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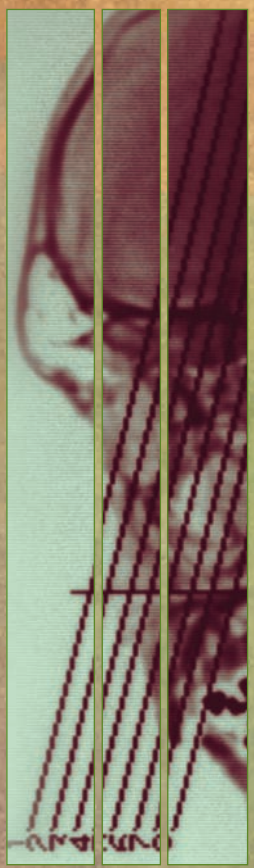
American Medical Directors Association

Recommendations for

COMPLETING DEATH CERTIFICATES



AMERICAN MEDICAL DIRECTORS ASSOCIATION

Recommendations for Completing Death Certificates

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Background

The purpose of the death certificate

Death certificates are not for the benefit of the deceased, they are for the benefit of the survivors. They are needed when applying for Social Security benefits, life insurance benefits, pensions, union benefits, and even for forgiving the balance of federally guaranteed student loans. They are needed to execute wills, activate trusts, and transfer property and real estate. They are also needed to close the bank and credit card accounts of the deceased.

Death certificates are also used by the state and federal governments as a means for collecting data on the population's general health. They are a means for discovering which illnesses mostly affect the population, and an invaluable tool for researchers who need to know which illnesses are found in combinations with other illnesses, giving insights into pathology and the ways lifestyles can put health at risk. In turn this translates into the amount of government funding allocated for efforts to combat each disease.

But beside the reasons related to finances and health, there are personal reasons, too. A death certificate provides a measure of closure for surviving family members, assisting in the grieving process by giving them a physical article which reminds them that the death of their loved one is an inevitable part of life.

Why the accuracy of a death certificate is important

In the past it used to be that typographical errors on death certificates could be fixed using white-out and erasers. Over the ensuing years jurisdictions have tightened their rules to reduce the ease of forging death certificates on the part of individuals wishing to defraud insurance companies and financial institutions. Now death certificates must be perfect, with absolutely no corrections made on the certificate itself: Small misspellings of names will now result in the State rejecting the application for the certificate. Even if the State erringly accepts a death certificate with a mistake on it, a private company still has reason not to pay out on their insurance and pension obligations if the names and social security numbers on their records do not match those on the death certificate. Either case can result in weeks of delays in getting money to the spouses and children of the deceased.

What a physician need to know before filling out a death certificate

By far, the most important thing a physician needs to know before filling out a death certificate is that the federal government has left it up to the States to develop their own sets of rules. What this means is not just that your state has laws that differ from the state it borders. It means that it's very possible for a physician to fill out a death certificate in one facility under one set of rules, and then cross the street into the next county and fill one out under another set of rules.

Some of these areas of difference may seem small, but the mistakes are consequential. For example, an area of difference between jurisdictions often may be in the administrative details. Some jurisdictions might require the month to be written out, while some will allow the corresponding number of the month as it falls in the year to be written down (e.g., "September 30, 2005'' versus "9/30/2005''). Some jurisdictions will allow abbreviations, some will not (as we will see below, a good rule of thumb is to forgo abbreviations entirely; instead, always write out the word in full). Most jurisdictions only allow black ink to be used in the completion of the death certificate, while some allow both black and blue ink to be used; be safe and use only black ink. Even more importantly, jurisdictions differ in which health care worker may pronounce death, who may certify death, and under which circumstances pronouncement and certification may be done.

Remember that there is absolutely no tolerance for errors allowed these days on a death certificate. Not doing one's homework on the regulations required in the jurisdiction where one is filling out the death certificate will more often than not result in the application's being rejected. If an application is rejected, the physician must take the time and effort to fill it out again correctly.

