Complete Death Certificates Promptly: It’s the Law

The State Medical Board reports an increasing number of complaints and inquiries from the public and funeral directors regarding physician failure to complete and sign death certificates in a timely manner. The Oklahoma State Department of Health’s Center for Health Statistics indicates a similar increase as well.

Most Oklahomans die in hospitals or nursing homes. The majority of death certificates in Oklahoma are completed in the medical examiner’s office, by hospitalists, physicians with large nursing home and/or hospice practices, or those in high risk, often hospital-based, specialties.

The inundation of medical, legal, insurance and government paperwork understandably might make physicians and their staffs who routinely deal with a limited number of death cases assign a low priority to death certificates requests. But Oklahoma law is quite clear.

A death certificate “shall be filed with the State Department of Health within three (3) days of such death.” [63 O.S. § 1-317]

The failure to file death certificates promptly may cause probate, insurance and/or financial problems for an already grieving family, and inhibit the ability of the Oklahoma State Department of Health to compile the health statistics so important in determining future health policy.

Funeral directors initiate the process by entering the deceased’s personal data on the death certificate, which must be delivered to the “physician in charge of the patient’s care for the illness or condition that resulted in death” or medical examiner within twenty-four (24) hours after the death. The physician then has forty-eight (48) hours to complete, sign and return the medical certification portion of the death certificate to the funeral director.

Physicians are required to certify “natural” deaths.
OPIOD - Natural or semi-synthetic derivatives of the opium poppy as well as similar synthetic compounds that have analgesic or pain relieving properties because of their effects on the central nervous system, including codeine, morphine, hydromorphone, hydrocodone, oxycodone, methadone, and fentanyl among others.

Opioids often are inappropriately referred to as narcotics, a legal term no longer used in medicine because it suggests opioids relieve pain by inducing sedation. While sedation can be a side effect of opioids, it is not the mechanism that produces pain relief.

Pain management is integral to good medical practice. Opioid therapy to relieve pain and improve function is a legitimate medical treatment for acute and chronic pain of both cancerous and non-cancerous conditions. While patients should not be denied opioid medications when indicated, physicians also have the responsibility to minimize the potential for abuse and diversion of controlled substances.

To help Oklahoma physicians navigate this often delicate and tricky course, the Medical Board sponsored a recent seminar on “Prescribing of Opioids for Chronic Pain: Balancing Safety and Efficacy.” A main text for the program was ‘Responsible Opioid Prescribing, a Physician’s Guide’, by Scott M. Fishman, MD. The second edition of the book will be available from the Federation of State Medical Boards (FSMB) in June 2012. The booklet also will be accredited for 7.25 hours of Category One Continuing Medical Education credit for physicians. To purchase the book and/or register for CME credits, go to fsmb.org/pain-overview.

Responsible Opioid Prescribing describes in detail the seven (7) steps in FSMB’s Model Policy for Opioid Prescribing:

Patient Evaluation

The complexity of treating chronic pain almost by definition makes such patients “difficult cases.” Therefore, a thorough history and comprehensive physical is even more important than usual. When possible, physicians should take extra time with their pain patients. The patient history should cover the location and character of the pain; how and when the pain started; involvement in legal proceedings related to the pain; effects of pain on sleep, mood, functioning at work; and quality of personal life and relationships by focusing on the patient and not just the pain. While remaining empathetic and compassionate, the dilemma for physicians is to remember that not all people seeking treatment are reliable or trustworthy. Physicians must “maintain a discreet but keen vigilance for the potential harm from any treatment… this must include the potential for deception and abuse.” For instance, a patient who asks for an opioid by its brand name may have a drug abuse problem. By not recognizing this potential signal, a physician may miss a valuable opportunity to help the patient.

Treatment Plan

In consort with their patients, physicians should develop written treatment plans for their pain patients with stated objectives to relieve pain and improve physical and psychosocial function. With adequate pain relief, patients maintain or gain function in their lives.

Function-based treatment in the new paradigm

Functional goals should be set collaboratively between doctor and patient. The goals should be realistic, verifiable, meaningful and achievable to the patient. Doctors and patients regularly should revisit and recalibrate the treatment plan and goals. Treatment goals should not be based primarily on changes in pain scores. “Switching to a function-based paradigm offers a useful
Prescribing Opioids, cont.

way to differentiate a patient who is succeeding with an analgesic treatment from someone who is not and may even be abusing, diverting or addicted."

Informed Consent Agreements

Physicians should discuss the risks and benefits of opioid treatment with the patient, the patient’s designee or guardian. If a patient appears to be a high risk for drug abuse, the physician may consider a written agreement between doctor and patient detailing the patient’s responsibilities, including urine and serum medication screenings; number and frequency of prescription refills; and the reason(s) why drug therapy may be discontinued (e.g., violation of agreement). Ideally, pain patients should receive prescriptions from one physician and one pharmacy at a time.

