COMPLETING THE MEDICAL CERTIFICATE OF DEATH

This is an information bulletin for physicians. A Handbook is available on the BC Vital Statistics website [http://www.vs.gov.bc.ca](http://www.vs.gov.bc.ca) located in Service Information Statistics, Reports and Legislation Special Interest Handbooks. A revision of this handbook will be available in 2011.

Vital Statistics Act (Excerpt)

18  (1) A medical certificate must be prepared in accordance with subsection (2) in any of the following circumstances:

(a) if a medical practitioner

   (i) attended the deceased during the deceased's last illness,

   (ii) is able to certify the medical cause of death with reasonable accuracy, and

   (iii) has no reason to believe that the deceased died under circumstances which require an investigation or inquest under the Coroners Act;

(b) if the death was natural and a medical practitioner

   (i) is able to certify the medical cause of death with reasonable accuracy, and

   (ii) has received the consent of a coroner to complete and sign the medical certificate;

(c) if a coroner conducts an investigation or inquest into the death under the Coroners Act.

(2) Within 48 hours after the death, the medical practitioner or the coroner, as applicable, must

(a) complete and sign a medical certificate in the form required by the chief executive officer stating in it the cause of death according to the international classification, and
(b) make the certificate available to the funeral director.

(3) If
(a) a death occurred without the attendance of a medical practitioner during the last illness of the deceased, or
(b) the medical practitioner who attended the deceased is for any reason unable to complete the medical certificate within 48 hours after the death, the funeral director or the medical practitioner, as the case may be, must promptly notify the coroner.

(4) If a cause of death cannot be determined within 48 hours after the death and
(a) an autopsy is performed, or
(b) an investigation or inquest is commenced under the Coroners Act, and the medical practitioner who performs the autopsy or the coroner who commences an investigation or inquest under the Coroners Act, as the case may be, considers that the body is no longer required for the purposes of the autopsy, investigation or inquest, the medical practitioner or the coroner, as the case may be, may, despite subsection (1), issue and must make available to the funeral director an interim medical certificate in the form required by the chief executive officer.

(5) After the conclusion of the autopsy, investigation or inquest referred to in subsection (4),
(a) the medical practitioner who performed the autopsy, or the coroner, must complete and sign the medical certificate referred to in subsection (2) and deliver it to the chief executive officer, and
(b) the coroner must deliver a copy of any report prepared under section 20 (4) (b) or 25 (2) of the Coroners Act to the chief executive officer.

Certifying Physician’s Responsibility:

If the immediate cause of death entered on line (a) was due to an accident, poisoning, or violence, Medical Certification must be completed by a coroner.

The attending Physician at the time of death is responsible for completion of the Medical Certificate.

In the event the death is an expected or planned home death, a physician familiar with the deceased (without having pronounced the death) can complete the medical certificate of death IF a “Notification of Expected Home Death Form” is completed.
If physician pronouncing death is not familiar with the deceased, attempts to obtain the medical history should be undertaken in order to provide the most probable circumstances leading to death.

Completion of the Medical Certificate can be delegated by the pronouncing physician to a physician more familiar with the deceased’s medical history. An “Interim” Medical Certificate can be provided to the funeral home with as much medical detail as possible. This Certificate should be labelled as “Interim” and a replacement provided to the Vital Statistics Medical Coding Unit as soon as more detail becomes available.

If the death occurred in a Hospice or Palliative Care Unit or designated bed, “Hospice” or “Palliative Care” should be recorded in the place of death section of the certificate.

Completing Part 1

Note: Only one condition should be entered on each line in Part 1.

Line (a) Enter the immediate cause of death the disease or complication that led directly to death.

There must always be an entry on line (a). This entry can be the only entry BUT:

Modes of dying, such as heart failure, respiratory failure, renal failure, liver failure, cardiac arrest etc. should be accompanied by a cause on the following line.

Lines (b), (c) and (d): Antecedent causes

If the immediate cause of death entered on line (a) was due to, or arose as a consequence of an antecedent disease, enter this condition on line (b).