In most jurisdictions there is nothing against the rules for having staff members complete demographic and non-medical areas of the death certificate for the physician's signature, or typing in the deceased's medical information precisely as provided under the supervision of the physician. However, the accurate completion of the certificate is the ultimate responsibility of the physician, and any information filled in by the staff member needs to be thoroughly proofed by the physician. The need for absolute accuracy should be reinforced by the physician to any staff member filling in information under the physician's supervision.

Finally, be aware that the health departments of some states place the governing authority for determining death into the hands of a medical examiner, while in other states' health departments that authority is given to local coroners. Some states do not even have coroners, such as Massachusetts; South Carolina, by contrast, has two medical examiners, but every county has a coroner entrusted with overseeing the certification of death in that county. This difference between medical examiners and coroners is another example of why it is necessary for a physician to research the laws of the local jurisdiction in which he or she is preparing the death certificate.

The National Center for Health Statistics within the Center for Disease Control has a link on its website to every states' and territories' health departments and bureaus for vital statistics. These health departments and centers for vital statistics will be able to inform a physician as to the governing jurisdiction and local rules for the completion of death certificates for that area. Go to http://www.cdc.gov/nchs/howto/w2w/w2welcom.htm to view the page.

The process for issuing a death certificate

The steps involved

Again, jurisdictions differ in their laws governing this, and there is much to be said for being proactive and contacting the local jurisdiction's health department beforehand to find out the specific laws and regulations surrounding the issuance of death certificates. Generally, several common steps are involved before a death certificate may be issued to the surviving family of the deceased.

Understanding the definition of death

Knowing that the individual has died is, of course, the very first step in the death certificate process. However, the very definition of death is where the differences between local jurisdictions start. In the past different states had different definitions of when death occurred.

Seeking to address the ambiguity, in 1980 the National Conference of Commissioners on Uniform State Laws met with the American Medical Association (AMA) and the American Bar Association (ABA). The result was the Uniform Determination of Death Act (UDDA) that states death occurs when there is (1) irreversible cessation of circulatory and respiratory functions, or (2) irreversible cessation of all functions of the entire brain, including the brain stem.

Today 39 states and the District of Columbia have adopted the UDDA. New York and North Carolina have very similar laws. In ten states, however, the legal point of death is different: Florida, Kentucky, Hawaii, Illinois, Iowa, Louisiana, Massachusetts, New Jersey, Texas, and Virginia. A physician in those ten states should review those states' laws on determining death.

Pronouncement and certification of death

There is a subtle difference between the pronouncement of death and the certification of death. To illustrate the difference, if a person is discovered dead in a car on the side of the road, the physician who pronounces the death only needs to know that the person is no longer alive. However, the physician who certifies the death needs to know why the person died.

In all states any licensed physician may pronounce death, based on the legal definitions of death accepted by the states as noted above. Some states also allow physicians Assistants (PAs) or Registered Nurses (RNs) to make the pronouncement as well. Licensed Vocational Nurses (LVNs) and Licensed Practical Nurses (LPNs) may not pronounce death as a condition of their licensure. In most states, if the physician is not readily available, the pronouncement of death may be done over the phone, with the nurse present describing the symptoms of death to the physician outside the facility. (Always note the time of the *pronouncement* of death, not the time of the incidence of death itself.)

In addition, medical directors should be aware of the laws governing the application of CPR to the deceased individual. In most states, unless the individual has a valid "Do Not Resuscitate (DNR)" order, a health care worker who is not qualified to pronounce death must continue CPR, even in cases of rigor mortis and obvious death. Physicians, of course, are able to avoid having to perform CPR on a dead body by simply pronouncing death. In any case, the death must be reported to the authorities within 24 hours. A death certificate must be filed anywhere from 24 hours to 10 days after the occurrence of the death, depending again on the jurisdiction.

The laws surrounding who may certify death can be complicated, but generally the physician who pronounces death does not necessarily have to be the same physician who certifies the death. Who may certify death differs with the jurisdiction, and especially the circumstances of the death. Usually the medical examiner or coroner has this power, sometimes non-attending physicians with knowledge of the deceased's dying process may certify, and occasionally a judge may be able to do the certification. In any event, the individual certifying the death should know about the events that led to the person's death, as well as the reason why the death occurred.