Links to standard informed consent agreements for opioid treatment are available through the American Academy of Pain Medicine (www.painmed.org) or FSMB (www.fsmb.org/pain). Membership in some organizations may be required to access the sample agreement forms. A free sample agreement form may be found at PartnersAgainstPain.com. [Look for “Pain Treatment Forms” on the Health Professionals page under the “Practice Tools” section.] It is always prudent for physicians to have any sample form reviewed by local legal counsel before incorporating it into their practices.

Periodic Review

Physicians should review the course of treatment regularly and make necessary adjustments.

Referral and Patient Management

Physicians should not delay in referring patients as necessary for additional evaluation and treatment. Pay special attention to patients at risk for prescription abuse or diversion or those with psychiatric disorders.

Documentation

Accurate and complete medical records—from history and physical through treatment objectives, risks and benefits, agreements, etc.—are vital with pain patients. Document any assessments, treatments, referrals, prescriptions, agreements, education, action plans, outcomes and monitoring.

Legal Compliance

Physicians should know and comply with all local, state and federal prescribing laws. The Oklahoma Prescription Monitoring Program (pmpadmin@obn.state.ok.us) is a tool every Oklahoma physician should use.

DEA Proposes Schedule I Classification for Some Cannabinoids

The U.S. Drug Enforcement Agency (DEA) issued a proposed regulation on March 1, 2012, placing five (5) synthetic cannabinoids in Schedule I pursuant to the Controlled Substance Act.

The synthetic cannabinoids are:

- 1-pentyl-3-(1-naphthoyl)indole (JWH-018)
- 1-butyl-3-(1-naphthoyl)indole (JWH-073)
- 1-[2-(4-morpholiny)ethyl]-3-(1-naphthoyl)indole (JWH-200)
- 5-(1,1-dimethyleptyl)-2-(3-hydroxycyclohexyl)-phenol (CP-47,497)
- 5-(1,1-dimethyloctyl)-2-(3-hydroxycyclohexyl)-phenol (cannabicyclohexanol, CP-47,497 C8 homologue).

The proposal includes their salts, isomers, and salts of isomers whenever the existence of such salts, isomers, and salts of isomers is possible.

The DEA document extends the temporary scheduling of these five (5) synthetic cannabinoids to August 29, 2012, or until rulemaking proceedings are completed, whichever comes first.
Death Certificates, Cont.

All other deaths are referred to the Medical Examiner. Medical Examiner cases include: all violent deaths, whether self-induced or not; deaths under suspicious, unusual or unnatural circumstances; deaths related to disease which constitute a threat to public health; deaths unattended by a licensed MD/DO for a fatal or potentially-fatal illness; deaths after unexplained coma; deaths that are medically unexpected and that occur in the course of a therapeutic procedure; deaths of incarcerated individuals; and deaths of persons whose bodies are to be cremated, buried at sea, transported out of state, or otherwise made unavailable for pathological study.

In discussing death certificates, the College of American Pathologists (CAP) notes that “the physician, coroner or medical examiner who indicates the cause of death on a death certificate and signs the certificate attesting to the cause of death is referred to as the certifier. The certifier may or may not be the same person who was responsible for the care of the patient (the attending physician) or who pronounced the person dead (the pronouncing physician).”

Who certifies death when the physician in charge of the patient is not present at the death? Oklahoma law states: “In the event that the physician in charge of the patient’s care for the illness or condition which resulted in death is not in attendance at the time of death, the medical certification shall be completed and signed within forty-eight (48) hours after the death by the physician in attendance at the time of death...Provided that such certification, if signed by other than the attending physician, shall note on the face the name of the attending physician and the information shown is only as reported.” [63 O.S. § 1-317(d)]

CAP recognizes that some physicians may be hesitant to certify death if they do not know the exact cause of death. CAP says: “Such hesitancy is usually unwarranted. Although the cause of death should ideally be accurate and specific, legally it is not a guarantee of accuracy...In essence, the cause of death as stated is the best opinion of the certifier.”

Professional liability should not be a concern when completing death certificates. Remember, the death certificate is a legal rather than a scientific document. The physician is not required to establish a specific anatomical reason for the death. A description of the general disease process or the condition most likely responsible for the death is acceptable.

Currently, the funeral director and physician must work with a paper death certificate form. However, OSDH has begun a conversion to an electronic death registration (EDR) process called ROVER (Registering Oklahoma Vital Event Records) that will allow on-line filing of the death certificate. OSDH’s ROVER in-services with Oklahoma funeral home directors will be complete this spring. OSDH will then concentrate on ROVER education for physicians and their staffs. All that is needed to implement ROVER in a physician office is broadband internet connection, Adobe Acrobat Reader, laser printer and Internet Explorer 6.0 or later. The Board will work with OSDH to provide physicians with the education necessary to make the transition to ROVER a smooth one.

