

# Action guide on reducing barriers to medical certification

This *CRVS action guide* is edited from 'Reducing barriers to the accurate medical certification of cause of death', a *CRVS development series* paper available at <https://crvsgateway.info/library>.

## 1 Review legislation

## 2 Raise awareness

## 3 Provide support

## 4 Provide training

## 5 Protect confidentiality

Real-time and high-quality COD statistics are essential for mortality surveillance. High-quality COD information provides the evidence base for national health policy, planning and resource prioritisation to:

- Decrease the burden of disease and associated risk factors.
- Target priority interventions to maximise health.

The information 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, gender and socioeconomic status allows a country to identify their most vulnerable population groups and the development of strategies to reduce inequities.

Despite the importance of accurate COD reporting for producing population health data, complex factors can arise that obstruct the ability or willingness of physicians to accurately record the underlying COD on the medical certificate. These factors are complex and subtle, and affect certification in four main ways (**Figure 1**).

## The importance of medical certification of cause of death

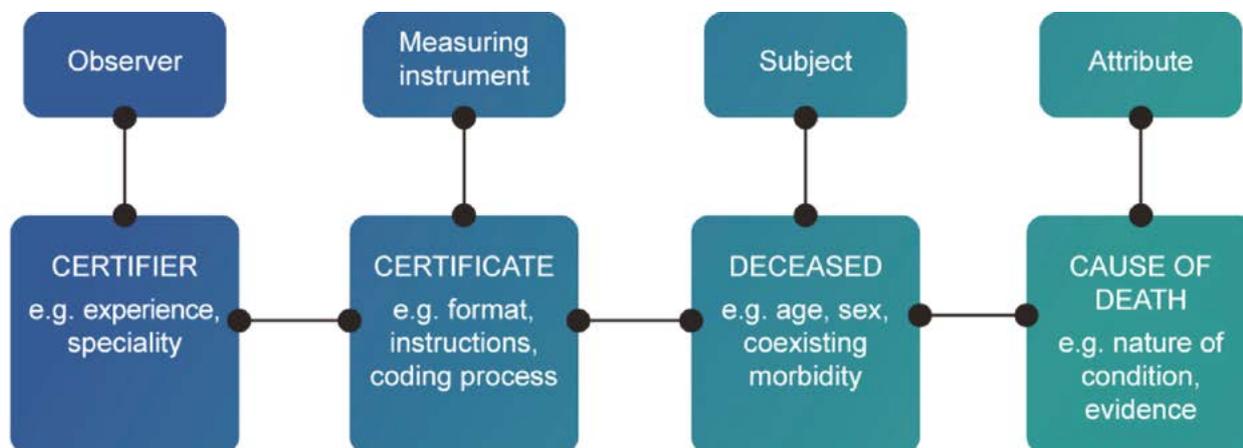
The most effective way of generating high-quality cause of death (COD) statistics is to have the COD medically certified by a physician according to World Health Organization (WHO) standards and to have the underlying COD appropriately coded to statistical categories according to the International Classification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

Medical certificates of cause of death provide the most timely and complete source of information about:

- which people are dying,
- where people are dying, and
- what diseases or conditions people are dying from.



**Figure 1 Four factors affecting medical certification of cause of death**



Sourced from: Maudsley G, Williams L. Death certification – a sad state of affairs. *Journal of Public Health Medicine* 1994; 16(3):370–371

This *CRVS action guide* is focused on the fourth factor: attributes of the cause of death. From reviewing the literature and based on in-country experience as part of the Bloomberg Philanthropies Data for Health (BD4H) Initiative, six common barriers to certification have been identified:

1. The death has been caused by a stigmatised disease or condition.
2. Pressure is placed on the physician by the deceased’s family not to disclose a stigmatised death on the death certificate.
3. Insurance payments to the deceased’s family are at risk if the death was due to a cause not covered in the policy.
4. There are doctor–patient confidentiality concerns in releasing the death certificate to the family.
5. The physician fears potential legal consequences.
6. The death is by homicide, suicide or other cause requiring a coronial enquiry.

Physicians have professional roles both as caretakers, and as persons responsible for the generation of information on the occurrence and reasons for death. As such, this action guide offers suggestions for countries and their partners on how they can best support physicians at both the systemic and individual levels to perform this key professional duty.

## Action guide – key tasks and challenges



### Step 1: Review legislation

It is important countries ensure that physicians have the legal safeguards to feel confident and comfortable to medically certify the causes of all deaths. As such, an analysis of country-specific medical certification legislative and policy frameworks should be undertaken.<sup>1</sup> This could be coordinated by the national civil registration and vital statistics committee, or subcommittee.