In cases of death from natural causes or illnesses, certification of death is first and foremost the purview of the individual's attending physician, because he or she is the one who knows the most about the causes of the individual's death. It is not necessary for the physician to have recently attended the individual. Cases of sudden or violent death, death from mysterious circumstances, or death within 24 hours of admission into a hospital or prison facility usually gives the purview of certifying death to the medical examiner or coroner.

However, it is important to note that in nursing facilities there are many cases of where deaths occur from natural causes that are the result of earlier accidents. An example would be in the case of where an elderly individual falls and breaks his or her hip, has surgery in a hospital, is released to a nursing facility, and dies a week later in the facility. In this case the death did not occur within 24 hours of admission to the nursing facility, and the death itself was a natural result of the patient's condition as he or she was admitted into the facility, but the conditions leading to the death were not natural. In these instances it may be acceptable, depending on the jurisdiction, for the physician to certify and sign the death certificate after notifying and getting permission from the medical examiner or coroner, usually granted in the form of a waiver to sign. This prevents the deceased's body from being unnecessarily taken to the medical examiner's or coroner's office for to undergo an examination for the purpose of identifying the conditions that caused the death itself.

Information that is filled out in a death certificate

In the community, the process of filling out the death certificate is usually started by the funeral director. The funeral director will meet with the surviving family, gather the demographic information on the deceased, and ask the family to review the accuracy of the information prior to submitting the death certificate to the physician who will certify the death. However, if the death occurred in a nursing facility or a hospice facility, the facility will usually begin the process.

After the certifying physician fills out the death certificate, several specific pieces of information need to be

filled in: 1) Date and time of death; 2) Confirmation that the person filling out the form is indeed the certifying physician; 3) signature and title of the certifying physician; 4) date that certificate is being filled out; 5) the name and address of the certifying physician; and 6) the cause of death.

The certifying physician should never fill out anything on the death certificate that he or she is not supposed to fill out. If the death certificate directs that a certain piece of information is to be filled out by the funeral director, then the certifying physician should absolutely not fill out that piece of information. This includes even not filling out the name of the deceased at the top of the death certificate if that piece of information is listed as being within an area designated for another professional to fill in. In South Carolina, filling out the name of the deceased is reserved as a task for the funeral director to complete because the funeral director is the individual who interviews the surviving family members for the personal details on the deceased. On the left side of South Carolina's death certificate there's a blank line on which the certifying physician may write down the deceased's name if the certifying physician receives the death certificate prior to the funeral director. This prevents the problem of the certifying physician from writing down a nickname or alias of the deceased as the official name. Some physicians use a pencil to write down the name of the deceased in the left hand margin, so it does not become a permanent part of the record.

Also, it is good practice for the certifying physician to read over the blank death certificate prior to filling in any information. This prevents incorrectly filling in information in one line that may be asked for in another line.

Filling in "Cause of Death"

The first five pieces of information are fairly straightforward. Many times the cause of death, however, is the piece of information that certifying physicians do not fill out correctly. Because of the importance of the death certificate in tracking health trends, certifying physicians should be careful not to simply write down the immediate cause of death, but rather focus on the contributing factors that led to the immediate cause of death. For example, writing down only that the person stopped breathing does nothing to distinguish between the youth who died in a car accident and the hospice patient who succumbed to emphysema. It is important that the *process* that led to the ultimate failure of the body to sustain life is what is conveyed on the death certificate.

Because knowledge of the process of death is so important to the government, the facility, and the family, the best case scenario would be one where the deceased's attending physician is the one who pronounces the death, fills in the cause of death, and ultimately certifies the death. However, for a variety of reasons it is impossible in any nursing facility for the attending physician to always be around the patient to accomplish all these tasks. When coupled with the legal constraints for the timely issue of a death certificate, the reality is that the attending physician may not always be the one who is able to certify the death. This is why the certifying physician needs not to have been the attending physician, but only a physician who is familiar with the cause of death of the individual.