In the meantime, if you have questions or encounter difficulty in filing a death certificate, contact Diana Pine, OSDH Center for Health Statistics, 405-271-2302.
Disposal Of Controlled Substances

The U.S. Drug Enforcement Agency (DEA) regulations do not allow a registrant to accept Controlled Drug Substances (CDS) from anyone except another registrant. (Registrants include any person or entity that holds a DEA license including pharmacies and practitioners.) DEA regulations also do not allow a registrant to destroy medications in any manner except by a reverse distributor.

The DEA has a list of reverse distributor companies. Contact numbers for regional offices of the DEA are: Dallas Division Office, 1-888-336-4704; Oklahoma City District Office, 405-475-7556; Tulsa Resident Office, 918-459-9600.

Here are some facts a physician should know:

♦ If a CDS prescription has been dispensed, a DEA registrant shall never accept it back under any circumstances.

♦ A DEA registrant shall always dispose of unwanted CDS in their inventory through a Reverse Distribution Service (RDS).

♦ A CDS in a pharmacy or physician’s office that is not in the original manufacturer’s packaging, such as a prescription in a vial that was not picked up by the patient or a compounded CDS prescription medication, must be disposed of through a DEA approved RDS.

Some individual RDS company policies may prohibit them from accepting compounded medications or drugs not in original packages. Nevertheless, it is the responsibility of the pharmacy or practitioner to locate a RDS that will accept the product. If you are unable to identify a RDS, contact the DEA. Pharmacies are required by Oklahoma state law to send unwanted or expired CDS to a RDS within six months after expiration.

♦ CDS prescriptions brought into a hospital by a patient must be returned to that patient or that patient’s family. The hospital may not dispose of the CDS prescription.

(Please note that law enforcement must be contacted in the event of attempted suicide.)

♦ CDS prescription medications dispensed to a hospice patient who dies must be left with the responsible family member upon the death of the patient. Hospice employees under federal law do not have the authority to accept or take the patient’s prescriptions from the possession of the patient or the patient’s responsible family member for any reason.

♦ CDS prescription medications dispensed to a nursing home patient must be given to the responsible family member upon the death of the patient. The nursing home may not destroy them or accept them for transfer to someone else for destruction.

♦ In hospital, hospice, assisted living or nursing home settings, physicians may encourage the patient or responsible family member to destroy the medication or take it to a law enforcement disposal box. Physicians, patients or family members may request a police officer come to the facility to accept the CDS. However, this is an optional law enforcement service.

♦ The DEA and/or the Oklahoma Bureau of Narcotics and Dangerous Drugs (OBNDD) sponsored take-back programs MAY NOT accept CDS from a registrant of DEA under any circumstances.

The DEA and/or the Oklahoma Bureau of Narcotics and Dangerous Drugs (OBNDD) sponsored take-back programs MAY NOT accept CDS from a registrant of DEA under any circumstances.
An appearance before the Board can be a life-changing experience for physicians and practitioners of the 12 other ancillary health care provider groups supervised by the Board.

While a primary responsibility of the Board is to identify, investigate, and, when necessary, discipline aberrant health care providers, an equally important part of the Board’s work is to assist and counsel practitioners so that they may return to productive practice and patient care. The training, education and experience of members of the health care community are resources too precious to waste.

The initial appearance before the Board may fill a practitioner with anxiety, trepidation, resentment and sometimes even anger. Fortunately, due to the Board’s commitment to rehabilitation and recovery, a final Board visit, more often than not, ends with thanks and gratitude.

Here’s just one story. A young practitioner (not a physician) becomes dependent on painkillers after suffering an injury. The practitioner subsequently is charged with illegal possession of controlled substances and receives a three-year deferred sentence and ordered to undergo two years of therapy. After three years the charges were expunged from the legal record but within two weeks, the practitioner had relapsed. During this time the practitioner became estranged from family and friends and experienced the drug overdose death of a beloved companion. This led to an appearance before the Board that resulted in an indefinite license suspension, mandated treatment, probation and a contract with the Oklahoma Health Professionals Program.

According to Board Compliance Officer Gary Ricks, the practitioner recognized from the very beginning that life, health and career depended on accepting the mandates of the recovery process which include treatment and then monthly activity reports, random drug tests and documented participation in 12-step program meetings. After a year of compliance, the Board reinstated the practitioner’s license with four years’ probation and continued monitoring.

At last, the day came for the final appearance before the Board and the end of probation. Most often the Board will congratulate and wish the practitioner well. Most practitioners thank the Board and leave but this one asked to make a statement:

“Just a couple of things…me not being present on the Earth had some intervention not taken place is true. I probably would not have lasted a couple of more weeks, and that’s being very forthright and honest. I am very humbled and I’m very grateful for the opportunity. I was about to lose sixteen years of my education and career over this. I’m very grateful for the opportunity to participate in the recovery program, that it is available.