It is recommended that analysis of the legal and regulatory frameworks extend to include analysis of key national insurance companies’ policies on death payments for potentially stigmatising illnesses and conditions causing death, such as HIV/AIDS and suicide. It is recommended that governments and insurance companies work in partnership to avoid or remove potentially penalising clauses in death insurance payouts, especially those likely to impact poor families and communities. This ensures that disadvantaged families are not penalised when seeking to apply for a death insurance payout because of the COD.

Governments should also work with medical associations and professional bodies to clarify current rules on penalising insurance payouts to physicians. The aim should be to alleviate physicians’ moral and ethical distress on this subject.

<sup>1</sup> Vital Strategies and the Global Health Advocacy Incubator, as part of BD4H, have developed a *Civil Registration and Vital Statistics Legal and Regulatory Review: Tool and Methodology*. Available at [https://www.vitalstrategies.org/wp-content/uploads/2018/01/CRVS-Legal-Toolkit\\_11\\_29\\_17.pdf](https://www.vitalstrategies.org/wp-content/uploads/2018/01/CRVS-Legal-Toolkit_11_29_17.pdf)



## Step 2: Raise awareness

It is important that countries work with medical associations and professional bodies to clearly communicate to physicians the legal and policy safeguards that are in place to support them to accurately and routinely medically certify deaths, as part of their ordinary professional duties. Clear communication will help mitigate physician fear and anxiety around legal exposure. This will also improve the quality of COD data by reducing the proportion of deaths assigned an incorrect COD.

To work towards destigmatising sensitive deaths, the nature of which will depend on the country or community-specific context, it is recommended that governments work with their public health and community partners to develop appropriate educational and awareness-raising strategies and campaigns. Community-based participatory research should be encouraged and invested in.<sup>2</sup> It can explore the sociocultural constructions of stigmatised deaths and how communities can respond, while also increasing the ability of families and communities to counter such stigma.



## Step 3: Provide support

Where necessary it is recommended that a physician consult a medical or hospital ethicist, legal advocate, medico-legal department, relevant ethics committee, or the overarching national medical association or professional body for advice and guidance if they find themselves presented with a challenging MCCOD case. Physicians should not feel they are alone in such circumstances, and they need to be able to comfortably liaise with legal authorities for deaths under suspicious circumstances. It is recommended that all advice given to the physician is in writing. It is also recommended that any advice given acknowledges the broader cultural background and political, economic, social and community contexts within which the physician functions.

<sup>2</sup> Gouda HN, Flaxman A, Brolan CE, et al. New challenges for verbal autopsy: Considering the ethical and social implications of verbal autopsy methods in routine health information systems. *Social Science and Medicine* 2017; 184:65-74.



## Step 4: Provide training

It is suggested that peer/near-peer or eLearning teaching schemes relating to death certification and its implications should be developed, because formal workshops on the subject, although useful, may not be readily accessible to all physicians.<sup>3</sup> It is also recommended that compulsory medical certification education and training be incorporated into the learning and professional development programs of medical students, junior physicians and interns, and more experienced practicing physicians.



## Step 5: Protect confidentiality

In the first instance, it is recommended that countries avoid or repeal death registration practices, prescribed by law, which instruct that the family or next of kin are responsible for hand-lodging a hardcopy of the medical certificate of COD with a civil registry office. If any document needs to be given to the family by the physician regarding the deceased's death, this could be a death certificate that confirms *proof* of death, not *type* or *cause* of death. Certifying physicians can also be given a medical certification identification number or code to place on the death certificate, in lieu of their own name. Nonetheless, it is still the duty of the physician to share information on the causes of death with the health authorities and, with protection of individual identity, with the statistical authorities.

<sup>3</sup> Khan A, Ah-kee E. Death certification: 800 years of practice; time to modernise teaching? *Scottish Medical Journal* 2016; 61:32-33.

## Summary

This *CRVS action guide* has discussed common barriers to the accurate certification of cause of death, and potential steps for improvement, in regards to attributes of the death event itself. It has not attempted to discuss the complex range of barriers that arise when for example, non-standard death certificates are used, or the complex health system and workplace issues related to certification.

Physicians can be placed in difficult situations ethically, morally and legally due to barriers that will impact the accuracy of their medical certification practice. Governments, working in collaboration with their partners (including national medical associations and professional bodies), can address these subtle but very real barriers to accurate medical certification by introducing and enforcing supportive legal and policy frameworks, providing peer-support and ongoing training opportunities to physicians, and by raising public awareness around the importance of accurate mortality data, including those associated with stigmatised or sensitive causes of death.

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