If the physician is allowed to certify death as either natural or accidental, they should think of the primary disease process which caused the death. In cases where the attending physician is unable to fulfill the role of certifying physician, the individual who becomes the certifying physician is allowed to supplement his or her general knowledge of the death with information gleaned from whatever sources are available. These sources may include the autopsy report, medical records, conversations with family members and other physicians familiar with the case, and whatever other sources are available that will accurately record the process of death. It is important to note that the cause of death may not always be obvious, and the certifying physician should use his or her best judgment when documenting the cause of death and underlying conditions.

Certifying physicians should be aware that different jurisdictions will allow or disallow certain causes of death from being listed on a death certificate, instead requiring a more specific list of causes that may be contained within a particular disease. For example, New York will not simply allow "Alzheimer's disease" to be listed on a death certificate, and Illinois will not allow "heart failure" as a cause of death.

A certifying physician should also check with the governing authority to see when under which circumstances, if any, it may be allowable to leave the cause of death as "undetermined," "probable," or "pending investigation." In some jurisdictions, in cases where knowledge is lacking of the disease process for the final cause of death, but where it is a reasonable certainty that the disease process was natural, it is acceptable to write down the disease process as being "undetermined", or to use the word "probable." For example, it may be written that the patient died from "Cardiac arrest due to probable heart disease," or "Cerebral hemorrhage due to unknown natural causes."

The cause of death with regards to older patients tends to be a result of multiple factors and conditions. Each factor that the certifying physician may determine to have contributed to the death should be listed in order of most recent to oldest, and must include the length of time the factor affected the individual. Because it is often difficult with many diseases to accurately determine how long the disease was afflicting the individual prior to diagnosis, in these cases it is acceptable to generalize the respective time factors listed next to these diseases in terms of the unit of time itself. For example, because it is nearly impossible to be able to write that the cause of death was contributable to "Prostate cancer – 14 years, 3 months, 2 weeks," it is acceptable to write only "Prostate cancer – years."

With older patients, particularly those in nursing homes and hospice facilities, dehydration and malnourishment are frequently a component of end of life situations. It is more important to indicate the underlying process that lead to death than end results. (For example when carcinoma of the esophagus leads to inability to tolerate oral feedings or fluids, the cause of death is carcinoma of the esophagus, not dehydration or malnutrition.) A physician who believes that a particular cause of death, such as dehydration or malnutrition, was the underlying cause of death, but that cause may be misconstrued, should contact the local authority about the

appropriateness of the inclusion of that cause in the death certificate.

There are several other things to be aware of when filling in the cause of death. Do not use abbreviations; instead, write out the entire word. Only when absolutely necessary should multiple conditions be listed on the same line, and then only if the conditions are causally linked (e.g., "systemic sepsis, due to perforated colon, due to advanced ulcerative colitis").

An entry onto a death certificate listing multiple causes of death may appear as below:

Example 1 – Specific times

Staphylococcal pneumonia	3 days
Carcinoma metastatic to both lungs	4 months
Poorly differentiated adenocarcinoma of colon	4 years

Example 2 – Generalized times

Aspiration pneumonia	Hours
Dysphagia	Weeks
Advanced dementia	Months
Alzheimer's disease	Years

Examples are taken from "Practical Considerations in Pronouncing and Certifying Death", Ronald J. Crossno, MD, CMD, FAAFP, FAAHPM, 28th Annual AMDA Symposium.

Remember that in most jurisdictions a physician may only certify a death if the cause of death is from natural causes, and medical examiners or coroners are responsible for certifying death otherwise. Therefore, in those jurisdictions if given the option on the death certificate, a certifying physician should never mark down anything but that the death occurred from natural causes.

If a family is in disagreement with what the certifying physician writes down as the cause of death, the physician should engage in a discussion with the family as to the clinical facts that lead to the diagnosis. The physician also should seek to obtain further information from the family that may possibly alter the cause of death to be recorded. In the event the physician and the family cannot reach accord as to the cause of death, the physician should refer the family to the governing authority for a request to review and amend the death certificate.

For greater detail on filling in the cause of death, refer to the following paragraphs excerpted from the Center for Disease Control's *Physician's Handbook on Medical Certification of Death, 2003 Revision*. The complete handbook may be found online at http://www.cdc.gov/nchs/data/misc/hb_cod.pdf.

