

**QUALITY ASSESSMENT OF MEDICAL
CERTIFICATION OF CAUSE OF DEATH IN
YANGON GENERAL HOSPITAL**

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ABSTRACT

Death certification is a vital source of information used in mortality statistics to assess the health of the general population. Death certificates can provide valuable health status data regarding disease incidence, prevalence and mortality in a community. It can guide local health policy and help in setting priorities. Incomplete and inaccurate death certificate data can significantly impair the precision of a national health information database. Therefore, quality of medical certification of cause of death is important. The objective is to assess the quality of death certificates documentation at Yangon General Hospital. This study used assessment tool of University of Melbourne. Absence of time interval between onset and death was 100% and overall incorrectly filled death certificate was also 100%. Underlying cause of death is not entered in last line of part I was 55.6%. Other errors were incorrect sequence of events (32.4%), additional errors (19.4%), blank line within the sequence of events (18.2%), multiple causes per line (12.5%), ill-defined condition entered as underlying cause of death (8.7%), abbreviation (2.3%) and illegible hand writing (1.7%). Regarding to error categories, there is no death certificate without error. One error was 37.4%, two errors was 24.8%, three errors was 11.3% and four and more errors was 26.5% respectively.

The perception of assistant surgeons and postgraduates in medical, surgical, orthopedic, radiation oncology and outpatient department on death certificate documentation was explored with in-depth interview. All the respondents answered that death certificate documentation was important and they told that complete death certification gave strong evidence for mortality statistics and public health problem. Regarding to facing difficulties, lack of training and lack of death certificate guidelines are main difficulties. Therefore, the result of this study pointed out to develop the death certificate documentation guidelines and to train medical professional through pre-service and in-service training to get better death certificate documentation. The frequent supervision and counterchecking of death certificate documentation was needed to improve the quality of mortality statistics.