If the antecedent cause of death entered on line (b) was due to, or arose as a consequence of an antecedent disease, enter this condition on line (c) and so on.

Add as many additional lines as are needed to enter the complete sequence of events leading to death. Do not enter in Part II a condition that belongs in the sequence of events leading to death unless you indicate it is a continuation of Part I with (e), (f) (g) etc.

If the immediate cause of death entered on line (a) arose as a complication of medical care, enter this medical care on line (b) and enter the condition necessitating the
medical care on line (c). Line (d) is used if an additional line is needed to enter the complete sequence of events leading to death.

COMPLICATIONS OF SURGERY

When any one of the conditions listed below is reported as the only entry OR first entry on the lowest used line in Part I, with surgery (within 28 days of death) also reported on the certificate, the condition is coded as a complication of surgery unless:

a) The surgery was performed more than 28 days prior to death.
b) When the surgery was performed for the condition reported.
c) When the condition predates the surgery.
d) A pre-existing condition or disease is reported to have caused the condition.
e) It is stated on the certificate “Not a post-operative complication” or “Not related to the surgery” or similar wording.

If these exceptions do not apply, the underlying cause of death (UCOD) will become the reason for the surgery (even if the reason is located in Part II or within the details of surgery section on the certificate.) If the surgery was performed due to an injury, the mechanism of the injury will become the UCOD. Eg. Pneumonia following hip surgery for a fractured hip (from a fall) = a UCOD of a fall. Even if the fall was due to natural disease, if the disease itself did not directly cause the death, this would be considered a Coroner’s case.

Complication List: (this list is not exclusive)

- Acute renal failure
- Aspiration
- Atelectasis
- Bacteremia
- Cardiac arrest
- Disseminated intravascular coagulopathy (DIC)
- Embolism (any site)
- Gas gangrene
- Hemolysis, haemolytic infection
- Hemorrhage NOS (not otherwise specified)
- Infarction (any site)
- Infection NOS
- Occlusion (any site)
- Phlebitis (any site)
- Phlebothrombosis (any site)
- Pneumonia
- Pneumothorax
- Pulmonary Insufficiency
- Septicemia (any)
- Shock
- Thrombophlebitis (any site)
- Thrombosis (any site)

Completing Part II: Other significant conditions
Enter in Part II, in order of significance, all other diseases or conditions which unfavourably influenced the course of the morbid process, and thus contributed to the fatal outcome, but were not part of the sequence of events directly leading to the death.

Some of the specific medical detail on Cause of Death requested for accurate coding according to the International Classification of Diseases – 10th edition:

**Infections**

Specify:
- acute, subacute, or chronic
- the name of the disease and/or infecting organism, where known (if studies are pending indicate “yes” in the section “May further information relating to death be available later)
- the originating site, if localized; mode of transmission where relevant
- for syphilis, whether primary or secondary, congenital or acquired
- for Human Immunodeficiency Virus (HIV) disease, include specific complication(s) and whether AIDS has been confirmed
- the etiology of Hep B, C and AIDS if known. If was due to a transfusion of blood or blood products, include the reason for the transfusion. Indicate “etiology unknown” if applicable

**Neoplasms**

Specify:
- the morphological type, if known
- malignant, benign, etc., if not specific to the morphology
- site of origin of primary growths (if not known indicate “unknown primary”)
- site(s) of metastases, if known
- acute or chronic when reporting leukemia

**Alcohol – related deaths**

If a condition is believed to be associated with alcohol abuse, include this information in a “due to” position.

**Deaths associated with pregnancy, childbirth, and the puerperium**

Specify:
- the nature of disease or complication (maternal or neonatal) leading to death
- Conditions in fetus or infant leading to death (specify whether congenital)
- conditions in mother or of placenta, cord or membranes, if believed to have affected the fetus or infant
- whether delivered by caesarean section
- for deaths associated with immaturity, state length of gestation and/or birthweight
- any birth trauma