The elderly decedent should have a clear and distinct etiological sequence for cause of death, if possible. Terms such as senescence, infirmity, and advanced age have little value for public health or medical research. Age is recorded elsewhere on the certificate. Certain processes need additional etiological information. An abbreviated list of examples pertinent to long term care includes:

Altered mental status; Anemia ; Anoxic encephalopathy; Arrhythmia; Ascites; Aspiration; Atrial fibrillation; Bacteremia ; Bedridden; Bowel obstruction; Cellulitis ; Coagulopathy; Compression fracture; Congestive heart failure; Decubiti; Dehydration; Dementia (when not otherwise specified); End-stage liver disease; End stage renal disease; Failure to thrive; Gangrene; Hyperglycemia; Hyperkalemia; Hyponatremia; Hypotension; Malnutrition; Metabolic encephalopathy; Old age; Pneumonia; Starvation; Sudden death; Urinary tract infection; Volume depletion.

When there are two or more possible sequences resulting in death, or if two conditions seem to have added together, choose and report the sequence thought to have had the greatest impact. Other conditions or conditions from the other sequence(s) should be reported. For example, in the case of a diabetic male with chronic ischemic heart disease who dies from pneumonia, the certifying physician must choose the sequence of conditions that had the greatest impact. One possible sequence that the certifier might report would be pneumonia due to diabetes mellitus with chronic ischemic heart disease reported as a contributing cause. Another possibility would be pneumonia due to the chronic ischemic heart disease entered as cause of death with diabetes mellitus reported as contributing cause. Or the certifier might consider the pneumonia to be due to the ischemic heart disease that was due to the diabetes mellitus and report this entire sequence as cause. Because these three different possibilities would be coded very differently, it is important for the certifying physician to decide which sequence most accurately describes the conditions causing death. In cases of doubt, it may be necessary to use qualifying phrases ("probable disease process of") in either the cause of death section or the contributing causes section to reflect uncertainty as to which conditions led to death.

In cases where the certifier is unable to establish a cause of death based upon reasonable medical certainty, he or she should enter "unknown" or "undetermined disease process" in the cause-of-death section. However, this should be shown only after all efforts have been made to determine the cause of death. An autopsy should be performed, if possible. The physician should indicate whether an autopsy was performed and whether the findings were available to complete the cause of death. If additional medical information or autopsy findings are received after the physician has certified the cause of death and he or she determines the cause to be different from what was originally entered on the death certificate, the original certificate should be amended by filing a supplemental report of cause of death with the State registrar. Information on the proper form to use and procedure to follow can be obtained from the State registrar."

Authorizing the release of the body.

Generally, if it were the attending physician who certified the death, then under a physician's order the health care worker who pronounced the death may release the body. If the medical examiner or coroner certified the death, then it is the medical examiner or coroner who determines when the body is to be released. If you are unsure, check with the local health department, medical examiner, or coroner.

Recap: General rules of thumb to follow when filling out a death certificate

Not all these rules of thumb apply to every jurisdiction. Check with your local governing authority to determine which rules of thumb apply to the jurisdiction in which you are filling out the death certificate.

Pronouncement of death

- ✔ The pronouncing physician only needs to know that the individual is dead, not why the individual died. The pronouncement of death may be done by any licensed physician.
- ✔ Some states also allow registered nurses and physicians assistants to pronounce death.
- ✔ Licensed Vocational Nurses (LVNs) and Licensed Practical Nurses (LPNs) may not pronounce death as a condition of their licensure.
- ✔ Some states allow the pronouncement of death to be done by the physician over the phone, as long as a nurse is present in the facility to describe the symptoms of death to the physician over the phone.
- ✔ When pronouncing death, always note the time of the pronouncement of death, not the time of the incidence of death itself.

