged to seek advice and guidance from the appropriate agency or professional – such as a medical or hospital ethicist, legal advocate, legal medical department, relevant ethics committee, or the overarching national medical association or professional body. Physicians need to also be able to comfortably liaise with legal authorities/police for deaths under suspicious circumstances.
- Countries should ensure legal and policy safeguards are in place – and physicians are aware of these safeguards – to support accurate MCCOD.
- It is important to build physician confidence by ensuring that MCCOD reporting is a mandatory learning module in medical school, for interns and junior doctors, and for more experienced practicing physicians.

2 Burger et al. Medical certification of death in South Africa – moving forward. *South African Medical Journal.* 2015;105(1):27-30.

Pressure from workplace and health systems to quickly complete the death certificate

Physicians (especially junior physicians) in busy, resource-limited hospital environments can experience pressure from hospital administrators, nurses and colleagues to attend a death and complete the death certificate quickly, with limited to no opportunity of adequately investigating the COD.

Suggestions:

- Countries should ensure legal and policy safeguards are in place – and physicians are aware of these safeguards – to support accurate MCCOD.
- Build physician confidence - MCCOD reporting should become a mandatory learning module in medical school, for interns and junior doctors, and for more experienced practicing physicians.
- Encourage physicians to seek advice and guidance from the appropriate professional – such as a medical or hospital ethicist, legal advocate, or relevant ethics committee.

Summary

Physicians can be placed in difficult situations ethically, morally and legally due to barriers that will impact the accuracy of their MCCOD practice. Governments, National CRVS Committees along with national medical associations and professional bodies, can address these subtle but very real roadblocks to accurate MCCOD.

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