“There were things I had to do that I didn’t like but I did them anyway. There were things that were difficult to do and I did them anyway to the best of my ability. Part of that recovery is participating and helping others who are maybe in the same boat. I’ve done that and received a lot of blessings from that.

“...The question was posed to me did I think a three-year probation would be enough. I can tell you that for me and some of the things I experienced in the length of sobriety that I have, that three years would not have been enough. I’m being very forthright and honest... [after] three years I was pretty stable in sobriety and living life but the last two years have allowed me to settle into that and to rebuild a life.

“I just feel that the terms weren’t too hard to live with if I wanted to live...”

I just feel that the terms weren’t too hard to live with if I wanted to live and if I wanted to continue in my chosen career field. I get to do what I love to do. I’ve been blessed in the company I work for. I’m glad you required me to be honest with my potential employers because that allowed me freedom to be who I am and to be real in it and I appreciate that.

“I’ve been blessed in my life. My life is completely different today. It is because of, partly due to this recovery program. I am an active member of an AA group and those guys save my life every day. I just wanted to say that I appreciate the opportunity and I am willing to help in any way I can if any of you have any questions or need my input or participation further in the recovery program.”
When J. Andy Sullivan, MD, called the January 2012 meeting of the Oklahoma State Board of Medical and Supervision (Board) to order, the eight other Board members turned on their I-Pads and Board Executive Director Lyle Kelsey, Deputy Executive Director Reji Varghese, and other staff members held their breath. The reason for their apprehension was simple. This was the Board’s very first paperless meeting.

There was no cause for concern. Now three meetings later, the Board’s transition from enormously cumbersome paper “Board books” to instant access for Board members to meeting material on a slim, reusable I-Pad was accomplished without a hitch.

Until this year, preparing and disseminating the Board meeting material was a costly, time-consuming, labor intensive process that produced a “meeting book” the size of a large briefcase.

The Board’s usual meeting agenda is heavy, routinely consisting of forty or more items including regular announcements and reports; review of new licenses recently issued to physicians, physician assistants (PA) and other health care professionals under the Board’s jurisdiction; and, most importantly, the disposition of licensure and/or disciplinary cases involving current Oklahoma physicians, PAs, and a few other practitioners.

Preparing “Board books” and getting them to Board members in a timely fashion was a major logistical undertaking. All materials needed to be organized, copied, collated, placed in three-ring binders and shipped to the nine Board members, three other officials and eight Board administrative staff.

“It was not unusual for each Board book to contain a ream of paper or more,” according to Varghese. “The costs of paper, copying, shipping and staff time are very expensive. Plus, we were asking our Board members, who all have active medical practices or businesses, to lug around a heavy, bulky binder.”

When reviewing the voluminous material in the paper meeting books, Board members would have to use highlighters, sticky notes or even dog-ear pages to identify pieces of information important for their final deliberations.

Immediately following each Board meeting, agency staff would collect all the Board books, disassemble them and finally shred all case documents that had been so painstakingly prepared.

Kelsey emphasized that “in a time of doing more with less, we wanted to maximize staff time for doing other productive agency work.”

There had to be a better way.

Kelsey and Varghese found their answer by adapting some every day technology to their agency’s particular needs.

Each Board member was assigned an I-Pad and given a brief tutorial on its use. Fortunately, most physicians are familiar with the technology.

While staff collects and organizes meeting material just as before, it is now scanned one time only to a “Board meeting PDF file” which is housed on a secure server. Board members are notified by e-mail when the file is available for them to access and download. They are also alerted electronically when additional or “last minute” information needs to be downloaded from the file thereby eliminating the need for expedited overnight shipping and sometimes even personal delivery of such material.

Continued on back page
Paperless, cont.

The “UPAD” application on the I-Pad allows Board members to use the device’s stylus to make notes, highlight or bookmark pertinent information for reference during the meeting.

Rather than spend countless staff hours shredding all the confidential information in the Board books, a simple “click” by a Board member now deletes the sensitive material on each I-Pad immediately after a meeting.

The savings generated by the paperless process will more than pay for the cost of the I-pads after only a few meetings.

Reaction of Board members is positive. The manageable size of the devices allows Board members to conveniently carry the “Board books” with them wherever they go and easily review material even if they only have a spare moment.

Kelsey and Varghese have found a better way. Time and money will be saved. Staff productivity will increase. Board members can prepare for meetings more easily. And no one knows how many trees will be saved. 

CME Opportunities

For Registration Information:
www.okmedicalboard.org

Medical & Legal Aspects of Pain Management
Friday, September 21, 2012
7:45 a.m. - 4 p.m.
Tulsa Marriott Southern Hills, 1902 East 7st, Tulsa.

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