Certification of death

- ✔ The certifying physician is the physician who knows why the person died.
- ✔ It is possible for the certifying physician and the pronouncing physician to be the same physician.
- ✔ A physician should only certify deaths which occur from natural causes.
- ✔ A medical examiner or coroner certifies deaths which occur from non-natural causes such as drugs, alcohol, and poisonings; accidents and other external forces; murder or suicide; unknown or mysterious causes; within 24 hours of admission to a jail or hospital; or if the individual was under the age of 6. There are also instances, particularly in nursing facilities, under which a physician may certify the death certificate for a death with non-natural causes with permission of the medical examiner or coroner.

Things to remember before you fill out the death certificate

- ✔ There is absolutely no room for typographical errors or errors of fact while filling out a death certificate.
- ✔ Contact the health department of the state, county, or municipality in which you are filling out the death certificate to ensure that you are following the standards of that jurisdiction.
- ✔ Know which entity in your area is entrusted by the state health department as the governing authority for certifying death. Often this is either the state medical examiner, or the local coroner.
- ✔ Read over the blank death certificate first. This prevents you from incorrectly filling in information in one line that may be asked for in another line, such as the deceasedís maiden name.
- ✔ The use of black ink is accepted in every jurisdiction, but blue ink is not; always use black ink.
- ✔ When contacting the relevant health departments, remember to ask about who has the ability to both pronounce death *and* certify death.
- ✔ Do not fill out anything on the death certificate that you are expressly not supposed to fill out, even the name of the deceased.
- ✔ If you are a physician who allows your staff members to fill out the death certificate under your direct supervision, make certain that the staff members are as familiar with the rules governing the completion of death certificates as you are.
- ✔ No matter which jurisdiction you are in, there is a tight deadline for notifying authorities of a death and for filing a death certificate. Typically a death must be reported to the governing authorities within 24 hours of its occurrence. Depending on the jurisdiction, death certificates must be filed within 24 hours to 10 days of the death.

Filling out the cause of death

- ✔ When certifying death, so not simply write down the immediate cause of death, but focus on the process that led to the death.
- ✔ The certifying physician is allowed to supplement his or her general knowledge of the death with information from whatever other sources are available that will accurately record the process of death.
- ✔ In some jurisdictions, in cases where the cause of death is not known, but is reasonably assumed to be of natural causes, it may be allowable to write that cause of death is ìpending investigation,íìprobably due toía certain factor, or ìundetermined. í
- ✔ Multiple contributing causes of death should be listed in order of most recent to oldest.
- ✔ It is acceptable to generalize the time factor listed next to a cause of death when the actual length of time cannot be known with certainty.
- ✔ Only when absolutely necessary should multiple conditions be listed on the same line, and then only if the conditions are causally linked.
- ✔ Using the phrases "ìundetermined disease process" or "probable disease process of" is aceptable if knowledge is lacking of the disease process for the final cause of death, but it is certain that the process was natural.
- ✔ Forgo abbreviations entirely; write out all words on the death certificate.
- ✔ The cause of death may not always be obvious, so the certifying physician should use his or her best judgment when documenting the cause of death and underlying conditions.

Sources of material & additional resources

The following resources were used during the preparation of this paper, and are recommended as additional sources of material on the subject of the completion of the death certificate:

- National Center for Health Statisticsílink to state health departments and bureaus for vital statistics to locate local jurisdictions governing the certification of death: http://www.cdc.gov/nchs/howto/w2w/w2welcom.htm.
- National Funeral Directors Association: http://www.nfda.org
- Santa Clara County Medical Examiner - Coroner's Office Link to guidelines for filling out death certificates: http://www.sccgov.org/scc/assets/docs/732553DCGuidelines11-04.pdf
- U.S. Department of Health and Human Services, Centers for Disease Control and Prevention. National Center for Health Statistics. Writing cause - of-death statements, 2004: http://www.cdc.gov/nchs/about/majpr/dvs/hand-bk.htm
- Physicianś Handbook on Medical Certification of Death; DHHS publication number PHS 2003-1108, 2003. Government Printing Office. U.S. Department of Health and Human Services, Public Health Service, National Center for Health Statistics, Hyattsville, Md.; http://www.cdc.gov/nchs/data/misc/hb_cod.pdf.
- Knowles, D.: *Curbside Consultation-Completing and Signing the Death Certificate.* Am Fam Physician 2004: 70 (9).

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